Inspection framework: Independent single specialty providers of Diagnostic Imaging

Log of changes since last version

Section / Report sub heading	Page number	Detail of update
All	All	The whole framework has been reviewed and updated throughout to reflect the new single assessment framework for health. .
		Inclusion of interventional radiology as part of the core service framework including associated standards and prompts
Service Description	1	Added text : Services that use NON-ionising radiation such as ultrasound and MRI, **DO NOT** need to comply with IR(ME)R. However please note CT, x-ray, fluoroscopy, PET and nuclear medicine services on the other hand **DO** need to comply with IR(ME)R.
Environment and Equipment	8	Removal of reference to PAT testing and insertion of reference to HSE guidance on maintaining portable electrical equipment and MHRA guidance on medical devices
Assessing and responding to patient risk	11	Amended sector specific prompt How does the service ensure that the requesting of CT, X-ray, fluoroscopy PET and nuclear medicine services by the GP or others is only made by staff/persons in accordance with the IR(ME)R?

Section / Report sub heading	Page number	Detail of update
Responding to complaints and concerns	41	To clarify ISCAS is only applicable if the IH provider subscribes to ISCAS and prompt added to sector specific guidance - what arrangements are in place for the independent review of complaints (iscas)?
Mandatory Training	4	Core skills Training added as link to professional standards
Safeguarding	4	Links updated to the safeguarding guidance for adults and children
Equipment and Environment	8	Linked added to MHRA MRI in clinical use
Assessing and responding to risk	11	New links to standards added including protecting pregnant patients guidance on the administration of radiopharmaceuticals and use of contrast agents
Records	15	Updated link to NICE QS15 statement
Medicines	17	Reference to NMC standards in medicines management removed RCR guidance on sedation added and on administration of medicines by non-medical staff
Incidents	18	Guidance on notifications of radiation incidents added
Evidence based care and treatment	20&21	Various links added to guidance including radiopharmaceutical, professional ultrasound BMJ best practice guides
Patient outcomes	23	Link to new quality standards for imaging
Competent staff	24&25	Links to SOR guidance on ultrasound, MRI and CT
Seven day working	27	Links updated
Consent	31	Links updated and guidance added on use of ultrasound in relation baby scans, RRT link added

Section / Report sub heading	Page number	Detail of update
Understanding and involving the patient	35	Updated links to NICE QS15 statements
Service delivery to meet the needs of local people	37	Updated links to NICE QS15 statements
Culture	45	Link to guidance on WRES standards for IH providers
Governance	48	Link to HSE and new additional prompt in relation to ionising radiation and notification to appropriate notification to HSE
Managing Information	49	Link to GDPR

Single Specialty: Diagnostic Imaging

This inspection framework should be used when inspecting the following types of service:

1. Single specialty services providing solely or mainly diagnostic imaging:

This service includes all areas where people:

- undergo physiological measurements and diagnostic testing
- receive diagnostic test results.

Diagnostic imaging includes imaging services and screening procedures, such as X-rays, fluoroscopy, MRIs, PET, CT and DEXA scans, ultrasound (including baby ultrasound that is not part of a maternity service), nuclear medicine scans, interventional radiological procedures and symptomatic mammography.

Services that use NON-ionising radiation such as ultrasound and MRI, **DO NOT** need to comply with IR(ME)R. However please note CT, x-ray, fluoroscopy, PET and nuclear medicine services on the other hand **DO** need to comply with IR(ME)R.

There are separate core service frameworks for teleradiology, baby keepsake ultrasound scanning and endoscopy services.

Areas to inspect*

The inspection team should carry out an initial visual inspection of each area. Consider your observations alongside data and surveillance to identify areas of risk or concern for further inspection.

- Diagnostic procedures[1], for example ECG, ECG, echo, angiograms, exercise test, chest pain clinic
- Diagnostic facilities or radiology/theatre suites providing interventional radiological procedures
- Sample of imaging areas, e.g. plain film, CT, MRI, ultrasound, nuclear medicine
- Sample of physiological monitoring areas, e.g. respiratory clinic
- Areas where symptomatic mammography takes place (NHS breast screening should not be included, as national cancer screening programmes are excluded from regulation)

Interviews, focus groups, observations

You should conduct interviews of the following people at every inspection:

- People who use services and those close to them
- Head of clinical services
- Head of imaging services (in some cases there may be a manager for each area, that is MRI, CT, radiology)
- Radiation protection advisor[2] (RPA - this person may not be on site as some providers have contracts with third parties to provide this advice)
- Radiation protection supervisor (RPS)
- Senior radiologist (This person may not be on site at the time of the inspection)
- Medical physics expert

[1] Please note the relevant exclusions as some physiological tests not included within the definition of physiological measurement.
[2] RPA reports gathered ahead of the inspection may help to determine if you require the individual(s) for interview at inspection.

You could gather information about the service from the following people, depending on the staffing structure:
• Ultrasonographers and radiographers • Radiologists • Technicians • Nuclear medicine practitioners • DEXA technicians • Administrative staff such as reception • Nurses • Doctors • Health Care Assistants • Pharmacist especially for locally generated nuclear medicine • People who use services, their relatives and carers • Estates Manager (or person responsible for maintaining premises and registration of premises in accordance with RSA93 (if they keep and use radioactive material or carry out nuclear imaging and tests) or person responsible for water quality and electrical backup if not the estate manager
Service specific things to consider
Some services may be provided from mobile units or facilities rather than at a fixed location. In such instances you should inspect the supply, storage, use and disposal of medicines including contrast media when the unit is staffed, closed or relocating between sites. Also does the unit have appropriate backup arrangements in place in case of loss of essential services e.g. power supply?

Safe

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Key lines of enquiry: **S1**

S1. How do systems, processes and practices keep people safe and safeguarded from abuse?

Report sub-heading: **Mandatory training**

Prompts	Professional standard	Sector specific guidance
• S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.5 Do staff receive effective training in safety systems, processes and practices?	• core skills training framework	• Is there evidence that staff working with radiation have appropriate training in the regulations, radiation risks, and use of radiation?

Report sub-heading: **Safeguarding**

• S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.2 How do systems, processes and practices protect people from abuse, neglect, harassment and breaches of their dignity and respect? How are these monitored and improved?	• Safeguarding children and young people: Roles and competencies for healthcare staff (January 2019) • Adult safeguarding: Roles and competencies for healthcare staff (August 2018)	• Does the service check three points of ID and/or use the society of radiographers "pause and check"? • Are staff aware of their responsibilities surrounding female genital mutilation? • If the service treats patients under the age of 18 years are there appropriate child safeguarding arrangements?

• S1.3 How are people protected from discrimination, which might amount to abuse or cause psychological harm? This includes harassment and discrimination in relation to protected characteristics under the Equality Act. • S1.4 How is safety promoted in recruitment practice, arrangements to support staff, disciplinary procedures,band ongoing checks? (For example, Disclosure and Barring Service checks.) • S1.5 Do staff receive effective training in safety systems, processes and practices? • S1.6 Are there arrangements to safeguard adults and children from abuse and neglect that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures, including working in partnership with other agencies? • S1.7 Do staff identify adults and children at risk of, or suffering, significant harm? How do they work in partnership with other agencies to ensure they are helped, supported and protected?	• HM Government: Working Together: Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. July 2018 • The radiological investigation of suspected physical abuse in children • Female genital mutilation multi-agency practice guidelines published in 2016 • DH Female Genital Mutilation and Safeguarding: Guidance for professionals March 2016 • Guidelines for physicians on the detection of child sexual exploitation (RCP, November 2015) • CQC cross sector DBS guidance.	• Is information regarding safeguarding from abuse displayed where patients will see it? **Where children are seen or treated:** • Does the service ensure that all staff are trained to appropriate level set out in the Intercollegiate Framework and are familiar with Government guidance 'Working Together to Safeguard Children'? • Are staff able to access a named or designated professional (internal or external) for advice at all times 24 hours a day? • Is there an identifiable lead responsible for co-ordinating communication for children at risk of safeguarding issues? • Do staff have an awareness of CSE and understand the law to detect and prevent maltreatment of children? • How do staff identify and respond to possible CSE offences? Are risk assessments used/in place? • What safeguarding actions are taken to protect possible victims of CSE? Are timely referrals made? And is there individualised and effective multi-agency follow up? • Are leaflets available about CSE with support contact details? What wider safeguarding protocol/guidance is in

		place - how are safeguarding issues talked about, who manages them, are lessons learned etc.? • Is there a chaperoning policy in place for children and young people? Are staff aware of and understand this policy? • If a child/young person is identified as being on a child protection plan, what systems are in place to ensure the correct information is shared and actions put in place • Are there protocols in place for children with safeguarding concerns?

Report sub-heading: **Cleanliness, infection control and hygiene**		
• S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.8 How are standards of cleanliness and hygiene maintained? Are there reliable systems in place to prevent and protect people from a healthcare-associated infection?	• NICE QS61 Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. • NICE QS61 Statement 4: People who need a urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it is no longer needed. • NICE QS61 Statement 5: People who need a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device and its removal as soon as it is no longer needed. • Health Technical Memorandum 01-01 decontamination of surgical instruments (medical devices) used in acute care: https://www.gov.uk/government/publications/management-and-	• What precautions are taken in radiology settings when seeing people with suspected communicable diseases? E.g. TB or Flu etc • What infection control measures are in use when carrying out a consultation /performing a scan on people requiring isolation? E.g. people with infectious diarrhoea. • What are the results of local cleaning /hand hygiene audits? • Are appropriate cleaning procedures for ultrasound probes, following an intimate examination?

	decontamination-of-surgical-instruments-used-in-acute-care	
Report sub-heading: **Environment and equipment**		
• S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.9 Do the design, maintenance and use of facilities and premises keep people safe? • S1.10 Do the maintenance and use of equipment keep people safe? • S1.11 Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.)	• HSE guidance on portable electrical equipment • MHRA Managing medical devices_-April 2015.pdf • Assessing Controlled Substances Hazardous to Health Regulations 2002 • MHRA magnetic resonance imaging equipment in clinical use • https://www.gov.uk/government/publications/dental-cone-beam-computed-tomography-safe-usage • https://www.gov.uk/government/publications/hand-held-dental-x-ray-equipment-guidance-on-safe-use	• Are facilities, surgical and anaesthetic equipment including resuscitation and anaesthetic equipment available, fit for purpose and checked in line with professional guidance? • Are instruments, equipment and implants in compliance with MHRA requirements? Are there process in place for providing feedback on product failure to the appropriate regulatory authority? • Are there procedures in place for the collapse of a patient in MRI and are these practiced? • Has the imaging service done a risk assessment for all new or modified use of radiation? Do the risk assessments address occupational safety as well as considering risks to people who use services and public? • Is all relevant MRI equipment labelled in line with MHRA recommendations e.g. MR Safe, MR Conditional, MR Unsafe?

		• How does the imaging service ensure that non-ionising and ionising radiation have arrangements to control the area and restrict access? • Is there clear signage where ionising radiation exposures occurs? • How does the service ensure specialised personal protective equipment is available and used by staff and carers when needed? How do they check that the lead aprons, lead screens and syringe shielding in nuclear medicine, and PET-CT scans are not damaged? For example, are any annual checks carried out on them? • Does the provider undertake assessments and reviews of their activities under the Control of Substances Hazardous to Health Regulations 2002 (COSHH)? • Does the provider follow the guidance for environment and equipment required to generate nuclear medicines/blood labelling including planned, preventative maintenance, environmental and equipment monitoring and external audit? • Does the provider have an equipment QA programme and are they doing this

		on all x-ray equipment at the appropriate time? • Does the service monitor staff for radiation exposure? • Is there 24/7 PACS support? What are the back-up plans in event of IT failure?

Key line of enquiry: **S2**

S2. How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?

Report sub-heading: **Assessing and responding to patient risk**

Prompts	**Professional standard**	**Sector specific guidance**
• S2.5 Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? • S2.6 How do staff identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges? Are staff able to seek support from senior staff in these situations?	• Sepsis: recognition, diagnosis and early management (NICE Guideline 51) • National Safety Standards for Invasive Procedures (NatSSIPs) Version number: 1 published: 7 September 2015 • Brief guide: NatSSIPs and LocSSIPs • Standards for the communication of radiological reports and fail-safe alert • HSIB report on communicating unexpected significant findings	• Are there processes to ensure the right person gets the right radiological scan at the right time? • Does the service check three points of ID and/or use the society of radiographers "pause and check"? • Are there clear pathways and processes for staff to assess people using services in radiology departments who are clinically unwell and need hospital admission? • Are there clear pathways if these people require admission to an NHS hospital?

	• Guidance on implementing safety checklists for radiological procedures • If children are treated there should be specific paediatric protocols in place for all imaging modalities. • Notes for guidance on the clinical administration of Radiopharmaceuticals and use of sealed Radioactive Sources: Guidance on the clinical administration of Radiopharmaceuticals and use of sealed radioactive sources • Protecting pregnant patients during diagnostic medical-exposures • The impact of IR(ME)R 2017 on pregnancy checking procedures • guidance on gadolinium based contrast agent administration in adult patients • RCR endorsement of the 2016 RANZCR Iodinated Contrast Guidelines which can be viewed at: https://www.ranzcr.com/search/ranzcr-iodinated-contrast-guidelines	Are procedures in place for out of hours imaging support for acutely unwell patients? • For services that treat children, what additional wider arrangements are there in place to manage a deteriorating child? • How does the imaging service ensure that the radiation protection advisor (RPA) and the medical physics expert (MPE) are easily accessible for providing radiation advice? • Has the service appointed radiation protection supervisors in each clinical area? (please note the RPS may cover more than one clinical area especially if it's a small department) • How does the service ensure that the requesting of CT, X-ray, fluoroscopy PET and nuclear medicine services by the GP or others is only made by staff/persons in accordance with the IR(ME)R? • Are there signs or information in the radiation department waiting area informing people about areas or rooms where radiation exposure takes place? • Are there signs or information in the radiation waiting area informing people about areas or rooms where radiation

	• https://www.sor.org/sites/default/files/document-versions/safety_in_magnetic_resonance_imaging_3.pdf • The potential risks of intravascular administration of contrast must be weighed against the potential benefits. Systems need to be in place including trained individuals that are able to recognise and treat severe contrast reactions, including anaphylaxis. This could be a registered nurse or radiographer or other appropriately trained healthcare professional. • Do they use SCoR Pause and Check, or a similar version adapted by the organisation? • Guide to IRMER	exposure takes place? • How does the imaging service ensure that women (including patients and staff) who are or may be pregnant always inform a member of staff before they are exposed to any radiation in accordance with IR(ME)R? • What are the local policies for the risk assessment and prevention of contrast-induced nephropathy? Are they in keeping with NICE Acute kidney injury guidelines and the Royal College of Radiologists standards for intravascular contrast agent administration? • What are the local policies to document, investigate, making a referral to a specialist drug allergy service and advising the patient in cases where significant suspected contrast reactions are suspected? • Are there clear processes to escalate unexpected or significant findings both at the examination and upon reporting? • Are there local rules (IRR) and employers procedures (IR(ME)R) which protect staff and patients from ionising radiation?

		• Does the imaging service ensure the WHO Surgical Safety Checklist for radiological interventions is effectively used when carrying out interventional radiology with the expectation that it can be adapted to fit local practice? • Is there information about emergency transfers (if you perforate an artery that is a SERIOUS emergency) or internal arrangements in place?

Report sub-heading: **Radiographers and Nurse (where appropriate) Staffing**		
• S2.1 How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times and staff do not work excessive hours? • S2.2 How do actual staffing levels and skill mix compare with the planned levels? Is cover provided for staff absence? • S2.3 Do arrangements for using bank, agency and locum staff keep people safe at all times? • S2.4 How do arrangements for handovers and shift changes ensure that people are safe? • S2.7 How is the impact on safety assessed and monitored when carrying out changes to the service or the staff?		• How are staffing requirements assessed or calculated? • Do they use agency? What are the local induction policies? • Does the provider carry out risk assessments to minimise risks associated with lone working? • For services that treat children, do they have access to a registered children's nurse that can provide advice at all times? The registered nurse does not have to be on site, however they must be reachable for advice at all times for example by telephone.
Report sub-heading: **Medical staffing**		
• S2.1 How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times and staff do not work excessive hours? • S2.2 How do actual staffing levels and skill mix compare with the planned levels? Is cover provided for staff absence? • S2.3 Do arrangements for using bank, agency and locum staff keep people safe at all times?	• Where intravascular contrast administration is carried out, systems need to be in place including trained individuals that are able to recognise and treat severe contrast reactions, including anaphylaxis. This could be a registered nurse or radiographer or other appropriately trained healthcare professional. intravascular-contrast-administration-adult-patients-third-edition	• Can the radiographers contact a radiologist for advice as the radiologist may not always be onsite? • How are medical staffing requirements ascertained? • Do they use agency? What are the local induction policies?

• S2.4 How do arrangements for handovers and shift changes ensure that people are safe? • S2.7 How is the impact on safety assessed and monitored when carrying out changes to the service or the staff?		• Does the provider carry out risk assessments to minimise risks associated with lone working?

Key line of enquiry: **S3**

S3. Do staff have all the information they need to deliver safe care and treatment to people?

Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Records**		
• S3.1 Are people's individual care records, including clinical data, written and managed in a way that keeps people safe? • S3.2 Is all the information needed to deliver safe care and treatment available to relevant staff in a timely and accessible way? (This may include test and imaging results, care and risk assessments, care plans and case notes.) • S3.3 When people move between teams, services and organisations (which may include at referral, discharge, transfer and transition), is all the information needed for their ongoing care shared appropriately, in a timely way and in line with relevant protocols? • S3.4 How well do the systems that manage information about people who use services support staff, carers and partner agencies to	• Records management code of practice for health and social care • https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-3-Information-exchange • Standards for the provision of teleradiology	• Does the service provide electronic access to diagnostic results? • Are the Radiology Information System and Picture Archiving and Communication System secure and password protected? • Is there a system in place to ensure that medical records generated by staff holding practising privileges are available to staff (or other providers) who may be required to provide care or treatment to the patient? • How does the provider communicate with GPs? How long does it take? Is this measured or monitored by the provider? This includes offsite reporting (e.g. where scans are taken then reported overseas).

deliver safe care and treatment? (This includes coordination between different electronic and paper-based systems and appropriate access for staff to records.)		• Is there a system for ensuring medical records availability?
		  - Is this audited?
		  - What has been done to increase compliance?
		  - Can risk be mitigated - i.e. are records available electronically?
		• What happens if records or scan pictures are not available - are procedures or investigations cancelled or people using services seen without records?
		• Where used, does the use of teleradiology follow RCR guidelines?

Key line of enquiry: S4		
S4. How does the provider ensure the proper and safe use of medicines, where the service is responsible?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Medicines**		
• S4.1 How are medicines and medicines-related stationery managed (that is, ordered, transported, stored and disposed of safely and securely)? (This includes medical gases and emergency medicines and equipment.) • S4.2 Are medicines appropriately prescribed, administered and/or supplied to people in line with the relevant legislation, current national guidance or best available evidence?	• NICE QS121 Statement 4: People in hospital who are prescribed an antimicrobial have a microbiological sample taken and their treatment reviewed when the results are available. • Start Smart then Focus: Antimicrobial Stewardship Toolkit	• If the service provides nuclear medicine examination does the provider hold a valid ARSAC license (or previous certificate in date)? Does the IR(ME)R practitioner hold a separate license within date?

• S4.3 Do people receive specific advice about their medicines in line with current national guidance or evidence? • S4.4 How does the service make sure that people receive their medicines as intended, and is this recorded appropriately? • S4.5 Are people's medicines reconciled in line with current national guidance on transfer between locations or changes in levels of care? • S4.6 Are people receiving appropriate therapeutic drug and physical health monitoring with appropriate follow-up in accordance with current national guidance or evidence? • S4.7 Are people's medicines regularly reviewed including the use of 'when required' medicines? • S4.8 How does the service make sure that people's behaviour is not controlled by excessive or inappropriate use of medicines?	• Royal college of radiologist adopted standard for contrast administration https://www.ranzcr.com/search/ranzcr-iodinated-contrast-guidelines • RCR guidance on sedation, analgesia and anaesthesia in the radiology department • https://www.gov.uk/government/publications/arsac-notes-for-guidance • Products administered with radiopharmaceuticals can be done by a non-healthcare profession: • Guidance for the administration of medicinal products by non-medical personnel	• In circumstances where patients may receive medicines or intravenous contrast medium, are allergies clearly documented in the patient record and prescribing document? Is there access to emergency medicines? • If radiographers are giving patients contrast agents or any other drugs, are they prescribed by an appropriate person, via an appropriate patient group direction or other appropriate processes within the medicines legislation? • Are contrast media and other drugs stored correctly? • Are Patient Group Directions in place, or are drugs prescribed by doctors? • What processes are there to ensure that the right radiopharmaceutical is injected? • Do radiologists who hold appropriate certificates for administration of radioactive medicinal products and if delegation of injecting is happening is this clearly documented? • How is the use of medicines such as furosemide risk assessed and documented so it can be administered by staff?

Key line of enquiry: **S5 & S6**

S5. What is the track record on safety?

S6. Are lessons learned and improvement made when things go wrong?

Prompts	Professional standard	Sector specific guidance
Report sub-heading: **Incidents**		
• S5.1 What is the safety performance over time? • S5.2 How does safety performance compare with other similar services? • S5.3 How well safety is monitored using information from a range of sources (including performance against safety goals where appropriate)? • S6.1 Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate? • S6.2 What are the arrangements for reviewing and investigating safety and safeguarding incidents and events when things go wrong? Are all relevant staff, services, partner organisations and people who use services involved in reviews and investigations	• A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined. • Never Events Policy and Revised Framework 2018 • Never Events List 2018 • Serious Incidents (SIs) should be investigated using the Serious Incident Framework 2015. • (NICE QS66 Statement 4): For adults who receive intravenous (IV) fluid therapy in hospital, clear incidents of	• In case of a service using radiation or radioactive substances are there effective arrangements in case of a radiation or radioactive incident occurring such as radioactive spillage while carrying out a PET-CT scan or another form of nuclear medicine imaging? • Is there evidence of adherence to duty of candour regulations, including a process for and evidence of written apologies? • How does the imaging service ensure that radiation incidents are fed into risk management and for accidental and unintended exposures, notified to us under IR(ME)R or to HSE under IRR requirements? • How is learning from clinical incidents disseminated?

• S6.3 How are lessons learned, and themes identified and is action taken as a result of investigations when things go wrong? • S6.4 How well is the learning from lessons shared to make sure that action is taken to improve safety? Do staff participate in and learn from reviews and investigations by other services and organisations? • S6.5 How effective are the arrangements to respond to relevant external safety alerts, recalls, inquiries, investigations or reviews?	fluid mismanagement are reported as critical incidents. • Duty of Candour: As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. • Notifications of radiation incidents (IRR) • IR(ME)R notifications • http://www.hse.gov.uk/radiation/ionising/exposure.htm	• How many incidents have occurred in the imaging department in the last year? What processes have been put in place as a result?

Effective

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Key line of enquiry: **E1**

E1. Are people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Prompts	Professional standard	Sector specific guidance
Report sub-heading: **Evidence-based care and treatment**		

• E1.1 Are people's physical, mental health and social needs holistically assessed, and is their care, treatment and support delivered in line with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes?
• E1.2 What processes are in place to ensure there is no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions?
• E1.3 How is technology and equipment used to enhance the delivery of effective care and treatment and to support people's independence?
	• NICE QS15 patient experience in adult NHS services
	• NICE CG68 Stroke and transient ischaemic attack in over 16s: diagnosis and initial management
	• NICE CG75 Metastatic spinal cord compression in adults
	• Evidence-based indications for the use of PET-CT in the United Kingdom 2016.
	• Standards of practice and guidance for trauma radiology in severely injured patients.
	• NICE pathways for cancer
		• How does the imaging service ensure the adoption and use of diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure?
		  ○ Are the levels used audited?
		  ○ If the service provides imaging for children, what processes are in place to ensure the correct dosage is given?
		• How does the service ensure it identified and implements relevant best practice and guidance, such as NICE guidance?
		• Do they audit their practice locally against the guidelines?

• E1.4 Are the rights of people subject to the Mental Health Act 1983 (MHA) protected and do staff have regard to the MHA Code of Practice? • E1.7 Are people told when they need to seek further help and advised what to do if their condition deteriorates?	• In relation to diagnostic procedures involving nuclear medicines the practitioner should note the diagnostic reference level for each adult investigation. It is important that the activity for each exposure is the optimised so it is the lowest practicable dose to the patient. - https://www.gov.uk/government/publications/diagnostic-radiology-national-diagnostic-reference-levels-ndrls/national-diagnostic-reference-levels-ndrls - https://www.rcr.ac.uk/publication/standards-angiography-and-image-guided-endovascular-interventions - Notes for Guidance on the Clinical Administration of Radiopharmaceuticals and use of sealed Radioactive sources (ARSAC January 2016): - https://www.gov.uk/government/publications/arsac-notes-for-guidance - • Guidelines for Professional Ultrasound Practice https://www.sor.org/sites/default/files/document-versions/2018.1.5_scor_bmus_guidelines_final.pdf • BMJ best Practice Guides	• How does the service ensure that NICE guidelines for acting on an image report/radiologist report are followed? • In assessing whether NICE guidance is followed, take the following into account: o Details of the provider's clinical audits programme to support and monitor implementation of NICE guidance o Participation in national benchmarking clinical audits • If the imaging service offers individual health assessment (medical procedure on an individual with no symptoms which is not part of a national screening programmes) involving CT imaging how do they ensure exposure is carried out in accordance with the Department of Health Guidance published in June 2014?

Report sub-heading: **Nutrition and hydration**		
• E1.5 How are people's nutrition and hydration needs (including those related to culture and religion) identified, monitored and met? Where relevant, what access is there to dietary and nutritional specialists to assist in this?		• What arrangements are there in terms of food and drink for patients who are there for any length of time? • Are there processes for vulnerable patients e.g. diabetic, frail that require pre-examination fasting or drinking before treatment?
Report sub-heading: **Pain relief**		
• E1.6 How is a person's pain assessed and managed, particularly for those people where there are difficulties in communicating?	• Core Standards for Pain Management Services in the UK	• How has the service implemented the Faculty of Pain Medicine's *Core Standards for Pain Management* (2015)? • Do staff use an appropriate tool to help assess the level of pain in patients who are non-verbal? For example, DisDAT (Disability Distress Assessment Tool) helps to identify the source of distress, e.g. pain, in people with severe communication difficulties. General Medical Council recommended. Abbey Pain Scale for people with dementia.

Key line of enquiry: **E2**		
E2. How are people's care and treatment outcomes monitored and how do they compare with other similar services?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub heading: **Patient outcomes**		
• E2.1 Is information about the outcomes of people's care and treatment (both physical and mental where appropriate) routinely collected and monitored? • E2.2 Does this information show that the intended outcomes for people are being achieved? • E2.3 How do outcomes for people in this service compare with other similar services and how have they changed over time? • E2.4 Is there participation in relevant quality improvement initiatives, such as local and national clinical audits, benchmarking, (approved) accreditation schemes, peer review, research, trials and other quality improvement initiatives? Are all relevant staff involved in activities to monitor and use information to improve outcomes?	• https://www.rcr.ac.uk/clinical-radiology/service-delivery/quality-standard-imaging-qsi • Standards for Learning from Discrepancies meetings • https://www.rcr.ac.uk/publication/lifelong-learning-and-building-teams-using-peer-feedback	• Does the provider participate in the Quality Standards for Imaging (? If so what departments are accredited and what level of accreditation does it hold? • Is the service regularly reviewing the effectiveness of care and treatment through local audit and national audit? • What evidence is there that the service has changed in response to their audits? • Do they have regular audit meetings to learn/ feedback? • Does the service undertake regular discrepancy meetings as per RCR guidance?

Key line of enquiry: **E3**		
E3. How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub heading: **Competent staff**		
• E3.1 Do people have their assessed needs, preferences and choices met by staff with the right skills and knowledge? • E3.2 How are the learning needs of all staff identified? Do staff have appropriate training to meet their learning needs to cover the scope of their work and is there protected time for this training? • E3.3 Are staff encouraged and given opportunities to develop? • E3.4 What are the arrangements for supporting and managing staff to deliver effective care and treatment? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.) • E3.5 How is poor or variable staff performance identified and managed? How are staff supported to improve? • E3.7 Are volunteers recruited where required, and are they trained and supported for the role they undertake?	• NICE NG11 - Challenging behaviour and learning disabilities prevention and interventions for people with learning disabilities whose behaviour challenges • NICE QS121 Statement 5: Individuals and teams responsible for antimicrobial stewardship monitor data and provide feedback on prescribing practice at prescriber, team, organisation and commissioner level. • Start Smart then Focus: Antimicrobial Stewardship Toolkit • Guidance for employers sharing information about healthcare workers where a risk to public or patient safety has been identified • https://www.rcr.ac.uk/publication/standards-interpretation-and-reporting-imaging-investigations-second-edition	• Are staff who administer radiation appropriately trained? • Are staff who are not formally trained in radiation administration, adequately supervised in accordance with legislation set out under IR(ME)R? • Are equipment training records available for any staff who operate imaging equipment, including, radiologists, surgeons, cardiologists as appropriate? • Are trainees adequately supervised in accordance with IR(ME)R? • Are sub-speciality clinics run by clinicians with the required training in the field? • If appropriate, does the imaging service have referral guidance and/or training on the electronic requesting system, as part of the induction for doctors and other referrers? • What induction and training do bank/agency staff receive?

	• https://www.sor.org/sites/default/files/document-versions/ultrasound_training_1_0.pdf • https://www.sor.org/sites/default/files/document-versions/final_safety_in_magnetic_resonance_imaging_2018_final_word_copy.pdf • https://www.sor.org/printpdf/book/export/html/17925 - the role of the radiographer in CT	• What are the arrangements for granting and reviewing practising privileges? • How does the service ensure that consultants working under practising privileges arrangements only carry out treatments, procedures or reporting that they are skilled, competent and experienced to perform? (e.g. do they perform similar work in their NHS practice?) • Are there arrangements to make sure that local healthcare providers are informed in cases where a staff member is suspended from duty? • Are there clear records showing who is entitled to administer radioactive medicinal products (RMP) together with who has the necessary license from 'The Administration of Radioactive Substances Advisory Committee' (ARSAC). • For services that treat children do staff have the appropriate skills to recognise and treat a deteriorating child? For example, allergic reaction to contrasting medium or vaccine? • In accordance with the Health and Care Professional Council (random) sampling

		of professions on its register, every two years. What support is given to radiographers to encourage or create opportunities for them to develop?

Key line of enquiry: **E4**		
E4. How well do staff, teams and services within and across organisations work together to deliver effective care and treatment?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Multidisciplinary working**		
• E4.1 Are all necessary staff, including those in different teams, services and organisations, involved in assessing, planning and delivering care and treatment? • E4.2 How is care delivered and reviewed in a coordinated way when different teams, services or organisations are involved? • E4.3 How are people assured that they will receive consistent coordinated, person-centred care and support when they use, or move between different services? • E4.4 Are all relevant teams, services and organisations informed when people are discharged from a service? Where relevant, is discharge undertaken at an appropriate time of day and only done when any necessary ongoing care is in place?	• PHSO: A report of investigations into unsafe discharge from hospital • RCR standards for MDMs https://www.rcr.ac.uk/publication/cancer-multidisciplinary-team-meetings-%E2%80%93-standards-clinical-radiologists	• Do Radiologists attend MDMs - multi-disciplinary meetings? • Does the service provide one-stop screening services involving different disciplines of staff working together? • Does the service support extended roles for radiographers and other healthcare professionals, such as reporting, and line insertions? Are these activities supported by radiologists? • As part of the justification process to carry out exposure to radiation, how does the imaging service attempt to make use of previous images of the same persons requiring the test, even if these have been taken elsewhere?
Report sub-heading: **Seven-day services**		
• E4.5 How are high-quality services made available that support care to be delivered seven days a week and how is their effect on improving patient outcomes monitored?	• Standards for providing a seven-day acute care diagnostic radiology service	• What arrangements are there for urgent MRI scans?

	• https://www.rcr.ac.uk/publication/standards-providing-24-hour-interventional-radiology-service-second-edition • https://www.england.nhs.uk/publication/seven-day-services-clinical-standards/	• Does the service offer open access for CT and MRI scans from GPs? • Is there a walk in service available for plain film imaging?

Key line of enquiry: **E5**

E5. How are people supported to live healthier lives and where the service is responsible, how does it improve the health of its population?

Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Health promotion**		

• E5.1 Are people identified who may need extra support? This includes:
  • people in the last 12 months of their lives
  • people at risk of developing a long-term condition
  • carers
• E5.2 How are people involved in regularly monitoring their health, including health assessments and checks, where appropriate and necessary		

• E5.3 Are people who use services empowered and supported to manage their own health, care and wellbeing and to maximise their independence? • E5.4 Where abnormalities or risk factors are identified that may require additional support or intervention, are changes to people's care or treatment discussed and followed up between staff, people and their carers where necessary? • E5.5 How are national priorities to improve the population's health supported? (For example, smoking cessation, obesity, drug and alcohol dependency, dementia and cancer.)		
Key line of enquiry: E6		
E6. Is consent to care and treatment always sought in line with legislation and guidance?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Consent, Mental Capacity Act and DOLs**		
• E6.1 Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004 and other relevant national standards and guidance? • E6.2 How are people supported to make decisions in line with relevant legislation and guidance?	• Consent: patients and doctors making decisions together (GMC) • Consent - The basics (Medical Protection) • Department of Health reference guide to consent for examination or treatment • BMA Consent Toolkit	• Are interventional procedures consented for appropriately? • How does the service ensure that people using the service who do not have symptoms indicating that imaging is required (i.e. people who choose to undergo well person screening tests) are informed of risks associated with such tests?

• E6.3 How and when is possible lack of mental capacity to make a particular decision assessed and recorded? • E6.4 How is the process for seeking consent monitored and reviewed to ensure it meets legal requirements and follows relevant national guidance? • E6.5 When people lack the mental capacity to make a decision, do staff ensure that best interests decisions are made in accordance with legislation? • E6.6 How does the service promote supportive practice that avoids the need for physical restraint? Where physical restraint may be necessary, how does the service ensure that it is used in a safe, proportionate, and monitored way as part of a wider person centred support plan? • E6.7 Do staff recognise when people aged 16 and over and who lack mental capacity are being deprived of their liberty, and do they seek authorisation to do so when they consider it necessary and proportionate?	• BMA Children and young people tool kit • Gillick competence • MHA 1983 Code of Practice (including children and young people – chapter 19) • Standards for patient consent particular to radiology, second edition, 2012, • PHE: Ultrasound: what it is, how it works and impact of exposure. Section 5 of this guidance is of particular relevance to baby souvenir scans' https://www.gov.uk/government/publications/ultrasound-what-it-is-how-it-works-and-the-impact-of-exposure/ultrasound-what-it-is-how-it-works-and-impact-of-exposure • http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp) or http://www.medicalprotection.org/uk/england-factsheets/consent-basics	**For where children are seen or treated**: • Is there a consent policy specific to CYP in place? • Is there a CYP specific consent form used? • Does the policy contain information for staff on Gillick competency and other issues around consent? • How are CYP engaged (age and developmentally appropriate) in the consent process? • How are the needs of older young people and their parents addressed in the consent and information sharing process?

	• Guidance from the society of radiographers about obtaining consent https://www.sor.org/sites/default/files/document-versions/obtaining_consent_170118.pdf • https://www.sor.org/sites/default/files/document-versions/consent_guidance_09110218.pdf - guidance on mental capacity decisions in diagnostic imaging and radiotherapy • BMA / RCP guidance on clinically-assisted nutrition and hydration and adults who lack capacity to consent • Restraint Reduction Training Standards 2019 (RRN) NHS	

Caring

By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect.

Key line of enquiry: **C1, C2 & C3**

C1. How does the service ensure that people are treated with kindness, dignity, respect and compassion, and that they are given emotional support when needed?

C2. How does the service support people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible?

C3. How is people's privacy and dignity respected and promoted?

Prompts	Professional Standard	Sector specific guidance
Report sub-heading: **Compassionate care**		
• C1.1 Do staff understand and respect the personal, cultural, social and religious needs of people and how these may relate to care needs, and do they take these into account in the way they deliver services? Is this information recorded and shared with other services or providers? • C1.2 Do staff take the time to interact with people who use the service and those close to them in a respectful and considerate way? • C1.3 Do staff show an encouraging, sensitive and supportive attitude to people who use services and those close to them?	• https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-1-Empathy-dignity-and-respect • https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-2-Contacts-for-ongoing-care • Intimate examinations and the use of chaperones	• Are patients able to speak to the receptionist without being overheard? • How do staff ensure that when intimate personal care and support is being given by a member of the opposite sex, patients are offered the option on a chaperone? • How do staff ensure that chaperones are, where possible, the same gender as the patient?

• C1.4 Do staff raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes? • C3.1 How does the service and staff make sure that people's privacy and dignity needs are understood and always respected, including during physical or intimate care and examinations? • C3.2 Do staff respond in a compassionate, timely and appropriate way when people experience physical pain, discomfort or emotional distress?		
Report sub-heading**: Emotional support**		
• C1.5 Do staff understand the impact that a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially? • C1.6 Are people given appropriate and timely support and information to cope emotionally with their care, treatment or condition? Are they advised how to find other support services? • C2.7 What emotional support and information is provided to those close to people who use services, including carers, family and dependants?		• Do staff provide people who use services with information leaflets / written information to explain their condition and treatment plan? • Are treatment options discussed with people and are they encouraged to be part of the decision making process? • Are patients provided with information and advice upon discharge? For example, do patients know who to contact if they have a concern or issue once they are discharged?

		• If a patient becomes distressed in an open environment, how do staff assist them to maintain their privacy and dignity?
Report sub-heading: **Understanding and involvement of patients and those close to them**		
• C2.1 Do staff communicate with people so that they understand their care, treatment and condition and any advice given? • C2.2 Do staff seek accessible ways to communicate with people when their protected equality or other characteristics make this necessary? • C2.3 How do staff make sure that people who use services and those close to them are able to find further information, including community and advocacy services, or ask questions about their care and treatment? How are they supported to access these? • C2.4 Are people empowered and supported, where necessary, to use and link with support networks and advocacy, so that it will have a positive impact on their health, care and wellbeing? • C2.5 Do staff routinely involve people who use services and those close to them (including carers and dependants) in planning and making shared decisions about their care and treatment? Do people feel listened to, respected and have their views considered?	• https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-5-Preferences-for-sharing-information • https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-6-Decision-making • GMC Guidance and resources for people with communication difficulties	• Following their appointment, do patients understand how and when they will receive test results / next appointment date? • Do patients describe receiving copies of letters sent between the provider and their GP? • Do patients describe knowing who to contact if they were worried about their condition or treatment after they have had their appointment, or when they get home? • Is information regarding safeguarding from abuse displayed where patients will see it? • Are patients informed in advance if there is a planned change of consultant?

• C2.6 Are people's carers, advocates and representatives including family members and friends, identified, welcomed, and treated as important partners in the delivery of their care? • C3.3 How are people assured that information about them is treated confidentially in a way that complies with the Data Protection Act and that staff support people to make and review choices about sharing their information?		• In cases where the patient will be responsible for full or partial cost of care or treatment, are there appropriate and sensitive discussions about cost? **Where children are seen or treated:** • Do staff communicate appropriately with children and young people and their relatives? • Is information and support provided in a child friendly format to help CYP make decisions about or agree to care and treatment (including consent/assessment). • Can older children talk to a clinician without a parent present?

Responsive

By responsive, we mean that services meet people's needs

Key line of enquiry: **R1 & R2**

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

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

Prompts	Professional standard	Sector specific guidance
Report sub-heading: **Service delivery to meet the needs of local people**		
• R1.1 Do the services provided reflect the needs of the population served and do they ensure flexibility, choice and continuity of care? • R1.2 Where people's needs and choices are not being met, is this identified and used to inform how services are improved and developed? • R1.3 Are the facilities and premises appropriate for the services that are delivered?	• Butterfly scheme (other schemes exist) • Change can disorientate people with these conditions, and sometimes triggers behaviour that challenges, for example: diagnosis and management of adults on NICE CG142 Autism: recognition, referral, the autism spectrum.	• Is the environment appropriate and patient centred (comfortable / sufficient seating, toilets and magazines, drinks machine, separate play area for children in an adult clinic)? • Is information provided to patients in accessible formats before appointments, e.g. contact details, map and directions, consultant name, information about any tests / samples / fasting required? • Are there out of hours services - evening and weekends?

		• Is there any use of telemedicine / skype/ telephone appointments as alternative to face to face appointments? **Where children are seen or treated:** • What steps have been taken to ensure areas where CYPs are treated are safe and suitable for the age group? • If CYP are seen in predominantly adult based areas - how are the needs CYP and parents met whilst in these areas e.g. is there a separate waiting area, is there a play area etc.? - Are waiting times kept to a minimum for CYP? • What reasonable adjustments are made for a child that might struggle with the hospital environment?

Report sub-heading: **Meeting people's individual needs**		
• R1.4 How does the service identify and meet the information and communication needs of people with a disability or sensory loss. How does it record, highlight and share this information with others when required, and gain people's consent to do so? • R2.1 How are services delivered, made accessible and coordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances? • R2.2 How are services delivered and co-ordinated to be accessible and responsive to people with complex needs?[3] • R2.3 How are people, supported during referral, transfer between services and discharge? • R2.4 Are reasonable adjustments made so that people with a disability can access and use services on an equal basis to others? • R2.5 Do key staff work across services to coordinate people's involvement with families and carers,	• https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-4-Individualised-care • Accessible Information Standard • NICE NG27 Transition between inpatient hospital settings and community or care home settings for adults with social care needs. Of particular relevance to Looked After Children and Young People – see NICE QS31	• How does the service ensure that appointments for new patients allow time to ask questions and have follow-up tests? • Does the service make sure translation services are readily available if required?

[3]. For example, people living with dementia or people with a learning disability or autism.

particularly for those with multiple long-term conditions?		

Key line of enquiry: **R3**

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

Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Access and flow**		
• R3.1 Do people have timely access to initial assessment, test results, diagnosis, or treatment? • R3.2 Can people access care and treatment at a time to suit them? • R3.3 What action is taken to minimise the length of time people have to wait for care, treatment, or advice? • R3.4 Do people with the most urgent needs have their care and treatment prioritised? • R3.5 Are appointment systems easy to use and do they support people to access appointments? • R3.6 Are appointments care and treatment only cancelled or delayed when absolutely necessary? Are delays or cancellations explained to people, and are people	• Diagnostic Waiting Times & Activity FAQs • NHS England Cancer Waiting Times standards: • https://www.england.nhs.uk/wp-content/uploads/2018/04/implementing-timed-colorectal-cancer-diagnostic-pathway.pdf • https://www.england.nhs.uk/wp-content/uploads/2018/04/implementing-timed-lung-cancer-diagnostic-pathway.pdf	• How does the provider manage inpatient diagnostic demand, particularly when bed pressures are at their highest? • How does the provider manage urgent cancer appointments? • How does the service ensure that it meets local KPIs for report turnaround time for medical staff requesting diagnostic imaging to be carried out? • Are patients offered a choice of appointments? • Are same day / next day appointments available if needed? (so called 'hot' clinics) • How long are people kept waiting once

supported to access care and treatment again as soon as possible? • R3.7 Do services run on time, and are people kept informed about any disruption? • R3.8 How is technology used to support timely access to care and treatment? Is the technology (including telephone systems and online/digital services) easy to use?		they arrive in the unit? • What is the waiting times for reports? Are reports prioritised based on clinical information and urgency? • What is the waiting times for appointments? • Is the waiting time for appointments / at appointments communicated? • How does the service manage DNA rates?

Key line of enquiry: **R4**

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

Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Learning from complaints and concerns**		
• R4.1 How well do people who use the service know how to make a complaint or raise concerns and how comfortable do they feel doing so in their own way? How are people encouraged to make a complaint, and how confident are they to speak up? • R4.2 How easy is it for people to use the system to make a complaint or raise concerns? Are people treated compassionately and given the help and support, through use of accessible	• The NHS constitution gives people the right to ➢ Have complaints dealt with efficiently and be investigated. ➢ Know the outcome of the investigation. ➢ Take their complaint to an independent Parliamentary and Health Service Ombudsman.	**Where children are seen or treated:** • Is there a child friendly complaints process appropriate for CYP of different age ranges to easily access and use? • Is there a child-friendly format inpatient patient satisfaction survey/ friends and family test, suggestion boxes etc.

information or protection measures if they need to make a complaint? • R4.3 How effectively are complaints handled, including to ensure openness and transparency, confidentially, regular updates for the complainant, a timely response and explanation of the outcome, and a formal record? • R4.4 How are people who raise concerns or complaints protected from discrimination, harassment or disadvantage? • R4.5 To what extent are concerns and complaints used as an opportunity to learn and drive improvement?	➢ Receive compensation if they have been harmed. • The Independent Sector Complaints Adjudication Service (ISCAS) is the patient complaints **adjudication** service for independent healthcare, only applicable though if the provider subscribes to ISCAS (please note that you may need to open this link in a non-IE browser)	• Where the internal complaints process has been exhausted, what arrangements are in place for the independent review of complaints where the patient is receiving non-NHS funded care (e.g. is the service a member of the Independent Services Complaint Advisory Services (ISCAS) of which membership is voluntary, and if not, does the provider have an alternative arrangement?). This includes NHS Private Patient Units, whose patients do not have access to the PHSO if their care is not NHS funded.

Well-led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Key line of enquiry: **W1**

W1. Is there the leadership capacity and capability to deliver high-quality, sustainable care?

Prompts	Professional standard	Sector specific guidance
Report sub-heading: **Leadership**		
• W1.1 Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis? • W1.2 Do leaders understand the challenges to quality and sustainability, and can they identify the actions needed to address them? • W1.3 Are leaders visible and approachable? • W1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?	• National Safety Standards for invasive procedures(NatSSIPs) Version number: 1 published: 7 September 2015. • Fit and Proper Persons Guidance	• How do leaders ensure employees who are involved in invasive procedures develop shared understanding, and are educated in good safety practice, as set out in the national standards? Applies to those providing NHS funded care.

Key line of enquiry: **W2**		
W2. Is there a clear vision and credible strategy to deliver high-quality sustainable care to people who use services, and robust plans to deliver?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Vision and strategy**		
• W2.1 Is there a clear vision and a set of values, with quality and sustainability as the top priorities? • W2.2 Is there a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care? • W2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners? • W2.4 Do staff know and understand what the vision, values and strategy are, and their role in achieving them? • W2.5 Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population? • W2.6 Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this?		

Key line of enquiry: **W3**		
W3. Is there a culture of high-quality, sustainable care?		
Prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Culture**		
• W3.1 Do staff feel supported, respected and valued? • W3.2 Is the culture centred on the needs and experience of people who use services? • W3.3 Do staff feel positive and proud to work in the organisation? • W3.4 Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority? • W3.5 Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised? • W3.6 Are there mechanisms for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations? • W3.7 Is there a strong emphasis on the safety and well-being of staff?	• NMC Openness and honesty when things go wrong: the professional duty of candour • NRLS - Being Open Communicating patient safety incidents with patients, their families and carers • Duty of Candour – CQC guidance • WRES in Independent health care providers	• What processes and procedures does the provider have to ensure they meet the duty of candour? For example, training, support for staff, policy and audits.

• W3.8 Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably? • W3.9 Are there cooperative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?		
Key line of enquiry: **W4**		
W4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?		
Prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Governance**		
• W4.1 Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved? • W4.2 Do all levels of governance and management function effectively and interact with each other appropriately? • W4.3 Are staff at all levels clear about their roles and do they understand what they are accountable for, and to whom?	• The Health Care and Associated Professions (Indemnity Arrangements) Order 2014	• What are the governance procedures for managing and monitoring any SLAs the provider has with third parties? • When using teleradiology companies, how does the provider ensure that the contract is appropriately managed, what are the monitoring arrangements, and how does the provider ensure the quality of the reports is maintained?

• W4.4 Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?		• If medical physics is sought through a third party provider, how does the service ensure that open contact and sufficient advice is sought? • How does the provider ensure that all staff undergo appropriate checks as required by Schedule 3 of the HSCA 2008 (Regulated Activities) Regulations 2014? • Is there regulation radiation protection committee meetings? How do these feed into the governance structure? What do the latest minutes say? • How does the service monitor reporting and appointment times? How does the service escalate and reduce any backlogs/waits? • How does the provider ensure that practitioners holding practising privileges have an appropriate level of valid professional indemnity insurance in place? • How does the provider make sure those medical practitioners involved in diagnostic imaging, inform their appraiser of this in their annual appraisal and maintain accurate information about their personal performance in line with national guidance on appraisal for doctors?

	• https://services.hse.gov.uk/bssd/	• In cases where there is a Medical Advisory Committee are roles and responsibilities set out and available? • If undertaking ionising radiation has the provider applied to notify, register or get consent from HSE as appropriate?
Key line of enquiry: **W5**		
W5. Are there clear and effective processes for managing risks, issues and performance?		
Prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Managing risks, issues and performance**		
• W5.1 Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved? • W5.2 Are there processes to manage current and future performance? Are these regularly reviewed and improved? • W5.3 Is there a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken?	• NICE QS61 Statement 2: Organisations that provide healthcare have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems. • NICE QS121 Statement 5: Individuals and teams responsible for antimicrobial stewardship monitor data and provide feedback on prescribing practice at prescriber, team, organisation and commissioner level.	• Does the service have tested back up emergency generators in case of failure of essential services? • In the case of a service using radiation or radioactive substances are there effective arrangements in place in case of a radiation or radioactive incident occurring?

• W5.4 Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'? • W5.5 Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities? • W5.6 When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?	• Electrical services – HTM 06-01 Electrical services supply and distribution: Part A – Design considerations – see section 16.70 to 16.79 for connections for mobile trailer units	

Key line of enquiry: **W6**

W6. Is appropriate and accurate information being effectively processed, challenged and acted upon?

Prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Managing information**		
• W6.1 Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance? • W6.2 Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have	• general-data-protection-regulation-gdpr • CAP: Healthcare: Overview	• Is there a system in place to ensure non-NHS-funded people using the service are provided with a statement that includes terms and conditions of the services being provided to the person and the amount and method of payment of fees? • Are arrangements for advertising or promotional events in accordance with

sufficient access to information, and do they challenge it appropriately? • W6.3 Are there clear and robust service performance measures, which are reported and monitored? • W6.4 Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified? • W6.5 Are information technology systems used effectively to monitor and improve the quality of care? • W6.6 Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required? • W6.7 Are there robust arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?		advertising legislation and professional guidance? References for further information CAP: Healthcare: Overview • Does the service provide electronic access to diagnostic results?

Key line of enquiry: **W7**

W.7 Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

Prompts	Professional Standard	Sector specific guidance
Report sub-heading: **Engagement**		
• W7.1 Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups? • W7.2 Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups? • W7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected characteristic? • W7.4 Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs? • W7.5 Is there transparency and openness with all stakeholders about performance?		• Are patient surveys in use and are the questions sufficiently open ended to allow people to express themselves? • Is there evidence of improvement from comments/complaints raised through patient surveys and the complaints process?

Key line of enquiry: **W8**		
W8. Are there robust systems and processes for learning, continuous improvement and innovation?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Learning, continuous improvement and innovation**		
• W8.1 In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes? • W8.2 Are there standardised improvement tools and methods, and do staff have the skills to use them? • W8.3 How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements? • W8.4 Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation? • W8.5 Are there systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?		