Inspection framework: NHS acute hospitals and independent health

Previously the core service frameworks for NHS and independent services were separate documents.

These have now been combined into one document. Where a particular prompt of professional standard only relates to one sector, this is indicated.

Log of changes since last version

Section / Report sub heading	Page number	Detail of update
S1 Mandatory training	9	S1 Mandatory training Added Skills for Health Core Skills Framework, which has 11 statutory / mandatory training areas and to who NHS Trusts declare their alignment. Added prompt regarding advanced airway techniques.
S1 Safeguarding	10	S1 Safeguarding Added Adult safeguarding: Roles and competencies for healthcare staff. Added NHSE Guidance on Managing Long Waiting Patients.
S1 Environment and Equipment	12	S1 Environment and Equipment Added HSE guidance on portable electrical equipment. Added MHRA guidance on managing medical devices. Added NICE CG179 relating to prevention and management of pressure ulcers.

		Added prompt about resuscitation equipment.
S2 Assessing and responding to patient risk	18	S2 Assessing and responding to patient risk Added NICE guidance CG151: Neutropenic sepsis: prevention and management in people with cancer. Added prompt about ambulance/immuno-suppressed patients. Added prompt on deteriorating patients. Added a prompt regarding MDT decision-making, and regular reviews.
S2 Nursing Staffing	16	S2 Nursing Staffing Added Health Education England – Cancer Workforce Plan guidance.
S2 Medical Staffing	17	S2 Medical Staffing Added Health Education England – Cancer Workforce Plan guidance.
S3 Records	18	S3 Records Added prompt about discharge summaries. Added prompt about GPs being informed that a person has been identified as requiring EOLC.
S4 Medicines	21	S4 Medicines Prompt on when people \re dicharged amended. Prompt on anticipatory prescribing amended. Prompt added regarding range of dose added. Prompt added on correct authorisation in place to enable administration of anticipatory medicines. Prompts added on syringe pumps. RPS - Professional guidance on the administration of medicines in healthcare settings added. NMC standards for medicine management removed. GMC - Good practice in prescribing and managing medicines and devices guidance added. NICE NG46 Controlled drugs: safe use and management guidance added.

		NICE CG76 Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence guidance added. NICE NG5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes guidance added. British National Formulary – Prescribing in palliative care guidance added. NICE QS13 Statement 4 guidance added. NICE QS61 Statement 1 removed. NICE QS121 Statement 4 removed. Start Smart then Focus: Antimicrobial Stewardship Toolkit removed. NICE CG52 Drug misuse in over 16s: opioid detoxification removed. NICE CG100 Alcohol-use disorders: diagnosis and management of physical complications removed.
E1 Evidence based care and treatment	25	E1 Evidence based care and treatment Added a question: 'Has the use of the Liverpool Care Pathway been stopped (if it was previously used?' 'RCP End of life Care Audit – Dying in Hospital' – this audit no longer exists and renamed as the 'National Audit for Care at the End of Life'. Added a prompt about decision making tools / apps being used – e.g. BMJ Best Practice decision making app. Added prompt about supporting people to and exercise choice until end of life. Prompt added about the side-effects of radiotherapy and chemotherapy. Prompt added about the Ambitions for Palliative and End of Life Care. Added NICE pathways for cancer types. Added DHSC guidance on Choice in End of Life Care.
E1 Nutrition and hydration	29	E1 Nutrition and hydration Amended prompt on appropriate nutritional support.
E2 Patient Outcomes	31	E2 Patient Outcomes Added reference to audit outliers. Added reference to BMA / RCP guidance on clinically-assisted nutrition and hydration and adults who lack capacity to consent.

		Added prompt and guidance on Gold Standards Framework Accreditation for Acute Hospitals
E3 Competent Staff	32	E3 Competent Staff Added prompt on the specific training the specialist palliative care team receive. Added prompt on whether staff in the cancer service have access to competency training or development opportunities.
E4 Multidisciplinary working	34	E4 Multidisciplinary working Added guidance on NHS England Cancer Alliance. Added guidance on Effective MDT working is in place. Added prompt on whether MDTs attended by all appropriate staff. Added prompt on whether the service working proactively and effectively with other providers in its Cancer Alliance.
E4 Seven day services	38	E4 Seven day services Added prompt about how the provider ensures appropriate 24/7 access to specialist cancer advice and services?
E5 Health Promotion	38	E5 Health Promotion Added prompt and guidance on Personalised Stratified Care.
E6 Consent, Mental Capacity Act and DOLs	39	E6 Consent, Mental Capacity Act and DOLs Added BILD RNN Training Standards 2019 as good practice.
C1, C2, C3 Compassionate care	41	C1, C2, C3 Compassionate care NICE QS15 Patient experience in adult NHS services link updated. Added prompt and guidance on the Macmillan Quality Environment Mark. Added prompt on the Cancer Patient Experience Survey.
C1, C2, C3 Emotional Support	43	C1, C2, C3 Emotional Support Added prompt on help to access further support services.

R1 & R2 Service delivery to meet the needs of local people	47	R1 & R2 Service delivery to meet the needs of local people Added NICE NG142: End of life care for adults: service delivery to meet the needs of local people. Added prompt and guidance on the Guidance for Cancer Alliances.
R1 & R2 meeting people's individual needs	48	R1 & R2 meeting people's individual needs Added prompt and guidance on Personalised Stratified Care. Added prompt on the Cancer Patient Experience Survey.
R3 Access and Flow	51	R3 Access and Flow Added prompt on How the provider manages urgent cancer appointments? Added prompt on service users being offered a choice of appointments. Added prompt on how are people who are eligible for fast tracked NHS continued care identified and assessed.
W1 Leadership	54	W1 Leadership Added prompts on local Cancer Alliance and national cancer strategy goals,
W3 Culture within the service	57	W3 Culture within the service A further question added 'What staff support mechanisms are in place'? Added prompt and guidance on Schwarz rounds.
W4 Governance	59	W4 Governance Added prompt on the Cancer Alliance.
W7 Public and Staff Engagement	66	W7 Public and Staff Engagement Added prompt on the National Cancer Patient Experience Survey.
W8 Innovation, improvement and sustainability	67	W8 Innovation, improvement and sustainability Added guidance on Cancer Alliances. Added guidance on Macmillan Quality Environment Award.

Core service: End of Life Care

End of life care involves all care for patients who are approaching the end of their life and following death. A provider may deliver care on any ward or as part of any of its services. It includes aspects of basic nursing care, specialist palliative care, bereavement support and mortuary services.

The definition of end of life includes patients who are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general frailty and co-existing conditions that mean they are expected to die within 12 months
- existing conditions that put them at risk of dying if there is a sudden acute crisis in that condition
- life-threatening acute conditions caused by sudden catastrophic events.

Where a provider reports a very small number of deaths, we may report end of life care in the most relevant core service. This will usually be medicine or surgery and is likely to only affect NHS specialist trusts and independent acute hospitals.

End of life care that relates to stillbirths is inspected under the maternity core service. End of life care that relates to terminations of pregnancy and miscarriages are inspected under the NHS gynaecology additional service and for independent providers the core service of termination of pregnancy or single specialty.

We inspect end of life care services that relate to children and young people under the core service for children and young people.

Areas to inspect*

The inspection team should carry out an initial visual inspection of each area. Your observations should be considered alongside data/surveillance to identify areas of risk or concern for further inspection

- Palliative care unit / ward / service. Including Care of the Elderly service
- Chaplain's office, chapel, multi-faith rooms and ablution areas
- Family rooms and / or other facilities associated with wards / services (these may or may not be in the immediate area, and may include overnight accommodation)
- Mortuary viewing area and bereavement office

Interviews/observations

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

- People who use services and those close to them (inspectors must consider whether it is appropriate to speak to people who use services and families who are experiencing EOLC at the time of the inspection)
- People who use services who are on wards / attending services where other people are receiving EOLC
- Clinical director/lead, including lead geriatrician
- Nursing lead for each ward/unit/area
- Directorate/divisional manager
- Board member with responsibility for oversight of EOLC
- Service improvement lead for EOLC, if there is one
- MDT leads for cancers
- MDT co-ordinators for cancers
- Provider Cancer Alliance lead/link (not applicable for independent acute providers that do not provide NHS-funded services)
- Nursing lead for cancer, if any
- Informatics staff
- Board member with responsibility for oversight of EOLC
- Service improvement lead for EOLC, if there is one

- Lead for patient involvement

You could gather information about the service from the following people, depending on the staffing structure:

- Privacy and dignity lead
- End of Life Facilitator or similar role
- Staff involved in consent for organ and tissue donation (internal staff as well as NHSBT)
- Religious representatives (Chaplain, Rabbi, etc.)
- Porters who transport bodies to the mortuary
- Specialist palliative care team
- Specialist cancer nurses, including research nurses
- Clinical Nurse Specialists in cancer
- Allied health professionals, e.g. physiotherapists, speech and
- Language therapists, dieticians, occupational therapists, phlebotomists
- Doctors of varying seniority on wards where people experiencing EOLC are nursed
- Non-specialist staff on the wards involved in caring for people at the end of their life.
- EOLC volunteers
- External providers / services that may be involved in EOLC, e.g. coroners and hospices
- Mortuary staff (note that Bereavement Officers may or may not be members of the mortuary)
- Bereavement officer / counsellor
- End of Life Facilitator or similar role
- Specialist palliative care team
- Volunteers, including EOLC and other cancer services

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?	• Refer to NICE guidance CG151: Neutropenic sepsis: prevention and management in people with cancer – "Healthcare professionals and staff who come into contact with patients having anticancer treatment should be provided with training on neutropenic sepsis. The training should be tailored according to the type of contact." • Skills for Health Core Skills Framework: 11 statutory / mandatory training areas and to which NHS Trusts declare their alignment	• Have staff have received training in the management of neutropenic sepsis? • What mandatory training do **all** staff receive in relation to EOLC? • What specific training do the specialist palliative care team receive in delivering EOLC. For example, the five priorities for end of life care? • Is there immediate access to a practitioner who is skilled with advanced airway techniques? **For NHS** • Have staff received training to make them aware of the potential needs of people with:

		• mental health conditions • learning disability • autism • dementia?
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? • 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 staff support arrangements, disciplinary procedures, and ongoing checks? (For example Disclosure and Barring Service checks). • S1.5 Do staff receive effective training in safety systems, processes and practices?	• MHA 1983 Section 5(2) the psychiatrist or approved clinician in charge of the patient's treatment for the mental disorder is the preferred person to use holding powers. • Not always restricted to, but includes interventions under the MHA, see MHA Code of Practice. • NMC Adult Safe Guarding Training Toolkit • CQC cross sector DBS guidance . • Process for potential clinical harm reviews – in NHSE Guidance on Managing Long Waiting Patients • Where an individual patient with a confirmed cancer diagnosis has waited over 104 days, there should be a clear, transparent process in place to identify if the extended delay has caused harm to the patient.	**For NHS** • If a patient is assessed to be at risk of suicide or self-harm, what arrangements are put in place to enable them to remain safe? • Are staff aware of the Mental Health Act S5(2) doctor's holding power and S5(4) nurse's holding power? Do they know when and how they can be used or do they know how to get urgent advice on this? • Are there policies and procedures in place for extra observation or supervision, restraint and, if needed, rapid tranquilisation? • What mandatory training do **all** staff receive in relation to EOLC? • What specific training do the specialist palliative care team receive in delivering EOLC. For example, the five priorities for end of life care?

• 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?	• Where there was a medical reason for the patient to wait for cancer treatment then there should be clear evidence that the patient pathway has been reviewed at regular intervals. • If either a single delay or a sequence of delays can be shown to have resulted in a serious harm event for the patient concerned, or the available evidence suggests that this may have been the case, then the Provider/s where such delays occurred should follow their policy for investigating and reporting the case as a SI. It would be good practice to undertake SI-type reviews for cases of harm not considered to be 'serious' under SI definitions. • Adult safeguarding: Roles and competencies for healthcare staff • Safeguarding children and young people: Roles and competencies for healthcare staff	
Report sub-heading: **Cleanliness, infection control and hygiene**		
• S1.1 How are safety and safeguarding systems, processes and practices	• NICE QS61 Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately	**Normally, not applicable and only include if there is a palliative care ward**:

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?	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. • Code of practice on the prevention and control of infections	• Does the service ensure that after death the health and safety of everyone that comes into contact with the deceased person's body is protected? • How are transfers to the mortuary dealt with, are staff aware of cultural/religious differences in end of life care? • Does the service ensure that after death the health and safety of everyone that comes into contact with the deceased person's body is protected?
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?	• MHRA – Managing Medical Devices: Guidance for healthcare and social services organisations • IRMER Regulations 2017, Schedule 2 should be in place: The employer's written procedures for exposures must include procedures—	Only apply to equipment and environment used specifically by the palliative care team • Are syringe pumps maintained and used in accordance with professional recommendation? • How does the service assure itself and provide evidence that it is following

• 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.)	(d) to ensure that quality assurance programmes in respect of written procedures, written protocols, and equipment are followed; (k) to ensure that the probability and magnitude of accidental or unintended exposure to individuals from radiological practices are reduced so far as reasonably practicable • HSE guidance on portable electrical equipment in the work place to prevent danger, under 'Environment and Equipment' • Pressure ulcers: prevention and management: [CG179]	appropriate guidance in relation to the service, maintenance and QA of: ➢ Equipment used for cancer diagnosis and planning, including X-ray, CT, PET-CT, MRI, ultrasound and nuclear medicine equipment ➢ Equipment used for treatment delivery including linear accelerators, orthovoltage / superficial x-ray, brachytherapy equipment (and protons if they have them) • Is there a policy for, and are staff aware of what to do, in the events of a cytotoxic spillage? • Has the service carried out a risk assessment for all new or modified use of radiation? Do the risk assessments address occupational safety as well as consideration of risks to people who use services and public? • How does the service ensure that non-ionising radiation premises have arrangements in place to control the area and restrict access? • Is resuscitation equipment readily available?

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) • NICE QS34 (Self harm) Statement 2 - initial assessments • NICE CG16 (Self harm in over 8s) • NICE guidance CG151: Neutropenic sepsis: prevention and management in people with cancer • There must be a provider-wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response.	• How does the provider ensure that if people have increased needs this is identified? I.e. mouth care, need for change to medication (especially if on syringe driver or if they need one)? • How often are people who are dying reviewed and what is taken into account? **For NHS** • Do staff have access to 24/7 mental health liaison (covering the age range of the ward/ clinic) and/or other specialist mental health support if they are concerned about risks associated with a patient's mental health? • Do staff know how to make an urgent referral to them? • Do they get a timely response?

		• Are staff provided with a debrief/ other support after involvement in aggressive or violent incidents? • Are patients at risk of and with suspected/confirmed sepsis, including neutropenic sepsis, receiving prompt assessment and treatment, including when escalated to multi-professional team? For example, Critical Outreach Team or Acute Oncology Team, including: ➢ information and support for patients and carers ➢ reducing the risk of septic complications of anticancer treatment ➢ emergency treatment and assessment ➢ further assessment ➢ starting antibiotic therapy ➢ assessing the patient's risk of septic complications ➢ duration of empiric antibiotic treatment • How does the provider ensure that the ambulance/immuno-suppressed patient is directed to the correct place, e.g. ED or ward and that the unit can see the patient

		promptly with their records, including treatment plans? • Is there a provider-wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response? • Does the radiotherapy service operate an accredited radiotherapy quality system? • Is the WHO surgical checklist for radiological interventions used? • Is there 24/7 access to IR and therapeutic endoscopy? (if not on-site then networked arrangements • Are there clear pathways and processes for the assessment of people within outpatient clinics or radiology departments who are clinically unwell and require hospital admission? • How are people who are identified as approaching the last hours and days of life identified, and MDT decision recorded, and a regular review recorded? Is there evidence of an individual end of life care plan?
Report sub-heading: **Nurse staffing**		
• S2.1 How are staffing levels and skill mix planned and reviewed so that people	• Health Education England – Cancer Workforce Plan	• If there is no palliative care ward, what specialist nurse provision is there?

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?		• Is there appropriate access to Clinical Nurse Specialist staffing or other appropriate care co-ordinator for all cancer patients? Is there a nominated lead or champion/ link worker for end of life care on each ward?NB – if wards are very busy and therefore people identified as EOL are not seen regularly by either medical or nursing staff, this should be commented on in Effective
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?	• Health Education England – Cancer Workforce Plan • There must be immediate access to a practitioner who is skilled with advanced airway techniques	• How does the provider ensure adequate consultant & non-consultant medical staffing for the care and treatment of cancer? • How does the provider ensure adequate staffing in the six other clinical professions,(i.e. in addition to CNS's) identified by Health Education England as experiencing shortages in the provision of cancer services: ○ Histopathology and health care scientists ○ Gastroenterology

• 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?		○ Clinical Radiology ○ Diagnostic Radiography ○ Medical and Clinical Oncology ○ Therapeutic Radiography NB – if wards are very busy and therefore people identified as EOL are not seen regularly by either medical or nursing staff, this should be commented on in Effective

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	• Records management code of practice for health and social care • NICE QS15 Statement 12: Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. • Discharge summaries should include: ➢ Reasons for admission ➢ Investigations done and results ➢ Changes to medication ➢ Destination on discharge ➢ Plan for follow up ➢ Plan for rehabilitation if appropriate	• Are GP's informed that a person has been identified as requiring EOLC? If so, how is this done? • Are medication changes, in particular those of older people with complex needs communicated promptly to the GP, and care home staff or domiciliary care staff if appropriate? • How is discharge communicated to GPs? How soon after discharge does this occur? • Are care summaries sent to the patient's GP on discharge to ensure continuity of care within the community?

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 deliver safe care and treatment? (This includes coordination between different electronic and paper-based systems and appropriate access for staff to records.)	➢ DNACPR status if appropriate ➢ Important information that will aid community management e.g. pressure risk, weight. • NICE QS121 Statement 3: People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record	• How does the service ensure that details of the surgery, and any implant used, are sent to the patient and the patient's GP? Do GPs have direct access? Can they speak to a medical consultant/SpR for advice on the phone? • Specifically looking at DNA CPR forms, have they been signed by an appropriately senior clinician? • Does the provider share comprehensive discharge summaries with patients' GPs, care home or domiciliary care staff, including details of any surgery, implants or medication changes to ensure effective continuity of care in the community? • Are GPs informed that a person has been identified as requiring EOLC? If so, how is this done? **For NHS** • When people are prescribed an antimicrobial do they have the clinical indication, dose and duration of treatment documented in their clinical record? • When appropriate, do records contain details of patients' ○ mental health needs ○ learning disability needs

		○ autism needs ○ dementia needs alongside their physical health needs? • Are staff confident the records will tell them if a patient has one of these underlying diagnoses? • What systems are in place to identify patients with pre-existing ○ mental health conditions ○ learning disability ○ autism diagnosis ○ dementia? • If a patient has been seen by a member of the mental health liaison team, is their mental health assessment, care plan and risk assessment accessible to staff on the ward/ clinic? • Does the staff team have advice from mental health liaison about what to do if the patient attempts to discharge themselves, refuses treatment or other contingencies? • When relevant, do staff have access to patient-specific information, such as care programme approach (CPA) care plans, positive behaviour support plans, health passports, communication aids? Do they use or refer to them?

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? • 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	• RPS - Professional guidance on the administration of medicines in healthcare settings • GMC - Good practice in prescribing and managing medicines and devices • NICE NG46 Controlled drugs: safe use and management • NICE CG76 Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence • NICE NG5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes • British National Formulary - Prescribing in palliative care • NICE QS13 Statement 4: People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met	**Do not duplicate what is reported on in other core service frameworks e.g. medical, surgical. Focus instead on:** • When people are discharged are their medicines (including anticipatory medicines) explained to them and to their carers and are they told what to do about their previous medication? • Is there appropriate anticipatory prescribing in place? Are the e indications and suitable dosages clearly written? • If a range of dose is prescribed are the incremental dose and maximum dose appropriate? • Is the correct authorisation in place to enable administration of anticipatory medicines? • Is there evidence of appropriate and clearly documented timely administration of anticipatory medicines?

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?	at any time of day or night, including access to medicines and equipment.	• Are syringe pumps prescribed and monitored correctly with the duration of infusion clearly indicated? • Do staff access appropriate resources to check the compatibilities of the medicines prescribed in a syringe pump?
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?	• A never event is a *serious*, *wholly preventable* patient safety incident that has the *potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.* ➢ Revised never events policy and framework (2015) ➢ Never events list 2015/16 ➢ Never Events List 2015/15 - FAQ • Serious Incidents (SIs) should be investigated using the Serious Incident Framework 2015.	**Only include incidents reported directly by or about EOLC and the palliative care service.** • Is there evidence in incident investigations that duty of candour has been applied?

• 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 • 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?	• (NICE QS66 Statement 4): For adults who receive intravenous (IV) fluid therapy in hospital, clear incidents of 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.	
Report sub-heading: **Safety Thermometer**		
• 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	• NICE QS3 Statement 1: All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool. • NICE QS3 Statement 4: Patients are re-assessed within 24 hours of admission for risk of VTE and bleeding.	***(Normally not applicable and only include if there is a palliative care ward and NHS specific)*** • NHS Safety Thermometer: Does the service monitor the incidence of any of the following for inpatients? Does the service take appropriate action as a result of the findings?

(including performance against safety goals where appropriate)?	• NICE QS86 Falls in older people The quality standard covers assessment after a fall and preventing further falls in older people in the community and during a hospital stay. • NICE QS90 UTI Urinary tract infection in adults The quality standard covers the management of suspected community acquired bacterial urinary tract infection in adults aged 16 and over. • Safety Thermometer	• Pressure Ulcers • Falls • Catheters and UTI • VTE *The NHS Safety Thermometer provides a **'temperature check'** on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients.* The NHS safety thermometer `system of recording` is only available to providers of NHS funded care**. Non NHS funded providers may have a similar system in place in order to monitor and measure the same types of harms.**

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	• NICE QS13 Statement: Defines clinical best practice within End of Life care for adults. • NICE NG31 Care of dying adults in last days of life The guideline covers the clinical care of adults (those over 18) who are dying during the last 2-3 days of life. • National Framework for end of life care: http://endoflifecareambitions.org.uk/ • NICE QS66 Statement 2: Adults receiving intravenous (IV) fluid therapy in hospital are cared for by healthcare professionals competent in assessing patients' fluid and electrolyte needs,	• Is EOLC managed in accordance with NICE guidelines? • Does EOLC achieve the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People? • What action has the service taken in response to the 2013 review of the Liverpool Care Pathway? • Has the use of the Liverpool Care Pathway been stopped (if it was previously used)? • What actions are they taking in relation to the implementation of the 'Ambitions for Palliative and End of Life Care: A

care and treatment and to support people's independence? • 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?	prescribing and administering IV fluids, and monitoring patient experience. • (NICE QS3 Statement 5): Patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidance. • NICE QS90 (2015) UTI in adults • NICE QS121 Statement 6: Prescribers in secondary and dental care use electronic prescribing systems that link indication with the antimicrobial prescription • Use of the Lester tool supports the recommendations in NICE CG 178 Psychosis and schizophrenia in adults: prevention and management and NICE CG 155 Psychosis and schizophrenia in children and young people: recognition and management • NICE NG10 - Violence and aggression: short-term management in mental health, health and community settings • NICE CG42 - Dementia: supporting people with dementia and their carers in health and social care • NICE CG90 - Depression in adults: recognition and management	national framework for local action 2015/2020? • Has an action plan been created in response to the service's performance in the 'National Audit for Care at the End of Life' – Dying in Hospital? • Have they audited any of the above – if so – what are the results? • What percentage of people are referred to specialist palliative care? • What percentage of people are seen by the Palliative care team within 24 hours? Is this audited? • How are the team made aware of newly admitted people with EOLC needs? Are they automatically flagged? • Do prescribers in secondary care use electronic prescribing systems which link the indication with the antimicrobial prescription? • Are best practice decision making tools encouraged and does the service monitor their use? - for example the BMJ Best Practice decision making app. • As part of the personalised, stratified pathway after treatment has finished, how does the service support people to

	• NICE CG91 - Depression in adults with a chronic physical health problem: recognition and management
	• NICE (QS13) End of life care for adults
	• BMJ Best Practice
	• NICE QS 15 Patient experience in adult NHS services: S3 Records -statement 3; C1 compassionate care - statements 1 and 2; C2 Understanding and involvement of patients and those close to them - statements 5 and 6, R1 Meeting people's individual needs - Statement 4.
	• NICE pathways for breast, lung, prostate colorectal cancer
	• NICE pathway for Managing metastatic malignant disease of unknown primary origin
	• Other NICE Guidance for:
	  ○ Breast cancer
	  ○ Lung cancer
	  ○ Prostate cancer
	  ○ Colorectal cancer
		and exercise choice until end of life (As recommended by The Choice Review 2015), stay as well as possible, including providing health education information/events/courses, potential late effects, contact information if patients have any questions or concerns, and how to access other support services and charities? How quickly are people seen, if it is decided that they require an appointment or urgent tests or treatment?
		• What steps are taken to minimise the side-effects of radiotherapy and chemotherapy? How is performance monitored and audited?
		• Is EOLC managed in accordance with national guidance and best practice, such as Ambitions for Palliative and End of Life Care: A national framework for local action 2015/2020?'
		• How are the the team made aware of newly admitted people with EOLC needs? Are they automatically flagged?
		For NHS
		• Do staff follow best practice for assessing and monitoring the physical health of people with severe mental illness? For example, do they undertake appropriate health screening for example

	• NICE QS56 Metastatic spinal cord compression in adults
	
	• NICE pathway for metastatic spinal cord compression
	
	• NICE QS13 Statement: Defines clinical best practice within End of Life care for adults.
	
	• NICE NG31 Care of dying adults in last days of life. The guideline covers the clinical care of adults (those over 18) who are dying during the last 2-3` days of life.
	
	• National Framework for Palliative and End of Life Care
	  ○ Each person is seen as an individual
	  ○ Each person gets fair access to care
	  ○ Maximising comfort and wellbeing
	  ○ Care is co-ordinated
	  ○ All staff are prepared to care
	  ○ Each community is prepared to help
	
	• Choice in End of Life Care (DHSC 2015)
	
	FOR NHS ONLY:
	
	• Assessing mental health in acute trusts – guidance for inspectors
		cardiometabolic screening and falls risk assessment?
		
		• Are relevant staff able to deal with any violence and aggression in an appropriate way?
		• Do staff handovers routinely refer to the psychological and emotional needs of patients, as well as their relatives / Do staff handovers routinely refer to the patients carers?
		
		• Do older people who may be frail or vulnerable receive (or get referred for) a comprehensive assessment of their physical, mental and social needs as a result of their contact with the service?
		
		• Are patients who are suspected to be experiencing depression referred for a mental health assessment?
		
		• Do patients have their physical and psychological needs met 24/7 (including access to medicines and equipment)? Is there evidence of the service identifying and responding to changing needs?
		
		• Are those close to the patient offered information on how to access emotional, psychological or bereavement support?

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?	• NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. • GMC guidance nutrition and hydration in End of Life Care	• Are they aware of GMC guidance for doctors in supporting nutrition and hydration in EOLC? • Are nutrition and hydration needs included in people's individual care plans? • How does the provider ensure appropriate nutritional support for patients, e.g. low fibre, light meals, etc and effective management of nausea and vomiting including ensuring that patients cultural and religious needs are being met?
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 Specifically: **Core Standards for Pain Management Services in the UK (Faculty of Pain Medicine, 2015)** *As these are new standards, the Faculty of Pain Medicine have identified the following standards as particularly relevant and an indicator as*	• How has the service implemented the Faculty of pain medicines' core standards for pain management (2015)? • Are anticipatory medications prescribed in people identified as requiring EOLC? ➢ Is this administered and prescribed appropriately? ➢ Have they audited this?

	good practice in this core service: **6.5 Standard 1** - Patients with cancer-related pain must receive a pain assessment when seen by a healthcare professional, which at a minimum establishes aetiology, intensity and the impact of any pain that they report. **6.5 Standard 2** - Access to analgesia must be available within 24 hours following a pain assessment which directs the need for analgesia. This must include access to a prescriber as well as access to a dispensed prescription. **6.5 Standard 3** - Patients and carers must receive adequate information on the use of analgesics, especially strong opioids (in accordance with NICE guidance on Opioids in Palliative Care). This must cover how to take analgesia, the likely effectiveness of this, how to monitor side effects, plans for further follow-up, and how to get help - especially out of hours • NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. • NICE CG140 Palliative Care for adults: strong Opioids for pain relief	**For NHS** • 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. GMC recommended. Abbey Pain Scale for people with dementia. • How does the service ensure that patients are given effective pain relief, including: ○ as part of specialist palliative care ensuring that patients with a terminal diagnosis who are admitted from home and have their drugs locked away are able to continue their 'regular home drug routine' for pain relief.

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?	• National Audit of Care at the End of Life (NACEL) • Gold Standards Framework Accreditation for Acute Hospitals (GSF) • Unplanned readmission rate to ICU within 48hrs of discharge, to a ward, should be minimal. • NICE guidance CG151: Neutropenic sepsis: prevention and management in people with cancer ○ E.g. door to needle time of 60 mins for administering antibiotics • Detection and management of outliers for National Clinical Audits: Implementation guide for NCAPOP providers	• Is the service working towards an independent accreditation standard, for example, have any of the wards achieved routes to success for hospitals or GSF? • What proportion of cancer patients are offered the opportunity to take part in clinical trials? • How does the provider ensure that it uses the results of its Cancer Patient Experience Survey and other cancer-related or cancer-specific patient surveys and feedback to improve quality and outcomes for people? • Is the provider working towards accreditation within the Gold Standards Framework? • For statistics audit outliers, and in line with the National Guidance on the management of audit outliers, does the service investigate why performance was

		much worse than expected, and make changes to improve care?
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?	• 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	• What EOLC training have staff had in identifying people in the last 12 months of their life in the last year? • What EOLC/ up-skilling is provided to ward staff, to ensure that peoples receive appropriate care 24/7. (i.e. specific training programme such as GSF Acute Hospitals Programme, Amber care bundle etc) • Are staff trained in Advance Care Planning? Are there regular discussions about care plans? • Is there specialist palliative care service staff providing support and training to generalist staff? • Are staff found to be too busy to see people in a timely manner?

• E3.7 Are volunteers recruited where required, and are they trained and supported for the role they undertake?		• Do individuals and teams responsible for antimicrobial stewardship monitor data and provide feedback on prescribing practice at prescriber level? • What specific training do the specialist palliative care team receive in delivering EOLC. For example, the five priorities for end of life care? • Do staff in the cancer service have access to competency training or development opportunities, including: ○ latest techniques and treatments so that patients get access to the right treatment first time ○ advanced communications training, for example in breaking bad news, ○ radiation administration, or appropriate supervision in accordance with IR(ME)R legislation ○ identifying people in their last year of life ○ EOLC upskilling for ward staff, e.g. GSF (Gold Standards Framework) Acute Hospitals Programme, Amber care bundle etc ○ Advanced Care Planning **For NHS**

		• Do staff have the skills, knowledge and experience to identify and manage issues arising from patients' • mental health conditions • learning disability • autism • dementia? • Does the psychiatric liaison or similar team have members with the skills, knowledge and experience to work with patients with • learning disabilities • autism • dementia diagnoses? • Do staff have the skills to sensitively manage any difficult behaviours that patients may display?
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,	• PHSO: A report of investigations into unsafe discharge from hospital	• Does the service use an Electronic Palliative Care Coordination System? If not, how is EOLC coordinated across areas, and with external providers and services?

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?	• Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE guideline 27) • NHS England Cancer Alliance Guidance • Effective MDT working is in place	• Does the service have a Palliative Care Multidisciplinary Team meeting? • Is there effective communication between the EOLC team and other services within the hospital; for example the medical services caring for older people? • Is there a personalised end of life care plan in use which helps staff identify and care for people at the end of their life? • Is there a clear process for the transfer of care from hospital to community services including care plans and medication? • Does the service avoid discharging older people late at night if they have complex needs and live alone? • How does the service ensure that the objectives of The Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients has been implemented? • Are all team members aware of who has overall responsibility for each individual's care?

		• Are people with complex needs receiving prompt screening by a multi-professional team, including physiotherapy, occupational therapy, nursing, pharmacy and medical staff? A clear MDT assessment should be undertaken within 14 hours and a treatment or management plan to be in place within 24 hours (London Quality Standards). • Are there weekly MDT meetings for people with complex needs? (and do social services attend?) • Are MDTs attended by all appropriate staff (including consultants, radiologists, physiotherapists, nutritionists etc) and operate in a collaborative and effective manner? Are all appropriate patients referred to and discussed by relevant MDTs in line with Guidance for Cancer Alliances? Do MDTs have sufficient time to provide effective care? • Are there clear pathways in existence for referral between specialities in the hospital? • Does the service use an Electronic Palliative Care Coordination System? If not, how is EOLC coordinated across areas, and with external providers and services?

		• Does the service have a Palliative Care Multidisciplinary Team meeting?
		
		• Is there effective communication between the EOLC team and other services within the hospital; for example the medical services caring for older people and cancer MDTs?
		
		• Is the service working proactively and effectively with other providers in its Cancer Alliance?
		
		For NHS
		
		• How is key information about older people with complex needs communicated to members of the community health team on discharge? For example, sharing of assessments, including tissue viability (pressure risk) and nutritional assessment and risk?
		  • Are there established links with
		  • mental health services
		  • learning disability
		  • autism
		  • dementia services?
		
		• Is there evidence of multi-disciplinary/ interagency working when required? If not, how do the staff ensure safe

		discharge arrangements for people with complex needs?
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?		• Is there, at minimum a 9-5pm 7/7 week, with telephone support out of hours service provided? • How does the provider ensure appropriate 24/7 access to specialist cancer advice and services?

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
	• Personalised Stratified Care	• How does the provider support people to as stay well as they can? Does the provider implement Personalised Stratified Care with patients in undertaking holistic assessments, including at end of life:
		  ○ Holistic Needs Assessment and Care Planning
		  ○ Summary Care Records
		  ○ Cancer Care Review

• 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.)		○ Health and Wellbeing Information and Support • Does it include support for people in EOL, or people recovering from cancer - probably can come out (Personalised care extends into EOLC. Renamed from Recovery Package to recognise that not everyone recovers).
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 DNA CPR decisions made appropriately and in line with national guidance? Is this audited? • When was the last audit of their DNA CPR forms conducted and what was the result? • Do they audit what time forms are signed? i.e. what proportion are signed

• 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?	• Resuscitation Council DNACPR decision making guidance • MHA Code of Practice (including children and young people - chapter 19) • BMA / RCP guidance on clinically-assisted nutrition and hydration and adults who lack capacity to consent • BILD Restraint reduction network Training Standards 2019	out of hours? (implication that decisions made by more junior members of staff) **For NHS** • Are any patients detained under the Mental Health Act? If so, are staff aware there are additional steps to consider if the patient does not consent to treatment? Do they know where to get advice on this?

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?

Generic 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	• NICE QS15 Patient experience in adult NHS services: statement 1 • The Macmillan Quality Environment Mark is a framework for assessing whether cancer care environments, including EOL services, meet the standards required by people with cancer. (Includes list of providers who have achieved award). Environments should be: ○ welcoming and accessible to all ○ respectful of people's privacy and dignity	• What do porters say about how ward staff handle bodies before they are transferred to the mortuary? • What do the mortuary staff say about the condition of bodies when they arrive in the mortuary? • Does the service ensure that care after death includes: ○ Honouring spiritual and cultural wishes of the deceased person and their family and carers whilst making sure legal obligations are met

people who use services and those close to them?
• 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?
	○ supportive to users' comfort and well-being
	○ giving choice and control to people using your service
	○ listening to the voice of the user.
		○ Preparing the body for transfer to the mortuary or funeral directors premises.
		○ Offering family and carers present the opportunity to participate in the process and supporting them to do so.
		○ Ensuring the privacy and dignity of the deceased person is maintained.
		○ Honouring people's wishes for organ and tissue donation.
		○ Returning the deceased person's possessions to the relatives in a sensitive caring manner.
		
		• Have any clinical areas within the service achieved the Macmillan Quality Environment Mark?
		
		For NHS
		• Do staff members display understanding and a non-judgemental attitude towards (or when talking about) patients who have
		  • mental health,
		  • learning disability,
		  • autism
		  • dementia diagnoses?
		
		• How do staff respond to patients who might be
		  • frightened

		• confused • phobic about medical procedures or any aspect of their care? • Is there adequate patient information and support relating to the NHS Cancer Drugs Fund? • How does the provider engage with cancer patients and their families and use the findings from its Cancer Patient Experience Survey to ensure that patients, including from all equality groups, feel well cared for and treated with dignity, respect and compassion?
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	• NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. • Bereavement Care Standards • End of life care for adults (QS13) Statement 5. People approaching the end of life are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences, and	• How are people receiving EOLC supported emotionally, especially people who do not have family, friends or carers to support them? • How do staff ensure that the needs of families and others important to a person who is dying are actively explored, respected and met as far as possible, including after the person has died? • Is there evidence of emotional support provided to people reaching the end of their lives including help to access

people who use services, including carers, family and dependants?	maximises independence and social participation for as long as possible	further support services, e.g. Maggies services, charities etc? • If a patient becomes distressed in an open environment, how do staff assist them to maintain their privacy and dignity? • Does support include sexuality, body image and daily living activities, which can be a priority for many patients, particularly for the four most common cancers? • 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 and other characteristics make this necessary to reduce or remove barriers? • C2.3 How do staff make sure that people who use services and those close to them are able to find further information,	• NICE QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills. • NICE QS15 Statement 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care. • NICE QS15 Statement 5: Patients are supported by healthcare professionals to understand relevant treatment options,	• How are patients who are likely to be in the last 12 months of life identified and what action does the service take? For example, are people who are approaching the end of life identified, offered and given the opportunity to create an advanced care plan, including EOLC wishes and any advanced directives (including organ donation)? • How do staff ensure that sensitive communication takes place between staff and the dying person, and those

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? • 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 information sharing?	including benefits, risks and potential consequences. • NICE QS15 Statement 13: Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care. • GMC Guidance and resources for people with communication difficulties	identified as important to them? • When a person is in the last days and hours of life, are the dying person and those identified as important to them, involved in decisions about treatment and care to the extent that the dying person wants? • When older people with complex needs are being discharged, do the staff involve those close to the person so that correct clothing can be brought into hospital? • Do staff have access to communication aids to help patients become partners in their care and treatment? For example, is there evidence that they use the patient's own preferred methods or are easy read materials available (and used)? • Following their outpatient appointment, do service users understand how and when they will receive test results / next appointment date?

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: • NICE CG142 Autism: recognition, referral, diagnosis and management of adults on the autism spectrum • End of life care for adults: service delivery: NICE guideline [NG142] • Following their outpatient appointment, do service users understand how and when they will	• Are there designated beds for people receiving palliative care? • How do they ensure that people receive a side room if requested? • What facilities are there for relatives? • Are there any systems or staff members in place to aid the delivery of care to patients in need of additional support? For example dementia champions or dementia symbols above bed or Learning Disability link nurses or stickers on paper records.

	receive test results / next appointment date? • Guidance for Cancer Alliances	• Are end of life care services organised and delivered in line with national guidance? • Does the provider have clear plans for delivering its commitments as part of the local Cancer Alliance's goals and priorities for meeting local people's needs, including regular monitoring and action for improvement? • Are there designated beds for people receiving palliative care? **For NHS** • Are the needs of patients with • mental health conditions • learning disability • autism • dementia routinely considered when any changes are made to the service? For example, through use of an impact assessment. • Does the EOLC MDT have the expertise to ensure that the needs of patients with mental health • learning disability • autism • dementia diagnoses are met?

		See, for example, National EoLC Programme, updated 2015
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?[1] • 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?	• NICE QS15 Statement 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions • Accessible Information Standard • Age UK (http://www.ageuk.org.uk/) operates a welcome home service in some areas and ensures houses are warm and fridges stocked with essentials for people on discharge http://www.ageuk.org.uk/suffolk/services-and-information/welcome-home-service/ • 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	• Are people's spiritual, religious, psychological and social needs taken into account and provided, rather than just religious and emotional needs? • Are staff involved in care informed of a person's Advance Care Plan and preferred place of care. Is this discussed? • What provisions are made for end of life care for disadvantaged groups e.g. Travellers, people where English is not their first language, LGBT? • Does the provider comply with Accessible Information Standard by identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability/sensory loss? • Are appropriate arrangements put into place to take account of individual needs of people being discharged who have complex health and social care needs that require special considerations, for

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

• R2.5 Do key staff work across services to coordinate people's involvement with families and carers, particularly for those with multiple long-term conditions?
• R2.8 How are services delivered and coordinated to ensure that people who may be approaching the end of their life are identified, including those with a protected equality characteristic and people whose circumstances may make them vulnerable, and that this information is shared?
• R2.9 How are people who may be approaching the end of their life supported to make informed choices about their care? Are people's decisions documented and delivered through a personalised care plan and shared with others who may need to be informed?
• R2.10 If any treatment is changed or withdrawn, what are the processes to ensure that this is managed openly and sensitively so that people have a comfortable and dignified death?
	• NHS Chaplaincy Guidelines: https://www.england.nhs.uk/ourwork/pe/chaplaincy/
	• Dementia Charter
	• Personalised Stratified Care–The package includes:
	  ○ Holistic Needs Assessment
	  ○ Personalised Care and Support Planning and Support
	  ○ End of Treatment Summaries
	  ○ Primary Care Cancer Care Review
	• Health and Wellbeing Information and Support
		example older people with complex needs?
		• Does the mortuary service have a policy to deal with deaths of those from different faiths and cultures?
		• Does the provider implement the Personalised Stratified Care (formerly known as the Macmillan Recovery Package) for every patient with cancer?
		• Is there appropriate access to Clinical Nurse Specialist staffing or other appropriate care co-ordinator for all cancer patients?
		• Are patients given a choice on how, e.g. at home or face to face, they would like to be given results or bad news? Is there adequate and suitable space for breaking bad news and supporting distressed patients, relatives and staff? Is access to the patient's **Clinical Nurse Specialists** or equivalent available at these times?
		• How does the provider ensure that it uses the results of its Cancer Patient Experience Survey and other cancer-related or cancer-specific patient surveys

		and feedback to improve quality and outcomes for people? • Do patients' relatives/close ones receive adequate support and information they can understand and is this accessible in alternative formats if required? **For NHS** • If people with • a mental health condition • learning disability • autism • dementia need extra support or supervision on the ward or in the clinic is this available? • Are appropriate discharge arrangements in place for people with complex health and social care needs? This may mean taking account of chaotic lifestyles. • When appropriate do Community Mental Health Teams (CMHTs), Community Learning Disabilities Teams (CLDTs), Child and Adolescent Mental Health Teams (CAMHS) or similar, get copied into discharge correspondence?
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 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		• What percentage of people die in their preferred place of death? • How rapid is their rapid discharge? • Is there an audit of the above points? • What provision is made for end of life care for disadvantaged groups e.g. travellers, English is not their first language, LGBT communities? • How does the provider manage urgent cancer appointments? • Are service users offered a choice of appointments? • How are people who are eligible for fast tracked NHS continued care identified and assessed? **For NHS** • Are people with urgent mental health needs seen within one hour of referral by an appropriate mental health clinician and assessed in a timely manner?

the technology (including telephone systems and online/digital services) easy to use?		

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 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?	• 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. ➢ Receive compensation if they have been harmed. For Independent providers: ➢ http://www.iscas.org.uk/ (you may need to open this link in a non-IE browser)	This should be specific to complaints around Palliative Care / EOLC. **Independent Health Providers** • 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) 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.

• 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?		

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?	• Fit and Proper Persons Guidance • https://improvement.nhs.uk/resources/national-safety-standards-invasive-procedures/ • Brief guide: NatSSIPs and LocSSIPs (CQC internal guidance)	• Is there a Board member with EOLC responsibilities? Do they understand the EOLC issues within the organisation and are they active and visible to staff? • Is there a non-executive member for EOLC? Do they understand the EOLC issues within the organisation and do they play an active role? • Is there a clinical lead for EOLC? • Is there a service improvement lead for EOLC? • Who leads on the delivery of EOLC on the wards? • Is there an organisation wide EOLC steering group or committee, is it

		representative of the breadth of EOLC i.e. includes the full range of specialities? What are its plans for the EOLC service, how active is it and when did it last meet? • How do leaders ensure that employees who are involved in the performance of invasive procedures develop shared understanding, be educated in good safety practice as set out in the national standards for invasive procedures? • Have managers ensured that there is a plan in place to develop local Safety Standards for Invasive Procedures using the national Safety Standards for Invasive Procedures. Have they assessed the need for these against all invasive procedures carried out? • Are there appropriate leadership arrangements in place to support improvement of the provider's cancer services in line with local Cancer Alliance and national cancer strategy goals? • Are there nominated leads for EOLC, e.g. NED, executive, medical at each level? • Do leaders look beyond their own Trust and take responsibility for the effective

		operation of the local cancer system as a whole, for example through active membership of their Cancer Alliance?

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 for this service**		
• 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	• Achieving World Class Cancer Outcomes: A strategy for England • NHS England cancer programme to support implementation of the strategy Six pillars: • Prevention and public health • Earlier diagnosis • Patient experience • Living with and beyond cancer • Investment in a high-quality, modern service • Commissioning, accountability and provision.	• Is there a clear vision and strategy specific to the EOLC service, i.e. is it distinct from the overall organisational strategy and vision? Does it reflect the whole spectrum of EOLC i.e. includes conditions other than cancer, is it trust wide or focused on wards? • How is the strategy being implemented, are activities appropriately aligned to delivering the strategy, are the targets realistic and how is progress reported on? • Does the strategy reflect the findings of previous CQC inspection reports; and does it reflect the current challenges the organisation faces in relation to EOLC services?

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?		• Does the provider have a clear vision and strategy for the delivery and improvement of its cancer services and in partnership with other providers, such as those in its Cancer Alliance? • Does this strategy specifically look at end of life care for frail elderly, people with dementia and people with long term conditions? • Who monitors the EOLC strategy? • How is this strategy disseminated to staff? • How engaged are staff in providing EOLC? Do they see this as an important part of their job? • How does the provider's cancer strategy link with it's EOLC strategy? • How engaged are staff in providing EOLC? Do they see this as an important part of their job?
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 within the service**		

• 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? • W3.8 Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular	• 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 • Eight high impact actions to improve the working environment for junior doctors • Schwarz Rounds • CQC guidance on WRES in IH	• What processes and procedures does the provider have in place to ensure they meet the duty of candour? For example, training, support for staff, policy and audits. • What priority is given to EOLC service as a whole; is it seen as important by staff? • Do staff feel supported to deliver good EOLC? • How do staff feel about the service is it regarded as an important aspect of their work? • What staff support mechanisms are in place'? **Independent Health providers** • Does the provider offer effective support to staff who are caring for people with cancer? For example, holding regular Schwarz Rounds or other clinical supervision, where staff can discuss the emotional aspects of caring for people with cancer.

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? • W4.4 Are arrangements with partners and third-party providers governed and managed effectively to encourage		• How do they get an understanding of EOLC performance at ward level? For example, how would they know which wards or services are providing 'good' EOLC? • Has EOLC got its own risk register and how does this link to the governance arrangements, for example are actions clearly taken and outcomes Is there a clinical lead for EOLC? • Is there a service improvement lead for EOLC?

appropriate interaction and promote coordinated, person-centred care?		• Is there a Board member with EOLC responsibilities? And are staff aware of who this is? • Are local governance arrangements clear about the role of the 'senior responsible clinician' in EOLC, particular their involvement in decision-making, and do they have a clear job plan for example? • What are the governance procedures for managing and monitoring any SLAs the provider has with third parties? • Does the mortuary service have a policy about how to response in the event of a major disaster? • Is there effective board oversight of performance regarding antimicrobial prescribing and stewardship? What action is taken when issues are identified? • How does the service manage the governance and business of MDT tumour groups? Are there non-clinical MDT tumour group meetings in place and how often do they meet?

		• Is there a sepsis lead who oversees the departmental/provider sepsis management, including neutropenic sepsis? Does the service monitor and investigate unplanned re-admissions due to neutropenic sepsis, and take action to improve and disseminate learning? • Does the Trust play an active role as part of its Cancer Alliance to ensure that the cancer system as a whole is well managed?

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: **Management of 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?	• NICE QS66 Statement 1: Hospitals have an intravenous (IV) fluids lead who has overall responsibility for training, clinical governance, adult and review of IV fluid prescribing and patient outcomes • NICE QS61 Statement 2: Organisations that provide healthcare have a strategy for continuous improvement in infection prevention and control, including accountable	• What systems are in place to learn from EOLC incidents specifically; and how is this information collected? For example, is it ward specific, or from across all divisions? • Has EOLC got its own risk register and how does this link to the governance arrangements, for

• 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? • 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?	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. • https://improvement.nhs.uk/resources/national-safety-standards-invasive-procedures/	example are actions clearly taken and outcomes Is there a clinical lead for EOLC? • Is there effective board oversight of performance regarding antimicrobial prescribing and stewardship? What action is taken when issues are identified? • What are the governance procedures for managing and monitoring any SLAs the provider has with third parties? • Does the mortuary service have a policy about how to response in the event of a major disaster? • Have managers ensured that there is a plan in place to develop local safety standards for invasive procedures using the national safety standards for invasive procedures? • Have they assessed the need for these against all invasive procedures carried out? • Does each element of the cancer service have its own risk register and how does this link to governance arrangements, for

		example are actions clearly taken and outcomes monitored? • Is the provider improving access to participation in clinical trials for cancer patients? Are they monitored closely in line with ongoing trial outcomes? **For NHS** • Does the service participate in any audits that are related to (or refer to) mental health and emotional wellbeing? Have there been any relevant actions arising from audits? • Are relevant senior staff members aware of any risks or issues related to mental health and emotional wellbeing in relation to the service? If so where have these been recorded and what action has been taken? **For independent providers** • How does the hospital manager ensure that consultant holding practising privileges have an appropriate level of valid professional indemnity insurance in place? I.e. arrangements to ensure

		those staff working under practising privileges hold appropriate indemnity insurance in accordance with The Health Care and Associated Professions (Indemnity Arrangements) Order 2014. • How does the hospital manager ensure that consultants who invite external staff (for example their own private nurse) to work with them or on their own, undergo appropriate checks as required by Schedule 3 of the HSCA Regulated Activity Regulations? • Are roles and responsibilities of the Medical Advisory Committee set out and available?
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: **Information Management**		
• W6.1 Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with	• Advertising Standards Authority	• What specific information is collated under each of the five key questions e.g. safe, effective, caring,

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 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,		responsive and well-led for EOLC services? • Are any senior members of staff expected to report on patients' mental health or emotional wellbeing? • Are there any systems that help or hinder access to up to date information about patients' mental health? • What information is collated for cancer service improvement and innovation to feed into the provider's cancer improvement plan, to it's Cancer Alliance and other information requirements as part of the National Cancer Strategy? • What specific information is collated under each of the five domains e.g. safe, effective, caring, responsive and well-led for EOLC services? **For independent providers** • Are arrangements for advertising or promotional events in accordance with advertising legislation and professional guidance?

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?		• Is there a system in place to ensure that people using the service are provided with a statement that includes terms and conditions of the service being provided to the person and the amount and method of payment of fees?

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: **Public and staff 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?	• National Cancer Patient Experience Survey	• How are staff engaged in providing EOLC e.g. through a champion or other role? • Are staff engaged with bereaved relatives, what is the process for this interaction? • Do they undertake a bereavement survey of relatives and friends? If so, what do the results tell them? • Do they explore the results from the national voices survey of bereaved relatives?

• 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?		
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: **Innovation, improvement and sustainability**		
• 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?	• NHS England. Developing Operational Delivery Networks: The Way Forward: The new commissioning system encourages the development of operational development networks (ODN) focused on co-ordinating patient pathways between providers over a wider area. • https://www.england.nhs.uk/personalised-health-and-care/eolc/ • https://www.england.nhs.uk/improvement-hub/ • National Cancer Strategy Implementation Plan	• What improvements have been made to the service in the last year, or since we last inspected? • What innovations are they involved in and what has been the impact of this innovation on EOLC, how do they evaluate innovations and what improvements have been made? • Are there any issues in relation to the sustainability of EOLC services? For example, if the funding was cut how would this impact on EOLC services?

• 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?	• Specific aims are to improve: survival, early diagnosis, patient experience and long-term quality of life for people living with cancer. • Guidance for Cancer Alliances ○ P12 link to radiotherapy provider networks • Macmillan Quality Environment Award	• Are end of life care performance measurements part of the service and organisations' dashboard? • Are lessons learned during mortality meetings within the service used to improve EOLC? **For NHS** • Does the service have anything planned or in progress in relation to learning, improvement or innovation which will assist the delivery of mental health care within the services?