Inspection framework: NHS Acute* and independent acute hospitals (*as an additional service for NHS only)

Inspection Service Framework: Diagnostic Imaging

This service includes all areas where people:

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

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

Services that use NON-ionising radiation such as ultrasound and MRI, **DO NOT** need to comply with IR(ME)R. However please note CT, X-ray, fluoroscopy, PET and nuclear medicine services on the other hand **DO** need to comply with IR(ME)R and IRR 17.

Note: Interventional radiology, theatre radiology and cardiac catheterisation imaging are not included in this framework please refer to surgery framework.

IMPORTANT – Prior to inspecting any service which included MRI or ionising radiation, you must be aware of the risks and follow the methods given to reduce your risk. For further information see the risk assessment and the diagnostic imaging ED modules.

Areas to inspect*

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

- Diagnostic procedures[1], for example EEG, echo, exercise test, chest pain clinic
- Sample of imaging areas, e.g. plain film/ X-ray, CT, MRI, PET, ultrasound, nuclear medicine
- Sample of physiological monitoring areas, e.g. respiratory clinic
- Areas where mammography takes place

Interviews, focus groups, observations

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

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

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

[1] Please note the relevant exclusions as some physiological tests not included within the definition of physiological measurement.

[2] RPA reports gathered ahead of the inspection may help to determine if you require the individual(s) for interview at inspection.

- Ultrasonographers and radiographers
- Radiologists
- Mammographers
- Technicians
- Nuclear medicine ARSAC licence holder
- DEXA technicians
- Administrative staff such as reception

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?
	• Skills for health core skills training framework	• Are there statutory and mandatory training records?
		• Have staff received training to make them aware of the potential needs of people with:
		  ○ mental health needs
		  ○ learning disability needs
		  ○ autism needs
		  ○ dementia needs

		• Is there evidence that staff working with radiation have appropriate training in the regulations, radiation risks, and use of radiation?
Report sub-heading: **Safeguarding**		
• S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.2 How do systems, processes and practices protect people from abuse, neglect, harassment and breaches of their dignity and respect? How are these monitored and improved? • S1.3 How are people protected from discrimination, which might amount to abuse or cause psychological harm? This includes harassment and discrimination in relation to protected characteristics under the Equality Act. • S1.4 How is safety promoted in recruitment practice, arrangements to support staff, disciplinary procedures, and ongoing checks? (For example, Disclosure and Barring Service checks.) • S1.5 Do staff receive effective training in safety systems, processes and practices? • S1.6 Are there arrangements to safeguard adults and children from abuse and neglect that reflect relevant legislation and local requirements? Do staff understand their	• Safeguarding children and young people: Roles and competencies for healthcare staff (January 2019) • Adult safeguarding: Roles and competencies for healthcare staff (August 2018) • HM Government: Working Together: Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. July 2018 • The radiological investigation of suspected physical abuse in children • Female genital mutilation multi-agency practice guidelines published in 2016 • DH Female Genital Mutilation and Safeguarding: Guidance for professionals March 2016 • Guidelines for physicians on the detection of child sexual exploitation (RCP, November 2015)	• Are staff aware of their responsibilities surrounding Female genital mutilation ? • If the service treats patients under the age of 18 years are there appropriate child safeguarding arrangements? • Is information regarding safeguarding from abuse displayed where service users will see it? **Where children are seen or treated:** • Does the service ensure that all staff are trained to appropriate level set out in the Intercollegiate Framework and are familiar with Government guidance 'Working Together to Safeguard Children'? • Are staff able to access a named or designated professional (internal or external) for advice at all times 24 hours a day?

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?	• CQC cross sector DBS guidance • MHA 1983 Code of Practice	• Is there an identifiable lead responsible for co-ordinating communication for children at risk of safeguarding issues? • Do staff have an awareness of CSE and understand the law to detect and prevent maltreatment of children? • How do staff identify and respond to possible CSE offences? Are risk assessments used/in place? • What safeguarding actions are taken to protect possible victims of CSE? Are timely referrals made? And is there individualised and effective multi-agency follow up? • Are leaflets available about CSE with support contact details? • What wider safeguarding protocol/guidance is in place - how are safeguarding issues talked about, who manages them, are lessons learned etc.? • Is there a chaperoning policy in place for children and young people? Are staff aware of and understand this policy?

		• If a child/young person is identified as being on a child protection plan, what systems are in place to ensure the correct information is shared and actions put in place? • Are there protocols in place for children with safeguarding concerns?
Report sub-heading: **Cleanliness, infection control and hygiene**		
• S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.8 How are standards of cleanliness and hygiene maintained? Are there reliable systems in place to prevent and protect people from a healthcare-associated infection?	• NICE QS61 Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. • NICE QS61 Statement 4: People who need a urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it is no longer needed. • NICE QS61 Statement 5: People who need a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device and its	• What precautions are taken in radiology settings when seeing people with suspected communicable diseases? E.g. TB or Flu etc. • What infection control measures are in use when carrying out a consultation / x-ray or performing a scan on people requiring isolation? E.g. people with infectious diarrhoea. • What are the results of local cleaning / hand hygiene audits? • Are appropriate cleaning procedures for ultrasound probes, following an intimate examination?

	removal as soon as it is no longer needed. • Health Technical Memorandum 01-01 decontamination of surgical instruments (medical devices) used in acute care: • https://www.gov.uk/government/publications/management-and-decontamination-of-surgical-instruments-used-in-acute-care	
Report sub-heading: **Environment and equipment**		
• S1.1 How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff? • S1.9 Do the design, maintenance and use of facilities and premises keep people safe? • S1.10 Do the maintenance and use of equipment keep people safe? • S1.11 Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.)	• HSE guidance on portable electrical equipment • guidelines and legislation impact on medical devices management • MHRA Managing medical devices • Assessing Controlled Substances Hazardous to Health Regulations 2002 • MHRA:https://www.gov.uk/government/publications/safety-guidelines-for-magnetic-resonance-imaging-equipment-in-clinical-use	• Is resuscitation equipment readily available? • Has the imaging service done a risk assessment for all new or modified use of radiation? Do the risk assessments address occupational safety as well as considering risks to people who use services and public? • Is all relevant MRI equipment labelled in line with MHRA recommendations e.g. MR Safe, MR Conditional, MR Unsafe? • How does the imaging service ensure that non-ionising and ionising radiation have arrangements to control the area and restrict access?

		• Is there clear signage where ionising radiation exposures occurs? • How does the service ensure specialised personal protective equipment is available and used by staff and carers when needed? How do they check that the lead aprons, lead screens and syringe/vial shielding in nuclear medicine? For example, are any annual checks carried out on them? • Does the provider undertake assessments and reviews of their activities under the Control of Substances Hazardous to Health Regulations 2002 (COSHH)? • Does the provider have an equipment QA programme and are they doing this on all x-ray equipment at the appropriate time as recommended by the medical physics experts, or the manufacturers recommendation? • Are there appropriate service contracts in place for equipment? Is there a clear process for maintenance of equipment and for reporting of any faults? Is there a process in place for the safe handover of equipment? • Does the service monitor staff for radiation exposure?

		• In case of a service using radiation or radioactive substances are there effective arrangements in place to contain the incident e.g. such as radioactive spillage while carrying out a PET-CT scan or another form of nuclear medicine imaging?

Key line of enquiry: **S2**		
S2. How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?		
Report sub-heading: **Assessing and responding to patient risk**		
Prompts	**Professional standard**	**Sector specific guidance**
• S2.5 Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? • S2.6 How do staff identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges? Are staff able to seek support from senior staff in these situations?	• Sepsis: recognition, diagnosis and early management (NICE Guideline 51) • National Safety Standards for Invasive Procedures (NatSSIPs) Version number: 1 published: 7 September 2015 • Brief guide: NatSSIPs and LocSSIPs • Standards for the communication of radiological reports and fail-safe alert • HSIB report on communicating unexpected significant findings • Guidance on implementing safety checklists for radiological procedures • If children are treated there should be specific paediatric protocols in place for all imaging modalities.	• Is there a policy for sepsis management and are staff aware of it? • Are there clear pathways and processes for the management of people using services within radiology departments who are clinically unwell and require hospital admission? • Are there processes to ensure the right person gets the right radiological scan at the right time? • Does the service follow the RCR standards for the communication of radiological reports and fail-safe alert notification? • Does the service check three points of ID and/or use the society of radiographers "pause and check"? • Are there clear pathways and processes for staff to assess outpatients using services in radiology departments who are clinically unwell and need hospital admission?

	• Notes for guidance on the clinical administration of Radiopharmaceuticals and use of sealed Radioactive Sources: Guidance on the clinical administration of Radiopharmaceuticals and use of sealed radioactive sources • Protecting pregnant patients during diagnostic medical-exposures • The impact of IR(ME)R 2017 on pregnancy checking procedures • IRMER Regulations 2017, Schedule 2 should be in place: The employer's written procedures for exposures must include procedures— (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 • guidance on gadolinium based contrast agent administration in adult patients	• How does the imaging service ensure that the radiation protection advisor and the medical physics expert are easily accessible for providing radiation advice? • Has the service appointed radiation protection supervisors, In departments which uses ionising radiation? • How does the service ensure that the 'requesting' of an X-ray, nuclear medicine or other radiation diagnostic test, e.g. by GP's or others is only made by staff / persons in accordance with IR(ME)R? Does the service adopt referral criteria? • Do staff do a debrief or give other support after aggressive or violent incidents? • How does the imaging service ensure that women (including patients and staff) who are or may be pregnant always inform a member of staff before they are exposed to any radiation in accordance with IR(ME)R and for staff in accordance with IRR? • Is there a pregnancy procedure in place? • What are the local policies for the risk

	• RCR endorsement of the 2016 RANZCR Iodinated Contrast Guidelines which can be viewed at: https://www.ranzcr.com/search/ranzcr-iodinated-contrast-guidelines • https://www.sor.org/sites/default/files/document-versions/safety_in_magnetic_resonance_imaging_3.pdf • The potential risks of intravascular administration of contrast must be weighed against the potential benefits. Systems need to be in place including trained individuals that are able to recognise and treat severe contrast reactions, including anaphylaxis. This could be a registered nurse or radiographer or other appropriately trained healthcare professional. • Do they use SCoR Pause and Check, or a similar version adapted by the organisation? • Guide to IRMER **Cancer** • NICE guidance CG151: Neutropenic sepsis: prevention and management in people with cancer	assessment and prevention of contrast-induced nephropathy? Are they in keeping with NICE Acute kidney injury guidelines and the Royal College of Radiologists standards for intravascular contrast agent administration? • What are the local policies to document, investigate, and make a referral to a specialist allergy service and the process for advising the patient in cases where significant suspected contrast reactions are suspected? • Are there clear processes to escalate unexpected or significant findings both at the examination and upon reporting? How are these flags escalated where reported by teleradiology services? • Are there procedures for the collapse of a patient in MRI, and are these practised? • 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? i.e. for

		US guided drainages or CT guided biopsies • Do they have processes in place to direct patients as to what to do if they have a complication post procedure? • Are there local rules (IRR) and employers procedures (IR(ME)R) which protect staff and patients from ionising radiation? • For services that treat children, what additional wider arrangements are there in place to manage a deteriorating child? For example if a child needs a crash team.
Report sub-heading: **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?	**Cancer** • Health Education England – Cancer Workforce Plan	• How are staffing requirements assessed or calculated? • Do they use agency? What are the local induction policies? • Does the provider carry out risk assessments to minimise risks associated with lone working? • **For services that treat children**, is there access to a member of staff skilled in Advanced or European Paediatric Life Support?

• 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?		**Cancer** • How does the provider ensure adequate diagnostic staffing, identified by Health Education England as experiencing shortages in the provision of cancer services: ○ Clinical Radiology ○ Diagnostic Radiography
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? • 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?	• Where intravascular contrast administration is carried out, systems need to be in place including trained individuals that are able to recognise and treat severe contrast reactions, including anaphylaxis. This could be a registered nurse or radiographer or other appropriately trained healthcare professional. intravascular-contrast-administration-adult-patients-third-edition	• Can the radiographers contact a radiologist for advice as the radiologist may not always be onsite? • How are staffing requirements ascertained? • Do they use agency? What are the local induction policies? • Does the provider carry out risk assessments to minimise risks associated with lone working? • Does the service use teleradiology services for out of hours work and/or normal reporting? Is there access to these radiologists? • Is there access to an appropriately trained clinician when contrast is administered?

Key line of enquiry: **S3**		
S3. Do staff have all the information they need to deliver safe care and treatment to people?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Records**		
• S3.1 Are people's individual care records, including clinical data, written and managed in a way that keeps people safe? • S3.2 Is all the information needed to deliver safe care and treatment available to relevant staff in a timely and accessible way? (This may include test and imaging results, care and risk assessments, care plans and case notes.) • S3.3 When people move between teams, services and organisations (which may include at referral, discharge, transfer and transition), is all the information needed for their ongoing care shared appropriately, in a timely way and in line with relevant protocols? • S3.4 How well do the systems that manage information about people who use services support staff, carers and partner agencies to deliver safe care and treatment? (This includes coordination between different electronic and paper-based systems and appropriate access for staff to records.)	• Records management code of practice for health and social care • https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-3-Information-exchange • GMC guidance on keeping records • NICE QS121 Statement 3: People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record. • Standards for the provision of teleradiology • Brief guide on teleradiology	• Does the service provide electronic access to diagnostic results? • How does the service ensure imaging requests are appropriate and include the relevant information to allow for requests to be justified in accordance with IR(ME)R? Does this include information relevant to keep patients safe? • Where appropriate, is patient information transported with patients when attending a scan or procedure? Are staff aware of relevant clinical and care requirements i.e. Fall assessments, DNACPR, NBM, pregnancy, renal function if contrast is to be used? • As part of the justification process to carry out exposure to radiation, how does the imaging service attempt to make use of previous images of the same persons requiring the test, even if these have been taken elsewhere?

		• When appropriate, do records contain details of patients'
		  ○ mental health needs
		  ○ learning disability needs
		  ○ autism needs
		  ○ dementia needs
		alongside their physical health needs?
		• Does the service have processes to ensure that transport of patients to radiology includes relevant clinical information e.g. infection risks or resus info or escort and portering requirements?
		• Where used, is there a secure transfer of data to and from teleradiology companies??
		• Where there are multiple IT systems, how do they ensure information is shared and accessed when required?
		Independent healthcare:
		• Is there a system in place to ensure that medical records generated by staff holding practising privileges are available to staff (or other providers) who may be required to provide care or treatment to the patient?
		Cancer

		• Is there an adequate system to ensure the diagnostic service's access to cancer patient records, whether paper or electronic? • If there are there multiple IT systems i.e. Electronic Patient Records and a separate cancer information system, how does the service ensure timely transfer of information between 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 accordance with current national guidance or evidence?	• NICE QS121 Statement 4: People in hospital who are prescribed an antimicrobial have a microbiological sample taken and their treatment reviewed when the results are available. • Start Smart then Focus: Antimicrobial Stewardship Toolkit • RCR guidance on sedation, analgesia and anaesthesia in the radiology department • https://www.gov.uk/government/publications/arsac-notes-for-guidance • Products administered with radiopharmaceuticals can be done by a non-healthcare profession: Guidance for the administration of medicinal products by non-medical personnel	• Are contrast media and other medicines stored correctly? • Are Patient Group Directions in place, or are medicines prescribed by doctors or registered non-medical prescribers? • What processes are there to ensure that the right radiopharmaceutical and activity is sourced, prepared and injected? • Do radiologists hold appropriate ARSAC licenses for the administration of each radioactive medicinal product? • Is there clear delegation for injecting radiopharmaceuticals Is this clearly documented? • Where medicines are administered in conjunction with a radioactive medicinal product, is this undertaken safely as specified by the Human Medicines Regulations 2012 as amended?

• 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?		• How is the use of medicines such as furosemide risk assessed and documented so it can be administered by staff?

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

S5. What is the track record on safety?

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

Prompts	Professional standard	Sector specific guidance
Report sub-heading: **Incidents**		
• S5.1 What is the safety performance over time? • S5.2 How does safety performance compare with other similar services? • S5.3 How well safety is monitored using information from a range of sources (including performance against safety goals where appropriate)? • S6.1 Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate? • S6.2 What are the arrangements for reviewing and investigating safety and safeguarding incidents and events when things go wrong? Are all relevant staff, services, partner organisations and people who use services involved in reviews and investigations • S6.3 How are lessons learned, and themes identified and is action taken as a result of investigations when things go wrong?	• A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined. never-events-policy-and-framework Never events 2018 • Serious Incidents (SIs) should be investigated using the Serious Incident Framework 2015. • (NICE QS66 Statement 4): For adults who receive intravenous (IV) fluid therapy in hospital, clear incidents of fluid mismanagement are reported as critical incidents.	• Is there evidence of adherence to duty of candour regulations, including a process for and evidence of written apologies? • How does the imaging service ensure that radiation incidents are fed into risk management and for accidental and unintended exposures, notified to us under IR(ME)R or to HSE under IRR requirements? • How is learning from clinical incidents disseminated? • How many incidents have occurred in the service in the last year? What processes have been put in place as a result? • Are incidents relating to dose of radiation received reviewed by a Medical Physics Expert (MPE)?

• 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?	• 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. • Compliance with patient safety alerts should be investigated using the National Patient Safety Alerting System guidance. • Notifications of radiation incidents (IRR) • IR(ME)R notifications • http://www.hse.gov.uk/radiation/ionising/exposure.htm	

Effective

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

Key line of enquiry: **E1**

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

Prompts	Professional standard	Sector specific guidance
Report sub-heading: **Evidence-based care and treatment**		
• E1.1 Are people's physical, mental health and social needs holistically assessed, and is their care, treatment and support delivered in line with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes? • E1.2 What processes are in place to ensure there is no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions? • E1.3 How is technology and equipment used to enhance the delivery of effective care and treatment and to support people's independence?	• NICE QS 15 Patient experience in adult NHS services • NICE CG68 Stroke and transient ischaemic attack in over 16s: diagnosis and initial management • NICE CG75 Metastatic spinal cord compression in adults • Evidence-based indications for the use of PET-CT in the United Kingdom 2016. • Standards of practice and guidance for trauma radiology in severely injured patients. • NICE pathways for cancer	• How does the service monitor patient doses? Are these in line with national/european diagnostic reference levels (DRLs)? • How does the service ensure it identified and implements relevant best practice and guidance, such as NICE guidance? • Do they audit their practice locally against the guidelines? • How does the service ensure that NICE guidelines for acting on an image report/radiologist report are followed?

• E1.4 Are the rights of people subject to the Mental Health Act 1983 (MHA) protected and do staff have regard to the MHA Code of Practice? • E1.7 Are people told when they need to seek further help and advised what to do if their condition deteriorates?	• In relation to diagnostic procedures involving nuclear medicines the practitioner should note the diagnostic reference level for each adult investigation. It is important that the activity for each exposure is the optimised so it is the lowest practicable dose to the patient. - https://www.gov.uk/government/publications/diagnostic-radiology-national-diagnostic-reference-levels-ndrls/national-diagnostic-reference-levels-ndrls - https://www.rcr.ac.uk/publication/standards-angiography-and-image-guided-endovascular-interventions - Notes for Guidance on the Clinical Administration of Radiopharmaceuticals and use of sealed Radioactive sources (ARSAC January 2016): - https://www.gov.uk/government/publications/arsac-notes-for-guidance - • Guidelines for Professional Ultrasound Practice https://www.sor.org/sites/default/files/document-versions/2018.1.5_scor_bmus_guidelines_final.pdf	• In assessing whether NICE guidance is followed, take the following into account: ○ Details of the provider's clinical audits programme to support and monitor implementation of NICE guidance ○ Participation in national benchmarking clinical audits • Are relevant staff able to deal with any violence and aggression in an appropriate way? • Are best practice decision making tools encouraged e.g. BMJ best practice decision making app, and does the service monitor their use?

	• BMJ best Practice Guides	
Report sub-heading: **Nutrition and hydration**		
• E1.5 How are people's nutrition and hydration needs (including those related to culture and religion) identified, monitored and met? Where relevant, what access is there to dietary and nutritional specialists to assist in this?		• What arrangements are there in terms of food and drink for patients who are in the department for any length of time? • Are there processes for vulnerable patients e.g. diabetic, frail that require pre-examination fasting or drinking before treatment? • Where used as part of an investigation which requires food or drink consumption, how does the service manage patients with special requirements?
Report sub-heading: **Pain relief**		
• E1.6 How is a person's pain assessed and managed, particularly for those people where there are difficulties in communicating?	• Core Standards for Pain Management Services in the UK	• How has the service implemented the Faculty of Pain Medicine's *Core Standards for Pain Management* (2015)? • Whilst a patient is in diagnostic imaging or nuclear medicines how are their regular medicines maintained? When other medicines are administered including pain relief how is this recorded and fed back to ED or the ward?

		• Do staff use an appropriate tool to help assess the level of pain in patients who are non-verbal? For example, DisDAT (Disability Distress Assessment Tool) helps to identify the source of distress, e.g. pain, in people with severe communication difficulties. General Medical Council recommended. Abbey Pain Scale for people with dementia.
Key line of enquiry: **E2**		
E2. How are people's care and treatment outcomes monitored and how do they compare with other similar services?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub heading: **Patient outcomes**		
• E2.1 Is information about the outcomes of people's care and treatment (both physical and mental where appropriate) routinely collected and monitored? • E2.2 Does this information show that the intended outcomes for people are being achieved? • E2.3 How do outcomes for people in this service compare with other similar services and how have they changed over time? • E2.4 Is there participation in relevant quality improvement initiatives, such as local and national clinical audits, benchmarking, (approved) accreditation schemes, peer review, research, trials and other quality improvement initiatives? Are all relevant	• Standards for Learning from Discrepancies meetings • https://www.rcr.ac.uk/publication/lifelong-learning-and-building-teams-using-peer-feedback • Detection and Management of Outliers for National Clinical audits(NHS)	• Does the provider participate in the Quality Standards for Imaging (? If so what departments are accredited and what level of accreditation does it hold? • Does the provider participate in the Improving Quality in Physiological Services (IQIPS)? If so what departments are accredited and what level of accreditation does it hold? • Does the service investigate why performance was much worse than expected and makes changes to improve care? • Is the service regularly reviewing the effectiveness of care and treatment

staff involved in activities to monitor and use information to improve outcomes?		through local audit and national audit? • What evidence is there that the service has changed in response to their audits? • Do they have regular audit meetings to learn/ feedback? • Does the service undertake regular discrepancy meetings as per RCR guidance?

Key line of enquiry: **E3**

E3. How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?

Prompts	**Professional standard**	**Sector specific guidance**
Report sub heading: **Competent staff**		
• E3.1 Do people have their assessed needs, preferences and choices met by staff with the right skills and knowledge? • E3.2 How are the learning needs of all staff identified? Do staff have appropriate training to meet their learning needs to cover the scope of their work and is there protected time for this training? • E3.3 Are staff encouraged and given opportunities to develop? • E3.4 What are the arrangements for supporting and managing staff to deliver effective care and treatment? (This	• 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.	• Are staff who work with radiation appropriately trained? • Are staff who are undergoing training, adequately supervised in accordance with legislation set out under IR(ME)R? • Are equipment training records available for any staff who operate imaging equipment, including, radiologists, radiographers, surgeons, cardiologists as appropriate? • If appropriate, does the imaging service

includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.) • E3.5 How is poor or variable staff performance identified and managed? How are staff supported to improve? • E3.7 Are volunteers recruited where required, and are they trained and supported for the role they undertake?	• Start Smart then Focus: Antimicrobial Stewardship Toolkit • Guidance for employers sharing information about healthcare workers where a risk to public or patient safety has been identified https://www.rcr.ac.uk/publication/standards-interpretation-and-reporting-imaging-investigations-second-edition • https://www.sor.org/sites/default/files/document-versions/ultrasound_training_1_0.pdf • https://www.sor.org/sites/default/files/document-versions/final_safety_in_magnetic_resonance_imaging_2018_final_word_copy.pdf • https://www.sor.org/printpdf/book/export/html/17925 - the role of the radiographer in CT	have referral guidance and/or training on the electronic requesting system, as part of the induction for doctors and other referrers? • Is HCPC random sampling undertaken every two years. What support is given? How do services ensure relevant staff continue registration with relevant bodies? • Do staff have the skills, knowledge and experience to identify and manage issues arising from patients' ○ mental health conditions ○ learning disability ○ autism ○ dementia? • Do staff have the skills to sensitively manage any difficult behaviours that patients may display? • What induction and training do bank / agency staff receive? Does this include training on equipment? • Where images are reported outside of radiology, is there evidence that these members of staff are trained and follow the RCR guidance? • For services that treat children do staff have the appropriate skills to recognise and treat a deteriorating child? For

		example, allergic reaction to contrasting medium or vaccine. **Independent healthcare:** • What are the arrangements for granting and reviewing practising privileges? • Are there arrangements to make sure that local healthcare providers are informed in cases where a staff member is suspended from duty?
Key line of enquiry: **E4**		
E4. How well do staff, teams and services within and across organisations work together to deliver effective care and treatment?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Multidisciplinary working**		
• E4.1 Are all necessary staff, including those in different teams, services and organisations, involved in assessing, planning and delivering care and treatment? • E4.2 How is care delivered and reviewed in a coordinated way when different teams, services or organisations are involved? • E4.3 How are people assured that they will receive consistent coordinated, person-centred care and support when they use, or move between different services?	• PHSO: A report of investigations into unsafe discharge from hospital **Cancer** • Cancer multidisciplinary team meetings – standards for clinical radiologists • NHS England and Improvement guidance: Streamlining Multi-Disciplinary Team Meetings –	• Do Radiologists attend MDMs - multi-disciplinary meetings? • Does the service provide one-stop screening services involving different disciplines of staff working together? • Does the service support extended roles for radiographers and other healthcare professionals, such as reporting, and line insertions? Are these activities supported by radiologists?

• 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?	Guidance for Cancer Alliances January 2020	• Are there established links with: ○ mental health needs ○ learning disability needs ○ autism needs ○ dementia needs • Is there evidence of multi-disciplinary/ interagency working when required? If not, how do staff ensure safe discharge arrangements for people with complex needs? • Are there established links with ○ Child and Adolescent Mental Health Services (CAMHS) ○ Children's Social Services teams? **Cancer** • Are there pathways / effective links and co-ordination between diagnostic imaging and other services/departments, including phlebotomy/labs, to ensure all diagnostic test results are available to support timely MDT decisions on cancer care and treatment plans and achievement of cancer waiting times standards? • Is the service implementing guidance on streamlining cancer MDTs, including: ○ Putting in place predetermined 'Standards of Care' for the diagnosis of cancer

		○ Incorporating NHS England's rapid cancer diagnostic and assessment pathways, as well as local diagnostic protocols where applicable, to support the Faster Diagnosis Standard ○ Ensuring that minimum diagnostic data requirements are accounted for in order to list a patient not for discussion at the MDT meeting ○ Creating more flexibility in management of the MDT meeting in order to use diagnostic time most effectively ○ Ensure radiology expertise is available to support triage of patients 'not for discussion' at the MDT meeting
Report sub-heading: **Seven-day services**		
• E4.5 How are high-quality services made available that support care to be delivered seven days a week and how is their effect on improving patient outcomes monitored?	• Standards for providing a seven-day acute care diagnostic radiology service • https://www.england.nhs.uk/publication/seven-day-services-clinical-standards/	• What arrangements are there for urgent MRI or CT scans? • Does the service offer open access for CT and MRI scans from GPs? • Is there a walk in service available for plain film imaging?

Key line of enquiry: **E5**		
E5. How are people supported to live healthier lives and where the service is responsible, how does it improve the health of its population?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Health promotion**		

• E5.1 Are people identified who may need extra support? This includes:
  • people in the last 12 months of their lives
  • people at risk of developing a long-term condition
  • carers
• E5.2 How are people involved in regularly monitoring their health, including health assessments and checks, where appropriate and necessary
• E5.3 Are people who use services empowered and supported to manage their own health, care and wellbeing and to maximise their independence?
• E5.4 Where abnormalities or risk factors are identified that may require additional support or intervention, are changes to people's care or treatment discussed and followed up between staff, people and their carers where necessary?
• E5.5 How are national priorities to improve the population's health supported? (For example, smoking cessation, obesity, drug and alcohol dependency, dementia and cancer.)		

Key line of enquiry: **E6**		
E6. Is consent to care and treatment always sought in line with legislation and guidance?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Consent, Mental Capacity Act and DOLs**		
• E6.1 Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004 and other relevant national standards and guidance? • E6.2 How are people supported to make decisions in line with relevant legislation and guidance? • 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?	• 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 • BMA Children and young people tool kit • Gillick competence • MHA 1983 Code of Practice (including children and young people – chapter 19) • Standards for patient consent particular to radiology, second edition, 2012,	• How do staff record best interest decisions? • How are staff made aware of decisions made by other clinicians?

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

Caring

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

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

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

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

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

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 people who use services and those close to them?	• https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-1-Empathy-dignity-and-respect • https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-2-Contacts-for-ongoing-care • Intimate examinations and the use of chaperones	• Are service users able to speak to the receptionist without being overheard? • How do staff ensure that when intimate personal care and support is being given by a member of the opposite sex, service users are offered the option on a chaperone? • How do staff ensure that chaperones are, where possible, the same gender as the service user?

• 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?		• 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?
Report sub-heading**: Emotional support**		
• C1.5 Do staff understand the impact that a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially? • C1.6 Are people given appropriate and timely support and information to cope emotionally with their care, treatment or condition? Are they advised how to find other support services? • C2.7 What emotional support and information is provided to those close to people who use		• Do staff provide people who use services with information leaflets / written information to explain their condition and treatment plan? • Are imaging options discussed with people and are they encouraged to be part of the decision making process? • If a patient becomes distressed in an open environment, how do staff

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

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

Responsive

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

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

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

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

Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Service delivery to meet the needs of local people**		
• R1.1 Do the services provided reflect the needs of the population served and do they ensure flexibility, choice and continuity of care? • R1.2 Where people's needs and choices are not being met, is this identified and used to inform how services are improved and developed? • R1.3 Are the facilities and premises appropriate for the services that are delivered?	• Butterfly scheme (other schemes exist) • Change can disorientate people with these conditions, and sometimes triggers behaviour that challenges, for example: diagnosis and management of adults on NICE CG142 Autism: recognition, referral, the autism spectrum.	• Is the environment appropriate and patient centred (comfortable / sufficient seating, toilets and magazines, drinks machine, separate play area for children in an adult clinic)? • Is there sufficient car parking available (change available from a machine, shuttle service from distant car parks, parking paid for on exit, one price per appointment therefore if clinics running late then still pay same amount)? • Is the department clearly signposted (or volunteers to help)? • Is information provided to service users in accessible formats before

		appointments, e.g. contact details, hospital map and directions, consultant name, information about any tests / samples / fasting required? • Is public transport availability considered? What is the timeliness of appointments? • Are there out of hours services - evening and weekends? • Are people who use services given pagers so they can leave the waiting room for a break? • Are there any systems or staff members 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. • 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.

		• Is there a quiet area where patients can wait if they find busy environments distressing? • How do staff know where to find patients who are not waiting in the usual place? • Are signage and/or public announcements clear enough to be understood by people who are unfamiliar with the environment? **Where children are seen or treated:** • What steps have been taken to ensure areas where CYPs are treated are safe and suitable for the age group? • If CYP are seen in predominantly adult based areas - how are the needs CYP and parents met whilst in these areas e.g. is there a separate waiting area, is there a play area etc.? - Are waiting times kept to a minimum for CYP? • What reasonable adjustments are made for a child that might struggle with the hospital environment?

Report sub-heading: **Meeting people's individual needs**		

• R1.4 How does the service identify and meet the information and communication needs of people with a disability or sensory loss. How does it record, highlight and share this information with others when required, and gain people's consent to do so?
• R2.1 How are services delivered, made accessible and coordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances?
• R2.2 How are services delivered and co-ordinated to be accessible and responsive to people with complex needs?[3]
• R2.3 How are people, supported during referral, transfer between services and discharge?
• R2.4 Are reasonable adjustments made so that people with a disability can access and use services on an equal basis to others?
• R2.5 Do key staff work across services to coordinate people's involvement with families and
	• https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-4-Individualised-care
	• Accessible Information Standard
	• NICE NG27 Transition between inpatient hospital settings and community or care home settings for adults with social care needs. Of particular relevance to Looked After Children and Young People – see NICE QS31
		• Is support with transport available to service users with mobility issues?
		• How does the service deal with bariatric patients particularly in MRI?
		• How does the service manage care of vulnerable service users; for example, allowing service users living with dementia to bypass queues at reception / when clinics are running late?
		• How does the service take account of individual needs of the following groups of patients:
		  ○ People with complex needs
		  ○ People with mental health conditions
		  ○ People with learning disabilities or autism
		  ○ People with dementia
		• In areas where ethnic minority groups form a significant proportion of the local population, are

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

carers, particularly for those with multiple long-term conditions?		processes to aide translation? • Does the service support people with learning disabilities? If people with: ○ mental health needs ○ learning disability needs ○ autism needs ○ dementia needs need extra support or supervision on the ward or in the clinic is this available? • Does the service make sure translation services are readily available if required?
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	• Diagnostic Waiting Times & Activity FAQs **Cancer** • NHS England Cancer Waiting Times standards: • How to Guide: Achieving Cancer Waiting Times	• Is the provider meeting the six week diagnostic test national standard? • What are the waiting times for tests not reported under Diagnostic waiting times

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 the technology (including telephone systems and online/digital services) easy to use?	• Timed rapid diagnostic and assessment pathways for colorectal, lung, prostate and oesophago-gastric cancers	monthly return (DM01)? Do patients undergoing non-DM01 tests/procedures wait longer? • How does the provider manage inpatient diagnostic demand, particularly when bed pressures are at their highest? • How does the provider manage urgent cancer appointments? • How does the service ensure that it meets local KPIs for report turnaround time for medical staff requesting diagnostic imaging to be carried out? • Are there arrangements in place for meeting individual needs e.g. temporary workforce / homeless / travellers (specifically thinking about communication of appointments and letters)? • Are service users offered a choice of appointments? • Are same day / next day appointments available if needed? (so called 'hot' clinics)

		• How long are people kept waiting once they arrive in the department? • What is the waiting times for reports? Are reports prioritised based on clinical information and urgency? • What is the waiting times for appointments? • Is the waiting time for appointments / at appointments communicated? • How does the service manage DNA rates? • How does the provider communicate with GPs? How long does it take? Is this measured or monitored by the provider? This includes offsite reporting (e.g. where scans are taken then reported overseas). **Cancer** • Are good quality diagnostic images and reports available to cancer MDTs in a timely way?

		• How does the diagnostic imaging service ensure it supports achievement of national cancer waiting standards, including implementation of rapid diagnostic and assessment pathways? Is there sufficient diagnostic capacity?

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? • R4.4 How are people who raise concerns or complaints protected	• 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. • The Independent Sector Complaints Adjudication Service (ISCAS) is the patient complaints **adjudication** service for independent healthcare, only applicable though if the provider subscribes to ISCAS (please note that you may need to open this link in a non-IE browser)	• How many complaints have been referred to the Parliamentary and Health Service Ombudsman? **Independent Health only:** • Where the internal complaints process has been exhausted, what arrangements are in place for the independent review of complaints where the patient is receiving non-NHS funded care (e.g. is the service a member of the Independent Services Complaint Advisory Services (ISCAS) of which membership is voluntary, and if not, does the provider have an alternative arrangement?). This includes NHS Private Patient Units, whose patients do not have access to the PHSO if their care is not NHS funded.

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?	• National Safety Standards for invasive procedures(NatSSIPs) Version number: 1 published: 7 September 2015. • Fit and Proper Persons Guidance	• How do leaders ensure employees who are involved in invasive procedures develop shared understanding, and are educated in good safety practice, as set out in the national standards? Applies to those providing NHS funded care.

Key line of enquiry: **W2**		
W2. Is there a clear vision and credible strategy to deliver high-quality sustainable care to people who use services, and robust plans to deliver?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Vision and strategy**		
• W2.1 Is there a clear vision and a set of values, with quality and sustainability as the top priorities? • W2.2 Is there a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care? • W2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners? • W2.4 Do staff know and understand what the vision, values and strategy are, and their role in achieving them? • W2.5 Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population? • W2.6 Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this?	**Cancer** • NHS Long Term Plan ambitions for cancer (2019-29) • National priorities for Cancer Alliances • Rapid cancer diagnostic and assessment pathways - timed pathways for colorectal, lung, prostate and oesophago-gastric pathways • Service specification for Rapid Diagnostic Centres • Achieving World Class Cancer Outcomes: A strategy for England (2015-20)	• How does the provider plan their staffing and plan ahead in light of these staffing groups being classed within the national shortage list - i.e. are they actively engaged in extended roles and liaising with universities? • How do they proactively monitor demand, activity and capacity across their modalities and how do they utilize IT systems to support this? • Does the radiology department have sufficient plans for the replacement of high cost equipment? Is this through managed services, lease or capital replacement? **Cancer** • Is the provider working effectively with other providers in its Cancer Alliance towards achieving local priorities on earlier and faster diagnosis, including developing Rapid Diagnostic Centres and

		implementing timed, rapid diagnostic and assessment pathways?
Key line of enquiry: **W3**		
W3. Is there a culture of high-quality, sustainable care?		
Generic prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Culture**		
• W3.1 Do staff feel supported, respected and valued? • W3.2 Is the culture centred on the needs and experience of people who use services? • W3.3 Do staff feel positive and proud to work in the organisation? • W3.4 Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority? • W3.5 Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?	• 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 For independent health care only: • WRES in Independent health care providers **Cancer** • Schwarz Rounds	• What processes and procedures does the provider have to ensure they meet the duty of candour? For example, training, support for staff, policy and audits. **Cancer** • Does the service offer effective support to staff who have contact with patients with life-changing or limiting conditions, such as cancer? For example, holding regular Schwarz Rounds where staff can discuss the emotional aspects assessment, care and treatment.

• 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 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?		
Generic 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?	• The Health Care and Associated Professions (Indemnity Arrangements) Order 2014	• What are the governance procedures for managing and monitoring any SLAs the provider has with third parties? • If medical physics is sought through a third party provider, how

• 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 appropriate interaction and promote coordinated, person-centred care?	• https://services.hse.gov.uk/bssd/	does the service ensure that open contact and sufficient advice is sought? • When using teleradiology companies, how does the provider ensure that the contract is appropriately managed, what are the monitoring arrangements, and how does the provider ensure the quality of the reports is maintained? • How does the provider ensure that all staff undergo appropriate checks as required by Schedule 3 of the HSCA 2008 (Regulated Activities) Regulations 2014? • Is there regulation radiation protection committee meetings? How do these feed into the governance structure? What do the latest minutes say? • If undertaking ionising radiation has the provider applied to notify, register or get consent from HSE as appropriate? **Cancer** • Is there a service improvement lead for cancer?

Key line of enquiry: **W5**		
W5. Are there clear and effective processes for managing risks, issues and performance?		
Generic prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Managing risks, issues and performance**		
• W5.1 Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved? • W5.2 Are there processes to manage current and future performance? Are these regularly reviewed and improved? • W5.3 Is there a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken? • 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?	• NICE QS61 Statement 2: Organisations that provide healthcare have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems. • NICE QS121 Statement 5: Individuals and teams responsible for antimicrobial stewardship monitor data and provide feedback on prescribing practice at prescriber, team, organisation and commissioner level.	• Does the service have tested back up emergency generators in case of failure of essential services? • Is there 24/7 PACS support? What are the back-up plans in event of IT failure? • In the case of a service using radiation or radioactive substances are there effective contingency arrangements in place in case of incident occurring? • How does the service monitor reporting and appointment times? How does the service escalate and reduce any backlogs/waits? **Cancer** • How is the provider working towards delivering a sustainable workforce

• 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?		that can deliver the Long Term Plan for Cancer? For example, is there a focus on nationally known workforce shortages, such as in radiology? • Are regulation radiation protection committee meetings held? How do these feed into the governance structure? What do the latest minutes say? • Does the diagnostic 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?

Key line of enquiry: **W6**		
W6. Is appropriate and accurate information being effectively processed, challenged and acted upon?		
Generic prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Managing information**		
• W6.1 Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance? • W6.2 Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have 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?	• general-data-protection-regulation-GDPR	**Cancer** • What information is collated for cancer service improvement and innovation to feed into the provider's cancer improvement plan, to its Cancer Alliance and other information requirements as part of the Long Term Plan for cancer?

• W6.6 Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required? • W6.7 Are there robust arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?		
Key line of enquiry: **W7**		
Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?		
Generic prompts	**Professional Standard**	**Sector specific guidance**
Report sub-heading: **Engagement**		
• W7.1 Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups? • W7.2 Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?		• Are the questions sufficiently open ended to allow people to express themselves?

• W7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected characteristic? • W7.4 Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs? • W7.5 Is there transparency and openness with all stakeholders about performance?		
Key line of enquiry: **W8**		
W8. Are there robust systems and processes for learning, continuous improvement and innovation?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Learning, continuous improvement and innovation**		
• W8.1 In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes? • W8.2 Are there standardised improvement tools and methods, and do staff have the skills to use them? • W8.3 How effective is participation in and learning from internal and external reviews,		• Does the service have anything planned or in progress in relation to learning, improvement or innovation which will assist the delivery of the service?

including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements? • W8.4 Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation? • W8.5 Are there systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?		