NEXT PHASE METHODOLOGY (2017)
Core services

Acute

Inspection framework: NHS and Independent acute hospitals

Core service: Medical Care (including older people's services)

Section / Report sub heading	Page number	Detail of update
Amended main title	1	Framework is for NHS and Independents
Core service definition	4	Added link to supporting information on closed cultures.
Areas to inspect	5	Areas to inspect: Pharmacy removed.
Interviews / Observations	5 - 6	Lead Pharmacist for Cancer removed. Renal pharmacist removed.

Safe	7 - 25	Guidance added to S1: Guidance for Adult safeguarding. Guidance added to S1: Skills for Health Core Skills Framework. Prompt added to S1: DH Health Building Notes. Guidance added to S2: NICE CG179 relating to prevention and management of pressure ulcers added. Guidance added to S2: Acute care toolkit 10: Ambulatory emergency care. Guidance added to S2: Non-invasive ventilation Staffing guidance added. Prompt added to S2: Reference to NEWS updated to NEWS2. Prompt added to S2: Reference to Quality and Safety Programme: London Quality Standards updated to The Society for Acute Medicine: Quality Standards. Prompt added to S2: 'How is the service delivered during out-of-hours?' Prompt removed from S2 '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?' 'Is there a nominated lead or champion/ link worker for end of life care on each ward?' Guidance removed from S3: Professional standard QS121. Prompt removed from S3 'When people are prescribed an antimicrobial do they have the clinical indication?' S4 revised in line with advice from Medicines Optimisation Team. Including: NMC standards for medicine management removed. Guidance added to S4: Royal Pharmaceutical Society - Professional guidance on the administration of medicines in the healthcare setting.
Effective	26 - 44	Prompt added to E1: 'Process and mechanisms in place to meet guidance on quality standards for medical conditions published by the NICE'. Prompt added to E1: 'If they are not using national guidance, why not? How do they provide assurance?' Prompt added to E1: 'Does the service provide special meals, pureed meals, PEG fed for stroke patients, religious/cultural needs etc.' Guidance added to E1: NICE QS24 Nutrition support in adults. Guidance added to E1: NICE CG174 Intravenous fluid therapy in adults in hospital.

		Prompt added to E1 about decision making tools / apps being used. Link to BMJ Best Practice decision making app added in standards section. Guidance added to E1: Kidney Care UK standards for dialysis transport added. Prompt added to E2: '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?' Guidance added to E2: Detection and Management of Outliers for National Clinical Audits: Implementation guide for NCAPOP providers added. Reference to Inpatient Falls audit added to E2. Prompt added to E3: 'What support is available for non-mental health staff who are not competent or confident in working with people's mental health or emotional needs?' NMC standards for medicine management removed from E4. Seven day service clinical standard 9 - Transfer to community, primary and social care added to E4. Guidance added to E6: Reference added to BMA / RCP guidance on clinically-assisted nutrition and hydration and adults who lack capacity to consent. Guidance added to E6: BILD RNN Training Standards 2019 as good practice.
Caring	45 - 48	Links to NICE QS15 Patient experience in adult NHS services in C1 and C2 updated.
Responsive	49 - 57	Prompt added to R1: 'Has the service done an equality impact assessment?' Prompt added to R1: 'Is the service available to people when they need it?' Prompt added to R1: 'Is the service served by transport? What are the car parking facilities?' Links to NICE QS15 Patient experience in adult NHS services in R1 updated. Prompt added to R4: '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.'
Well led	58 - 67	Guidance added to W3: CQC guidance on WRES in IH. Prompt added to W8: 'Is the provider improving access to participation in clinical trials for patients? Are they monitored closely in line with ongoing trial outcomes?'

This includes the broad range of specialties not included in the other core services. In general terms, medical care includes those services that involve assessment, diagnosis and treatment of adults by medical interventions rather than surgery. Medical care also includes endoscopy services. Areas that we will inspect include:

- acute assessment units (also known as medical assessment units)
- general wards
- specialty wards, including gerontology (also known as care of the elderly) wards.

This is a core service where there may be a higher inherent risk of a closed culture that might lead to abuse or breaches of human rights. Please ensure you are familiar with the supporting information on identifying and responding to closed culture, which can be found here (internal link only).

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.

- Acute/medical assessment units, including sites for chair-based rapid assessment.
- General medical wards.
- Specialist wards.
- Care of the elderly wards/gerontology.
- Stroke unit and HASU (wherever angiographs and thrombolysis take place).
- Wards open for the purposes of escalation, overflow or winter pressure.
- Cardiac care unit.
- Discharge lounge/ward.
- Diagnostic areas (radiology and pathology).
- Frailty units
- Chemotherapy
- Radiotherapy
- Proton beam therapy (PBT) where provided
- Acute oncology service (if any)
- Specialist cancer wards (if any)

Interviews / observations

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

- People who use services (including cancer services) and those close to them
- Clinical director / lead for cancer services
- Nursing lead for each ward / unit / area
- Directorate / divisional manager
- MDT leads
- Nursing lead for cancer (if any)

- Managers for cancer services
- Informatics staff
- Lead for patient involvement - regarding cancer services

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

- Diagnostic area staff (radiology and pathology)
- Bed managers
- Ward managers
- Doctors of varying seniority
- General nurses of varying seniority
- Specialist nurses (e.g. cancer, dementia, mental health, LD, tissue viability, falls, infection control, diabetes)
- Dietitian
- Nurse consultant's
- Pharmacists
- Pharmacy assistants, medicines management technicians
- Allied health professionals
- Therapists
- Healthcare assistants
- Porters
- Physician assistants
- External providers and services such as GPs, district nurses
- Discharge coordinators
- Liaison between medical teams and other areas of the hospital, if there is one
- Liaison between medical and non-medical teams, if there is one
- Dialysis technician

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?	• Renal Association haemodialysis guidelines • Guideline 8.4 - HD: Prevention and detection of venous fistula needle or venous line disconnection • Skills for Health Core Skills Framework - 11 statutory / mandatory training areas and to which NHS Trusts declare their alignment **Cancer assessment framework** • 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	• Are there statutory and mandatory training records? • Is there a policy for sepsis management and are staff aware of it? • Have staff received training to make them aware of the potential needs of people with: ○ mental health conditions ○ learning disability ○ autism ○ dementia? • Have all dialysis staff got a contemporaneous training record on following standard operating procedures to minimise the risk of infection, electrolyte imbalance, symptomatic dialysis-related hypotension and/or

	sepsis. The training should be tailored according to the type of contact.”	accidental venous needle/line disconnection? **Cancer assessment framework** • Have staff received annual training on sepsis management (including neutropenic sepsis); including the use of sepsis screening tools and use of sepsis care bundles?
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).	• Safeguarding intranet page and inspector handbook on safeguarding includes guidance on level of training required and CQC inspection of safeguarding. ➢ 2018 position statement on safeguarding children training ➢ First edition of Intercollegiate Guidance for Adult Safeguarding (2018) ➢ Safeguarding Children and Young People: Roles and Competencies for Health Care Staff’ (March 2014) • HM Government: Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. March 2015 • Female genital mutilation multi-agency practice guidelines published in 2016	• Is there safeguarding training in mandatory training records? • Are there arrangements in place to safeguard women or children with, or at risk of, Female Genital Mutilation (FGM)? • 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? **Prompts relevant for AMSAT in NHS Acute Trusts** • 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?

• S1.5 Do staff receive effective training in safety systems, processes and practices? • S1.6 Are there arrangements to safeguard adults and children from abuse and neglect that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures, including working in partnership with other agencies? • S1.7 Do staff identify adults and children at risk of, or suffering, significant harm? How do they work in partnership with other agencies to ensure they are helped, supported and protected?	• DH Female Genital Mutilation and Safeguarding: Guidance for professionals March 2015 • FGM Mandatory reporting of FGM in healthcare • Guidelines for physicians on the detection of child sexual exploitation (RCP, November 2015) **Standards and guidance relevant for AMSAT in NHS Acute Trusts** • 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.	• Are there policies and procedures in place extra observation or supervision, restraint and, if needed, rapid tranquilisation? **Cancer assessment framework** • Do cancer patients have alert cards where required, such as for chemotherapy or malignant spinal cord compression and do staff, including A&E reception staff recognise these and know how to keep patients safe, e.g. isolated?
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	• Code of Practice on the prevention and control of infections • NICE QS61 Statement 3: People receive healthcare from healthcare workers who decontaminate their	• Are there cleaning audits (and evidence of re-audits if they perform badly)? • How does the service screen new admissions for MRSA/c-difficile/MSSA and GNBSI (specifically e.coli)?

systems in place to prevent and protect people from a healthcare-associated infection?	hands immediately before and after every episode of direct contact or care. • NICE QS61 Statement 4: People who need a urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it is no longer needed. • NICE QS61 Statement 5: People who need a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device and its removal as soon as it is no longer needed. • Decontamination of surgical instruments (CFPP 01-01) (chapter 6) • Health Technical Memorandum 01-06: Decontamination of flexible endoscopes • Renal Association Blood Borne Virus Infection guidelines • There should be an allocation of one to two isolation rooms per 12 stations.	• Are protocols in place for the protection of other people who use the service? • What are the unit infection rates? ○ C-Difficile ○ Blood steam infections ○ MRSA acquisition rate ○ CVC related blood stream infections (CVCBSI) ○ Ventilator Associated ○ Complications including VAP • What precautions are taken in radiology and endoscopy settings when seeing people with suspected communicable diseases (e.g. TB / Flu etc)? • Is the trust managing and decontaminating reusable medical devices in line with national guidance such as the DH Health Technical Memorandum on decontamination? • Is the trust following the guidance outlined in the management and decontamination of flexible endoscopes HTM? • What arrangements are in place for those patients returning from holiday in high risk of infection regions?

	• The isolation room should be accessible from the main dialysis area, and a viewing window to that area should be provided. • Refer to joint guideline on water treatment systems, dialysis water and dialysis fluid quality for haemodialysis and related therapies. Clinical Practice Guideline January 2016	• Are there procedures in place to assess patients as carriers of blood borne viruses (BBV) such as Hepatitis B and C. What measures are in place if such a carrier is identified and what actions are undertaken to mitigate the risk of BBV cross infection? • Is there evidence of bacteriological surveillance of haemodialysis fluids, and standards in place for specification of the water treatment system and biocompatible membranes?
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.)	• Adult inpatient and clinical facilities should be designed in keeping with the DH Health Building Notes including HBN 04-01. • MHRA guidance on the Management of medical devices • Pressure ulcers: prevention and management: [CG179] • Renal Association haemodialysis guidelines • Renal Association Guideline 2. Suggests that machines should be replaced between seven and ten years' service or after completing between 25,000 and 40,000 hours of	• How does service make sure facilities conform to professional standards? • Do staff have regard for alarm guards on the dialysis machines and ensure these alarm appropriately and not overridden? So that significant risks such as detection of dislodged needles can be identified at the earliest opportunity so that risk of significant blood loss or cardiac arrest can be avoided). **Cancer assessment framework** • How does the service assure itself and provide evidence that it is following appropriate guidance in relation to the service, maintenance and QA of:

	use for haemodialysis, depending upon an assessment of machine condition. (2C) - See: http://www.renal.org/guidelines/modules/haemodialysis#s1 • HSE guidance: Maintaining portable electrical equipment **Cancer assessment framework** • Achieving World Class Cancer Outcomes: A strategy for England	○ Equipment used for treatment delivery including linear accelerators, orthovoltage / superficial x-ray, brachytherapy equipment (and protons if they have them). • Is there a rolling plan to upgrade and replace linear accelerators in line with the national cancer strategy? • 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? • In the case of endoscopic procedures, do staff have access to appropriate accessories (e.g. Clips, diathermy) for any immediate procedure related bleeds?
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) The Society for Acute Medicine: Quality Standards • National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS NEWS2 • For endoscopic procedures, the service takes into account the BSG Quality and Safety Indicators for Endoscopy • Royal College of Physicians - Acute care toolkit 9: Sepsis • Acute care toolkit 10: Ambulatory emergency care • NICE CG179 relating to prevention and management of pressure ulcers **Standards and guidance relevant for AMSAT in NHS Acute Trusts**	• Does the provider assure itself against and implement NICE standards on things such as falls assessment? • How does the provider ensure that urgent or un-planned medical admissions are seen and assessed by a relevant consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital (Society for Acute Medicine: Quality Standards) and that they are assessed by a suitably qualified medical practitioner within 30 minutes? • Are all people admitted acutely continually assessed and monitored using the National Early Warning System (NEWS) 2? Is the NEWS2 competency-based escalation trigger protocol used for all people who use the service? • Is there a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response? How is the service delivered during out-of-hours?

	• NICE QS34 (Self harm) Statement 2 - initial assessments • NICE CG16 (Self harm in over 8s) • National Safety Standards for Invasive Procedures (NatSSIPs) Version number: 1 published: 7 September 2015 • Brief guide: NatSSIPs and LocSSIPs (CQC internal guidance) • Clinical Practice Guideline Peritoneal Dialysis in Adults and Children June 2017 **Cancer assessment framework** • NICE guidance CG151: Neutropenic sepsis: prevention and management in people with cancer	• Are there clear pathways and processes for the assessment of people using services within endoscopy clinics or radiology • departments who are clinically unwell and require hospital admission? Is there evidence of use of a sepsis care bundle for the management of patients with presumed/confirmed sepsis (i.e. 'Sepsis 6' care bundle)? Is there an escalation policy for patients with resumed/confirmed sepsis who require immediate review? • Is treatment delivered to patients with presumed sepsis within the recommended sepsis pathway timelines? E.g. antibiotics within an hour (Sepsis 6). Are sepsis patients receiving prompt assessment when escalated to multi-professional team? (for example: Critical Outreach Team). • How do leaders ensure that employees who are involved in the performance of invasive procedures develop shared understanding and are educated in good safety practice?, 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?

		• For endoscopic patients, do they have systems and processes in place to escalate patients who are in need of a higher level of care due to a perforation - (although this is perhaps more relevant for IH single speciality than NHS) • Do they have processes in place to direct patients as to what to do if they have a complication post procedure? **Prompts relevant for AMSAT in NHS Acute Trusts** • 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? **Cancer assessment framework** • Are patients at risk of and with suspected/confirmed sepsis receiving

		prompt assessment and treatment, 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 • When escalated to multi-professional team? For example, Critical Outreach Team or Acute Oncology Team. • Does the provider have an acute oncology service (AOS) in line with the recommendations of the National Chemotherapy Advisory Group report? • 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.

Report sub-heading: **Nurse 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?	• NICE guideline SG1 recommends a systematic approach to nurse staffing at ward level to ensure that patients receive the nursing care they need, regardless of the ward to which they are allocated, the time of the day, or the day of the week. It sets out that the occurrence of nursing red flag events (shown in section 1.4 of the NICE guidance is monitored throughout each 24-hour period. Monitoring of other events may be agreed locally. • The National Quality Board: How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability? • Royal College of Nursing: Safe staffing for older people's wards • HD therapy has been standardized by the Renal Workforce Planning Group. Refer to page 16 for WTE nursing staff per bed. • Non-invasive ventilation Staffing guidance	• Is staffing based on national guidance set out in The National Quality Board's publication? • **AHPs and Non-medical professionals** **Cancer assessment framework** • Is there appropriate access to Clinical Nurse Specialist staffing or other appropriate care co-ordinator for all cancer patients?

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?	• Quality Standards in Acute Medical Units • Renal Workforce Planning Group	• Is there a consultant trained in General Internal Medicine or Acute Internal Medicine, or with equivalent experience, on call at all times for each Acute Medical Unit, and able to reach the unit within 30 minutes? • Are staffing skill mixes and distribution of staff grades made in accordance with the standards set in the Society for Acute Medicine and the West Midlands Quality Review Service publication, Quality Standards in the AMU? • Is a doctor trained in the speciality of General Internal Medicine or Acute Internal Medicine at level ST3 or above or equivalent SAS grade, or a registered healthcare professional with equivalent competences, immediately available at all times? Do they have up-to-date competences in ALS? Reword - ST3 has to be registered with the RCP • Physician Associates • Resident Medical Officer (IH) • How does the provider ensure adequate consultant & non-consultant medical staffing?

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 • GMC guidance on keeping records • CG2 – Record Keeping Guidelines • NICE QS15 Patient experience in adult NHS services: statement 3	• Are admission notes legibly documented in keeping with appropriate national guidance? • Are nursing assessments and records in line with guidance/ standards for nursing / AHPs such CG2 – Record Keeping Guidelines? **Prompts relevant for AMSAT in NHS Acute Trusts** • 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? **Cancer assessment framework** • Are there multiple IT systems i.e. Electronic Patient Records and a separate cancer information system? If so, how do they ensure timely transfer of information between them? • Do patient records include all Multi-Disciplinary Team staff involved in patient's treatment, clear MDT plan, including other providers, for supporting the patient through the pathway?

		• 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?

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	• 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	• Are allergies clearly documented in the prescribing record used? • When people are prescribed an antimicrobial, is this in line with local microbiology protocols and do they have the clinical indication, dose and duration of treatment documented in their clinical record? • When people are discharged are their medicines explained to them and to their carers, and are they told what to do with their previous medicines. • Are there systems in place to identify, report and learn from medicines related safety incidents and alerts?

transfer between locations or changes in levels of care? • S4.6 Are people receiving appropriate therapeutic drug and physical health monitoring with appropriate follow-up in accordance with current national guidance or evidence? • S4.7 Are people's medicines regularly reviewed including the use of 'when required' medicines? • S4.8 How does the service make sure that people's behaviour is not controlled by excessive or inappropriate use of medicines?	• NICE QS121 Antimicrobial stewardship • NICE QS61 Statement 1: People are prescribed antibiotics in accordance with local antibiotic formularies as part of antimicrobial stewardship • NICE NG10 Violence and aggression: short-term management in mental health, health and community settings. • NICE QS120 Statement 4: People who are inpatients in an acute setting have a reconciled list of their medicines within 24 hours of admission. • Drug misuse in over 16's opioid	• When people are prescribed psychotropic medicines for challenging behaviour, is this in line with local protocols and national guidance, and is the rationale and duration documented with timely review? • When someone dependent on alcohol or misusing substances is admitted, are they offered medicines to assist their withdrawal and associated side effects.

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?	• 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	• How is learning from clinical incidents disseminated?

• 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? • 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?	level, and should have been implemented by all providers. They have 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. • (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. • Compliance with patient safety alerts should be investigated using the	• Is there evidence in incident investigations that duty of candour has been applied? • Do mortality and morbidity reviews feed into service improvement? Are these undertaken monthly, MDT attended, minuted and lessons learned?

	National Patient Safety Alerting System guidance. • RCN: Management of Pressure Ulcers: All pressure ulcers grade 2 and above should be documented as a local clinical incident.	
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 (including performance against safety goals where appropriate)?	• 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. • NICE QS89 Statement 1: People admitted to hospital or a care home with nursing have a pressure ulcer risk assessment within 6 hours of admission. • NICE QS86 statement 1: Older people who present for medical attention because of a fall have a multifactorial falls risk assessment. • NICE CG161 This clinical guideline offers evidence-based advice on	• NHS Safety Thermometer Does the service monitor the incidence of any of the following for medical inpatients? Does the service take appropriate action as a result of the findings? ○ Pressure ulcers ○ Falls ○ Catheters and UTIs ○ VTE

	assessing and preventing falls in older people during a hospital stay • Safety Thermometer	

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? • E1.4 Are the rights of people subject to the Mental Health Act 1983 (MHA) protected and	• NICE Quality standard [QS9]: Chronic Heart Failure • NICE Quality standard [QS5]: Chronic Kidney Disease in adults • NICE Quality standard [QS68]: Acute coronary syndromes • NICE Quality standard [QS76]: Acute kidney injury • NICE Quality standard [QS38]: Acute upper gastrointestinal bleeding • NICE Hip Fracture QS 16 • NICE Quality standard [QS6]: Diabetes in adults	• Has the service adapted guidance on quality standards for medical conditions published by the NICE? Process and mechanisms in place to meet these For example: - Chronic heart failure and an acute episode - Chronic kidney disease - Diabetes in adults - Acute coronary syndromes - Acute kidney injury - Acute upper gastrointestinal bleeding • If they are not using national guidance, why not? How do they provide assurance?

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?	• NICE guideline NG94: Emergency and acute medical care in over 16s: service delivery and organisation • 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, 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 • Review NICE standards for different conditions (dermatology? Haematology? Rheumatology? Stroke?) Needs to be flexible to meet different provision. What is in PIR? • Royal College of Physicians - Acute care toolkit 9: Sepsis • NICE QS121 Statement 6: Prescribers in secondary and dental care use electronic prescribing systems that	• Is sepsis screening and management done effectively, in line with National guidance (i.e. NICE guidance; UK Sepsis Trust) • Are all people on the AMU seen and reviewed by a consultant twice daily? To maximise continuity of care, are consultants working multiple day blocks? • Once transferred from the acute area of the hospital to a general ward, are people reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway? • Are endoscopic procedures, for example, diagnostic upper GI endoscopy carried out in line with professional guidance? • In assessing whether NICE guidance in followed, take the following into account: ○ Details of the Clinical Audit programme to support and monitor implementation of NICE guidance ○ Participation in National clinical audits • Are there measures in place for continued assessment of a patient's

	link indication with the antimicrobial prescription • Kidney Care UK standards for dialysis transport **Standards and guidance relevant for AMSAT in NHS Acute Trusts** • 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 • NICE CG91 - Depression in adults with a chronic physical health problem: recognition and management	vascular access e.g. arteriovenous fistula and line rates, process for regular monitoring of vascular access function? **Prompts relevant for AMSAT in NHS Acute Trusts** • 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 cardiometabolic screening and falls risk assessment? • Are patients who are suspected to be experiencing depression referred for a mental health assessment? • Do staff handovers routinely refer to the psychological and emotional needs of patients, as well as their relatives / carers? • Are relevant staff able to deal with any violence and aggression in an appropriate way? • 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?

	• Assessing mental health in acute trusts – guidance for inspectors **Cancer assessment framework** • NICE guidance CG151: Neutropenic sepsis: prevention and management in people with cancer • NICE pathway for breast, lung, prostate colorectal • NICE pathways for cancer: Breast: ○ Advanced breast cancer ○ Early and locally advanced breast cancer ○ Familial breast cancer Lung: ○ Diagnosis and staging of lung cancer ○ Managing lung cancer ○ Treating non-small-cell lung cancer ○ Treating small-cell lung cancer ○ Supportive and palliative care for lung cancer ○ First-line systemic anticancer treatment for advanced or metastatic non-small-cell lung cancer ○ Systemic anticancer treatment for previously treated advanced or metastatic non-small-cell lung cancer	• Are best practice decision making tools encouraged and does the service monitor their use - for example the BMJ Best Practice decision making app?

	Prostate: ○ Prostate cancer overview ○ Assessing suspected prostate cancer ○ Managing localised or locally advanced prostate cancer ○ Radical treatment for localised or locally advanced prostate cancer ○ Managing metastatic prostate cancer ○ Treating hormone-relapsed metastatic prostate cancer Colorectal ○ Colorectal cancer overview ○ Managing local colorectal tumours ○ Managing advanced and metastatic colorectal cancer • Other NICE Guidance for: ○ Breast cancer ○ Lung cancer ○ Prostate cancer ○ Colorectal cancer • Stratified pathways – How to Guide – for people living with and beyond cancer • NHS England – Guidance for Cancer Alliances • All breast cancer patients have access to stratified follow up pathways of	

	care, and, dependent on evidence from pilots, from 2018/19 all prostate and colorectal cancer patients have access to stratified follow up pathways of care. • BMJ Best Practice	
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 QS24: Nutrition support in adults: Screening for the risk of malnutrition • NICE CG174: Intravenous fluid therapy in adults in hospital	• Do people using the service have a nutritional assessment on admission, if this is clinically indicated? • Do staff have access to dietitian services? Does the service provide special meals, pureed meals, PEG fed for stroke patients / religious /cultural needs etc?
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?	• RCP National guideline: Assessment of pain in older people • Core Standards for Pain Management Services in the UK	• How has the service implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015)? • Do staff use an appropriate tool to help assess the level of pain in patients who are non-verbal? For example, DisDAT (Disability Distress Assessment Tool) helps to identify the source of distress, e.g. pain, in people with severe communication difficulties. GMC recommended. Abbey Pain Scale for people with dementia.

		• How does the service ensure that patients are given effective pain relief, including: ○ 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? • Is there a specialist pain team? Are they available 24/7?
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	• Royal College of Physicians Clinical Audits • Detection and management of outliers for National Clinical Audits: Implementation guide for NCAPOP providers • UK Renal Registry provides independent audit and analysis of renal replacement therapy in the UK. The Registry acts as a source of comparative data, for	• 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? • Is the service regularly reviewing the effectiveness of care and treatment through local audit and national audit? Are there audits that the service does not contribute to? What are their outcomes compared

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?	audit/benchmarking, planning, clinical governance and research. • The Renal association recommend that every patient with end-stage chronic renal failure receiving thrice weekly HD should have consistently: either urea reduction ratio (URR) > 65% or equilibrated Kt/V of >1.2 (or sp Kt/V of > 1.3) calculated from pre- and post-dialysis urea values, duration of dialysis and weight loss during dialysis. Refer to: http://www.renal.org/guidelines/modules/haemodialysis#s1 • Refer also to: NICE Renal replacement therapy services for adults Quality standard [QS72]	with benchmarks? For example: Respiratory ○ National Asthma and COPD Audit Programme (NACAP) Cardiology • MINAP (NICOR / HQIP) • Heart Failure Audit (NICOR / HQIP) • National Audit of Cardiac Rhythm Management (NICOR / HQIP) Coronary Angioplasty (percutaneous coronary interventions) (NICOR / HQIP) Gastroenterology • Inflammatory Bowel Disease Audit (IBD Registry / HQIP) • National Bowel Cancer Audit (HSCIC / HQIP) – including rate of laparoscopic completed rather than 'attempted' Neurology • National Dementia Audit (RCP / HQIP) • Stroke Audit (SSNAP) • National Audit of Seizure Management (NASH/HQIP) Cancer • National Bowel Cancer Audit (HSCIC / HQIP including rate of laparoscopic completed rather than 'attempted'

		• National Lung Cancer Audit (LUCADA) • National Prostate Cancer Audit • Breast Cancer in Older People Other ○ UK Renal Registry ○ National Diabetes Inpatient Audit (HQIP) ○ Rheumatoid and Early Inflammatory Arthritis Audit (HQIP) ○ Inpatient Falls Audit • Does the provider participate in the Joint Advisory Group on GI Endoscopy (JAG)? If so what level of accreditation does it hold? • Is there evidence of action plans being created to address deviations from national targets? • How much does this trust compare against the national standards, and how do they benchmarks against other similar services? Analysts reports against this. • Does the service hold regular audit meetings to review performance in patient outcomes? Has there been evidence of quality improvement?' Evidence of support and training? **Cancer assessment framework**

		• National Cancer Patient Experience Survey • Is the service regularly reviewing the effectiveness of care and treatment for cancer through local and national audit? Are there audits that the service does not contribute to? What are their outcomes compared with benchmarks and does the provider implement action plans that it monitors to address any deviations from national targets For example, in the four most common cancers: breast, lung, prostate and colon? • What proportion of cancer patients are offered the opportunity to take part in clinical trials? Are all cancer patients informed about all ongoing 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?
Key line of enquiry: **E3**		
E3. How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?		
Prompts	**Professional standard**	**Sector specific guidance**
Report sub heading: **Competent staff**		

• E3.1 Do people have their assessed needs, preferences and choices met by staff with the right skills and knowledge? • E3.2 How are the learning needs of all staff identified? Do staff have appropriate training to meet their learning needs to cover the scope of their work and is there protected time for this training? • E3.3 Are staff encouraged and given opportunities to develop? • E3.4 What are the arrangements for supporting and managing staff to deliver effective care and treatment? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.) • E3.5 How is poor or variable staff performance identified and managed? How are staff supported to improve? • E3.7 Are volunteers recruited where required, and are they trained and supported for the role they undertake?	• NMC Standards for competence for registered nurses • RCN: Management of Pressure Ulcers: The health care team should have undergone appropriate training and have demonstrated competence in pressure ulcer management. • 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. **Standards and guidance relevant for AMSAT in NHS Acute Trusts** • NICE NG11 - Challenging behaviour and learning disabilities prevention and interventions for people with learning disabilities whose behaviour challenges	**Prompts relevant for AMSAT in NHS Acute Trusts** • 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? • What support is available for non-mental health staff who are not competent or confident in working with people's mental health or emotional needs? **Cancer assessment framework** • Does the provider undertake analyses of training gaps and competency mix in the cancer service?

		• Do staff in the cancer service have competency-based training

Key line of enquiry: **E4**

E4. How well do staff, teams and services within and across organisations work together to deliver effective care and treatment?

Prompts	**Professional standard**	**Sector specific guidance**
Report sub-heading: **Multidisciplinary working**		
• E4.1 Are all necessary staff, including those in different teams, services and organisations, involved in assessing, planning and delivering care and treatment? • E4.2 How is care delivered and reviewed in a coordinated way when different teams, services or organisations are involved? • E4.3 How are people assured that they will receive consistent coordinated, person-centred care and support when they use, or move between different services? • E4.4 Are all relevant teams, services and organisations informed when people are discharged from a service? Where relevant, is discharge undertaken at an appropriate time of day and only done when any necessary ongoing care is in place?	• PHSO: A report of investigations into unsafe discharge from hospital • Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE guideline 27) • London Quality Standards **Cancer assessment framework** • NHS England Cancer Alliance Guidance • Effective MDT working is in place • MDTs review a monthly audit report of patients who have died within 30 days of active treatment (39) • MDTs consider appropriate pathways of care for metastatic cancer patients	• Are people with complex needs receiving prompt screening by a multi-professional team, including physiotherapy, occupational therapy, nursing, pharmacy and medical staff, social services ? A clear MDT assessment should be undertaken within 14 hours and a treatment or management plan to be in place within 24 hours (RCP Standards) • Are there regular MDT meetings for people with complex needs? (and do social services attend?) • Are there pathways in existence for referral between specialities in the hospital? • Are there pathways in existence between other trusts – e.g. Referral for specialist advice? How effective do staff find this?

		• Are all team members aware of who has overall responsibility for each individual's care?
		
		• Are there established links with:
		  ○ mental health services
		  ○ learning disability
		  ○ autism
		  ○ dementia services?
		
		• Is there evidence of multi-disciplinary/ interagency working when required?
		
		Cancer assessment framework
		• Do the MDT Terms of Reference include links with other MDTs and services, such as where teenagers and young adults (TYA) with solid tumours are managed by an adult MDT, that access to the TYA MDT and other TYA services is clearly included?
		
		• Do regular clinical discussions support effective protocol management of non-complex cancer patients and how are the patients' views and wishes heard? Move second part to caring.
		
		• Does the service support delivery of the Recovery Package of interventions, including delivery of Holistic Needs Assessments and the preparation of Treatment Summaries to improve

		communication between cancer services, patients and primary care? • Is the service working proactively and effectively with other providers in its Cancer Alliance?
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?	• RCP: Acute medical care: The right person, in the right setting – first time
	
	• RCP: Delivering a 12-hour, 7-day consultant presence on the acute medical unit
	  ○ AOMRC: Seven day consultant present care
	  ○ RCP: Future Hospital Commission
	
	• Seven Day Services Clinical Standards
	
	Standard 2:*Time to first consultant review*
	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital.
	
	• Standard 5: *Diagnostics*
	Hospital inpatients must have scheduled seven-day access to
		• Does the provider meet the NHS Services, Seven Days a Week Forum's seven day services priority standards for:
		  ○ Time to First Consultant Review
		  ○ Diagnostics
		  ○ Intervention/ Key Services
		  ○ Ongoing Review

	diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: ▪ Within 1 hour for critical patients ▪ Within 12 hours for urgent patients ▪ Within 24 hours for non-urgent patients • Standard 6: *Intervention / key services* Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be: ○ Critical care ○ Interventional radiology ○ Interventional endoscopy ○ Emergency general surgery ○ Emergency renal replacement therapy ○ Urgent radiotherapy ○ Stroke thrombolysis ○ Percutaneous Coronary Intervention	

	○ Cardiac pacing (either temporary via internal wire or permanent) • Standard 8: *Ongoing review* All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway. • Standard 9: *Transfer to community, primary and social care* Once transferred from an acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	

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? • 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	• 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 Code of Practice (including children and young people - chapter 19) • Recommendations from the Gosport Inquiry • BMA / RCP guidance on clinically-assisted nutrition and hydration and adults who lack capacity to consent • BILD Restraint reduction network Training Standards 2019	AMSAT • What is the sedation policy in use on wards? • Is there evidence of the inappropriate use of sedation? • 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? • Have they considered recommendations from the Gosport Inquiry?

seek authorisation to do so when they consider it necessary and proportionate?		

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?	• NICE QS15 Patient experience in adult NHS services: statement 1 and 2 **Cancer assessment framework** • The Macmillan Quality Environment Award is a framework for assessing whether cancer care environments meet the standards required by people living with cancer. (Includes list of providers who have achieved award). *This will be incorporated into a new Macmillan Quality Standard later in 2018, covering a wider range of cancer interventions, including professional posts,*	• Do staff show awareness of the 6 Cs? • Do staff take account of psychosocial aspects of care as well as physical? • 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

• 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?	*and with enhanced evidence requirements.*	○ 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 services, including carers, family and dependants?		• Are patients (and their families) who receive life-changing diagnoses given appropriate emotional support, including help to access further support services? (Life-changing conditions include, but are not limited to, terminal illness, bariatric surgery, dialysis or HIV. Menopause can also impact on women's emotional health) • If a patient becomes distressed in an open environment, how do staff assist them to maintain their privacy and dignity? • Do patients' relatives/close ones receive adequate support and information? E.g. access to

		psychological services – is there a waiting list, how do they access it? What other services are available locally, through the voluntary service, how do people access other services?
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	• NICE QS15 Patient experience in adult NHS services: statement 5 and 6 • GMC Guidance and resources for people with communication difficulties	• When older people with complex needs are being discharged, do the staff involve those close to the person

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 sharing their information?		

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) • The National Service Framework for Renal Services **Standards and guidance relevant for AMSAT in NHS Acute Trusts** • 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. **Cancer assessment framework** • Guidance for Cancer Alliances	• What are the arrangements for ambulatory care (and opening hours)? • Are the needs of patients with ○ mental health conditions ○ learning disability ○ autism ○ dementia routinely considered when the provider conducts impact assessments or is undergoing changes. • Has the service done an equality impact assessment? • Is the service available to people when they need it?

	• Macmillan Recovery Package - recognised by the national cancer taskforce, which outlines a commitment to ensuring that 'every person with cancer has access to the elements of the Recovery Package by 2020'. The package includes:
	  ○ Holistic Needs Assessment
	  ○ Care Planning
	  ○ Treatment Summary
	  ○ Cancer Care Review
	  ○ Health and Wellbeing Events
	• By 2018/19 (NHS Shared Planning Guidance – link p7 in Guidance for Cancer Alliances):
	• Ensure all parts of the Recovery Package are available to all patients including:
	  ○ ensure all patients have a holistic needs assessment and care plan at the point of diagnosis and at the end of treatment
	  ○ ensure that a treatment summary is sent to the patient's GP at the end of treatment
		• Is the service served by transport? What are the car parking facilities?
		
		Cancer assessment framework
		• 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.
		• Does the provider implement the MacMillan Recovery Package for every patient with cancer?
		• How does the provider tackle variations in access to services and treatment outcomes between different groups of patients, such as older people, and learning disabilities, people with a mental health condition, and people with from a BME community or a seldom heard group?
		• Is there adequate patient information and support relating to the NHS Cancer Drugs Fund?

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	• NICE QS15 Patient experience in adult NHS services: statement 4	• Are there any systems or staff members in place to aid the delivery of care to patients in need of

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? • 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?	• Accessible Information Standard • Age UK operates a welcome home service in some areas and ensures houses are warm and fridges stocked with essentials for people on discharge see links for examples: 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 • Dementia Charter	additional support? For example dementia champions or dementia symbols above bed or Learning Disability link nurses or stickers on paper records. • How well do they care for people living with dementia? Is there a dementia-friendly ward/area? How many staff have dementia training? Is dementia assessed on admission? • Are there arrangements in place for people who need translation services? • Are there suitable arrangements in place for people with a learning disability? • How well does the service care for people with other complex needs, e.g. deaf/blind/wheelchair access? • Is there single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum in person response time of 30 minutes?[2] • How are complex discharges supported? How is key information about older people with complex needs communicated to members of the community health team on

[1]. For example, people living with dementia or people with a learning disability or autism.
[2] AoMRC (200*) Managing urgent mental health needs in the acute trust

		discharge? For example sharing of assessments, including tissue viability (pressure risk) and nutritional assessment and risk. • 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." • 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)? • Does the service avoid discharging older people late at night if they have complex needs and live alone? **Prompts relevant for AMSAT in NHS Acute Trusts** • 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? • Are patients given a choice on how, e.g. by phone 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 CNS or equivalent available at these times?
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 the technology (including telephone systems and online/digital services) easy to use?	**Cancer assessment framework** • NHS England Cancer Waiting Times standards: ○ Guidance on delivering waiting times standards: All trusts should maintain a weekly patient tracking list (PTL) and hold a weekly PTL meeting, involving the departments directly supporting and overseeing the delivery of cancer waiting times. ○ Two weeks from urgent GP referral for suspected cancer to first appointment (93%) ○ Two weeks from referral for breast symptoms (whether cancer is suspected or not) to first appointment (93%) **Note** - Cancer Strategy: Ambition is that that by 2020 95% of people referred for testing by a GP are diagnosed definitively with cancer, or cancer is excluded, and the result communicated to the patient, within four weeks, and 50% within two weeks. Phase out urgent referral (two week) pathway. The **new 28 day 'Faster Diagnosis Standard'** (28 days from referral to diagnosis or cancer ruled out) is being introduced from April 2018.	• Are there rapid access/'hot' clinics – e.g. TIA/RACP? **Spell out** • Number of medical outliers (and arrangements for review – are they seen at the end of ward rounds or by a separate team?) • Is there a trust OOH discharge policy? • Average and maximum number of bed moves during stay? • Number of bed moves occurring out of hours (10pm to 6am)? • When is discharge planning started? Is it on admission? • Do daily 'Board Rounds' occur? • Who coordinates the flow within the hospital? How well do they work with the rest of the hospital? (site team). • How effective are escalation policies work (i.e. when on OPEL 4)? • Are any escalation beds open? How are these managed?

	○ 62 days from urgent GP referral for suspected cancer to first treatment (31 days for children's cancers, testicular cancer, and acute leukaemia) (85%) ○ 62 days from urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) to first treatment (90%) ○ 62 days from a consultant's decision to upgrade the urgency of a patient (e.g. following a non-urgent referral) due to a suspicion of cancer to first treatment (no operational standard set) ○ 31 days from diagnosis (decision to treat) to first treatment for all cancers (96%) ○ 31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (surgery or radiotherapy) (94%) ○ 31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (anti-cancer drug therapy, e.g. chemotherapy) (96%) • National cancer breach allocation guidance	• What time do discharges occur? (ideally they should be before 11am) Is this monitored? • What are the reasons for delayed discharges? • How does the service ensure that it meets clinical guidance for report turnaround time for medical staff requesting diagnostic imaging and endoscopy to be carried out? **Prompts relevant for AMSAT in NHS Acute Trusts** • 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? • How does the provider manage achievement of waiting times in line with national guidance and use tools provided? • • How is the flow between the provider and other providers, including tertiary services working, including capacity to accept referrals and repatriation of patients?

	It is essential that tracking of cancer patients continues after a breach has occurred by the provider responsible for the patient's care, and also following any patient transfer to another provider, for the purposes of either the delivery of treatment, or diagnostic tests and investigations.	

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	• 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. **Private patients only**	**Private patients 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) 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. "

explanation of the outcome, and a formal record? • R4.4 How are people who raise concerns or complaints protected from discrimination, harassment or disadvantage? • R4.5 To what extent are concerns and complaints used as an opportunity to learn and drive improvement?	• ISCAS: Patient complaints adjudication service for independent healthcare	

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?	• NMC Raising and escalating concerns: Guidance for nurses and midwives • NMC whistleblowing Policy	• Are staff aware of the whistleblowing and applicable policy (if appropriate)? • Who has the lead for mental health within the service / department? Do they have appropriate expertise in this area or are they supported by someone who does? • Are there appropriate leadership arrangements in place to support improvement of the providers services? • Do they understand the services issues within the provider and are they active and visible to staff?

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 assessment framework** • 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. • NHS E priorities for 2018/19, as stated by national programme director: ○ Infrastructure: workforce, data, new RTT. ○ Early diagnosis incl lung CT [other priorities here are outside acute remit: FIT & HPV screening].	**Prompts relevant for AMSAT in NHS Acute Trusts** • If the trust has a vision and strategy specific to, or inclusive of, mental health, who in the service knows about this? What is the service's contribution to achieving it? • Does the provider have a clear vision and strategy for the delivery and improvement of its services and in partnership with other providers? • How does their strategy link with the national networks?

	○ Improving personalised treatment: new linear accelerators, structured follow-up, Recovery Package, Quality of Life survey / metric for cancer patients.	

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 • Committee of Advertising Practice: Healthcare - Overview • Eight high impact actions to improve the working environment for junior doctors • 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. 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

• 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? • W4.2 Do all levels of governance and management function effectively and interact with each other appropriately?	• The Health Care and Associated Professions (Indemnity Arrangements) Order 2014 **Cancer assessment framework** • Reporting of cancer patients with a long waiting time	• What are the governance procedures for managing and monitoring any SLAs the provider has with third parties? • Is there a sepsis lead who oversees the departmental/trust sepsis management?

• 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?	• The Trust Board should receive routine reports on cancer waiting times performance. These reports must show performance against each of the cancer operational standards and the actions being taken to improve and sustain cancer performance. • These reports should be presented in a way which allows the Trust Board to see the number and proportion of patients with a long waiting time. • Where required, the Trust Board should see outcomes of the root cause analysis (RCA) in relation to the cancer pathway/s concerned, and may request further forms of exception reporting as required by local circumstances. • Health Education England 'Cancer Workforce Plan'	• 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.
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	• NICE QS61 Statement 2: Organisations that provide healthcare have a strategy for continuous	• In relationship to sepsis and antimicrobial prescribing and

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? • 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?	improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems. • 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 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. **Cancer assessment framework** • Cancer Alliance Guidance Improved access to clinical trials	stewardship, how is performance in and patient outcomes fed back to the trust board? Is there effective trust board oversight of performance regarding antimicrobial prescribing and stewardship? What action is taken when issues are identified? What are arrangements to ensure safety in cases of failure of essential utilities? (e.g. back up emergency generators) • What is the Local Emergency Preparedness Resilience Policy (EPRR policy)?

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? • 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		**Prompts relevant for AMSAT in NHS Acute Trusts** • Are any senior staff members required to regularly report on any aspect of patients' mental health or emotional wellbeing? • Are there any systems that help or hinder access to up-to-date information about patients' mental health? • How does the provider assure itself that it has an effective information management system in place, including electronic and paper-based and that it links well with other information systems?

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? • 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	**Cancer assessment framework** • National Cancer Strategy Implementation Plan • NHS England - Guidance for Cancer Alliances	• 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? • Does the ward leadership team understand how their staff feel about delivering or coordinating care that meets both the physical and mental health needs of patients? **Public Engagement** • Have they involved any external organisations to help them improve or sustain the care provided to patients with mental health or emotional wellbeing issues?

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, 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?	• 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. • NHS England Service Specifications for: ○ Radiotherapy ○ Chemotherapy ○ Specialised cancer diagnostics ○ Looks at these – could be evidence based care and treatment) • Macmillan Quality Environment Award	• Does the service have anything planned or in progress in relation to learning, improvement or innovation which will assist the delivery of the service? • Is the provider improving access to participation in clinical trials for patients? Are they monitored closely in line with ongoing trial outcomes?

• 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?		