

Criteria for assessing core
standards in 2009/10

Mental health and learning disability trusts

July 2009

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Use of “we” (Overview section)

The new Care Quality Commission replaced the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission from April 2009, providing an integrated approach to regulation across these bodies’ current areas of responsibility. The Care Quality Commission was established on 1 October 2008 with limited preparatory functions and took over the regulation of health and adult social care from 1 April 2009.

The Care Quality Commission is responsible for delivery of the 2009/10 periodic review, including the core standards based assessment from 1 April 2009.

Where this document refers to “we” this is a reference to the Care Quality Commission from 1 April 2009.

Overview

This document proposes the criteria to be used for assessing core standards between 1 April 2009 and 31 March 2010 for trusts that provide mental health and learning disability services within England. All trusts should use this document when determining whether they have reasonable assurance of their compliance against core standards, and subsequently when completing trust declarations of compliance for the period 1 April 2009 to 31 October 2009 as part of the 2009/10 periodic review. This criteria document is intended to assist in preparation and, as for previous years, we have set out our criteria as 'elements' for each of the core standards.

What has changed?

Assessment in 2009/10

2009/10 is a transitional year between the previous system of the annual health check in 2008/09 and our new systems of registration and periodic review. Our review of NHS trusts and primary care trusts as providers will have three components of assessment:

- Compliance with core standards.
- Performance against the government's national priorities and existing commitments.
- Quality of financial management.

To avoid confusion with providers' applications for registration, which will start in January 2010, we will request a core standards declaration mid year. However, Trusts are required to comply with the core standards for the entire assessment year 1 April 2009 to 31 March 2010.

We will be asking NHS provider trusts, including primary care trusts as providers, to make a declaration at the end of November 2009 of their performance against core standards in the first seven months of the year from 1 April 2009 to 31 October 2009. We will ask organisations to include a statement on the progress of their action plans to rectify lapses outstanding from 2008/09 and changes as a result of inspections relating to the 2008/09 declaration.

What else has changed?

We will not ask primary care trusts as commissioners to make a mid-year declaration.

Declarations will not include standards related to healthcare-associated infections. From the 1 April 2009, all NHS organisations to which the Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Healthcare Associated Infections applies were registered with the Care Quality Commission. Standards **C4a** and **C4c** are therefore covered by our registration of trusts in 2009/10.

Trusts should note that a declaration for standard C21 will be required. However, element two of core standard **C21** will not be assessed for all NHS provider trusts in 2009/10 as element two is also covered by our registration of trusts in 2009/10.

How should trusts' boards consider the elements?

The criteria are written to reflect the requirements upon trusts throughout the assessment year; they do not introduce new requirements. As in previous years of the core standards assessment we ask NHS trust boards, when making their declaration, to determine whether they have reasonable assurance of compliance with a standard, without a significant lapse, from 1 April 2009 to 31 October 2009. For the remainder of the assessment year, from 1 November 2009 to

31 March 2010, trust boards are required to maintain their assurance systems with regard to compliance with the core standards, which remain in place for the whole year, and are required to inform the Care Quality Commission of any significant lapses or any gaps in assurance for the remainder of that year up until 31 March 2010. Their final score will be amended accordingly and their declaration will be amended accordingly.

Reasonable assurance

Reasonable assurance, by definition, is not absolute assurance. At the same time, reasonable assurance cannot be based on assumption. Reasonable assurance is based on documentary evidence that can stand up to internal and external challenge. In determining what level of assurance is a reasonable, trusts must recognise that the core standards are not optional and describe a level of service which is acceptable and which must be universal. Our expectation is that each trust's objectives will include compliance with the core standards. This will be managed through the trust's routine processes for assurance.

Trusts' boards should consider **all** aspects of their services when judging whether they have reasonable assurance that they are meeting the published criteria for assessment. Where healthcare organisations provide services directly, they have primary responsibility for ensuring that they meet the core standards. However, their responsibility also extends to those services that they provide via partnerships or other forms of contractual arrangement (for example, where human resource functions are provided through a shared service). When such arrangements are in place, each organisation should have reasonable assurance that those services meet the requirements of the standards.

Significant lapse

Trusts' boards should decide whether a given lapse is significant or not. In making this decision, we expect that boards will consider the extent of risk of harm this lapse posed to patients, staff and the public, or indeed the harm actually done as a result of the lapse. The type of harm could be any sort of detriment caused by lapse or lapses in compliance with a standard, such as loss of privacy, compromised personal data or injury, etc. Clearly this decision will need to include consideration of a lapse's duration, its potential harmful impact and the likelihood of that harmful impact occurring or re-occurring. There is no simple formula to determine what constitutes a 'significant lapse'. This is, in part, because our assessment of compliance with core standards is based on a process of self-declaration through which a trust's board states that it has received 'reasonable assurance' of compliance. A simple quantification of the actual and/or potential impact of a lapse, such as the loss of more than £1 million or the death of a patient or a breach of confidentiality, for example, cannot provide a complete answer.

Determining what constitutes a significant lapse depends on the standard that is under consideration:

- The circumstances in which a trust operates (such as the services they provide, their functions and the population they serve)
- The extent of the lapse that has been identified (for example, the duration of the lapse and the range of services affected, the numbers exposed to the increased risk of harm, the likely severity of harm to those exposed to the risk (taking account their vulnerability to the potential harm) etc.) Note that where a number of issues have been identified, these issues should be considered together in order to determine whether they constitute a significant lapse.

Equality, diversity and human rights

The Care Quality Commission recognises that services need to encourage respect within

services for people's human rights and for their diversity, and to promote action to reduce inequalities in people's health and experiences of healthcare. In line with the intention of *Standards for Better Health*, we expect that healthcare organisations will interpret and implement the standards in ways which challenge discrimination, promote equity of access and quality of services, reduce inequalities in health, and which respect and protect human rights.

More specifically, core standard C7e asks trusts to challenge discrimination, promote equality and respect human rights. The proposed criteria for C7e include a focus on how the trust is promoting equality, including by publishing information specified by statute in relation to race, disability and gender.

Registration

With the introduction of the Health and Social Care Act 2008 and the Health and Social Care Act (Registration Requirements) Regulations 2009, Standards for Better Health for the NHS are being replaced by registration requirements – essential common quality standards across the care sector. From April 2010 all regulated health and adult social care providers will be required by law to register with CQC and to do so they must show they are meeting these essential common quality standards.

We are currently consulting on our draft guidance about compliance, which makes clear to providers what they must do to comply with the essential common quality standards.

In January 2010 we will invite trusts to apply to be registered and ask them to make a declaration of their compliance with registration requirements. We will assess their applications and, where appropriate, make further enquiries, including some inspections, in order to register trusts at 1 April 2010. It is our intention that our resources, and those of trusts, are focussed on driving improvement in preparation for registration, rather than on inspections related to the outgoing core standards. To further assist NHS providers, we will publish a guide to the links between registration requirements and Standards for Better Health. We will also be holding workshops in the autumn to help NHS Trusts understand how to register against the essential common quality standards.

Information received as part of core standards' declarations will be used as part of our cross check of information to inform our decision on trusts' registration status in April 2010, where appropriate.

Criteria for assessing core standards in Mental Health and Learning Disability Trusts

Introduction

In the following pages you will find the criteria for assessment of core standards in 2009/10 along with the rationale for them, including commentaries on changes from the previous 2008/09 criteria (also provided in this document for ease of reference). They are laid out in order of the core standards and grouped by domain, and the domain outcomes and standards themselves are quoted.

In-year revisions to legislation, codes of practice and guidance

All legislation, codes of practice and guidance referred to in the core standard criteria/elements are up to date at the time of publishing. During the assessment year trusts are expected to ensure they comply with any replacements, revisions, amendments or supplements to the said legislation, codes of practice or guidance, or any new legislation, codes of practice or guidance as applicable to the standard, and will be assessed on this basis

First domain: safety

Domain outcome: Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Core standard C1a

Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.

Elements

Element one

Incidents are reported locally and nationally via the appropriate reporting route/s to the National Patient Safety Agency (NPSA), Health and Safety Executive, Medicines and Healthcare products Regulatory Agency (MHRA), Health Protection Agency, Care Quality Commission (CQC), the Counter Fraud and Security Management Service and all other national organisations to which the healthcare organisation is required to report incidents.

Element two

Individual incidents are analysed rapidly after they occur to identify actions required to reduce further immediate risks, and where appropriate individual incidents are analysed to seek to identify root causes, likelihood of repetition and actions required to prevent the reoccurrence of incidents in the future.

Element three

Reported incidents are aggregated and analysed to seek to identify common patterns, relevant trends, likelihood of repetition and actions required to prevent the reoccurrence of similar incidents in the future, for the benefit of patients / service users as a whole.

Rationale

Element one

Healthcare organisations should report incidents locally within their healthcare organisation (via systems that meet their requirements for local reporting). They should also report incidents to all national organisations to which the healthcare organisation is required to report. The element has been amended to reflect the creation of the Care Quality Commission (CQC). The CQC brings together independent regulation of health, mental health and adult social care. Before 1 April 2009, this work was carried out by the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection. These organisations no longer exist.

Element two

No change to this element from 2008/09. The Healthcare organisations should analyse incidents rapidly after they occur so that immediate risks are removed for those involved in the incident. Furthermore, where appropriate, incidents should be analysed to identify root causes, and likelihood of repetition in order to prevent the reoccurrence of incidents in the future. The information arising from the analysis of incidents must also enable the identification of actions required to prevent the reoccurrence of incidents.

Element three

No change to this element from 2008/09. Incidents should be aggregated (including all incidents reported over a period of time) and analysed, to identify relevant trends, common patterns and likelihood of repetition, in order to prevent the reoccurrence of incidents in the future.

Common patterns include factors such as location of incident, time of day of incident, patient

characteristics, etc. The analysis of relevant trends includes changes over time. As with element two regarding individual incidents, the information arising from the analysis of aggregated incidents must also enable the identification of actions required to prevent the reoccurrence of incidents.

Element four

Demonstrable improvements in practice are made to prevent the reoccurrence of incidents based on information arising from the analysis of local incidents and the national analysis of incidents by the organisations stated in element one (above).

Element four

No change to this element from 2008/09. Healthcare organisations should make demonstrable improvements in practice to prevent the reoccurrence of incidents based on the analysis of their local incidents and the national analysis of incidents. The national analysis of incidents is carried out by the NPSA and a wider range of organisations that have been listed in element one.

Core standard C1b

Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.

Elements

Element one

All relevant communications requiring action concerning patient safety issued on behalf of the Medicines and Healthcare products Regulatory Agency (MHRA), the National Patient Safety Agency (NPSA), and the Department of Health (DH) via national distribution systems, including the Central Alert System (CAS), are implemented within the required timescales.

Rationale

Element one

All patient safety alerts, medical device alerts, drug alerts and other patient safety communications are now issued via CAS.

Other communications are issued via systems other than CAS. For example, the MHRA issues targeted safety letters about medical devices to a limited number of healthcare organisations known to be affected by a particular issue such as a medical device field safety corrective action.

Core standard C2

Healthcare organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.

Elements

Element one

The healthcare organisation has made arrangements to safeguard children under Section 11 of the Children Act 2004 having regard to statutory guidance entitled *Statutory Guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004*.

Rationale

Element one

No change to this element from 2008/09. In 2007 statutory guidance was published, updating previous guidance based on the Children Act 2004. Compliance with this was required by October 2005. The guidance issued under section 11(4) of the Children Act 2004 requires each person or body to which the Section 11 duty applies to have regard to any guidance given to them by the Secretary of

State. This means that they must take this guidance into account and, if they decide to depart from it, have clear reasons for doing so.

Element two

The healthcare organisation works with partners to protect children and participate in reviews as set out in *Working together to safeguard children* (HM Government, 2006).

Element three

The healthcare organisation has agreed systems, standards and protocols about sharing information about a child and their family both within the organisation and with outside agencies, having regard to *Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004*.

Element two

No change to this element from 2008/09. This element includes activities that are required, such as participation in serious case reviews and child death reviews.

Element three

No change to this element from 2008/09. The information sharing process can include the Common Assessment Framework, Contact Point and a general responsibility on boards to ensure that systems are in place. Outside agencies referred to include for example, local authorities, the police, Connexions, Probation service, Youth Offending Teams, prisons etc.

Core standard C3

Healthcare organisations protect patients by following NICE Interventional Procedures guidance.

Elements

Element one

The healthcare organisation follows NICE interventional procedures¹ guidance in accordance with *The interventional procedures programme* (Health Service Circular 2003/011). Arrangements for compliance are communicated to all relevant staff.

Rationale

Element one

No change to this element from 2008/09 as there has been no change to the interventional procedures processes which provider trusts need to follow. HSC 2003/11 still stands.

National Institute for Clinical Excellence (NICE) interventional procedures guidance applies to any trust that carries out interventional procedures. The element makes reference to the need to communicate arrangements to all relevant staff. This is to reflect that even where no 'new' interventional procedures² have been undertaken in the last year (which may be more likely in non-acute trusts) an organisation should still ensure that relevant staff are aware of the process in case it occurs.

¹ 'An interventional procedure is one used for diagnosis or treatment that involved incision, puncture, entry into a body cavity, electromagnetic or acoustic energy.' (Source: *The interventional procedures programme*, Health Service Circular 2003/011).

² An interventional procedure is considered 'new' if a clinician no longer in a training post is using it for the first time in his or her NHS clinical practice.

Core standard C4a

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA).

Elements

Element one

This standard will not be assessed in 2009/10.

Rationale

Element one

From 1 April 2009, all NHS organisations to which the Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Healthcare Associated Infections applies were registered with the Care Quality Commission.

Core standard C4b

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.

Elements

Element one

The healthcare organisation has systems in place to minimise the risks associated with the acquisition and use of medical devices in accordance with guidance issued by the Medicines Healthcare Products Regulatory Authority.

Rationale

Element one

No change to this element from 08/09.

Element two

The healthcare organisation has systems in place to meet the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 [IR(ME)R] and any subsequent amendment.

Element two

No change to this element from 2008/09. One of the amendments to the IRMER 2000 regulations was in 2006 when enforcement responsibilities were transferred to the Healthcare Commission, one of CQC's predecessor organisations. Further amendments are likely and so an explicit reference is made to this.

Core standard C4c

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.

Elements

Element one

This standard will not be assessed in 2009/10.

Rationale

Element one

From 1 April 2009, all NHS organisations to which the Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Healthcare Associated Infections applies were registered with the Care Quality Commission.

Core standard C4d

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely.

Elements

Element one

Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored, in accordance with the Medicines Act 1968 (as amended, and subsequent regulations, including the Medicines for Human Use (Prescribing) Order 2005), the Health and Safety at Work Act 1974, as amended, and subsequent regulations including the Control of Substances Hazardous to Health Regulations 2002; and the good practice identified in *The safe and secure handling of medicines: A team approach* (RPS, March 2005) should be considered and where appropriate followed.

Element two

Controlled drugs are handled safely and securely in accordance with the *Misuse of Drugs Act 1971* (and amendments), *Safer Management of Controlled Drugs: Guidance on strengthened governance arrangements* (Department of Health, Jan 2007) and *The Controlled Drugs (Supervision of Management and Use) Regulations 2006*.

Rationale

Element one

No change to this element from 2008/09. In referring to the Medicines Act, all amendments and subsequent regulations are included within this reference. Subsequent regulations include the Medicines for Human Use (Prescribing) Order, which provides additional requirements for prescribing. The Duthie Report (*The safe and secure handling of medicines: A Team approach*) has been included as it describes recognised good practice and requirements underpinned by the legislation referred to in the criteria (Medicines Act, Health and Safety at Work Act and the Control of Substances Hazardous to Health) for several elements of medicines management (with the exceptions being procurement and monitoring).

Element two

The element makes reference to all amendments for the Misuse of Drugs Act 1971. The guidance on strengthened governance arrangements refers to the updated 2007 version. The element additionally makes reference to the Controlled Drugs Regulation, which came into effect on 1 January 2007.

Core standard C4e

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

Elements

Element one

The prevention, segregation, handling, transport and disposal of waste is properly managed to minimise the risks to patients/service users, staff, the public and the environment in accordance with all relevant legislative requirements referred to in Environment and Sustainability: Health Technical

Rationale

Element one

No change to this element from 2008/09. Element one was amended in 2007/08 to incorporate HTM 07-05, which relates to the management of electrical and electronic equipment waste, which was published in June 2007. This supplements the broader HTM 07-01, and addresses the requirements of the European Waste Electrical and Electronic Equipment (WEEE) Directive (2003) and

Memorandum 07-01: Safe management of healthcare waste (Department of Health, November 2006) and Environment and sustainability: Health Technical Memorandum 07-05: The treatment, recovery, recycling and safe disposal of waste electrical and electronic equipment (Department of Health, June 2007).

the Use of Hazardous Substances in Electrical and Electronic Equipment Regulations (RoHS). The advice contained in documents HTM 07-01 and HTM 07-05 are not in themselves mandatory, but the legislative requirements described therein are. Healthcare organisations choosing not to follow this advice must take alternative steps to comply with all relevant legislation.

Second domain: clinical and cost effectiveness

Domain outcome: Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.

Core standard C5a

Healthcare organisations ensure that they conform to National Institute for Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

Elements

Element one

The healthcare organisation ensures that it conforms to new and existing NICE technology appraisals where relevant to its services. Mechanisms are in place to: identify relevant technology appraisals; take account of clinical views and current practice in decision-making; and where necessary assess costs, and develop, communicate, implement and review an action plan for relevant technology appraisals.

Element two

The healthcare organisation can demonstrate how it takes into account new and existing nationally agreed guidance where it is available as defined in National Strategies, National Service Frameworks (NSFs), NICE guidelines, and nationally agreed guidance, when delivering care and treatment. The healthcare organisation has mechanisms in place to: identify relevant guidance; take account of clinical views and current practice in decision-making; and where necessary assess costs, and develop, communicate, implement and review an action plan for appropriate guidelines.

Rationale

Element one

The element has been changed slightly from 2008/09. Words 'new and existing' have been added to clarify that this element relates to all current guidelines whether they are published this year or in previous years.

Element two

2009/10 element two wording is mainly unchanged. There is one amendment to reflect Department of Health policy that it will now produce National Strategies rather than National Service Frameworks (although ongoing NSFs will still apply). NHS trusts must also, therefore, take into account any relevant new national strategies (eg National Dementia Strategy as published in February 2009).

Words 'new and existing' have also been added to clarify that this element relates to all current guidelines whether they are published this year or in previous years.

Core standard C5b

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

Elements

Rationale

Element one

The healthcare organisation ensures that appropriate supervision and clinical leadership is provided to staff when delivering clinical care and treatment. Where appropriate, staff also have the opportunity to receive 'clinical supervision'³; and where appropriate, this is in accordance with requirements from relevant professional bodies. Arrangements for clinical leadership and supervision (including 'clinical supervision') are communicated to all relevant staff. The effectiveness of these arrangements is monitored and reviewed on a regular basis and action is taken accordingly.

Element two

The healthcare organisation ensures that it provides opportunities for clinicians⁴ to develop their clinical leadership skills and experience.

Element one

No change to this element from 2008/09. Element one indicates that supervision of staff in the day-to-day delivery of clinical care and treatment, and the formal process of receiving 'clinical supervision' (see definition below) are two distinct concepts that are both important to ensuring that people receive care which will lead to effective clinical outcomes. The Care Quality Commission would expect an organisation to assure itself that arrangements for both of the above, and clinical leadership, are in place and effective.

Element two

No change to this element from 2008/09.

Core standard C5c

Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work.

Elements**Element one**

The healthcare organisation ensures that clinicians from all disciplines participate in activities to update the skills and techniques that are relevant to their clinical work in accordance with relevant guidance and curricula. This includes identifying and reviewing skills needs and skills gaps; providing and supporting on-the-job training and other training opportunities; and where appropriate working in partnership with education and training providers to ensure effective delivery of training.

Rationale**Element one**

No change to this element from 2008/09. Current healthcare policy emphasises the importance of the quality of clinical care. The skills and techniques of clinicians are vital to ensuring good quality care. To reflect this, the element gives explicit focus to the different aspects of the standard against which we would expect an organisation to assure itself.

Core standard C5d

³ Clinical supervision is 'a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations.' (Quoted in various sources, including *Clinical supervision for registered nurses*, MNC, 2008).

⁴ Clinicians are 'professionally qualified staff providing clinical care to patients'. (Source: Standards for Better Health, DH, 2004)

Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.

Elements

Element one

The healthcare organisation ensures that clinicians⁵ are involved in prioritising, conducting, reporting and acting on regular clinical audits⁶.

Element two

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

Rationale

Element one

No change to this element from 2008/09.

Element two

No change to this element from 2008/09.

Core standard C6

Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

Elements

Element one

The healthcare organisation works in partnership with other health and social care organisations to ensure that the individual needs of patients / service users are properly managed and met:

- Where responsibility for the care of a patient is shared between the organisation and one or more other health and/or social care organisations.

and/or

- Where the major responsibility for a patient's care is moved (due to admission, referral, discharge or transfer⁷ across organisational boundaries.

Where appropriate, these arrangements are in accordance with:

- Section 75 partnership arrangements of the National Health Service Act

Rationale

Element one

The element has changed slightly from 2008/09. All of the specific referenced documents still apply. The NSF and strategy examples given have been slightly changed to reflect some newer frameworks. Words 'new and existing' have also been added to clarify that this element relates to all current guidelines whether they are published this year or in previous years.

⁵ Clinicians are 'professionally qualified staff providing clinical care to patients'. (Source: Standards for Better Health, DH, 2004)

⁶ Clinical audit is 'a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against specific criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.' (Source: Standards for Better Health, DH, 2004)

⁷ The term 'transfer' is as defined by the NHSLA Risk Management Standard, 'the process whereby a patient is moved from one clinical area to another within the organisation or to another organisation'. (Source:

<http://www.nhsla.com/Publications/>)

2006 (previously section 31 of the Health Act 1999).

- The Community Care (Delayed Discharges etc.) Act 2003 and Discharge from hospital pathway, process and practice (DH, 2003).

Where appropriate, these arrangements are in accordance with the relevant aspects of the following guidance or equally effective alternatives:

- *Guidance on the Health Act Section 31* partnership agreements (DH, 1999).
- Guidance on partnership working contained within relevant National Service Frameworks and new and existing national strategies (for example, the NSF for Coronary Heart Disease (DH, 2000), the NSF for Older People (DH, 2001), the End of Life Care Strategy (DH, 2008), the Dementia Strategy (DH, 2009) and the Cancer Reform Strategy (DH, 2007).

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (DH, 2007).

Element two

Staff concerned with all aspects of the provision of healthcare work in partnership with colleagues in other health and social care organisations to ensure that the needs of the patient / service user are properly managed and met.

Element two

No change to this element from 2008/09.

Third domain: governance

Domain outcome: Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.

Core standard C7a&c

Healthcare organisations:

- a) apply the principles of sound clinical and corporate governance; and
- c) undertake systematic risk assessment and risk management.

Elements

Element one

The healthcare organisation has effective clinical governance⁸ arrangements in place to promote clinical leadership and improve and assure the quality of clinical services (effectiveness, safety and patient experience) for patients/service users.

Element two

The healthcare organisation has effective corporate governance⁹ arrangements in place that where appropriate are in accordance with *Governing the NHS: A guide for NHS boards* (Department of Health and NHS Appointments Commission, 2003), and the *Primary care trusts model standing orders, reservation and delegation of powers and standing financial instructions August 2006* (DH, 2006).

Element three

The healthcare organisation systematically assesses¹⁰ and manages¹¹ its risks, both corporate/clinical risks in order to ensure probity, clinical quality and patient safety.

Rationale

Element one

The wording of this element has been amended to reflect the three aspects of quality (effectiveness, safety and patient experience) that are identified in the final report of the NHS next stage review, *High quality care for all* (DH, 2008). This review describes how high quality should be the driving principle for the NHS.

Element two

No change to this element from 2008/09.

Element three

No change to this element from 2008/09.

⁸ Clinical governance is 'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish' (Source: Standards for Better Health, DH, 2004).

⁹ Governance is 'a mechanism to provide accountability for the way an organisation manages itself' (Source: Standards for Better Health, DH, 2004).

¹⁰ Systematic risk assessment is 'a systematic approach to the identification and assessment of risks using explicit risk management techniques.' (Source: Standards for Better Health, DH, 2004).

¹¹ Risk management 'covers all processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.' (Source: Standards for Better Health, DH, 2004).

Core standard C7b

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

Elements

Element one

The healthcare organisation actively promotes openness, honesty, probity and accountability to its staff and ensures that resources are protected from fraud and corruption in accordance with the *Code of conduct for NHS managers* (Department of Health, 2002), *NHS Counter fraud & corruption manual third edition* (NHS Counter Fraud Service, 2006), and having regard to guidance or advice issued by the CFSMS.

Rationale

Element one

No change to this element from 2008/09. The Directions to NHS bodies on the Counter Fraud Measures 2004 (as amended) state at Direction 2(1) that "Each NHS Body must take all necessary steps to counter fraud in the National Health Service in accordance with....the NHS Counter Fraud and Corruption Manual;and having regard to guidance or advice issued by the CFSMS". The NHS Counter Fraud and Corruption Manual remains the operational guidance for all Local Counter Fraud Specialists. Note that the CFSMS Compound Indicators are based on this Manual.

Core standard C7d

Healthcare organisations ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources.

Elements

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

Rationale

Not applicable

Core standard C7e

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

Elements

Element one

The healthcare organisation challenges discrimination and respects human rights in accordance with the:

- Human Rights Act 1998.
- *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (Department of Health, 2000).
- The general and specific duties imposed on public bodies in relation to race, disability and gender (including, among other things, equality schemes for race, disability and gender, along with impact

Rationale

Element one

No change to this element from 2008/09. The Race Relations (Amendment) Act 2000, Disability Discrimination Act 2005, and Equality Act 2006 each have associated codes of practice, listed below:

- 'The Statutory Code of Practice on the Duty to Promote Race Equality' (issued by Commission for Racial Equality published May 2002)
- 'The Duty to Promote Disability Equality. Statutory Code of Practice' (England and Wales) (issued by Disability Rights Commission published 2005)
- 'Gender Equality Duty Code of Practice (England and Wales)' (issued by Equal Opportunities Commission published 2007)

assessments) under the “public body duties”*.

- “Employment and equalities legislation”** including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time.

**“Acting in accordance with ‘public body duties’” means: Acting in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following statutes:

- Race Relations (Amendment) Act 2000.
- Disability Discrimination Act 2005.
- Equality Act 2006.

and, where appropriate, having due regard to the associated codes of practice.

***“Acting in accordance with “employment and equalities legislation” means: Acting in accordance with relevant legislation including:

- Equal Pay Act 1970 (as amended).
- Sex Discrimination Act 1975 (as amended).
- Race Relations Act 1976 (as amended).
- Disability Discrimination Act 1995.
- Employment Equality (Religion or Belief) Regulations 2003.
- Employment Equality (Sexual Orientation) Regulations 2003.
- Employment Equality (Age) regulations 2006.
- Part Time workers (Protection from Less Favourable Treatment) Regulations 2000.
- Fixed Term Employees (Protection from Less Favourable Treatment Regulations 2002).

Similarly the acts cited under “employment and equalities legislation” have associated codes of practice, including:

- CRE Code of practice on equality in employment 2005.
- EOC Code of practice on sex discrimination 1985.
- EOC Code of practice on equal pay 2003.
- DWP Guidance on the definition of disability 2006.
- DRC Code of Practice on Employment and Occupation 2004.

These codes of practice and guidance provide guidance to assist relevant persons or bodies to effectively and appropriately carry out their statutory public body duties and employment law obligations (as appropriate). The acts do not impose a legal duty to comply with the codes but those to whom the codes of practice are addressed should have regard to the guidance contained in the codes. The Codes are admissible in evidence in any legal action and can be taken into account by courts and tribunals.

- Employment Rights Act section 80F-I (relating to the right to request flexible working).
- Working Time Regulations 1998 (as amended).

And, where appropriate, having due regard to the associated codes of practice.

Element two

The healthcare organisation promotes equality, including by publishing information specified by statute, in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under:

- The Race Relations (Amendment) Act 2000.
- The Disability Discrimination Act 2005.
- The Equality Act 2006.

And where appropriate, having due regard to the associated codes of practice; and in accordance with Delivering Race Equality in Mental Health Care (Department of Health, 2005).

Element two

No change to this element from 2008/09. In 2008/09 there were minor changes to the wording of the element to emphasise that this element is concerned with the duties to promote equality, rather than the anti discrimination focus of the original 1975, 1976 and 1995 Acts.

See the rationale to element one above for detail on the codes of practice.

Core standard C7f

Healthcare organisations meet the existing performance requirements.

Elements

This standard will be measured through the existing national targets assessment

Rationale

Not applicable

Core standard C8a

Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.

Elements

Element one

Staff are supported, and know how, to

Rationale

Element one

No change to this element from 2008/09. The HSC

raise concerns about services confidentially and without prejudicing their position including in accordance with The Public Disclosure Act 1998: Whistle blowing in the NHS (HSC 1999/198).

1999/198 has been confirmed by Department of Health as being extant. It is concerned with the Public Disclosure Act 1998 which is the legislation relating to whistle blowing.

Core standard C8b

Healthcare organisations support their staff through having organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.

Elements

Element one

The healthcare organisation supports and involves staff in organisational and personal development programmes as defined by the relevant areas of the Improving Working Lives (IWL) standard at Practice Plus level and in accordance with “employment and equalities legislation”* including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its “public body duties”* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice.

* The phrases “public body duties” and “employment and equalities legislation” are defined in C7e

Element two

Staff from minority groups are offered opportunities for personal development to address under-representation in the workforce compared to the local population in accordance with “employment and equalities legislation”* including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its “public body duties”* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender.

Rationale

Element one

No change to this element from 2008/09. The standard deals specifically with the under representation of minority groups and the element reflects requirements to monitor the participation in personal development opportunities by gender, race, disability etc, not explicitly required under IWL. The addition of discrimination legislation to this element in 2008/09 is intended to address this.

The phrases “public body duties” and “employment and equalities legislation” are defined in C7e and information about the codes of practice is given in the rationale to C7e.

Element two

No change to this Element from 2008/09. This element addresses under-representation across the whole workforce, not limited to senior roles. Under-representation remains a concern at senior roles but also in other areas for example, in particular occupations or specialism.

* The phrases “public body duties” and “employment and equalities legislation” are defined in C7e.

Core standard C9

Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

Elements

Element one

The healthcare organisation has effective systems for managing records in accordance with *Records management: NHS code of practice* (Department of Health, April 2006; Part 2 updated January 2009), *Information security management: NHS code of practice* (Department of Health, April 2007) and *NHS Information Governance* (Department of Health, September 2007).

Healthcare organisations comply with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and demonstrate they are complying with supplemental mandates and guidance if they are introduced during the assessment period.

Rationale

Element one

Part 2 of the Records management: NHS code of practice was updated regarding retention schedules and published on January 2009. Organisations are expected to use the revised schedules from that date. The reference to the code has been changed to reflect this; there are no other changes in element one.

Records management involves the creation and implementation of systematic controls for records and information activities, from the moment of creation through to disposal. Information governance is the application of law and good practice that governs the way in which information is obtained, handled, used and disclosed. Records management provides the systems, frameworks and procedures to ensure staff comply with information governance requirements.

The *Records management: NHS code of practice* (Department of Health, April 2006) is a guide to the standards of practice required for the management of NHS records, based on current legal requirements and professional best practice.

Information security management: NHS code of practice (Department of Health, April 2007) and *NHS Information Governance* (Department of Health, September 2007) update guidance on legal, information security and other requirements.

The NHS Chief Executive's letter of 20 May 2008 to all NHS Chief Executives (Gateway reference 9912) identifies three specific actions for all NHS organisations, two of which are relevant to C9 (actions v and vi):

- NHS organisations must make specific reference to information governance and identifying and managing information risks in their annual statements from 2007/08.

- NHS organisations must identify a Senior Information Risk Owner.
And one of which is relevant to C13c (iv).

Element two

The healthcare organisation has a strategy to ensure the correct NHS Number is recorded for each active patient and that it is used routinely in clinical communications. Planning for the correct assignment and use of NHS Numbers was mandated in *The NHS in England: the Operating Framework for 2008/09* (Department of Health, December 2007), hence organisations must have a relevant strategy. *The NHS in England: the Operating Framework for 2009/10* (Department of Health, December 2008) has mandated implementation and the achievement of level 2 performance in the Information Governance Toolkit key requirement 401 by the end of 2009/10.

Element two

The NHS Medical Director wrote to all NHS chief executives and medical directors on the importance of using NHS Numbers as the main patient identifier on clinical records and the numerous incidents, and some cases of serious harm and death, related to duplication in local numbering systems. These deficiencies in records management should no longer be acceptable (letter of 13 May 2008, Gateway reference 9801). Planning for the assignment of a correct NHS Number was mandated in *The NHS in England: the Operating Framework for 2008/09* (Department of Health, December 2007). *The NHS in England: the Operating Framework for 2009/10* (Department of Health, December 2008) mandates the implementation of the strategy via the Information Governance Toolkit key requirement 401, where level 2 performance (95% verified NHS Number for active patients in the Master Patient Index) will be required by the end of 2009/10.

Core standard C10a

Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.

Elements

Element one

The necessary checks are undertaken in respect of all applications for NHS positions (prospective employees) and staff in ongoing NHS employment¹² in accordance with the NHS Employment Check Standards (NHS Employers 2008).

Rationale

Element one

No change to this element from 2008/09. NHS Employers published a revised set of employment check standards in 2008. These standards are mandatory for all applicants for NHS positions and employment checks should be carried out prior to appointment of individuals to work in health settings. Six documents make up the NHS Employment Check standards which include those checks that are required by law, those that are Department of Health policy and those that are required for access to the NHS Care record service.

Core standard C10b

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

¹² This includes permanent staff, staff on fixed-term contracts, temporary staff, volunteers, students, trainees, contractors and highly mobile staff supplied by an agency. Trusts appointing locums and agency staff will need to ensure that their providers comply with these standards.

Elements	Rationale
<p>Element one</p> <p>The healthcare organisation explicitly requires all employed healthcare professionals¹³ to abide by relevant codes of professional conduct. Mechanisms are in place to identify, report and take appropriate action when codes of conduct are breached.</p>	<p>Element one</p> <p>No change to this element from 2008/09</p>

Core standard 11a

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake.

Elements	Rationale
<p>Element one</p> <p>The healthcare organisation recruits staff in accordance with “employment and equalities legislation”* including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part time workers, fixed term employees, flexible working and working time; and in accordance with its “public body duties”* in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice.</p> <p>* The phrases “public body duties” and “employment and equalities legislation” are defined in C7e.</p>	<p>Element one</p> <p>No change to the element from 2008/09.</p> <p>*The phrases “public body duties” and “employment and equalities legislation” are defined in C07e.</p>

<p>Element two</p> <p>The healthcare organisation aligns workforce requirements to its service needs by undertaking workforce planning, and by ensuring that its staff are appropriately trained and qualified for the work they undertake.</p>	<p>Element two</p> <p>No change to this element from 2008/09. The element reflects the standard by making explicit reference to training and qualification combined with workforce planning.</p>
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¹³ A healthcare professional is ‘a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Healthcare Professions Act 2002’ (Source: Section 93, National Health Services Act 2006). The bodies mentioned in Section 25(3) which regulate professionals within England are: the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Health Professions Council (HPC), the General Dental Council (GDC), the General Optical Council (GOC), the General Chiropractic Council (GCC), the General Osteopathic Council (GOsC), the Royal Pharmaceutical Society of Great Britain (RPSGB).

Core standard 11b

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes.

Elements

Element one

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

Element two

Staff and students participate in relevant induction programmes.

Element three

The healthcare organisation verifies that staff participate in those mandatory training programmes necessary to ensure probity, clinical quality and patient safety (including that referred to in element one). Where the healthcare organisation identifies non-attendance, action is taken to rectify this.

Rationale

Element one

No change to this element from 2008/09.

Element two

No change to this element from 2008/09.

Element three

This element was added in 2008/09 to reflect the need for trusts to check uptake of training in order to ensure participation. This is the case for all types of mandatory training necessary to ensure the domain outcome – i.e., probity, clinical quality and patient safety (including risk management training referred to in the NHSLA risk management standards and element one). Thus, an explicit link has been made to the outcome required by the domain.

Core standard 11c

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives.

Elements

Element one

The healthcare organisation ensures that all staff concerned with all aspects of the provision of healthcare have opportunities to participate in professional and occupational development at all points in their career.

- This is done in accordance with “employment and equalities legislation”* including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part time workers, fixed term employees, flexible working and working time; and in accordance with its “public body duties”** in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due

Rationale

Element one

No change to this element from 2008/09.

The phrases “public body duties” and “employment and equalities legislation” are defined in C07e and information about the codes of practice is given in the rationale to C07e.

Reference to this legislation is included to reflect the need for organisations to ensure that comparable development opportunities are provided to all staff.

The document *Working together – learning together* (DH, 2001) is a strategic framework that sets out a co-ordinated approach to lifelong learning in healthcare. While trusts are not legally obliged to conform to the framework and we are aware that it is not currently in widespread use, the framework has not as yet been replaced and the principles remain valid. The phrase ‘or an equally effective alternative’

regard to the associated codes of practice.

- This is also done in accordance with the relevant aspects of *Working together – learning together: a framework for lifelong learning for the NHS* (Department of Health 2001) or an equally effective alternative.

allows flexibility in how a trust is assured that it is meeting the requirements of the standard (for example by using an alternative or adapted framework).

* The phrases “public body duties” and “employment and equalities legislation” are defined in C7e.

Core standard C12

Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirement of the research governance framework are consistently applied.

Elements

Element one

The healthcare organisation has effective research governance in place, which complies with the principles and requirements of the *Research governance framework for health and social care, second edition* (DH 2005), (annex amended 2008).

Rationale

Element one

No changes to the wording of the element from 2008/09. The only change is that the Annex to the research governance framework was updated in September 2008.

Fourth domain: patient focus

Domain outcome: Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

Core standard C13a

Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.

Elements

Element one

The healthcare organisation ensures that staff treat patients / service users, carers and relatives with dignity and respect at every stage of their care and treatment, and, where relevant, identify, and take preventive and corrective actions where there are issues and risks with dignity and respect.

Element two

The healthcare organisation meets the needs and rights of different patient groups with regard to dignity including by acting in accordance with the Human Rights Act 1998 and the general and specific duties imposed on public bodies in relation to race, disability and gender (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following “public body duties”* statutes:

- the Race Relations (Amendment) Act 2000
- the Disability Discrimination Act 2005
- the Equality Act 2006.

And where appropriate, having due regard to the associated codes of practice.

The PCT should act in accordance with the requirements in the National Service Framework for older people (Health

Rationale

Element one

No change to this element from 2008/09. The wording of the element includes identification of risk and appropriate action to reduce the risk of occurrence of compromise in dignity or respect. The wording highlights the need for healthcare organisations to ensure dignity and respect throughout the stages of care e.g. End of Life (EoL), dementia etc. and during transfers. It also emphasises the need to take preventive action to ensure compromise in dignity and respect does not happen.

Element two

No change to this element from 2008/09. Note that the Race Relations Amendment Act (2000), the Disability Discrimination Act (2005) and the Equality Act (2006) have associated codes of practice and explicit reference to these were added in 2008/09.

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

The codes of practice provide guidance to assist relevant persons or bodies to effectively and appropriately carry out their duties. The Acts do not impose a legal duty to comply with the codes but those to whom the codes of practice are addressed should have regard to the guidance contained in the codes. The codes of practice provide a practical framework for adhering to legal obligations under the Acts.

An addition was made in 2008/09 to include the National Service Framework (NSF) for older people (DH notification letter HSC 2001/007) which specifically addresses age discrimination, amongst other things.

Service circular 2001/007), to ensure that older people are not unfairly discriminated against in accessing NHS or social care services as a result of their age.

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

Core standard C13b

Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information.

Elements

Element one

Valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures (including post-mortem) investigations and decisions in accordance with the Human Rights Act 1998, the *Reference guide to consent for examination or treatment* (Department of Health 2001), *Human Tissue Authority: a code of practice* (July 2006), and having regard to the *Code of Practice to the Mental Health Act 1983 and 2007* and the *Code of Practice to the Mental Capacity Act 2005*.

Element two

Patients/service users, including those with language and/or communication

Rationale

Element one

No change to this element from 2008/09. The element refers to the Human Rights Act 1998 (HRA) as issues around consent could, and have led, to breaches of the Act under a number of different Articles, namely 8 and 14. The addition of a reference to HRA provides a legal imperative for the guidance on consent that is referred to particularly in relation to Article 8. Consent issues in health have been at the centre of the development of Human Rights case law and associated guidance (for example, Bournemouth and Glass vs UK cases, Bristol, Alder Hey and the introduction of the Human Tissue Act and associated Authority).

Relying solely on reference to the Department of Health and Department of Constitutional Affairs guidance would not give sufficient emphasis to the implications for Human Rights. This is particularly true regarding the protection of the human rights of patients who are not being treated by Mental Health or Learning Disability Trusts. The Code of Practice to the Mental Capacity Act deals only briefly with communication/language issues. The other guidance was produced before recent case law as HRA applies to all patients and service users the additional requirement helps ensure that these criteria for assessment continue to reflect standards now expected of a healthcare organisation in obtaining valid consent for all patients/service users. So as the capacity of patients/service users needs to be considered at all stages of all interventions, the need to comply with MCA guidance (code of practice), which includes deprivation of liberty safeguards, is included in the element.

Element two

No change to this element from 2008/09. The element makes it clear that the Information provided

support needs, are provided with appropriate and sufficient information suitable to their needs, on the use and disclosure of confidential information held about them in accordance with *Confidentiality: NHS code of practice* (Department of Health 2003).

must be suitable and sufficient for patient/service user needs.

Element three

The healthcare organisation monitors and reviews current practices to ensure effective consent processes.

Element three

No change to this element from 2008/09. The element supports an outcome focus to consent standards and to improve consent processes.

Core standard C13c
Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary.

Elements	Rationale
<p>Element one When using and disclosing patients/service users' personal information staff act in accordance with the Data Protection Act 1998, the Human Rights Act 1998, the Freedom of Information Act 2000 and <i>Confidentiality: NHS code of practice</i> (Department of Health 2003), <i>Caldicott Guardian Manual 2006</i> (Department of Health 2006).</p> <p>The healthcare organisation complies with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and with supplemental mandates and guidance if they are introduced during the assessment period.</p>	<p>Element one No change to this element from 2008/09. The legislation and guidance quoted cover instances when patient information can be disclosed.</p> <p>The NHS Chief Executive's letter of 20 May 2008 to all NHS Chief Executives (Gateway reference 9912) identifies three specific actions for all NHS organisations, two of which are relevant to C9 (actions v and vi) and one which is relevant to C13c (iv):</p> <ul style="list-style-type: none"> • NHS organisations must include details of Serious Untoward Incidents involving data loss or confidentiality breaches in their annual reports from 2007/08.

Core standard C14a
Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services.

Elements	Rationale
<p>Element one Patients / service users, relatives and carers are given suitable and accessible information about, and can easily access, a formal complaints system, including information about how to escalate their concerns; and the healthcare organisation acts in accordance with The Local Authority Social Services and NHS</p>	<p>Element one In 2006, the Government committed to helping NHS and adult social care organisations to improve the way they deal with complaints, in order to make services more effective, personal and safe. To meet that commitment a new single approach for dealing with complaints has been introduced. The new legislation came into force on 1 April 2009 and requires:</p>

Complaints (England) Regulations 1 April 2009 in so far as they are relevant to the healthcare organisation.

- a trust to publicise complaints procedures
- acknowledge receipt of a complaint and investigate them properly and appropriately
- write to the complainant on completion of a complaints investigation, explaining how it was resolved, what action has been taken and reminding them of their right to take the matter to the PHSO or Local Govt. Ombudsman
- produce an annual report about complaints that have been received, the issues they raise, and any matters where action has been taken or is to be taken to improve services as a result of those complaints
- assist the complainant if following the complaints procedure, or provide advice on where they may obtain such assistance
- ensure there is a designated manager for complaints
- have someone who is senior responsible for both the complaints policy and learning from complaints

[DN: The second bullet was in the 2004 regulations. The first is more complicated – it was in the 2006 LASS regulations, but not the 2004 NHS regulations]

Element two

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

Element two

No change to this element from 2008/09.

Core standard C14b

Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made.

Elements

Element one

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

Rationale

Element one

No change to this element from 2008/09.

Core standard C14c

Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

Elements

Element one

The healthcare organisation acts on, and

Rationale

Element one

In 2006, the Government committed to helping NHS

responds to, complaints appropriately and in a timely manner; and acts in accordance with The Local Authority Social Services and NHS Complaints (England) Regulations 1 April 2009 in so far as they are relevant to the healthcare organisation.

and adult social care organisations to improve the way they deal with complaints, in order to make services more effective, personal and safe. To meet that commitment a new single approach for dealing with complaints has been introduced. The 2009 regulations came into force on 1 April reforming the whole approach to handling complaints at local level and requires the healthcare organisation to produce an annual report about complaints that have been received, the issues they raise, and any matters where action has been taken or is to be taken to improve services as a result of those complaints.

Element two

Demonstrable improvements are made to service delivery as a result of concerns and complaints from patients / service users, relatives and carers.

Element two

No change to this element from 2008/09.

Core standard C15a

Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet.

Elements

Element one

Patients/service users are offered a choice of food and drink in line with the requirements of a balanced diet reflecting the rights (including the rights of different faith groups), needs (including cultural needs) and preferences of its service user population.

Rationale

Element one

No change to this element from 2008/09. The element makes explicit the inclusion of drink as an integral part of food which is consistent with the *Food Safety Act 1990* which defines food to include food and drink (note this is the approach also taken with C15b). The element also makes the rights of faith groups explicit as determined by *article 9 of the Human Rights Act 1998*.

The term “balanced diet” is a concept well recognised by users and providers of health services; this is reinforced by considerable publicity by various agencies such as NHS Direct and Food Standards Agency. Additionally the importance of balanced and healthy diet is part of the training for nutritionists and dieticians. It is expected that when these professionals assess dietary requirements they would ensure that the requirements identified include meeting the needs of a balanced diet.

Element two

The preparation, distribution, delivery, handling and serving of food, storage, and disposal of food is carried out in accordance with food safety legislation including the *Food Safety Act 1990* and the *Food Hygiene (England) Regulations 2006*.

Element two

No change to this element from 2008/09. The *Food Safety Act 1990* provides the framework for procuring and selling food in a manner that is safe for the consumer. It also provides for the duties for safe handling of food and provision of training for staff in food hygiene. The amendment to this Act in 2004 brought this in line with the new EC regulations. The Food Hygiene (England) Regulations 2006 provide for the execution and

enforcement in relation to England of the EC food hygiene regulations 852/2004 (hygiene of foodstuffs) and 853/2004 (specific hygiene rules for food of animal origin) in England. These Regulations apply to all stages of production, processing and distribution of food.

Core standard C15b

Where food is provided, healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.

Elements

Element one

Patients/service users have access to food and drink that meets the individual needs of the patients / service users 24 hours a day.

Element two

The nutritional, personal and clinical dietary requirements of individual patients/service users are assessed and met, including the right to have religious dietary requirements met at all stages of their care and treatment.

Element three

Patients/service users requiring assistance with eating and drinking are provided with appropriate support including provision of dedicated meal times, adapted appliances and appropriate consistency of food where necessary.

Rationale

Element one

No change to this element from 2008/09. It should be noted that individual food preferences are not within the scope of this element. The wording of the element was amended in 2008/09 to make it clear that meeting individual needs are in scope of the element. It is not sufficient for a trust to provide food and drink 24 hrs a day if patients / service users who need it are unable to eat it, for example due to swallowing difficulties, food intolerance, faith/cultural reasons etc.

Element two

No change to this element from 2008/09. The element was amended in 2008/09 to include "at all stages of their care" to emphasise the expectation that there are no gaps in the service provision. This continuity is important for continued effective care. For instance, if the condition of a patient changes such as they have lost weight or have developed a need for pureed food it is expected that the changed need is catered for. Similarly if patients/service users have moved to a different ward the nutritional assessment details should be passed on to ensure continuity.

Element three

No change to this element from 2008/09. The wording was amended in 2008/09 to include, "including provision of dedicated meal times, adapted appliances and appropriate consistency of food where necessary". These are essential to providing meals in a safe manner, including support with eating and drinking. These are recommended by NICE and are recognised across the service as acceptable reasonable standards. There is evidence from NPSA that due to inadequate dedicated support at mealtimes both in terms of time and staff assistance there have been incidents, which have led to patients being unable to eat meals.

Core standard C16

Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.

Elements

Element one

The healthcare organisation has identified the information needs of its service population, and provides suitable and accessible information on the services it provides in response to these needs. This includes the provision of information in relevant languages and formats in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following “public body duties”^{*} statutes:

- the Race Relations (Amendment) Act 2000
- the Disability Discrimination Act 2005
- the Equality Act 2006.

And where appropriate, having due regard to the associated codes of practice.

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

Element two

The healthcare organisation provides patients / service users and, where appropriate, carers with sufficient and accessible information on the patient’s individual care, treatment and after care, including those patients / service users and carers with communication or language support needs. In doing so healthcare organisations must have regard, where appropriate, to the *Code of Practice to the Mental Capacity Act 2005* (Department of Constitutional Affairs 2007) and the *Code of Practice to the Mental Health Act* (Department of Constitutional Affairs 1983, revised 2008).

Rationale

Element one

No change to this element from 2008/09. The element emphasises the need for healthcare organisations to identify the needs of its service population in the first instance.

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

Element two

No change to this element from 2008/09 09 except the *Code of Practice to the Mental Health Act* was revised in 2008. The element emphasises sufficient and accessible information provision for all patients and carers (as well as for patients with particular language and communication support needs).

Fifth domain: accessible and responsive care

Domain outcome: Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

Core standard C17

The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

Elements

Element one

The healthcare organisation seeks and takes account of the views and experiences of patients, users, carers and the local community (including Local Involvement Networks), particularly those people who are seldom listened to, on an ongoing basis, when designing, planning, delivering and improving healthcare services as required by Section 242 (1B) of the *National Health Services Act 2006*, and having regard to *Real Involvement, Working with people to improve health services (Department of Health 2008)*) and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation acts in accordance with the general and specific duties imposed on public bodies (including, amongst other things, equality schemes for race, disability and gender, along with impact assessments) under the following “public body duties”

*statutes:

- the Race Relations (Amendment) Act 2000
- the Disability Discrimination Act 2005
- the Equality Act 2006.

and where appropriate, having due regard to the associated codes of practice.

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

Element two

The healthcare organisation demonstrates to patients, users, carers and the local community (including Local

Rationale

Element one

Updated legislation and new statutory guidance on patient and public engagement came out from DH during the previous assessment year. This now applies to the whole assessment year for 09-10 and to all elements.

The emphasis for element one has been shifted to focus on TAKING ACCOUNT of people’s views and experiences.

Trusts must “have regard to” Real Involvement when undertaking their duty to involve under S242(1B). “Have regard to” means that an organisation must properly consider and take into account the guidance when undertaking the S242(1B) duty. This does not mean that the organisation must comply with the guidance in all cases but it must have good reason for any decision to depart from it.

This element is designed to identify whether providers have sought peoples’ views and taken them into account when they have made decisions. This may include research, consultation or other discussions with people to find out their views and experiences. There is then evidence that this information has been considered when decisions are made by managers and staff in the organisation.

Element two

Updated legislation and new statutory guidance on patient and public engagement came out from DH during the previous assessment year. This now

Involvement Networks), particularly those people who are seldom listened to, how it has taken their views and experiences into account in the designing, planning, delivering and improving healthcare services, having regard to *Real Involvement, Working with people to improve health services (Department of Health 2008)*, and any other statutory guidance introduced in the assessment year, and in accordance with the duties listed in element one.

Element Three

The healthcare organisation actively involves patients, users, carers and the local community (including Local Involvement Networks), on an ongoing basis, in the decisions made about the design, planning, delivery and improvement of services, particularly those people who are seldom listened to, having regard to Real Involvement, Working with people to improve health services (Department of Health 2008), and any other statutory guidance introduced in the assessment year, and in accordance with the duties listed in element one.

applies to the whole assessment year for 09-10 and to all elements.

This element is designed to identify whether providers are transparent about the decision making processes and the impact that people have had in the planning and design of services. They are required to give feedback to people about how their views and experiences have been used. It ensures that providers have made this public and is a tangible way of assessing whether they are building ongoing relationships with local people that is required in Real Involvement.

Element Three

Updated legislation and new statutory guidance on patient and public engagement came out from DH during the previous assessment year. This now applies to the whole assessment year for 09-10 and to all elements.

A new element three has been introduced to focus on the ACTIVE INVOLVEMENT of people in decision making.

This element is designed to identify whether providers have given people an opportunity to help make the decisions about planning and providing services. This may include having representatives on committees and steering groups, co-designing services directly with people and delegating activities to users and community reps where appropriate. It reflects the requirements in Real Involvement for people to be given a greater say – not just asked about their views as the objects of a research exercise.

Core standard C18

Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

Elements

Element one

The healthcare organisation enables that all members of the population it serves are able to access its services equally, including acting in accordance with: The general and specific duties imposed on public bodies (including, amongst other things, equality schemes for race, disability and gender, along with impact assessments) under the following “public body duties” statutes:

- the Race Relations (Amendment)

Rationale

Element one

This element is changed to include assessment of providers’ compliance with their obligation to act in accordance with the “goods, facilities and services provisions” of the anti-discrimination legislation relating to sex, race, disability, religion/belief and sexual orientation [NB there are currently no such provisions in relation to age].

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

-
- Act 2000,
 - the Disability Discrimination Act 2005
 - the Equality Act 2006.

And with the “goods, facilities and services provisions” of the following statutes:

- the Sex Discrimination Act 1975
- the Race Relations Act 1976
- the Disability Discrimination Act 1995
- the Equality Act 2006
- the Equality Act [Sexual Orientation]
- Regulations 2007.

And where appropriate, having due regard to the associated codes of practice.

* The phrase “public body duties” is defined in C7e

Under the “goods, facilities and services provisions” set out above it is unlawful for any person or body concerned with the provision [for payment or not] of goods, facilities or services to the public or a section of the public to discriminate against a person, on grounds of sex, race, disability, religion/belief or sexual orientation, by refusing or deliberately omitting to provide him/her with any such goods, facilities or services, or by providing goods, facilities or services of inferior quality or in a less favourable manner.

Element two

The healthcare organisation offers patients/service users choice in access to services and treatment, and those choices in access to services and treatment are offered on a fair, just and reasonable basis, including to disadvantaged groups and including acting in accordance with the general and specific duties imposed on public bodies as in element one and including, where appropriate, having due regard to the associated codes of practice.

Element two

No change to this element from 2008/09. As in element one, wording was changed in 2008/09 for clarity and to more precisely express the meaning of this element. In particular more appropriate emphasis is given to providers ensuring that all members of the population are offered choice in access to services and treatment equally.

Core standard C19

Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.

Elements**Rationale**

This standard will be measured under the existing national targets and new national targets assessment	Not applicable
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Sixth domain: care environments and amenities

Domain outcome: Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

Core standard C20a

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation.

Elements

Element one

The healthcare organisation effectively manages the health, safety and environmental risks to patients/service users, staff and visitors, in accordance with all relevant¹⁴ health and safety legislation, fire safety legislation, the *Disability Discrimination Act 1995*, and the *Disability Discrimination Act 2005*; and by having regard to *The duty to promote disability equality: Statutory Code of practice* (Disability Rights Commission, 2005). It also acts in accordance with the mandatory requirements set out in *Firecode – fire safety in the NHS Health Technical Memorandum (HTM) 05-01: Managing healthcare fire safety* (Department of Health, 2006), in so far as the requirements are relevant to the healthcare organisation, and follows the guidance contained therein, or equally effective alternative means to achieve the same objectives. It also considers, and where appropriate follows, the good practice guidance referred to in *The NHS Healthy Workplaces Handbook* (NHS Employers 2007) or equally effective alternative means to achieve the same objectives.

Rationale

Element one

No change to this element from 2008/09.

The Disability Discrimination Act 1995 was amended by the Disability Discrimination Act 2005 and includes a new duty of disability equality. The associated code of practice provides public authorities with guidance on how to understand and meet the general duty and specific duties, which include undertaking an impact assessment of its policies and practices on equality for disabled persons and having due regard to the requirement to take steps to take account of the needs of disabled persons.

The mandatory requirements relating to fire safety in the NHS are contained within *Firecode – fire safety in the NHS Health Technical Memorandum (HTM) 05-01: Managing healthcare fire safety* (Department of Health, 2006), which have been mandated by the Minister of State (Delivery and Quality). This document also contains a suite of guidance covering fire safety in the NHS. However, alternative means of achieving the same outcomes may be possible. Where alternative solutions to *Firecode* are proposed, healthcare organisations should demonstrate that they result in equally effective standards of fire safety.

The Management of Health, Safety and Welfare

¹⁴ Relevant legislation includes:

- Health and Safety at Work etc Act 1974
- Display Screen Equipment Regulations 1992
- Management of Health and Safety at Work Regulations 1999
- Manual Handling Operations Regulations 1992
- Provision and Use of Work Equipment Regulations (PUWER) 1998
- Control of Substances Hazardous to Health Regulations 2002

Issues for NHS staff (NHS Employers 2005) has been updated and published as The NHS Healthy Workplaces Handbook (NHS Employers 2007). This covers both NHS employers' legal responsibilities and other elements of recognised good practice with regard to providing a healthy workplace. While this good practice is not mandatory in its own right, organisations choosing not to adopt it should have equally effective alternative measures in place to achieve the overall outcomes of the standard.

Element two

The healthcare organisation provides a secure environment which protects patients/service users, staff, visitors and their property, and the physical assets of the organisation, including in accordance with Secretary of State directions on measures to tackle violence against staff and professionals who work in or provide services to the NHS (Department of Health 2003, as amended 2006) and Secretary of State directions on NHS security management measures (Department of Health 2004, as amended 2006).

Element two

No change to this element from 2008/09. Element two was amended in 2008/09 to include mandatory Secretary of State Directions to the NHS on security management arrangements and work to tackle violence, and recent amendments. Trusts should also note that these directions require trusts to have regard to any other guidance or advice issued by the NHS Security Management Service, and therefore that this will be assessed as part of this element.

Core standard C20b

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.

Elements

Element one

The healthcare organisation provides services in environments that are supportive of patient privacy and confidentiality, including the provision of single sex facilities and accommodation, access to private areas for religious and spiritual needs and for confidential consultations. This should happen at all stages of care and during transfers¹⁵.

Rationale

Element one

No change to this element from 2008/09. The wording of the element was changed in 2008/09 to include privacy for spiritual needs and confidential consultations which is an integral part of the requirements of privacy.

This year all sectors have again been combined on the basis that the types of measures that need to be taken to ensure patient privacy and confidentiality are broadly the same across the sectors (such as locks on bathroom doors which can be overridden in emergencies, partitions that offer auditory and visual privacy, staff not entering closed curtains unannounced etc.) Each sector will of course need to take into account the specific aspects of their service and condition of patients in deciding exactly what combination of measures are appropriate. It is

¹⁵ The term "transfer(s)" is as defined by the NHSLA Risk Management Standard, 'the process whereby a patient is moved from one clinical area to another within the organisation or to another organisation'. (Source: <http://www.nhsla.com/Publications/>)

also recognised that the need for privacy and confidentiality will often need to be balanced with measures needed to deliver effective and safe healthcare in the various stages of care. Again the specific measures in achieving this balance will vary according to sector and circumstance.

Element two

Healthcare organisations have systems in place to ensure that preventive and corrective actions are taken in situations where there are risks and/or issues with patient privacy and/or confidentiality.

Element two

No change to this element from 2008/09. This is important to ensure that the criteria for assessment of this standard includes whether there are adequate checks and proactive approach to prevent situations where patient privacy and/or confidentiality may be compromised.

Core standard C21

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

Elements

Element one

The healthcare organisation has systems in place and has taken steps to ensure that care is provided in well designed and well maintained environments, including in accordance with all relevant legislative requirements referred to in Health Building Notes (HBN) and Health Technical Memoranda (HTM), and by following the guidance contained therein, or equally effective alternative means to achieve the outcomes of the HBNs/HTMs. The healthcare organisation should also act in accordance with the *Disability Discrimination Act 1995*, the *Disability Discrimination Act 2005*; and have regard to *The duty to promote disability equality: Statutory Code of practice* (Disability Rights Commission, 2005).

Element two

This element of the standard will not be assessed in 2009/10.

Rationale

Element one

This wording of this element was modified in 2008/09 to focus on assurance systems as well as the technical guidance.

Health Building Notes and Health Technical Memoranda contain both legal requirements and good practice guidance. While the guidance in the memoranda assists healthcare organisations to achieve well designed and well maintained environments, there may be alternative ways of achieving the same objectives. Where alternative solutions are proposed, healthcare organisations should demonstrate that equally effective outcomes are achieved.

The *Disability Discrimination Act 1995* was amended by the *Disability Discrimination Act 2005* and includes a new duty of disability equality. The associated code of practice provides public authorities with guidance on how to understand and meet the general duty and specific duties, which include undertaking an impact assessment of its policies and practices on equality for disabled persons and having due regard to the requirement to take steps to take account of the needs of disabled persons.

Element two

From 1 April 2009, all NHS organisations to which the Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Healthcare Associated Infections applies were registered with the Care Quality Commission.

Seventh domain: public health

Domain outcome: Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Core standard C22a&c

Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:

- a) co-operating with each other and with local authorities and other organisations; and
- c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.

Elements

Element one

The healthcare organisation actively works with other healthcare organisations, local government and other local partners to promote, protect and demonstrably improve the health of the community served and narrow health inequalities, such as by working to improve care pathways for patients / service users across the health community and between the health, social care and the criminal justice system, and/or participating in the JSNA and health equity audits to identify population health needs.

Element two

The healthcare organisation contributes appropriately and effectively to nationally recognised and/or statutory partnerships, such as the Local Strategic Partnership, children's partnership arrangements and, where appropriate, the Crime and Disorder Reduction Partnership.

Element three

The healthcare organisation monitors and reviews their contribution to public health partnership arrangements and takes action as required.

Rationale

Element one

No change to this element from 2008/09.

Note: JSNA stands for Joint Strategic Needs Assessment.

Element two

No change to this element from 2008/09.

Note: For PCTs, there is a legal duty to: be a member of the Crime and Disorder Reduction Partnerships; to cooperate in children's partnership arrangements; to cooperate to agree targets as part of Local Strategic Partnerships.

Element three

No change to this element from 2008/09.

Core standard C22b

Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by ensuring that the local Director of Public Health's Annual Report informs their policies and practices.

Elements	Rationale
<p>Element one</p> <p>The healthcare organisation's policies and practice to improve health and narrow health inequalities are informed by the local director(s) of public health's (DPH) annual public health report(s).</p>	<p>Element one</p> <p>No change to this element from 2008/09. apart from changing "director "of public health to "director(s)" and annual public health "report" to "report(s)" to reflect the fact that for some trusts there may be more than one relevant DPH and annual public health report.</p>

Core standard C23

Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

Elements	Rationale
<p>Element one</p> <p>The healthcare organisation collects, analyses and shares data about its patients/service users and services, including where relevant data on ethnicity, gender, age, disability and socio-economic factors, including with its commissioners, to influence health needs assessments and strategic planning to improve the health of the community served.</p>	<p>Element one</p> <p>No change to this element from 2008/09.</p>
<p>Element two</p> <p>The healthcare organisation provides assessment and evidence based care and advice to service users along their care pathway in relation to public health priority areas and their physical health needs, including referral to primary healthcare and ensuring access to health checks and screening programmes.</p>	<p>Element two</p> <p>No change to this element from 2008/09.</p>
<p>Element three</p> <p>The healthcare organisation implements policies and practices to improve the health and wellbeing of its workforce.</p>	<p>Element three</p> <p>No change to this element from 2008/09.</p>
<p>Element four</p> <p>The healthcare organisation provides support and advice for service users to improve their mental health and well being, including support in retaining or accessing employment, training or volunteering opportunities.</p>	<p>Element four</p> <p>No change to this element from 2008/09.</p>

Core standard C24

Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.

Elements

Element one

The healthcare organisation protects the public by having a planned, prepared, tested, exercised and regularly reviewed response to incidents and emergency situations (including control of communicable diseases), which includes arrangements for business continuity management, in accordance with the Civil Contingencies Act (2004), The NHS Emergency Planning Guidance 2005, underpinning material and other associated supplements (Department of Health, 2005, 2007), and Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic (Department of Health November 2007).

Rationale

Element one

Not all NHS organisations have duties under the Civil Contingencies Act 2004 (CCA). However, the Department of Health (within the Emergency Planning Guidance 2005) states in relation to NHS organisations without legal duties under CCA, that they expect them “to act as if they had to comply with the requirements of the Act”. Therefore the CCA remains as part of the element for all provider trusts.

Although it is wording from the standard, “**where possible**” has been deleted as, within the context of the element, it does not add any meaning. The phrase “in accordance with... NHS Emergency Planning guidance 2005” effectively defines the minimum requirements for “practise” (and is therefore “possible”).

Similarly “**practised**” is replaced by “**tested and exercised**” as this is the language used in the NHS Emergency Planning guidance 2005 to address “practise”.

“**Underpinning material**” has been added to the reference to the Emergency Planning Guidance for clarity. There is a series of guidance documents relevant to specific sectors or activities entitled “The NHS Emergency Planning Guidance 2005: underpinning materials” including for each of the sectors: “Acute trusts and foundation trusts”; “Ambulance Services”; “Non-acute and specialist trusts”; “Primary care trusts”. Other “**associated supplements**” include for instance “Strategic command arrangements for the NHS during a major incident” “NHS Emergency Planning Guidance 2005: Planning for the management of blast injured patients NHS” “Emergency Planning Guidance 2005: Planning for the management of burn-injured patients in the event of a major incident” etc.

“**Regular review**” added for clarity. The NHS Emergency Planning guidance states that this is an essential aspect of emergency planning, itself a key element of preparedness.

Appendix one: Reference documents

For the 2005/06, 2006/07, 2007/08 and 2008/09 assessment of core standards, we published a number of elements that included references to guidance that we asked trusts to “take into account”. Our intention had been that this guidance would, in many cases, provide a starting point for trusts to consider, when reviewing their compliance with a standard. However, as this guidance is not sufficient or necessary for trusts to use to determine whether they have met a particular standard, we have taken the decision to remove these references.

We have provided the references below as some trusts may still find them helpful when considering their compliance. The list is not an exhaustive list of references for each standard, but instead may be useful to trusts as a starting point.

Standard	Guidance
C01a	<i>Building a safer NHS for patients: implementing an organisation with a memory</i> (Department of Health, 2001)
C02	<i>Safeguarding Children and Young People: Roles and Competencies for Health Care Staff</i> (Royal College of Paediatrics and Child Health April 2006) <i>Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities</i> (DCSF 2008) <i>Sharing personal information: How governance supports good practice</i> (DCSF August 2008)
C04a	<i>Essential steps to safe, clean care: introduction and guidance</i> (Department of Health, 2006) <i>National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services</i> (Ambulance Service Association, 2004) Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance PROC 12 <i>Infection control practices for ambulance services</i> (Infection Control Nurses Association, April 2001)
C04d	<i>Building a safer NHS: improving medication safety</i> (Department of Health 2004)
C05a	<i>How to put NICE guidance into practice</i> (NICE, December 2005)
C07ac	<i>Clinical governance in the new NHS</i> (HSC 1999/065) <i>Assurance: the board agenda</i> (Department of Health 2002) <i>Building the assurance framework: a practical guide for NHS boards</i> (Department of Health 2003)
C7b	<i>Directions to NHS Bodies on counter fraud measures</i> (Department of Health, 2004)
C08b	<i>Leadership and Race Equality in the NHS Action Plan</i> (Department of Health 2004)
C10a	The set of six documents that make up the NHS Employment Standards: <ol style="list-style-type: none"> 1. <i>Verification of identity checks</i> 2. <i>Right to work checks</i> 3. <i>Registration and qualification checks</i> 4. <i>Employment history and reference checks</i> 5. <i>Criminal record checks</i> 6. <i>Occupational health checks</i> These are downloadable from www.nhsemployers.org/primary/primary-3524.cfm

	<p>The Criminal Record Bureau website provides additional information on Criminal record checks. See www.crb.gov.uk</p> <p>The UK Border Agency website provides information on their checking service for employers. See http://www.bia.homeoffice.gov.uk/employers/employersupport/ecs</p>
C11a	<i>Code of practice for the international recruitment of healthcare professionals</i> (Department of Health 2004)
C11c	<p><i>Continuing professional development: quality in the new NHS</i> (HSC 1999/154)</p> <p><i>Continuing professional development: quality in the new NHS</i> (DH, 1999)</p>
C13a	<i>NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff</i> (Department of Health, 2003).
C13b	<p><i>Good practice in consent: achieving the NHS plan commitment to patient centred consent practice</i> (HSC 2001/023)</p> <p><i>Seeking Consent: working with children</i> (Department of Health 2001)</p>
C16	<p><i>Toolkit for producing patient information</i> (Department of Health 2003)</p> <p><i>Information for patients</i> (NICE)</p> <p><i>Guidance On Developing Local Communication Support Services And Strategies</i> (Department of Health 2004) and other nationally agreed guidance where available</p>
C17	<p>Key principles of effective patient and public involvement (PPI) (The National Centre for Involvement, 2007)</p> <p><i>Community Engagement in Health</i> (NICE public health guidance Feb 2008)</p>
C18	<i>Building on the best: Choice, responsiveness and equity in the NHS</i> (Department of Health 2003).
C20a	<p><i>A professional approach to managing security in the NHS</i> (Counter Fraud and Security Management Service 2003) and other relevant national guidance</p> <p><i>Design for patient safety: Towards future ambulances</i> (National Patient Safety Agency and The Helen Hamblyn Trust, 2007) for ambulance trusts only</p> <p>BS EN 1789:2000 Medical vehicles and their equipment – road ambulances</p>
C21	<p><i>Developing an estate's strategy</i> (1999)</p> <p><i>Developing an estates strategy</i> (Department of Health, 2008), updated version of previous document, but was not published until August 2008</p> <p><i>A risk based methodology for establishing and managing backlog</i> (NHS Estates, 2004)</p> <p>Add <i>BS EN 1789: 2007 Medical vehicles and their equipment</i> for ambulance trusts only</p> <p><i>Design for patient safety: Towards future ambulances</i> (National Patient Safety Agency and The Helen Hamblyn Trust, 2007) for ambulance trusts only</p> <p><i>National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services</i> (Ambulance Service Association, 2004) for ambulance trusts only</p> <p>BS EN 1789:2000 Medical vehicles and their equipment – road ambulances</p>

C22ac	<p><i>Choosing health: making healthier choices easier</i> (Department of Health 2004)</p> <p><i>Tackling health inequalities: a programme for action</i> (Department of Health 2003)</p> <p><i>Making partnerships work for patients, carers and service users</i> (Department of Health 2004)</p> <p><i>Guidance on Joint Strategic Needs Assessment</i> (Department of Health, 2007)</p>
C23	<p><i>Choosing health: making healthy choices easier</i> (Department of Health 2004)</p> <p><i>Delivering Choosing health: making healthier choices easier</i> (Department of Health 2005)</p> <p><i>Tackling Health Inequalities: A programme for action</i> (Department of Health 2003)</p> <p><i>Guidance on Joint Strategic Needs Assessment</i> (Department of Health, 2007)</p>
C24	<p><i>Getting Ahead of the Curve</i> (Department of Health, 2002)</p> <p><i>Beyond a major incident</i> (Department of Health, 2004)</p>