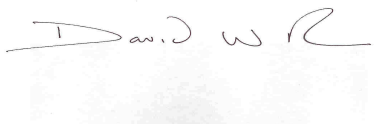
Public Document Pack

Healthy Halton Policy and Performance Board

Tuesday, 10 March 2009 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	Labour
Councillor Joan Lowe (Vice-Chairman)	Labour
Councillor Dave Austin	Liberal Democrat
Councillor Robert Gilligan	Labour
Councillor Trevor Higginson	Liberal Democrat
Councillor Margaret Horabin	Labour
Councillor Martha Lloyd Jones	Labour
Councillor Ged Philbin	Labour
Councillor Ernest Ratcliffe	Liberal Democrat
Councillor Geoffrey Swift	Conservative
Councillor Pamela Wallace	Labour
LINk Co-optee Vacancy	

Please contact Michelle Simpson on 0151 907 8300 Ext. 1126 or e-mail michelle.simpson@halton.gov.uk for further information.
The next meeting of the Board is on Tuesday, 9 June 2009

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

Agenda Item 3

REPORT TO: Healthy Halton Services Policy & Performance Board

DATE: 10 March 2009

REPORTING OFFICER: Strategic Director, Corporate and Policy

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To consider any questions submitted by the Public in accordance with Standing Order 34(9).

1.2 Details of any questions received will be circulated at the meeting.

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

3.1 Standing Order 34(9) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for dealing with questions from members of the public who are residents of the Borough, to ask questions at meetings of the Policy and Performance Boards.

(ii) Members of the public can ask questions on any matter relating to the agenda.

(iii) Members of the public can ask questions. Written notice of questions must be given by 4.00 pm on the working day prior to the date of the meeting to the Committee Services Manager. At any one meeting no person/organisation may submit more than one question.

(iv) One supplementary question (relating to the original question) may be asked by the questioner, which may or may not be answered at the meeting.

(v) The Chair or proper officer may reject a question if it:-

- Is not about a matter for which the local authority has a responsibility or which affects the Borough;
- Is defamatory, frivolous, offensive, abusive or racist;
- Is substantially the same as a question which has been put at a meeting of the Council in the past six months; or

- Requires the disclosure of confidential or exempt information.

(vi) In the interests of natural justice, public questions cannot relate to a planning or licensing application or to any matter which is not dealt with in the public part of a meeting.

(vii) The Chairperson will ask for people to indicate that they wish to ask a question.

(viii) **PLEASE NOTE** that the maximum amount of time each questioner will be allowed is 3 minutes.

(ix) If you do not receive a response at the meeting, a Council Officer will ask for your name and address and make sure that you receive a written response.

Please bear in mind that public question time lasts for a maximum of 30 minutes. To help in making the most of this opportunity to speak:-

- Please keep your questions as concise as possible.
- Please do not repeat or make statements on earlier questions as this reduces the time available for other issues to be raised.
- Please note public question time is not intended for debate – issues raised will be responded to either at the meeting or in writing at a later date.

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton** - none.

6.2 **Employment, Learning and Skills in Halton** - none.

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

6.5 **Halton's Urban Renewal** – none.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 10 March 2009

REPORTING OFFICER: Strategic Director, Corporate and Policy

SUBJECT: Executive Board Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health Portfolio which have been considered by the Executive Board and Executive Board Sub are attached at Appendix 1 for information.

1.2 The Minutes are submitted to inform the Policy and Performance Board of decisions taken in their area.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

None.

4.0 OTHER IMPLICATIONS

None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

5.2 **Employment, Learning and Skills in Halton**

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

APPENDIX 1

Extract of Executive Board and Executive Board Sub Committee Minutes Relevant to the Healthy Halton Policy and Performance Board.

EXECUTIVE BOARD MEETING HELD ON 15 JANUARY 2009

HEALTH AND SOCIAL CARE PORTFOLIO

EXB94 Customer Service Excellence

The Board considered a report of the Strategic Director – Health and Community outlining progress to consider and develop the Government's Customer Service Excellence Standards.

It was noted that, earlier in the year, the Cabinet Office had launched its approach to improving standards within Customer Services. The aim of Government was for "public services to be efficient, effective, excellent, equitable and empower – with the citizen always and everywhere at the heart of public service provision". Standards and a toolkit had therefore been prepared and Local Authorities were expected to achieve accreditation through a nationally recognised process, in some ways replacing the Charter Mark. The Council had to adopt and achieve accreditation for Contact Centres during 2009 or demonstrate progress to achieve accreditation. Thereafter, it was expected that all services with a customer focus should be accredited. Potentially, this could mean a significant number of teams and services within the Council.

The Corporate Services Policy and Performance Board Working Group had already addressed a range of issues surrounding customer care and complaints and had tasked the Strategic Director – Health and Community with producing a plan to address the standards. A small officer working group had therefore been established to examine the issues and the progress made to date in terms of both Customer Service Excellence and Customer Services Strategy were outlined for the Board's consideration.

The final draft of the Council's Customer Services Strategy was attached to the report. Members noted the Strategy and, in particular, the opportunities for sharing information with partners; for example, the Fire Service had produced a booklet for Iranian families in the area, which had been well received. It was confirmed that the opportunity for the Council producing a similar booklet would be investigated.

RESOLVED: That

(1) the process to achieve accreditation as outlined within the report be supported; and

(2) the Customer Services Strategy be approved.

EXECUTIVE BOARD MEETING HELD ON 28 JANUARY 2009

EXB99 Care Standards Commission Performance Rating

The Board considered a report of the Strategic Director – Health and Community advising of the further improvements in the performance rating of the Health and Community Directorate, and of the impending changes in the way the performance of Social Care services would be assessed commencing 2008/09.

It was noted that the Directorate had its performance rated annually by the Care Standards Commission (CSCI). The performance rating was linked to how well the Directorate provided social care services to all adults and the rating received fed into the Comprehensive Performance Assessment (CPA) rating for Halton Borough Council.

In September 2006 CSCI announced that, as well as looking at quantitative data, they would also be judging performance based on the outcomes that were delivered for people. Seven new outcomes and two new domains were announced against which performance would be judged: details were outlined within the report for Members' information.

Performance for 2007/08, announced on 27th November 2008, had been rated by CSCI as being three star. The actual performance judgement based on the new performance ratings was:

- Delivering Outcomes – excellent; and
- Capacity for Improvement – excellent.

A copy of the performance judgement letter and summary report received from CSCI were attached at Appendix 1 to the report. The Council's key strengths that had been identified were outlined in the report for Members' information, together with details of how the Directorate had previously been rated.

The Board was advised that this was the last year that the Star Ratings and Performance Judgements would be used as a new system was to be implemented next year. The Council had finished at the highest level within the existing performance assessment framework, one of only 25 Local Authorities in England in this position, and all staff and Members involved were congratulated on this achievement.

At this stage it was not clear how the new performance system would operate as CSCI was being re-formed with other Commissions into a new Care Standards Commission. However, the indicators were that any performance judgement for 2008/09 would continue to focus on the

results that people who used the services advised had been delivered.

RESOLVED: That

(1) the improved performance of the Directorate be noted; and

(2) it be noted that the performance assessment framework is undergoing a period of continuous change and that the framework will change again in 2008/09.

EXECUTIVE BOARD SUB-COMMITTEE MEETING HELD ON 12 FEBRUARY 2009

ES81 One Year Extension to current Drug Service Contract

The Sub-Committee received a report of the Strategic Director, Health and Community, which sought authority to increase and extend the contracts of ARCH Initiatives and Addaction until 31st March 2010.

It was noted in May 2008, the Strategic Director, Health and Community was authorised to proceed with the open tendering and procurement of a community based Drug Service. The planned start date for this service was April 2009. As a consequence current service providers were issued with notices of termination of contracts. The notice was to expire on 31st March 2009.

It was further noted that following discussions in November 2008 with the Chief Executive, Strategic Director Health and Community, Deputy Director of Public Health and Operational Director for Partnership Commissioning (Halton and St. Helens Primary Care Trust (PCT)) the decision was taken to halt this tender process.

During this process, Halton and St. Helens PCT indicated that significant additional resources would be made available for the provision of alcohol treatment from April 2009. In the interests of economy, efficiency and effectiveness, the Council and the PCT were now discussing how the alcohol and drugs resources could be combined with a view to tendering for a combined substance misuse service, commencing April 2010. Therefore to prevent any gaps in service it was necessary to withdraw termination notices and extend contracts for a further year with both ARCH Initiatives and Addaction.

Members were advised that ARCH Initiatives currently provided the screening and assessment functions for the single point of access at Ashley House. They also provided time-limited support to individuals that used stimulant drugs. The contract value to provide these services in 2009/10 would be £144,000. However, it was the intention of the Drug Action Team to invest a further £80,000 to also provide an improved service for Carers and increase referrals from local hospitals. The total contract value for 2009/10 would therefore be £224,000.

Members were further advised that Addaction currently provided the Outreach Service and Drug Intervention Programme targeted at drug using offenders. The contract for 2009/10 would be £304,000. However, in order to provide additional capacity to support the Prolific Offender team and establish an increased presence at the police custody suite at Manor Park, the Drug Action Team intended to invest a further £36,000. Therefore the total contract value for 2009/10 would be £340,000.

RESOLVED: That for the purposes of Standing Order 1.6b, authority be delegated to the Operational Director, Culture and Leisure Services in consultation with the Executive Board Member for Health and Social Care to extend the contracts of ARCH initiatives and Addaction until 31st March 2010 without competitive tendering and at the additional cost of £80,000 and £36,000 respectively.

ES82 PERSONALISATION AGENDA AND INDIVIDUAL BUDGETS – WAIVER OF PROCUREMENT TENDERING STANDING ORDERS

The Sub-Committee received a report of the Strategic Director – Health and Community which requested the waiving of Procurement Standing Orders 3.1 – 3.7 which placed a requirement on the Council to tender for contracts set up with external providers of services.

Members were advised that long-term demographic changes meant that the current systems of delivering social care needed to be fundamentally changed and modernised if they were to respond to pressures of increased expectations and substantial culture change. Any changes would have to recognise the need to explore options for the long-term funding of the care and support system.

It was noted that the Government's approach to personalisation could be summarised as "the way in which services were tailored to the needs and preferences of citizens. The overall vision that the state should empower citizens to shape their own lives and the services they received."

It was further noted that the Government was clear that everybody received social care support in any setting, regardless of their level of need, would have choice and control over how this support was delivered. The intention was that people would be able to live their own lives, as they wished, confident that services were of high quality, were safe and promoted their own individual requirements for independence, well-being and dignity.

Members were advised that at the core of self-directed services was a change in process that intended to give those people involved new initiatives and power to shape services and get better value for money and, as such, there were many associated workforce issues that would need to be addressed via an appropriate Workforce and Training

Programme.

Members were further advised that the proposed provider, Helen Sanderson Associates were market experts in providing training, workforce development and associated support, advice and guidance on Personalisation and Person Centred Planning and, as such, had worked with a number of local authorities, as outlined in the report. The Operational Director for Health and Partnerships was satisfied that the cost of £129,100, for 116 training days to a wide variety of employees, Service users, Carters and Contracted Providers, was a fair price was value for money.

A number of further options had been investigated, however these had been rejected due to a lack of expertise, skills and knowledge of the staff identified.

The Workforce and Training Programme was designed to create a truly personalised care system and would deliver those outcomes identified in Halton Borough Council's Self-Directed Support Project Plan.

RESVOLED: That Procurement Standing Orders 3.1 – 3.7 be waived in accordance with Standing Order 1.6 and the Operational Director Health and Partnerships be authorised to award the contract for the Personalisation Workforce Development and Training Programme to Helen Sanderson Associates Limited, for the sum of £129,100 in light of the exceptional circumstances outlined within the report, due to there being only one possible contractor.

ES83 REVIEW OF FEES & CHARGES 2009-10 FOR HEALTH & COMMUNITY SERVICES

The Sub-Committee were presented with a report which proposed increases in fees and charges for Health and Community Care services.

Members' attention was drawn to Appendix 1 which showed the current charges for social care services and the proposed charges for 2009/10. The recommended increased fees and charges for social care services listed for 2009/10 had been inflated by 3%.

Members were advised that fees and charges for Health and Community Care would be increased with effect from 6th April 2009 to coincide with the annual increase in Welfare Benefit rates.

It was noted that current 08/09 Direct Payment rates were detailed within the report. It was proposed that these remained unchanged pending the outcome of consultation with key stakeholders about how resources should be calculated and allocated to Individual Budget holders. The results of the consultation and proposed outcomes would be reported to the Executive Board Sub-Committee for approval.

RESOLVED: That

(1) the proposed changes in fees and charges outlined in Appendix 1, be approved with effect from 6th April 2009 which was the date on which Welfare Benefits were increased; and

(2) that Direct Payment rates remain unchanged until the outcome of the impending consultation with key stakeholders on the new resource allocation system for Direct Payments/Individual Budgets was completed. Any new resource allocated proposals would be submitted to the Executive Board Sub-Committee for approval.

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 10 March 2009

REPORTING OFFICER: Chief Executive

SUBJECT: Specialist Strategic Partnership minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Social Care Portfolio which have been considered by the Health Specialist Strategic Partnership are attached at Appendix 1 for information.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

5.2 **Employment, Learning and Skills in Halton**

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

Halton Strategic PARTNERSHIP

HALTON HEALTH PARTNERSHIP BOARD

MINUTES OF THE MEETING FROM

13 November 2008

Present : Fiona Johnstone (Chair), Cllr Ellen Cargill, Eugene Lavan, Ian Stewardson, Karen Tonge, Melissa Critchley, Stuart Baxter, Jane Trevor, Cllr Ann Gerrard, Diane Lloyd, Glenda Cave, Jim Wilson, Lorraine Butcher, Peter Barron

In Support: Karen Thompson

Fiona Johnstone thanked Karen Tonge for Chairing the last meeting.

		ACTION
1.	**Apologies** Dwayne Johnson, Gerald Meehan, John Kelly, Sue Milner and Tom McInerney	
2.	**Minutes of the previous meeting** These were agreed as a correct record with the following amendments. **Ambition for Health (AFH) / Commissioning Strategic Plan** Karen Tonge reported that following division into Groups it was unclear who Halton representatives were and who St Helens representatives were and that this could be used as a learning point to build upon. **LAA Health Indicators** Remove PH from last paragraph. **The following amendment to the minutes of the meeting held on 17th July 2008 was requested:** **Halton Health Study** KT: "Area Forums do not relate to communities" should read "Some wards within area forums have different needs".	
3.	**Matters Arising** **Child Poverty** Glenda Cave reported that some feedback had been received on the worst five wards in the Borough in terms of benefit claimants and will be circulated to members once detailed breakdown has been received. It was agreed that Data Protection and Information Sharing be an item on a future agenda. **Women's Health Event** The event held on 10th October was well attended and good feedback received.	**GC/AG**

Halton Strategic PARTNERSHIP

		ACTION
4.	**Health & Community Care Forum Feedback** The PCT Management Executive Team (MET) received a copy of an interim report completed by HVA and St Helens CVS outlining the work being undertaken to review Voluntary Sector Provision. The final report will be submitted to MET in December 08. Following on from this a short discussion took place on the next steps in taking forward the actions and recommendations detailed in the report. A celebration event is being held on 17th December 08 which will include a workshop on what LiNks means and taking good practice forward. HVA have agreed that MC and KT will continue as their representatives. The involvement of LINKs with the partnership will need to be agreed directly with them.	
5.	**Ambition for Health (AFH) / Commissioning Strategic Plan** EL gave a presentation and overview to the Partnership of the Commissioning Strategic Plan of key points and principles. Key Principles are: • Helping people to stay healthy • To detect illnesses earlier • Improve the quality, safety & efficiency of our health care services Strategic outcomes which will be clinically driven by Practice Based Consortia are: • Cancer mortality rates • CVD mortality rate • Chronic liver disease • Infant mortality • Mortality rate amenable to health care • Alcohol related harm • COPD prevalence • Childhood obesity JW thanked EL for the presentation and reminded members that this was what the Partnership is about. Systems need to be accountable and will be recognised in future structures. This work will also be widened to look at the Third sector to ensure they are part of the pathway. Agencies will need to think how work be developed beyond an original Expression of Interest. The Partnership was keen to build on work already done with mainstream engagement. How can GPs be made aware of lifestyle / leisure activities available within the community. This could be achieved through signposting to services, but need to understand	
6.	**Performance Sub Group** *Local Authority Indicators* Indicators were circulated to members of the Group and PB updated the Partnership.	

Halton Strategic PARTNERSHIP

		ACTION
	It was noted that there were gaps in terms of information and a more detailed scrutiny programme is required to target information and to split between commissioning and performance. Concerns were raised about performance management of LAA targets. Without detailed information the Partnership will not know if a difference is being made on key targets. The Chair recognised and thanked those involved in this work. Priority data sets are required and FJ requested that by the next meeting a significant improvement would be reported back. A suggestion was made to look at developing a Commissioning Sub Group. FJ welcomed the opportunity to discuss these issues further outside the Partnership meeting and add weight to expectations. The Terms of Reference for the Sub Group will be reviewed to link in with the current work of the existing Performance Sub Group and requirements of the Health Partnership. Need to ensure that the appropriate people are in attendance to bring together data and analysis. *Finance Update* No significant problems were reported. GC agreed to circulate information electronically to members. It was noted that Peter Barron was taking up a secondment position and was thanked by the Chair and members for his contribution to Partnership meetings	**GC/PB** **FJ/GC/DL /PB/AG/LB** **GC**
7.	**Teenage Pregnancy** A report was circulated and provided a summary of the recent Teenage Pregnancy National Support Team Visit to Halton on key issues for action – these were: • Support to be given to continue the strategic approach for addressing teenage pregnancy within the Borough. • Support is given to the development of an action plan incorporating the key recommendations. • A progress report is submitted to Halton Health Partnership Board on a 6 monthly basis. The Partnership recognised that it would be at least 15 months before impact of any work done to reduce teenage pregnancies would be known. JT circulated two papers around welfare benefit and employment support allowance. It was noted that there were also changes to lone parent benefit and these would be circulated electronically.	**JT/GC**
8.	**Health Inequalities National Support Team Visit** The NST will carry out a four-day visit to the area from 9th to 13th February 2009. During this time the NST will undertake a number of discussions with individual stakeholders as well as speaking to the local health economy and partnerships. This will include a half-day workshop programme examining detailed work in a number of key contributory subject areas e.g. cardiovascular disease; tobacco control. The members of the Partnership meeting were asked to note these dates in their diaries.	**ALL**

Halton Strategic PARTNERSHIP

		ACTION
9.	**Health Partnership Review** The next meeting on 22nd January from 9a.m. to 12.30 p.m. will become a Partnership away day and will look at goals and priorities for 2009 and how the Partnership should move these forward. It was agreed that a Neighbourhood Management Representative be invited to Away Day Review. It was agreed that following draft minutes being circulated to members of the Partnership for amendment they would then be submitted to Overview and Scrutiny Panel.	**FJ/DL**
10.	**Date of Next Meeting** Thursday 22nd January 2009 at Stobart Stadium Halton 9.00 a.m. – 12.30 p.m.	

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 10 March 2009

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: The Healthcare Commission Annual Health Check 2008/9

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 To update the Policy and Performance Board of progress made with the self assessment against the Standards for Better Health during the period April 2008 - March 2009 within: -

- Halton and St Helens PCT
- North Cheshire Hospitals NHS Trust
- 5 Borough Partnerships NHS Trust

2.0 RECOMMENDATION: That the Board :-

- **Make a 3rd party commentary to accompany the submissions of the Annual Health Check declarations to the NHS Trusts outlined above and to be made public on the Trusts' websites from 22 May 2009.**

3.0 SUPPORTING INFORMATION

3.1 The annual health check in 2008/09 will assess how well NHS trusts perform during the financial year from 1st April 2008 to 31st March 2009.

The Healthcare Commission published "The Annual Health Check 2008/09: Assessing and Rating the NHS" in June 2008. The guidance sets out :

- Porposals for the annual health check in 2008/9 and related processess
- How the annual health check focuses on the issues that are most important to patients
- How the annual health check will be better tailored to different types of trust

The Commission have also published the criteria for assessing performance against the core standards. There are different sets of criteria, one for each type of trust: acute services, mental health services and learning disability services, ambulance services and primary care trusts

A copy of the criteira documents for each of the Trusts outlined in parargragh 1.1 can be found at Appendix 1.

3.2 There is a need to feed in the views of patients and the public into the annual health check cross-checking process. The Commission have outlined the need for third party organisations to comment on trust performance as part of the 2008/09 annual health check. By third parties the commission mean LINks, overview and scrutiny committees and representatives from foundation trust boards of governors

4.0 POLICY IMPLICATIONS

4.1 Local government and primary care trusts have a joint responsibility for improving the health and well being of the local population through effective commissioning. As a consequence these two bodies are mutually dependent on each other's performance in order to make a significant difference to the lives of local people.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children and Young People in Halton

The annual health check covers all NHS Trusts including maternity services and children's hospitals. Given these services are checked against national quality standards, the outcome of this process will either have a detrimental or beneficial effect on the realisation of council priorities.

5.2 Employment, Learning and Skills in Halton

None identified.

5.3 A Healthy Halton

Effective health service delivery supports and complements HBC efforts to improve the health and well being of the people of Halton.

5.4 A Safer Halton

None identified.

5.5 Halton's Urban Renewal

None identified.

6.0 RISK ANALYSIS

6.1 This is a key opportunity to demonstrate to the Board compliance with the nominated Standards for Better Health and the evidence base that can be provided as assurance to the Board.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 The key standards for self-assessment include equality and diversity issues.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background documents under the meaning of this Act

Inspecting Informing Improving

Healthcare Commission

Criteria for assessing core standards in 2008/09

Acute trusts

Updated December 2008

Contents

Use of "we" (Overview section)

The new Care Quality Commission will replace 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 to enable it to take over the regulation of health and adult social care from 1 April 2009.

The Care Quality Commission will be responsible for delivery of the 2008/2009 annual health check, including the core standards based assessment from 1 April 2009.

Where this document refers to "we" this is a reference to the Healthcare Commission up until 31 March 2009 and to the Care Quality Commission from 1 April 2009.

Overview

These are the 2008/09 criteria for assessing core standards between 1 April 2008 and 31 March 2009 for trusts that provide acute and specialist services. As for previous years, we have set out our criteria as 'elements' for each of the core standards.

What has changed?

Primary care trusts
The main change this year affects primary care trusts (PCTs). As set out in the Healthcare Commission publication, *The Annual Health Check in 2008/09: Assessing and rating the NHS*, our assessment of PCTs for the performance rating in 2008/09 will have a different structure from previous years. This will allow us to report separately on the performance of services that a PCT provides itself (such as community health services) and its role as a commissioner of healthcare services for its local community. We have developed two sets of criteria for assessing PCTs; one for their role as providers and one set for their role as commissioners of services. A single PCT document containing both 2008/09 sets of criteria has been produced and is available to PCT trusts.

What else has changed?
This year, we have expanded our rationales in order to assist trusts further in the assessment process. Some criteria have also been written for greater clarity and in some cases this has made them longer. Although some documents have, in turn, become longer, trusts should find the criteria and the rationales more explicit, clearer and hence helpful when assuring themselves of their compliance against core standards.

As set out in our publication *The Annual Health Check in 2008/09: Assessing and rating the NHS*, while we have split the criteria for PCTs into provider and commissioner criteria, there has been limited change to actual content of criteria. We have however reviewed the elements in order to:

- Continue to increase the focus on the outcomes of the standards. We expect trusts' boards to consider these outcomes when reviewing their assurance of compliance with the standards.

- Add further clarity to elements by explicitly stating within the criteria the status of guidance, codes of practice, etc referred to. For example, where clear legal duties are referred to, trusts are assessed as to whether they have acted "in accordance with" those duties; or for some statutory codes of practice whether they "have had regard to" them, as required by the code. Where the core standard itself refers to specific guidance, this gives that guidance a "must-do" status and the criteria will also reflect this. Other guidance has varying status and we have tried to make this explicit within the criteria.

  For example:

  - The healthcare organisation follows National Institute for Clinical Excellence (NICE) interventional procedures[1] guidance **in accordance with** *The Interventional Procedures Programme* (Health Service Circular 2003/011). (C03) (NICE interventional procedures are required by the standard itself).

[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).

- Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored, **in accordance with** the Medicines Act 1968…, 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**. (C04d)

Where references are recognised as useful for trusts but are not directly the subject of assessment, again we will provide these in an appendix to the final document. However, as was the case with the documents in Appendix 2 of the 2007/08 criteria, these references will not be the basis on which we will make judgments in inspection.

Trusts should also note that core standards C3, C4c and C22b will be assessed for all provider sectors in 2008/09. See rationales in this document for further details.

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 that NHS trusts' boards determine whether they have reasonable assurance of compliance with a standard, without a significant lapse, from 1 April 2008 to 31 March 2009. As part of the annual health check, trusts will then be asked to make a declaration of their compliance for the whole year.

Reasonable assurance
Reasonable assurance, by definition, is not absolute assurance. Conversely, 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 reasonable, trusts must reflect 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. 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), and 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

One of the Healthcare Commission's strategic goals continues to be 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 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. Note that we have run three audits of trusts' websites, looking for this information, and we remain concerned that many trusts are still not compliant with legislation, particularly in relation to race equality.

Using the findings of others

We will continue to make use of the findings of others and have reviewed how we do this in order to increase this where possible, and to ensure that it is effective, both in reducing burden on trusts and also in targeting our inspections. Note that, as in 2007/08, we will make use of others' in-year findings – i.e, findings based on observance of compliance during the assessment year 2008/09, as evidence of assurance of compliance during the year 2008/09. Findings of others relating to recent years will be used to help target inspections.

The NHS Litigation Authority's Risk Management Standards have now been rolled out to all sectors enabling us to make in-year use of their findings for all sectors in 2008/09 where this provides a level of assurance of compliance.

Please see Appendix 1 for more details about this and other changes, in particular a change in the way we use patient environment action team findings.

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, 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	Rationale
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, Healthcare Commission, the Counter Fraud and Security Management Service and all other national organisations to which the healthcare organisation is required to report incidents.	**Elements one and two** Healthcare organisations should report incidents nationally to the relevant national organisations. These organisations include the National Patient Safety Agency (NPSA) and a wider range of organisations that have been listed in the element. 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 and this has been made more explicit in the element.
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 reoccurence 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	**Element three** 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

the reoccurence of similar incidents in the future, for the benefit of patients / service users as a whole.	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. Analysis of relevant trends includes changes over time. This requirement was previously included in element two in 2007/08 and has been brought out in a separate element to provide greater clarity. 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 and this has been made more explicit in the element.
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** Healthcare organisations should make changes to practice based on the analysis of local incidents and the national analysis of incidents. The national analysis of incidents is carried out by 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	Rationale
Element one All communications concerning patient safety issued from the National Patient Safety Agency (NPSA) and the Medicines Healthcare products Regulatory Agency (MHRA) via national distribution systems, including the Safety Alert Broadcast System (SABS), the Central Alert System (CAS) the UK Public Health Link System (UKPHLS), are implemented within the required timescales.	**Element one** SABS is being brought together with the UKPHLS to form the CAS. However, it is likely that all three systems will continue to be used in parallel during the introductory phase of CAS. There are other routes through which this information may be issued. For example MHRA issues field safety notices via its website and targets particular trusts with directly mailed safety letters. While these cannot be considered official distribution systems, they do communicate information regarding patient safety that may occasionally require trusts to take 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	Rationale
Element one The healthcare organisations have 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*.	**Element one** In March 2007 statutory guidance was published, updating previous guidance, which is based on the Children Act 2004. Compliance with this was required by October 2005 and all elements should now be in place. The guidance issued under section 11(4) of the Children Act 2004 which 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 two** Again this element has been extended to include activities that are required, such as participation in serious case reviews and child death reviews, both requirements from 1 April 2008.
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 three** There was some overlap between the 2007/08 element three (CRB checks) and Core standard C10a so this is removed. Instead a particular aspect of the Statutory Guidance is drawn out and wording is used from this document to emphasise the importance of information sharing between agencies. This information sharing process can include the Common Assessment Framework, ContactPoint when it is introduced, 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	Rationale
Element one The healthcare organisation follows NICE interventional procedures[2] guidance in accordance with *The interventional procedures programme* (Health Service Circular 2003/011). Arrangements for compliance are communicated to all relevant staff.	**Element one** National Institute for Clinical Excellence (NICE) interventional procedures guidance applies to any trust that carries out interventional procedures. Following clarification from NICE and Department of Health (DH) the application of the standard has been extended to all trust types to better reflect this. The element makes reference to the need to communicate arrangements to all relevant staff. This is to reflect that even where no 'new' interventional procedures[3] 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.

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	Rationale
Element one The healthcare organisation has systems to ensure the risk of healthcare associated infection is reduced in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008). To note: the measurement of the MRSA target is undertaken through the 'national priorities' component of the annual health checks.	**Element one** The Hygiene Code was revised in January 2008. All healthcare associated infection issues are covered by this criteria with the exception of the following: **Covered by C21 – Cleaning of the environment:** • Hygiene Code Duty 4 (a, b, (in relation to cleaning) c, d, e, g and h). **Covered by C4c – Decontamination of reusable medical devices:** • Hygiene Code Duty 3 (if related to decontamination) • Hygiene Code 4b

[2] "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).

[3] 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.

- Hygiene Code 4f.

Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and, where appropriate, follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation.

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	Rationale
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.	**Element one** No change to this element from 2007/08
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** One of the amendments to the IRMER 2000 regulations was in 2006 when enforcement responsibilities were transferred to the Healthcare Commission. Further amendments are likely and so an explicit reference is now 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	Rationale
Element one Reusable medical devices are properly decontaminated in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008).	**Element one** The Hygiene code was revised in January 2008. Criteria C4c covers: • Hygiene Code Duty 3 (if related to decontamination) • Hygiene Code 4b • Hygiene Code 4f. All other aspects of healthcare associated infection and duties of the Hygiene Code are covered by C4a or C21. Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must

consider and, where appropriate, follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation.

In 2006/07, this standard was not assessed for ambulance trusts and mental health trusts as the focus for assessment was on the sterilisation of invasive medical equipment that presented a known risk of infection. However, this criteria will apply to all trust types on 2008/09 because:

- Decontamination has a wider meaning than sterilisation alone and is defined as a combination of processes, including cleaning, disinfection and sterilisation, used to render a reusable item safe for further use on patients / service users and handling by staff.
- Medical devices refers to all products, except medicines, used in healthcare for diagnosis, prevention, monitoring or treatment.

A single use medical device is a device that is intended to be used on an individual patient during a single procedure and then discarded. Therefore, any device which is not single use must be considered a reusable medical device. These devices are used by ambulance and mental health trusts.

Core standard C4d

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

Elements	Rationale
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 one** In referring to the Medicines Act, all amendments and subsequent regulations are now included within this reference. Subsequent regulations include the Medicines for Human Use (Prescribing) Order, which provides additional requirements for prescribing (eg, reauthorising repeat prescriptions every six months). The Duthie Report *(The safe and secure handling of medicines: A Team approach)* has now 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).

	In addition feedback received during the 2008/09 annual health check consultations suggested including this reference within the criteria for C4d.
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.*	**Element two** The proposed element makes reference to all amendments for the Misuse of Drugs Act 1971. The guidance on strengthened governance arrangements has been replaced with the updated 2007 version. The proposed 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	Rationale
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 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).	**Element one** Element one has been amended to incorporate HTM 07-05 relating 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 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 NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

Elements	Rationale
Element one The healthcare organisation ensures that it conforms to 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.	**Elements one and two** New technology appraisals are always under development, therefore all NHS trusts need to have mechanisms in place to review the appropriateness of these for their service, even if many of them will not be relevant to some trust types. Current healthcare policy emphasises the importance of the quality of clinical care and of having consistent care for all patients / service users. The effective implementation of NICE technology appraisals and use of clinical guidelines that are based on best practice are crucial to the promotion of consistent and high quality clinical care. To reflect this, elements one and two have been made more explicit to give greater focus on the different aspects of the standard.
Element two The healthcare organisation can demonstrate how it takes into account nationally agreed guidance where it is available as defined in National Service Frameworks (NSFs), NICE guidelines, national plans 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.	

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'[4]; 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 one** The wording of the elements has been amended to clarify that the responsibility being assessed is that of the organisation and not that of individual clinicians. Element one has been amended to clarify 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 patients / service users receive care which will lead to effective clinical outcomes. When making a declaration against this standard the Healthcare Commission would expect an organisation to assure itself that arrangements for both of the above are in place and effective. Current healthcare policy emphasises the importance of clinician-led services. To reflect this, the elements have been made more explicit to give greater focus on the different aspects of the standard against which we would expect an organisation to assure itself.
Element two The healthcare organisation ensures that it provides opportunities for clinicians[5] to develop their clinical leadership skills and experience.	**Element two** With this additional element the criteria now better reflects the standard

Core standard C5c

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

Elements	Rationale
Element one The healthcare organisation ensures that clinicians from all disciplines participate	**Element one** The wording of the elements has been amended to better reflect the standard and to clarify that the

[4] 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*, NMC, 2008).

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

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.	responsibility being assessed is that of the organisation and not that of individual clinicians. 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 has been made more explicit to give greater focus on the different aspects of the standard against which we would expect an organisation to assure itself.

Core standard C5d

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

Elements	Rationale
Element one The healthcare organisation ensures that clinicians[6] are involved in prioritising, conducting, reporting and acting on regular clinical audits[7]. **Element two** The healthcare organisation ensures that clinicians participate in regular reviews of the effectiveness of clinical services through evaluation, audit or research.	**Elements one and two** The wording of the elements have been amended to better reflect the standard and to clarify that the responsibility being assessed is that of the organisation and not that of individual clinicians.

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	Rationale
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	**Elements one and two** The structure and wording of the elements have been amended to better reflect the standard and to clarify that the partnership responsibilities being assessed are those of the organisation as well as those of staff. Element one considers an organisation's responsibility to ensure effective partnership agreements and working at an

[6] Clinicians are "professionally qualified staff providing clinical care to patients". (Source: Standards for Better Health, DH, 2004)

[7] 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)

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 transfer[8]) across organisational boundaries.

Where appropriate, these arrangements are in accordance with:

- Section 75 partnership arrangements of the National Health Service Act 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 national strategies (for example, the National Service Framework for Mental Health (DH, 1999), the National Service Framework for Older People (DH, 2001) and the Cancer Reform Strategy (DH, December 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.

organisational level. Element two focuses on the need for groups of staff from different organisations to work together to meet the needs of patients / service users. This may be facilitated through engagement in clinical networks, for example.

Element one has been made more explicit to indicate that we would expect an organisation to be assured that it is using partnerships to ensure that a patient's/service user's needs are met when they move between organisations and when more than one organisation is contributing to a patient's care.

Various guidance and legislative documents are relevant to this standard.

- Organisations are legally obliged to comply with arrangements laid out in Section 75 of the National Health Service Act 2006 and the Community Care (Delayed Discharges etc.) Act 2003.
- The additional documents listed in element one are all good practice guidance or strategic frameworks which organisations are not mandated to follow. The Healthcare Commission would, however, expect an organisation to have good reason and clear rationale for following a different course of action from that set out in these documents.

Element two

With this additional element the criteria now better reflects the standard

[8] 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/)

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	Rationale
Element one The healthcare organisation has effective clinical governance[9] arrangements in place to promote clinical leadership and improve and assure the quality and safety of clinical services for patients / service users.	**Element one** Element one has been revised to clarify the link with the domain outcome.
Element two The healthcare organisation has effective corporate governance[10] 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 *NHS trust model standing orders, reservation and delegation of powers and standing financial instructions March 2006* (DH, 2006).	**Element two** Element two has been updated to provide more clarity about the relevant directives and guidance against which we would expect trusts to develop their corporate governance structures.
Element three The healthcare organisation systematically assesses[11] and manages[12] its risks, both corporate/clinical risks in order to ensure probity, clinical quality and patient safety.	**Element three** Element three has been revised to clarify that it refers to both corporate and clinical risks and to focus on the domain outcome.

[9] 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).
[10] Governance is "a mechanism to provide accountability for the way an organisation manages itself" (Source: Standards for Better Health, DH, 2004).
[11] 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).
[12] 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	Rationale
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.	**Element one** There is a change to wording to better reflect legislative requirements. 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*". Reference to "having regard to guidance or advice issued by the CFSMS" has therefore been added. However 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	Rationale
This standard will be measured through the use of resources assessment.	Not applicable

Core standard C7e

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

Elements	Rationale
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	**Element one** This element has been amended to emphasise that trusts need to cover the issues in terms of challenging discrimination in the provision of services, goods and facilities, as well as employment. 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

(including, among other things, equality schemes for race, disability and gender, along with impact 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)

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

Similarly the acts cited under “employment and equalities legislation” have associate 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, and
- 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.

Regulations 2000. • Fixed Term Employees (Protection from Less Favourable Treatment Regulations 2002). • 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.	**Element two** There have been minor changes to wording 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	Rationale
This standard will be measured through the existing national targets assessment	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	Rationale
Element one Staff are supported, and know how, to	**Element one** No change to the element. The HSC 1999/198 has

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).	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	Rationale
Element one	**Elements one and two**
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	The standard deals specifically with the under representation of minority groups and the element now 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 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 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. * The phrases *"public body duties"* and "*employment and equalities legislation"* are defined in C7e.	**Element two** The meaning of "under-representation" is now more clearly stated. This element also now 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 specialisms.

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 orgainsation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

Elements	Rationale
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), *Information security management: NHS code of practice* (Department of Health, April 2007) and *NHS Information Governance* (Department of Health, September 2007). 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.	**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 information management and technology plan for the organisation demonstrates how a correct NHS Number will be assigned to every clinical record, in accordance with *The NHS in England: the Operating Framework for 2008/09* (Department of Health, December 2007).	**Element two** A new element has been included to reflect that the NHS Medical Director has written 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). The operating framework sets out the priorities for the year; the Department of Health expects that NHS organisations will produce an information management and technology plan in 2008/09 to deliver the mandated use of the NHS Number.

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	**Rationale**
Element one The necessary checks are undertaken in respect of all applications for NHS positions (prospective employees) and staff in ongoing NHS employment[13] in accordance with the NHS Employment Check Standards (NHS Employers) 2008)	**Element one** NHS Employers published a revised set of standards in March 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 replace, from April 08, the previous publications “Safer recruitment – A guide for NHS Employers” and “CRB disclosures in the NHS”

[13] 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.

	The new standards were launched on 18 March 2008 and 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. Launch of the standards was announced in the NHS Employers workforce bulletin issue 105 dated 25 March 2008[14].

Core standard C10b

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

Elements	Rationale
Element one The healthcare organisation explicitly requires all employed healthcare professionals[15] 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.	**Element one** Following clarification from the Department of Health, the details of this element have been updated to clarify that the standard is concerned with employed healthcare professionals only.

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
Element one 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,	**Element one** The changes have been made to include employment legislation covering equalities related issues such as flexible working but at the same time to avoid extending the list of legislation in the element itself at the risk of reducing clarity. The changes also provide more clarity regarding the equality duties requirements in that the criteria now specifically require organisation to meet the employment related duties under RRA, DDA and Equality Act under this standard.

[14] The bulletin can be found at www.nhsemployers.org/files/workforcearchive/NHSWorkforceBulletin-105.html

[15] 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).

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.	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
Element two 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.	**Element two** The wording has been changed to more clearly reflect the standard by making explicit reference to training and qualification combined with workforce planning.

Core standard 11b

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

Elements	Rationale
Element one Staff participate in relevant mandatory training programmes as defined by the relevant sector-specific NHSLA Risk Management Standards	**Element one** In 2007/08 the NHSLA Risk Management Standards operated in full in the acute sector, and were piloted in other sectors. The Risk Management Standards have now been published (March 2008) and are operating in full in all types of trusts for the year 2008/09. The criterion/criteria have been updated to reflect this.
Element two Staff and students participate in relevant induction programmes.	**Element two** No change to this element from 2007/08.
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 identify non-attendance, action is taken to rectify this.	**Element three** This element has been added to reflect the need for trusts to check uptake of training in order to ensure participation. This will be the case for all types of mandatory training necessary to ensure the domain outcome – ie, probity, clinical quality and patient safety (including risk management training referred to in the NHSLA risk management standards and element one). 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	Rationale
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 in accordance with "employment and equalities legislation"*. This includes 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; and 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. * The phrases "public body duties" and "employment and equalities legislation" are defined in C7e	**Element one** The wording of the element has been amended to better reflect the standard and to clarify that the responsibility being assessed is that of the organisation and not that of individual staff members. 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 we would expect a trust to have good reasons and clear rationale for following a different course of action from that set out in the framework.

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	Rationale
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).	**Element one** Minor amendments have been made to make the criteria clearer: two references to "framework" could be slightly confusing so " principles" replaces the first occurrence, (which also brings the element closer to the wording of the standard)

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	Rationale
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 one** The wording of the element has been changed to include identification of risk and appropriate action to reduce the risk of occurrence of compromise in dignity or respect. The change highlights the need for healthcare organisations to ensure dignity and respect throughout the stages of care, for example, 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 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 healthcare organisation should act in accordance with the requirements in the National Service Framework for older people (Health Service circular	**Element two** 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 has been added this year. 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 codesThe Codes are admissible in evidence in any legal action and can be taken into account by courts and tribunals. A further addition has been made to include the National Service Framework (NSF) for older people (DH notification letter HSC 2001/007) which specifically addresses age discrimination, among other things.

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	Rationale
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 one** The changes from 2007/08 criteria include adding the term “decisions” as well as treatments and procedures to reach a consistent approach across all healthcare organisations as it applies across the board and in particular to those subject to the Mental Health Act in acute or other hospitals. The Human Tissues Authority guidance now referred to supersedes the Families and Post-Mortems guidance referred to in 2007/08. Note that trusts are expected to have regard to a revised version of The Code of Practice to the Mental Health Act from 03/11/08 when revisions to this Code take effect. 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 (e.g. Bournewood and Glass vs UK cases, Bristol, Alder Hey and the introduction of the Human Tissue Act and associated Authority). Continuing to rely solely on reference to the Department of Health and Department of Constitutional Affairs guidance (as in 2007/08) would no longer 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 is added to the element.
Element two Patients/service users, including those with language and/or communication 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).	**Element two** Changes in wording to make clear that information provided 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** This 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
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 *Confidentiality: NHS code of practice* (Department of Health 2003), *Caldicott Guardian Manual 2006* (Department of Health 2006). 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.	**Element one** The element has been updated to take into account the updated Caldicott Guardian Manual. 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 of which is relevant to C13c (iv): • 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
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 NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	**Element one** The reference in element one to the NHS (Complaints) Regulations 2004 ("Regulations") has been added because the Regulations place specific legal obligations on healthcare organisations in relation to complaints. The term 'in so far as relevant' has been added because the Regulations apply differently to foundation and non-foundation trusts. For example, the Regulations require non-foundation trusts, but not foundation trusts, to inform complainants of their right to complain locally.
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 2007/08.

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	Rationale
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.	**Element one** No change to this element from 2007/08.

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	Rationale
Element one The healthcare organisation acts on, and responds to, complaints appropriately and in a timely manner; and acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	**Element one** The Regulations place specific legal obligations on healthcare organisations in relation to complaints. The term 'in so far as relevant' has been added because the Regulations apply differently to foundation and non-foundation trusts. For example, the Regulations require non-foundation trusts, but not foundation trusts, to inform complainants of their right to complain locally.

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** Has been revised to emphasise the improvements expected in response to concerns and complaints raised by patients / service users, relatives and carers.

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	Rationale
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.	**Element one** There are two changes to the wording of this element: 1. Making 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) and 2. Making 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** 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	Rationale
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 one** It should be noted that individual food preferences are not within the scope of this element. However the wording has been amended 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 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 two** The wording has been amended to include "at all stages of their care" to emphasise within the element 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 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.	**Element three** The wording has been amended 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	Rationale
Element one	**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.	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 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).	**Element two** The wording has been changed to ensure adequate emphasis on 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	Rationale
Element one The healthcare organisation seeks and collects the views and experiences of patients/service users, carers and the local community, 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 of the *National Health Services Act* 2006 in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) 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, 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 one and two** Element one has been re-written to make it clear that the trust 'seeks **and collects'** the 'views **and experiences'** of patients/service users, carers and the local community as public views reflect service delivery and are more often based on experience. This helps to clarify that trusts are expected to bring information from patients and the public together across the organisation, and that this information should include the stories of the experiences of users and carers as well as their views of services. The reference to 'disadvantaged and marginalised groups' has been replaced with '**seldom listened to'** groups so that trusts are clear that this is to encompass any people whose views are not commonly gathered Section 11 of the Health and Social Care Act 2001, which placed a duty on NHS organisations to involve and consult, became Section 242 of the National Health Service Act 2006, as of 1 March 2007. Reference to equalities legislation and their associated codes of practice is included to reflect the need for organisations to ensure that their duties are carried out in a manner compatible with the legislation. 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
The healthcare organisation demonstrates to patients/service users, carers and the local community, 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, in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation should act 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.

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	Rationale
Element one The healthcare organisation enables all members of the population it serves to access its services equally, including 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)	**Element one** The reference to public body duties has replaced previous reference to discrimination and equality legislation in order to clarify that the public bodies have a duty with regard to ensuring access to services. The phrase "public body duties" is defined in C7e and information about the codes of practice is given

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 phrases “public body duties” is defined in C7e.	in the rationale to C7e.
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** As in element one, wording changed for clarity and to more precisely express the meaning of this element. In particular more appropiate 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

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 orgainsation.

Elements	Rationale
Element one The healthcare organisation effectively manages the health, safety and environmental risks to patients/service users, staff and visitors, in accordance with all relevant[16] 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.	**Element one** The Disability Discrimination Act 1995 has been 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 Issues for NHS staff (NHS Employers 2005) has been updated and published as The NHS Healthy

[16] 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

	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** Element two has been amended 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 CFSMS, 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	Rationale
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 transfers[17].	**Element one** The wording of the element has been changed to include privacy for spiritual needs and confidential consultations which is an integral part of the requirements of privacy. This year all sectors have 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 also recognised that the need for privacy and

[17] 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/)

	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** 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	Rationale
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 one Modified wording 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* has been 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 Care is provided in clean environments, in accordance with the relevant[18]	**Element two** The hygiene code was updated in January 2008.

[18] The decontamination of reusable medical device related aspects of sub-duties 4b and 4f of the *Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* are covered by standard C04c

requirements of duty four of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, revised 2008).

The overarching duty 4 is to provide and maintain a clean and appropriate environment for healthcare. Sub-duty 4d states that “the cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available".

Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and where appropriate follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation.

The *National specification for cleanliness in the NHS* (NPSA, 2007) is referenced in the revised version of the Hygiene Code (2008) and provides guidance for trusts on cleaning standards. However, this guidance is not mandatory and a trust may specify its cleaning standards in a different manner to those set out in the NPSA specification so long as the standards meet the overall objectives set out in duty four.

This standard only considers specific aspects of duty four of the Hygiene Code. These are sub duties 4 a, b (in relation to cleaning), c, d, e, g and h. The decontamination of reusable medical device related aspects of sub-duties 4b and 4f of the Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections are covered by standard C04c.

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	Rationale
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 one** Adding Joint Strategic Needs Assessments (JSNA) updates the element to reflect changes in the system. Other partners (social care and the criminal justice system) are included to improve the element and reflect changes to the system.
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 two** Role of the LSP and children's trust partnerships updates element and reflects developments in partnerships at local level.
Element three The healthcare organisation monitors and reviews their contribution to public health partnership arrangements and takes action as required.	**Element three** With this additional element the criteria now better reflect the standard with its focus on outcomes.

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
Element one The healthcare organisation's policies and practice to improve health and narrow health inequalities are informed by the local director of public health's (DPH) annual public health report.	**Element one** This element was removed in 2007/08 with the rationale that reinforcement of other elements in C22 and C23 meant that this was less critical for providers. Inspection has revealed that this has not been sufficiently covered elsewhere, so it has been reintroduced.

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
Element one 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.	**Element one** This better reflects the standard for Acute and Specialist services.
Element two Patients/service users are provided with evidence-based care and advice along their care pathway in relation to public health priority areas, including through referral to specialist advice/services.	**Element two** This now better matches the standard and the outcome focus of the domain for all providers.
Element three The healthcare organisation implements policies and practices to improve the health and wellbeing of its workforce.	**Element three** No change to this element from 2007/08

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	Rationale
Element one The healthcare organisation protects the public by having a planned, prepared and, where possible, practised response	**Element one** The sentence has been amended by adding 'protects the public' in order to ensure outcome, as well as process, is assessed.

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, and associated supplements (Department of Health, 2005, 2007) and Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic (Department of Health November 2007).	Guidance on all counts has been updated. NHS emergency planning guidance is best practice guidance - a set of general principles published by the Department of Health to guide all NHS organisations in developing their ability to respond to a major incident(s) and to manage recovery and its effects, locally, regionally or nationally within the context of the requirements of the Civil Contingencies Act 2004. Associated supplements include: ▪ *Planning for the management of burn-injured patients in the event of a major incident (December 2007)* ▪ *Critical care contingency planning in the event of an emergency where the numbers of patients substantially exceeds normal critical care capacity (December 2007)* ▪ *Planning for the management of blast injured patients (December 2007)* ▪ *Strategic command arrangements for the NHS during a major incident (December 2007) – supersedes the command and control section of the NHS Emergency Planning Guidance 2005* ▪ *Mass casualties incidents: a framework for planning (March 2007) – supersedes beyond a major incident* ▪ *New guidance on the provision of public health advice during a major incident (April 2007)* Interim guidance has been released for business continuity (This is guidance for all NHS organisations on Business Continuity Management (BCM). It will be further developed, refined and revised by the NHS Resilience Project Team who will issue final BCM guidance). NHS organisations are expected to follow this interim guidance and emerging supplements starting from the publication date of June 2008. *Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic* (Department of Health November 2007) superseded the previous plan (*UK influenza pandemic contingency plan* (Department of Health, 2005)) in November 2007.
Element two The healthcare organisation protects the public by working with key partner organisations, including through Local Resilience Forums, in the preparation of, training for and annual testing of emergency preparedness plans, in accordance with the *Civil Contingencies Act 2004*, *The NHS Emergency Planning*	**Element two** “Protects the public” has been added in order to ensure outcome as well as process are assessed. Guidance has been updated as in element one.

Guidance 2005 and associated annexes (Department of Health 2005, 2007) and *Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic* (Department of Health November 2007).

Appendix one: Healthcare Commission's use of the findings of others in the Core standards assessment 2008/09

Working with others

The Healthcare Commission has a statutory responsibility to promote the effective coordination of reviews or assessments relating to the provision of healthcare by or for the English NHS bodies and cross-border Special Health Authorities. To do this, we work with other organisations to remove unnecessary burdens associated with inspections, audits or reviews, including targeting inspection activity effectively. While existing inspection methodologies have been developed as the best ways to meet the needs of the services for which they have been developed (and so a single inspection methodology would not be appropriate) the aim is to achieve greater consistency and cohesion in the inspection of health and healthcare. In line with this, we make use of findings as detailed below in relation to the annual health check.

Use of the findings of others

The Healthcare Commission continues to make use of the findings of others to assist its work and to reduce duplication of assessment when possible. As described in the following sections, some of the findings of others relating to matters identified during the assessment year 2008/09 will be used directly to provide evidence of assurance in relation to compliance.

Other recent, as well as in year findings of others, will also be used in our screening process to help target inspections; so that for example where there are positive findings in relation to a trust, this will reduce the chances of that trust being selected for inspection.

As well as the Healthcare Commission's use of the findings of others in this way, trusts also have the option of using findings of others that relate to matters within the assessment year as part of their assurance processes, but it is not a requirement and it is always open to trusts to assure themselves of compliance with the core standards in other ways.

NHSLA Risk Management Standards

The core of the NHSLA's risk management programme is provided by a range of NHSLA standards and assessments. The NHSLA regularly assesses healthcare organisations against these risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHSLA.

The NHS Litigation Authority's Risk Management Standards have now been rolled out to all provider sectors enabling us to make in-year use of their findings for all sectors in 2008/09 where this provides a level of assurance of compliance. There is a single set of risk management standards for each type of healthcare organisation incorporating organisational, clinical, and health and safety risks. The sets of standards that the Healthcare Commission will make use of, as appropriate to the sector are:

- NHSLA Risk Management Standards for Acute Trusts (applicable to all acute and specialist hospital NHS trusts)
- NHSLA Risk Management Standards for Mental Health and Learning Disability Standards
- NHSLA Risk Management Standards for Ambulance Standards
- NHSLA Risk Management Standards for Primary Care Trusts Standards

For the remainder of this appendix these are referred to collectively as the "Risk Management Standards (RMS)".

Each of the "standards" within the **NHSLA** *Risk Management Standards* are assessed using criteria. It is many of these criteria which are directly relevant to the core standards listed below^ and the Healthcare Commission will continue to use positive RMS findings in relation to the criteria where appropriate, to inform their assessment of core standards, both to:

- reduce the chance of trusts being selected for inspection (by informing our assessment of the risk of undeclared non-compliance using findings from current and recent years),
- reduce evidence required during inspections of the standards listed below, where findings are from an RMS assessment carried out by the NHSLA during the assessment year 2008/09 **ONLY***.

NOTE that in a change from 2007/08 we will use findings of Level 2 (or 3) in any relevant *RMS criteria* whether or not the trust succeeds in achieving an overall Level 2 (or 3). This means that, we will make use of any findings of level 2 or 3 at *RMS criteria* level for all trusts that are assessed at this level and not just those who also succeed at the overall level.

We would also expect (but do not require) trusts to make use of in-year level 2 or 3 achievements in relevant *RMS criteria* (where they have been directly assessed by the NHSLA within the year 2008/09) to contribute to their assurance of compliance with the core standards listed below, but we do not consider that this on its own, will give trusts sufficient assurance of compliance with any one standard as a whole. It remains the responsibility of trusts to determine whether they have reasonable assurance of compliance with core standards, whether or not they are relying on NHSLA findings from 2008/09.

Trusts will wish to note that the Healthcare Commission will consider achievement of an overall level 2 or 3 in the NHSLA RMS indicative of performance in risk management and this will inform our assessment of the risk of non-compliance with core standard C7a&c (and so reduce the chance of being selected for inspection).

***PLEASE ALSO NOTE** that we are aware that where Trusts have achieved a Level 2 or Level 3 in the RMS they are not automatically assessed against the RMS every year, but that the NHSLA – for their purposes – considers the level awarded to be current until a subsequent assessment. For the purposes of the annual health check, however, evidence of assurance of compliance with Core Standards MUST relate to compliance during the year assessed. We will therefore NOT consider Level 2 or 3 for criteria awarded outside the assessment year alone as evidence of assurance of compliance. The scope of the inspection will therefore NOT be reduced on this basis. (Note that this does not preclude a trust from themselves presenting evidence of current level 2 status, along with other evidence, as part of their evidence of assurance of compliance during inspection. Assessors will then consider all the evidence to assess whether this is reasonable assurance of compliance during assessment year in question)

^ NHSLA List: C1a, C4a, C4b, C4d, C5a, C6, C9, C10a, C11b, C13b, C14a, C14b, C14c, C16, C20a

Audit Commission

We work closely with the Audit Commission to ensure that where overlap exists our assessments are aligned, evidence is shared and duplication minimised. All parties are committed to using each others' work wherever possible. In 2006/07 and 2007/08 the Audit Commission and the Healthcare Commission followed a procedure of information sharing which enabled the Healthcare Commission to rely on the work of auditors on these areas of overlap, thus minimising duplication of work. We anticipate the same process will be used for 2008/09.

We expect that evidence collected by trusts to provide assurance for the **Audit Commission Auditors' Local Evaluation (ALE)** for the assessment year 2008/09 can also be considered by trusts when making their core standards declaration for those relevant aspects of the standards. It is also important that Statements on Internal Control are fully aligned with core standards declarations. Where a trust has declared non-compliance with core standards as part of the self-declaration process, it should disclose a control weakness in the Statement on Internal Control and vice versa.

Relevant in-year **ALE** data is used within our screening process when we select trusts for inspections in the summer.

We also use the ALE findings directly as part of our inspections. For particular standards which have been selected for inspection, where positive assurance is provided from ALE this information is used as evidence and substitutes the need for additional local work by the Healthcare Commission and therefore reduces the number of questions that we need to ask a trust in the event that they are selected for inspection. Other (negative) findings from ALE would not be used alone to determine a lack of assurance of compliance but will inform questions that assessors will ask during inspection

We are working with the Audit Commission to apply the same methodology when considering the findings of their **use of resources** assessment for primary care trusts.

ALE List: C6, C7ac, C7b, C8a, C14a, C17, C21

Patient Environment Action Teams (PEAT)

PEAT findings are also relevant to core standards, and the Healthcare Commission will continue to use these findings, but only to inform our assessment of the risk of non-compliance (and so reduce the chance of being selected for inspection) in relation to the standards listed below. However, we will not this year be using these findings ourselves as assurance of compliance during inspection. This does not prevent Trusts themselves using PEAT findings as part of their assurance. Indeed we would expect (but do not require) trusts to make use of findings of "excellent" as part of their assurance of compliance with the core standards listed below, but do not consider that this, on its own, will give trusts sufficient assurance of compliance with any one standard.

PEAT List: C15a (Element 1), C15b, C20b, C21 (Element 2)

Appendix two – reference documents

For the 2005/06, 2006/07 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	*Building a safer NHS for patients: implementing an organisation with a memory* (Department of Health, 2001)
C02	*Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (Royal College of Paediatrics and Child Health April 2006) *Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities* (DCSF 2008) *Sharing personal information: How governance supports good practice* (DCSF August 2008)
C04a	E*ssential steps to safe, clean care: introduction and guidance* (Department of Health, 2006) *National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services* (Ambulance Service Association, 2004) Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance PROC 12 *Infection control practices for ambulance services* (Infection Control Nurses Association, April 2001)
C04d	*Building a safer NHS: improving medication safety* (Department of Health 2004)
C05a	*How to put NICE guidance into practice* (NICE, December 2005)
C07ac	*Clinical governance in the new NHS* (HSC 1999/065) *Assurance: the board agenda* (Department of Health 2002) *Building the assurance framework: a practical guide for NHS boards* (Department of Health 2003)
C7b	*Directions to NHS Bodies on counter fraud measures* (Department of Health, 2004)
C08b	*Leadership and Race Equality in the NHS Action Plan* (Department of Health 2004)
C10a	The set of six documents that make up the NHS Employment Standards: *1. Verification of identity checks*

	2. Right to work checks *3. Registration and qualification checks* *4. Employment history and reference checks* *5. Criminal record checks* *6. Occupational health checks* These are downloadable from www.nhsemployers.org/primary/primary-3524.cfm The Criminal Record Bureau website provides additional information on Criminal record checks. See www.crb.gov.uk The UK Border Agency website provides information on their checking service for employers. See http://www.bia.homeoffice.gov.uk/employers/employersupport/ecs
C11a	*Code of practice for the international recruitment of healthcare professionals* (Department of Health 2004)
C11c	*Continuing professional development: quality in the new NHS* (HSC 1999/154) *Continuing professional development: quality in the new NHS* (DH, 1999)
C13a	*NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff* (Department of Health, 2003).
C13b	*Good practice in consent: achieving the NHS plan commitment to patient centred consent practice* (HSC 2001/023) *Seeking Consent: working with children* (Department of Health 2001)
C16	*Toolkit for producing patient information* (Department of Health 2003) *Information for patients* (NICE) *Guidance On Developing Local Communication Support Services And Strategies* (Department of Health 2004) and other nationally agreed guidance where available
C17	Key principles of effective patient and public involvement (PPI) (The National Centre for Involvement, 2007) *Community Engagement in Health* (NICE public health guidance Feb 2008)
C18	*Building on the best: Choice, responsiveness and equity in the NHS* (Department of Health 2003).
C20a	*A professional approach to managing security in the NHS* (Counter Fraud and Security Management Service2003) and other relevant national guidance *Design for patient safety: Towards future ambulances* (National Patient Safety Agency and The Helen Hamblyn Trust, 2007) for ambulance trusts only BS EN 1789:2000 Medical vehicles and their equipment – road ambulances
C21	*Developing an estate's strategy* (1999) *Developing an estates strategy* (Department of Health, 2008), updated

	version of previous document, but was not published until August 2008 *A risk based methodology for establishing and managing backlog* (NHS Estates, 2004) Add *BS EN 1789: 2007 Medical vehicles and their equipment* for ambulance trusts only *Design for patient safety: Towards future ambulances* (National Patient Safety Agency and The Helen Hamblyn Trust, 2007) for ambulance trusts only *National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services* (Ambulance Service Association, 2004) for ambulance trusts only BS EN 1789:2000 Medical vehicles and their equipment – road ambulances
C22ac	*Choosing health: making healthier choices easier* (Department of Health 2004) *Tackling health inequalities: a programme for action* (Department of Health 2003) *Making partnerships work for patients, carers and service users* (Department of Health 2004) *Guidance on Joint Strategic Needs Assessment* (Department of Health, 2007)
C23	*Choosing health: making healthy choices easier* (Department of Health 2004) *Delivering Choosing health: making healthier choices easier (*Department of Health 2005) *Tackling Health Inequalities: A programme for action* (Department of Health 2003) *Guidance on Joint Strategic Needs Assessment* (Department of Health, 2007)
C24	*Getting Ahead of the Curve* (Department of Health, 2002) *Beyond a major incident* (Department of Health, 2004)

Inspecting Informing Improving

Healthcare Commission

Criteria for assessing core standards in 2008/09

Mental health and learning disability trusts

Updated December 2008

Contents

Use of "we" (Overview section)

The new Care Quality Commission will replace 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 to enable it to take over the regulation of health and adult social care from 1 April 2009.

The Care Quality Commission will be responsible for delivery of the 2008/2009 annual health check, including the core standards based assessment from 1 April 2009.

Where this document refers to "we" this is a reference to the Healthcare Commission up until 31 March 2009 and to the Care Quality Commission from 1 April 2009.

Overview

These are the 2008/09 criteria for assessing core standards between 1 April 2008 and 31 March 2009 for trusts that provide mental health / learning disability services. As for previous years, we have set out our criteria as 'elements' for each of the core standards.

What has changed?

Primary care trusts
The main change this year affects primary care trusts (PCTs). As set out in the Healthcare Commission publication, *The Annual Health Check in 2008/09: Assessing and rating the NHS*, our assessment of PCTs for the performance rating in 2008/09 will have a different structure from previous years. This will allow us to report separately on the performance of services that a PCT provides itself (such as community health services) and its role as a commissioner of healthcare services for its local community. We have developed two sets of criteria for assessing PCTs; one for their role as providers and one set for their role as commissioners of services. A single PCT document containing both 2008/09 sets of criteria has been produced and is available to PCT trusts.

What else has changed?
This year, we have expanded our rationales, in order to assist trusts further in the assessment process. Some criteria have also been written for greater clarity and in some cases this has made them longer. Although the document has, in turn, become longer, trusts should find the criteria and the rationales more explicit, clearer and therefore helpful when assuring themselves of their compliance against core standards.

As set out in our publication *The Annual Health Check in 2008/09: Assessing and rating the NHS*, while we have split the criteria for PCTs into those for providers and commissioners, there has been limited change to actual content of criteria. We have however reviewed the elements in order to:

- Continue to increase the focus on the outcomes of the standards. We expect trusts' boards to consider these outcomes when reviewing their assurance of compliance with the standards.

- Add further clarity to elements by explicitly stating within the criteria the status of guidance, codes of practice, etc referred to. For example, where clear legal duties are referred to, trusts are assessed as to whether they have acted "in accordance with" those duties; or for some statutory codes of practice whether they "have had regard to" them, as required by the code. Where the core standard itself refers to specific guidance, this gives that guidance a "must-do" status and the criteria will also reflect this. Other guidance has varying status and we have tried to make this explicit within the criteria.

  For example:

  - The healthcare organisation follows National Institute for Clinical

Excellence (NICE) interventional procedures[1] guidance **in accordance with** *The Interventional Procedures Programme* (Health Service Circular 2003/011). (C03)
(NICE interventional procedures are required by the standard itself).

- Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored, **in accordance with** the Medicines Act 1968 ….., 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**. (C04d)

Where references are recognised as useful for trusts but are not directly the subject of assessment, again we will provide these in an appendix to the final document. However, as was the case with the documents in Appendix 2 of the 2007/08 criteria, these references will not be the basis on which we will make judgments in inspection.

Trusts should also note that core standards C3, C4c and C22b will be assessed for all provider sectors in 2008/09. See rationales in this document for further details.

How should trusts' boards consider the elements?
The criteria are written to reflect the requirements on trusts throughout the assessment year; they do not introduce new requirements. As in previous years of the core standards assessment, we ask that NHS trusts' boards determine whether they have reasonable assurance of compliance with a standard, without a significant lapse, from 1 April 2008 to 31 March 2009. As part of the annual health check, trusts will then be asked to make a declaration of their compliance for the whole year.

Reasonable assurance
Reasonable assurance, by definition, is not absolute assurance. Conversely, 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 reasonable, trusts must reflect that the core standards are not optional and describe a level of service that 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

[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).

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. 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), and 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 of 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

One of the Healthcare Commission's strategic goals continues to be 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 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. Note that we have run three audits of trusts' websites, looking for this information, and we remain concerned that many trusts are still not compliant with legislation, particularly in relation to race equality.

Using the findings of others

We will continue to make use of the findings of others and have reviewed how we do this in order to increase this where possible, and to ensure that it is effective, both in reducing burden on trusts and also in targeting our inspections. Note that, as in 2007/08, we will make use of others' **in-year findings** (ie, findings based on observance of compliance during the assessment year 2008/09) as evidence of assurance of compliance during the year 2008/09. Findings of others relating to recent years will be used to help target inspections.

The NHS Litigation Authority's Risk Management Standards have now been rolled out to all sectors enabling us to make in-year use of their findings for all sectors in 2008/09 where this provides a level of assurance of compliance.

Please see Appendix 1 for more details about this and other changes, in particular a change in the way we use patient environment action team findings.

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, 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	Rationale
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, Healthcare Commission, the Counter Fraud and Security Management Service and all other national organisations to which the healthcare organisation is required to report incidents.	**Elements one and two** Healthcare organisations should report incidents nationally to the relevant national organisations. These organisations include the National Patient Safety Agency (NPSA) and a wider range of organisations that have been listed in the element. 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 and this has been made more explicit in the element.
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 reoccurence 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	**Element three** 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

the reoccurence of similar incidents in the future, for the benefit of patients / service users as a whole.	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. Analysis of relevant trends includes changes over time. This requirement was previously included in element two in 2007/08 and has been brought out in a separate element to provide greater clarity. 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 and this has been made more explicit in the element.
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** Healthcare organisations should make changes to practice based on the analysis of local incidents and the national analysis of incidents. The national analysis of incidents is carried out by 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	Rationale
Element one All communications concerning patient safety issued from the National Patient Safety Agency (NPSA) and the Medicines Healthcare products Regulatory Agency (MHRA) via national distribution systems, including the Safety Alert Broadcast System (SABS), the Central Alert System (CAS) the UK Public Health Link System (UKPHLS), are implemented within the required timescales.	**Element one** SABS is being brought together with the UKPHLS to form the CAS. However, it is likely that all three systems will continue to be used in parallel during the introductory phase of CAS. There are other routes through which this information may be issued. For example MHRA issues field safety notices via its website and targets particular trusts with directly mailed safety letters. While these cannot be considered official distribution systems, they do communicate information regarding patient safety that may occasionally require trusts to take 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	Rationale
Element one The healthcare organisations have 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*.	**Element one** In March 2007 statutory guidance was published, updating previous guidance, which is based on the Children Act 2004. Compliance with this was required by October 2005 and all elements should now be in place. The guidance issued under section 11(4) of the Children Act 2004 which 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 two** Again this element has been extended to include activities that are required, such as participation in serious case reviews and child death reviews, both requirements from 1 April 2008.
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 three** There was some overlap between the 2007/08 element three (CRB checks) and Core standard C10a so this is removed. Instead a particular aspect of the Statutory Guidance is drawn out and wording is used from this document to emphasise the importance of information sharing between agencies. This information sharing process can include the Common Assessment Framework, ContactPoint when it is introduced, 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	Rationale
Element one The healthcare organisation follows NICE interventional procedures[2] guidance in accordance with *The interventional procedures programme* (Health Service Circular 2003/011). Arrangements for compliance are communicated to all relevant staff.	**Element one** National Institute for Clinical Excellence (NICE) interventional procedures guidance applies to any trust that carries out interventional procedures. Following clarification from NICE and the Department of Health (DH) the application of the standard has been extended to all trust types to better reflect this. The element makes reference to the need to communicate arrangements to all relevant staff. This is to reflect that even where no 'new' interventional procedures[3] 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.

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	Rationale
Element one The healthcare organisation has systems to ensure the risk of healthcare associated infection is reduced in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008).	**Element one** The Hygiene Code was revised in January 2008. All healthcare associated infection issues are covered by this criteria with the exception of the following: **Covered by C21 – Cleaning of the environment:** • Hygiene Code Duty 4 (a,b, (in relation to cleaning) c, d, e, g and h). **Covered by C4c – Decontamination of reusable medical devices:** • Hygiene Code Duty 3 (if related to decontamination)

[2] "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).
[3] 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.

- Hygiene Code 4b
- Hygiene Code 4f.

Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and, where appropriate, follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation.

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	Rationale
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.	**Element one** No change to this element from 2007/08.
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** One of the amendments to the IRMER 2000 regulations was in 2006 when enforcement responsibilities where transferred to the Healthcare Commission. Further amendments are likely and so an explicit reference is now 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	Rationale
Element one Reusable medical devices are properly decontaminated in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008).	**Element one** The Hygiene code was revised in January 2008. Criteria C4c covers: • Hygiene Code Duty 3 (if related to decontamination) • Hygiene Code 4b • Hygiene Code 4f. All other aspects of healthcare associated infection and duties of the Hygiene Code are covered by C4a or C21. Note that, in complying with a provision specified in

any duty contained in the Code, an NHS body must consider and, where appropriate, follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation.

In 2006/07, this standard was not assessed for ambulance trusts and mental health trusts as the focus for assessment was on the sterilisation of invasive medical equipment that presented a known risk of infection. However, this criteria will apply to all trust types on 2008/09 because:

- Decontamination has a wider meaning than sterilisation alone and is defined as a combination of processes, including cleaning, disinfection and sterilisation, used to render a reusable item safe for further use on patients / service users and handling by staff.
- Medical devices refers to all products, except medicines, used in healthcare for diagnosis, prevention, monitoring or treatment.

A single use medical device is a device that is intended to be used on an individual patient during a single procedure and then discarded. Therefore, any device which is not single use must be considered a reusable medical device. These devices are used by ambulance and mental health trusts.

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.

Rationale

Element one

In referring to the Medicines Act, all amendments and subsequent regulations are now included within this reference. Subsequent regulations include the Medicines for Human Use (Prescribing) Order, which provides additional requirements for prescribing (for example, reauthorising repeat prescriptions every six months).

The Duthie Report *(The safe and secure handling of medicines: A Team approach)* has now 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). In addition, feedback received during the 2008/09 annual health check consultations suggested including this reference within the criteria for C4d.
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.*	**Element two** The proposed element makes reference to all amendments for the Misuse of Drugs Act 1971. The guidance on strengthened governance arrangements has been replaced with the updated 2007 version. The proposed 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	Rationale
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 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).	**Element one** Element one has been amended to incorporate HTM 07-05 relating 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 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 NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

Elements	Rationale
Element one The healthcare organisation ensures that it conforms to 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.	**Elements one and two** New technology appraisals are always under development, therefore all NHS trusts need to have mechanisms in place to review the appropriateness of these for their service, even if many of them will not be relevant to some trust types. Current healthcare policy emphasises the importance of the quality of clinical care and of having consistent care for all patients / service users. The effective implementation of NICE technology appraisals and use of clinical guidelines that are based on best practice are crucial to the promotion of consistent and high quality clinical care. To reflect this, elements one and two have been made more explicit to give greater focus on the different aspects of the standard.
Element two The healthcare organisation can demonstrate how it takes into account nationally agreed guidance where it is available as defined in National Service Frameworks (NSFs), NICE guidelines, national plans 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.	

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'[4]; 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 one** The wording of the elements has been amended to clarify that the responsibility being assessed is that of the organisation and not that of individual clinicians. Element one has been amended to clarify 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 patients / service users receive care which will lead to effective clinical outcomes. When making a declaration against this standard the Healthcare Commission would expect an organisation to assure itself that arrangements for both of the above are in place and effective. Current healthcare policy emphasises the importance of clinician-led services. To reflect this, the elements have been made more explicit to give greater focus on the different aspects of the standard against which we would expect an organisation to assure itself.
Element two The healthcare organisation ensures that it provides opportunities for clinicians[5] to develop their clinical leadership skills and experience.	**Element two** With this additional element the criteria now better reflects the standard

Core standard C5c

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

Elements	Rationale
Element one The healthcare organisation ensures that	**Element one** The wording of the elements has been amended to

[4] 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*, NMC, 2008).
[5] Clinicians are "professionally qualified staff providing clinical care to patients". (Source: Standards for Better Health, DH, 2004)

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.	better reflect the standard and to clarify that the responsibility being assessed is that of the organisation and not that of individual clinicians. 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 has been made more explicit to give greater focus on the different aspects of the standard against which we would expect an organisation to assure itself.

Core standard C5d

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

Elements	Rationale
Element one The healthcare organisation ensures that clinicians[6] are involved in prioritising, conducting, reporting and acting on regular clinical audits[7]. **Element two** The healthcare organisation ensures that clinicians participate in regular reviews of the effectiveness of clinical services through evaluation, audit or research.	**Elements one and two** The wording of the elements have been amended to better reflect the standard and to clarify that the responsibility being assessed is that of the organisation and not that of individual clinicians.

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	Rationale
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	**Elements one and two** The structure and wording of the elements have been amended to better reflect the standard and to clarify that the partnership responsibilities being assessed are those of the organisation as well as those of staff. Element one considers an organisation's responsibility to ensure effective

[6] Clinicians are "professionally qualified staff providing clinical care to patients". (Source: Standards for Better Health, DH, 2004)

[7] 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)

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 transfer[8]) across organisational boundaries.

Where appropriate, these arrangements are in accordance with:

- Section 75 partnership arrangements of the National Health Service Act 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 national strategies (for example, the National Service Framework for Mental Health (DH, 1999), the National Service Framework for Older People (DH, 2001) and the Cancer Reform Strategy (DH, December 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.

partnership agreements and working at an organisational level. Element two focuses on the need for groups of staff from different organisations to work together to meet the needs of patients / service users. This may be facilitated through engagement in clinical networks, for example.

Element one has been made more explicit to indicate that we would expect an organisation to be assured that it is using partnerships to ensure that a patient's/service user's needs are met when they move between organisations and when more than one organisation is contributing to a patient's care.

Various guidance and legislative documents are relevant to this standard.

- Organisations are legally obliged to comply with arrangements laid out in Section 75 of the National Health Service Act 2006 and the Community Care (Delayed Discharges etc.) Act 2003.
- The additional documents listed in element one are all good practice guidance or strategic frameworks which organisations are not mandated to follow. The Healthcare Commission would, however, expect an organisation to have good reason and clear rationale for following a different course of action from that set out in these documents.

Element two

With this additional element the criteria now better reflects the standard.

[8] 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/)

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	Rationale
Element one The healthcare organisation has effective clinical governance[9] arrangements in place to promote clinical leadership and improve and assure the quality and safety of clinical services for patients / service users.	**Element one** Element one has been revised to clarify the link with the domain outcome.
Element two The healthcare organisation has effective corporate governance[10] 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 *NHS trust model standing orders, reservation and delegation of powers and standing financial instructions March 2006* (DH, 2006).	**Element two** Element two has been updated to provide more clarity about the relevant directives and guidance against which we would expect trusts to develop their corporate governance structures.
Element three The healthcare organisation systematically assesses[11] and manages[12] its risks, both corporate/clinical risks in order to ensure probity, clinical quality and patient safety.	**Element three** Element three has been revised to clarify that it refers to both corporate and clinical risks and to focus on the domain outcome.

[9] 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).
[10] Governance is "a mechanism to provide accountability for the way an organisation manages itself" (Source: Standards for Better Health, DH, 2004).
[11] 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).
[12] 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	Rationale
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.	**Element one** There is a change of wording to better reflect legislative requirements. 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". Reference to "having regard to guidance or advice issued by the CFSMS" has therefore been added. However 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	Rationale
This standard will be measured through the use of resources assessment.	Not applicable

Core standard C7e

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

Elements	Rationale
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,	**Element one** This element has been amended to emphasise that trusts need to cover the issues in terms of challenging discrimination in the provision of services, goods and facilities, as well as employment. 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.

equality schemes for race, disability and gender, along with impact 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 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.

Similarly the acts cited under "employment and equalities legislation" have associate 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 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.

from Less Favourable Treatment Regulations 2002). • 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** There have been minor changes to wording 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	Rationale
This standard will be measured through the existing national targets assessment.	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	Rationale
Element one Staff are supported, and know how, to	**Element one** No change to the element. The HSC 1999/198 has

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).	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	Rationale
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"**. This includes 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	**Elements one and two** The Standard deals specifically with the under representation of minority groups and the element now 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 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 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. * The phrases *"public body duties"* and "*employment and equalities legislation"* are defined in C7e.	**Element two** The meaning of "under-representation" is now more clearly stated. This element also now 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 specialisms.

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 orgainsation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

Elements	Rationale
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), *Information security management: NHS code of practice* (Department of Health, April 2007) and *NHS Information Governance* (Department of Health, September 2007). 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.	**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 information management and technology plan for the organisation demonstrates how a correct NHS Number will be assigned to every clinical record, in accordance with *The NHS in England: the Operating Framework for 2008/09* (Department of Health, December 2007).	**Element two** A new element has been included to reflect that the NHS Medical Director has written 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). The operating framework sets out the priorities for the year; the Department of Health expects that NHS organisations will produce an information management and technology plan in 2008/09 to deliver the mandated use of the NHS Number.

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	Rationale
Element one The necessary checks are undertaken in respect of all applications for NHS positions (prospective employees) and staff in ongoing NHS employment[13] in accordance with the NHS Employment Check Standards (NHS Employers) 2008).	**Element one** NHS Employers published a revised set of standards in March 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 replace, from April 08, the previous publications *Safer recruitment – A guide for NHS Employers* and *CRB disclosures in the NHS*. The new standards were launched on 18 March 2008 and include those checks that are required by

[13] 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.

law, those that are Department of Health policy and those that are required for access to the NHS Care record service.

Launch of the standards was announced in the NHS Employers workforce bulletin issue 105 dated 25 March 2008[14].

Core standard C10b

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

Elements	Rationale
Element one The healthcare organisation explicitly requires all employed healthcare professionals[15] 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.	**Element one** Following clarification from the Department of Health, the details of this element have been updated to clarify that the standard is concerned with employed healthcare professionals only.

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
Element one 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,	**Element one** The changes have been made to include employment legislation covering equalities related issues such as flexible working but at the same time to avoid extending the list of legislation in the element itself at the risk of reducing clarity. The changes also provide more clarity regarding the equality duties requirements in that the criteria now specifically require organisation to meet the employment related duties under RRA, DDA and

[14] The bulletin can be found at www.nhsemployers.org/files/workforcearchive/NHSWorkforceBulletin-105.html

[15] 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).

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.	Equality Act under this standard. 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
Element two 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.	**Element two** The wording has been changed to more clearly reflect the standard by making explicit reference to training and qualification combined with workforce planning.

Core standard 11b

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

Elements	Rationale
Element one Staff participate in relevant mandatory training programmes as defined by the relevant sector-specific NHSLA Risk Management Standards.	**Element one** In 2007/08 the NHSLA Risk Management Standards operated in full in the acute sector, and were piloted in other sectors. The Risk Management Standards have now been published (March 2008) and are operating in full in all types of trusts for the year 2008/09. The criterion/criteria have been updated to reflect this.
Element two Staff and students participate in relevant induction programmes.	**Element two** No change to this element from 2007/08.
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.	**Element three** This element has been added to reflect the need for trusts to check uptake of training in order to ensure participation. This will be the case for all types of mandatory training necessary to ensure the domain outcome – ie, probity, clinical quality and patient safety (including risk management training referred to in the NHSLA risk management standards and element one). 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	Rationale
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 in accordance with "employment and equalities legislation"*. This includes 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; and 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. * The phrases "public body duties" and "employment and equalities legislation" are defined in C7e.	**Element one** The wording of the element has been amended to better reflect the standard and to clarify that the responsibility being assessed is that of the organisation and not that of individual staff members. 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 coordinated approach to lifelong learning in healthcare. While trusts are not legally obliged to conform to the framework we would expect a trust to have good reasons and clear rationale for following a different course of action from that set out in the framework.

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	Rationale
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).	**Element one** Minor amendments have been made to make the criteria clearer: two references to "framework" could be slightly confusing so "principles" replaces the first occurrence (which also brings the element closer to the wording of the standard).

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	Rationale
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 one** The wording of the element has been changed to include identification of risk and appropriate action to reduce the risk of occurrence of compromise in dignity or respect. The change highlights the need for healthcare organisations to ensure dignity and respect throughout the stages of care (for example, 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 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, and • the Equality Act 2006. and where appropriate, having due regard to the associated codes of practice. The healthcare organisation should act in accordance with the requirements in the National Service Framework for older people (Health Service circular	**Element two** 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 has been added this year. 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 codesThe Codes are admissible in evidence in any legal action and can be taken into account by courts and tribunals. A further addition has been made to include the National Service Framework (NSF) for older people (DH notification letter HSC 2001/007) which specifically addresses age discrimination, among other things.

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	Rationale
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 one** The Human Tissues Authority guidance now referred to supersedes the Families and Post-Mortems guidance referred to in 2007/08.
	Element one Note that trusts are expected to have regard to a revised version of The Code of Practice to the Mental Health Act from 03/11/08 when revisions to this Code take effect. 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, Bournewood and Glass vs UK cases, Bristol, Alder Hey and the introduction of the Human Tissue Act and associated Authority). Continuing to rely solely on reference to the Department of Health and Department of Constitutional Affairs guidance (as in 2007/08) would

	no longer 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 is added to the element.
Element two Patients/service users, including those with language and/or communication 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).	**Element two** Changes in wording to make clear that information provided 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** This 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
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 *Confidentiality: NHS code of practice* (Department of Health 2003), *Caldicott Guardian Manual 2006* (Department of Health 2006). The healthcare organisation complies with the actions specified in the NHS Chief Executive's letter of 20 May 2008	**Element one** The element has been updated to take into account the updated Caldicott Guardian Manual. 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 of which is relevant to C13c (iv): • NHS organisations must include details of Serious Untoward Incidents involving data loss or confidentiality breaches in their annual reports from 2007/08.

(Gateway reference 9912); and with supplemental mandates and guidance if they are introduced during the assessment period.

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
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 NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	**Element one** The Regulations place specific legal obligations on healthcare organisations in relation to complaints. The term 'in so far as relevant' has been added because the Regulations apply differently to foundation and non-foundation trusts. For example, the Regulations require non-foundation trusts, but not foundation trusts, to inform complainants of their right to complain locally.
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 2007/08.

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	Rationale
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.	**Element one** No change to this element from 2007/08.

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	Rationale
Element one The healthcare organisation acts on, and responds to, complaints appropriately and in a timely manner; and acts in accordance with the NHS (Complaints)	**Element one** The reference in element one to the NHS (Complaints) Regulations 2004 (“Regulations”) has been added because the Regulations place specific legal obligations on healthcare organisations in

Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	relation to complaints. The term “in so far as relevant” has been added because the Regulations apply differently to foundation and non-foundation trusts. For example, the Regulations require non-foundation trusts, but not foundation trusts, to inform complainants of their right to complain locally.
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** Has been revised to emphasise the improvements expected in response to concerns and complaints raised by patients / service users, relatives and carers.

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	Rationale
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.	**Element one** There are two changes to the wording of this element: 1. Making 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) and 2. Making 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
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.

Rationale

Element one
It should be noted that individual food preferences are not within the scope of this element. However the wording has been amended 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
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 two
The wording has been amended to include "at all stages of their care" to emphasise within the element 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 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.	**Element three** The wording has been amended 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	Rationale
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 one** 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 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,	**Element two** The wording has been changed to ensure adequate emphasis on sufficient and accessible information provision for all patients and carers (as well as for patients with particular language and communication support needs).

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).

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	Rationale
Element one The healthcare organisation seeks and collects the views and experiences of patients/service users, carers and the local community, 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 of the *National Health Services Act* 2006 in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) 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, 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, and • 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 one and two** Element one has been re-written to make it clear that the trust 'seeks **and collects'** the 'views **and experiences'** of patients/service users, carers and the local community as public views reflect service delivery and are more often based on experience. This helps to clarify that trusts are expected to bring information from patients and the public together across the organisation, and that this information should include the stories of the experiences of users and carers as well as their views of services. The reference to 'disadvantaged and marginalised groups' has been replaced with '**seldom listened to'** groups so that trusts are clear that this is to encompass any people whose views are not commonly gathered Section 11 of the Health and Social Care Act 2001, which placed a duty on NHS organisations to involve and consult, became Section 242 of the National Health Service Act 2006, as of 1st March 2007. Reference to equalities legislation and their associated codes of practice is included to reflect the need for organisations to ensure that their duties are carried out in a manner compatible with the legislation. 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
The healthcare organisation demonstrates to patients/service users, carers and the local community, 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, in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation should act 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, and
- 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.

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	Rationale
Element one The healthcare organisation enables all members of the population it serves to access its services equally, including acting in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and	**Element one** The reference to public body duties has replaced previous reference to discrimination and equality legislation in order to clarify that the public bodies have a duty with regard to ensuring access to services. The phrase "public body duties" is defined in C7e

gender, along with impact assessments) under the following “public body duties”*statutes: • the Race Relations (Amendment) Act 2000 • the Disability Discrimination Act 2005, and • the Equality Act 2006. And where appropriate, having due regard to the associated codes of practice. * The phrases “public body duties” is defined in C7e.	and information about the codes of practice is given in the rationale to C7e.
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** As in element one, wording changed for clarity and to more precisely express the meaning of this element. In particular more appropiate 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.

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 orgainsation.

Elements	Rationale
Element one The healthcare organisation effectively manages the health, safety and environmental risks to patients/service users, staff and visitors, in accordance with all relevant[16] 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	**Element one** The Disability Discrimination Act 1995 has been 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 Issues for NHS staff (NHS Employers 2005) has

[16] 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

alternative means to achieve the same objectives.	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** Element two has been amended 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 CFSMS, 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	Rationale
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 transfers[17].	**Element one** The wording of the element has been changed to include privacy for spiritual needs and confidential consultations which is an integral part of the requirements of privacy. This year all sectors have 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 also recognised that the need for privacy and

[17] 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/)

	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. **Mental health trusts and acute trusts** will need to consider patients who may have dementia/ confusion or have severe mental or physical illness. In **mental health services** in addition to safety, issues should be considered with respect to gender separation and to ensure that patients are not intruded by other patients in sleeping accommodation, toilets or bathrooms.
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** 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	Rationale
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 one** Modified wording 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* has been 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
Care is provided in clean environments, in accordance with the relevant[18] requirements of duty four of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, revised 2008).

Element two
The hygiene code was updated in January 2008.

The overarching duty 4 is to provide and maintain a clean and appropriate environment for healthcare. Sub-duty 4d states that “the cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available".

Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and where appropriate follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation. The *National specification for cleanliness in the NHS* (NPSA, 2007) is referenced in the revised version of the Hygiene Code (2008) and provides guidance for trusts on cleaning standards. However, this guidance is not mandatory and a trust may specify its cleaning standards in a different manner to those set out in the NPSA specification so long as the standards meet the overall objectives set out in duty four.

This standard only considers specific aspects of duty four of the Hygiene Code. These are sub duties 4 a, b (in relation to cleaning), c, d, e, g and h. The decontamination of reusable medical device related aspects of sub-duties 4b and 4f of the Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections are covered by standard C04c.

[18] The decontamination of reusable medical device related aspects of sub-duties 4b and 4f of the *Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* are covered by standard C04c

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	Rationale
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 one** Adding Joint Strategic Needs Assessment (JSNA) updates the element to reflect changes in the system. Other partners (social care and the criminal justice system) are included to improve the element and reflect changes to the system.
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 two** Role of the LSP and children's trust partnerships updates element and reflects developments in partnerships at local level.
Element three The healthcare organisation monitors and reviews their contribution to public health partnership arrangements and takes action as required.	**Element three** With this additional element the criteria now better reflect the standard with its focus on outcomes.

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
Element one The healthcare organisation's policies and practice to improve health and narrow health inequalities are informed by the local director of public health's (DPH) annual public health report.	**Element one** This element was removed in 2007/08 with the rationale that reinforcement of other elements in C22 and C23 meant that this was less critical for providers. Inspection has revealed that this has not been sufficiently covered elsewhere, so it has been reintroduced.

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
Element one 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.	**Element one** This better reflects the standard for mental health / learning disability services.
Element two 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.	**Element two** This now better matches the standard and the outcome focus of the domain for all providers.
Element three The healthcare organisation implements policies and practices to improve the health and wellbeing of its workforce.	**Element three** As drafted in 2007/08 this adequately addresses the standard. Although not a natural flow for Mental Health & Learning Disability, the order of elements 3 and 4 are changed in Mental Health & Learning Disability for common reference to elements between sectors.
Element four The healthcare organisation provides support and advice for service users to improve their mental health and wellbeing, including support in retaining or accessing employment, training or volunteering opportunities.	**Element four** This adequately addresses the standard. Although not a natural flow for Mental Health & Learning Disability, the order of elements 3 and 4 changed for common reference to elements between sectors.

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	Rationale
Element one The healthcare organisation protects the public by having a planned, prepared and, where possible, practised 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 (204), The NHS Emergency Planning Guidance 2005, and associated supplements (Department of Health, 2005, 2007) and Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic (Department of Health November 2007).	**Element one** The sentence has been amended by adding 'protects the public' in order to ensure outcome, as well as process, is assessed. Guidance on all counts has been updated. NHS emergency planning guidance is best practice guidance – a set of general principles published by the Department of Health to guide all NHS organisations in developing their ability to respond to a major incident(s) and to manage recovery and its effects, locally, regionally or nationally within the context of the requirements of the Civil Contingencies Act 2004. Associated supplements include: ▪ *Planning for the management of burn-injured patients in the event of a major incident (December 2007)* ▪ *Critical care contingency planning in the event of an emergency where the numbers of patients substantially exceeds normal critical care capacity (December 2007)* ▪ *Planning for the management of blast injured patients (December 2007)* ▪ *Strategic command arrangements for the NHS during a major incident (December 2007) – supersedes the command and control section of the NHS Emergency Planning Guidance 2005* ▪ *Mass casualties incidents: a framework for planning (March 2007) – supersedes beyond a major incident* ▪ *New guidance on the provision of public health advice during a major incident (April 2007)* Interim guidance has been released for business continuity (This is guidance for all NHS organisations on Business Continuity Management (BCM). It will be further developed, refined and revised by the NHS Resilience Project Team who will issue final BCM guidance). NHS organisations are expected to follow this interim guidance and emerging supplements starting from the publication date of June 2008. *Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic* (Department of Health November 2007) superseded the previous plan (*UK influenza pandemic contingency plan* (Department of Health, 2005)) in November 2007.

Appendix one: Healthcare Commission's use of the findings of others in the core standards assessment 2008/09

Working with others

The Healthcare Commission has a statutory responsibility to promote the effective coordination of reviews or assessments relating to the provision of healthcare by or for the English NHS bodies and cross-border Special Health Authorities. To do this, we work with other organisations to remove unnecessary burdens associated with inspections, audits or reviews, including targeting inspection activity effectively. While existing inspection methodologies have been developed as the best ways to meet the needs of the services for which they have been developed (and so a single inspection methodology would not be appropriate) the aim is to achieve greater consistency and cohesion in the inspection of health and healthcare. In line with this, we make use of findings as detailed below in relation to the annual health check.

Use of the findings of others

The Healthcare Commission continues to make use of the findings of others to assist its work and to reduce duplication of assessment when possible. As described in the following sections, some of the findings of others relating to matters identified during the assessment year 2008/09 will be used directly to provide evidence of assurance in relation to compliance.

Other recent, as well as in year findings of others, will also be used in our screening process to help target inspections; so that for example where there are positive findings in relation to a trust, this will reduce the chances of that trust being selected for inspection.

As well as the Healthcare Commission's use of the findings of others in this way, trusts also have the option of using findings of others that relate to matters within the assessment year as part of their assurance processes, but it is not a requirement and it is always open to trusts to assure themselves of compliance with the core standards in other ways.

NHSLA Risk Management Standards

The core of the NHSLA's risk management programme is provided by a range of NHSLA standards and assessments. The NHSLA regularly assesses healthcare organisations against these risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHSLA.

The NHS Litigation Authority's Risk Management Standards have now been rolled out to all provider sectors enabling us to make in-year use of their findings for all sectors in 2008/09 where this provides a level of assurance of compliance. There is a single set of risk management standards for each type of healthcare organisation incorporating organisational, clinical, and health & safety risks. The sets of standards that the Healthcare Commission will make use of, as appropriate to the sector are:

- NHSLA Risk Management Standards for Acute Trusts (applicable to all acute and specialist hospital NHS trusts).
- NHSLA Risk Management Standards for Mental Health and Learning Disability Standards.

- NHSLA Risk Management Standards for Ambulance Standards.
- NHSLA Risk Management Standards for Primary Care Trusts Standards.

For the remainder of this appendix these are referred to collectively as the "Risk Management Standards (RMS)".

Each of the "standards" within the **NHSLA** *Risk Management Standards* are assessed using criteria. It is many of these criteria which are directly relevant to the core standards listed below^ and the Healthcare Commission will continue to use positive RMS findings in relation to these criteria where appropriate, to inform their assessment of core standards, both to:

- Reduce the chance of trusts being selected for inspection (by informing our assessment of the risk of undeclared non-compliance using findings from current and recent years).
- Reduce evidence required during inspections of the standards listed below, where findings are from an RMS assessment carried out by the NHSLA during the assessment year 2008/09 **ONLY***.

NOTE that in a change from 2007/08 we will use findings of Level 2 (or 3) in any relevant RMS criteria whether or not the trust succeeds in achieving an overall Level 2 (or 3). This means that, we will make use of any findings of level 2 or 3 at RMS criteria level for all trusts that are assessed at this level and not just those who also succeed at the overall level.

We would also expect (but do not require) trusts to make use of in-year level 2 or 3 achievements in relevant *RMS criteria* (where they have been directly assessed by the NHSLA within the year 2008/09) to contribute to their assurance of compliance with the core standards listed below, but we do not consider that this on its own, will give trusts sufficient assurance of compliance with any one standard as a whole. It remains the responsibility of trusts to determine whether they have reasonable assurance of compliance with core standards, whether or not they are relying on NHSLA findings from 2008/09.

Trusts will wish to note that the Healthcare Commission will consider achievement of an overall level 2 or 3 in the NHSLA RMS indicative of performance in risk management and this will inform our assessment of the risk of non-compliance with core standard C7a&c (and so reduce the chance of being selected for inspection).

***PLEASE ALSO NOTE** that we are aware that where Trusts have achieved a Level 2 or Level 3 in the RMS they are not automatically assessed against the RMS every year, but that the NHSLA – for their purposes – considers the level awarded to be current until a subsequent assessment. For the purposes of the annual health check, however, evidence of assurance of compliance with Core Standards MUST relate to compliance during the year assessed. We will therefore NOT consider Level 2 or 3 for criteria awarded outside the assessment year alone as evidence of assurance of compliance. The scope of the inspection will therefore NOT be reduced on this basis. (Note that this does not preclude a trust from themselves presenting evidence of current level 2 status, along with other evidence, as part of their evidence of assurance of compliance during inspection. Assessors will then consider all the evidence to assess whether this is reasonable assurance of compliance during assessment year in question).

^ NHSLA List: C1a, C4a, C4b, C4d, C5a, C6, C9, C10a, C11b, C13b, C14a, C14b, C14c, C16, C20a

Audit Commission

We work closely with the Audit Commission to ensure that where overlap exists our assessments are aligned, evidence is shared and duplication minimised. All parties are committed to using each others' work wherever possible. In 2006/07 and 2007/08 the Audit Commission and the Healthcare Commission followed a procedure of information sharing which enabled the Healthcare Commission to rely on the work of auditors on these areas of overlap, thus minimising duplication of work. We anticipate the same process will be used for 2008/09.

We expect that evidence collected by trusts to provide assurance for the **Audit Commission Auditors' Local Evaluation (ALE)** for the assessment year 2008/09 can also be considered by trusts when making their core standards declaration for those relevant aspects of the standards. It is also important that Statements on Internal Control are fully aligned with core standards declarations. Where a trust has declared non-compliance with core standards as part of the self-declaration process, it should disclose a control weakness in the Statement on Internal Control and vice versa.

Relevant in-year **ALE** data is used within our screening process when we select trusts for inspections in the summer.

We also use the ALE findings directly as part of our inspections. For particular standards which have been selected for inspection, where positive assurance is provided from ALE this information is used as evidence and substitutes the need for additional local work by the Healthcare Commission and therefore reduces the number of questions that we need to ask a trust in the event that they are selected for inspection. Other (negative) findings from ALE would not be used alone to determine a lack of assurance of compliance but will inform questions that assessors will ask during inspection

We are working with the Audit Commission to apply the same methodology when considering the findings of their **use of resources** assessment for primary care trusts.

ALE List: C6, C7ac, C7b, C8a, C14a, C17, C21

Patient Environment Action Teams (PEAT)

PEAT findings are also relevant to core standards, and the Healthcare Commission will continue to use these findings, but only to inform our assessment of the risk of non-compliance (and so reduce the chance of being selected for inspection) in relation to the standards listed below. However, we will not this year be using these findings ourselves as assurance of compliance during inspection. This does not prevent Trusts themselves using PEAT findings as part of their assurance. Indeed we would expect (but do not require) trusts to make use of findings of "excellent" as part of their assurance of compliance with the core standards listed below, but do not consider that this, on its own, will give trusts sufficient assurance of compliance with any one standard.

PEAT List: C15a (Element 1), C15b, C20b, C21 (Element 2)

Appendix two – reference documents

For the 2005/06, 2006/07 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	*Building a safer NHS for patients: implementing an organisation with a memory* (Department of Health, 2001)
C02	*Safeguarding Children and Young People : Roles and Competencies for Health Care Staff* (Royal College of Paediatrics and Child Health April 2006) *Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities* (DCSF 2008) *Sharing personal information: How governance supports good practice* (DCSF August 2008)
C04a	*Essential steps to safe, clean care: introduction and guidance* (Department of Health, 2006) *National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services* (Ambulance Service Association, 2004) Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance PROC 12 *Infection control practices for ambulance services* (Infection Control Nurses Association, April 2001)
C04d	*Building a safer NHS: improving medication safety* (Department of Health 2004)
C05a	*How to put NICE guidance into practice* (NICE, December 2005)
C07ac	*Clinical governance in the new NHS* (HSC 1999/065). *Assurance: the board agenda* (Department of Health 2002) *Building the assurance framework: a practical guide for NHS boards* (Department of Health 2003)
C7b	*Directions to NHS Bodies on counter fraud measures* (Department of Health, 2004).
C08b	*Leadership and Race Equality in the NHS Action Plan* (Department of Health 2004)
C10a	The set of six documents that make up the NHS Employment Standards: *1. Verification of identity checks* *2. Right to work checks* *3. Registration and qualification checks*

	4. Employment history and reference checks *5. Criminal record checks* *6. Occupational health checks* These are downloadable from www.nhsemployers.org/primary/primary-3524.cfm The Criminal Record Bureau website provides additional information on Criminal record checks. See www.crb.gov.uk The UK Border Agency website provides information on their checking service for employers. See http://www.bia.homeoffice.gov.uk/employers/employersupport/ecs
C11a	Code of practice for the international recruitment of healthcare professionals (Department of Health 2004)
C11c	Continuing professional development: quality in the new NHS (HSC 1999/154) *Continuing professional development: quality in the new NHS* (DH, 1999)
C13a	*NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff* (Department of Health, 2003).
C13b	*Good practice in consent: achieving the NHS plan commitment to patient centred consent practice* (HSC 2001/023) *Seeking Consent: working with children* (Department of Health 2001)
C16	*Toolkit for producing patient information* (Department of Health 2003) *Information for patients* (NICE) *Guidance On Developing Local Communication Support Services And Strategies* (Department of Health 2004) and other nationally agreed guidance where available
C17	*Key principles of effective patient and public involvement (PPI)* (The National Centre for Involvement, 2007) *Community Engagement in Health* (NICE public health guidance Feb 2008)
C18	*Building on the best: Choice, responsiveness and equity in the NHS* (Department of Health 2003).
C20a	*A professional approach to managing security in the NHS* (Counter Fraud and Security Management Service 2003) and other relevant national guidance. *Design for patient safety: Towards future ambulances* (National Patient Safety Agency and The Helen Hamblyn Trust, 2007) for ambulance trusts only. BS EN 1789:2000 Medical vehicles and their equipment – road ambulances
C21	*Developing an estate's strategy* (1999) *Developing an estates strategy* (Department of Health, 2008), updated version of previous document, but was not published until August 2008 A risk based methodology for establishing and managing backlog (NHS

	Estates, 2004) Add *BS EN 1789: 2007 Medical vehicles and their equipment* for ambulance trusts only *Design for patient safety: Towards future ambulances* (National Patient Safety Agency and The Helen Hamblyn Trust, 2007) for ambulance trusts only *National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services* (Ambulance Service Association, 2004) for ambulance trusts only BS EN 1789:2000 Medical vehicles and their equipment – road ambulances
C22ac	*Choosing health: making healthier choices easier* (Department of Health 2004) *Tackling health inequalities: a programme for action* (Department of Health 2003) *Making partnerships work for patients, carers and service users* (Department of Health 2004) *Guidance on Joint Strategic Needs Assessment* (Department of Health, 2007)
C23	*Choosing health: making healthy choices easier* (Department of Health 2004) *Delivering Choosing health: making healthier choices easier (*Department of Health 2005) *Tackling Health Inequalities: A programme for action* (Department of Health 2003) *Guidance on Joint Strategic Needs Assessment* (Department of Health, 2007)
C24	*Getting Ahead of the Curve* (Department of Health, 2002) *Beyond a major incident* (Department of Health, 2004)

Inspecting Informing Improving

Healthcare Commission

Criteria for assessing core standards in 2008/09

Primary care trusts (as providers and commissioners)

December 2008

Criteria for assessing core standards in 2008/09: Primary care trusts (as providers and commissioners)

As set out in the Healthcare Commission publication *The Annual Health Check in 2008/09: Assessing and rating the NHS*, our assessment of primary care trusts (PCTs) for the performance rating in 2008/09 will have a different structure from previous years. This will allow us to report separately on the performance of services that a PCT provides itself (such as community health services) and its role as a commissioner of healthcare services for its local community. We have developed two sets of criteria for assessing PCTs; one for their role as providers and one set for their role as commissioners of services.

The structure of the 2008/09 criteria document for PCTs has also been changed to reflect this difference in the assessment process by dividing the criteria for PCTs as providers and PCTs as commissioner into two parts. Part One of this document will outline the PCT provider criteria, while Part Two outlines commissioning criteria.

Provider and commissioning criteria will have separate overviews and appendices to provide further information relevant to their assessment process in 2008/09.

The Care Quality Commission

The new Care Quality Commission will replace 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 to enable it to take over the regulation of health and adult social care from 1 April 2009.

The Care Quality Commission will be responsible for delivery of the 2008/09 annual health check, including the core standards based assessment from 1 April 2009.

Where this document refers to "we" this is a reference to the Healthcare Commission up until 31 March 2009 and to the Care Quality Commission from 1 April 2009.

Contents

Part One

Criteria for assessing core standards in 2008/09 for primary care trusts as a provider of services

Overview

These are the 2008/09 criteria for assessing core standards between 1 April 2008 and 31 March 2009 for primary care trusts (PCTs) as health service **provider** bodies within England . As for previous years, we have set out our criteria as 'elements' for each of the core standards.

What has changed?

Primary care trusts
The main change this year affects PCTs. See *Criteria for assessing core standards for 2008/09: Primary Care Trusts (Providers and Commissioners)* section at the beginning of the document.

What else has changed?
This year, we have expanded on our rationales in order to assist trusts further in the assessment process. Some criteria have also been written for greater clarity and in some cases this has made them longer. Although the document has, in turn, become longer, trusts should find the criteria read with the rationales more explicit, clearer and hence helpful when assuring themselves of their compliance against core standards.

As set out in the Healthcare Commission publication *The Annual Health Check in 2008/09: Assessing and rating the NHS*, while we have split the criteria for PCTs into provider and commissioner criteria, there has been limited change to actual content of criteria. We have however reviewed the elements in order to:

- Continue to increase the focus on the outcomes of the standards. We expect trust boards to consider these outcomes when reviewing their assurance of compliance with the standards.

- Add further clarity to elements by explicitly stating within the criteria the status of guidance, codes of practice, etc referred to. For example, where clear legal duties are referred to, trusts are assessed as to whether they have acted "in accordance with" those duties; or for some statutory codes of practice whether they "have had regard to" them, as required by the code. Where the core standard itself refers to specific guidance, this gives that guidance a "must-do" status and the criteria will also reflect this. Other guidance has varying status and we have tried to make this explicit within the criteria.

  For example:

- The healthcare organisation follows National Institute for Clinical Excellence (NICE) interventional procedures[1] guidance **in accordance with** *The Interventional Procedures Programme* (Health Service Circular 2003/011). (C3)
  (NICE interventional procedures are required by the standard itself).

- Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored, **in accordance with** the Medicines Act 1968 ….., 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**. (C4d)

Where references are recognised as useful for trusts but are not directly the subject of

[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).

assessment, again we will provide these in an appendix to the final document. However, as was the case with the documents in Appendix 2 of the 2007/08 criteria, these references will not be the basis on which we will make judgments in inspection.

Trusts should also note that core standards C3, C4c and C22b will be assessed for all provider sectors in 2008/09. See rationales in this document for further details.

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 that NHS trust boards determine whether they have reasonable assurance of compliance with a standard, without a significant lapse, from 1 April 2008 to 31 March 2009. As part of the annual health check, trusts will then be asked to make a declaration of their compliance for the whole year.

Reasonable assurance
Reasonable assurance, by definition, is not absolute assurance. Conversely, 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 reasonable, trusts must reflect 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. 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), and 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

One of the Healthcare Commission's strategic goals continues to be 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 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. Note that we have run three audits of trusts' websites, looking for this information, and we remain concerned that many trusts are still not compliant with legislation, particularly in relation to race equality.

Using the findings of others

We will continue to make use of the findings of others and have reviewed how we do this in order to increase this where possible, and to ensure that it is effective, both in reducing burden on trusts and also in targeting our inspections. Note that, as in 2007/08, we will make use of others' **in-year findings** – ie, findings based on observance of compliance during the assessment year 2008/09, as evidence of assurance of compliance during the year 2008/09. Findings of others relating to recent years will be used to help target inspections.

Mandatory assessment of the NHS Litigation Authority's Risk Management Standards has been suspended for PCTs for the 2008/09 assessment year. (ie, 31 March 2008 to 1 April 2009). However, we will still make in-year use of their findings for PCTs who undergo volunteer assessment or have achieved **in-year** (ie, 31 March 2008 to 1 April 2009) level 2 (or 3) in 2008/09 where this provides a level of assurance of compliance.

Please see Appendix 1 for more details about this and other changes, in particular a change in the way we use PEAT findings and the Audit Commission's Use of Resources.

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, and will be assessed on this basis.

Part One – 2008/09 PCT provider criteria

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	Rationale
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, Healthcare Commission, the Counter Fraud and Security Management Service and all other national organisations to which the healthcare organisation is required to report incidents.	**Elements one & two** Healthcare organisations should report incidents nationally to the relevant national organisations. These organisations include the National Patient Safety Agency (NPSA) and a wider range of organisations that have been listed in the element. 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 and this has been made more explicit in the element.

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 reoccurence 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 reoccurence of similar incidents in the future, for the benefit of patients / service users as a whole.	**Element three** 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. Analysis of relevant trends includes changes over time. This requirement was previously included in element two in 2007/08 and has been brought out in a separate element to provide greater clarity. 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 and this has been made more explicit in the element.
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** Healthcare organisations should make changes to practice based on the analysis of local incidents and the national analysis of incidents. The national analysis of incidents is carried out by 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	Rationale
Element one All communications concerning patient safety issued from the National Patient Safety Agency (NPSA) and the Medicines Healthcare products Regulatory Agency (MHRA) via national	**Element one** SABS is being brought together with the UKPHLS to form the CAS. However, it is likely that all three systems will continue to be used in parallel during the introductory phase of CAS.

distribution systems, including the Safety Alert Broadcast System (SABS), the Central Alert System (CAS) the UK Public Health Link System (UKPHLS), are implemented within the required timescales.	There are other routes through which this information may be issued. For example MHRA issues field safety notices via its website and targets particular trusts with directly mailed safety letters. While these cannot be considered official distribution systems, they do communicate information regarding patient safety that may occasionally require trusts to take 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	Rationale
Element one The PCT 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*.	**Element one** In March 2007 statutory guidance was published, updating previous guidance, which is based on the Children Act 2004. Compliance with this was required by October 2005 and all elements should now be in place. The guidance issued under section 11(4) of the Children Act 2004 which 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 PCT works with partners to protect children and participate in reviews as set out in *Working together to safeguard children* (HM Government, 2006).	**Element two** Again this element has been extended to include activities that are required, such as participation in serious case reviews and child death reviews, both requirements from 1 April 2008.
Element three The PCT 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 three** There was some overlap between the 2007/08 element three (CRB checks) and Core standard C10a so this is removed. Instead a particular aspect of the Statutory Guidance is drawn out and wording is used from this document to emphasise the importance of information sharing between agencies. This information sharing process can include the Common Assessment Framework, ContactPoint when it is introduced, 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	Rationale
Element one The PCT follows NICE interventional procedures[2] guidance in accordance with *The interventional procedures programme* (Health Service Circular 2003/011). Arrangements for compliance are communicated to all relevant staff.	**Element one** National Institute for Clinical Excellence (NICE) interventional procedures guidance applies to any trust that carries out interventional procedures. Following clarification from NICE and Department of Health (DH) the application of the standard has been extended to all trust types to better reflect this. The element makes reference to the need to communicate arrangements to all relevant staff. This is to reflect that even where no 'new' interventional procedures[3] 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.

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	Rationale
Element one The PCT has systems to ensure the risk of healthcare associated infection is reduced in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008).	**Element one** The Hygiene Code was revised in January 2008. All healthcare associated infection issues are covered by this criteria with the exception of the following: **Covered by C21 – Cleaning of the environment:** • Hygiene Code Duty 4 (a,b,(in relation to cleaning) c,d,e,g and h). **Covered by C4c – Decontamination of reusable medical devices:** • Hygiene Code Duty 3 (if related to decontamination) • Hygiene Code 4b • Hygiene Code 4f. Note that, in complying with a provision specified in

[2] '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).
[3] 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.

	any duty contained in the Code, an NHS body must consider and, where appropriate, follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation.

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	Rationale
Element one The PCT 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.	**Element one** No change to this element from 2007/08
Element two The PCT 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** One of the amendments to the IRMER 2000 regulations was in 2006 when enforcement responsibilities were transferred to the Healthcare Commission. Further amendments are likely and so an explicit reference is now 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	Rationale
Element one Reusable medical devices are properly decontaminated in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008).	**Element one** The Hygiene code was revised in January 2008. Criteria C4c covers: • Hygiene Code Duty 3 (if related to decontamination) • Hygiene Code 4b • Hygiene Code 4f. All other aspects of healthcare associated infection and duties of the Hygiene Code are covered by C4a or C21. Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and, where appropriate, follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation.

In 2006/07, this standard was not assessed for ambulance trusts and mental health trusts as the focus for assessment was on the sterilisation of invasive medical equipment that presented a known risk of infection. However, this criteria will apply to all trust types on 2008/09 because:

- Decontamination has a wider meaning than sterilisation alone and is defined as a combination of processes, including cleaning, disinfection and sterilisation, used to render a reusable item safe for further use on patients / service users and handling by staff.
- Medical devices refers to all products, except medicines, used in healthcare for diagnosis, prevention, monitoring or treatment.

A single use medical device is a device that is intended to be used on an individual patient during a single procedure and then discarded. Therefore, any device which is not single use must be considered a reusable medical device. These devices are used by ambulance and mental health trusts.

Core Standard C4d

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

Elements	Rationale
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 one** In referring to the Medicines Act, all amendments and subsequent regulations are now included within this reference. Subsequent regulations include the Medicines for Human Use (Prescribing) Order, which provides additional requirements for prescribing (eg, reauthorising repeat prescriptions every six months). The Duthie Report *(The safe and secure handling of medicines: A Team approach)* has now 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). In addition feedback received during the 2008/09 annual health check consultations suggested including this reference within the criteria for C4d.

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.*	**Element two** The proposed element makes reference to all amendments for the Misuse of Drugs Act 1971. The guidance on strengthened governance arrangements has been replaced with the updated 2007 version. The proposed 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	Rationale
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 Memorandum (HTM) 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).	**Element one** Element one has been amended to incorporate HTM 07-05 relating 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 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 NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

Elements	Rationale
Element one The PCT ensures that it conforms to 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.	**Elements one & two** New technology appraisals are always under development, therefore all NHS trusts need to have mechanisms in place to review the appropriateness of these for their service, even if many of them will not be relevant to some trust types. Current healthcare policy emphasises the importance of the quality of clinical care and of having consistent care for all patients / service users. The effective implementation of NICE technology appraisals and use of clinical guidelines that are based on best practice are crucial to the promotion of consistent and high quality clinical care. To reflect this, elements one and two have been made more explicit to give greater focus on the different aspects of the standard against which we would expect an orgainsation to assure itself.
Element two The healthcare organisation can demonstrate how it takes into account nationally agreed guidance where it is available as defined in National Service Frameworks (NSFs), NICE guidelines, national plans 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.	

Core Standard C5b

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

Elements	Rationale
Element one The PCT 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'[4]; 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 are monitored and reviewed on a regular basis and action is taken accordingly.	**Element one** The wording of the elements has been amended to clarify that the responsibility being assessed is that of the organisation and not that of individual clinicians. Element one has been amended to clarify 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 patients / service users receive care which will lead to effective clinical outcomes. When making a declaration against this standard the Healthcare Commission would expect an organisation to assure itself that arrangements for both of the above are in place and effective. Current healthcare policy emphasises the importance of clinician-led services. To reflect this, the elements have been made more explicit to give greater focus on the different aspects of the standard against which we would expect an organisation to assure itself.
Element two The PCT ensures that it provides opportunities for clinicians[5] to develop their clinical leadership skills and experience.	**Element two** With this additional element, the criteria now better reflects the standard.

Core Standard C5c

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

Elements	Rationale
Element one The PCT ensures that clinicians from all disciplines participate in activities to update the skills and techniques that are	**Element one** The wording of the elements has been amended to better reflect the standard and to clarify that the responsibility being assessed is that of the

[4] 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*, NMC, 2008).
[5] Clinicians are 'professionally qualified staff providing clinical care to patients'. (Source: Standards for Better Health, DH, 2004)

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.	organisation and not that of individual clinicians. 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 has been made more explicit to give greater focus on the different aspects of the standard against which we would expect an organisation to assure itself.

Core Standard C5d

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

Elements	Rationale
Element one The PCT ensures that clinicians[6] are involved in prioritising, conducting, reporting and acting on regular clinical audits[7]. **Element two** The PCT ensures that clinicians participate in regular reviews of the effectiveness of clinical services through evaluation, audit or research.	**Elements one & two** The wording of the elements have been amended to better reflect the standard and to clarify that the responsibility being assessed is that of the organisation and not that of individual clinicians.

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	Rationale
Element one The PCT 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	**Elements one & two** The structure and wording of the elements have been amended to better reflect the standard and to clarify that the partnership responsibilities being assessed are those of the organisation as well as those of staff. Element one considers an organisation's responsibility to ensure effective partnership agreements and working at an organisational level. Element two focuses on the

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

[7] 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)

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 transfer[8]) across organisational boundaries.

Where appropriate, these arrangements are in accordance with:

- Section 75 partnership arrangements of the National Health Service Act 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 national strategies (for example, the National Service Framework for Mental Health (DH, 1999), the National Service Framework for Older People (DH, 2001) and the Cancer Reform Strategy (DH, December 2007).
- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (DH, 2007).

need for groups of staff from different organisations to work together to meet the needs of patients / service users. This may be facilitated through engagement in clinical networks, for example.

Element one has been made more explicit to indicate that we would expect an organisation to be assured that it is using partnerships to ensure that a patient's/service user's needs are met when they move between organisations and when more than one organisation is contributing to a patient's care.

Various guidance and legislative documents are relevant to this standard.

- Organisations are legally obliged to comply with arrangements laid out in Section 75 of the National Health Service Act 2006 and the Community Care (Delayed Discharges etc.) Act 2003.
- The additional documents listed in element one are all good practice guidance or strategic frameworks which organisations are not mandated to follow. The Commission would, however, expect an organisation to have good reason and clear rationale for following a different course of action from that set out in these documents.

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

With this additional element, the criteria now better reflects the standard.

[8] 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/)

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	Rationale
Element one The PCT has effective clinical governance[9] arrangements in place to promote clinical leadership and improve and assure the quality and safety of clinical services for patients / service users.	**Element one** Element one has been revised to clarify the link with the domain outcome.
Element two The PCT has effective corporate governance[10] 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 two** Element two has been updated to provide more clarity about the relevant directives and guidance against which we would expect trusts to develop their corporate governance structures.
Element three The PCT systematically assesses[11] and manages[12] its risks, both corporate/clinical risks in order to ensure probity, clinical quality and patient safety.	**Element three** Element three has been revised to clarify that it refers to both corporate and clinical risks and to focus on the domain outcome.

Core Standard C7b

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

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[9] 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).
[10] Governance is 'a mechanism to provide accountability for the way an organisation manages itself' (Source: Standards for Better Health, DH, 2004).
[11] 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).
[12] 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).

Elements	Rationale
Element one The PCT 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.	**Element one** There is a change to wording to better reflect legislative requirements. 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*". Reference to "having regard to guidance or advice issued by the CFSMS" has therefore been added. However 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	Rationale
This standard will be measured under the use of resources quality of financial management assessment.	Not applicable

Core Standard C7e

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

Elements	Rationale
Element one The PCT 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, amongst other things, equality schemes for race, disability and gender, along with impact	**Element one** This element has been amended to emphasise that trusts need to cover the issues in terms of challenging discrimination in the provision of services, goods and facilities, as well as employment. 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)

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, amongst 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).

(issued by Disability Rights Commission published 2005)

- 'Gender Equality Duty Code of Practice (England and Wales)' (issued by Equal Opportunities Commission published 2007

Similarly the acts cited under "employment and equalities legislation" have associate 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, and
- 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 PCT promotes equality, including by publishing information specified by statute, 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 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

There have been minor changes to wording 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	Rationale
This standard will be measured under the indicators-based assessment	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	Rationale
Element one Staff are supported, and know how, to raise	**Element one** No change to the element. The HSC 1999/198 has been

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).	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	Rationale
Element one The PCT 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	**Elements one & two** The standard deals specifically with the under representation of minority groups and the element now 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 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 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. * The phrases *"public body duties"* and "*employment and equalities legislation"* are defined in C7e.	**Element two** The meaning of "under-representation" is now more clearly stated. This element also now 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 e.g., in particular occupations or specialisms.

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 orgainsation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

Elements	**Rationale**
Element one The PCT has effective systems for managing records in accordance with *Records management: NHS code of practice* (Department of Health, April 2006), *Information security management: NHS code of practice* (Department of Health, April 2007) and *NHS Information Governance* (Department of Health, September 2007). Healthcare organisation complies 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.	**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 information management and technology plan for the organisation demonstrates how a correct NHS Number will be assigned to every clinical record, in accordance with *The NHS in England: the Operating Framework for 2008/09* (Department of Health, December 2007).	**Element two** A new element has been included to reflect that the NHS Medical Director has written 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). The operating framework sets out the priorities for the year; the Department of Health expects that NHS organisations will produce an information management and technology plan in 2008/09 to deliver the mandated use of the NHS Number.

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	Rationale
Element one The necessary checks are undertaken in respect of all applications for NHS positions (prospective employees) and staff in ongoing NHS employment[13] in accordance with the NHS Employment Check Standards (NHS Employers) 2008)	**Element one** NHS Employers published a revised set of standards in March 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 replace, from April 08, the previous publications “Safer recruitment – A guide for NHS Employers” and “CRB disclosures in the NHS” The new standards were launched on 18th March

[13] 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.

	2008 and 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. Launch of the standards was announced in the NHS Employers workforce bulletin issue 105 dated 25 March 2008[14].

Core Standard C10b

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

Elements	Rationale
Element one The PCT explicitly requires all employed healthcare professionals[15] 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.	**Element one** Following clarification from the Department of Health, the details of this element have been updated to clarify that the standard is concerned with employed healthcare professionals only.

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
Element one The PCT 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. * The phrases *"public body duties"* and	**Element one** The changes have been made to include employment legislation covering equalities related issues such as flexible working but at the same time to avoid extending the list of legislation in the element itself at the risk of reducing clarity. The changes also provide more clarity regarding the equality duties requirements in that the criteria now specifically require organisation to meet the employment related duties under RRA, DDA and Equality Act under this standard. 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 C7e

[14] The bulletin can be found at www.nhsemployers.org/files/workforcearchive/NHSWorkforceBulletin-105.html

[15] 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).

"employment and equalities legislation" are defined in C7e.	
Element two The PCT 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.	**Element two** The wording has been changed to more clearly reflect the standard by making explicit reference to training and qualification combined with workforce planning.

Core Standard 11b

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

Elements	Rationale
Element one Staff participate in relevant mandatory training programmes. Note: For PCTs who achieve Level 2 (or 3) in the NHSLA's Risk Management Standards in the assessment year 1 April 2008 to 31 March 2009, we will continue to use that NHSLA data relevant to this element as either partial or full evidence of assurance of compliance during inspections for 2008/09. See Appendix 1 for more information regarding Use of Findings of Others	**Element one** In 2007/08 the NHSLA Risk Management Standards operated in full in the acute sector, and were piloted in other sectors. The Risk Management Standards have now been published (March 2008) and are operating in full in the assessment year 1 April 2008 to 31 March 2009 for the following trust types • Acute and Specialists, • Mental Health & Learning Disability and • Ambulance. However, for PCTs, since publication of draft criteria in September 2008, the HC has become aware that the NHSLA has suspended mandatory assessment of its Risk Management Standards for 08/09 for that sector. It is open to PCTs to request a assessment in 08/09 on a voluntary basis. In the light of this decision, reference to NHSLA in element one has been removed as it is not mandatory. As noted, if a trust chooses to be assessed and achieves Level 2 (or 3) of NHSLA Risk Management Standards in 08/09, this will be used as either partial or full evidence of assurance in relation to this element.
Element two Staff and students participate in relevant induction programmes.	**Element two** No change to this element from 2007/08.
Element three The PCT 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 identify non-	**Element three** This element has been added to reflect the need for trusts to check uptake of training in order to ensure participation. This will be 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

attendance, action is taken to rectify this.	to in the NHSLA risk management standards and element one). 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	Rationale
Element one The PCT 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 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; and 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. * The phrases *"public body duties"* and "*employment and equalities legislation"* are defined in C7e	**Element one** The wording of the element has been amended to better reflect the standard and to clarify that the responsibility being assessed is that of the organisation and not that of individual staff members. 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 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 we would expect a trust to have good reasons and clear rationale for following a different course of action from that set out in the framework.

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	Rationale
Element one The PCT 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).	**Element one** Minor amendments have been made to make the criteria clearer: two references to "framework" could be slightly confusing so " principles" replaces the first occurrence, (which also brings the element closer to the wording of the standard)

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	Rationale
Element one The PCT 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 one** The wording of the element has been changed to include identification of risk and appropriate action to reduce the risk of occurrence of compromise in dignity or respect. The change 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 The PCT 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, 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, and* ▪ *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 Service circular 2001/007), to ensure that older people are not unfairly discriminated against in accessing NHS	**Element two** 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 has been added this year. 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 codesThe Codes are admissible in evidence in any legal action and can be taken into account by courts and tribunals A further addition has been made to include the National Service Framework (NSF) for older people (DH notification letter HSC 2001/007) which specifically addresses age discrimination, amongst other things.

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	Rationale
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 one** The changes from 2007/08 criteria include adding the term "decisions" as well as treatments and procedures to reach a consistent approach across all healthcare organisations as it applies across the board and in particular to those subject to the Mental Health Act in acute or other hospitals. The Human Tissues Authority guidance now referred to supersedes the Families and Post-Mortems guidance referred to in 2007/08.
Element one Valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures, investigations and decisions in accordance with the Human Rights Act 1998, the *Reference guide to consent for examination or treatment* (Department of Health, 2001), and having regard to the *Code of Practice to the Mental Health Act and 2007 and 2007,* and *Code of Practice to the Mental Capacity Act 2005*	Note that trusts are expected to have regard to a revised version of The Code of Practice to the Mental Health Act from 03/11/08 when revisions to this Code take effect. 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 (e.g. Bournewood and Glass vs UK cases, Bristol, Alder Hey and the introduction of the Human Tissue Act and associated Authority). Continuing to rely solely on reference to the Department of Health and Department of Constitutional Affairs guidance (as in 2007/08) would no longer 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 (MCA) 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 is added to the element.
Element two Patients/service users, including those with language and/or communication 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).	**Element two** Changes in wording to make clear that information provided must be suitable and sufficient for patient/service user needs.
Element three The PCT monitors and reviews current practices to ensure effective consent processes.	**Element three** This 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
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 *Confidentiality: NHS code of practice* (Department of Health 2003), *Caldicott Guardian Manual 2006* (Department of Health 2006). The PCT 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.	**Element one** The element has been updated to take into account the updated Caldicott Guardian Manual. 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 of which is relevant to C13c (iv): • 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
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 PCT acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	**Element one** The reference in element one to the NHS (Complaints) Regulations 2004 ("Regulations") has been added because the Regulations place specific legal obligations on healthcare organisations in relation to complaints. The term 'in so far as relevant' has been added because the Regulations apply differently to foundation and non-foundation trusts. For example, the Regulations require non-foundation trusts, but not foundation trusts, to inform complainants of their right to complain locally.
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 2007/08.

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	Rationale
Element one The PCT has systems in place to ensure that patients / service users, carers and relatives are not treated adversely as a result of having complained.	**Element one** No change to this element from 2007/08.

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	Rationale
Element one The PCT acts on, and responds to, complaints appropriately and in a timely manner; and acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	**Element one** The reference in element one to the NHS (Complaints) Regulations 2004 ("Regulations") has been added because the Regulations place specific legal obligations on healthcare organisations in relation to complaints. The term 'in so far as relevant' has been added because the Regulations apply differently to foundation and non-foundation trusts. For example, the Regulations require non-foundation trusts, but not foundation trusts, to inform complainants of their right to complain locally.

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** Has been revised to emphasise the improvements expected in response to concerns and complaints raised by patients / service users, relatives and carers.

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	Rationale
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.	**Element one** There are two changes to the wording of this element: 1. Making 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) and 2. Making 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** 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 European Commission (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	Rationale
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 one** It should be noted that individual food preferences are not within the scope of this element. However the wording has been amended 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 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 two** The wording has been amended to include "at all stages of their care" to emphasise within the element 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 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.	**Element three** The wording has been amended 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	Rationale
Element one The PCT 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, 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) Act2000* ▪ *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 one** 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 The PCT 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).	**Element two** The wording has been changed to ensure adequate emphasis on 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	Rationale
Element one The PCT seeks and collects the views and experiences of patients/service users, carers and the local community, 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 of the *National Health Services Act* 2006 in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) 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, and* • *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 one and two** Element one has been re-written to make it clear that the trust 'seeks **and collects'** the 'views **and experiences'** of patients/service users, carers and the local community as public views reflect service delivery and are more often based on experience. This helps to clarify that trusts are expected to bring information from patients and the public together across the organisation, and that this information should include the stories of the experiences of users and carers as well as their views of services. The reference to 'disadvantaged and marginalised groups' has been replaced with '**seldom listened to'** groups so that trusts are clear that this is to encompass any people whose views are not commonly gathered Section 11 of the Health and Social Care Act 2001, which placed a duty on NHS organisations to involve and consult, became Section 242 of the National Health Service Act 2006, as of 1 March 2007. Reference to equalities legislation and their associated codes of practice is included to reflect the need for organisations to ensure that their duties are carried out in a manner compatible with the legislation. 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
The PCT demonstrates to patients/service users, carers and the local community, 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, in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation should act 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, and*
- *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.

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	Rationale
Element one The PCT enables all members of the population it serves 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	**Element one** The reference to public body duties has replaced previous reference to discrimination and equality legislation in order to clarify that the public bodies have a duty with regard to enabling access to services. The phrase "*public body duties*" is defined in C7e and information about the codes of practice is given

"*public body duties*"*statutes: ▪ *the Race Relations (Amendment) Act 2000,* ▪ *the Disability Discrimination Act 2005, and* ▪ *the Equality Act 2006* ; and where appropriate, having due regard to the associated codes of practice. * The phrases *"public body duties"* is defined in C7e	in the rationale to C7e.
Element two The PCT 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** As in element one, wording changed for clarity and to more precisely express the meaning of this element. In particular more appropiate 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 indicators-based assessment	Not applicable

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 orgainsation.

Elements	Rationale
Element one The PCT effectively manages the health, safety and environmental risks to patients/service users, staff and visitors, in accordance with all relevant[16] 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.	**Element one** The Disability Discrimination Act 1995 has been 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 Issues for NHS staff (NHS Employers 2005) has

[16] 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

	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 PCT 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** Element two has been amended 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 CFSMS, 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	**Rationale**
Element one The PCT 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 transfers[17].	**Element one** The wording of the element has been changed to include privacy for spiritual needs and confidential consultations which is an integral part of the requirements of privacy. This year all sectors have 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 also recognised that the need for privacy and

[17] 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/)

	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 PCTs 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** 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	Rationale
Element one The PCT 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 one** Modified wording 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* has been 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 Care is provided in clean environments, in accordance with the relevant[18] requirements of duty four of *The Health*	**Element two** The hygiene code was updated in January 2008. The overarching duty 4 is to provide and maintain a

[18] The decontamination of reusable medical device related aspects of sub-duties 4b and 4f of the *Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* are covered by standard C04c

Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections (Department of Health, revised 2008).

clean and appropriate environment for healthcare. Sub-duty 4d states that “the cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available".

Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and where appropriate follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation. The *National specification for cleanliness in the NHS* (NPSA, 2007) is referenced in the revised version of the Hygiene Code (2008) and provides guidance for trusts on cleaning standards. However, this guidance is not mandatory and a trust may specify its cleaning standards in a different manner to those set out in the NPSA specification so long as the standards meet the overall objectives set out in duty four.

This standard only considers specific aspects of duty four of the Hygiene Code. These are sub duties 4 a, b (in relation to cleaning), c, d, e, g and h. The decontamination of reusable medical device related aspects of sub-duties 4b and 4f of the Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections are covered by standard C04c.

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	Rationale
Element one The PCT 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 Joint Strategic Needs Assessment (JSNA) and health equity audits to identify population health needs.	**Element one** Adding JSNA updates the element to reflect changes in the system. Other partners (social care and the criminal justice system) are included to improve the element and reflect changes to the system.
Element two The PCT contributes appropriately and effectively to nationally recognised and/or statutory partnerships, such as the Local Strategic Partnership (LSP), children's partnership arrangements and, where appropriate, the Crime and Disorder Reduction Partnership.	**Element two** Role of the LSP and children's trust partnerships updates element and reflects developments in partnerships at local level.
Element three The PCT monitors and reviews their contribution to public health partnership arrangements and takes action as required.	**Element three** With this additional element the criteria now better reflect the standard with its focus on outcomes.

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
Element one The PCT's policies and practice to improve health and narrow health inequalities are informed by the local director of public health's (DPH) annual public health report.	**Element one** This element was removed in 2007/08 with the rationale that reinforcement of other elements in C22 and C23 meant that this was less critical for providers. Inspection has revealed that this has not been sufficiently covered elsewhere, so it has been reintroduced.

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
Element one The PCT 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.	**Element one** This now matches the criteria for the other provider sectors and better reflects the standard.
Element two Patients/service users are provided with evidence-based care and advice along their care pathway in relation to public health priority areas, including through referral to specialist advice/services.	**Element two** This now better matches the standard and the outcome focus of the domain.
Element three The PCT implements policies and practices to improve the health and well-being of its workforce.	**Element three** No change to this element from 2007/08.

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	Rationale
Element one The PCT protects the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations (including control	**Element one** The sentence has been amended by adding 'protects the public' in order to ensure outcome, as well as process, is assessed. Guidance on all counts has been updated. NHS

of communicable diseases), which includes arrangements for business continuity management, in accordance with the Civil Contingencies Act (2004), The NHS Emergency Planning Guidance 2005, and associated supplements (Department of Health, 2005, 2007) and Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic (Department of Health November 2007).	emergency planning guidance is best practice guidance - a set of general principles published by the Department of Health to guide all NHS organisations in developing their ability to respond to a major incident(s) and to manage recovery and its effects, locally, regionally or nationally within the context of the requirements of the Civil Contingencies Act 2004. Associated supplements include: ▪ *Planning for the management of burn-injured patients in the event of a major incident (December 2007)* ▪ *Critical care contingency planning in the event of an emergency where the numbers of patients substantially exceeds normal critical care capacity (December 2007)* ▪ *Planning for the management of blast injured patients (December 2007)* ▪ *Strategic command arrangements for the NHS during a major incident (December 2007) – supersedes the command and control section of the NHS Emergency Planning Guidance 2005* ▪ *Mass casualties incidents: a framework for planning (March 2007) – supersedes beyond a major incident* ▪ *New guidance on the provision of public health advice during a major incident (April 2007)* *Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic* (Department of Health November 2007) superseded the previous plan (*UK influenza pandemic contingency plan* (Department of Health, 2005)) in November 2007.
Element two The PCT protects the public by working with key partner organisations, including through Local Resilience Forums, in the preparation of, training for and annual testing of emergency preparedness plans, in accordance with the *Civil Contingencies Act 2004*, *The NHS Emergency Planning Guidance 2005 and associated annexes* (Department of Health 2005, 2007) and *Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic* (Department of Health November 2007).	**Element two** “Protects the public” has been added in order to ensure outcome as well as process are assessed. Guidance has been updated as in element one.

Appendix 1 – Healthcare Commission's use of the findings of others in the core standards assessment 2008/09 of PCTs as Providers

Working with others

The Healthcare Commission has a statutory responsibility to review the provision of healthcare by or for the English NHS bodies and cross-border Special Health Authorities. To do this, we work with other organisations to remove unnecessary burdens associated with inspections, audits or reviews, including targeting inspection activity effectively. Whilst existing inspection methodologies have been developed to meet the needs of the services for which they have been developed (and so a single inspection methodology would not be appropriate) the aim is to achieve greater consistency and cohesion in the inspection of health and healthcare. In line with this, we make use of findings as detailed below in relation to the annual health check.

Use of the findings of others

The Healthcare Commission continues to make use of the findings of others to assist its work and to reduce duplication of assessment when possible. As described in the following sections, some of the findings of others relating to matters identified during the assessment year 2008/09 will be used directly to provide evidence of assurance in relation to compliance.

In year findings of others will also be used in our screening process to help target inspections; so that for example where there are positive findings in relation to a trust, this will reduce the chances of that trust being selected for inspection.

As well as the Healthcare Commission's use of the findings of others in this way, trusts also have the option of using findings of others that relate to matters within the assessment year as part of their assurance processes, but it is not a requirement and it is always open to trusts to assure themselves of compliance with the core standards in other ways.

NHSLA Risk Management Standards

The core of the NHSLA's risk management programme is provided by a range of NHSLA standards and assessments. The NHSLA regularly assesses healthcare organisations against these risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHSLA.

The NHS Litigation Authority's Risk Management Standards have now been rolled out to all provider sectors enabling us to make in-year use of their findings for all sectors in 2008/09 where this provides a level of assurance of compliance. There is a single set of risk management standards for each type of healthcare organisation incorporating organisational, clinical, and health & safety risks. The sets of standards that the Healthcare Commission will make use of, as appropriate to the sector are:

- NHSLA Risk Management Standards for Acute Trusts (applicable to all acute and specialist hospital NHS trusts)
- NHSLA Risk Management Standards for Mental Health and Learning Disability Trusts
- NHSLA Risk Management Standards for Ambulance Trusts
- NHSLA Risk Management Standards for Primary Care Trusts

For the remainder of this appendix these are referred to collectively as the "Risk Management Standards (RMS)".

Each of the "standards" within the **NHSLA** *Risk Management Standards* are assessed using *criteria.* It is many of these *criteria* which are directly relevant to the core standards listed below^ and the Healthcare Commission will continue to use positive *RMS* findings in relation to their criteria where appropriate, to inform their assessment of core standards, both to:

- reduce the chance of trusts being selected for inspection (by informing our assessment of the risk of undeclared non-compliance using findings from current and previous years),
- reduce evidence required during inspections of the standards listed below, where findings are from an RMS assessment carried out by the NHSLA during the assessment year 2008/09 **ONLY***.

NOTE that in a change from 2007/08 we will use findings of Level 2 (or 3) in any relevant *RMS criteria* whether or not the trust succeeds in achieving an overall Level 2 (or 3). This means that, we will make use of any findings of level 2 or 3 at *RMS criteria* level for all trusts that are assessed at this level and not just those who also succeed at the overall level.

We would also expect (but do not require) trusts to make use of in-year level 2 or 3 achievements in relevant *RMS criteria* (where they have been directly assessed by the NHSLA within the year 2008/09) to contribute to their assurance of compliance with the core standards listed below, but we do not consider that this on its own, will give trusts sufficient assurance of compliance with any one standard as a whole. It remains the responsibility of trusts to determine whether they have reasonable assurance of compliance with core standards, whether or not they are relying on NHSLA findings from 2008/09.

Trusts will wish to note that the Healthcare Commission will consider achievement of an overall level 2 or 3 in the NHSLA RMS indicative of performance in risk management and this will inform our assessment of the risk of non-compliance with core standard C7a&c (and so reduce the chance of being selected for inspection).

***PLEASE ALSO NOTE** that we are aware that where Trusts have achieved a Level 2 or Level 3 in the RMS they are not automatically assessed against the RMS every year, but that the NHSLA – for their purposes – considers the level awarded to be current until a subsequent assessment. For the purposes of the annual health check, however, evidence of assurance of compliance with Core Standards MUST relate to compliance during the year assessed. We will therefore NOT consider Level 2 or 3 for criteria awarded outside the 2008/09 assessment year alone as evidence of assurance of compliance. The scope of the inspection will therefore NOT be reduced on this basis. (Note that this does not preclude a trust from themselves presenting evidence of current level 2 status, along with other evidence, as part of their evidence of assurance of compliance during inspection. Assessors will then consider all the evidence to assess whether this is reasonable assurance of compliance during assessment year in question)

^NHSLA List: C1a, C4a, C4b, C4d, C5a, C6, C9, C10a, C11b, C13b, C14a, C14b, C14c, C16 and C20a

Audit Commission

We work closely with the Audit Commission to ensure that where overlap exists our assessments are aligned, evidence is shared and duplication minimised. All parties are committed to using each others' work wherever possible. In 2006/07 and 2007/08 the Audit Commission and the Healthcare Commission followed a procedure of information sharing which

enabled the Healthcare Commission to rely on the work of auditors on these areas of overlap, thus minimising duplication of work. We anticipate the same process will be used for 2008/09.

The assessment undertaken by the Audit Commission has changed and in 2008/09 the auditor's local evaluation assessment has been replaced by the **Use of Resources assessment (UoR)** which is undertaken on the PCT as a single body. Further information on this can be found on the Audit Commission's website. We are working with the Audit Commission to finalise how we will apply this single assessment to both arms of the PCT as they are assessed through the core standards assessment process.

We expect that evidence collected by trusts to provide assurance for UoR for the assessment year 2008/09 can also be considered by trusts when making their core standards declaration for those relevant aspects of the standards. It is also important that Statements on Internal Control are fully aligned with core standards declarations. Where a trust has declared non-compliance with core standards as part of the self-declaration process, it should disclose a control weakness in the Statement on Internal Control and vice versa.

Relevant in-year UoR data is used within our screening process when we select trusts for inspections in the summer.

We also intend to use the UoR findings directly as part of our inspections. For particular standards which have been selected for inspection, where positive assurance is provided from UoR this information is used as evidence and substitutes the need for additional assessment by the Healthcare Commission and therefore reduces the number of questions that we need to ask a trust in the event that they are selected for inspection. Other (negative) findings from UoR would not be used alone to determine a lack of assurance of compliance but will inform questions that assessors will ask during inspection

UoR List: C7b, C8a, C7ac, C21

PEAT Patient Environment Action Teams

PEAT findings are also relevant to core standards, and the Healthcare Commission will continue to use these findings, but only to inform our assessment of the risk of non-compliance (and so reduce the chance of being selected for inspection) in relation to the standards listed below. However, we will not this year be using these findings ourselves as assurance of compliance during inspection. This does not prevent Trusts themselves using PEAT findings as part of their assurance. Indeed we would expect (but do not require) trusts to make use of findings of "excellent" as part of their assurance of compliance with the core standards listed below, but do not consider that this, on its own, will give trusts sufficient assurance of compliance with any one standard.

PEAT List: C15a (Element 1), C15b, C20b, C21 (Element 2)

Appendix 2 – Reference documents

For the 2005/06 and 2006/07 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
C1a	*Building a safer NHS for patients: implementing an organisation with a memory* (Department of Health, 2001)
C2	*Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (Royal College of Paediatrics and Child Health April 2006) *Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities* (DCSF 2008) *Sharing personal information: How governance supports good practice* (DCSF August 2008)
C4a	E*ssential steps to safe, clean care: introduction and guidance* (Department of Health, 2006) *National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services* (Ambulance Service Association, 2004) Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance PROC 12 *Infection control practices for ambulance services* (Infection Control Nurses Association, April 2001)
C4d	*Building a safer NHS: improving medication safety* (Department of Health 2004)
C5a	*How to put NICE guidance into practice* (NICE, December 2005)
C7ac	*Clinical governance in the new NHS* (HSC 1999/065) *Assurance: the board agenda* (Department of Health 2002) *Building the assurance framework: a practical guide for NHS boards* (Department of Health 2003)
C7b	*Directions to NHS Bodies on counter fraud measures* (Department of Health, 2004)
C8b	*Leadership and Race Equality in the NHS Action Plan* (Department of Health 2004)
C10a	The set of six documents that make up the NHS Employment Standards: *1. Verification of identity checks* *2. Right to work checks* *3. Registration and qualification checks* *4. Employment history and reference checks* *5. Criminal record checks* *6. Occupational health checks* These are downloadable from www.nhsemployers.org/primary/primary-3524.cfm

	The Criminal Record Bureau website provides additional information on Criminal record checks. See www.crb.gov.uk The UK Border Agency website provides information on their checking service for employers. See http://www.bia.homeoffice.gov.uk/employers/employersupport/ecs
C11a	*Code of practice for the international recruitment of healthcare professionals* (Department of Health 2004)
C11c	*Continuing professional development: quality in the new NHS* (HSC 1999/154) *Continuing professional development: quality in the new NHS* (DH, 1999)
C13a	*NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff* (Department of Health, 2003).
C13b	*Good practice in consent: achieving the NHS plan commitment to patient centred consent practice* (HSC 2001/023) *Seeking Consent: working with children* (Department of Health 2001)
C16	*Toolkit for producing patient information* (Department of Health 2003) *Information for patients* (NICE) *Guidance On Developing Local Communication Support Services And Strategies* (Department of Health 2004) and other nationally agreed guidance where available
C17	Key principles of effective patient and public involvement (PPI) (The National Centre for Involvement, 2007) *Community Engagement in Health* (NICE public health guidance Feb 2008)
C18	*Building on the best: Choice, responsiveness and equity in the NHS* (Department of Health 2003).
C20a	*A professional approach to managing security in the NHS* (Counter Fraud and Security Management Service2003) and other relevant national guidance *Design for patient safety: Towards future ambulances* (National Patient Safety Agency and The Helen Hamblyn Trust, 2007) for ambulance trusts only BS EN 1789:2000 Medical vehicles and their equipment – road ambulances
C21	*Developing an estate's strategy* (1999) *Developing an estates strategy* (Department of Health, 2008), updated version of previous document, but was not published until August 2008 *A risk based methodology for establishing and managing backlog* (NHS Estates, 2004) Add *BS EN 1789: 2007 Medical vehicles and their equipment* for ambulance trusts only *Design for patient safety: Towards future ambulances* (National Patient Safety Agency and The Helen Hamblyn Trust, 2007) for ambulance trusts only *National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services* (Ambulance Service Association, 2004) for ambulance trusts only

	BS EN 1789:2000 Medical vehicles and their equipment – road ambulances
C22ac	*Choosing health: making healthier choices easier* (Department of Health 2004) *Tackling health inequalities: a programme for action* (Department of Health 2003) *Making partnerships work for patients, carers and service users* (Department of Health 2004) *Guidance on Joint Strategic Needs Assessment* (Department of Health, 2007)
C23	*Choosing health: making healthy choices easier* (Department of Health 2004) *Delivering Choosing health: making healthier choices easier (*Department of Health 2005) *Tackling Health Inequalities: A programme for action* (Department of Health 2003) *Guidance on Joint Strategic Needs Assessment* (Department of Health, 2007)
C24	*Getting Ahead of the Curve* (Department of Health, 2002) *Beyond a major incident* (Department of Health, 2004)

Part Two

Criteria for assessing core standards in 2008/09 for primary care trusts as a commissioner of services

Overview

These are the 2008/09 criteria for assessing core standards between 1 April 2008 and 31 March 2009 for primary care trusts (PCTs) as **commissioning** bodies within England. As for the provider criteria in previous years, we have set out our criteria as 'elements' for each of the core standards.

What has changed?

As set out in the Healthcare Commission's publication *The annual health check in 2008/09: Assessing and rating the NHS,* our assessment of PCTs for the performance rating in 2008/09 will have a different structure from previous years. This will allow us to report separately on the performance of services that a PCT provides itself (such as community health services) and its role as a commissioner of healthcare services for its local community. We have developed a set of criteria for assessing PCTs as commissioners. These revised criteria clarify how the assessment of standards relates to commissioning.

For the purposes of assessing PCTs as commissioners, the core standards, and their component elements, have been considered from three perspectives, which are combined into a single declaration. Each of these is described below:

- **PCT commissioners (as corporate bodies)** – ie, standards as they apply to any organisation, regardless of its functions. These standards are about how organisations function. Examples of standards in this category include those which relate, for example, to the wellbeing of staff.

- **PCT commissioners (commissioning functions)** – ie, the standards that are relevant to a PCT's role as a commissioner. There are aspects of many of the standards applicable to PCTs which relate to their commissioning function. In addition there are a number of standards that **particularly** concern commissioning activities, namely: C5a, C6, C7e, C17, C18, C22 a&c, C22 b, C23 and C24. These cover issues such as assessing the health needs of the population.

- For the purposes of this overview section, when we refer to PCTs commissioning services, we are referring to commissioned services in their broadest sense (including those commissioned from NHS providers, the independent sector, and independent contractors) unless otherwise specified. However, within the detail of the criteria, the "commissioned services" and "independent contractor" tests remain distinct from one another.

- **PCTs' role in relation to the quality and safety of its commissioned services** – ie, whether it has 'appropriate mechanisms' in place and has taken 'reasonable steps' with regard to commissioned services and independent contractors respectively. **These tests apply to every standard, in the same way as they have in previous years. More information on these tests is given later in this section.**[1]

[1] Further information regarding the commissioned services and independent contractors tests can be found on pages 54 – 62 of this document.

Declaration

In its declaration as a commissioner, the PCT will be required to declare its assurance of compliance against every standard in two ways:

1) as a corporate body and commissioning activities **and**
2) in relation to its commissioned services and independent contractors

The declaration will encapsulate its corporate and commissioning activities, as well as its assurance of compliance with regard to commissioned services and independent contractor tests (as described above). **This declaration will be entirely separate from their declaration as a provider organisation**, and the criteria have been amended to reflect the focus on the PCT as a commissioning body and with regard to its commissioning functions.

There may be occasions where the same evidence will inform a PCT's declaration as a commissioner, and its separate declaration as a provider (for example, where services are shared). This will depend on the way in which PCTs have separated out their governance arrangements for commissioner and provider functions.

PCTs have asked the Healthcare Commission to ensure that the system of assessment is as stable as possible. We have therefore made only those changes to the criteria which are necessary to enable us to provide the necessary focus on commissioning.

In addition, there are changes to criteria and rationales which aim to increase their clarity. Where these relate to the criteria for provider organisations, these are explained fully in Part 1 of this document which relates to PCTs as providers.

How should trusts' boards consider the elements?

The criteria are written to reflect the requirements made of PCTs as commissioners throughout the assessment year; they do not introduce new requirements, but they do make more explicit some of the obligations on PCTs as commissioners. As in the two previous years of the core standards assessment, we ask that NHS trust boards determine whether they have reasonable assurance of compliance with a standard, without a significant lapse, from 1 April 2008 to 31 March 2009. As part of the annual health check, trusts will then be asked to make a declaration of their assurance of compliance for the whole year. As standard contracts are applied more widely within the NHS, in future assessment years the requirements of these contacts may be used to underpin the criteria.

Commissioned services and independent contractors

As in previous years, the 2008/09 assessment of PCTs' assurance of compliance with core standards includes reference to the PCT commissioner's role in relation to the quality of its commissioned services and the arrangements it makes with its independent contractors. To underline the importance of this role, we have explicitly included reference to this for every standard (for commissioned services) and for relevant aspects of each element (for independent contractors). The generic nature of the tests applied remains. When considering how to complete their declaration, we ask PCTs to consider the services provided by commissioned services and independent contractors in the following ways[2]:

[2] Please note, PCTs are asked to declare at the (more detailed) element level when thinking about independent contractors, but at the level of the whole standard, for commissioned services.

The commissioned services test

PCTs are expected to have appropriate mechanisms in place for identifying and responding to significant concerns regarding the providers' services that they commission. A PCT commissioner should consider whether it has appropriate mechanisms through which it can identify and where appropriate respond to any significant concerns with regard to those commissioned services being consistent with the overall standard.

The Healthcare Commission recognises that PCTs will differ in the mechanisms used in relation to quality and safety in their commissioned services. PCTs will be formalising their requirements and monitoring arrangements more through detailed contractual clauses and service level agreements and, increasingly, the new standard contracts.

For PCTs (whether in their capacity as co-ordinating PCTs or associate PCTs) that are in contractual agreements using the NHS standard contract for acute trusts, "mechanism" means complying with the obligations contained in that contract (which include requirements relating to the *Standards for Better Health*). Specific examples are:

- Clause 33 of the standard NHS contract for acute services sets down specific duties on PCTs and acute providers in relation to Clinical Quality Reviews which could be applicable when considering whether appropriate mechanisms are in place in relation to core standards which relate to the quality of clinical care – for example C 5a.
- Clause 15 of the standard NHS contract for acute services sets down specific duties on PCTs and acute providers in relation to reporting and learning from incidents which could be applicable when considering whether appropriate mechanisms are place in relation to core standard C1a.

PCTs will also be taking part in the world class commissioning assurance process which includes an assessment of PCT performance against a set of indicators, competencies and governance arrangements. In relation to competency 10 (which expects PCTs to "effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes for value for money") the guidance says that:

> "Commissioners will need to manage their relationships and contracts with providers in order to ensure that they deliver the highest possible quality of service and value for money. This will involve working closely with providers to sustain and improve provision, engaging in constructive performance discussions to ensure continuous improvement. Commissioners will need to ensure that their providers understand and promote the values of the NHS."

The assurance framework looks to PCTs to:
- Use performer information.
- Implement regular provider performance discussions.
- Have mechanisms for resolving ongoing contractual issues.

The level at which PCTs are performing against this competency will vary, but at level 2, criteria include:

- Data is accessible and used to monitor provider performance.
- Regular reports (at least monthly) addressing performance of major providers, acute care, primary and community care and social care for internal and external use.
- Contracts indicate when intervention is required. etc[3].

Relationship with world class commissioning assurance – general guidance

In a number of cases there are similarities between some components of the world class commissioning competencies and aspects of the Healthcare Commission's core standards assessment (see table below). The Healthcare Commission is working closely with the Department of Health (DH) to ensure that the annual health check's core standards assessment and DH's world class commissioning assurance systems are complementary and some additional information on this is given below.

The Healthcare Commission will use the outputs from the world class commissioning assurance process as one of the large number of items in its screening process, which aims to verify the declarations that PCTs make in relation to core standards. However, the Healthcare Commission will **not** be using the outputs of the world class commissioning assurance programme to provide assurance in relation to any standard, and PCTs must still make a declaration of compliance for the whole year of assessment, in the usual way. This is because world class commissioning assurance cannot provide assurance for the whole of the 2008/09 assessment year. In addition, the standards and competencies, largely, are not directly comparable. We will be undertaking some work with DH in the coming year to examine the correlation between the two systems, and to explore how this might help streamline the assessments in future.

However, for the number of standards where there are similarities, our intention is that the gathering of evidence by PCTs will enable them to minimise duplication of effort in collecting and collating evidence. The areas of similarity are described more fully in the table below.

[3] *World class commissioning: Commissioning assurance handbook* (Department of Health, Dec 2007)

Table A – Similarities between core standards assessment and world class commissioning competencies

Core standard (commissioner)	World class commissioning competency
C14 c) 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. **Element one** The PCT acts on, and responds to, complaints appropriately and in a timely manner and acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the PCT. **Element two** Demonstrable improvements are made to the delivery of a PCT's functions as a commissioning body as a result of concerns and complaints from patients/ service users, relatives and carers.	**3)** Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health.
C17 The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services. **Element one** The PCT seeks and collects the views and experiences of patients/service users, carers and the local community, particularly those people who are seldom listened to, on an ongoing basis when commissioning, designing, planning, and improving healthcare services, as required by Section 242 of the National Health Services Act 2006 in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. In doing so the PCT acts 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, and* ▪ *the Equality Act 2006*;	**3)** Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health.

and where appropriate, having due regard to the associated codes of practice. • The phrase *"public body duties"* is defined in C7e. **Element two** The PCT demonstrates to patients/ service users, carers and the local community, particularly those people who are seldom listened to, how it has taken their views and experiences into account in commissioning, designing, planning, and improving healthcare services in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. The PCT should act 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, and* ▪ *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.	
C22 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. **Element one** The PCT 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 through the Local Strategic Partnership(s), children's partnership arrangements, Crime and Disorder Reduction Partnerships, and other recognised partnerships, such as Youth Offending Teams.	**1)** Are recognised as the local leader of the NHS. **2)** Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities. **3)** Proactively seek and build continuous and meaningful engagement with the public and

Element two The PCT works closely with partners in coordinating health equity audits, conducting a comprehensive Joint Strategic Needs Assessment (JSNA), and contributing to developing the health and health-related Local Area Agreements, which are reflected in their strategic or operational planning. **Element three** Commissioning decisions are taken based on the JSNA and in line with the LAA, and taken in consultation with clinicians, local authorities and other partners, including patients, the public and their representatives. **Element four** The PCT monitors and reviews its contribution to public health partnership arrangements and takes action as required.	patients, to shape services and improve health **5)** Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements. **6)** Prioritise investment according to local needs, service requirements and the values of the NHS.
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. **Element one** The PCT coordinates health equity audit, equality impact assessments and assesses the health needs of its local population, including analysis of its demography, health status and health inequalities, health and social care use, and patient and public views and contributes this to the joint strategic needs assessment (JSNA). **Element two** The PCT's commissioning decisions and local target setting are informed by intelligence from its assessment of health needs, the JSNA, the Director of Public Health's Annual Public Health Report (APHR), information from health equity audits, equality impact assessments, evidence of effectiveness and national priorities.	**2)** Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities. **3)** Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health **5)** Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and

Element three The PCT commissions good-quality, evidence-based programmes and services to improve health and well-being, and narrow health inequalities, based on the needs of the population served. **Element four** The PCT monitors and reviews its commissioning decisions in relation to improving health and tackling health inequalities and, where appropriate, makes changes. **Element five** The PCT implements policies and practices to improve the health and wellbeing of its workforce.	requirements. **6)** Prioritise investment according to local needs, service requirements and the values of the NHS. **7)** Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes.

The Department of Health will also be relying on some key aspects of current regulatory activities (including the Core Standards Assessment from 2007/08) to support world class commissioning assurance (particularly in relation to the Board section of the governance assessment, financial performance via the Audit Commission's Use of Resources assessment, some indicators (eg national cancer waiting time targets), and by drawing on the Commission's patient survey programme where relevant. DH will include this information in its contextual information for WCC analysts. The DH will also send SHAs details of core standards for which the PCT is not assured of compliance. All core standards for which the PCT is not assured of compliance and the competency to which they are relevant will be included in the briefing for panel members undertaking world class commissioning reviews.

The independent contractor test

PCTs should consider whether they have taken **reasonable steps** to assure themselves that the services provided by independent contractors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the elements set out in the criteria document. In doing so, they will need to have regard to the published **provider** criteria, rather than those that relate to the corporate and commissioning functions.

We recognise that PCTs have different ways of taking reasonable steps to engage and communicate with independent contractors. For example, they could do this through the work of the executive committee (or PEC), by reviewing information from the quality outcomes framework (QOF) or by engaging with local networks (for example the local dental practice board, local pharmacy committee, local optometry committee.)

Our discussions with PCTs regarding current practice in holding independent contractors to account indicates that systematic rather than ad hoc arrangements are in place in many PCTs. Some examples are given below, but this list is intended to be neither prescriptive nor exhaustive.

Their overall approach

- The PCT has established arrangements with independent contractors, setting out: the approach to monitoring, the performance information to be collected, and how unsatisfactory performance will be dealt with, for example through the administration of their performers' lists.

The structures and processes in place in relation to independent contractors

- The PCT has clearly identified staff responsible for addressing primary care commissioning.

The nature of engagement with independent contractors

- The PCT promotes awareness of the need for services to be consistent with the relevant aspects of criteria among independent contractors and has systematic processes for engaging with the full range of independent contractors.

The nature of the mechanisms in place to understand performance in relation to independent contractors

- The PCT is using the mechanisms already in place for the performance management of independent contractors, to seek assurance on core standards, for example contract monitoring[4].

[4] For example, part 22 of the Standard GMS contract states that the Contractor shall comply with all relevant legislation and have regard to all relevant guidance issued by the PCT, SHA or SoS.

Whether there are mechanisms to support improvement where necessary

- The PCT has in place a range of support and incentives to address issues of non-compliance and poor performance.

The PCT may wish to consider the above when considering whether it has taken reasonable steps to ensure that the services provided by independent contractors are consistent with the relevant aspects of the elements set out in the criteria document.

Reasonable assurance

Reasonable assurance, by definition, is not absolute assurance. Conversely, 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 reasonable, trusts must reflect 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 PCT's objectives will include compliance with the core standards. This will be managed through the trust's routine processes for assurance.

Significant lapse

Trust 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. 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 or potential impact of a lapse, such as the loss of more than £1 million or the death of a patient 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 commission, their functions and the population they serve), and 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.

PCTs' boards should consider **all** aspects of their services when judging whether they have reasonable assurance that they are meeting the published criteria. When PCTs provide services directly, they have primary responsibility for ensuring they meet the core standards. In this respect, PCTs will be making a separate declaration in respect of any services that they directly provide, either alone or in partnership.

For PCT commissioners, boards will need to make a declaration that relates to their responsibilities as corporate bodies and commissioners of services. In addition, they

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Examples of aspects of the NGMS contract that relate to core standards include: requirements on premises, information for patients, complaints, use of personal information, access to practice lists and discrimination, medicines management, safeguarding children, infection control and decontamination, appropriate professional registration, indemnity, appraisal, confidentiality of data, data protection, employment rights, clinical governance, and consent.

should consider whether they have assurance of compliance for commissioned services and independent contractors, as described above.

Equality, diversity and human rights

One of the Healthcare Commission's strategic goals continues to be 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. Note that we have run three audits of trusts' websites, looking for this information, and we remain concerned that many trusts are still not compliant with legislation, particularly in relation to race equality.

Using the findings of others

Please see Appendix 3 for information regarding using the findings of others for commissioning criteria.

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

All legislation, codes of practice and guidance referred to in the core standard criteria are up to date at 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 and will be assessed on this basis.

Part Two – 2008/09 Criteria for assessing core standards for PCTs as commissioner of services

In the following pages you will find the criteria for the assessment of core standards in 2008/09 for PCT commissioners. This section cross-refers to the provider criteria, along with rationales for any changes. They are laid out in order of the core standards and grouped by domain, and the domain outcomes and standards themselves are quoted.

Part Two – 2008/09 PCT commissioning criteria

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Commissioning decisions are informed by information arising from the analysis of incidents reported to it by the providers of commissioned services (in accordance with the PCT's own requirements set down for incidents to be reported to it by its commissioned services) and the national analysis of incidents.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C1a rationale (element one)

- PCTs' systems to ensure that providers are reporting SUIs to them, as the commissioning body may be set down in the PCT's own policies, in policies agreed with SHAs, and / or in contractual arrangements. This element reflects that PCTs should be using information about reported incidents to inform commissioning decisions. It also recognises that for Foundation Trusts, these systems may not be in place, since the transfer of SUI performance management responsibility to commissioning PCTs is ongoing during 2008/09.

- National analysis of incidents may come from a range of organisations including the National Patient Safety Agency (NPSA), Health and Safety Executive, Medicines and Healthcare products Regulatory Agency (MHRA), Health Protection Agency, and the Counter Fraud and Security

Management Service.

- The provider elements related to incident reporting and analysis have not been replicated for commissioners, as the nature of reportable incidents for PCT commissioners do not directly concern patient safety, and therefore would go beyond the domain outcome.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one PCTs have in place policies for the timely management of all communications concerning patient safety issued from the National Patient Safety Agency (NPSA) and the Medicines Healthcare Products Regulatory Agency (MHRA) via national distribution systems, including the Safety Alert Broadcast System (SABS), the Central Alert System (CAS) the UK Public Health Link System (UKPHLS). Such policies are operated effectively.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C1b rationale (element one)

- As per provider criteria. Element amended to reflect commissioning PCTs' responsibilities to manage patient safety communications as appropriate, rather than direct implementation.

Core standard C2

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT 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".*	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two The PCT works with partners to protect children and participate in reviews as set out in *Working together to safeguard children* (HM Government, 2006).	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
Element three The PCT should have 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".	

C2 rationale (elements one, two and three)

- In March 2007 statutory guidance was published, updating previous guidance, which is based on the Children Act 2004. Compliance with this was required by October 2005 and all elements should now be in place. The guidance issued under section 11(4) of the Children Act 2004 which 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.
- PCTs have specific duties in this area to safeguard children. Section 11 of the Children Act 2004 places a duty on PCTs to ensure that in discharging their functions they have regard to the need to safeguard children and they must co-operate with the Local Authority in the establishment and operation of the Local Safeguarding Childrens Board (LSCB) and, as partners must share responsibility for the effective discharge of its function in safeguarding children. PCT Chief Executives have responsibility for ensuring that the health contribution to safeguarding children is discharged effectively across the whole local health economy through the PCT's commissioning arrangements. Where practice based commissioners undertake commissioning services, this should be done in partnership with PCTs who need to ensure their safeguarding duties are fulfilled. The PCT must also ensure that all health organisations, including the independent healthcare sector with whom they have commissioning arrangements, have links with a specific LSCB, and that health agencies work in partnership in accordance with their agreed LSCB plan.

Statutory guidance (Section 5) states that PCTs should be "ensuring that their staff are trained and competent to be alert to potential indicators of abuse or neglect in children, know how to act on their concerns and fulfil their responsibilities in line with LSCB procedures".

Core standard C3

Healthcare organisations protect patients following NICE Interventional Procedures guidance.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**Not applicable**

C3 rationale (element one)

- Not applicable – These procedures are not directly undertaken by a commissioning body.

Core standard C4a

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare 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).

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C4a rationale (element one)

- Not applicable to this standard, as the Hygiene Code is targeting NHS providers who are commissioning services relevant to this standard (not PCT commissioning).

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Not applicable	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C4b rationale (elements one and two)

- Not applicable as concerns the provision of clinical care

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs

will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C4c rationale (element one)

- Not applicable as the Hygiene Code is targeting NHS providers who are commissioning services relevant to this standard (not PCT commissioning).

Core standard C4d

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Not applicable	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C4d rationale (elements one and two)

- Not applicable as more relevant to commissioned services and independent contractors than the commissioning process.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C4e rationale (element one)

- Not applicable to commissioning bodies.

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 NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The PCT funds the implementation of relevant NICE technology appraisals within its commissioned services for patients whose clinicians recommend treatments in line with NICE technology appraisals. 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 PCT can demonstrate how it takes into account nationally agreed guidance where it is available as defined in National Service Frameworks (NSFs), NICE clinical guidelines, national plans and nationally agreed guidance, when commissioning and when planning services, care and treatment. The PCT has mechanisms in place to identify guidance that is relevant to the services it commissions and meet the needs of its local population. The PCT has mechanisms in place to: 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 guidelines.

Independent contractors test

For each relevant provider element

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C5a rationale (elements one and two)

- As for provider rationale. Wording adjusted to make it relevant to PCTs' commissioning and planning functions.

- The Secretary of State's directions to the service relate to the funding of technology appraisal guidance The National Health Service Act 1977, Directions to Primary Care Trusts and NHS Trusts for the Funding of Technology Appraisal Guidance from the National Institute for Clinical Excellence (NICE). July 2003, and all subsequent amendments and further directions.

Core standard C5b

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For provider element one only** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
Element two Not applicable	**Element two** Not applicable

C5b rationale (elements one and two)

- Not applicable – This concerns the delivery of clinical care.

Core standard C5c

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C5c rationale (element one)

- Not applicable – as concerns the provision of clinical care

Core standard C5d

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Not applicable	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C5d rationale (elements one and two)

- Not applicable.

Core standard C6

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The PCT works in partnership with other health and social care organisations to commission services (including joint commissioning) 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 transfer) across organisational boundaries.

Where appropriate, these arrangements are in accordance with:

- Section 75 partnership arrangements of the National Health Service Act 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 national strategies (for example, the National Service Framework for Mental Health (DH, 1999), the National Service Framework for Older People (DH, 2001) and the Cancer Reform Strategy (DH, December 2007);
- the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (DH, 2007).

Element two

Not applicable

Independent contractors test

For each relevant provider element

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C6 rationale (element one)

- Element one - As per provider rationale. Wording has been amended to reflect PCTs' commissioning functions.

- The structure and wording of the elements have been amended to better reflect the standard and to clarify that the partnership responsibilities being assessed include those of the organisation. Element one has been made more explicit to indicate that we would expect organisations to be assured that they using partnerships to ensure that patients' needs are met when they move between organisations and when more than one organisation is contributing to patients' care. Various guidance and legislative documents are relevant to this standard. Organisations are legally obliged to comply with arrangements laid out in Section 75 of the National Health Service Act 2006 and the Community Care (Delayed Discharges etc.) Act 2003. The additional documents listed in element one are all good practice guidance or strategic frameworks which organisations are not mandated to follow. The Commission would, however, expect an organisation to have good reason and clear rationale for following a different course of action from that set out in these documents.

- Principles and Rules of Cooperation and Competition (principle 2) states that "Providers and commissioners must co-operate to ensure that the patient experience is of a seamless health services regardless of organisational boundaries, and to ensure service continuity and sustainability"(DH, 13/12/07 Gateway ref. 9244).

C6 rationale (element two)

- Not applicable as this concerns the delivery of care

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one
The PCT has effective clinical governance arrangements in place to promote clinical leadership and improve and assure the quality and safety of clinical services for patients/ service users.

Element two
The PCT has effective corporate governance 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 PCT systematically assesses and manages its risks, both corporate and clinical, in order to ensure probity, clinical quality and patient safety.

Independent contractors test

For each relevant provider element
For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C7a&c rationale (elements one, two and three)

- As per provider criteria.

Core standard C7b

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT 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.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C7b rationale (element one)

- As per provider criteria.

Core standard C7d

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

PCT commissioned service test (for whole standard)

Not applicable

Elements	Independent contractors test
Element one Not applicable	Not applicable

C7d rationale

- Not applicable – This standard will be measured under the use of resources quality of financial management assessment

Core standard C7e

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The PCT should challenge discrimination and respect 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 assessments) under the *"public body duties"*,* and
- *"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

Independent contractors test

For provider element one only

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

- 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)
- 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 equalities and employment legislation regarding age, disability, gender, race, religion and belief and sexual orientation, including discrimination legislation; and where appropriate, having due regard to the associated codes of practice.

Element two

The PCT 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).*

C7e rationale (elements one and two)

- As per provider criteria.
- The PCT should ensure that all documents such as service specifications, invitations to tender and service contracts, fully reflect their policy for the protection of vulnerable adults and specify how they expect providers to meet the requirements of the policy. They should require that any allegation or complaint about abuse that may have occurred within a service subject to contract specifications be brought to the attention of the contracts officer of any purchasing authority. Monitoring arrangements should include adult protection issues.
- PCTs are obliged to undertake equality impact assessments of relevant functions and policies.

Such assessments should consider the impact on the promotion of race, disability and gender equality as a minimum. Commissioning of goods facilities and services by a PCT carries with it the potential for adverse impact (for example on disabled people or on Black and Minority ethnic groups) if these services facilities or goods are not delivered equitably or are not accessible to all. PCTs should use their Commissioning function to promote equality by ensuring for example that the services it contracts out meet the needs of different groups.

Core standard C7f

Healthcare organisations meet the existing performance requirements

PCT commissioned service test (for whole standard)

Not applicable

Elements	Independent contractors test
Element one Not applicable	Not applicable

C7f rationale

- Not applicable – This standard will be measured under the indicators-based assessment

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one PCT staff are supported, and know how, to 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)	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with

the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C8a rationale (element one)

- No changes proposed

Core standard C8b

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT supports and involves its staff in organisational and personal development programmes as defined by the relevant areas of the Improving Working Lives standard at Practice Plus level and in accordance with *"employment and equalities legislation"**; and where appropriate, having regard to the associated codes of practice. 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	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
Element two PCT 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.

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

C8b rationale (elements one and two)

- As per provider criteria.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT has effective systems for managing records in accordance with *Records management: NHS code of practice* (Department of Health, April 2006), *Information security management: NHS code of practice* (Department of Health, April 2007) and *NHS Information Governance* (Department of Health, September 2007). The PCT should 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.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
Element two Not applicable	

C9 rationale (elements one and two)

- As per provider criteria

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The necessary checks are undertaken in respect of all applications for NHS positions (prospective employees) and staff in ongoing NHS employment in accordance with the NHS Employment Standards (NHS Employers) 2008 **Element two (new)** PCTs meet their specific duties in relation to ensuring that those who join their performers list as GPs medical practitioners and, dentists and ophthalmic practitioners have the appropriate checks.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C10a rationale (elements one and two)

As per provider criteria. Element 2 added to reflect PCTs' specific duties regarding independent contractors.

Core standard C10b

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT explicitly requires all employed healthcare professionals to abide by relevant codes of professional conduct. Mechanisms are in place to identify, report and take appropriate	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community

action when codes of conduct are breached.

pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C10b rationale (element one)

- As per provider criteria

Core standard C11a

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT recruits staff in accordance with relevant *"employment and equalities legislation"** and with particular regard to employment and equalities regulations including legislation regarding age, disability, gender, race, religion and belief, and 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 discrimination legislation; 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.	**For provider element one only** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
Element two The PCT 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 as a commissioning organisation.	

C11a rationale (elements one and two)

As per provider criteria. Wording adjusted to reflect PCTs' commissioning functions.

Core standard C11b

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Staff participate in relevant mandatory training programmes **Element two** Staff and students participate in relevant induction programmes **Element three** The PCT verifies that staff participate in mandatory training programmes (including those referred to in Element 1). Where trusts identify non-attendance, action is taken to rectify this.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C11b rationale (elements one, two and three)

- Rationale as per provider criteria.
- Element three has been amended to cover PCT verification of staff participation in all mandatory training programmes. This would include training necessary to ensure probilty (as per provider criteria), but given the commissioner role, would be less likely to concern clinical quality and patient safety.

Core standard C11c

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT ensures that all staff concerned with all aspects of the commissioning of healthcare have	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that

opportunities to participate in professional and occupational development at all points in their career 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; and 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.

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

the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C11c rationale (elements one and two)

- As per provider criteria. Wording adjusted to reflect PCTs' commissioning function.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT 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 (Department of Health 2005).	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C12 rationale (element one)

- As per provider criteria.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The PCT ensures that staff treat patients/ service users, carers and relatives with dignity and respect and, where relevant, identify, and take preventive and corrective actions where there are issues and risks with dignity and respect

Element two

In commissioning healthcare services, the PCT seeks to meet the needs and rights of different patient groups with regard to dignity including by meeting the relevant requirements 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, and*
- *the Equality Act 2006.*

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

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

Independent contractors test

For each relevant provider element

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C13a rationale (element ones and two)

- As per provider criteria. PCTs may have contact with patients, carers, and relatives within its commissioning function, so this element will apply.
- As per provider criteria. Wording adjusted to reflect PCTs' commissioning function.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two The PCT provides patients/service users, including those with language and/or communication support needs, 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)	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
Element three The PCT monitors and reviews current practices to ensure effective consent processes relating to element 2 (on the use and disclosure of confidential information held about them).	

C13b rationale (elements one, two and three)

- Not applicable – as concerns the delivery of clinical care.
- As per provider criteria. Wording adjusted to reflect PCTs' commissioning function. Element three refers to element two.

Core standard C13c

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

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one When using and disclosing patients'/ service users personal information, PCT staff act in accordance with the Data Protection Act 1998, the Human Rights Act 1998, the Freedom of Information Act 2000 and Confidentiality: NHS code of practice (Department of Health 2003), Caldicott Guardian Manual 2006 (Department of Health 2006) PCTs should 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.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C13c rationale (element one)

- As per provider criteria.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one PCTs ensure that patients/ service users,	**For each relevant provider element** For independent contractors, the PCT should

relatives and carers are given suitable and accessible information about, and can easily access, a formal complaints system relating to the PCT's functions as a commissioning body, including information about how to escalate their concerns; and the PCT acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to them.

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

have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C14a rationale (elements one and two)

As per provider criteria. Wording amended to reflect that this element relates to PCTs' commissioning functions.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT has systems in place to ensure that patients/ service users, carers and relatives are not treated adversely as a result of having complained.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C14b rationale (element one)

- No change.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT acts on, and responds to, complaints appropriately and in a timely manner and acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the PCT.	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Demonstrable improvements are made to the delivery of a PCT's functions as a commissioning body as a result of concerns and complaints from patients/ service users, relatives and carers.	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C14c rationale (elements one and two)

- As per provider criteria. Wording amended to reflect PCT commissioning functions.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	Not applicable
Element two Not applicable	

C15a rationale (elements one and two)

- Not applicable as standard concerns provision of food to patients/ service users.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	Not applicable
Element two Not applicable	
Element three Not applicable	

C15b rationale (elements one, two and three)

- Not applicable as standard concerns provision of food to patients/ service users.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT has identified the information needs of its service population, and provides suitable and accessible information on the services it commissions 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:	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

- *the Race Relations (Amendment) Act (2000),*
- *the Disability Discrimination Act (2005), and*
- *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 PCT provides patients/ service users and, where appropriate, carers with sufficient and accessible information on the services it commissions, including those patients/ service users and carers with communication or language support needs. In doing so PCTs 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).

C16 rationale (elements one and two)

- As per provider criteria. Wording adjusted to reflect PCTs' functions.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The PCT seeks and collects the views and experiences of patients/service users, carers and the local community, particularly those people who are seldom listened to, on an ongoing basis when commissioning, designing, planning, and improving healthcare services, as required by Section 242 of the National Health Services Act 2006 in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. In doing so the PCT acts 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, and*
- *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 PCT demonstrates to patients/ service users, carers and the local community, particularly those people who are seldom listened to, how it has taken their views and experiences into account in

Independent contractors test

For each relevant provider element

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

commissioning, designing, planning, and improving healthcare services in accordance with *Strengthening Accountability, patient and public involvement policy guidance – section 11 of the Health and Social Care Act 2001* (Department of Health 2003) and any subsequent statutory guidance introduced in the assessment year. The PCT should act 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, and*
- *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.

C17 rationale (elements one and two)

- As per provider criteria. Wording adjusted to reflect PCTs' commissioning function. Reference to PCTs "commissioning, designing, planning, and improving healthcare services" relate to their commissioning function.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one When commissioning services, the PCT takes steps to enable all members of the population it serves to access them equally, including 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 "*public body duties*"*statutes: • *the Race Relations (Amendment) Act 2000,* • *the Disability Discrimination Act 2005, and* • *the Equality Act 2006* ;	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

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

* The phrases *"public body duties"* is defined in C7e.

Element two
In commissioning services, the PCT takes steps to ensure that patients/ service users are offered 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.

C18 rationale (elements one and two)

- As per provider criteria. Wording adjusted to reflect PCTs' commissioning function, which is one step removed from direct service provision.
- In addition, PCTs are obliged to undertake equality impact assessments of relevant functions and policies (originally proposed within the Race Relations Amendment Act 2000, and subsequently other equality legislation). Such assessments should consider the impact on the promotion of race, disability and gender equality as a minimum. Commissioning of goods facilities and services by a PCT carries with it the potential for adverse impact (for example on disabled people or on Black and Minority ethnic groups) if these services facilities or goods are not delivered equitably or are not accessible to all. PCTs should use their Commissioning function to promote equality by ensuring for example that the services it contracts out meet the needs of different groups.

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.

PCT commissioned service test (for whole standard)

Not applicable

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** Not applicable

C19 rationale (elements one)

- Not applicable – This standard will be measured under the indicators-based assessment

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements

Element one

The healthcare organisation effectively manages the health, safety and environmental risks to staff and visitors, in accordance with all relevant 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 PCT, 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.

Element two

The PCT provides a secure environment which protects, 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

Independent contractors test

For each relevant provider element

For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

amended 2006) and *Secretary of State directions on NHS security management measures* (Department of Health 2004, as amended 2006)

C20a rationale (elements one and two)

- As per provider criteria. Wording amended to reflect PCTs role in commissioning services, and focus on staff and visitors, rather than patients, as clinical care is not provided by PCT commissioners.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Not applicable	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C20b rationale (elements one and two)

- Not applicable as this standard relates to provision of healthcare. The confidential handling of patient records will be assessed under C9.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one Not applicable	**For provider element one only** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*
Element two Not applicable	*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C21 rationale (elements one and two)

- Not applicable as concerns provision of clinical care

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT 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 through the Local Strategic Partnership(s), children's partnership arrangements, Crime and Disorder Reduction Partnerships, and other recognised partnerships, such as Youth Offending Teams.	Not applicable
Element two The PCT works closely with partners in coordinating health equity audits, conducting a comprehensive Joint Strategic Needs Assessment (JSNA), and contributing to developing the health and health-related Local Area Agreements, which are reflected in their strategic or operational planning.	
Element three Commissioning decisions are taken based on the JSNA and in line with the LAA, and taken in consultation with clinicians, local authorities and other partners, including patients, the public and their representatives.	
Element four The PCT monitors and reviews its contribution to public health partnership arrangements and takes action as required.	

C22a&c rationale (elements one, two three and four)

- As per provider criteria. Updated to reflect current guidance.
- Element one – "Promote and protect" more closely reflects the stands. Children's partnership arrangements are of increasing importance at a local level.
- Element two – The JSNA came into effect in April 2008 as a statutory requirement in relation to needs assessment and feeds into the local joint plan, the Local Area Agreement (LAA).
- Element three – See element 2.
- Element four – This reflects the standard and contributes to its outcome focus.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT's policies and practice to improve health and narrow health inequalities are informed by the local director of public health's (DPH) annual public health report (APHR).	Not applicable

C22b rationale (element one)

- No change needed. The APHR continues to be seen as a key document to influence PCT policies and practice for commissioning.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one The PCT coordinates health equity audit, equality	**For each relevant provider element** For independent contractors, the PCT should

impact assessments and assesses the health needs of its local population, including analysis of its demography, health status and health inequalities, health and social care use, and patient and public views and contributes this to the joint strategic needs assessment (JSNA).

Element two
The PCT's commissioning decisions and local target setting are informed by intelligence from its assessment of health needs, the JSNA, the Director of Public Health's Annual Public Health Report (APHR), information from health equity audits, equality impact assessments, evidence of effectiveness and national priorities

Element three
The PCT commissions good-quality, evidence-based programmes and services to improve health and well-being, and narrow health inequalities, based on the needs of the population served.

Element four
The PCT monitors and reviews its commissioning decisions in relation to improving health and tackling health inequalities and, where appropriate, makes changes

Element five
The PCT implements policies and practices to improve the health and wellbeing of its workforce.

have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.*

*(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)

C23 rationale (elements one, two, three, four and five))

- Element one – The JSNA reflects current developments and updates the element. The inclusion of health inequalities better reflects the standard and contributes to domain outcomes.
- Element two – See rationale for element one above. The range of intelligence better reflects the standard.
- Element three – This focuses on the outcome of commissioning, and more closely reflects the standard.
- Element four – This adequately addresses the standard.
- Element five – This adequately addresses the standard.

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.

PCT commissioned service test (for whole standard)

For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.

Elements	Independent contractors test
Element one In commissioning services, the PCT is satisfied that the provider will protect the public by having a planned, prepared and, where possible, practised 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, and associated supplements (Department of Health, 2005, 2007) and Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic (Department of Health November 2007). **Element two** The PCT protects the public by working with key partner organisations, including through Local Resilience Forums, in the preparation of, training for and annual testing of emergency preparedness plans, in accordance with the Civil Contingencies Act 2004, The NHS Emergency Planning Guidance 2005 and associated annexes (Department of Health 2005, 2007) and Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic (Department of Health November 2007).	**For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document) *N/A for general dental practitioners and community optometrists

C24 rationale (elements one and two)

As per provider criteria. Updated to reflect current guidance. Commissioning resilience is fundamental to ensure that all organisations are able to achieve robust arrangements for dealing with incidents. PCTs provide the local management function for the NHS and operate as both providers and commissioners of services for their locality. PCTs must ensure that for all functions for which they are responsible, the highest level of service to patients is maintained regardless of what might happen to clinical/non clinical procedures or the infrastructure of facilities. The Civil Contingencies Act 2004 identifies PCTs as a 'Category 1 Responder', and imposes a statutory requirement on the PCT to have robust Business Continuity Management (BCM) arrangements in place to manage disruptions to the delivery of services, ensuring that all commissioned service providers are capable of providing services at an appropriate level. The PCT BCM requirements should be explicitly described and covered by commissioning, procurement and contract management processes.

Appendix 3 – Healthcare Commission's use of the findings of others in the Core standards assessment 2008/09 of PCTs as Commissioners

Use of the findings of others

We will continue to make use of the findings of others and have reviewed how we do this in order to increase this where possible, and to ensure that it is effective, both in reducing burden on trusts and also in targeting our inspections. Note that, as in 2007/08, we will make use of others' **in-year findings** – i.e. findings based on observance of compliance during the assessment year (i.e. 31 March 2008 to 1 April 2009), as evidence of assurance of compliance during the year 2008/2009. Findings of others relating to recent years will be used to help target inspections.

Mandatory assessment of the NHS Litigation Authority's Risk Management Standards has been suspended for PCTs for the 2008/09 assessment year. However, we will still make in-year use of their findings for PCTs who undergo volunteer assessment or have achieved **in-year** (i.e. 31 March 2008 to 1 April 2009) level 2 (or 3) in 2008/09 where this provides a level of assurance of compliance.

In year findings of others will also be used in our screening process to help target inspections; so that for example where there are positive findings in relation to a trust, this will reduce the chances of that trust being selected for inspection.

As well as the Healthcare Commission's use of the findings of others in this way, trusts also have the option of using findings of others that relate to matters within the assessment year as part of their assurance processes, but it is not a requirement and it is always open to trusts to assure themselves of compliance with the core standards in other ways.

Appendix 4 – Standards and elements applicable to independent contractors

When making its declaration, each PCT should consider whether it has taken reasonable steps to ensure that its independent contractors are meeting the standards. The Healthcare Commission recognises that each PCT will have different arrangements in place through which they do this, and that the arrangements will be different for the each of the independent contractor groups.

In the table below we have set out the relevant standards that the Healthcare Commission will apply the 'reasonable steps' assessment in the 2008/09 assessment. For the standards where we will not apply the reasonable steps, for a particular independent contractor group, this is marked with an N/A. The standards identified as N/A, are generally where the assessment focuses on the role of the PCT (such as C22a&c – public health partnerships), or where the standards are not relevant to the services provided by the contractor (such as C15 – food).

Standard	General Practitioner	General dental practitioners	Community pharmacists	Community optometrists
C1a	√	√	√	√
C1b	√	√	√	√
C2	√	√	√	√
C3	N/A	N/A	N/A	N/A
C4a	√	√	N/A	√
C4b	√	√	√	√
C4c	√	√	√	√
C4d	√	√	√	√
C4e	√	√	√	X
C5a	√	√	√	√
C5b	√ (element one for GP registrars and medical students)	N/A	N/A	N/A
C5c	√	√	√	√
C5d	√	√	√	√
C6	√	√	√	√
C7ac	√	√	√	√
C7b	√	√	√	√
C7e	√ (element one)	√ (element one)	√ (element one))	√ (element one)
C8a	√	√	√	√
C8b	√	√	√	√
C9	√	√	√	√
C10a	√	√	√	√
C10b	√	√	√	√
C11a	√ (element one)	√ (element one)	√ (element one)	√ (element one)
C11b	√	√	√	√
C11c	√	√	√	√
C12	√	√	√	√
C13a	√	√	√	√

Standard	General Practitioner	General dental practitioners	Community pharmacists	Community optometrists
C13b	√	√	√	√
C13c	√	√	√	√
C14a	√	√	√	√
C14b	√	√	√	√
C14c	√	√	√	√
C15a	N/A	N/A	N/A	N/A
C15b	N/A	N/A	N/A	N/A
C16	√	√	√	√
C17	√	√	√	√
C18	√	√	√	√
C20a	√	√	√	√
C20b	√	√	√	√
C21	√	√	√ (element one)	√ (element one)
C22ac	N/A	N/A	N/A	N/A
C22b	N/A	N/A	N/A	N/A
C23	√	√	√	√
C24	√ (communicable disease control)	N/A	√ (communicable disease control)	N/A

REPORT TO: Healthy Halton Policy and Performance Board

DATE: 10th March 2009

REPORTING OFFICER: Strategic Director – Health and Community

SUBJECT: Consultation on Application for NHS Foundation Trust status

WARDS: Borough-wide

1. PURPOSE OF THE REPORT

1.1 To provide members of the Healthy Halton Policy and Performance Board with information on the 5 Boroughs Partnership NHS Trust's consultation regarding its application for Foundation Trust status and its organisational proposals.

1.2 RECOMMENDATION: That

1.3 The Partnership Board scrutinises the Trust's proposals, as contained within the Consultation document, as part of the statutory requirement for public consultation and for Overview and Scrutiny of local healthcare provision;

1.4 Following consideration of the consultation proposals and questions, the Committee provides the Trust with any comments arising from its deliberations, within the consultation period which commenced on 26th January 2009 and ends on 19th April 2009.

2. SUPPORTING INFORMATION

2.1 NHS Foundation Trusts are established under the Health and Social Care (Community Health and Standards Act) 2003 ('the 2003 Act'). They have grown out of the wider NHS reform programme, offering greater autonomy and freedoms for NHS organisations within a national framework of standards and inspections.

2.2 All NHS Provider Trusts have been tasked with achieving the position at which they can be considered as potential Foundation Trusts. A Foundation Trust is an NHS organisation that operates on the principle of working with its members for public benefit. A Foundation Trust remains part of the NHS and maintains the principles and standards of the NHS, such as delivering services without charge.

2.3 Foundation Trusts are subject to NHS standards, performance measures and inspection processes. Foundation Trusts are overseen by an independent regulator, Monitor, and inspected by the Healthcare Commission (to be replaced by the Care Quality Commission in April 2009), which is the body that ensures that Foundation Trusts meet their obligations.

2.4 NHS Foundation Trusts are:

- accountable to local people, who can become 'members' of the Foundation Trust and be elected to the Council of Members;
- free to retain and build up surpluses that they generate and decide how to use these funds for the benefit of patients, service users and the communities they serve;
- able to borrow from commercial sources within limits set by Monitor;
- able to more easily restructure and modernise in order to increase service capacity and efficiency.

Trusts must be able to demonstrate that they are:

- Legally Constituted
- Financially viable
- Well Governed

2.5 5 Boroughs is now ready to be considered for Foundation Trust status. Significant improvements have been made over the last twelve months in managing our finances and in improving services. During the last year the 5 Boroughs Partnership NHS Trust has been successful in achieving Level 2 of the NHS Litigation Authorities' assessment of its ability to manage risk. The Trust is one of only four mental health trusts that have achieved this position. In addition, the Trust's submission for the Annual Health Check was assessed by the Healthcare Commission as achieving a rating of 'Excellent' for the Quality of Services, having been assessed as 'Fair' in the previous year.

2.6 The Trust's consultation document describes its proposals for the future organisational arrangements for governance, which comprises three main components:

- a membership community made up of local people, service users, their carers and staff (enhanced local accountability)
- a Council of Members, comprising elected members of the public and staff along with people appointed from partner organisations and chaired by the Trust's Chairman

- a Board of Directors made up of a Chairman and Non-Executive Directors appointed by the Council of Members, a Chief Executive appointed by the Non-Executive Directors with the approval of the Council of Members and Executive Directors appointed by the Chief Executive and Non-Executive Directors.

2.7 Copies of the Consultation document have previously been provided for circulation to members of the Health and Social Care Partnership Board.

3. POLICY IMPLICATIONS

3.1 Nil as a consequence of this report or the consultation process.

4. OTHER IMPLICATIONS

4.1 Foundation Trusts are accountable to their local membership and the communities they serve. Part of that accountability is the inclusion of nominated representatives of partner organisations on the Council of Members. Representation of Halton Borough Council is included in the Trust's proposals for the construct of the Council of Members.

5. RISK ANALYSIS

5.1 The Trust's proposals provide an opportunity for the Council to be directly involved in the governance of the organisation through its nominated representative in addition to the existing Partnership processes and the Overview and Scrutiny function.

6. EQUALITY AND DIVERSITY ISSUES

6.1 It is a requirement of Foundation Trusts that their membership reflects the demography of the populations they serve. The Trust will actively recruit members, in a targeted manner if this is required, to ensure that its membership is diverse and that opportunity for election to the Council of Members is equitable.

REPORT TO: Healthy Halton Policy & Performance Board

DATE: 10 March 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Work Topic Report

1.0 **PURPOSE OF REPORT**

1.1 To present to Healthy Halton Policy and Performance Board the proposed forthcoming work topics for 2009/10 for the Boards consideration as detailed in Appendix 1

2.0 **RECOMMENDATION**

That the Board considers and agrees the proposed work topics for 2009/10.

3.0 **SUPPORTING INFORMATION**

3.1 Topics for inclusion in the work programme for 2009/10 are as follows:

- Employment Opportunities for people with a learning or physical disability or mental health issue.
- Disability Facilities Grant

The Healthy Halton Policy and Performance Board may be invited to participate in other topics to be progressed jointly with other Policy and Performance Boards, for example children's health.

4.0 **POLICY IMPLICATIONS**

4.1 The Council's priorities are further developed through the 2009/10 scrutiny topics

5.0 **FINANCIAL/RESOURCE IMPLICATIONS**

5.1 It is not possible to specify at this stage whether there will be resource implications.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

Children and Young People in Halton

Selection of scrutiny topics for 2009/10 leads to further development

of the Council's priorities.

Employment, Learning and Skills in Halton

Selection of scrutiny topics for 2009/10 leads to further development of the Council's priorities.

Healthy Halton

Selection of scrutiny topics for 2009/10 leads to further development of the Council's priorities.

Safer Halton

Selection of scrutiny topics for 2009/10 leads to further development of the Council's priorities.

Halton's Urban Renewal

Selection of scrutiny topics for 2009/10 leads to further development of the Council's priorities.

7.0 RISK ANALYSIS

7.1 Achievement of the outcome based performance indicators will require service provision to be based around a bespoke approach to improving health and well being.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The approach recommended in this report seeks to enhance health and well-being commissioning and service provision for those most in need.

TOPIC BRIEF

Topic Title:	Employment opportunities for people with a learning or physical disability or mental health issue
Officer Lead:	Gerry Fitzpatrick/Stiofan OSuilibhan
Target PPB Meeting	March 2010 (NB. It is anticipated that this will be a joint scrutiny topic with the Employment, Learning & Skills Policy & Performance Board)

Topic Description and scope:

An examination of the current processes involved in supporting those Service Users known to Social Care, who have a learning or physical disability or a mental health issue into appropriate employment.

Why this topic was chosen:

From the CSCI (Commission for Social Care Inspection) performance assessment report carried out July – Sep 2008, it was noted that Halton Borough Council has helped more people with a learning or physical disability or mental health issue into employment than it had planned, but that this was still lower than comparator Councils. As a result this was identified by CSCI as an area for development/improvement .

Key outputs and outcomes sought:

- Exploration of how employment opportunities for people with a learning or physical disability or mental health issue are identified.
- An understanding of the complexities of the financial processes/issues around employment for people with a learning or physical disability or mental health issue
- Raise awareness of the service provided to service users known to Social Care
- Develop an action plan to ensure that CSCI targets are met and that the service continues to develop
- Consider national best practice in terms of supporting people into employment opportunities
- An understanding of the Corporate responsibilities in supporting vulnerable people into employment

Which of Halton's 5 strategic priorities this topic addressed and the key objectives and improvement targets it will help to achieve:

Employment Learning & Skills in Halton

Key Objective C: To promote and increase the employability of local people and to remove any barriers to employment and get more people into work.

Nature of expected/descried PPB input:

Member led scrutiny review of the employment opportunities for people with a learning or physical disability or mental health issue.

Preferred mode of operation:

- Review of current employment opportunities for people with a learning or physical disability or mental health issue.
- Benchmarking with comparative local authorities
- Visits/meetings including:

  Job Centre Plus
  Service Users – someone who has used the service
  Providers
  5BP
  LSC (Learning Skills Council)
  Warrington Disability Employment Forum

Agreed and signed by:

PPB chair …… **Officer …….**

Date …….. **Date ……**

TOPIC BRIEF

Topic Title: Disability Facilities Grant

Officer Lead: Operational Director (Adults of Working Age)

Planned start date: April 2009

Target PPB Meeting: March 2010

Topic Description and scope:

A review of the Disability Facilities Grant, focussing on developing an understanding of the complexities of the finances within adaptations.

Why this topic was chosen:

Over the last two years, major changes have been made internally to the structure and processes within adaptations. In April 2008 the Independent Living Team, grants team and Home Improvement Agency integrated becoming the new HHIILS Team (Halton Home Improvement and Independent Living Service) based at John Briggs House.

Key outputs and outcomes sought:

- An understanding of the complexities of the financial processes/issues around adaptations;
- Consider national best practice and research in terms of self-assessment, personalisation and the use of modular buildings;
- Raise awareness generally of the service and the value of adaptations for service-users (including finance and independence);
- Examine the effectiveness of specifications/plans to ascertain if these could be simplified; and
- Consider resources available in terms of IT systems to ensure adequate monitoring of the DFG.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will help to achieve:

<u>Improving Health:</u>

Key Objective C: To promote a healthy living environment and lifestyles to protect the health of the public, sustain individual good health and well-being and help prevent and efficiently manage illness.

Key Objective E: To remove the barriers that disable people and contribute to

poor health through ensuring that people have ready access to a wide range of social, community and housing services, and cultural and sporting activities that enhance their quality of life.

Nature of expected/desired PPB input:

Member led scrutiny review of the Disability Facilities Grant.

Preferred mode of operation:

- Review of the Disability Facilities Grant – including assessment process, other grants, specifications and plans
- Literature review/best practice in other areas, in particular the impact of Personalisation
- Field visits including:
    - To a local authority who use Self-Assessment within DFG;
    - To a local authority who use Modular buildings;
    - Teams involved with DFG working at Halton BC; and
    - Service-users

Agreed and signed by:

PPB chair …… **Officer ……**

Date …….. **Date …….**

REPORT TO: Healthy Halton PPB

DATE: 10 March, 2009

REPORTING OFFICER: Chief Executive

SUBJECT: Performance Management Reports for 2008/09

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To consider and raise any questions or points of clarification in respect of the 3rd quarter performance management reports on progress against service plan objectives and performance targets, performance trends/comparisons, factors affecting the services etc. for;

- Adults of Working Age
- Older People's and Independent Living Services
- Health & Partnerships

2.0 RECOMMENDATION: That the Policy & Performance Board;

1) Receive the 3rd quarter performance management reports;

2) Consider the progress and performance information and raise any questions or points for clarification; and

3) Highlight any areas of interest and/or concern where further information is to be reported at a future meeting of the Policy and Performance Board.

3.0 SUPPORTING INFORMATION

3.1 The departmental service plans provide a clear statement on what the services are planning to achieve and to show how they contribute to the Council's strategic priorities. The service plans are central to the Council's performance management arrangements and the Policy and Performance Board has a key role in monitoring performance and strengthening accountability.

3.2 The quarterly reports are on the Information Bulletin to reduce the amount of paperwork sent out with the agendas and to allow Members access to the reports as soon as they have become available. It also provides Members with an opportunity to give advance notice of any questions, points or requests for further information that will be raised to ensure the appropriate Officers are available at the PPB meeting.

4.0 POLICY IMPLICATIONS

There are no policy implications associated with this report.

5.0 OTHER IMPLICATIONS

There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

The quarterly performance monitoring reports demonstrate how services are delivering against the objectives set out in the relevant service plan. Although some objectives link specifically to one priority area, the nature of the cross-cutting activities being reported means that to a greater or lesser extent a contribution is made to one or more of the priorities listed below;

6.1 **Children and Young People in Halton**

6.2 **Employment, Learning and Skills in Halton**

6.3 **A Healthy Halton**

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

6.6 **Corporate Effectiveness and Efficient Service Delivery**

7.0 RISK ANALYSIS

N/A

8.0 EQUALITY AND DIVERSITY ISSUES

N/A

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officer
N/A		

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Adults of Working Age**

PERIOD: **Quarter 3 to period end 31st December 2008**

1.0 INTRODUCTION

This quarterly monitoring report covers the Adults of Working Age Department third quarter period up to 31 December 2008. It describes key developments and progress against key objectives and performance indicators for the service.

The way in which traffic light symbols have been used to reflect progress to date is explained in Appendix 5.

2.0 KEY DEVELOPMENTS

Mental Health Act 2007

The Act came into force fully (other than a small number of separate provisions) on 3rd November 2008. All existing Approved Social Workers (ASW's) had training in the new legislation, and all have successfully made the transition to become Approved Mental Health Practitioners (AMHP's). An approach has been made to the 5BoroughsPartnership to seek their views on the appointment of AMHPs from within the health services. Policies and procedures are in place but will need to be reviewed in May 2009 to ensure that they are fit for purpose; a system has been established with the front line staff to ensure that proposed changes can be recorded on a day to day basis. National guidance on the new Independent Mental Health Advocacy service was released late in December 2008, and an implementation programme will be established to ensure that this is fully implemented locally. The Steering Group continues to meet each month to oversee implementation of the Act.

Deprivation of Liberty Safeguards

These safeguards - designed to ensure that people who lack capacity are not de facto detained in hospital or care settings – are to be in place as from 1st April 2009. Considerable work has been taking place to develop the appropriate policies and procedures for this important new piece of legislation, and it is expected that these will be in place by the end of January 2009. A local training and awareness programme is being developed to ensure that all relevant people are aware of their roles and responsibilities. Eight staff are undertaking detailed training as Best Interests Assessors at Chester University in the next quarter. As with the Mental Health Act, this is overseen by the multiagency Steering Group which meets regularly.

Mental Capacity Act 2005
The implementation of this Act has continued smoothly and all processes are in place. Substantial training has been delivered to a wide range of services and agencies. However, the early work by the new Mental Capacity Act Co-ordinator has revealed that there are still substantial gaps in knowledge, even amongst people who have received training, and the focus of the work in 2009 will be to ensure that these gaps are filled.

Care Programme Approach
This important tool – which is the assessment and care management process for mental health services – has yet to be fully implemented, despite its introduction in October 2008. The lead role for development of the CPA lies within the 5BoroughsPartnership NHS Trust and this has been strongly supported by partner local authorities, including Halton. Despite this, the work remains at draft stage and needs further revision. This will be a priority for the first Quarter of 2009.

Integrated Partnership
Following the secondment of a Principal Manager to take overall responsibility for the Community Mental Health Teams, a project plan has been developed to deliver more fully integrated services. This plan – with a timescale of nine – eighteen months – will be overseen by the Mental Health Partnership Board.

3.0 EMERGING ISSUES

Personalisation
A successful workshop took place in October 2008, organised by Warrington Social Services, to introduce the concept of personalisation within mental health services. More recently, mental health front line practitioners attended a service planning event which focused on personalisation. This challenging change to culture and process will be fully implemented by Halton Borough Council in 2009 – 10 and mental health services will be playing a key role in this.

Mental Health Single Point of Access
In the autumn of 2008, Halton and St Helens PCT undertook a detailed review of the arrangements for referrals in to primary and secondary mental health care services. This concluded that a new Single Point of Access into mental health services in general should be set up, based within Primary Care, with the removal of the current arrangements based within the 5BoroughsPartnership. This process has been fully supported by the Borough Council, and in consequence the new service model has a strong social care and social inclusion perspective. The Council has committed to providing a social work input into this new service, through the mechanism of a partnership agreement. A detailed project plan has been developed by the PCT and full implementation is due by autumn 2009.

Employment
The employment of people with a severe mental health problem has become a national priority and is the subject of a new national performance indicator. It has also been declared as a local target in the LAA. Data collection for this indicator is unreliable but an initial baseline has been identified. A detailed project plan to improve the local position is being developed and will be implemented through 2009.

Integrated electronic systems
Mental health social care staff currently input all their case material into the health services electronic system within the 5BoroughsPartnership known as Otter. There are three current issues with this: Otter does not have the capability of reporting Local Authority performance data, and this has to be input separately by Council staff; CareFirst is to be upgraded to a system which requires input by social workers, which will repeat the work they do on Otter; and Otter itself is to replaced, with the 5BoroughsPartnership acting as a national pilot site for a new system known as Lorenzo, which currently has little social care information on it. The Borough Council and 5Boroughs Partnership are working closely together on these issues.

Mental health information
There have been substantial changes to processes and procedures relating to mental health and mental capacity in the past two years, and services have also developed considerably. The information available to staff, service users, carers and the general public has not kept pace with this however, and needs fully reviewing and revising. Much of the Council's web-based material is out of date and other information needs to be completely rewritten. This work will be undertaken by the Mental Health Information Group.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**25**		**25**		**0**		**0**

There are 16 key service plan milestones for this service and these are being reported this quarter. Of the nine 'other' indicators for the service, all are progressing satisfactorily, and none of these are being reported by exception. These milestones will be routinely reported again in quarter 4. For a full commentary against each key milestone, please refer to Appendix 1.

5.0 SERVICE REVIEW

Nothing to report this quarter.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**13**		**5**		**2**		**2**

Of the thirteen key indicators for the service, nine have a report of progress against target and have been assigned traffic lights. One indicator – NI 136 – is reported, however a target was not set as this is a new indicator for this year. A further three new national indicators cannot currently be reported as data is not yet available. For further information and commentary, please refer to Appendix 2.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**15**		**8**		**1**		**1**

Other indicators are routinely reported in quarters 2 and 4. Of the fifteen other indicators for the service, eight are progressing satisfactorily against target and are not reported this quarter. A further five indicators cannot be assessed as data is not yet available, these are new National Indicators. Two indicators are being reported by exception this quarter, for further information and commentary, please refer to Appendix 3.

7.0 PROGRESS AGAINST LPSA TARGETS

This service is not responsible for any LPSA targets. The service contributes to an LPSA around services for carers that is reported in the Older People's Services monitoring report.

8.0 RISK CONTROL MEASURES

During the production of the 2008-09 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.

9.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2007/08 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4.

10.0 DATA QUALITY

The author provides assurance that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, has been sourced directly from partner or other agencies, or where there are any concerns regarding the limitations of its use this has been clearly annotated.

11.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress against Key Performance Indicators
Appendix 3- Progress against Other Performance Indicators
Appendix 4- Financial Statement
Appendix 5- Explanation of traffic light symbols

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
AWA 1	Evaluate, plan, commission and redesign services to ensure they meet the need of vulnerable people within the local population, including those from hard to reach groups (including the black and minority ethnic community)	Development of Person Centred reviews with particular focus for adults with Profound and Multiple Learning Disabilities to enhance service delivery Mar 2009.		A dedicated Speech and Language Therapist has been working with 10 people identified as Profound Multiple Learning Disability to analyse their non-verbal behaviours. Their responses are to inform service provision.
		Establish strategy to improve performance and service delivery to the Black & Minority Ethnic community, to ensure services are meeting the needs of the community Jun 2008.		In conjunction with CHAWREC, work continues within the Directorate to improve the access and the signposting of members of the Black and Minority Ethnic community to support services.
		Evaluate "In Control/Individualised Budgets" pilot and extend to other service user groups as appropriate, thus enabling people needing social care and associated services to design that support Mar 2009.		Divisional Manager in post and financial officer supporting. Project management structure in place and project implementation document developed.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		Agree and implement the reconfiguration of ALD health and care management services to enhance service delivery Mar 2009.		The integrated health and care management team managed and employed by HBC has been operational since August 2008. Early evaluation suggests there is less duplication of work and increase in response times.
		Review services and supports for younger adults with dementias and establish a strategy to improve services to this group Mar 2009		The Scrutiny Committee Topic group has continued to meet. Member visits will be taking place in January 2009. Literature has been reviewed and some examples of good practice identified.
		Review Care Management Services for Physical and Sensory Disabilities to enhance service delivery Sep 2008.		Review complete. Divisional Manager now implementing new duty system
AWA 2	Work in partnership to enhance joint working arrangement and delivery of services to vulnerable people	Mainstream review of Bridge Building Day Services Model to ensure that it supports the priorities of the modernisation agenda Sep 2008.		Some funding to mainstream this service has been identified and a further financial commitment from Supporting People has been obtained for 2009/10. Day services are being reviewed
		Review the Payments and Expenses Policy and Procedure to ensure payment levels are appropriate and procedures are adequate Jun 2008		Completed. Policy amended and agreed by SMT December 2008

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		Develop and implement, in partnership with key stakeholders, all policies, processes and procedures necessary to fully implement the Mental Health Act 2007 Oct 2008		The Mental Health Act Steering group continues to meet. All ASWs successfully became AMHPs; policies and procedures have been developed and training put in place. Information is currently being updated and the new Advocacy Service developed.
		To agree and implement a joint process for implementation of new national guidance on Continuing Health Care Mar 2009		Joint MDT meetings with St Helen's LA and PCT established weekly. Disputes process agreed.
		Continue to implement the modernisation of Day Services to enhance service delivery Jun 2008		Modernisation continues. The PSD catering project will be qualified to produce food to be sold at Norton Priory by 26th Feb 09. Development of a supported employment type model lead by Mersey Valley Ground Work organisation is close to a start date for the pilot scheme. Further employment opportunities will be generated in the Norton Priory Catering project and the Market Gardens. Together with opportunities at the Stadium a target of 20-30 people with disabilities has been set for April

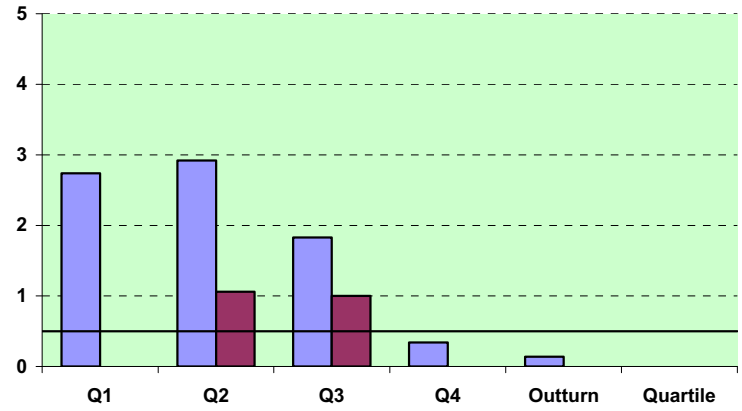
Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
				09.Created a detached leisure day in partnership with Kingsway leisure centre. Designated link person attends Community Bridge Builders team meetings. Quality Improvement Team of stakeholders inspects day service community venues to determine if fit for purpose. Working in partnership with Halton Speak Out to progress Person Centred Plan's for people with PMLD.
		Review services and supports for children and adults with an Autistic Spectrum Disorder Mar 2009		Review completed, presented to Management Team 06/01/09. Action plan agreed.
		Implement a behaviour solutions approach to develop quality services for adults with challenging behaviour Mar 2009.		Behavioural psychologist supporting and advising in house and external providers.
AWA 3	Provide facilities and support to carers, assisting them to maintain good health	Refresh the Carers Strategy in light of the new national Carers Strategy, thus ensuring Carers needs continue to be met Jun 2008.		Consultation event to refresh strategy arranged for Feb 2009.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
AWA 4	Ensure that service delivery, commissioning and procurement arrangements are efficient and offer value for money	Build on learning for Halton from CSED improving care management efficiency project, identifying further areas and priorities for redesign Jun 2008.		Areas identified. Consultant commissioned to review domiciliary care contract and day, residential and nursing home contracts.
		Continue to implement ALD's financial recovery plan to ensure that the service becomes increasingly efficient and effective Mar 2009.		Transfer of funding from PCT to HBC agreed 1 / 12 / 09

AWA LI4

Percentage of adults assessed in year where ethnicity is not stated

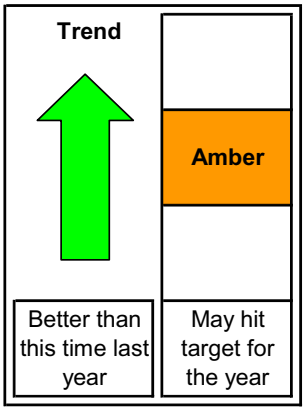
Lower figures represent better performance



Key

2007/8
2008/9
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available



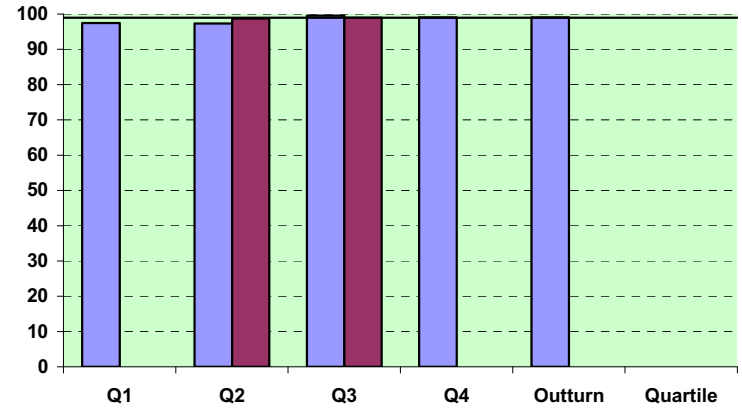
Commentary

There have been a higher number of people assessed where it was not possible to determine thnicity. This has been identified in assessment reports and the % could reduce in Q 4

AWA LI13

Percentage of people receiving a statement of their needs and how they will be met.

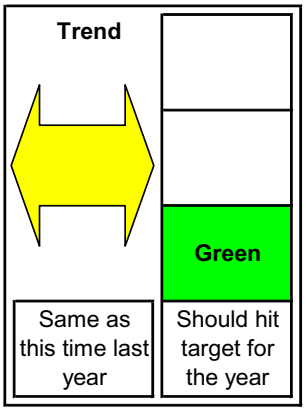
Higher figures represent better performance



Key

2007/8
2008/9
Target
Top 25%
Middle 50%
Bottom 25%

No quartile data available



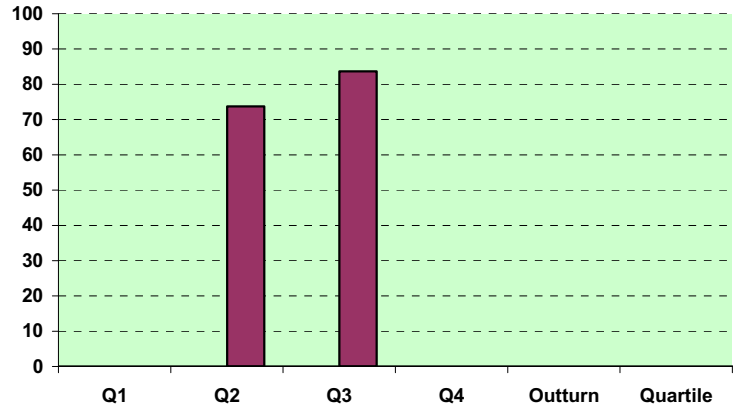
Commentary

This indicator continues to be on target

AWA NI 132

Timeliness of social care assessment DH DSO

Higher figures represent better performance



Key

- 2007/8
- 2008/9
- Target
- Top 25%
- Middle 50%
- Bottom 25%

No quartile data available

Trend

Worse than this time last year	Red
Unlikely to hit target for the year	

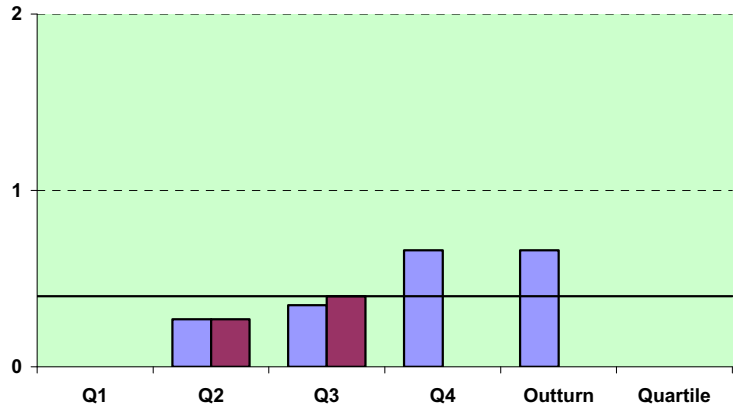
Commentary

Part 2 of the indicator is pulling the overall performance down for this aggregated indicator.
This is a result of the combination of Physical and Sensory Disability Team and the Halton Independent Living Services Team. The latter has a higher number of referrals and has been unable to meet the 28 day target. A review of procedures is underway to improve this

AWA LI15

Admissions of Supported Residents aged 18-64 into residential/nursing care

Lower figures represent better performance



Key

- 2007/8
- 2008/9
- Target
- Top 25%
- Middle 50%
- Bottom 25%

No quartile data available

Trend

Better than this time last year	Green
Should hit target for the year	

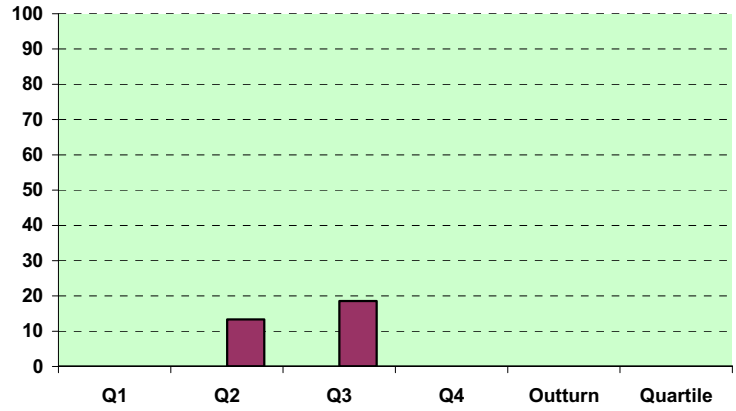
Commentary

On target, no problematic areas identified

AWA NI 135

Carers receiving needs assessment or review and a specific carer's service, or advice and information DH DSO

Higher figures represent better performance



Key

2007/8

2008/9

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Better than this time last year

Green

Should hit target for the year

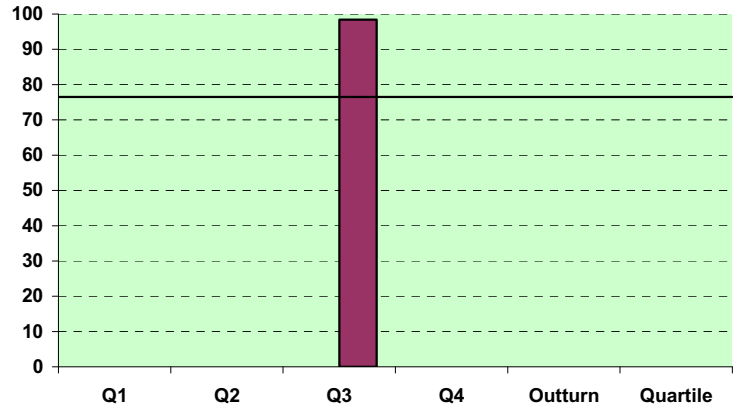
Commentary

The figure for Q3 is a cumulative figure. Indications are that target will be exceeded at year end

AWA NI 141

Number of vulnerable people achieving independent living CLG DSO

Higher figures represent better performance



Key

2007/8

2008/9

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Better than this time last year

Green

Should hit target for the year

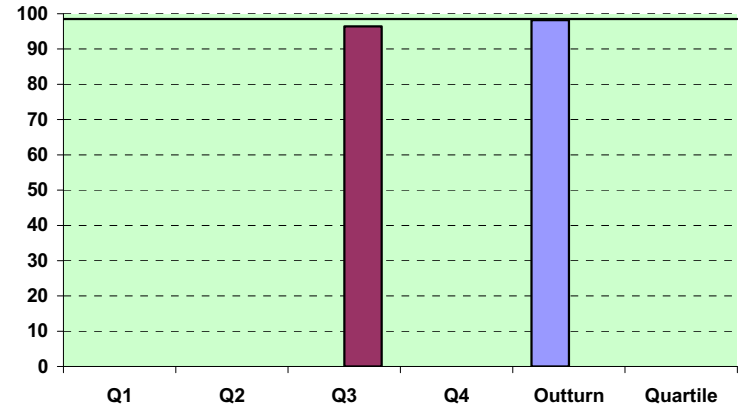
Commentary

Target is being exceeded at Q3 and indications are that target will be exceeded at year end

AWA NI 142

Number of vulnerable people who are supported to maintain independent living CLG DSO

Higher figures represent better performance



Key

2007/8

2008/9

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Amber

No data for same Qtr last year

May hit target for the year

Commentary

This service is provided by a number of teams. Services within Generic Group are being repurposed and also an action plan is now in place to improve performance for Team Parents

Key performance indicators not being reported: -

NI 136 People supported to live independently through Social Care services;
This is a new indicator and it is not possible to compare against comparator data

NI 131 data not yet available from PCT

NI 145 Adults with Learning Disabilities in Settled accommodation;

NI 146 Adults with Learning Disabilities in Employment;
Equates to 9 service users known to Adult Social Care as a proportion of 307 service users known to Adult Social Care. It is difficult to compare performance of this new indicator until we are able to compare against comparator data.

Ref.	Description	Actual 2007/08	Target 2008/09	Quarter 3	Progress	Commentary
Cost & Efficiency						
AWA LI1	Intensive home care as a percentage of intensive home care and residential care	27.15	28	25.53		The HH1 outturn for intensive households dropped in 2008 (some impact from CHC). Therefore the lower number of intensive households has resulted in a lower outturn for this indicator.
Service Delivery						
AWA LI17	Adults with learning disabilities helped to live at home	3.92	4.3	4.08%		A slight shortfall against this target for this indicator due to the closure of service users from the Carefirst system early in 2008 (CIC etc).

HEALTH & COMMUNITY – ADULTS OF WORKING AGE (ALD, MH, PSD)
Revenue Budget as at 31st December 2008

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Staffing	3,131	2,198	2,180	18	2,236
Premises	131	0	0	0	0
Other Premises	83	52	50	2	60
Joint Equipment Service	110	0	0	0	0
Other Supplies & Services	553	128	121	7	170
Food Provisions	10	8	8	0	29
Aid & Adaptations	124	93	121	(28)	218
Transport of Clients	702	372	363	9	578
Other Transport	24	18	21	(3)	21
Departmental Support Services	898	0	0	0	0
Central Support Services	334	0	0	0	0
Contract & SLAs	791	433	430	3	513
Emergency Duty Team	95	48	50	(2)	50
Community Care:					
Residential Care	1,359	941	723	218	723
Nursing Care	45	7	8	(1)	8
Home Care	483	334	483	(149)	483
Direct Payments	525	363	550	(187)	550
Supported Living	166	115	87	28	87
Day Care	27	19	6	13	6
Asset Charges	195	0	0	0	0
Contribution to ALD Budget	7,255	4,146	4,156	(10)	4,233
Total Expenditure	**17,041**	**9,275**	**9.357**	**(82)**	**9,965**
Income					
Residential & Nursing Fees	-204	-141	-109	(32)	-109
Fees & Charges	-124	-86	-122	36	-126
Preserved Rights Grant	-519	-389	-389	0	-389
Supporting People Grant	-557	-68	-65	(3)	-65
Mental Health Grant	-477	-358	-358	0	-358
Carer Grant	-431	-323	-323	0	-323
-67Mental Capacity IMCA Grant	-84	-66	-67	1	-67
Aids Support Grant	-5	-3	-9	6	-9
Social Care Reform Grant	-220	-220	-220	0	-220
Local Involvement NetworkGrant	-121	-94	-93	(1)	-93
Community Roll Out Funding	-138	-138	-138	0	-138
Nursing Fees – PCT	-45	-11	-12	1	-12
PCT Reimbursement	-387	-194	-198	4	-198
Other Income	-9	-6	-4	(2)	-4
Total Income	**-3,321**	**-2,097**	**-2,107**	**10**	**-2,111**
Net Expenditure	**13,720**	**7,178**	**7,250**	**(72)**	**7,777**

APPENDIX FOUR – FINANCIAL STATEMENT
Adults of Working Age

Comments on the above figures:

In overall terms the revenue spending at the end of Quarter 3 is £62k over budget profile, excluding the ALD pool budget.

Expenditure on Staff costs is slightly less than expected at this stage of the year due to a number of Social Worker posts being vacant within the Mental Health & PSD teams.

Expenditure on the aids and adaptations budget continues to be over budget profile. This area is difficult to predict as it depends on how many applications are put to panel. This budget will continue to be scrutinised closely, however it is anticipated that expenditure will be over budget profile at year-end, although it will be contained within the Departments total budget.

As in previously quarters this financial year pressure on the Community Care budget continues for service users with mental health needs and those with physical and sensory disabilities. The Homecare and Direct Payments budgets in particular are significantly over budget profile however this is offset by the underspend on residential care. This is due to increasing numbers of services users being supported within their own homes rather than in residential accommodation.

Work is currently being undertaken to realign the Community Care budgets within both Adults and Older People's services so that budgets reflect expenditure more accurately. Community Care budgets in 2009/10 will reflect these changes.

Note: A summary of the H.B.C. Contribution to ALD Pooled Budget can be found on the following page:

HEALTH & COMMUNITY – ADULTS WITH LEARNING DISABILITIES

Contribution to ALD Pooled Budget

Revenue Budget as at 31st December 2008

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Nursing Care	48	8	7	1	7
Residential Care	883	611	699	(88)	699
Supported Living	1,954	1453	1,358	95	1,358
Home Care	1,829	1,266	1,078	188	1,078
Direct Payments	530	398	561	(164)	561
Day Services	1,967	1,299	1,234	65	1,254
Specialist LD Team	801	498	524	(26)	593
Management Costs	1,312	125	132	(7)	127
Respite	355	195	174	21	167
Other Expenditure	0	0	1	0	1
Total Expenditure	**9,679**	**5,853**	**5,768**	**85**	**5,845**
Income					
Rents & Service Charges	-28	-20	-10	(10)	-10
Community Care Fees	-101	-70	-42	(28)	42
Residential Fees	-113	-78	-85	7	-85
Direct Payments	0	0	-29	29	-29
Campus Closure Grant	-26	-26	-26	0	-26
Supporting People Grant	-1,098	-651	-655	4	-655
LDDF	-150	-112	-112	0	-112
CITC – Astmoor	-53	-22	0	(22)	0
CITC – Special Needs	-6	0	0	0	0
Other Client Income	-31	-22	0	(22)	0
CHC – PCT Reimbursement	-340	-305	-305	0	-305
Nursing Care – PCT Reimbursement	-48	-16	-15	(1)	-15
Other Fees & Charges	-430	-385	-333	(52)	-333
Total Income	**-2,424**	**-1,707**	**-1,612**	**(95)**	**-1,612**
Net Expenditure	**7,255**	**4,146**	**4,156**	**(10)**	**4,233**

Revenue spending is expected to be in line with the budget by the end of the financial year.

HEALTH & COMMUNITY – LOCAL STRATEGIC PARTNERSHIP BUDGET

Budget as at 31st December 2008

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (Overspend) £'000	Actual Including Committed Items £'000
Priority 1 Healthy Halton					
Diet & Exercise Programme	22	16	0	16	0
Vunerable Adults Task Force	200	150	156	(6)	156
Vol. Sector Counselling Proj.	40	30	16	14	16
Info. Outreach Services	34	26	17	9	17
Reach for the Stars	35	26	0	26	0
Health & Comm Care & Vol Sector Carers' Forum	40	30	23	7	23
Healthy Living Programme	20	15	0	15	0
Advocacy	44	33	49	(16)	49
Capacity Building	25	19	0	19	0
Dignity	25	19	0	19	0
Falls Monitor	27	20	0	20	0
Mens Health Exp	60	45	0	45	0
Mens Health over 75	40	30	0	30	0
Malnutrition	20	15	0	15	0
Relationship Centre	20	15	0	15	0
Priority 2 Urban Renewal					
Landlord Accreditation Programme	30	22	29	(7)	29
Priority 4 Employment Learning & Skills					
Voluntary Sector Sustainability	7	5	0	5	0
Priority 5 Safer Halton					
Good Neighbour Pilot	10	7	2	5	2
Grassroots Development	9	7	5	2	5
Total Expenditure	**708**	**530**	**297**	**233**	**297**

APPENDIX FOUR – FINANCIAL STATEMENT
Adults of Working Age

HEALTH & COMMUNITY

Capital Budget as at 31st December 2008

	2008/09 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Social Care & Health				
Redesign Oakmeadow Communal Spaces & Furnishings	72	50	0	72
Major Adaptations for Equity release/Loan Schemes	100	70	0	100
Pods utilising DFG	40	30	0	40
Women's Centre	19	14	3	16
DDA	24	18	0	24
Total Spending	255	182	3	252

Comments on the above figures:

Work started on the redesign of Oakmeadow communal spaces & furnishings on January 4th 2009. This project is expected to be fully committed at year-end.

The two POD schemes utilising DFG are still progressing however the organisational and preparatory work in delivering this innovative way of carrying out adaptations has been more complicated & protracted than anticipated & other factors have resulted in delays. If either case is completed the budget will be fully spent at year-end.

Work has commenced on the Women's centre and the remaining allocation is fully committed.

All work has now been completed on the Direct Door Access therefore the budget is committed and invoices are due to be paid this financial quarter.

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage, due to a lack of information or a key milestone date being missed, whether the objective will be achieved within the appropriate timeframe.	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Health & Partnerships**

PERIOD: **Quarter 3 to period end 31st December 2008**

1.0 INTRODUCTION

This quarterly monitoring report covers the Health & Partnerships Department third quarter period up to 31 December 2008. It describes key developments and progress against key objectives and performance indicators for the service.

The way in which traffic light symbols have been used to reflect progress to date is explained in Appendix 5

It should be noted that this report is presented to a number of Policy and Performance Boards. Those objectives and indicators that are not directly relevant to this Board have been shaded grey.

2.0 KEY DEVELOPMENTS

Consumer Protection

The contract with Warrington Borough Council, for the provision of a comprehensive Trading Standards Service for Halton, commenced on 1 December 2008.

The Registration Service has been approved by the Office of the Immigration Services Commissioner to provide initial immigration advice to those accessing the Nationality Checking Service in order to ascertain that their application for citizenship was properly completed.

Work is ongoing on the provision of civil funeral ceremonies by Bereavement and Registration Officers.

Following work with the Federation of Burial and Cremation Authorities more comprehensive cremation documents have been distributed to all local funeral directors, GP surgeries and hospitals.

Business Support

Work with Corporate ICT on the scoping of projects on electronic care monitoring, use of digital pens, mobile working, single assessment process and electronic document storage is continuing. We are awaiting the delivery of the 3 and 5 year ICT Strategy from Corporate ICT.

The new hardware contract that Corporate ICT have negotiated in conjunction with the implementation of Carefirst 6 may offer the Directorate real opportunities to increase mobile working solutions and avoid data duplication.

Commissioning
HBC & HStHPCT are in the process of securing eternal support to develop a framework to take forward the delivery of the Section 75 Partnership agreement for the commissioning of health and social care services.

Quality Assurance and Supporting People
Following the successful completion of a tender process new contracts have been awarded for the provision of Domiciliary Care across Halton. The new contracts are due to commence in April 2009.

Service Planning & Training
Following ratification by Executive Board in February 2008, the Carers Centre based at 62 Church Street Runcorn transferred to the charitable trust, Halton Carers Centre and the Centre run from the Age Concern offices in Widnes closed.

The Joint Strategic Needs Assessment (Health & Wellbeing) was completed and the consultation process with members and officers began

The management of the Joint Training Partnership (Learning Disabilities) transferred from Halton & St Helens PCT to Health & Community's Training Section.

Housing Strategy and Homelessness
The Housing strategy 2008-2001 was endorsed at Executive Board on 18th December 2008. Performance against delivery of the action plan will be reported to the Housing partnership Board and Urban Renewal PPB.

3.0 EMERGING ISSUES

Consumer Protection
The re-introduction of the web-based system for birth and death registration is scheduled to be taken forward at the end of March 2009

Business Support
Health & Partnerships are working with operational teams, Corporate ICT and the Contact Centre to scope the introduction of a single point of access enablement service that is able to meet short term needs quickly to aid reablement and reduce longer term needs and associated costs. It is anticipated that this will develop into a multi agency service that meets needs holistically. A report will be submitted to the Directorate's Senior Management Team in due course.

Quality Assurance and Supporting People
Work is due to commence on a feasibility study for the development of a single point of access or 'Gateway' service for supported housing. 'Gateway' services provide a single access point for vulnerable people in need of housing and housing related support. The service will assess and prioritise clients in relation to level of need and vulnerability and will work with providers to develop pathways into housing related support services and to develop a 'move on' pathway into general needs housing.

Service Planning & Training
Valuing People Now, which sets out the Governments strategy for people with learning disabilities for the next 3 years, is due for publication in January 2009 and will have a significant impact on the way services are delivered.

Cutting the cake Fairly: CSCI review of eligibility criteria for social care was published in October 2008 and work has already began on assessing the implications, particularly focusing on the implications on the delivery of preventative and personalised services.

Housing Strategy and Homelessness
As part of the Regional spatial strategy partial review 4NW embarked on consultation relating to traveller pitch allocating for the region.

A new regional housing strategy has been produced which will guide investment decisions for the region.

NW Development agency and 4nw have launched a principles and issues paper for the forth-coming single regional strategy. The consultation period ends 30th April 2009.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**19**		**12**		**7**		**0**

Key service plan milestones are being reported this quarter, of which there are 8. Non-key milestones are routinely reported in quarters 2 and 4, however 3 non-key milestones are being reported this quarter as they have been assigned amber ratings. These are designated by the use if *italic* text in the description. In summary, of the 19 milestones for the service, 12 are on track and seven have been assigned amber lights. For further details, please refer to Appendix 1.

5.0 SERVICE REVIEW

Consumer Protection

The Registration Service is currently surveying all customers who have applied for certificates by post to obtain feedback on the provision of this service.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**7**		**2**		**0**		**1**

Of the 7 key indicators for the service, three have a report of progress against target. A further three indicators cannot currently be reported as data is not available (NI 127, 182, 183). These are new National Indicators for which data protocols are not yet established. One indicator, NI 130, is being reported, however a traffic light is not assigned as a baseline is being calculated this year. For further information and commentary, please refer to Appendix 2.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**23**		**12**		**0**		**0**

'Other' indicators are routinely reported at quarter 2 and 4, however 3 indicators are being reported by exception this quarter. These are indicators that were deferred from quarter 2 because the data was not available then. One of these is a place survey indicator, for which a traffic light has not been assigned.
In summary, of the 23 other indicators for the service, twelve are on track. A further ten indicators, which are new National Indicators, cannot currently be reported as data is not yet available. For further information and commentary, please refer to Appendix 3.

7.0 PROGRESS AGAINST LPSA TARGETS

There are no LPSA targets for this service

8.0 RISK CONTROL MEASURES

During the production of the 2008-09 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4.

9.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2007/08 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4.

10.0 DATA QUALITY

The author provides assurance that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, has been sourced directly from partner or other agencies, or where there are any concerns regarding the limitations of its use this has been clearly annotated.

11.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress against Key Performance Indicators
Appendix 3- Progress against Other Performance Indicators
Appendix 4- Financial Statement
Appendix 5- Explanation of traffic light symbols

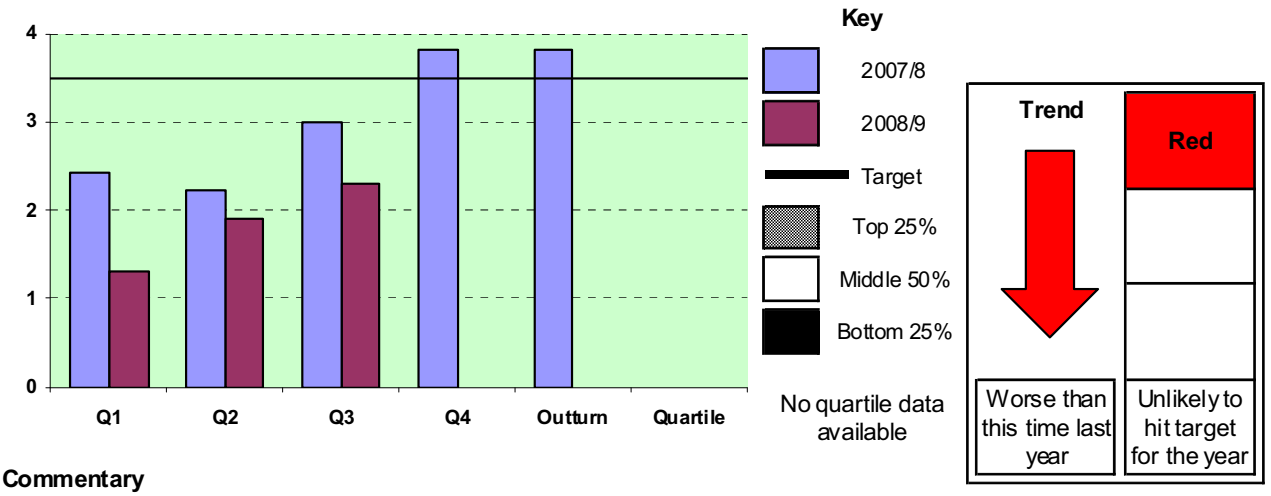
Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
HP 1	Ensure that high level strategies are in place, and working to deliver service improvements, and support frontline services to deliver improved outcomes to the residents of Halton	Review and update the Joint Strategic Needs Assessment (JSNA) to ensure that the outcomes, with identified priorities are incorporated into the LAA May 2008		Draft JSNA complete. Presented for comment at SMT and circulated internally for consultation, presented to all HBC Policy and performance Boards in January. Period of public consultation to commence in Feb 09.
HP 2	Work with operational managers to make best use of the workforce and IT resources, to improve service delivery and assist services to continuously improve within a robust performance management framework	*Review the Directorate IT strategy and business processes in conjunction with Corporate IT to ensure that systems available are accessible and deliver a quick and responsive service to those that need them Jun 2008.*		The Business process reviews of operational teams are ongoing and are being delivered by Corporate ICT.
		Develop and implement an electronic solution to the Single Assessment Process (SAP) to ensure that data currently written in assessments can be effectively loaded into Carefirst, Health and other agency services information systems Jun 2008.		The Directorate intends to purchase a copyright license from Sheffield University so that it can implement an electronic version of Easy Care SAP using Careassess forms overlaying Carefirst 6. Health partners have been invited to discuss how they will utilise this system with us. Electronic SAP cannot be delivered until Carefirst 6 is operational.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		Review complaints procedures in light of national guidance to ensure a more consistent and holistic approach, leading to lessons learned being shared will colleagues across the sector Nov 2008.		The new national complaints guidance has yet to be published and therefore we are not planning to amend our policy or procedure yet
HP 3	To deliver high quality Bereavement, Consumer and Registration Services, that are fit-for-purpose and meet the needs, dignity and safety requirements of the Halton community	Develop a project plan to deliver longer-term cemetery provision, based on member decision, and commence delivery in accordance with project plan timeframes, to ensure the continued availability of new grave space to meet the needs of the Community in 2015 and beyond Jun 2008.		Whilst the June milestone has not been met, a cost benefit analysis of the various options has been completed. Members are scheduled to consider the various options resulting in decisions being made and the development of the project plan prior to financial year-end.
		Produce an initial Consumer Protection Strategic Assessment, in line with the National Intelligence Model, to support intelligence-led Trading Standards service delivery during 2009/10 Dec2008		Completed. This assessment will now inform the service delivery of the new Warrington and Halton Trading Standards service during 2009 / 2010.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		Benchmark performance against national standards with relevant benchmarking group to inform improvement plan aimed at supporting continual service improvement Sep 2008.		The Service has benchmarked its performance against the national standards in the GRO/LACORS Good Practice Guide with other "new governance" services. It is hoped that a North West benchmarking exercise can be completed in quarter 4
HP 4	Ensure that effective financial strategies and services are in place to enable the Directorate to procure and deliver high quality value for money services that meet people's needs.	Commence procurement for new residential care contracts, to enhance service delivery and cost effectiveness, with a view to new contracts being in place April 2008.		Negotiations are due to start from in February 2009 with the Residential Care Providers. The draft Residential Care Strategy is on target to be completed by April 09 however there are delays in the Financial Modelling of this project.
		Commence procurement for new domiciliary care contracts, to enhance service delivery and cost effectiveness, with a view to new contracts being in place April 2008.		The Domiciliary Care contracts are on target to commence in April 09. The tender process has been completed and all the Providers have been informed. Progress is reported on an ongoing basis to service users, operational teams and stakeholders.
		Project team to be established to ensure implementation of the recommendations of the commissioning framework Mar 2009.		PID agreed with Health to deliver the section 75 agreement. PCT in process of appointing consultants to lead project.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		Review the usage of Direct Payments against performance target strategy to ensure that targets on uptake are being met March 2009		Usage of Direct Payments has been reviewed and slippage has been identified against the 08/09 target. Need to align Direct Payments to Individualised Budgets and the Personalisation agenda.

HP LI2 **% of SSD gross current expenditure on staffing which was spent on training the Council's directly employed staff during the financial year**

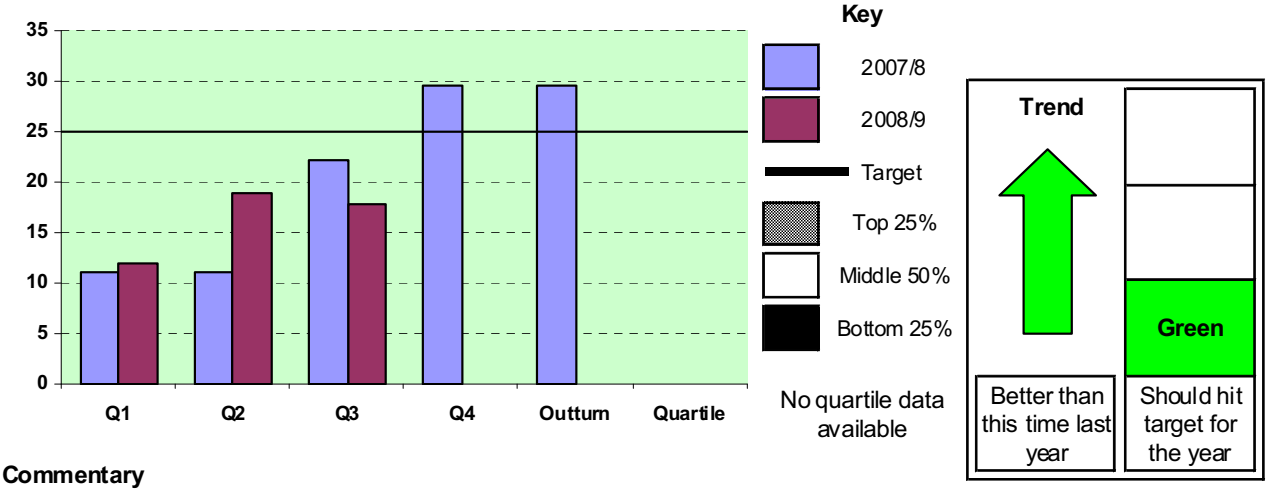


Commentary

Spend is not in line with target at this point in the year. Ongoing monitoring of spend will take place, along with bi-monthly monitoring through the Adult & Children's Training Group to keep a track of performance against this indicator.

Training Budget spend in 3rd quarter against cost centres 6060, 6000, 6200 & 6220, divided by the social care staffing for the 3rd quarter, not including Children Services. T&D Spend £268,403 divided by £11,821,852 multiplied by 100. Staff costs provided by finance.

HP LI5 **No. of assessed social work practice learning days per whole time equivalent social worker**



Commentary

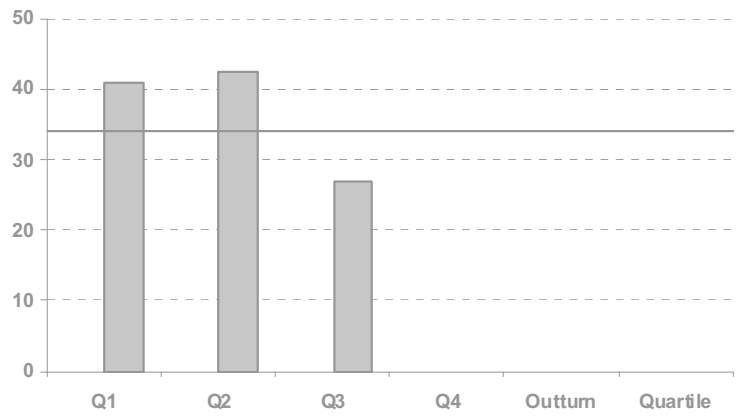
Performance is on track.

Last year we were awarded 1080 vols and we can confidently anticipate at least this number in future years because the total no of students has increased. The number of practice learning days to date 1620 (divided by WTE 91.5= 17.70).

With a further intake of 760 student days in January 2009, the forecast is to exceed target with a year end figure around 26.

NI 156

Number of households living in Temporary Accommodation



Key

2007/8

2008/9

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

No data for same Qtr last year

Should hit target for the year

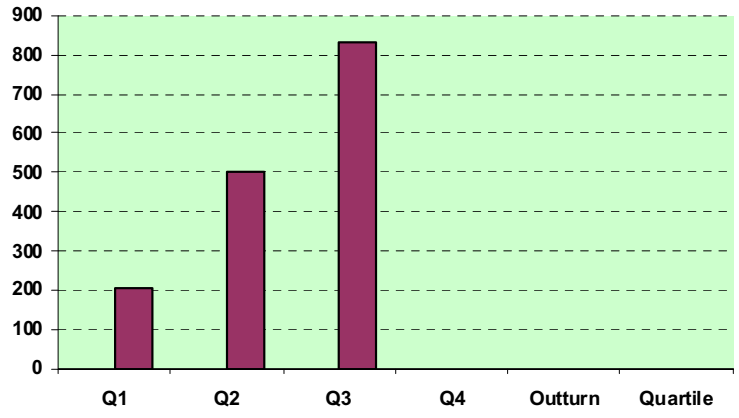
Commentary

Good performance to date. Numbers currently accommodated in either Grangeway Court or B&B are within the target figure, but quarter 4 is historically the peak time for homeless presentations so maintaining this position may be challenging.

NI 130

Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets) DH DSO

Higher figures represent better performance



Key

2007/8

2008/9

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

No data for same Qtr last year

Commentary

This is a new national indicator that was adapted from the previous BVPI 201 (Direct Payments measire)

The target of 200 for this indicator had been transferred from the previous PAF indicator, however the way the new indicator is calculated is different, and as such the target has become meaningless. This year is the baseline year for this indicator and guidance indicates that the definition will change again for 09/10. The target has been removed, and a traffic light is not being assigned. It should be noted however that based on preliminary comparison with NW authorities, performance appears to be good.

Key Performance Indicators not being reported this quarter;

NI 127, Self reported experience of Social Care Users
This indicator cannot be reported on in quarter 1 as it is based on a survey which does not take place until Quarter 4.

NI 182, Satisfaction of Businesses with Local Authority Regulation Services
This is a new indicator that forms part of the new National Indicator data set and systems are not currently in place to calculate the out-turn percentage. However, the indicator is based on survey data and in Quarter 1, 40% of Consumer Protection respondees gave the highest rating whilst 60 % gave the second highest rating in answer to the two relevant questions. The single, year-end return will also include the performance of the Environmental Health and Licensing functions of the Council.

NI 183, Impact of LA Regulatory Services on the Fair Trading Environment
This is a new indicator that forms part of the new National Indicator data set. It is a year-end return based on four factors, two of which are to be provided to local authorities by central government at year-end. Hence it is not possible to provide quarterly performance information.

Ref.	Description	Actual 2007/08	Target 2008/09	Quarter 3	Progress	Commentary
Cost & Efficiency						
HP LI1	% of SSD directly employed posts vacant on 30 September	-	9	8.23		A report was not available on this indicator in Q2. Number of vacant posts = 51, number of staff posts = 620 taken from SSDS001 The above % figure relates to vacancies as at 30th September 2008 within Adult Services, Health & Partnership (excluding housing strategy and consumer protection and Culture & leisure) and Older People's Services.
Service Delivery						
NI 119	Self-reported measure of people's overall health and wellbeing DH DSO	-	-	73.7	Refer to comment	This is a new Place Survey indicator, for which data has just been released. Given the nature of this indicator, no target was set and until comparative data becomes available, it is difficult to place this performance figure in context. A further report will be made when the performance can be placed in context.

APPENDIX THREE - PROGRESS AGAINST OTHER INDICATORS
Health & Partnerships

Ref.	Description	Actual 2007/08	Target 2008/09	Quarter 3	Progress	Commentary
HP LI13	% of SSD directly employed staff that left during the year.	7.69	8	5		A report was not available on this indicator in Q2. Commentary:- actual leavers = 31, number of staff posts = 620 taken from SSDS001 Figures from Trent on actual leavers for Health & Community from April – December 2008 exclude Culture & Leisure, Housing Strategy and Consumer Protection. SSDS001 figure is number of posts, excluding the service areas above.

HEALTH & COMMUNITY - HEALTH AND PARTNERSHIP

Revenue Budget as at 31st December 2008

	Annual Revised Budget £'000	Budget To Date £'000	Actual To Date £'000	**Variance To Date** (overspend) £'000	Actual Including Committed Items £'000
Expenditure					
Employees	3,752	2,602	2,575	27	2,668
Premises Support	244	0	0	0	0
Other Premises	46	22	23	(1)	26
Supplies & Services	653	342	386	(44)	416
Training	147	12	24	(12)	31
Transport	15	12	15	(3)	15
Departmental Support Services	169	0	0	0	0
Central Support Services	630	0	0	0	0
Agency Related	248	151	168	(17)	195
Supporting People Payments to Providers	7,603	4,391	4,388	3	4,388
Asset Charges	1,203	0	0	0	0
Total Expenditure	**14,710**	**7,532**	**7,579**	**(47)**	**7,739**
Income					
Sales	-13	-10	-10	0	-10
Receivership	-32	-24	-51	27	-51
Rents	-65	-63	-152	89	-152
Supporting People Main Grant	-7,799	-5,847	-5,836	(11)	-5,836
Disabled Facilities Grant	-40	-40	-56	16	-56
Departmental Support Services	-3,730	0	0	0	0
Other Grants	-614	-513	-512	(1)	-512
Re-imbursements	-160	-160	-163	3	-163
Other Income	-84	-58	-58	0	-58
Total Income	**-12537**	**-6,715**	**-6,838**	**123**	**-6,838**
Net Expenditure	**2,173**	**817**	**741**	**76**	**901**

Comments on the above figures:

In overall terms the revenue spending at the end of Quarter 3 is £76k below budget profile, due in the main to expenditure on staff costs to date being less than expected and the overachievement of income being considerably more than anticipated at budget setting time.

Employee costs are lower than expected at the end of Quarter 3 due to a several vacancies within the department, however these posts have now been appointed to and this underspend is expected to reduce during the remaining 3 months of this financial year.

Receivership income continues to overachieve against budget profile as anticipated in Quarter2.This is as a result of service users changing from appointee to receivership status in line with the Mental Health Act. The additional income will be used to fund a post in order to meet current demand and facilitate the transfer of appointee service users from HSHN to the Appointee & Receivership section.

Rents received to date, also continue to overachieve against budget and will continue to do so for the remainder of this financial year.

Other income includes £58k received from the PCT to be spent on training for Council, PCT and external provider staff, all members of the Joint Training Partnership which HBC now manages.

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Health & Partnerships

Capital Projects as at 31st December 2008

	2008/9 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Allocation Remaining £'000
Private Sector Housing				
Housing Grants/Loans	284	213	205	79
Disabled Facilities Grants	1,122	800	344	778
Travellers' Transit Site	668	501	584	84
Home Link	10	7	0	10
Energy Promotion	100	70	33	67
Riverview	55	41	38	17
Adaptations Initiative	92	60	18	74
Total Expenditure	**2,331**	**1,692**	**1,222**	**1,109**

APPENDIX THREE - PROGRESS AGAINST OTHER INDICATORS
Health & Partnerships

HEALTH & COMMUNITY – LOCAL STRATEGIC PARTNERSHIP BUDGET

Budget as at 31st December 2008

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (Overspend) £'000	Actual Including Committed Items £'000
Priority 1 Healthy Halton					
Diet & Exercise Programme	22	16	0	16	0
Vunerable Adults Task Force	200	150	156	(6)	156
Vol. Sector Counselling Proj.	40	30	16	14	16
Info. Outreach Services	34	26	17	9	17
Reach for the Stars	35	26	0	26	0
Health & Comm Care & Vol Sector Carers' Forum	40	30	23	7	23
Healthy Living Programme	20	15	0	15	0
Advocacy	44	33	49	(16)	49
Capacity Building	25	19	0	19	0
Dignity	25	19	0	19	0
Falls Monitor	27	20	0	20	0
Mens Health Exp	60	45	0	45	0
Mens Health over 75	40	30	0	30	0
Malnutrition	20	15	0	15	0
Relationship Centre	20	15	0	15	0
Priority 2 Urban Renewal					
Landlord Accreditation Programme	30	22	29	(7)	29
Priority 4 Employment Learning & Skills					
Voluntary Sector Sustainability	7	5	0	5	0
Priority 5 Safer Halton					
Good Neighbour Pilot	10	7	2	5	2
Grassroots Development	9	7	5	2	5
Total Expenditure	**708**	**530**	**297**	**233**	**297**

APPENDIX THREE - PROGRESS AGAINST OTHER INDICATORS
Health & Partnerships

HEALTH & COMMUNITY

Capital Budget as at 31st December 2008

	2008/09 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Social Care & Health				
Redesign Oakmeadow Communal Spaces & Furnishings	72	50	0	72
Major Adaptations for Equity release/Loan Schemes	100	70	0	100
Pods utilising DFG	40	30	0	40
Women's Centre	19	14	3	16
DDA	24	18	0	24
Total Spending	255	182	3	252

Comments on the above figures:

Work started on the redesign of Oakmeadow communal spaces & furnishings on January 4th 2009. This project is expected to be fully committed at year-end.

The two POD schemes utilising DFG are still progressing however the organisational and preparatory work in delivering this innovative way of carrying out adaptations has been more complicated & protracted than anticipated & other factors have resulted in delays. If either case is completed the budget will be fully spent at year-end.

Work has commenced on the Women's centre and the remaining allocation is fully committed.

All work has now been completed on the Direct Door Access therefore the budget is committed and invoices are due to be paid this financial quarter.

FAIR TRADING & LIFE EVENTS

Revenue Budget as at 31st December 2008

	Annual Revised Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000	Actual Including Committed Items £'000
Expenditure					
Employees	657	544	566	(22)	572
Premises Support	109	0	0	0	0
Other Premises	255	72	71	1	134
Hired & Contracted Services	43	34	31	3	32
Supplies & Services	94	78	71	7	76
Transport	24	19	20	(1)	20
Support Services	405	0	0	0	0
Contract Recharge	135	0	0	0	135
Asset Charges	65	0	0	0	0
Total Expenditure	1,787	**747**	**759**	**(12)**	**969**
Income					
Sales	-88	-61	-64	3	-64
Fees & Charges	-644	-455	-452	(3)	-452
Grants	-1	-1	-1	0	-1
Rents	-4	-4	-2	(2)	-2
Support Recharge	-93	0	0	0	0
Total Income	-830	**-521**	**-519**	**(2)**	**-519**
Net Expenditure	957	**226**	**240**	**(14)**	**450**

Comments on the above figures:
In overall terms the revenue spending to the end of quarter 3 is £14,000 above the budget profile.

Expenditure on employees needs to be monitored. The 2008/09 Budget includes a £75,000 saving item relating to the proposed outsourcing of the Consumer Protection Service. This transfer did not take place until 1 December 2008, meaning that only 4 months of the anticipated savings could be achieved. This would imply a shortfall of £50,000 against the proposed full-year saving. However, a number of vacant posts were kept unfilled prior to the

transfer with a view towards contributing to this savings item. This resulted in the savings shortfall in respect of Consumer Protection as at 1 December being reduced to £25,000.

Income budgets are running broadly to target at this stage in the year. Income from burials and cremations is running below the budget profile, although this is offset by memorials income running above target. However, due to the nature of the service it is difficult to estimate whether this trend will continue for the year.

Capital Projects as at 31st December 2008

	2008-09 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Allocation Remaining £'000
Headstone Safety Programme	25	19	19	6

Bereavement Services Capital Programme
Sufficient materials for the scheme have been obtained in previous years so apart from a single purchase of specialist equipment, the allocation will be split over two years to cover labour/service costs, and will now last through to March 2010 to fund the project through to its completion.

WNF, External or Grant Funded Items as at 31st December 2008

	Annual Revised Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000	Actual Including Committed Items £'000
Budgeting Skills Project	33	24	16	8	33

Regular monitoring reports are sent to the LSP in respect of all LSP projects and any areas of concern are dealt with throughout the year by the LSP support team and individual project managers. Some variances against the budget are expected, as the LSP have deliberately over-programmed in order to ensure that the full allocation of Working Neighbourhood Fund grant is spent during the year.

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage, due to a lack of information or a key milestone date being missed, whether the objective will be achieved within the appropriate timeframe.	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.

QUARTERLY MONITORING REPORT

DIRECTORATE: **Health & Community**

SERVICE: **Older People's Services**

PERIOD: **Quarter 3 to period end 31st December 2008**

1.0 INTRODUCTION

This quarterly monitoring report covers the Older People's Services Department third quarter period up to 31 December 2008 It describes key developments and progress against key objectives and performance indicators for the service.

The way in which traffic light symbols have been used to reflect progress to date is explained in Appendix 6

2.0 KEY DEVELOPMENTS

Modernisation of day services continues and all the projects, including the catering project will be evaluated in February.

Streamlining of the Halton Home Improvement and Independent Living Service will continue as part of the Carefirst 6 programme. The Adaptations Liaison Officer post to progress chase adaptation work is being evaluated and once completed recruitment will begin.

Registered Social Landlord partnership agreement expenditure is currently at £204K

The partnership with Warrington Disability Partnership is progressing well. Halton Disability Alliance has become the Halton Disability Partnership.

The Adult Placement Service has been inspected by the Commission for Social Care Inspection and the service was rated good. Two recommendations were made about recording and training and these have been implemented.

The Intermediate Care business plan; which includes the opening of a sub acute unit, assessment team, and age reduction to 18+, is on target to be delivered by April 2009.

The redesign of home care is on target for completion and being fully operational by 1st April 2009.

The community extra care service is now fully operational, and will be evaluated by April 2009.

Social care in practice pilot is operational, and will be evaluated by July 2009.

3.0 EMERGING ISSUES

A Halton Home Improvement and Independent Living Service database will be established when the Adaptations Liaison Officer has been appointed, providing more comprehensive information to monitor timescales and targets. Work on the feedback and information packs continues.

To date, 110 adaptations have been approved under the partnership agreement with the Registered Social Landlords.

Leases on both units at Dewar Court have now been signed and refurbishment work at one unit estimated to take six weeks to complete is underway. IT services to both units need to be connected. Once work is completed the equipment store will be relocated.

Further investment from the PCT to support the impact of MDT approach within hospitals to ensure timely discharges, has been secured. Further work is ongoing in relation to developing a more integrated approach to continuing health care.

Reductions in the hospital bed base across both local acute trusts continues to have a significant impact across social care and Intermediate Care services.

Discussions with the PCT in relation to developing a wider range of local community services is taking place.

4.0 PROGRESS AGAINST MILESTONES/OBJECTIVES

Total	**25**		**18**		**1**		**0**

There are 19 key service plan milestones for this service and these are being reported this quarter. Of the six ‘other’ milestones for the service, all are progressing satisfactorily, and none of these are being reported by exception. These milestones will be routinely reported again in quarter 4. For a full commentary against each key milestone, please refer to Appendix 1.

5.0 SERVICE REVIEW

A review of the Halton Integrated Community Equipment Service has been commissioned as part of a Therapy Review in partnership with Halton and St Helens NHS. A report is expected early in 2009.

Environmental improvements at Oakmeadow are on target for completion by 1st April 2009.

Home Care consultation process has been completed, on target for new service to be rolled out from April 1st 2009.

Initial report on older people's mental health service has been completed. Further work to agree action plan to deliver on the strategic framework is now underway, and is anticipated to be in place by 1st April 2009.

6.0 PROGRESS AGAINST KEY PERFORMANCE INDICATORS

Total	**14**		**5**		**2**		**3**

Of the 14 key indicators for the service, ten have a report of progress against target and have been assigned traffic lights. A further 3 new national indicators cannot currently be reported as data is not yet available. For further information and commentary, please refer to Appendix 2.

6.1 PROGRESS AGAINST OTHER PERFORMANCE INDICATORS

Total	**14**		**2**		**3**		**3**

Other indicators are routinely reported in quarters 2 and 4. Of the fourteen 'other' indicators for the service, two are progressing satisfactorily against target and are not reported this quarter. A further four indicators cannot be assessed as data is not yet available, these are new National Indicators. Two Place Survey indicators are being reported for the first time this quarter, but no traffic light is assigned as these are new and targets were not set. SDix further indicators are being reported by exception this quarter, for further information and commentary, please refer to Appendix 3.

7.0 PROGRESS AGAINST LPSA TARGETS

For details against progress towards LPSA targets, please refer to Appendix 4

8.0 RISK CONTROL MEASURES

During the production of the 2008-09 Service Plan, the service was required to undertake a risk assessment of all Key Service Objectives.

Where a Key Service Objective has been assessed and found to have associated 'High' risk, progress against the application of risk treatment measures is to be monitored, and reported in the quarterly monitoring report in quarters 2 and 4. There were no high priority risk treatment measures established for this service.

9.0 PROGRESS AGAINST HIGH PRIORITY EQUALITY ACTIONS

During 2007/08 the service was required to undertake an Equality Impact Assessment. Progress against actions identified through that assessment, with associated High priority are to be reported in the quarterly monitoring report in quarters 2 and 4.

10.0 DATA QUALITY

The author provides assurance that the information contained within this report is accurate and valid and that every effort has been made to avoid the omission of data. Where data has been estimated, has been sourced directly from partner or other agencies, or where there are any concerns regarding the limitations of its use this has been clearly annotated.

11.0 APPENDICES

Appendix 1- Progress against Key Objectives/ Milestones
Appendix 2- Progress against Key Performance Indicators
Appendix 3- Progress against Other Performance Indicators
Appendix 4- Progress against LPSA targets
Appendix 5- Financial Statement
Appendix 6- Explanation of traffic light symbols

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
OPS 1	Evaluate, plan, commission and redesign services to ensure they meet the need of vulnerable people within the local population, including those from hard to reach group (including the black and minority ethnic community)	Analyse need and submit bids to DoH, Housing Corporation or other pots for at least one extra care development to provide additional extra care tenancies in Halton Mar 2009.		Analysis and extra care strategy complete, application submission to the housing corporation needs to be completed.
		Establish strategy to improve performance and service delivery to BME Community, to ensure services are meeting the needs of the community Jun 2008.		Peer review completed. Council wide steering group considering the needs of all minority groups within the borough to ensure we target services at all groups proportionally.
		Complete review of extra care housing model for Halton Jul 2008.		Review completed.
		Identify options to re-design Older People Day Services May 2008		All community projects to be evaluated in February as part of day service modernisation programme.
OPS 2	Work in partnership to enhance joint working arrangements and delivery of services to vulnerable people	Lead council input into developing Local Area Agreement Health and Older Peoples block June 08		Complete - agreement signed off.

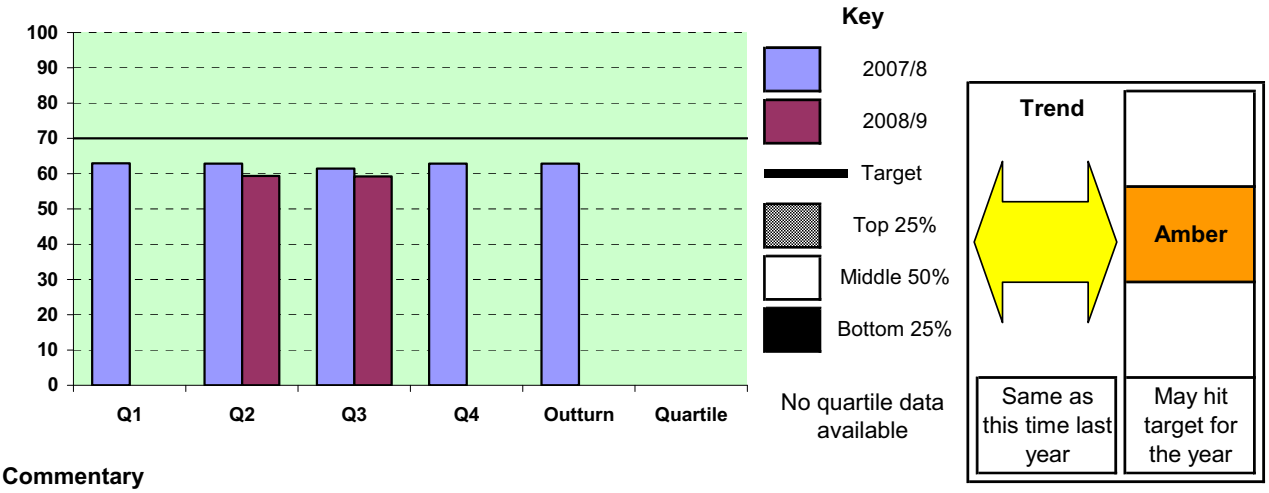
Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		Continue to contribute to the implementation of Change for the Better, the 5BP's new model of care for mental health services, thus ensuring that services are based on recovery and social inclusion Mar 2009.		On target for agreement to deliver on new model of care by March 2009.
		In partnership with Halton and St Helen's PCT, refocus care provision at Oakmeadow in line with Intermediate Care approach Nov 2008		Completed within agreed timescales.
		Redesign of Intermediate Care Services, in partnership with Halton and St Helens PCT Mar 2008		Review Completed.
		Establish pilot joint service to support primary care through Runcorn Practice Based Commissioning (PBC) Consortium July 2008		Pilot established and fully operational.
OPS 3	Provide facilities and support to carers, assisting them to maintain good health and well-being	Increase the number of carers provided with assessments leading to provision of services, including black and minority ethnic carers, to ensure Carers needs are met Mar 2009		On target to exceed the anticipated number of carers identified.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		Maintain the numbers of carers receiving a carers break Mar 2009		On target to increase the number of carers and carers breaks.
OPS 4	Ensure that service delivery, commissioning and procurement arrangements are efficient and offer value for money	Aim to reduce the cost of transport element of meals on wheels contract to ensure cost effectiveness May 2008.		Completed.
		Establish or participate in working group with neighbouring authorities to re-provide equipment services linked to developing a retail model Oct 2008		Options to re-provide service now being considered as part of Therapy Review commissioned in partnership with Halton and St Helens NHS
		Build on learning for Halton from CSED improving care management efficiency project, identifying potential areas and priorities for redesign Jun 2008.		Areas for redesign have been identified and are being addressed.
		Integrate Home Improvement Agency and Independent Living Team to improve waiting times and efficiency Jun 2008.		Main project completed and continuous improvement programme in operation.
OPS 5	Promote physical activity, preventative services and therapy for vulnerable people to maintain optimum levels of health and wellbeing	Support development of joint process with PCT for implementation of new national guidance and toolkit for continuing health care Apr 2008		Completed.

Service Plan Ref.	Objective	2008/09 Milestone	Progress to date	Commentary
		Report to Health PPB on progress with delivering the Advancing Well Strategy Mar 2009		The linked action plan for the advancing well strategy has been reviewed and reported to the Healthy Halton PPB in December 2008.

OP LI7

Assessments of adults and older people leading to provision of a service



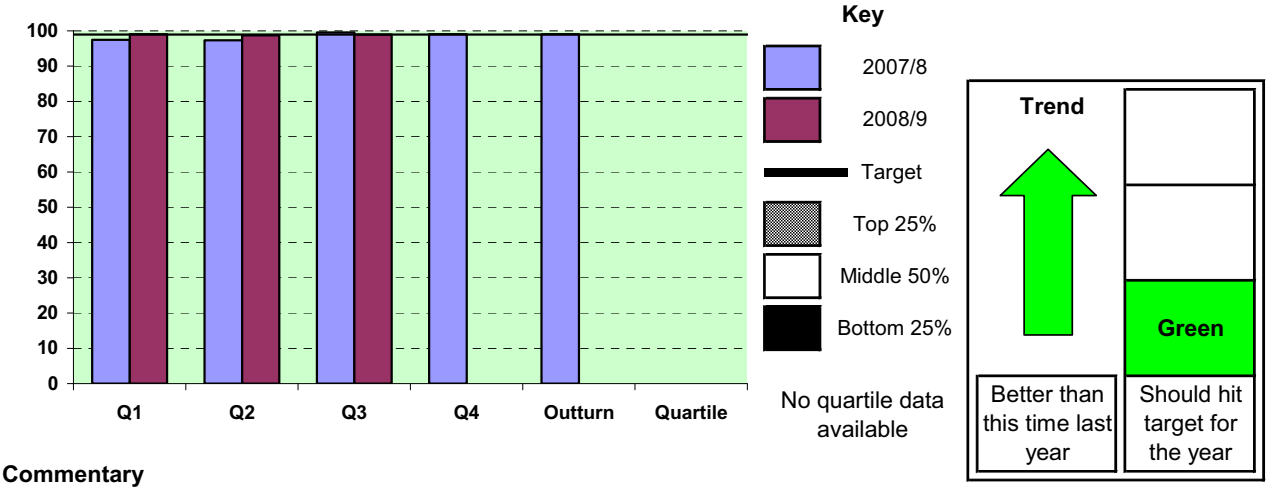
Commentary

Some teams are conducting investigative work as to the outcome of assessment to determine the reasons for the shortfall against this target.

Particular attention is being paid to methods to improve screening procedures

OP LI12

Percentage of people receiving a statement of their needs and how they will be met.

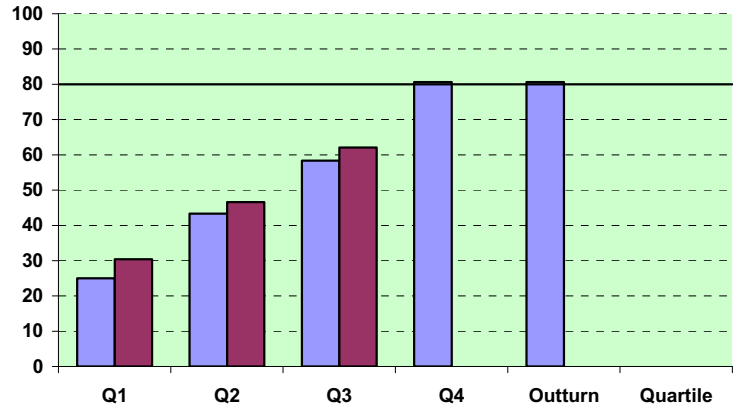


Commentary

Target met, no issues of concern

OP LI13

Clients receiving a review as a %age of adult clients receiving a service



Key

2007/8

2008/9

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Green

Better than this time last year

Should hit target for the year

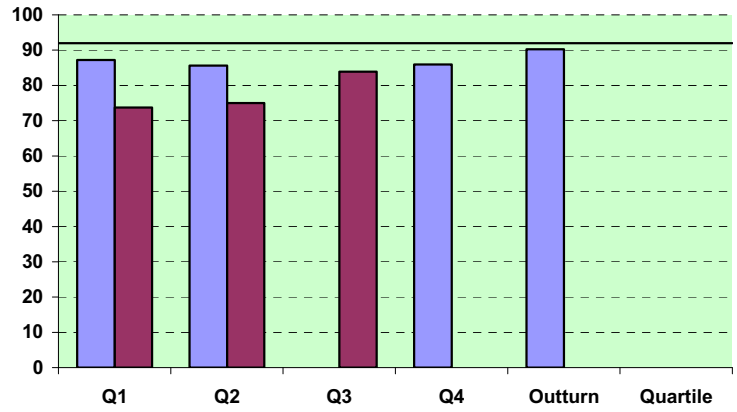
Commentary

Figure for Q3 is a cumulative. Indications are that target will be exceeded at year end.

OP LI14

Percentage of items of equipment delivered within 7 working days

Higher figures represent better performance



Key

2007/8

2008/9

Target

Top 25%

Middle 50%

Bottom 25%

No quartile data available

Trend

Red

Worse than this time last year

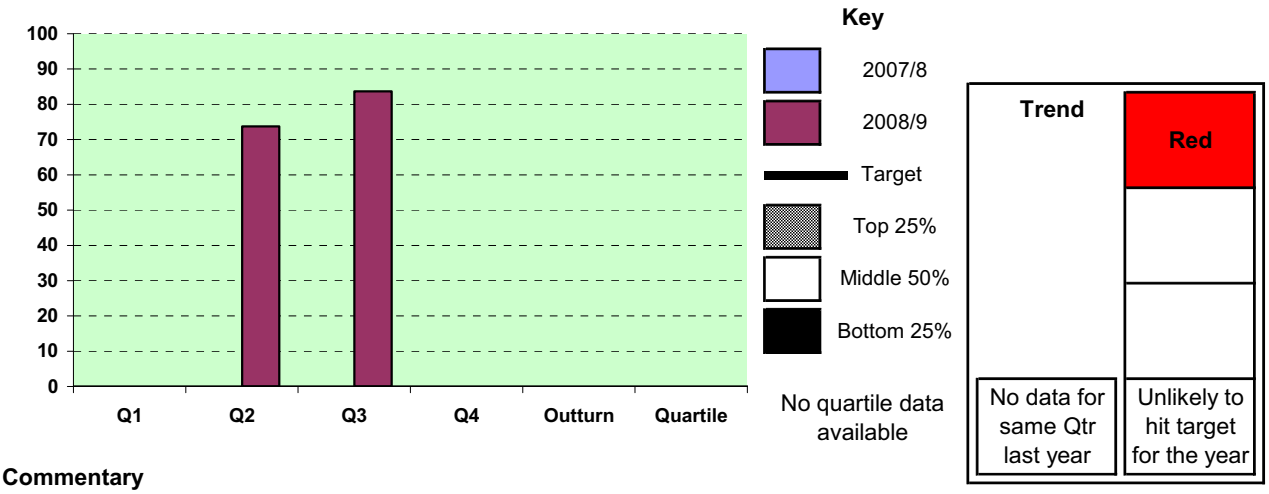
Unlikely to hit target for the year

Commentary

Several factors have led to a longer lead time between date of decision to delivery of equipment/adaptations, namely issues with the availability of the Joint Equipment store.

The amalgamation of the Joint Equipment Store with Health raised issues of hygiene for some existing equipment, which needed to be rectified prior to issue. This combined to ongoing problems with recalling some equipment has led to turnaround targets not being met.

OP NI 132 **Timeliness of social care assessment DH DSO**

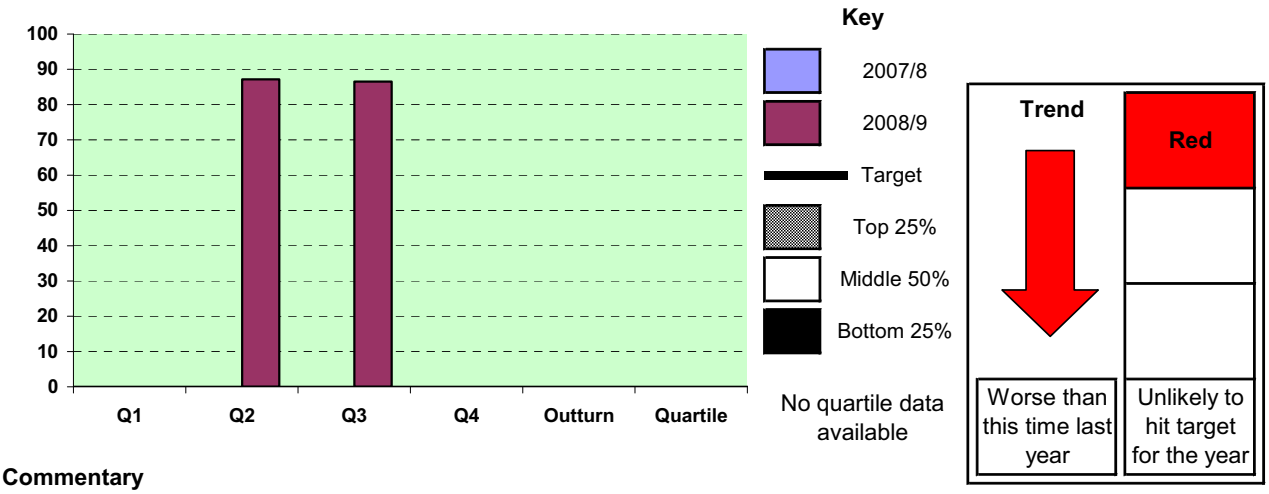


Commentary

Part 2 of the indicator is pulling the overall performance down for this aggregated indicator.

This is a result of the combination of Physical and Sensory Disability Team and the Halton Independent Living Services Team. The latter has a higher number of referrals and has been unable to meet the 28 day target. A review of procedures is underway to improve this.

OP NI 133 **Timeliness of social care packages DH DSO**



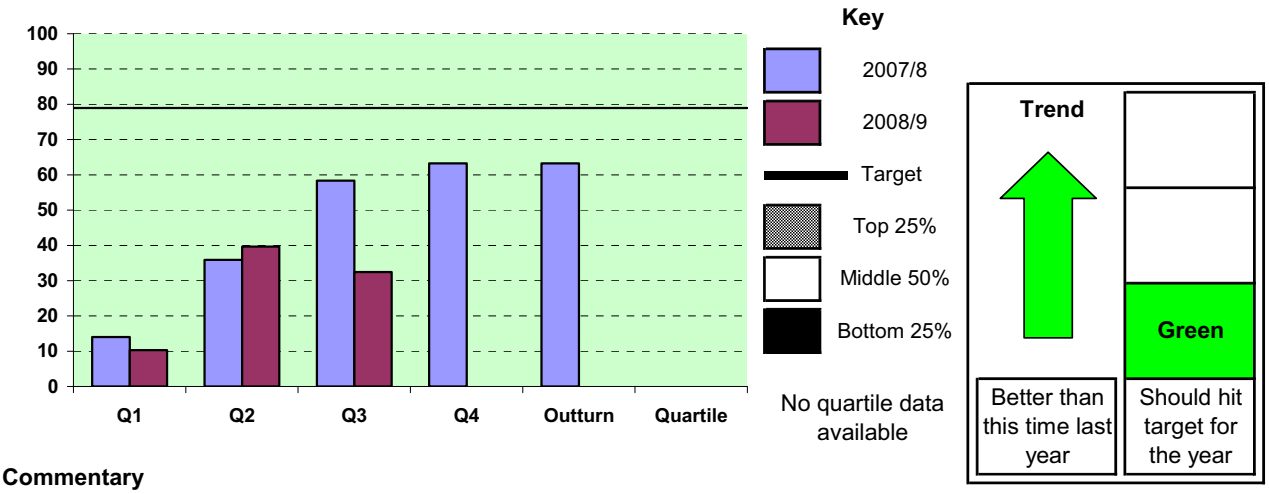
Commentary

Waiting times within 28 days is under-performing. Target amended to match SAS target.

This is a result of the combination of Physical and Sensory Disability Team and the Halton Independent Living Services Team. The latter has a higher number of referrals and has been unable to meet the 28 day target. A review of procedures is underway to improve this.

OP LI15

Admissions of supported residents aged 65+ to permanent residential/nursing care (per 10,000 population)

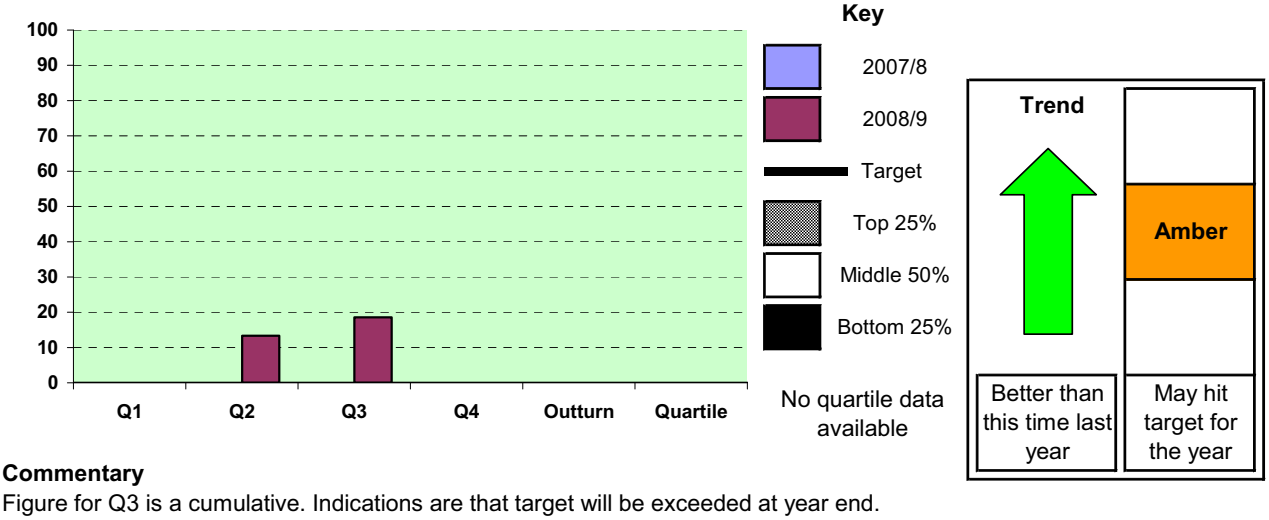


Commentary

Admissions Figure is low (54 Admissions to end December). The Older People population has increased meaning a lower outturn for Q3 as a result.

OP NI 135

Carers receiving needs assessment or review and a specific carer's service, or advice and information DH DSO

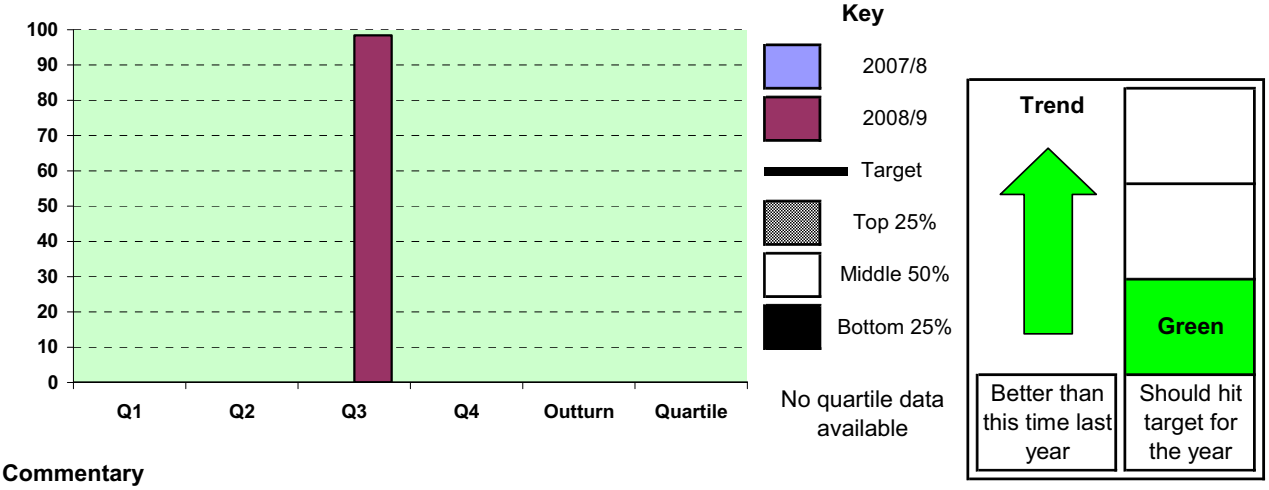


Commentary

Figure for Q3 is a cumulative. Indications are that target will be exceeded at year end.

OP NI 141

Number of vulnerable people achieving independent living CLG DSO

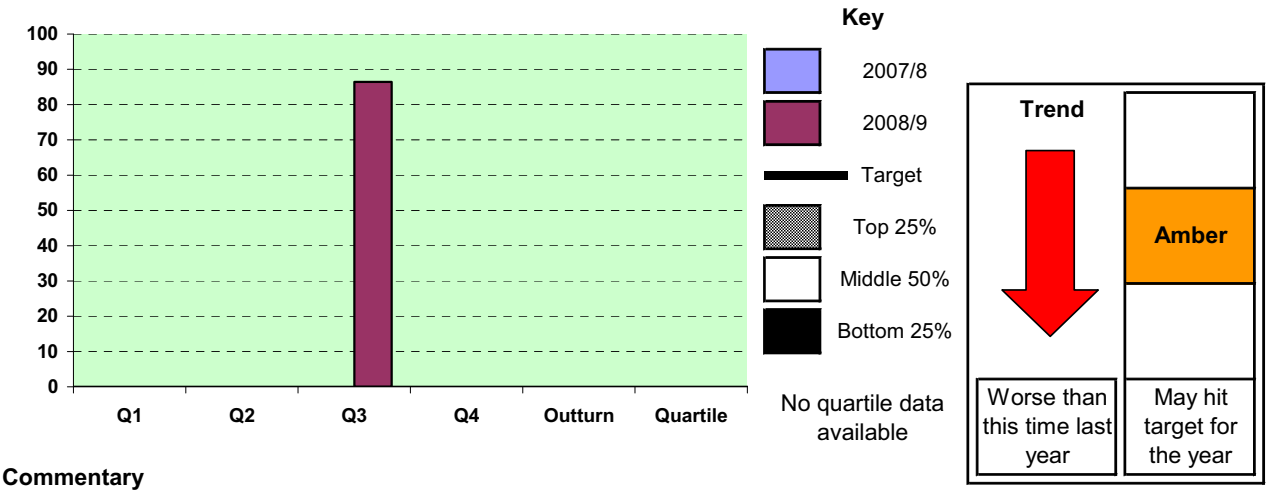


Commentary

Target is being exceeded at Q3 and indications are that target will be exceeded at year end

OP NI 142

Number of vulnerable people who are supported to maintain independent living CLG DSO



Commentary

The services within the generic group have been/are in the process of being re-purposed and there is an action plan in place for the Team Parent service.

KPIs not being reported this quarter

OP LI 4 No. of days reimbursement as a result of delayed discharge of older people;
Data not yet available from the PCT

NI 131 Delayed transfers of care;
Data not yet available from the PCT

NI 136 People Supported to Live independently through Social Care Services;
It is difficult to compare performance of this new indicator until we are able to compare against comparator data. The indicator includes data from the voluntary sector and caution should therefore be exercised regarding data quality. Targets here are incorrect and refer to the old PAF indicator that ceases to exist.

NI 125 Achieving independence for Older People through rehabilitation/Intermediate Care;
Data not available to report against this indicator. Work is being undertaken to develop this indicator.

Ref.	Description	Actual 2007/08	Target 2008/09	Quarter 3	Progress	Commentary
Cost & Efficiency						
OP LI1	Intensive home care as a percentage of intensive home care and residential care	27.15	28	25.53		The HH1 outturn for intensive households dropped in 2008 (some impact from CHC). Therefore the lower number of intensive households has resulted in a lower outturn for this indicator.
Fair Access						
OP LI5	Ethnicity of older people receiving assessment	0.19	1.1	0.78		Figures for Older People BME receiving an assessment are lower than the proportion of Older people BME in the local population.
OP LI6	Ethnicity of older people receiving services following assessment	0	1	0.56		Figures for Older People BME receiving services following assessment is low. Suggesting that people assessed from a BME group are less likely to receive a service than the White group of Older people in Halton.
OP LI8	% of older people being supported to live at home intensively, as a proportion of all those supported intensively at home or in residential care	38.28	28	25.53		The HH1 outturn for intensive households dropped in 2008 (some impact from CHC). Therefore the lower number of intensive households has resulted in a lower outturn for this indicator.
OP LI9	Percentage of adults assessed in year where ethnicity is not stated	0.14	0.5	1.00%		
Service Delivery						
OP LI16	Intensive home care per 1000 population aged 65 or over	11.43	13	10.3		The HH1 outturn for intensive households dropped in 2008 (some impact from CHC). Therefore the lower number of intensive households has resulted in a lower outturn for this indicator.

Ref.	Description	Actual 2007/08	Target 2008/09	Quarter 3	Progress	Commentary
NI 138	Satisfaction of people over 65 with both home and neighbourhood PSA 17	-	-	77.2%	Refer to comment	This is a new Place Survey indicator, for which data has just been released. Given the nature of this indicator, no target was set and until comparative data becomes available, it is difficult to place this performance figure in context. A further report will be made when the performance can be placed in context.
NI 139	The extent to which older people receive the support they need to live independently at home PSA 17	-	-	30.4%	Refer to comment	This is a new Place Survey indicator, for which data has just been released. Given the nature of this indicator, no target was set and until comparative data becomes available, it is difficult to place this performance figure in context. A further report will be made when the performance can be placed in context.

LPSA Ref.	Indicator	Baseline	Target	Perform 07/08	Perform. 08/09 Q3	Traffic light	Commentary
8.1	**Improved care for long term conditions and support for carers** Number of unplanned emergency bed days (Halton PCT registered population)	58,649 04/05	- 6% (55,130) for 08/09	47569	Refer to comment	-	Data to enable an update on this indicator has not yet been received from the PCT. Indicator will be reported at the earliest opportunity.
8.2	**Improved care for long term conditions and support for carers** Number of carers receiving a specific carer service from Halton Borough Council and it's partners, after receiving a carer's assessment or review	195 first six months of 04/05	600 for 08/09	823	775		There have been progressive and significant increases in delivery of this activity. The target for carers receiving services was exceeded in 2007/08, and is forecast to be further exceeded in 2008/09. This represents excellent performance against the LPSA target.

HEALTH & COMMUNITY – OLDER PEOPLE

Revenue Budget as at 31st December 2008

	Annual Revised Budget £000	Budget To Date £000	Actual To Date £000	Variance To Date (overspend) £000	Actual Including Committed Items £000
Expenditure					
Employees	6,019	4,284	4,217	67	4,242
Premises Support	178	0	0	0	0
Other Premises	174	30	24	6	34
Food Provisions	45	34	39	(5)	90
Supplies & Services	498	207	170	37	301
Transport	200	91	94	(3)	96
Departmental Support Services	1,759	0	0	0	0
Central Support Services	538	0	0	0	0
Community Care:					
Residential Care	7,611	4,743	3,872	871	3,872
Nursing Care	569	90	86	4	86
Home Care	2,040	1,311	1,266	45	1,266
Supported Living	347	223	261	(38)	261
Day Care	40	26	34	(8)	34
Meals	124	80	144	(64)	144
Direct Payments	297	191	192	(1)	192
Other Agency	1,022	187	172	15	173
Asset Charges	52	0	0	0	0
Total Expenditure	**21,513**	**11,497**	**10,571**	**926**	**10,791**
Income					
Residential & Nursing Fees	-2,926	-1,881	-1,823	(58)	-1,823
Fees & Charges	-675	-434	-493	59	-493
Preserved Rights Grant	-64	-49	-48	(1)	-48
Supporting People Grant	-849	-490	-423	(67)	-423
Nursing Fees - PCT	-569	-129	-125	(4)	-125
PCT Reimbursement	-118	-10	-10	0	-10
Joint Finance – PCT	-32	-16	-17	1	-17
Adult Stroke Services Grant	-85	-85	-85	0	-85
Reimbursements from PCT	-135	-135	-166	31	-166
Other Income	-1,157	-32	-37	5	-37
Total Income	**-6,610**	**-3,261**	**-3,227**	**(34)**	**-3,277**
Net Expenditure	**14,903**	**8,236**	**7,344**	**892**	**7,514**

Comments on the above figures:

In overall terms revenue spending at the end of Quarter 3 is under budget profile by £892k due mainly to expenditure on the Community Care budget being much less than anticipated at this stage of the year. However this also means a corresponding underachievement of residential income as less service users are being placed in residential accommodation.

APPENDIX FIVE – FINANCIAL STATEMENT
Older People's Services

It must be noted though, the proportion of service users paying higher contributions or even full costs has increased for both residential and domiciliary care services.

Expenditure on staff costs are below budget profile at this stage of the year due to a number of vacancies within the department. This budget is expected to be under budget profile at year-end.

The Community Care budget continues in its trend to be under budget profile, as more elderly people are being supported within their own homes rather than in residential accommodation. The success in gaining Continuing Care funding for residents is largely responsible for this underspend and the Community Care budget as a whole will continue to be monitored closely throughout the remainder of the financial year.

HEALTH & COMMUNITY – LOCAL STRATEGIC PARTNERSHIP BUDGET

Budget as at 31st December 2008

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (Overspend) £'000	Actual Including Committed Items £'000
Priority 1 Healthy Halton					
Diet & Exercise Programme	22	16	0	16	0
Vunerable Adults Task Force	200	150	156	(6)	156
Vol. Sector Counselling Proj.	40	30	16	14	16
Info. Outreach Services	34	26	17	9	17
Reach for the Stars	35	26	0	26	0
Health & Comm Care & Vol Sector Carers' Forum	40	30	23	7	23
Healthy Living Programme	20	15	0	15	0
Advocacy	44	33	49	(16)	49
Capacity Building	25	19	0	19	0
Dignity	25	19	0	19	0
Falls Monitor	27	20	0	20	0
Mens Health Exp	60	45	0	45	0
Mens Health over 75	40	30	0	30	0
Malnutrition	20	15	0	15	0
Relationship Centre	20	15	0	15	0
Priority 2 Urban Renewal					
Landlord Accreditation Programme	30	22	29	(7)	29
Priority 4 Employment Learning & Skills					
Voluntary Sector Sustainability	7	5	0	5	0
Priority 5 Safer Halton					
Good Neighbour Pilot	10	7	2	5	2
Grassroots Development	9	7	5	2	5
Total Expenditure	**708**	**530**	**297**	**233**	**297**

APPENDIX FIVE – FINANCIAL STATEMENT
Older People's Services

HEALTH & COMMUNITY

Capital Budget as at 31st December 2008

	2008/09 Capital Allocation £000	Allocation To Date £000	Actual Spend To Date £000	Allocation Remaining £000
Social Care & Health				
Redesign Oakmeadow Communal Spaces & Furnishings	72	50	0	72
Major Adaptations for Equity release/Loan Schemes	100	70	0	100
Pods utilising DFG	40	30	0	40
Women's Centre	19	14	3	16
DDA	24	18	0	24
Total Spending	255	182	3	252

Comments on the above figures:

Work started on the redesign of Oakmeadow communal spaces & furnishings on January 4th 2009. This project is expected to be fully committed at year-end.

The two POD schemes utilising DFG are still progressing however the organisational and preparatory work in delivering this innovative way of carrying out adaptations has been more complicated & protracted than anticipated & other factors have resulted in delays. If either case is completed the budget will be fully spent at year-end.

Work has commenced on the Women's centre and the remaining allocation is fully committed.

All work has now been completed on the Direct Door Access therefore the budget is committed and invoices are due to be paid this financial quarter.

The traffic light symbols are used in the following manner:

		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	Indicates that the target is on course to be achieved.
Amber		Indicates that it is unclear at this stage, due to a lack of information or a key milestone date being missed, whether the objective will be achieved within the appropriate timeframe.	Indicates that it is either unclear at this stage or too early to state whether the target is on course to be achieved.
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	Indicates that the target will not be achieved unless there is an intervention or remedial action taken.