The Health
Quality Service

HQS

in association with
the King's Fund

The Health Quality Service accreditation programme

VOLUME
ONE

THIRD EDITION

The Health Quality Service
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in association with the King's Fund

UKAS QUALITY MANAGEMENT
083

The Health Quality Service accreditation programme

VOLUME ONE

The Health Quality Service organisational standards incorporating the controls assurance programme, for organisations providing acute hospital services, community health services, learning disability services, mental health

THIRD EDITION

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Preface

THIS NEW edition of The Health Quality Service accreditation programme has been extensively revised and updated to reflect government health policy and guidance in the various parts of the United Kingdom as well as taking account of changes and developments in quality assurance and improvement programmes nationally and internationally.

These latest standards address our main development concerns around the patients' experience of care, the experience of staff working within the organisation, clinical governance, leadership and teamwork. The standards also continue to include those previous and essential elements concerning systems, processes and environment.

The philosophy that continues to inform our work and which is reflected in this new programme is that quality care and service for individuals is best assured when:

- There is a strong commitment to continuous improvement in patients' care and experience whilst ensuring the resources are used well.
- The requisite physical, technical and organisational environments are in place to enable staff to give of their best.
- Those who provide and deliver service are fully engaged and supported in influencing and achieving desirable change.
- The promotion of continuous improvement and self development is based on proper accountability and the achievement of essential standards of good practice.
- The whole organisation, service or systems are functioning well.

These revised standards we believe are demanding but realistic and arise from legislation, research evidence, professional guidance and extensive consultation with people working within the health care system. However, perhaps the main way that we develop our standards and process is by receiving comments and suggestions from the clients that we work with and we hope that you continue to make that essential contribution.

Peter Griffiths
Executive Director

Health Quality Service: List of Directors

Executive Director:	Peter Griffiths
Director of Development:	Andrew Corbett-Nolan
Director of Operations:	Gordon Mitchell

Introduction

WELCOME to the third edition of The Health Quality Service accreditation programme standards manual, for NHS trusts providing acute hospital services, community health services, mental health services, learning disability services and specialist palliative care services. The standards and criteria have been developed and extensively revised in response to the government's white papers, shaping a new approach to health services.

The accreditation programme comprises a whole system, quality improvement tool. The standards measure the quality capability of the trust through the assessment of the patient's experience of the organisation, staff experience of the organisation, clinical effectiveness of the care provided, efficiency of the trust's services and access to those services. The themes of people, process and environment run through all the standards as a common thread.

Links to other quality programmes

The Health Quality Service accreditation programme complements local and national quality initiatives, recognises and spreads good practice within the trust and supports continuous organisational development.

The accreditation programme covers the issues addressed in the NHS Executive risk management strategy evaluation guide, which sets out those systems which need to be in place with regard to the controls assurance statement made by the chief executive on behalf of the trust board.

Also included within the standards are criteria which relate to the clauses of the ISO9002 quality systems standard. Those organisations which wish to be audited to the ISO9002 standard will need to demonstrate that they comply with all the criteria indicated as ISO linked in the text of the standards.

In addition, the standards and criteria cover some of the same themes as the indicators which make up the Investors in People national standard. Working with the HQS accreditation programme will mean that many elements are in place for an Investors in People assessment, likewise, an organisation that has achieved Investors in People recognition will find that the work significantly contributes towards full compliance with criteria relating to staff development and training in the accreditation programme.

The standards framework

The standards have been developed through extensive consultation with organisations representing the interests of patients and service users, health professionals, employers and statutory bodies. The development process included workshops, individual submissions and discussions, together with the circulation of standards for comment to over 100 professional bodies, consumer organisations, sections of the Department of Health and experienced HQS peer review surveyors.

The standards are grouped in four sections:

Section 1: corporate and clinical governance

Covering the corporate functions of an NHS trust; organisational structure and management; human resources; financial management; risk management; the trust's responsibilities with

respect to clinical governance and an overview of the leadership of the organisation.

Section 2 : operational management
All services and departments across the trust work with this set of core standards which include management and training at service level, setting objectives and planning for service delivery, the environment within which the service operates and quality improvement and development of services.

Section 3 : the patient's experience
This section covers patients' rights, the response of the trust to the individual needs of patients and how initiatives for partnership with patients are taken forward. All services in the organisation need to be aware these standards and contribute to achieving them. The second group of standards in section 3 tracks the patient's journey from referral and admission through treatment and care to discharge and the recording of this in the health record. All clinical services work with the four standards that make up the patient's journey section.

Section 4 : service specific standards
These standards cover a range of specific clinical and non clinical services and should be distributed as appropriate to the services/departments within the trust. This is not intended to be a comprehensive list of all services but includes criteria which are specific to certain services only. For many services, key functions are covered through section 2 : operational management standards and section 3 : the patient's experience standards. Service specific standards should always be used in conjunction with the operational management standards and with the patient's experience standards for clinical services.

In addition, there are three appendices:

Corporate checklist
A list of criteria from section 1: corporate and clinical governance, which will need to be tested throughout the trust by the HQS survey, for example, criteria which require circulation of trust strategies and policies and the involvement of staff in the development of these.

References
Lists the legislation, official guidance, professional guidance and other publications which are referenced within the standards, either in criteria or the supporting guidance.

Glossary of terms
The glossary gives guidance on how certain terms have been interpreted in the accreditation programme.

Format of each standard

Each standard covers a discrete issue, or area of work and is made up of criteria statements, which are designed to be measurable through the assessment and survey process, flexible and applicable across a range of different types of organisation and settings, adaptable in that they can be implemented according to local circumstances.

Weighting classifications
The criteria are each allocated a priority weighting, in order to identify criteria relating to essential practice, to help prioritise the work and to determine those criteria which must be in place in order for the trust to be awarded accreditation. The weightings have been agreed in consultation with health professionals and with advice from professional associations. The classifications are:

A Accreditation criteria
Relating to:

- legal, professional or Department of Health requirements or guidance
- potential risk to patients/users, staff or visitors
- the patient's rights
- accepted standards of sound organisational practice

B Enhanced practice criteria
organisations aiming to provide quality services should be working to achieve these.

Guidance
Guidance information is shown in italics beneath many of the criteria in the manual. The aims of the guidance are threefold: firstly, to help staff interpret the criteria and to provide a reference to the relevant legislation or professional guidance; secondly, to provide guidelines for meeting the criteria; and thirdly, to provide an indication of the areas that the surveyors will be assessing during the survey.

Key to symbols
New standards in this edition of the programme are indicated by a flag (⚑) in the contents list and by the title of the standard in the body of the manual. In other standards, criteria that are new (rather than revised) in this edition also have the flag symbol next to the weighting.

Criteria that link to the clauses of the ISO9002 standard for quality systems are identified by 'ISO' in the column next to the criteria weighting.

Outline of the programme

The programme works through several assessment stages to measure compliance with the standards, beginning with self assessment in services/departments, followed an internal survey undertaken by the trust. The final assessment stage is an external peer review survey, facilitated by the Health Quality Service, carried out by a team of senior healthcare professionals. From the survey findings a report is compiled which goes to the HQS Accreditation Committee for assessment of the level of accreditation to be awarded.

Preparation, self-assessment and implementation
From the point of commitment to the accreditation programme, a trust will usually work towards the external peer review survey over a period of approximately twelve months, using the standards as a framework for service development and improvement. The appointment of a project manager within the trust to lead the process and an active steering group are central to gaining maximum benefit from participation in the programme. Full information on the accreditation programme and the implementation process are found in the publication, Guidance for project managers.

The first stage of implementation is the distribution of standards across the organisation, with all services working with the operational management standards (section 2) and all clinical services working with the patient's journey standards (included in section 3). An initial baseline assessment of compliance with the standards and criteria is carried out to identify priorities for action through completing the self-assessment questionnaires for each appropriate standard. These are completed for each department/service.

Staff at all levels should be involved in working with the criteria relevant to their area of work. This will encourage ownership of the process and group discussion. It will also facilitate the identification of weak and problem areas, bringing out different staff members' perceptions of how well their service is complying with the criteria. There is limited value in a manager completing the self assessment of the service against the criteria based only on their own view of the situation.

A cross-departmental, internal survey is recommended, to be conducted four to six months before the HQS survey. Six weeks prior to the survey, a new set of self-assessment forms (supplied on disk from HQS) are completed and circulated to the survey team with supporting background documentation, such as the trust's business plan and annual report to give the survey team an overview of the organisation.

The Survey
An independent team of senior health professionals, chosen for their experience, knowledge, credibility and appropriateness for the organisation, undertake the peer review survey. Surveyors are selected and trained by The Health Quality Service. The survey, which lasts between two to five days, starts with a documentation review, checking compliance with the A weighted accreditation criteria in the programme which require documents for verification, (for organisations seeking ISO9002 certification, documents relating to B weighted criteria will also need to be presented as part of the documentation review). This is followed by a series of scheduled interviews with staff at all levels in the trust, informal meetings with patients/users and visits to a wide range of service areas to observe the environment and work practices in operation. (Detailed instructions on preparation for the survey are contained in the publication, Guidance for project managers).

Survey Report
A short verbal debriefing is given at the end of the survey, summarising key themes and overall observations. A written report follows which includes a comprehensive assessment of compliance against the standards. The report also highlights good practice and provides a basis for developing action plans and monitoring progress.

Accreditation Award
Decisions with regard to HQS accreditation and certification to ISO9002 are based upon the findings recorded in the survey report and are made by the Accreditation Committee of The Health Quality Service. The members of the committee comprise the directors of HQS and members of the HQS advisory council, who are drawn from national professional associations, relating to health care.

In order to achieve full HQS accreditation, the trust must demonstrate compliance with all applicable A weighted criteria. Accreditation may be achieved through a staged approach with the survey findings highlighting points for further action in order to achieve accreditation. Further assessment is undertaken through either the submission of documentation, or a focused re-survey.

To gain ISO9002 certification an organisation must, in addition, meet those B weighted criteria which are identified in the standards, as linking to the clauses of the ISO 9002 standard.

Standards Review and Revision

In order to ensure that The Health Quality Service standards and criteria reflect changes in health care and are representative of best practice, we will continue to review them on an ongoing basis, in response to National Service Frameworks and other developments.

To assist us in this process there is a section at the end of each standard for comments to be recorded. Please encourage staff working with the standards to complete the feedback sheets and return to HQS, so that we are kept up to date with feedback from programme participants.

Andrew Corbett-Nolan
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Acknowledgements

The production of the accreditation programme standards manual would not have been possible without the contribution of many individuals. These include:

- staff at all levels from NHS trusts and independent hospitals who contributed to the standards development process through commenting on the standards while participating in the programme, attendance at standards development workshops and responses at the consultation phase

- HQS surveyors who contributed to the standards development workshops and in the consultation exercise, bringing their health care expertise and experience of surveying to bear on standards development

- the professional bodies, consumer organisations and user groups who have contributed, through attending workshops and in response to consultation, to ensure that different perspectives are reflected in the standards

- representatives from statutory and professional organisations who provided specific expertise on the relevant regulations and guidance.

We acknowledge the extent to which the standards draw on existing guidance, produced by the Department of Health and professional bodies, the source material is referenced throughout the manual and listed in full in the appendices.

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Age Concern

Association for Hospice Management
Association for Improvements in the Maternity Services
Association for Palliative Medicine
Association of British Paediatric Nurses
Association of Clinical Pathologists
Association of Community Health Councils for England and Wales
Association of Domestic Management
Association of Healthcare Human Resource Management
Association of Hospice Social Workers
Association of Hospice Voluntary Service Co-ordinators
British Association for Accident and Emergency Medicine
British Association of Day Surgery
British Association of Medical Managers
British Association of Otorhinolaryngologists
British Dietetic Association
British Medical Association
British Orthopic Society
Carers National Association
Chartered Institute of Purchasing and Supply
Chartered Society of Physiotherapy
Clinical Pathology Accreditation UK Ltd
College of Health
College of Health Care Chaplains
College of Occupational Therapists
College of Optometrists
Community Practitioners & Health Visitors Association
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Faculty of Occupational Medicine
General Medical Council
Health & Safety Executive
Health Estate Facilities Management Association
Healthcare Financial Management Association
Help the Hospices
Hospice and Specialist Palliative Care Nurse Managers' Forum
Independent Healthcare Association
Infection Control Nurses Association
Institute of Health Services Management
Institute of Sterile Services Management
Institute of Wastes Management
Macmillan Cancer Relief
Medical Protection Society
Mental Health Foundation
MIND
National Association of Hospital Fire Officers
National Association of Theatre Nurses
National Board for Nursing, Midwifery and Health Visiting for Scotland
National Consumer Council
National Council for Hospices and Specialist Palliative Care
NHS Confederation
NHS Executive
Public Health Laboratory Service
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians & Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Speech and Language Therapists

Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Scottish Association for Mental Health
Scottish Association of Health Councils
The Association of Anaesthetists of Great Britain and Ireland
The Association of Medical Secretaries, Practice Administrators, and Receptionists Ltd
The Association of Operating Department Practitioners
The British Institute of Radiology
The Faculty of Accident and Emergency Medicine
The Medical Defence Union Ltd
The Medico-Legal Society
The Royal Society of Medicine
The Sainsbury Centre for Mental Health
United Kingdom Central Council for Nursing, Midwifery and Health Visiting
Welsh National Board for Nursing, Midwifery and Health Visiting

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Linda Howard	for the development of criteria on the patient's experience and staff experience throughout the manual, particularly the human resources, healthy workplace, staff development and education and patient's journey standards
Maurice Taylor	for contribution to information management and technology standard

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Section 1: corporate and clinical governance

The standards in this section cover the corporate functions of the trust from the organisational structure and management arrangements, to human resources, financial management and risk management, together with the trust's responsibilities in respect of clinical governance and an over view of the leadership of the organisation.

Standards:
Section 1: corporate and clinical governance

Standard 1	organisational and service leadership	
Standard 2	corporate governance	
Standard 3	clinical governance	
Standard 4	working with commissioners	
Standard 5	quality improvement	
Standard 6	risk management - health and safety - fire safety - infection control - waste disposal - security	
Standard 7	human resources - healthy workplace	
Standard 8	occupational health	
Standard 9	staff experience	
Standard 10	communication	
Standard 11	financial management	
Standard 12	buying and selling goods and services	
Standard 13	information management	
Standard 14	facilities and estates management	

Working with the Standards and Criteria
(This information needs to be copied and to accompany every set of standards distributed for self assessment throughout the trust)

Format of each standard
Each standard covers a discrete issue, or area of work and is made up of criteria statements.

Weighting classifications
The criteria are each allocated a priority weighting, in order to identify criteria relating to essential practice, to help prioritise the work and to determine those criteria which must be in place in order for the trust to be awarded accreditation. The classifications are:

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Guidance
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In addition, some criteria are cross referenced to other standards, where they relate, in part, to the work of other services/departments.

Key to symbols
New standards in this edition of the programme are indicated by a flag (⚑) in the contents list and by the title of the standard. In other standards, criteria that are new (rather than revised) in this edition also have the flag symbol in the column next to the weighting. Criteria that link to the clauses of the ISO9002 standard for quality systems are identified by 'ISO' in the column next to the criteria weighting.

Outline of the programme
The programme works through several assessment stages to measure compliance with the standards, beginning with self assessment in services/departments. Once individual services/departments have had the opportunity to devise and implement action plans to develop services, in response to findings of the self-assessment, it is recommended that a cross-departmental internal survey is undertaken by the trust. The final assessment stage is an external peer review survey, facilitated by the Health Quality Service, carried out by a team of senior healthcare professionals. From the survey findings a report is compiled which goes to the HQS Accreditation Committee for assessment of the level of accreditation to be awarded.

Completing the self-assessment
Staff at all levels should be involved in working with the criteria relevant to their area of work to encourage ownership of the process and group discussion. Collating a range of different staff members'

Section 1: corporate and clinical governance

The standards in this section cover the corporate functions of the trust from the organisational structure and management arrangements, to human resources, financial management and risk management, together with the trust's responsibilities in respect of clinical governance and an over view of the leadership of the organisation.

Standards:
Section 1: corporate and clinical governance

Standard 1	organisational and service leadership	⚑
Standard 2	corporate governance	
Standard 3	clinical governance	⚑
Standard 4	working with commissioners	⚑
Standard 5	quality improvement	
Standard 6	risk management	
	- health and safety	
	- fire safety	
	- infection control	
	- waste disposal	
	- security	
Standard 7	human resources	
	- healthy workplace	
Standard 8	occupational health	
Standard 9	staff experience	⚑
Standard 10	communication	
Standard 11	financial management	
Standard 12	buying and selling goods and services	
Standard 13	information management	
Standard 14	facilities and estates management	

perceptions of how well their service is complying with the criteria will facilitate the identification of weak and problem areas. There is limited value in a manager completing the self assessment of the service against the criteria based only on their own view of the situation.

For each criterion, indicate the level of compliance by ticking the box for 'yes', 'no' or 'progress' as appropriate. Where the response is 'no' or 'progress', notes should be included on what is in place and the plans for achieving compliance.

The self-assessment should be carried out at least twice, once as a baseline assessment at the start of the process and later, once there has been the opportunity to start to implement action plans, as agreed by the trust's steering group and facilitated by the project manager.

Accreditation and certification
Note, in order to achieve HQS accreditation there must be compliance with all A weighted criteria.

In order to achieve ISO9002 certification there must be compliance with all criteria identified as 'ISO'.

Feedback to HQS on the standards
Please use the feedback sheet at the end of the section to alert HQS if there are criteria which are difficult to interpret, out of date or require further guidance

Standard 1 : organisational and service leadership

The subject of leadership and its particular attributes occupies increasing numbers of books and libraries and the following is an attempt to distil the literature and define the essential characteristics of leadership in a health organisation context. Increasingly leadership is seen as being distributed among diverse individuals, with leaders sharing responsibility for creating the organisation's future. The following definitions and criteria provide a framework for reviewing and improving leadership performance at all levels.

Definition
Leadership in health care embraces good management (doing the right things) and good administration (doing things the right way) but is concerned overall with:-

- Shaping and managing change and improvement for the future taking account of the experience, views and aspirations of service users, providers and funders **(Direction)**
- Providing the necessary supportive, physical, technical and organisational environment that enable and encourage individuals and teams to make the best use of their skills, experience and creativity **(Motivation)**
- defining and seeking to continuously improve standards of care and service **(Performance)**

Criteria

Direction

			YES	NO	PROGRESS
1.1	The ambitions and aspirations for how services will be delivered and developed are stated and communicated.	B	☐	☐	☐

Notes for action planning:

Standard 1: organisational and service leadership
CONTINUED

1.2 All stakeholders have the opportunity to influence the statement of aspiration and intent and are involved in reviewing its impact.

B YES ☐ NO ☐ PROGRESS ☐

1.3 There are documented means for identifying specific objectives, priorities and timescales for carrying forward declared aims.

B YES ☐ NO ☐ PROGRESS ☐

1.4 There are parallel communication channels for the flow of information between management and staff at all levels, and these are used to disseminate messages about the aspirations, aims, objectives and their implementation.

B YES ☐ NO ☐ PROGRESS ☐

Motivation

1.5 The experience of stakeholders, that is, patients/users staff and commissioners is routinely assessed and informs how services are managed, delivered and developed.

B YES ☐ NO ☐ PROGRESS ☐

1.6 Ideas about service improvement and creative solutions to identified problems are actively encouraged from staff at all levels in the trust.

B YES ☐ NO ☐ PROGRESS ☐

1.7 The development and performance of individuals and teams is regarded as the most important means of securing quality care and service.

B YES ☐ NO ☐ PROGRESS ☐

1.8 Individuals and teams are involved in determining and reviewing the standards of physical, technical and organisational environments that will affect their performance.

B YES ☐ NO ☐ PROGRESS ☐

1.9 Systems and processes are in place for assessing and actioning the development needs of those individuals and teams.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 1: organisational and service leadership
CONTINUED

Performance

			YES	NO	PROGRESS
1.10	The standards of care and service to be achieved are defined and formally reviewed.	B	☐	☐	☐
1.11	There are policies, procedures and systems in place to facilitate the achievement of the stated standards of care and service.	B	☐	☐	☐
1.12	The accountabilities and responsibilities of individuals and teams are defined, widely communicated and regularly reviewed.	B	☐	☐	☐
1.13	Information systems and processes are in place to:				
1.13.1	support the efficient and effective delivery of care and services	B	☐	☐	☐
1.13.2	assess stakeholders' experience	B	☐	☐	☐
1.13.3	regularly review progress in achieving objectives	B	☐	☐	☐
1.13.4	maintain financial control.	B	☐	☐	☐
1.14	The channels of face to face and written communication, including performance review are defined, well understood and regularly reviewed.	B	☐	☐	☐
1.15	There is a review system in place for measuring the performance of the trust as a whole against the stated ambitions and aspirations.	B	☐	☐	☐
1.16	The achievements and performance of the service as a whole is reported on, at least annually, to all stakeholders.	B	☐	☐	☐

Notes for action planning:

Standard 1: organisational and service leadership
CONTINUED

Teamworking

Teams are the essential means through which people share their knowledge, skills, experience and perspectives in order to:

- achieve well co-ordinated care or treatment for patients/users
- meet defined project, service or whole organisation objectives and requirements
- enhance personal and collective learning and development.

Teams have formal recognition and accountability (as opposed to informal groups). Listening is as important as talking in team communication

Purpose, objectives, accountabilities

1.17	The overall purpose of the team is defined and widely communicated.	B	YES ☐	NO ☐	PROGRESS ☐
1.18	The composition of the team is set out, as are the responsibilities and accountabilities of team members.	B	YES ☐	NO ☐	PROGRESS ☐
1.19	The role of the team leader, the individual responsible for the overall performance and effectiveness of the team, is communicated.	B	YES ☐	NO ☐	PROGRESS ☐
1.20	The specific objectives and priorities for the team are explicitly agreed.	B	YES ☐	NO ☐	PROGRESS ☐
1.21	The team reviews its work regularly in the context of the results it is achieving.	B	YES ☐	NO ☐	PROGRESS ☐
1.22	The team identifies its development needs.	B	YES ☐	NO ☐	PROGRESS ☐

Notes for action planning:

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Standard 1: organisational and service leadership
CONTINUED

1.23 The team has processes and procedures in place to govern the following:

1.23.1 recording, agreeing and actioning team conclusions and decisions

1.23.2 frequency, location, timing and duration of meetings

1.23.3 attendance at meetings

1.23.4 communications, internally and externally.

B YES ☐ NO ☐ PROGRESS ☐

B YES ☐ NO ☐ PROGRESS ☐

B YES ☐ NO ☐ PROGRESS ☐

B YES ☐ NO ☐ PROGRESS ☐

Motivation, performance and development

1.24 Teams are most effective where the contribution of all members is encouraged, expected and valued.

B YES ☐ NO ☐ PROGRESS ☐

1.25 Team members should feel able to contribute fully on all subjects and not be restricted to particular contributions only. Making use of individual personal qualities and strengths is as important as professional contributions.

B YES ☐ NO ☐ PROGRESS ☐

1.26 Team leaders have a particular responsibility in setting the tone for meetings, encouraging contribution and listening, resolving difficulties and ultimately deciding, or recommending to others, the action to be taken.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 1: organisational and service leadership

feedback sheet

HQS needs the input of programme users to ensure that the standards and criteria are relevant, and up-to-date.

Please use this sheet to record your comments on this standard, for example letting HQS know if criteria are difficult to interpret, if terminology used is incorrect, or if you know of more up-to-date references which should be included. Please return completed feedback sheets to the project manager in your organisation in the first instance, who will then forward to HQS.

Thank you

Criteria	Comment	Criteria	Comment

Standard 2 : corporate governance

There are governance systems and a defined management structure in place which enable the NHS trust to achieve its aspirations and objectives.

Criteria

Management structure

2.1 There is an up-to-date published organisational structure, which:

2.1.1 defines lines of accountability and specifies roles — ISO A — YES ☐ NO ☐ PROGRESS ☐

2.1.2 is regularly reviewed. — ISO A — YES ☐ NO ☐ PROGRESS ☐

2.2 The roles, functions and responsibilities of the chief executive, the chairman, the non-executive directors and the executive directors of the trust board are clearly set out in a public document. — ISO A — YES ☐ NO ☐ PROGRESS ☐

2.3 There are executive directors on the board with designated responsibilities for all aspects of the trust. — ISO A — YES ☐ NO ☐ PROGRESS ☐

2.4 There is a designated deputy for the chief executive to cover in his/her absence. — B — YES ☐ NO ☐ PROGRESS ☐

Guidance

This may be rotated around the executive directors.

2.5 There is a document which states the constitutional arrangements of the trust which:

Notes for action planning:

Standard 2 : corporate governance CONTINUED

2.5.1 meets the requirements of legislation and national guidelines on corporate governance

A YES ☐ NO ☐ PROGRESS ☐

2.5.2 is approved by the board of directors

A YES ☐ NO ☐ PROGRESS ☐

Guidance

The document includes, for example:

- *a description of the powers and duties of the board of directors*
- *a scheme of delegation*
- *standing orders*
- *standing financial instructions*
- *a list of the decisions referred for the board of directors.*

2.5.3 is made accessible to all staff.

A YES ☐ NO ☐ PROGRESS ☐

2.6 The board of directors and designated individual managers ensure that:

2.6.1 the trust board meets regularly in public and that meetings are minuted

A YES ☐ NO ☐ PROGRESS ☐

2.6.2 the key issues resulting from board meetings, board sub-committees and board working groups are communicated to staff

A YES ☐ NO ☐ PROGRESS ☐

2.6.3 the advice of medical, nursing, other clinical and non-clinical staff and specialist advice is systematically sought in the development of trust policy

A YES ☐ NO ☐ PROGRESS ☐

2.6.4 the views and experiences of patients/users and others in the community are systematically sought in the development of organisational policy and proposed service changes.

A YES ☐ NO ☐ PROGRESS ☐

2.7 There is a register of directors' interests relevant to NHS business

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 2 : corporate governance CONTINUED

2.8 The register is:

2.8.1 reviewed on a systematic basis

2.8.2 open to public inspection.

2.9 There is an up-to-date register of gifts and hospitality received by directors and members of staff.

2.10 There is a dated, documented trust-wide policy, written/ reviewed within the last three years, which sets out the acceptable limits and arrangements for accepting and declaring gifts and hospitality and which gives guidelines for when these should be refused.

Guidance

The policy should be in line with NHS guidance.

2.11 There is a financial audit committee with terms of reference.

Guidance

These include, for example:
- *membership*
- *limits to powers*
- *arrangements for reporting back to the board.*

2.12 There is a remuneration and terms of service committee with terms of reference.

Guidance

The committee's terms of reference should cover at least the executive directors and senior managers of the trust.

		YES	NO	PROGRESS
A		☐	☐	☐
A		☐	☐	☐
B		☐	☐	☐
B		☐	☐	☐
ISO	A	☐	☐	☐
A		☐	☐	☐

Notes for action planning:

Standard 2 : corporate governance CONTINUED

2.13 There is a designated secretary to the board, or one or more designated persons, who take responsibility for board secretary activities.

A YES ☐ NO ☐ PROGRESS ☐

2.14 The responsibilities of the secretary are defined.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

These include, for example:

- *maintaining standing orders*
- *maintaining standing financial instructions in liaison with the director of finance*
- *retaining the corporate seal and its applications*
- *keeping a register of directors' interests.*

Controls assurance

2.15 The board publishes an annual report and annual accounts which are available to the public.

ISO A YES ☐ NO ☐ PROGRESS ☐

2.16 The annual report includes a controls assurance statement that the trust has a comprehensive risk strategy in place to cover all significant non-clinical areas.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

The controls assurance statement covers the following key areas:

- *business planning*
- *corporate strategy*
- *environment (property and estates)*
- *human resources*
- *service management.*

Notes for action planning:

Standard 2 : corporate governance CONTINUED

The chief executive and the board will need to have evidence that the trust's risk management strategy is being actively implemented, see Standard 6, risk management also HSC 1998/070, Controls Assurance Statements and NHS Executive Risk Management Strategy Evaluation Guide.

2.17 The annual report includes progress achieved on:

2.17.1	using input from patients/users and carers to improve the quality of services		B	YES ☐	NO ☐ PROGRESS ☐
2.17.2	meeting the stated objectives for the development and delivery of clinical services		B	YES ☐	NO ☐ PROGRESS ☐
2.17.3	meeting financial targets		B	YES ☐	NO ☐ PROGRESS ☐
2.17.4	using results from staff attitude surveys to inform initiatives on improving staff health and the working environment.		B	YES ☐	NO ☐ PROGRESS ☐
2.18	There is a dated, documented policy and procedure, written/reviewed within the last three years, enabling staff to raise their concerns about maladministration, breaches of codes of conduct and accountability and other concerns of an ethical nature.	ISO	A	YES ☐	NO ☐ PROGRESS ☐

Guidance

This should be well publicised to all staff in the trust, for example in the staff handbook.

Objectives and business planning

2.19 The trust's strategic direction document:

2.19.1	identifies the trust's aims and objectives	ISO	A	YES ☐	NO ☐ PROGRESS ☐

Notes for action planning:

Standard 2 : corporate governance CONTINUED

2.19.2	identifies the need to maintain a skilled and motivated workforce		A	YES ☐	NO ☐	PROGRESS ☐	
2.19.3	is developed with input from clinical and non-clinical staff		A	YES ☐	NO ☐	PROGRESS ☐	
2.19.4	is developed in consultation with commissioning agencies		A	YES ☐	NO ☐	PROGRESS ☐	
2.19.5	is in line with priorities and planning guidance for the NHS.		A	YES ☐	NO ☐	PROGRESS ☐	
2.20	The trust's annual business plan sets out:						
2.20.1	plans for achieving the trust's objectives	ISO	A	YES ☐	NO ☐	PROGRESS ☐	
2.20.2	the overall staff development and training needs in order to achieve the trust's objectives and how these will be met.	ISO	A	YES ☐	NO ☐	PROGRESS ☐	
2.21	The trust consults with the health authority/board and primary care groups as part of the business planning process.		A	YES ☐	NO ☐	PROGRESS ☐	
2.22	The achievement of the trust against the business plan objectives is reviewed annually by the trust board.	ISO	B	YES ☐	NO ☐	PROGRESS ☐	
2.23	The strategic direction document and the annual business plan are:						
2.23.1	available to all staff		A	YES ☐	NO ☐	PROGRESS ☐	
2.23.2	publicised widely.		B	YES ☐	NO ☐	PROGRESS ☐	

Notes for action planning:

Partnership working

2.24 The trust undertakes its duty of partnership through involvement in the development of the local health improvement plan and its implementation.

A YES ☐ NO ☐ PROGRESS ☐

2.25 The trust contributes to the development of primary care groups' programmes of action and primary care investment plans.

B YES ☐ NO ☐ PROGRESS ☐

2.26 The trust contributes to development plans of other health and social care agencies in response to consultation exercises.

B YES ☐ NO ☐ PROGRESS ☐

2.27 The trust develops partnership working arrangements, as appropriate, in order improve services, reduce duplication and avoid gaps in service provision, with:

2.27.1 other health service providers

B YES ☐ NO ☐ PROGRESS ☐

2.27.2 social services

B YES ☐ NO ☐ PROGRESS ☐

2.27.3 other local authority services

B YES ☐ NO ☐ PROGRESS ☐

2.27.4 voluntary sector organisations.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

Depending upon the services offered by the trust, this will include partnership working arrangements for the following services:

- *mental health services*
- *learning disability services*
- *children's services*
- *services for vulnerable people, particularly the frail elderly.*

Notes for action planning:

2.28 The trust contributes to development of joint investment plans for the provision of co-ordinated services to vulnerable people, as part of the local health improvement plan.

Guidance

The joint investment plan should aim to:

- *improve the co-ordination of local services, in order to improve the ability of people to live independently*
- *to inform agreed strategies objectives and service development objectives*
- *support the reshaping of services across the local health and social care economy*
- *enable the implementation of health improving strategies across the health and social care interface.*

See, Partnership in Action, new opportunities for joint working between health and social services, Department of Health 1998.

A YES ☐ NO ☐ PROGRESS ☐

2.29 Members of joint planning groups with other agencies have clear lines of accountability.

B YES ☐ NO ☐ PROGRESS ☐

2.30 Joint planning groups develop strategies which are consistent with the mission and objectives of the trust.

Guidance

This may involve the members of joint planning groups making a significant input to the shaping of the trust's objectives to ensure that they are congruent with the emerging strategies of the local health and social care economy.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Corporate process

2.31 Corporate policies and procedures are:

Standard 2 : corporate governance CONTINUED

2.31.1	developed in accordance with statutory requirements *Guidance* *This includes, for example:* • *legislation which affects any aspect of the trust's work* • *Health Service Circulars.*	ISO	A	YES ☐	NO ☐	PROGRESS ☐
2.31.2	developed with staff input *Guidance:* *This includes, for example, staff representatives from professional associations and trade unions.*		A	YES ☐	NO ☐	PROGRESS ☐
2.31.3	dated	ISO	A	YES ☐	NO ☐	PROGRESS ☐
2.31.4	published with the name of the post/group responsible for drafting and review	ISO	B	YES ☐	NO ☐	PROGRESS ☐
2.31.5	centrally indexed and compiled into a policy manual	ISO	A	YES ☐	NO ☐	PROGRESS ☐
2.31.6	subject to a systematic review process	ISO	A	YES ☐	NO ☐	PROGRESS ☐
2.31.7	officially ratified by the organisation and, subsequent to review, all amendments are ratified by the same group *Guidance* *The group that ratifies policies may be, for example, the trust board.*	ISO	B	YES ☐	NO ☐	PROGRESS ☐
2.31.8	disseminated throughout the organisation. *Guidance* *There should be a document control process for the circulation of trust policies and procedures, this may include signing for the receipt of policies and procedures, by the holders of trust policy manuals, and the return of superseded documents.*	ISO	A	YES ☐	NO ☐	PROGRESS ☐

Notes for action planning:

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Standard 2 : corporate governance CONTINUED

2.32 Working practices are monitored to ensure that they are consistent with the trust's documented policies and procedures.

ISO B YES ☐ NO ☐ PROGRESS ☐

Guidance

This may be part of the trust's overall quality monitoring arrangements, (see Standard 5, quality improvement).

Complaints

2.33 There is a dated, documented policy and procedure, written/reviewed within the last three years on dealing with complaints from patients/users, carers or members of the public *(see also Standard 21, the patient's rights).*

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

- *There should be a specified complaints procedure in accordance with the Wilson Report and the NHS Complaints Procedure guidance, EL (96) 19.*
- *The response to complaints should be completed within a four week timescale, or acknowledgement sent and explanation of why it will take longer than four weeks to conclude.*
- *The complaints procedure should include details of the independent review panel and how this is activated.*

2.34 The trust encourages patients/users and carers to make comments, suggestions and complaints about the trust's services and the mechanisms for these communications are made clear in information material on public display.

ISO A YES ☐ NO ☐ PROGRESS ☐

2.35 Corporate records are kept of all complaints and these records include responses to the patient/user, carer or member of the public who has made the complaint.

ISO A YES ☐ NO ☐ PROGRESS ☐

2.36 Action taken in response to complaints is documented.

ISO A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

2.37 Reports on complaints and action taken are reported to the trust board.

ISO A YES ☐ NO ☐ PROGRESS ☐

Valid consent

2.38 There is a dated, documented corporate policy and procedure, written/reviewed within the last three years, for obtaining valid consent from patients/users.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The policy and procedure include reference to, for example:

- *routine medication*
- *anaesthesia*
- *sedation*
- *electro-convulsive therapy*
- *participation in research projects*
- *photographic and audio-visual recording*
- *surgical procedures*
- *unusual medications and routes of administration*
- *hazardous assessment procedures.*

Note, this is not intended to be an inclusive list of all circumstances in which valid consent should be sought.

2.39 The policy and procedure on valid consent includes reference to the following:

2.39.1 guidance on who can obtain consent, and in what circumstances

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 2 : corporate governance CONTINUED

Guidance

This may include reference to the following:

Consent must be obtained by a doctor familiar with the procedure and the associated risks and any alternative procedures/treatment.

Where the procedure is not performed by a doctor, consent may be obtained by the health professional who is going to perform the procedure. It should be documented that the patient/user was informed that the procedure was not to be performed by a doctor where it is judged that the patient/user might reasonably have expected that a doctor would be performing the procedure.

Procedures to follow when medical treatment and/or surgical intervention need to be undertaken on a patient who is not able to give consent, if it is considered essential and in the best interests of the patient.

2.39.2 procedure for the completion of consent forms.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

This may include instructions with regard to:

- *not using abbreviations on consent forms*
- *not making alterations to the form once signed*
- *using a new form and consulting with the patient/ user again if there is a change in the planned procedure*
- *patient/users may not give consent after the administration of a sedative or any anaesthetic*
- *the procedure to follow when obtaining valid consent in special circumstances (for example, children under the age of 16, Jehovah's Witnesses, terminations)*
- *using interpreters to gain valid consent from patients.*

Notes for action planning:

Admission and discharge

2.40 There is a dated, documented corporate policy, written/ reviewed within the last three years, for admission to the trust services which clearly states its aims and objectives and identifies areas of special concern. It includes reference to:

2.40.1 routine admissions — ISO A — YES ☐ NO ☐ PROGRESS ☐

2.40.2 emergency admissions — ISO A — YES ☐ NO ☐ PROGRESS ☐

2.40.3 the special needs of children, where the trust undertakes paediatric care *(see also Standard 31, children's services).* — ISO A — YES ☐ NO ☐ PROGRESS ☐

Guidance

The corporate policy should provide a framework for individual services to build upon for service specific procedures (see also Standard 24, referrals, access and admission).

2.41 A senior manager is responsible for overall supervision, administration and management of the admission policy and its implementation. — B — YES ☐ NO ☐ PROGRESS ☐

Guidance

The job description (or equivalent) of the individual designated to this role includes specific reference to the duties and responsibilities of the role.

2.42 There is a dated, documented corporate policy, written/ reviewed within the last three years, for the safe discharge of the patient/user. — ISO A — YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 2 : corporate governance CONTINUED

Guidance

The corporate policy should provide a framework for individual services to build upon for service specific procedures (see also, Standard 26, leaving a service/discharge).

2.43 The discharge policy includes:

2.43.1 a commitment to the safe and timely discharge of patients/users

A YES ☐ NO ☐ PROGRESS ☐

Guidance

The policy covers the need for discharge planning to begin on the day of admission or before admission where possible.

2.43.2 communication systems to provide continuity of care between primary care, community services and hospital services

A YES ☐ NO ☐ PROGRESS ☐

2.43.3 consideration of arrangements to facilitate the safe, ordered transfer of patients/users to other health and social care facilities

B YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes, for example:

- *issues relating to supervised discharge of patients/users*
- *ensuring that no NHS patient/user is discharged to a nursing/residential home against his/her wishes if he/she or a relative is personally responsible for paying the home's fees*
- *information on funding if long-term nursing care is required*
- *minimum notice required by the external services contributing to post-discharge care.*

2.43.4 the identification of categories of patients/users to whom particular attention needs to be paid in discharge arrangements.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

Patient categories needing special attention include: patients living alone, the frail and elderly, terminally ill, babies and children at risk, psychiatric patients, people with a continuing disability.

2.44 The policy is circulated to the health authority/board, primary care groups and the local authority social services department for comment and consultation.

B YES ☐ NO ☐ PROGRESS ☐

2.45 A senior manager is responsible for overall supervision, administration and management of the discharge policy and its implementation.

B YES ☐ NO ☐ PROGRESS ☐

Guidance:

The job description (or equivalent) of the individual designated to this role includes specific reference to the duties and responsibilities of the role.

Advocacy

2.46 There is a dated, documented corporate policy, written/reviewed within the last three years, on advocacy arrangements for the trust.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes, for example, how the service understands the issues relating to advocacy and how it will respond to the individual needs of the care group (see also Standard 21, the patient's rights, Standard 36, learning disabilities services and Standard 52, mental health services).

Notes for action planning:

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Standard 2 : corporate governance CONTINUED

Staff charter

2.47 There is a staff charter, developed in consultation with staff and approved by the trust board, which sets out the principal rights and responsibilities of employees and the trust's responsibilities in relation to these as employer.

Guidance

The issues might include training and development, health and safety, consultation and communication, employment practices, management practice, values and ethics.

B YES ☐ NO ☐ PROGRESS ☐

Waiting list management

2.48 There is a dated, documented plan for the management of waiting lists.

Guidance

A senior manager has designated responsibility for the development, implementation and monitoring of the waiting list management plan.

A YES ☐ NO ☐ PROGRESS ☐

2.49 The plan includes clear targets to be achieved.

A YES ☐ NO ☐ PROGRESS ☐

2.50 Waiting lists are reviewed on a systematic basis against the stated targets.

Equal opportunities

2.51 There is a dated, documented policy, written/ reviewed within the last three years, on equality of opportunity and antidiscriminatory practices, and equal access to services.

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

This includes, for example:

- *statements on race, culture, language, gender, disability, sexual orientation, age, religion*
- *statements on patients/users with mental health problems and learning disabilities.*

2.52 The equality of opportunity policy is available to:

2.52.1	staff	A	YES ☐	NO ☐	PROGRESS ☐
2.52.2	patients/users	A	YES ☐	NO ☐	PROGRESS ☐
2.52.3	carers	A	YES ☐	NO ☐	PROGRESS ☐
2.52.4	primary care groups	B	YES ☐	NO ☐	PROGRESS ☐
2.52.5	health authorities/boards.	B	YES ☐	NO ☐	PROGRESS ☐

Notes for action planning:

feedback sheet

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Please use this sheet to record your comments on this standard, for example letting HQS know if criteria are difficult to interpret, if terminology used is incorrect, or if you know of more up-to-date references which should be included. Please return completed feedback sheets to the project manager in your organisation in the first instance, who will then forward to HQS.

Thank you

Criteria	Comment	Criteria	Comment

Standard 3 : clinical governance

The trust has systems in place to ensure that high quality patient care is provided through the implementation of multi-professional clinical governance arrangements which include the use and review of the evidence of clinical effectiveness and clinical quality

Criteria

Trust board arrangements

3.1 There is an dated, documented, trust-wide strategy for the implementation of clinical governance.

ISO A | YES ☐ | NO ☐ | PROGRESS ☐

Guidance

The strategy includes the following elements:

- *definitions of the roles and responsibilities of the key personnel involved in the overseeing and monitoring of clinical governance.*
- *the identification of the required skills and knowledge*
- *the identification of training needs and details of how these will be met*
- *the identification of resources to implement the clinical governance strategy*
- *definition of the required outcomes of the strategy implementation.*
- *a timetable for implementation*
- *a review mechanism*
- *where appropriate the arrangements for cross organisation clinical governance.*

Notes for action planning:

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Standard 3 : clinical governance CONTINUED

3.2 The clinical governance strategy:

3.2.1 reflects the local health improvement plan

A YES ☐ NO ☐ PROGRESS ☐

3.2.2 identifies the implications of shared primary, community and secondary care.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

Examples of shared care include; rapid response scheme; anti-coagulation monitoring. The implications of shared care include resources, organisational logistics and training.

3.3 The chief executive is identified as the accountable officer for clinical governance.

ISO A YES ☐ NO ☐ PROGRESS ☐

3.4 The following are in place to ensure that responsibility is delineated for clinical governance in the organisation:

3.4.1 there is a senior clinician at board level with a lead role across professions for overseeing clinical governance systems

ISO A YES ☐ NO ☐ PROGRESS ☐

3.4.2 clinical quality is a regular agenda item at trust board level.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

The board should receive a report on clinical governance activities. The board, or a formal sub-committee, should also be engaged in discussions about clinical quality. The report to the board, or the sub-committee as appropriate, may include, for example, results of routine audits, a summary of adverse clinical incidents reports for the period, a summary of complaints relating to clinical practice for the period, notification of research projects, notification of clinical training and education initiatives.

Notes for action planning:

Standard 3 : clinical governance CONTINUED

3.5 Communication lines are established so that clinical information from all directorate services is centralised in order to contribute to the report to the trust board.

B YES ☐ NO ☐ PROGRESS ☐

3.6 An annual report is produced on clinical governance.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The annual report may include: summaries of audit results, complaints relating to clinical practice and adverse clinical incidents together with the changes in practice that have been implemented as a result of these. It may also include reports of clinical training and education programmes and research and development projects.

3.7 The clinical governance report includes an assurance statement of clinical quality signed by the chief executive on behalf of the board.

A YES ☐ NO ☐ PROGRESS ☐

3.8 There is a trust-wide clinical governance implementation group or equivalent body.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

The membership includes:

- *the lead clinician for clinical governance*
- *a non-executive member of the trust board*
- *the key personnel responsible for leading on elements of clinical governance*

The responsibilities of the clinical governance committee may be included in an existing group or committee, with a different title.

3.9 The clinical governance implementation group or equivalent body establishes links and information flows with committees/groups responsible for :

3.9.1 risk management and health and safety

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 3 : clinical governance CONTINUED

3.9.2	education, training and continuing professional development		B	YES ☐	NO ☐	PROGRESS ☐
3.9.3	clinical audit and effective practice development		B	YES ☐	NO ☐	PROGRESS ☐
3.9.4	health record content audit	ISO	B	YES ☐	NO ☐	PROGRESS ☐
3.9.5	review of complaints	ISO	B	YES ☐	NO ☐	PROGRESS ☐
3.9.6	research and development		B	YES ☐	NO ☐	PROGRESS ☐
3.9.7	non-clinical quality improvement initiatives	ISO	B	YES ☐	NO ☐	PROGRESS ☐

Guidance

The clinical governance framework should link other initiatives and their respective committees/implementation groups in a co-ordinated and cohesive way.

3.10	Each clinical directorate or service grouping has a clinical governance plan which links in to the trust-wide clinical governance and quality improvement strategies.	B	YES ☐	NO ☐	PROGRESS ☐

Guidance

Arrangements will vary according to the trust size and structure, some trusts may choose a different organisational approach at this level to achieve the same results.

The directorate/service plan may include for example, continuing professional development, clinical audit activities, research projects, clinical risk management, development of clinical guidelines and/or care pathways.

Notes for action planning:

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Standard 3 : clinical governance CONTINUED

Quality improvement strategy

3.11	The lead clinician for clinical governance, with the clinical governance committee (or equivalent group), is responsible for development and overseeing the implementation of the trust's quality improvement strategy in relation to clinical quality.	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.12	The trust-wide quality improvement strategy embraces a wide framework which includes:					
3.12.1	clinical effectiveness	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.12.2	clinical audit	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.12.3	quality improvement for both clinical and non-clinical services	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.12.4	clinical risk management	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.12.5	complaints and litigation	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.12.6	patient/user feedback on services		B	YES ☐	NO ☐	PROGRESS ☐
3.12.7	research and development		B	YES ☐	NO ☐	PROGRESS ☐
3.12.8	continuing professional development		B	YES ☐	NO ☐	PROGRESS ☐
3.12.9	mechanisms for managing poor performance.	ISO	B	YES ☐	NO ☐	PROGRESS ☐
3.13	There is a systematic approach to and review of clinical quality indicators across the organisation.		A	YES ☐	NO ☐	PROGRESS ☐

Notes for action planning:

Guidance

The routine and systematic review of clinical quality indicators includes, for example:

- *cancelled operations and treatments, where applicable*
- *other appointments cancelled by the organisation*
- *complaints which are unresolved or have unsatisfactory resolutions*
- *drug errors*
- *patients/users not arriving for admission/treatment*
- *mortality and morbidity including at least the following:*
  - *avoidable complications*
  - *unexpected death*
  - *adverse clinical incidents.*

Clinical audit

3.14 Trust-wide priorities for clinical audit are identified and documented. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

These are in line with national priorities for clinical audit. The clinical audit programme links with other local programmes run, for example, by the health authority board and primary care organisations.

3.15 There are documented procedures for carrying out clinical audit projects. ISO B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

These include, for example:

- *the multiprofessional nature of clinical audit development*
- *clinical audit meetings and other peer review activities are supported by the chief executive as part of the quality improvement strategy*
- *clinical audit meetings are held regularly and outcomes recorded*
- *clinical audit reports contain action plans for change*
- *attendance at clinical audit meetings is recorded*
- *there is evidence of management action as a result of audit findings.*

3.16 All clinicians participate in programmes of clinical audit.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

This will include national programmes endorsed by the Commission for Health Improvement.

3.17 There are arrangements for ensuring that clinical audit across the trust addresses evidence of effectiveness and monitors the implementation of effective clinical practice.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

The clinical audit cycle should use standards which are evidence-based as far as possible.

3.18 Clinical audit programmes are supported and co-ordinated across the organisation.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

The resources should be commensurate with the size of the organisation, for example there may be a clinical audit co-ordinator or a clinical audit department.

Notes for action planning:

Standard 3 : clinical governance CONTINUED

3.19	An integral part of the clinical audit programme is the dissemination of the results of audit studies, throughout the trust. *Guidance* *The dissemination system for audit results may include regular reports and up-date bulletins.* *The effectiveness of dissemination systems used should be evaluated.*		B	YES ☐	NO ☐	PROGRESS ☐
3.20	Changes in practice are introduced as a result of clinical audit programmes.	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.21	In line with arrangements outlined by the National Institute for Clinical Excellence, the following are reported:					
3.21.1	maternal deaths are referred to the Confidential Enquiry into Maternal Deaths		A	YES ☐	NO ☐	PROGRESS ☐
3.21.2	peri-operative deaths are referred to the National Confidential Enquiry into Peri-Operative Deaths		A	YES ☐	NO ☐	PROGRESS ☐
3.21.3	stillbirths and deaths in infancy are referred to the Confidential Enquiry into Stillbirths and Deaths in Infancy		A	YES ☐	NO ☐	PROGRESS ☐
3.21.4	homicides and suicides are referred, as appropriate, to the Confidential Enquiry into Homicide and Suicide by Mentally Ill People.		A	YES ☐	NO ☐	PROGRESS ☐
3.22	The trust collects data to monitor performance against Our Healthier Nation targets, as appropriate to the organisation's services, for:					
3.22.1	coronary heart disease and stroke	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.22.2	mental health	ISO	A	YES ☐	NO ☐	PROGRESS ☐

Notes for action planning:

3.22.3 cancers.

3.23 The trust collects data to monitor performance against targets set out in:

3.23.1 national service frameworks

3.23.2 national performance indicators

Implementation of evidence-based practice

3.24 Health professionals have access to up-to-date information on evidence-based clinical practice, through the availability of:

3.24.1 published of research findings

Guidance

The organisation should make every effort to ensure that information from the NHS, and other sources is available, for example the Cochrane database on CD-Rom.

3.24.2 access to Med-line

3.24.3 access to internet facilities

3.24.4 library and library search facilities.

Guidance

Library facilities should be accessible to all space clinical professionals.

3.25 There are systems for disseminating information about effective practice throughout the organisation.

ISO A YES ☐ NO ☐ PROGRESS ☐

ISO A YES ☐ NO ☐ PROGRESS ☐

ISO A YES ☐ NO ☐ PROGRESS ☐

B YES ☐ NO ☐ PROGRESS ☐

B YES ☐ NO ☐ PROGRESS ☐

B YES ☐ NO ☐ PROGRESS ☐

B YES ☐ NO ☐ PROGRESS ☐

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

Methods may include:

- *clinical audit meetings*
- *circulation of contents pages and specific articles from professional journals.*

Clinical guidelines/care pathways

3.26 There is a planned programme to develop and implement clinical guidelines and/or care pathways or equivalents, across the trust.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

Care pathways should be developed around systems of care, which may cross organisational boundaries, both internal and external.

3.27 Locally agreed practice standards for common conditions are developed by multiprofessional groups of staff.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

These are based on national guidelines, such as national service frameworks and recommendations from the National Institute for Clinical Excellence

3.28 In the development of local standards/care pathways, clinical guidelines, or equivalents there is a named person to provide guidance and support for staff across the trust.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

This is to aid co-ordination across the organisation and to facilitate the sharing of ideas and methods for this work across the organisation.

Notes for action planning:

Standard 3 : clinical governance CONTINUED

3.29 Staff with responsibility for leading the development of clinical guidelines are trained in critical appraisal techniques.

B YES ☐ NO ☐ PROGRESS ☐

3.30 Research findings are used in the development of local care pathways and clinical guidelines or equivalents.

B YES ☐ NO ☐ PROGRESS ☐

3.31 There is a house style document to ensure consistency of presentation of care pathways and clinical guidelines or equivalents.

B YES ☐ NO ☐ PROGRESS ☐

3.32 Feedback from patients is used, to gain a patient perspective in the development and review of care pathways and clinical guidelines or equivalents.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

This may be from patient surveys or follow-up studies that have been carried out locally, or from published literature.

3.33 Networks are established to share experience internally and with external organisations on the development and implementation of care pathways.

B YES ☐ NO ☐ PROGRESS ☐

3.34 There is routine audit and review of clinical guidelines and care pathways, or equivalents.

ISO B YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes variance reporting in relation to care pathways.

3.35 There are links with external agencies to share good practice, inform development of clinical effectiveness and evidence-based practice, and ensure best use of available resources.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

These should include regular contact and information-sharing with

- *other trusts*
- *primary care groups*
- *health authorities/boards*
- *mental health services*
- *patient/user organisations*
- *learning disability services*
- *Royal Colleges and other professional associations*
- *national sources of critically appraised reviews of evidence such as:*
  - *The Cochrane Centre*
  - *Effective Health Care Bulletins*
  - *Bandolier*
  - *Centre for Evidence-Based Medicine*
  - *Welsh Clinical Effectiveness Group*
  - *York University Centre for Reviews and Dissemination.*

Continuing professional development

3.36 There are continuing professional development programmes for all clinicians in line with:

3.36.1	the recommendations of the appropriate colleges and professional associations	ISO A	YES ☐	NO ☐	PROGRESS ☐
3.36.2	the trust objectives for clinical governance	ISO A	YES ☐	NO ☐	PROGRESS ☐
3.36.3	local clinical strategies and the health improvement programme.	B	YES ☐	NO ☐	PROGRESS ☐

3.37 Education programmes and training are provided:

Notes for action planning:

Standard 3 : clinical governance CONTINUED

3.37.1 to ensure that all health professionals are able to provide care that is based on currently available evidence

Guidance

The education programmes should help staff understand the philosophy of evidence-based clinical practice, how to access the relevant information, the hierarchies of research findings, discerning good and bad research and applying it to patient care.

B YES ☐ NO ☐ PROGRESS ☐

3.37.2 linked to clinical audit findings, and assist professionals in changing their practice.

Guidance

The trust needs to ensure that clinicians have the right education, training and skills to deliver the care needed by patients.

B YES ☐ NO ☐ PROGRESS ☐

3.38 All clinicians are involved in a regular programme of clinical supervision.

Guidance

Supervision in this sense relates to time set aside for formal reflection on clinical practice, usually with a more experienced practitioner or, for senior clinicians, a peer practitioner. Supervision may be part of the role of mentor or may happen through a different framework.

B YES ☐ NO ☐ PROGRESS ☐

3.39 The organisation is involved in and fully co-operates with existing systems for professional self regulation.

Guidance

There is clear accountability for the implementation of professional self-regulation schemes.

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Clinical risk management

3.40	All clinical services undertake clinical risk assessments.	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.41	There is training for staff in undertaking clinical risk assessments.	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.42	The findings from clinical risk assessments are analysed and work practices reviewed and changed as necessary to reduce risks.	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.43	Standard clinical adverse incident reports are used across the organisation.	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.44	Clinical adverse incident reports, near miss records and complaints are integrated and analysed.	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.45	There is 'no-blame' investigation of near misses.		B	YES ☐	NO ☐	PROGRESS ☐
3.46	Changes in practice are introduced as a result of complaints, clinical adverse incidents and near misses.	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.47	There are systems to identify and remedy problems related to clinical performance which include:					
3.47.1	review of practice in response to complaints and incidents	ISO	A	YES ☐	NO ☐	PROGRESS ☐
3.47.2	documented arrangements for reporting and acting on the concerns of staff regarding the performance of their colleagues.		A	YES ☐	NO ☐	PROGRESS ☐

Guidance

Reference could be made to:

- *Medical (Professional Performance) Act 1995*
- *The New Performance Procedures, GMC, May 1997*

Notes for action planning:

Information for patients/users

3.48 Information is available to patients/users that helps them make informed choices based on the best available evidence on effective and appropriate interventions.

Guidance

The decision of patients/users not to wish to make decisions about their treatment should also be respected and in these cases clinicians should make the decisions for the patient/user.

B YES ☐ NO ☐ PROGRESS ☐

3.49 Evidence-based information for patients/users on options for care and treatment is:

3.49.1 easy to understand

B YES ☐ NO ☐ PROGRESS ☐

3.49.2 available to patients/users

B YES ☐ NO ☐ PROGRESS ☐

3.49.3 produced in a range of media and formats.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

Information is developed with patient/user input on content and presentation.

Information may be available in large print, other languages, makaton symbols, other media such as audio or video tapes.

3.50 Patients/users are encouraged to discuss the information they are given before making a decision.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

Where appropriate, patients/users are sent information about treatment options in advance of their appointment, for non-emergency conditions, to enable them to discuss these treatment options. Where it is not appropriate to send information in advance, sufficient time is allowed in the consultation to discuss the options for treatment with clinicians.

Research and development programmes

3.51 Priorities for research and development are identified and documented.

A YES ☐ NO ☐ PROGRESS ☐

3.52 There is access to a research database.

B YES ☐ NO ☐ PROGRESS ☐

3.53 There is a process for obtaining funding for research and development proposals.

B YES ☐ NO ☐ PROGRESS ☐

3.54 Changes to services are introduced in response to validated research findings.

B YES ☐ NO ☐ PROGRESS ☐

3.55 There are protocols for obtaining valid consent from patients/users and carers for their participation in research and development.

A YES ☐ NO ☐ PROGRESS ☐

3.56 Proposals for research programmes are referred to the ethics committee.

A YES ☐ NO ☐ PROGRESS ☐

Ethics

3.57 There is a local research ethics committee.

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

The remit of the committee includes the consideration of ethical issues such as the implications of research programmes and prevention of harm to patients/users.

The research ethics committee should approve projects involving the use of health records.

3.58 There is a forum for discussing ethical issues.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

This encompasses, for example:

- *the adoption of a multiprofessional approach to the consideration of ethical issues*
- *advising on the implementation of policies relating to ethical issues (clinical and non-clinical).*

Notes for action planning:

Standard 3 : clinical governance

feedback sheet

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Thank you

Criteria	Comment	Criteria	Comment

Standard 4 : working with health commissioners

The trust works in collaboration with commissioners of health services to deliver effective care in line with the local health improvement programme.

Criteria

				YES	NO	PROGRESS
4.1	The trust contributes to the work of the health authority/board and primary care groups in agreeing local health priorities.		B	☐	☐	☐
4.2	The trust contributes to the development of the health improvement programme.		B	☐	☐	☐
4.3	The trust contributes to the development of commissioning plans.		B	☐	☐	☐
4.4	Service agreements are in place and are consistent with the health improvement programme. *Guidance* *Service agreements should be set in the framework of the longer term relationships between the partners and the agreed strategic direction that will best serve the local community.*	ISO	A	☐	☐	☐
4.5	Lines of communication between the trust and commissioning agencies are defined.	ISO	B	☐	☐	☐
4.6	There is multiprofessional involvement in the development of service agreements.	ISO	B	☐	☐	☐
4.7	There are named individuals with responsibility for the development of service agreements, including leading on action and monitoring progress of the agreement.	ISO	B	☐	☐	☐

Notes for action planning:

Standard 4 : working with health commissioners CONTINUED

4.8 Service agreements include the following dimensions:

4.8.1 quality, both clinical and non-clinical aspects

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

Agreements should work towards incorporating quality measures developed by clinicians.

4.8.2 cost

ISO A YES ☐ NO ☐ PROGRESS ☐

4.8.3 volume/activity

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

Agreements need to cover within this arrangements for handling variations in activity levels.

4.8.4 the period it covers and whether or not it has a fixed renewal/end date

ISO B YES ☐ NO ☐ PROGRESS ☐

4.8.5 specification of the monitoring data required, the format in which it should be presented and intervals at which it is required

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

All local health and social care organisations should be working towards the development of a core clinical database.

4.8.6 procedures for dealing with problems in service delivery

ISO B YES ☐ NO ☐ PROGRESS ☐

4.8.7 specification of mediation procedures in case of dispute.

ISO B YES ☐ NO ☐ PROGRESS ☐

Guidance

These should be based on dialogue and review.

Notes for action planning:

Standard 4 : working with health commissioners CONTINUED

4.9	The service to be provided is clearly defined in the service agreement and includes:					
4.9.1	a description of the service to be provided *Guidance* *In order to define individual services precisely, the ICD code should be used to ensure a more consistent approach to commissioning.*	ISO	A	YES ☐	NO ☐	PROGRESS ☐
4.9.2	the provision of the service by people that are appropriately qualified and can demonstrate continuing professional development	ISO	A	YES ☐	NO ☐	PROGRESS ☐
4.9.3	outline of clinical guidelines/care pathways or equivalents which indicate the different responsibilities of staff		B	YES ☐	NO ☐	PROGRESS ☐
4.9.4	measurable objectives for the service, based on the health improvement programme. *Guidance* *Objectives should also be linked where appropriate to the national performance framework.*	ISO	A	YES ☐	NO ☐	PROGRESS ☐
4.10	All service agreements are signed by a representative of the trust and a commissioning agency representative.	ISO	A	YES ☐	NO ☐	PROGRESS ☐
4.11	Service agreements are reviewed regularly at defined intervals.	ISO	B	YES ☐	NO ☐	PROGRESS ☐
4.12	Any changes in service agreements result from a planned process.		B	YES ☐	NO ☐	PROGRESS ☐
4.13	Changes in the pattern and location of services are discussed and planned for.		B	YES ☐	NO ☐	PROGRESS ☐

Notes for action planning:

Guidance

This should be part of the ongoing programme for rolling forward the health improvement programme each year.

4.14 There are arrangements in place for out of area treatments.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

These are limited services commissioned directly by the health authority. For an out of area treatment covered by the main commissioner's service agreement, the trust should be able to track the resources accordingly.

4.15 Long term service agreements are in place.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

The long term service agreements take account of the national service frameworks, as appropriate to the organisation's services, for:

- *coronary heart disease*
- *mental health*
- *cancer services.*

4.16 The trust works in partnership with other agencies to develop a care pathway approach for long term service agreements.

B YES ☐ NO ☐ PROGRESS ☐

4.17 Long term service agreements are based upon the following:

4.17.1 ongoing dialogue between clinicians, patients/users and carers as well as managers

B YES ☐ NO ☐ PROGRESS ☐

4.17.2 the involvement of all those who contribute to the pathway of care

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

This includes, primary care, secondary care, and, where appropriate, social care.

4.17.3 measurable objectives and targets for improvement B YES ☐ NO ☐ PROGRESS ☐

4.17.4 a period of at least three years. B YES ☐ NO ☐ PROGRESS ☐

Guidance

The agreement should be based on a financial framework set out for the duration of the agreement.

4.18 Arrangements are in place for specialised commissioning of the relevant services. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

Services are subject to specialised commissioning where patient numbers across the population are small. These services are therefore commissioned over a larger geographical area than other services in order to ensure optimum outcomes, sustain clinical competence, sustain specialised training of staff and ensure cost effectiveness of provision. See HSC 1998/198 Commissioning in the New NHS Annex B for an initial list of services subject to specialised commissioning arrangements.

Notes for action planning:

Standard 4 : working with health commissioners

feedback sheet

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Thank you

Criteria	Comment	Criteria	Comment

Standard 5 : quality improvement

There is a quality improvement strategy for the trust which supports the business plan and reflects the mission statement.

Criteria

General

5.1 There is a designated individual at board level responsible for the quality improvement strategy of the trust.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This may be the lead clinician for clinical governance or may be another board level director who liaises with the lead clinician for clinical governance.

5.2 There is a dated, documented quality improvement strategy for the organisation. *(See Standard 3, clinical governance, for elements of the quality improvement strategy.)*

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The quality improvement strategy details, for example:

- *objectives of the programme*
- *methods to achieve these objectives*
- *implementation timetable*
- *management responsibility for, and the organisational structure to support, the commitment to quality management*
- *a mechanism for providing the necessary resources to support the quality improvement and evaluation activities.*

Notes for action planning:

Standard 5 : quality improvement CONTINUED

5.3	The quality improvement strategy and progress against objectives are reviewed on an annual basis.	ISO	B	YES ☐	NO ☐ PROGRESS ☐
5.4	The quality improvement strategy is developed in consultation with:				
5.4.1	key staff		B	YES ☐	NO ☐ PROGRESS ☐
5.4.2	patient/user representatives		B	YES ☐	NO ☐ PROGRESS ☐
5.4.3	carer representatives		B	YES ☐	NO ☐ PROGRESS ☐
5.4.4	commissioning agencies.		B	YES ☐	NO ☐ PROGRESS ☐
5.5	The strategy is disseminated throughout the trust.	ISO	A	YES ☐	NO ☐ PROGRESS ☐
5.6	Staff at all levels in the trust are involved in the implementation of the quality improvement strategy.		A	YES ☐	NO ☐ PROGRESS ☐
5.7	Quality monitoring systems include the audit of activities against the trust's documented policies and procedures	ISO	B	YES ☐	NO ☐ PROGRESS ☐
5.8	Staff are trained in the development, implementation and review of quality activities.	ISO	B	YES ☐	NO ☐ PROGRESS ☐
	Guidance				
	These staff should include those responsible for the co-ordination of local quality activities (see Standard 20, quality improvement of services).				
5.9	The impact of quality improvement programmes is evaluated.		B	YES ☐	NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

This includes assessment of cost reduction, increased activity, better use of staff resources, improved patient/user satisfaction responses, reduction in waiting times for appointments, test results, letters.

5.10 Reports are produced on the outcomes of quality improvement initiatives.

ISO B YES ☐ NO ☐ PROGRESS ☐

5.11 There is an agreed programme for the board to review:

5.11.1 trust-wide quality, performance and outcome measures relating to patient care

B YES ☐ NO ☐ PROGRESS ☐

5.11.2 trust-wide quality, performance and outcome measures relating to staff.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

An annual schedule is developed so that key quality indicators and performance monitoring feature as a regular item on the board agenda.

5.12 Staff at all levels of the organisation have the opportunity to contribute to, and access, reports on quality initiatives.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 5 : quality improvement

feedback sheet

HQS needs the input of programme users to ensure that the standards and criteria are relevant, and up-to-date.

Please use this sheet to record your comments on this standard, for example letting HQS know if criteria are difficult to interpret, if terminology used is incorrect, or if you know of more up-to-date references which should be included. Please return completed feedback sheets to the project manager in your organisation in the first instance, who will then forward to HQS.

Thank you

Criteria	Comment	Criteria	Comment

Standard 6 : risk management

There is a structured approach to the management of risk in the trust which results in safer systems of work, safer practices, safer premises and a greater staff awareness of danger and liability.

Criteria

General

6.1 A board director is responsible for the management of risk within the trust. ISO A YES ☐ NO ☐ PROGRESS ☐

6.2 A board director is responsible for the management of clinical risk within the trust. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This may be the same person as for 6.1 above.

6.3 There is a risk management strategy for the trust, which includes the management of clinical risk. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This should be endorsed by the organisation and should detail aims, objectives and individual responsibilities

The risk management strategy links to the requirement for the trust to make a controls assurance statement and must include the following elements:

- *the continuous identification and prioritisation of key risks*
- *description of actions taken to manage each risk*
- *the identification of how risk is measured.*

Notes for action planning:

Standard 6 : risk management CONTINUED

The risk management strategy needs to cover the areas of:

- *business planning*
- *corporate strategy*
- *environment (property and estates)*
- *human resources*
- *service management.*

See HSC 1998/070 Controls Assurance statements for more details.

Clinical risk management arrangements may be set out in greater detail in, for example, the organisation's clinical governance strategy.

6.4 The risk management strategy is made available to all staff.

A YES ☐ NO ☐ PROGRESS ☐

6.5 Risks are assessed in each service/department throughout the organisation.

ISO A YES ☐ NO ☐ PROGRESS ☐

6.6 Risk assessment findings are documented.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This should be in line with current guidelines, for example, on controls assurance.

6.7 Risk assessment findings across the organisation are collated.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The collation of findings should be used to plan organisation-wide prioritisation and implementation of control measures.

6.8 Control measures (preventative and protective) are documented, prioritised and implemented.

ISO A YES ☐ NO ☐ PROGRESS ☐

6.9 Risk assessments are reviewed and updated on a systematic basis and when circumstances change.

ISO A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

This may include for example, when services move premises, have premises refurbished or when substantially different equipment is introduced.

6.10 There is an incident reporting system, which encompasses all types of untoward incidents. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This should include the grading of incidents as minor or serious.

6.11 Serious untoward incidents are individually investigated. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

There is an organisational procedure which sets out the steps to be taken in an investigation, which includes identifying action needed to prevent recurrence.

6.12 Corporate records of all accidents, errors and untoward incidents are:

6.12.1 kept ISO A YES ☐ NO ☐ PROGRESS ☐

6.12.2 monitored ISO A YES ☐ NO ☐ PROGRESS ☐

6.12.3 evaluated ISO A YES ☐ NO ☐ PROGRESS ☐

6.12.4 acted upon. ISO A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

All types of incident should be recorded, for example burglary, unexpected patient death, staff accidents and incidents of violence to staff. See Working Together - securing a quality workforce for the NHS (HSC 1998/162). Details recorded should identify whether the incident is reported to police and the action taken to prevent recurrence.

6.13 Reports on untoward incidents are:

6.13.1 produced on a systematic basis — ISO A — YES ☐ NO ☐ PROGRESS ☐

6.13.2 issued to the relevant department/service area for action. — ISO A — YES ☐ NO ☐ PROGRESS ☐

Guidance

Reports include some level of trend analysis of untoward incidents.

Litigation and claims handling

6.14 There is a designated individual responsible for:

6.14.1 liaising with legal professionals, insurance companies and claimants — ISO A — YES ☐ NO ☐ PROGRESS ☐

6.14.2 processing claims against the trust — ISO A — YES ☐ NO ☐ PROGRESS ☐

6.15 Claims against the trust are handled in line with Department of Health guidance. — ISO A — YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes HSC 1998/183 Handling Clinical Negligence Claims and the procedures developed by the NHS Litigation Authority.

Notes for action planning:

6.16 In cases of potential clinical negligence claims, the trust follows the pre-action protocol.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

This protocol includes:

- *management of information referring to the claim*
- *handling health records as evidence*
- *process to follow in exchange of formal letters.*

6.17 Summary reports of claims and litigation in progress are produced and presented to the trust board and the trust's clinical governance and risk management group(s).

B YES ☐ NO ☐ PROGRESS ☐

Major incident plans (external and internal)

6.18 The organisation has a major incident, all-hazards plan written/reviewed within the last three years (organisations that have a role in an external major accident response, *see also Standard 28 accident and emergency service).*

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The major incident plan should be written in line with HSC 1998/197 Planning for Major Incidents: The NHS Guidance.

These incidents include, for example:

- *bomb threats and explosions*
- *fire*
- *loss of vital services (for example, electricity, water)*
- *transport disasters*
- *industrial disasters (such as chemical leakage).*

The plans include evacuation procedures.

Notes for action planning:

Standard 6 : risk management CONTINUED

6.19 The external major incident plan is developed in consultation with:

6.19.1 emergency services — A — YES ☐ NO ☐ PROGRESS ☐

6.19.2 local authorities — A — YES ☐ NO ☐ PROGRESS ☐

6.19.3 health authorities. — A — YES ☐ NO ☐ PROGRESS ☐

Guidance

*Only those organisations which are part of the area disaster response plan are expected to have **external** major incident plans.*

6.20 There is a nominated senior officer with overall responsibility for all aspects of major incident planning. — ISO — A — YES ☐ NO ☐ PROGRESS ☐

6.21 All departments/services having a role in the response to a major incident (external or internal) are involved in the preparation of the action plans. — ISO — A — YES ☐ NO ☐ PROGRESS ☐

Guidance

The action plan ensures that all staff are aware of their individual responsibilities in the event of a major incident. Any training needs highlighted during the development of action plans should be incorporated into the organisation's training and development plans.

6.22 The organisation has a full scale, live exercise to rehearse the major incident plan, at least every three years. — A — YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

Rehearsals are part of a co-ordinated practice in which other emergency services participate and rehearsals involve medical, nursing, managerial and other staff as appropriate. If a full scale rehearsal does not take place, the organisation must demonstrate clear evidence that the major incident plan has been tested by other means.

6.23 All major incidents are evaluated and a written report produced which is considered by the board. ISO **B** YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Health and safety

6.24 A board director has overall responsibility for formulating, implementing and developing health and safety policy. ISO A YES ☐ NO ☐ PROGRESS ☐

6.25 There is a dated, documented, trust-wide health and safety policy, written/reviewed within the last three years. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This should conform to the requirements of current legislation and should be signed and dated by the board director responsible for health and safety.

6.26 Arrangements are in place for obtaining competent health and safety advice. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This should be in line with the requirements of the Management of Health and Safety at Work Regulations: all employers must appoint one or more 'competent' persons to help them comply with health and safety legislation.

The authority and accountability of the adviser (however named) should be defined and a direct reporting line to the organisation's executive management team should be established.

Competent refers to someone with sufficient training, experience and knowledge to enable proper assistance to be given. This person may be an employee or may be an independent health and safety expert.

The organisation may need more than one adviser to cover all health and safety matters.

6.27 There is a trust-wide, multiprofessional safety committee (or committees). ISO A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

This includes, for example, senior management, staff and trade union representation (in line with the Health and Safety: Consultation with Employees Regulations). The committee should be consulted on the development, implementation and monitoring of the health and safety policy. The committee should also be involved in the setting and monitoring of performance standards for health and safety.

6.28 The committee reports to the trust's executive management/board on a regular basis.

B YES ☐ NO ☐ PROGRESS ☐

6.29 There is a dated, documented health and safety plan, written/reviewed within the last twelve months.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The health and safety plan should identify health and safety objectives, set targets, set timescales for action and be developed in consultation with staff.

6.30 An annual health and safety report is produced.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This should be presented to the organisation's executive management team and should be made available to all staff within the organisation.

The report should detail the health and safety objectives and targets for the past year, together with the initiatives that have been developed and the action implemented to meet them. The report may also include an outline of the health and safety objectives for the year ahead.

6.31 First aid arrangements are in place and are in accordance with current legislation.

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 6 : risk management – health and safety CONTINUED

Guidance

Rules for the provision of first aid facilities are laid down in the Health and Safety (First Aid) Regulations.

6.32 There is a health and safety education programme for all staff. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

Most health and safety regulations have a requirement for sufficient training for employees to know the risks and the precautions needed in their work. Training includes, for example:

- *induction training programmes for all new recruits including clinical staff*
- *regular refresher training for all employees*
- *training for employees who are transferred or promoted (this should be carried out before the post holder moves)*
- *in areas where there is a higher risk of violence, staff training to handle potentially aggressive situations.*

6.33 The health and safety education programme is subject to systematic review. B YES ☐ NO ☐ PROGRESS ☐

6.34 Records of health and safety training given to staff are maintained. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This should be recorded for each employee, together with the date on which the training took place.

6.35 All temporary workers are given information on health and safety matters that may be encountered in their work. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

Temporary workers include locum staff, contract staff, subcontract staff, bank staff and agency staff.

Notes for action planning:

Standard 6 : risk management – health and safety CONTINUED

6.36 The reporting of injuries, diseases and dangerous occurrences is carried out in accordance with current legislation.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

All reportable injuries, diseases and dangerous occurrences should be reported to the enforcing authority (Health & Safety Executive) within the timescale required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.

6.37 Safety notices and hazard notices are:

6.37.1 disseminated to the relevant staff

ISO A YES ☐ NO ☐ PROGRESS ☐

6.37.2 acted on, with actions recorded.

ISO A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Fire safety

6.38 The chief executive signs a dated, documented, trust-wide fire safety policy annually, which is presented to the board.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The Firecode policies and principles document should be referred to for full details of the content of the policy.

6.39 There is an annual certificate of compliance with the Firecode policy and principles, signed by the chief executive or board level director, appointed by him/her.

A YES ☐ NO ☐ PROGRESS ☐

6.40 There is access to an appropriately qualified and experienced fire safety adviser.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The responsibilities of the adviser should be in accordance with the Firecode policies and principles document.

6.41 At each site there is a member of staff designated as the nominated officer (fire).

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The responsibilities of the nominated officer (fire) should be in accordance with the Firecode policies and principles document.

6.42 There is written evidence of the extent to which buildings comply with fire safety legislation.

ISO A YES ☐ NO ☐ PROGRESS ☐

6.43 For designated areas (as defined by current legislation) there is written evidence that a fire inspection by the local fire authority has taken place within the last three years.

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

6.44 There is a documented response to recommendations made by the local fire authority.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

This sets out the action already taken or proposed by the organisation, the rationale on which it is based and the planned timetable of compliance.

The timetable shows evidence of priority being given to, for example:

- *achieving certification for the relevant parts of the estate*
- *recommendations which have a direct bearing on issues of patients/users safety*
- *eradication of gross fire hazards*
- *early compliance with recommendations that are readily achievable.*

6.45 Comprehensive assessments of fire risks are regularly conducted and the findings recorded.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

These assessments should include carrying out safety checks in unused buildings. Assessments should be made in accordance with the Firecode policies and principles document and the Fire Precautions (Places of Work) Regulations.

6.46 There is written evidence of approval from the local authority in relation to:

6.46.1 new buildings — A YES ☐ NO ☐ PROGRESS ☐

6.46.2 major works — A YES ☐ NO ☐ PROGRESS ☐

6.46.3 alterations, as appropriate. — A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Fire systems and equipment

6.47 Fire fighting equipment is:

				YES	NO	PROGRESS
6.47.1	provided in all the organisation's facilities	ISO	A	☐	☐	☐
6.47.2	appropriate to the type of fire most likely to occur in the area in which it is located	ISO	A	☐	☐	☐
6.47.3	clearly marked with regard to the type of appliance and instructions for use.	ISO	A	☐	☐	☐

Guidance

Fire fighting equipment includes, for example:

- *fire extinguishers*
- *hydrants*
- *hose reels*
- *fire blankets.*

Particular attention should be given to hazardous areas such as, for example:

- *engineering plant rooms/boiler rooms*
- *fuel and gas storage compounds*
- *health records storage areas*
- *kitchens*
- *laundry storage areas and linen rooms*
- *refuse collection and storage areas*
- *rooms or spaces used for permanent or temporary storage of combustible supplies and equipment*
- *treatment rooms and patient/user bed areas where oxygen and other potentially hazardous gases are used.*

Notes for action planning:

6.48 There are documented records to demonstrate that the testing and maintenance of fire systems and equipment is carried out:

6.48.1 on a systematic basis

6.48.2 by a qualified person.

6.49 Where fire alarm, fire detection and emergency lighting systems do not conform to regulations, a programme for upgrading the equipment is produced.

6.50 There are designated "fire routes" for fire engines which are always kept clear.

ISO A YES ☐ NO ☐ PROGRESS ☐

ISO A YES ☐ NO ☐ PROGRESS ☐

ISO A YES ☐ NO ☐ PROGRESS ☐

A YES ☐ NO ☐ PROGRESS ☐

Evacuation

6.51 Fire escape routes are:

6.51.1 accessible at all times

6.51.2 wide enough for the evacuation of non-ambulant patients/users and staff

6.51.3 not used to store combustible materials.

A YES ☐ NO ☐ PROGRESS ☐

A YES ☐ NO ☐ PROGRESS ☐

A YES ☐ NO ☐ PROGRESS ☐

A YES ☐ NO ☐ PROGRESS ☐

A YES ☐ NO ☐ PROGRESS ☐

6.52 Fire exit signs are clearly displayed.

6.53 Patients'/users' rooms and fire exit doors are kept unlocked at all times.

Guidance

Liaison between staff responsible for fire safety and for security is essential to ensure that fire exits do not provide a way of unauthorised entry to buildings.

Notes for action planning:

Standard 6 : risk management – fire safety CONTINUED

6.54 In areas where doors must be locked there are written and pictorial instructions detailing the means of escape during a fire.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

This may apply in some psychiatric units; these doors should be on a fire alarm release system.

6.55 Fire instruction notices are clearly displayed throughout the organisation.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

These should be prominently displayed and should state the essentials of the action to be taken on discovering a fire and on hearing the fire alarm.

6.56 Procedures detailing action to be taken in the event of patients/users having to be moved are displayed in patient/user areas.

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

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Fire training

6.57 There is a fire training programme for all staff.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

Staff should receive training in, for example:

- *fire alarm notification*
- *the operation of fire fighting equipment*
- *evacuation techniques.*

Training sessions should be held frequently and at different times of the day and night to give all staff the opportunity to attend, and in different locations for organisations on more than one site.

Standard 6 : risk management – fire safety CONTINUED

6.58 All staff attend fire training at least annually, or as dictated by the fire certificate.

Guidance

The fire certificate may require fire training for staff every six months.

A YES ☐ NO ☐ PROGRESS ☐

6.59 Staff attendance at fire training is recorded.

ISO A YES ☐ NO ☐ PROGRESS ☐

6.60 Practice fire drills are held for day and night staff.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

If there is a policy decision not to carry out fire drills this must be documented and there must be clear evidence to demonstrate that fire procedures have been fully tested by other means.

6.61 Staff attendance at fire drills is recorded.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

Fire drills do not need to involve the evacuation of patients/users, however all staff should carry out a practice evacuation within their working environment.

6.62 All drills are evaluated and a written report produced.

ISO A YES ☐ NO ☐ PROGRESS ☐

Fire incidents

6.63 All fire incidents are reported and investigated by the nominated officer (fire).

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This may be in conjunction with the local fire authority, as appropriate.

Notes for action planning:

Infection control

Responsibilities

6.64 The chief executive or equivalent is accountable for establishing and maintaining infection control arrangements across the trust.

ISO A YES ☐ NO ☐ PROGRESS ☐

6.65 Infection control advice is provided by a qualified person who is responsible for ensuring that timely advice is given, including the formulation and promulgation of infection control policy.

ISO A YES ☐ NO ☐ PROGRESS ☐

6.66 There is an infection control team.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The infection control team includes, for example, an infection control doctor, an infection control nurse and, if the infection control doctor is from another specialty, a consultant medical microbiologist.

Resources provided for infection control should meet Hospital Infection Control – Guidance on control of infection in hospitals HSG (95)10 .

Units which are not large enough to require an infection control team must make formal arrangements for advice and assistance to be provided from a nearby NHS trust.

6.67 There is a multiprofessional infection control committee which advises and supports the infection control team.

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

The committee, for example:

- *reviews the annual infection control programme*
- *reviews recent outbreaks*
- *reviews all procedures in relation to infection control*
- *discusses specific areas of concern raised by the infection control team*
- *agrees guidelines for the surveillance of infections and infection potential*
- *reviews results of infection control audits.*

The committee membership includes, for example, the infection control team, the consultant in communicable disease control, representation from medical, nursing and managerial staff and paramedical and support services as appropriate - for example, pharmacy, engineering, sterile services.

Trusts which do not have an internal infection control committee (because of size, or the type of services offered for example) must have formal arrangements for linking in to the infection control committee at a nearby NHS trust, for example, through an infection control link nurse, who sits on the committee at the other trust.

6.68 The infection control committee:

6.68.1 meets twice per year, as a minimum

6.68.2 minutes its meetings.

Guidance

The committee should ensure that minutes of its meetings and reports produced are sent to the organisation's executive management team/trust board and individual directorates where in place.

	YES	NO	PROGRESS
A	☐	☐	☐
A	☐	☐	☐

Notes for action planning:

Process

6.69	There are dated documented infection control policies and procedures, written/reviewed within the last three years which cover:					
6.69.1	procedures for routine occupational hygiene for all health professionals	ISO	A	YES ☐	NO ☐	PROGRESS ☐
6.69.2	disposal procedures for clinical and non clinical waste	ISO	A	YES ☐	NO ☐	PROGRESS ☐
6.69.3	procedure for handling outbreaks of infection	ISO	A	YES ☐	NO ☐	PROGRESS ☐
6.69.4	isolation techniques	ISO	A	YES ☐	NO ☐	PROGRESS ☐
6.69.5	guidelines on prevention of spread of blood-borne viruses	ISO	A	YES ☐	NO ☐	PROGRESS ☐
6.69.6	protection of staff from infection	ISO	A	YES ☐	NO ☐	PROGRESS ☐
6.69.7	dealing with sharps incidents (including needlestick injuries)	ISO	A	YES ☐	NO ☐	PROGRESS ☐
6.69.8	working with high risk patients/users (for example immunosuppressed) and those with communicable diseases	ISO	A	YES ☐	NO ☐	PROGRESS ☐
6.69.9	sterilization and disinfection	ISO	A	YES ☐	NO ☐	PROGRESS ☐
6.69.10	procedures for control of infection in house-keeping, laundry and catering	ISO	A	YES ☐	NO ☐	PROGRESS ☐
6.69.11	guidance on last offices and mortuary procedures with regard to infection control.	ISO	A	YES ☐	NO ☐	PROGRESS ☐

Notes for action planning:

6.70 The infection control policies and procedures are distributed throughout the organisation.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The distribution should be appropriate to the work of various services/departments within the organisation.

6.71 Policies and procedures are:

6.71.1 referenced to appropriate legislation or published professional guidance

A YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes, Guidance for clinical health care workers: Protection against infection with blood-borne viruses, recommendations of the expert advisory group on AIDS and the advisory group on hepatitis.

6.71.2 contained within a manual.

A YES ☐ NO ☐ PROGRESS ☐

Staff training

6.72 There is an ongoing education programme for all staff within the organisation.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

All staff should have regular up-dating on measures for infection control relating to their area of work. When new systems of work are introduced, consideration should be given to the need for infection control updating.

6.73 The infection control team is involved in:

6.73.1 the trust-wide induction programme

ISO A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 6 : risk management – infection control CONTINUED

6.73.2	junior doctors' orientation and induction programme	ISO	A	YES ☐	NO ☐	PROGRESS ☐	
6.73.3	basic level training of other health care personnel (for example, nursing students, medical students, health care assistants).	ISO	A	YES ☐	NO ☐	PROGRESS ☐	

Infection control measures

6.74	Facilities for infectious patients and those requiring isolation are available.	ISO	A	YES ☐	NO ☐	PROGRESS ☐	
6.75	There are hand washing facilities in all areas where poor hand-washing or lack of hand-washing facilities could cause the spread of MRSA.		A	YES ☐	NO ☐	PROGRESS ☐	
6.76	There is an infection surveillance programme in place across the organisation that includes the collection, analysis and dissemination of data.		A	YES ☐	NO ☐	PROGRESS ☐	

Guidance

This should be in line with Hospital Infection Control - Guidance on control of infection in hospitals HSG (95/10).

The results from the infection surveillance programme should link into other clinical audit studies.

6.77	The infection team undertake infection control risk assessments.	B	YES ☐	NO ☐	PROGRESS ☐	
6.78	Arrangements are in place for controlling outbreaks of infection.	A	YES ☐	NO ☐	PROGRESS ☐	
6.79	Advice from the infection control team is sought in the following areas:					

Notes for action planning:

Standard 6 : risk management – infection control CONTINUED

6.79.1	equipment and consumable items intended for patients'/users' to ensure that they conform with infection control standards	A	YES ☐ NO ☐	PROGRESS ☐
6.79.2	proposed building constructions to ensure that they are designed in line with infection control requirements.	A	YES ☐ NO ☐	PROGRESS ☐
6.80	An environmental hygiene audit of the organisation is undertaken.	B	YES ☐ NO ☐	PROGRESS ☐
6.81	There is ongoing communication between the infection control team and:			
6.81.1	the consultant in communicable disease control	A	YES ☐ NO ☐	PROGRESS ☐
6.81.2	the organisation's laboratory service	A	YES ☐ NO ☐	PROGRESS ☐
6.81.3	the clinical audit department/co-ordinator	B	YES ☐ NO ☐	PROGRESS ☐
6.81.4	external services	B	YES ☐ NO ☐	PROGRESS ☐
	Guidance			
	Examples of external services include the local authority, general practitioners, the public health laboratory service.			
6.81.5	the occupational health service	A	YES ☐ NO ☐	PROGRESS ☐
	Guidance			
	This is important to ensure that there are consistent trust-wide advice and procedures on measures to avoid the transmission of infection.			
6.81.6	the health and safety committee.	A	YES ☐ NO ☐	PROGRESS ☐

Notes for action planning:

Standard 6 : risk management – waste disposal

Waste disposal

6.82 There is a dated documented waste disposal strategy, written/reviewed within the last three years. ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes the designation of a responsible officer and covers waste segregation and coding, waste reduction, re-use of equipment and re-cycling, options for cost effective disposal of waste.

The strategy should be line with NHS Estates Safe Disposal of Clinical Waste, Health Guidance Note EPL/95/13.

6.83 There are dated, documented procedures, written/reviewed within the last three years, for waste disposal which cover:

6.83.1 segregating general and contaminated waste at the site of generation including colour coding and labelling ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

Labelling should enable the waste to be traced back to its point of origin.

6.83.2 disposing of sharp objects in suitable containers ISO A YES ☐ NO ☐ PROGRESS ☐

6.83.3 labelling and disposing of cytotoxic and radioactive waste ISO A YES ☐ NO ☐ PROGRESS ☐

6.83.4 safe handling of contaminated waste ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes, for example, the use of approved contaminated waste bags, protective clothing, and appropriate storage facility prior to incineration or removal from the site.

Notes for action planning:

Standard 6 : risk management – waste disposal CONTINUED

6.83.5 timely and safe disposal of large items of waste (for example mattresses exposed to a source of infection)

ISO A YES ☐ NO ☐ PROGRESS ☐

6.83.6 disposing of special waste (for example, prescription returns).

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

Procedures should be in line with NHS Estates document, Safe Disposal of Clinical Waste: Whole Hospital Policy Guidance, NHS Executive, 1995.

Procedures for disposal of clinical waste should be in line with the Environmental Protection Act 1990 which lays a duty of care on organisations to dispose of clinical waste safely.

6.84 The implementation of waste handling and disposal procedures is audited.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

For example, this may be a function of the health and safety committee.

Waste disposal facilities

6.85 Approved containers are provided to all departments suitable for the type of waste generated.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes the provision general waste and clinical waste collection sacks, sharps containers and suitable bins/trolleys/pens to hold the sacks and containers.

Containers used for road transport of clinical waste must meet UN approval requirements for carriage by road, including marking with the biohazard sign and the appropriate UN number.

Notes for action planning:

Standard 6 : risk management – waste disposal CONTINUED

6.86 Storage of waste is kept to a minimum and kept secure at all times.

Guidance

For example, clinical waste should be stored in lockable wheeled bins that allow for 'single handling' of the waste.

Sharps containers must be kept in secure areas to prevent the removal of objects from the box.

A YES ☐ NO ☐ PROGRESS ☐

6.87 Waste collection schedules are drawn up and agreed with service areas to reflect levels and types of waste generated.

A YES ☐ NO ☐ PROGRESS ☐

6.88 Protective clothing is readily available and used by staff transferring and transporting waste.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes, for example gloves, goggles, boiler suits, overboots, dependent upon the type of waste and the amount of handling involved, as a minimum, gloves should be worn.

6.89 Vehicles used specifically to transport waste are cleaned:

6.89.1 at least weekly

A YES ☐ NO ☐ PROGRESS ☐

6.89.2 when leakage or spillage has occurred.

A YES ☐ NO ☐ PROGRESS ☐

6.90 There are separate vehicles to transport waste and non-waste items.

A YES ☐ NO ☐ PROGRESS ☐

6.91 All staff involved in handling clinical waste receive training.

ISO A YES ☐ NO ☐ PROGRESS ☐

6.92 The incinerator operator has a valid licence.

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 6 : risk management – waste disposal CONTINUED

Guidance

Even where waste is disposed of off-site, under contract the organisation has a duty of care under the Environmental Protection Act 1990 for the safe disposal of clinical waste produced by the organisation.

Notes for action planning:

Security

Strategy and communications

6.93 There is a security strategy for the trust.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The strategy includes, for example:

- *management responsibility for security*
- *staff training on security measures*
- *crime prevention*
- *access to buildings*
- *security systems and equipment*
- *reporting of security incidents*
- *ongoing review of security issues.*

6.94 The manager responsible for security has knowledge and experience of legal and security issues, or has access to advice from qualified, competent individuals.

ISO A YES ☐ NO ☐ PROGRESS ☐

6.95 There is a trust-wide security forum/committee.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

The forum/committee should help to maintain a high profile for security issues and includes wide representation from service areas.

The remit of the committee includes the discussion of security issues, the responsibilities of all employees with regard to security, organisation-wide crime prevention initiatives, management of violence and aggression throughout the organisation.

See advice in Violence and aggression to staff in health services: guidance on assessment and management, Health and Safety Commission.

Notes for action planning:

Standard 6 : risk management – security CONTINUED

6.96 There are arrangements for liaison with the police in response to security incidents and for on-going advice and training links.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

The manager responsible for security should have a close working relationship with a named community police liaison officer. There may be police input into a trust crime prevention initiative and to staff training.

Process

6.97 There are dated, documented procedures written/reviewed within the last three years, for:

6.97.1 procedure for control of access to buildings and entrances to be locked out of hours

ISO A YES ☐ NO ☐ PROGRESS ☐

6.97.2 procedures for safe keeping of patients'/users' property

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The system should include for example:

- *who is responsible for keeping money and valuables*
- *how they can be accessed out of office hours*
- *the procedures in the event of patient's/user's death and to whom the money and valuables can be released.*

6.97.3 procedure to be followed in the case of a missing patient

ISO A YES ☐ NO ☐ PROGRESS ☐

6.97.4 procedure for key-holding and key issue

ISO A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

This includes, for example:

- *residencies*
- *patient/user keys (where appropriate)*
- *access for emergency services.*

6.97.5 communication with the workplace for staff who work in isolation and/or visit people in their own homes — ISO A — YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes, for example:

- *staff leaving clear information about visiting schedules at their office base*
- *procedures for calling-in when working in the community.*

Adherence to the communication procedure and its effectiveness are monitored and reviewed regularly.

6.97.6 procedure for the operation of closed circuit television, where this is installed — ISO A — YES ☐ NO ☐ PROGRESS ☐

6.97.7 procedure for cash handling where security staff are responsible for collection and transportation of cash — ISO A — YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes, for example, car parking fees, emptying payphones and vending machines.

6.97.8 procedure for the reporting of security incidents, response and follow-up incidents — ISO A — YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 6 : risk management – security CONTINUED

Guidance

These cover, for example:

- *reporting of incidents to the police*
- *resetting of alarms*
- *boarding up windows/doors*
- *alerting the head of the affected department*
- *internal recording of incidents*
- *recording of stolen items.*

The policies are in line with NHS Executive guidance and local requirements for information on patient/user related incidents.

6.97.9 procedure on the role of the security service in managing controlled drugs and preventing their misuse

B YES ☐ NO ☐ PROGRESS ☐

6.97.10 procedure for maintaining car park security.

B YES ☐ NO ☐ PROGRESS ☐

6.98 Reports are produced, half-yearly as a minimum, that detail security incident trends, severity and levels of criminal activity.

B YES ☐ NO ☐ PROGRESS ☐

Security measures

6.99 There is a staff and contractor identification system in place.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

All staff, including sub-contractors, agency and locum staff, are issued with identification badges, to be worn at all times, which include as a minimum the individual's name and post/designation.

6.100 Security of unoccupied offices/departmental areas is maintained at all times.

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

This includes, for example:
- *empty/disused rooms and buildings*
- *areas which may be temporarily unoccupied during the day or at night.*

6.101 A security risk assessment of the trust is undertaken.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

This is carried out annually, as a minimum and should include security risks for all areas during working hours, out of hours and at night for 24-hour services. The security risk assessment process should include recommendations and action plans.

6.102 Security measures are in place at night.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

These include, for example:
- *internal and external security inspection tours of the buildings*
- *monitoring via closed circuit television.*

6.103 Special precautions are taken to minimise risk in high risk/vulnerable areas.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

These areas include pharmacies and any drugs storage areas, and unoccupied rooms with computers and other electrical equipment.

Precautions may include to mechanical security aids (for example, personal attack alarms, panic buttons).

6.104 Designated security staff have communication equipment such as two-way radios, mobile phones, two way speech bleeps.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

The communication equipment should enable continuous communication from anywhere on the organisation's premises.

6.105 The means of raising an alarm are available for staff if they are in difficulty. A YES ☐ NO ☐ PROGRESS ☐

Guidance

These include, for example:

- *panic buttons*
- *personal alarms*
- *mobile telephones.*

6.106 There is consultation with the fire safety officer before the implementation of physical security measures such as window bars or locks on external and internal doors. A YES ☐ NO ☐ PROGRESS ☐

People – staff development and education

6.107 The recruitment and selection process for designated security staff includes verbal and written communication skills and is supported by police checks and follow-up of references. B YES ☐ NO ☐ PROGRESS ☐

6.108 Security staff receive training in:

6.108.1 handling physical and verbal violence ISO B YES ☐ NO ☐ PROGRESS ☐

Guidance

This training should also be available to other staff as appropriate.

6.108.2 basic legal issues relevant to their role ISO B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

This may include, for example:

- *trespass laws*
- *making a citizen's arrest*
- *report writing*
- *rules of evidence*
- *control and restraint.*

6.108.3 communication skills and customer care. ISO B YES ☐ NO ☐ PROGRESS ☐

People – staff support

6.109 There is a debriefing service for staff involved in a violent or abusive incident. B YES ☐ NO ☐ PROGRESS ☐

Guidance

This should include access to counselling if required.

6.110 Guidelines giving advice on handling physical and verbal violence are available for all staff. B YES ☐ NO ☐ PROGRESS ☐

Guidance

The guidelines include:

- *how to record all incidents involving verbal abuse and threats*
- *information on training for staff in high risk/vulnerable areas.*

See advice in: Violence and aggression to staff in health services: guidance on assessment and management, Health & Safety Commission.

Notes for action planning:

Standard 6 : risk management

feedback sheet

HQS needs the input of programme users to ensure that the standards and criteria are relevant, and up-to-date.

Please use this sheet to record your comments on this standard, for example letting HQS know if criteria are difficult to interpret, if terminology used is incorrect, or if you know of more up-to-date references which should be included. Please return completed feedback sheets to the project manager in your organisation in the first instance, who will then forward to HQS.

Thank you

Criteria	Comment	Criteria	Comment

Standard 7 : human resources

There is a human resource strategy and human resource policies and procedures which enable the trust to meet its objectives and which promote an ethical approach to managing staff.

Criteria

7.1 There is a dated, documented human resource strategy, written/ reviewed within the last twelve months, which links with the overall business strategy and is designed to provide work conditions conducive to good health and high performance.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The strategy takes account of the NHS human resources strategy, Working Together – securing a quality workforce for the NHS, HSC1998/162. The following issues are considered when drawing up the strategy, for example:

- *skills and qualifications required to run the trust's services*
- *workforce planning and employee resourcing*
- *recruiting and retaining staff*
- *redundancy/outplacement of staff*
- *staff training and development*
- *employee health and welfare*
- *employee relations*
- *equal opportunities, including the ethnic monitoring of staff*
- *managing performance*
- *pay and reward mechanisms*
- *milestones for review of the strategy.*

Notes for action planning:

7.2 The human resource strategy identifies indicators which are used in measuring the performance of the human resource function, both centrally and in people management across the organisation.

Guidance

- *The indicators may include for example:*
- *staff turnover*
- *reported sickness as a percentage of WTE*
- *total staff costs of HR functions as a percentage of total organisation staff costs*

For further guidance see Towards a model of HRM effectiveness, HMSC and NHSP 1998.

B YES ☐ NO ☐ PROGRESS ☐

7.3 The human resource strategy is communicated throughout the organisation.

B YES ☐ NO ☐ PROGRESS ☐

7.4 There are dated, documented human resource policies and procedures, written/reviewed within the last three years which comply with employment legislation.

Guidance

This includes

- *The Sex Discrimination Act 1975*
- *The Race Relations Act 1976*
- *The Disability Discrimination Act 1995*
- *The Welsh Language Act 1993*
- *Working Time Regulations 1998.*

ISO A YES ☐ NO ☐ PROGRESS ☐

7.5 Human resource policies and procedures are developed collaboratively with input from disciplines such as occupational health, health and safety and health promotion.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

7.6 There is a dated, documented policy and procedure, written reviewed within the last three years, to address staff harassment by other staff members and/or patients/users.

Guidance

The incidence of reported harassment is recorded. The policy may include, for example:

- *the right of staff to be treated by colleagues and patients with courtesy, dignity, fairness and respect at all times*
- *treating bullying and/or the abuse of power as serious misconduct and subject to disciplinary action.*

The RCN has produced a model policy on harassment at work, RCN, May 1997.

A YES ☐ NO ☐ PROGRESS ☐

7.7 The incidence of harassment is monitored.

Guidance

As required by the NHS Executive in Working Together – securing a quality workforce for the NHS (HSC 1998/162).

A YES ☐ NO ☐ PROGRESS ☐

7.8 "Family friendly" policies are implemented so that staff are helped to work flexibly to match the requirements of work to their family and other needs, wherever this can be accommodated within operational/organisational needs.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

Policies may include, for example:

- *provision of child care facilities*
- *school holiday clubs*
- *extended leave for family crises*
- *flexible shift patterns*
- *annual hours contracts*
- *term-time working*
- *job-share*
- *paternity leave*
- *adoption leave*

The organisation should consult with staff on the type of policies most valued prior to implementation.

				YES	NO	PROGRESS
7.9	The trust reviews progress in introducing "family friendly" policies.		B	☐	☐	☐

Recruitment and selection

				YES	NO	PROGRESS
7.10	Before the appointment of new staff:					
7.10.1	an analysis of staffing levels in relation to workload is carried out		B	☐	☐	☐
7.10.2	skills required are assessed and jobs designed accordingly.		B	☐	☐	☐
7.11	There is a dated, documented procedure, written/ reviewed in the last three years, for the recruitment and selection of all staff.	ISO	A	☐	☐	☐

Notes for action planning:

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Guidance

The procedure includes, for example, details on:

- *guidelines for advertising posts*
- *job descriptions/role profiles or equivalent*
- *person specifications*
- *selection criteria*
- *obtaining references*
- *health screening*
- *issuing the letter of appointment*

These points should also apply to the recruitment and screening of volunteers.

7.12 Recruitment procedures adhere to the equality of opportunities policy *(see also Standard 2 corporate governance)*.

A YES ☐ NO ☐ PROGRESS ☐

7.13 Data collection and monitoring of equal opportunities are carried out.

A YES ☐ NO ☐ PROGRESS ☐

7.14 Findings from the data collection and monitoring are acted upon.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

This should be in line with Ethnic Monitoring of Staff in the NHS: A programme of action, EL (94) 12. Adherence to the policy is monitored.

7.15 All recruitment episodes start with:

7.15.1 a job description/ role profile or equivalent

A YES ☐ NO ☐ PROGRESS ☐

7.15.2 a person specification stating the necessary and desirable criteria for selection or a competency framework which includes an indicator of roles and responsibilities.

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

7.16 Selection decisions are made using a range of tools which are relevant to the job and reflect the selection criteria.

Guidance

For example:

Application interviews, psychological testing, work sampling exercises and group discussions

B YES ☐ NO ☐ PROGRESS ☐

7.17 All personnel involved in the selection process have training in the application of the selection tools they are using.

Guidance

For example

- *training in interview techniques*
- *the process of using psychometric tests is in accordance with the Institute of Personnel Development's code of practice 1997.*

ISO B YES ☐ NO ☐ PROGRESS ☐

7.18 As part of the recruitment process professional qualifications are checked.

ISO A YES ☐ NO ☐ PROGRESS ☐

7.19 Prior to appointment criminal convictions are checked.

Guidance

On implementation of part V of the Police Act 1997, the establishment of a criminal records agency, prospective employees and volunteers should be asked to produce a criminal conviction certificate (and be reimbursed for any costs incurred). Prior to the establishment of the agency, police forces will continue to provide the record checking service.

A YES ☐ NO ☐ PROGRESS ☐

7.20 The use of locums:

Notes for action planning:

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Standard 7 : human resources CONTINUED

7.20.1	complies with the NHS Code of Practice in locum appointment and employment (1997)	ISO	B	YES ☐	NO ☐	PROGRESS ☐
7.20.2	is minimised to fill vacant posts		B	YES ☐	NO ☐	PROGRESS ☐
7.20.3	exceeds three months duration only in exceptional circumstances.		B	YES ☐	NO ☐	PROGRESS ☐
7.21	All staff receive written contracts of employment within eight weeks of appointment.		A	YES ☐	NO ☐	PROGRESS ☐
7.22	All employees have access to written terms and conditions of service.		A	YES ☐	NO ☐	PROGRESS ☐
7.23	Individual employees are consulted on any changes to the terms and conditions of their employment.		A	YES ☐	NO ☐	PROGRESS ☐
7.24	The issue of temporary or fixed-term contracts of less than one year (excluding medical staff) is monitored.		B	YES ☐	NO ☐	PROGRESS ☐
	Guidance					
	Reports should be reviewed by the human resources department on a quarterly basis and by the trust board annually.					
7.25	Job descriptions/role profiles or equivalent:					
7.25.1	specify the job title and grade, job purpose, objectives, and accountability	ISO	A	YES ☐	NO ☐	PROGRESS ☐
7.25.2	are dated and issued to staff on appointment for all posts		B	YES ☐	NO ☐	PROGRESS ☐
7.25.3	are reviewed when the job is re-advertised		B	YES ☐	NO ☐	PROGRESS ☐
7.25.4	are reviewed annually as part of the performance review process		A	YES ☐	NO ☐	PROGRESS ☐

Notes for action planning:

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7.25.5 include the job holder's responsibilities for self-development on a continuous basis.

B YES NO PROGRESS

7.26 All manual and computerised personnel data:

7.26.1 comply with current legislation on data protection

A YES NO PROGRESS

7.26.2 are maintained in a confidential manner.

A YES NO PROGRESS

Guidance

These records include, for example:

- *application form/curriculum vitae*
- *references*
- *the contract of employment and any amendments issued*
- *an up-to-date job description*
- *details of qualifications held*
- *UKCC pin number and due date for renewal*
- *records of leave and sickness*
- *performance review details.*

7.27 Employees are informed of their rights of access to information held about them.

A YES NO PROGRESS

Orientation and induction

7.28 All newly appointed staff complete a corporate induction programme within a specified timescale, the induction programme includes:

7.28.1 fire safety

ISO A YES NO PROGRESS

7.28.2 health and safety

ISO A YES NO PROGRESS

7.28.3 patient/user confidentiality

ISO A YES NO PROGRESS

Notes for action planning:

Standard 7 : human resources CONTINUED

7.28.4	accident and untoward incident reporting	ISO	A	YES ☐	NO ☐	PROGRESS ☐
7.28.5	security	ISO	A	YES ☐	NO ☐	PROGRESS ☐
7.28.6	infection control	ISO	A	YES ☐	NO ☐	PROGRESS ☐
7.28.7	staff health		A	YES ☐	NO ☐	PROGRESS ☐
7.28.8	pay arrangements		B	YES ☐	NO ☐	PROGRESS ☐
7.28.9	performance review	ISO	B	YES ☐	NO ☐	PROGRESS ☐
7.28.10	organisational values and objectives	ISO	B	YES ☐	NO ☐	PROGRESS ☐
7.28.11	patient/user involvement in choice and decision making		B	YES ☐	NO ☐	PROGRESS ☐
7.28.12	introduction to the staff handbook	ISO	B	YES ☐	NO ☐	PROGRESS ☐
7.28.13	customer care.	ISO	B	YES ☐	NO ☐	PROGRESS ☐

Guidance

Volunteers working in the organisation should have access to the corporate induction programme.

Representatives from local patient/user groups might be used to give the patient's/user perspective in relation to customer care and patient/user involvement in choice and decision making.

7.29	The content of the corporate induction programme is reviewed annually.	ISO	B	YES ☐	NO ☐	PROGRESS ☐
7.30	The completion of the corporate induction programme is recorded.	ISO	A	YES ☐	NO ☐	PROGRESS ☐

Notes for action planning:

Guidance

There should be corporate records of attendance at sessions together with an individual record of attendance given to the staff inducted.

Training and development

7.31 There is a dated, documented training and development plan for the trust, written/ reviewed within the last twelve months.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The plan addresses, for example:

- *the training needs associated with the trust's overall objectives*
- *the training needs in response to changes in practice, the law and new technology*
- *meeting the training needs of individuals, as identified within the performance review system.*

7.32 The training and development plan includes the following elements:

7.32.1 an outline of the development needs of the trust, linked to the organisational objectives

ISO B YES ☐ NO ☐ PROGRESS ☐

7.32.2 identification of the resources available for training.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

Resources include money, facilities, equipment, expertise, people and time.

Organisations may have a budget for training and development which is centrally controlled or devolved to individual managers. Either way, managers need to be aware of the amount of resources available.

Notes for action planning:

7.33 Training and development activities are assessed for their contribution to the achievement of the trust's objectives.

ISO B YES ☐ NO ☐ PROGRESS ☐

Guidance

Training and development activity is related to the objectives included in the business plan. The review takes place at individual, department and organisation levels.

7.34 Educational and developmental opportunities for staff are publicised.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

These include, for example:

- *courses*
- *vocational qualifications*
- *secondment opportunities*
- *on the job development opportunities.*

7.35 Records of study leave for all disciplines are maintained.

B YES ☐ NO ☐ PROGRESS ☐

7.36 Where the organisation provides clinical experience for students, there is a written agreement between the organisation and the educational establishment detailing the responsibility for induction, teaching, supervision and assessment.

ISO B YES ☐ NO ☐ PROGRESS ☐

7.37 The human resources department provides ongoing support to managers throughout the trust in their staff management role.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

For example, managers and supervisors are

- *kept up to date about the assistance available from the human resources department when considering job design, multi-skilling and new generic roles*
- *given the opportunity to attend in-house training on issues which relate to staff management*

This can also be facilitated by the human resource department operating as an "in-house consultant".

7.38 Initiatives are promoted to support staff in skills development and broadening experience.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

Initiatives may include:

- *shadowing,*
- *secondments*
- *research projects*
- *learning sets*
- *a workplace mentoring programme.*

Performance management

7.39 There is a documented performance review system, developed/reviewed within the last three years, for all staff which is developed and implemented with the involvement of line managers

ISO A YES ☐ NO ☐ PROGRESS ☐

7.40 The performance review of individual staff :

7.40.1 is based on the staff member's job description/ role profile or equivalent

A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 7 : human resources CONTINUED

7.40.2	is based on the stated individual, team, departmental and/or trust objectives for the past twelve months		B	YES NO PROGRESS	
7.40.3	identifies strengths in performance and areas for improvement		A	YES NO PROGRESS	
7.40.4	identifies individual, team and/or department and/or trust objectives to be achieved or contributed to, by the next review		B	YES NO PROGRESS	
7.40.5	identifies training needs and the basis for a personal development plan		A	YES NO PROGRESS	
7.40.6	includes the date of the next review, within 12 months.		B	YES NO PROGRESS	
	Guidance *Methods of staff appraisal may vary and range from evaluations by supervisors/managers to self-evaluation and/or input from co-workers.*				
7.41	The criteria to be used in evaluating performance are available to staff as part of the performance review system.		B	YES NO PROGRESS	
7.42	The performance review system is regularly monitored and amended as necessary.	ISO	B	YES NO PROGRESS	
7.43	Managers/supervisors responsible for performance review and training needs assessment have received training, or up-date training, within the last three years.	ISO	B	YES NO PROGRESS	
7.44	There is a dated, documented sickness absence policy, written/reviewed within the last three years, which applies to all staff.		B	YES NO PROGRESS	
7.45	Managers receive training in the administration of the sickness absence policy.		B	YES NO PROGRESS	

Notes for action planning:

Guidance

It is important that the policy is administered consistently with all staff, and with some degree of flexibility and discretion to avoid alienating employees with genuine sickness.

Employee relations

7.46 There is a dated, documented policy and procedures, written /reviewed within the last three years, on security of employment, redeployment and redundancy.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

The policy and procedures include the following:

- *how the organisation plans to manage any reduction in the workforce to minimise financial and emotional costs to the individuals affected*
- *how selection criteria are identified*
- *consideration of alternatives to compulsory redundancy in exchange for employee flexibility*
- *use of voluntary redundancy and redeployment*
- *development of a severance package which includes access to outplacement services.*

The policy and procedures are designed with staff involvement.

7.47 There are documented channels of communication open to all staff in the event of grievance, disputes or complaints.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The procedures to follow in the event of grievance, disputes or complaints by staff should be well publicised, for example in a staff handbook, staff newsletter or staff noticeboards.

Notes for action planning:

Standard 7 : human resources CONTINUED

7.48 There are dated, documented policies and procedures, written/reviewed within the last three years for the conduct of employee relations activities.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

These include, for example:
- *a disciplinary procedure*
- *a grievance procedure*
- *a disputes procedure*
- *an appeals procedure*
- *arrangements for job evaluation*
- *a documented recognition agreement.*

7.49 A workplace partnership agreement exists between the organisation and its employee representatives.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

This may be based on some, or all, of the following principles:
- *commitment to the success of the organisation*
- *commitment to employment security*
- *focus on the quality of working life*
- *transparency (such as openness in communication, early consultation)*
- *adding value (harnessing a greater proportion of employee talent/ideas to improve effectiveness)*

See DTI/DfEE Partnerships with People, 1997 and TUC, Promoting Best Practice Through Workplace Partnership 1998.

Notes for action planning:

Employee support

7.50 There is a dated, documented strategy, written/ reviewed within the last three years, outlining the trust's arrangements for staff support at times of major change, both significant changes within services and across the whole trust (such as a merger).

A YES ☐ NO ☐ PROGRESS ☐

Guidance

The strategy includes:

- *a programme of action to prepare and help staff through the period of change*
- *a proactive approach to assessing the psychological implications of change for staff*
- *a review of existing communication systems and adaptation as required*
- *identification of managers requiring training in change management*
- *access for all staff to a confidential counselling system prior to and during the period.*

The outline strategy should be prepared in advance and reviewed in response to a participation in major change. The strategy may either be a separate document or incorporated, but clearly identified, within the human resource strategy.

Notes for action planning:

Human resources information

7.51 Systems exist for the collection, storage and aggregation of human resource information to meet:

7.51.1 statutory requirements

A YES ☐ NO ☐ PROGRESS ☐

Standard 7 : human resources CONTINUED

			YES	NO	PROGRESS
7.51.2	workforce planning requirements.	B	☐	☐	☐
7.52	The following records are kept and monitored:				
7.52.1	records of staff absenteeism	A	☐	☐	☐
7.52.2	records of staff sickness	A	☐	☐	☐
7.52.3	records of retirements on the grounds of ill health	A	☐	☐	☐
7.52.4	records of dismissals on the grounds of ill health	A	☐	☐	☐
7.52.5	records of staff turnover	A	☐	☐	☐
7.52.6	records of staff stability (staff in post with one or more years' service)	B	☐	☐	☐
7.52.7	records of working hours	A	☐	☐	☐
	Records on working hours should relate to the requirements of the Working Time Regulations 1998.				
7.52.8	records of special leave (for example maternity/paternity leave)	A	☐	☐	☐
7.52.9	records of the ethnic group of all staff.	A	☐	☐	☐

Guidance

Working Together - securing a quality workforce for the NHS, HSC 1998/162, includes the need to demonstrate year on year:

- *improvement in sickness absence rates*
- *improvement in retention rates*
- *progress towards a workforce that becomes more representative of the community it serves at all levels of the organisation.*

Notes for action planning:

7.53 Summaries based on the human resource records maintained:

7.53.1 are provided to managers, the executive team and board

7.53.2 enable trends to be identified.

Guidance

The summaries should be used to inform workforce planning in response to the trends identified.

B YES ☐ NO ☐ PROGRESS ☐

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Healthy workplace

7.54 The organisation has a dated, documented strategy, written/reviewed within the last three years, for its approach to providing a healthy workplace, the strategy:

7.54.1 is approved by the board — A — YES ☐ NO ☐ PROGRESS ☐

7.54.2 specifies long term goals in relation to staff health at work — A — YES ☐ NO ☐ PROGRESS ☐

7.54.3 is developed in consultation with staff, so that it incorporates the expressed needs of staff — B — YES ☐ NO ☐ PROGRESS ☐

7.54.4 takes into consideration NHS targets and priorities — A — YES ☐ NO ☐ PROGRESS ☐

Guidance

This may include Our Healthier Nation targets, where applicable.

7.54.5 identifies targets for healthy workplace initiatives — B — YES ☐ NO ☐ PROGRESS ☐

7.54.6 identifies the evaluation criteria and monitoring mechanisms for healthy workplace initiatives — B — YES ☐ NO ☐ PROGRESS ☐

7.54.7 identifies resource allocation to implement the strategy. — B — YES ☐ NO ☐ PROGRESS ☐

Guidance
Resources may need to include training for staff directly responsible for implementation of healthy workplace initiatives.

See: Improving the health of the NHS workforce – report of the partnership on the health of the NHS workforce, The Nuffield Trust, 1998.

7.55 There is a trust-wide co-ordinator for healthy workplace activities. — B — YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 7 : human resources – healthy workplace
CONTINUED

Guidance

In planning the activities the following may be taken into consideration, for example:

- *the involvement of staff in the planning and running of events helps to increase interest and impact*
- *services and facilities need to be available to all staff and not limited to certain directorates or groups*
- *events are held at more than one location in multi-site organisations and at different times to accommodate part-time, shift workers and night staff*
- *targeting of population groups which may be vulnerable to specific diseases*
- *use of evaluation reports to inform and revise healthy workplace activities.*

The Health Education Authority provide training and advice on implementation of health at work activities.

7.59 The trust promotes individual health by the development and regular review of health promotion policies which relate to staff and to patients/users, carers and visitors where appropriate.

YES ☐ NO ☐ PROGRESS ☐

A

7.60 There are dated, documented policies, written/ reviewed in the last three years, relating to

7.60.1 smoking (in particular on the trust's premises)

YES ☐ NO ☐ PROGRESS ☐

A

7.60.2 use of alcohol (in particular on trust premises and during working hours)

YES ☐ NO ☐ PROGRESS ☐

A

7.60.3 substance abuse

YES ☐ NO ☐ PROGRESS ☐

A

7.60.4 healthy eating (in particular in relation to the trust's catering service)

YES ☐ NO ☐ PROGRESS ☐

B

Notes for action planning:

Standard 7 : human resources – healthy workplace
CONTINUED

7.56 There is a healthy workplace co-ordinating group or committee.

Guidance

The committee/group membership includes:
- *a board level executive*
- *representatives from different departments across the trust to reflect the broad remit for health at work and which extends beyond occupational health, health and safety and personnel.*

The board level executive should regularly attend group/ committee meetings to demonstrate the board's commitment to staff health.

B YES ☐ NO ☐ PROGRESS ☐

7.57 The co-ordinating group or committee produces an annual progress report on implementation of the healthy workplace strategy.

B YES ☐ NO ☐ PROGRESS ☐

7.58 There is a scheduled programme of events and initiatives to support the strategy which:

7.58.1 incorporates requirements/and or priorities identified by staff

Guidance:

Needs assessment surveys can identify issues of importance to the staff. Staff can be asked, via team brief, to identify the national campaigns in which they wish to participate.

B YES ☐ NO ☐ PROGRESS ☐

7.58.2 encourages staff to participate in activities to maintain their physical and mental health.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 7 : human resources – healthy workplace
CONTINUED

7.60.5 physical activity/exercise

7.60.6 sexual health

7.60.7 health screening for staff

7.60.8 a mental health policy for staff.

Guidance

Advice on content and model policies can be seen in: Healthy Workplace Indicators, The Wessex Institute for Health Research and Development 1997.

The health screening policy may come within the Occupational Health Service remit. Where the Occupational Health Service is contracted out, the Human Resource Department monitors the development and review of a health screening policy.

B YES ☐ NO ☐ PROGRESS ☐

B YES ☐ NO ☐ PROGRESS ☐

B YES ☐ NO ☐ PROGRESS ☐

A YES ☐ NO ☐ PROGRESS ☐

7.61 Sources of stress in the workplace are identified and monitored.

Guidance

This may be via a stress audit, staff survey or data obtained via the performance review process or exit interviews. See: Organisational stress - planning a programme to address organisational stress in the NHS, Health at Work in the NHS, 1996.

A YES ☐ NO ☐ PROGRESS ☐

7.62 There is information for staff about stress, its effects and techniques for coping with stress.

B YES ☐ NO ☐ PROGRESS ☐

7.63 Access is available to a confidential counselling service for staff, provided by trained counsellors.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 7 : human resources – healthy workplace
CONTINUED

Guidance

Consideration might be given to implementing an Employee Assistance Programme. The type and scope of the EAP is tailored to the needs of the organisation. In addition to stress counselling, employees can benefit from specialist advice on key life issues which may not be work related but can affect attendance or performance. For example: problems relating to debt, drug abuse, violence in the home, bereavement.

For an EAP to succeed it must have full management support, clear goals, highly trained and experienced counsellors and be externally audited to monitor quality and efficiency.

7.64 Access is available for staff to a smoking cessation service.

B YES ☐ NO ☐ PROGRESS ☐

7.65 Facilities are provided to encourage staff to look after their health.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

The range of facilities is likely to vary depending upon the organisation's size, location and resources available but may include for example:

- *information leaflets*
- *healthy eating options in canteen and vending machines*
- *access to stress management techniques*
- *a health promotion/information "shop" available for use by staff, patients and visitors*
- *provision of staff gym or subsidised membership to local sports centre*
- *secure bicycle racks*
- *well-women and well-men clinics*
- *health screening, for example, cholesterol, blood pressure, body-mass index*

Notes for action planning:

Standard 7 : human resources

feedback sheet

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Thank you

Criteria	Comment	Criteria	Comment

Standard 8 : occupational health

Criteria

8.1 All staff have access to a confidential occupational health service.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

This may be provided in-house, or under contract from another provider.

8.2 The service employs nurses and physicians with qualifications in occupational health.

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

The relevant qualifications are:

Nurses - *BSc Health Studies (Occupational Health)*

Occupational Health Nursing Certificate/Diploma

Doctors - *Fellow of the Faculty of Occupational Medicine*

Member of the Faculty of Occupational Medicine

Associate of the Faculty of Occupational Medicine

Diploma in Occupational Medicine

Nurses & Doctors - *Masters Degree in Medical Science (Occupational Health)*

Notes for action planning:

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Standard 8 : occupational health CONTINUED

Not all staff employed by the service need to have a qualification in occupational health, the proportion of specialty qualified staff will depend on the size of department and range of services offered.

Where the service does not employ a qualified occupational health physician, the occupational health staff need to have formal arrangements for access to advice from a specialist occupational physician on the Specialist Register maintained by the General Medical Council.

8.3 There is an occupational health operational procedure which has been endorsed by the organisation.

ISO A YES ☐ NO ☐ PROGRESS ☐

8.4 The operational procedure includes:

8.4.1 the arrangements for service provision

ISO B YES ☐ NO ☐ PROGRESS ☐

Guidance

This includes agreement on the range of occupational health services to be provided

A YES ☐ NO ☐ PROGRESS ☐

8.4.2 the aims and objectives of the service

ISO A YES ☐ NO ☐ PROGRESS ☐

8.4.3 for contracted-in services, the reporting arrangements to the senior management of the trust.

ISO B YES ☐ NO ☐ PROGRESS ☐

8.5 There is a service level agreement for occupational health services provided to/by external agencies.

ISO A YES ☐ NO ☐ PROGRESS ☐

8.6 The trust has agreed policies which clearly identify the lead role and responsibilities of the occupational health service and the roles of other relevant departments in the following processes:

8.6.1 policy and procedure for pre-employment health assessment

ISO B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

8.6.2 policy on the role of the service in control of infection/immunisation programmes

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

These include, for example:

- *hepatitis B and other blood borne viruses*
- *TB*
- *polio*
- *rubella*
- *MRSA*
- *varicella*

8.6.3 procedure for the management of sharps incidents

ISO A YES ☐ NO ☐ PROGRESS ☐

Guidance

There should be arrangements for 24-hour advice for staff injured in a sharps incident and the ability to prescribe post exposure prophylaxis against HIV and other blood-borne viruses. Such systems require access to a specialist physician able to prescribe this medication on a named patient basis as it is currently unlicensed for this indication in the UK.

8.6.4 policies and procedures for sickness absence, rehabilitation and retirement

ISO A YES ☐ NO ☐ PROGRESS ☐

8.6.5 arrangements for the occupational health service to advise on health and safety

ISO B YES ☐ NO ☐ PROGRESS ☐

8.6.6 risk assessments of workplace hazards and a system to ensure that health surveillance is carried out accordingly

ISO A YES ☐ NO ☐ PROGRESS ☐

8.6.7 procedures for health surveillance for specific hazards

ISO A YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Guidance

These include, for example:
- *glutaraldehyde*
- *noise*
- *display screen equipment*

8.6.8	procedure for the management of manual handling incidents	ISO	A	YES ☐	NO ☐	PROGRESS ☐
8.6.9	role of the service in stress counselling services		B	YES ☐	NO ☐	PROGRESS ☐
8.6.10	role of the service in healthy workplace initiatives		B	YES ☐	NO ☐	PROGRESS ☐
8.6.11	role of the service in the provision and training for first aid arrangements.		B	YES ☐	NO ☐	PROGRESS ☐
8.7	There is a dated documented service policy and procedure, written/reviewed within the last three years, on confidentiality and all staff in the department are aware of the contents.	ISO	A	YES ☐	NO ☐	PROGRESS ☐

Guidance

A written, signed statement, as outlined in appendix 3 of Guidance on Ethics for Occupational Physicians, Faculty of Occupational Medicine, 1993, may be appropriate.

8.8	All nursing/medical staff working in the occupational health department have had appropriate immunisation such as hepatitis B, BCG.		A	YES ☐	NO ☐	PROGRESS ☐

Notes for action planning:

Communication and liaison

8.9 There is a dated, documented procedure written/reviewed within the last three years to ensure that all staff engaged in exposure prone work have had hepatitis B immunisation.

ISO A YES ☐ NO ☐ PROGRESS ☐

8.10 There are records of hepatitis B immunisation for all such staff and a follow-up system where immunisation has not been recorded.

ISO A YES ☐ NO ☐ PROGRESS ☐

8.11 There are dated documented procedures, written/reviewed within the last three years, in liaison with the infection control team, on immunisation for staff against infection.

ISO A YES ☐ NO ☐ PROGRESS ☐

8.12 The service maintains lines of communication with infection control staff.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

This liaison is important in order to provide consistent advice to staff on measures to avoid transmission of infection.

8.13 The occupational health service has regular meetings to review the service with:

8.13.1 the human resources service

B YES ☐ NO ☐ PROGRESS ☐

8.13.2 senior management of the organisation

B YES ☐ NO ☐ PROGRESS ☐

8.13.3 staff representatives.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

For example, this can be through links with union representatives or users' groups.

Notes for action planning:

Standard 8 : occupational health CONTINUED

8.14 The service contributes to the trust-wide induction programmes on occupational health and safe working practices.

ISO A YES ☐ NO ☐ PROGRESS ☐

8.15 The service receives:

8.15.1 records and statistics relating to staff absenteeism, turnover, retirement

B YES ☐ NO ☐ PROGRESS ☐

8.15.2 records and statistics relating to work accidents.

A YES ☐ NO ☐ PROGRESS ☐

8.16 The service uses these records and statistics to compile advice to the organisation on:

8.16.1 the management of absenteeism, turnover and retirement

B YES ☐ NO ☐ PROGRESS ☐

8.16.2 steps to reduce the incidence of work accidents.

ISO A YES ☐ NO ☐ PROGRESS ☐

Environment

8.17 The occupational health service is delivered in close proximity to the organisation.

B YES ☐ NO ☐ PROGRESS ☐

8.18 The hours of opening are set to facilitate access for all staff.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

The hours reflect the needs of shift workers, night staff, and those located at peripheral sites or in the community. For example an early opening time, such as 08.00am, may help night staff to visit at the end of shifts.

8.19 The facilities of the service include:

Notes for action planning:

Standard 8 : occupational health CONTINUED

				YES	NO	PROGRESS
8.19.1	a reception area which allows auditory privacy from the waiting area	ISO	A	☐	☐	☐
8.19.2	confidential consulting rooms	ISO	A	☐	☐	☐
8.19.3	computerised information systems for immunisation and administrative purposes		B	☐	☐	☐
8.19.4	health promotion information.		B	☐	☐	☐

Records

				YES	NO	PROGRESS
8.20	Occupational health records are maintained by the service.	ISO	A	☐	☐	☐
8.21	Information on service use is collated which includes:					
8.21.1	total referrals by staff group		B	☐	☐	☐
8.21.2	referral type by staff group.		B	☐	☐	☐
8.22	There are facilities for the safe and confidential storage of clinical records:					
8.22.1	during employment	ISO	A	☐	☐	☐
8.22.2	after employment.	ISO	A	☐	☐	☐
8.23	The service complies with the requirements of the Access to Health Records Act 1990 and the Access to Medical Reports Act 1988.	ISO	A	☐	☐	☐

Notes for action planning:

feedback sheet

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Thank you

Criteria	Comment	Criteria	Comment

Standard 9 : staff experience

There is a systematic, formal and confidential process which enables the views of staff on the quality of their working life to be measured and monitored over time.

Criteria

9.1 Staff views and/or attitudes are monitored regularly.

A YES ☐ NO ☐ PROGRESS ☐

Guidance

Staff throughout the organisation have the opportunity to participate in an attitude survey at least once a year in accordance with Working Together- securing a quality workforce for the NHS, HSC 1998/162.

The use of standardised surveys, focus groups and/or one-to-one interviews may be included in the process of obtaining staff views. The topic areas include:

- *organisational values and objectives*
- *communication*
- *supervision and support*
- *physical and mental health*
- *morale and job satisfaction*
- *personal development.*

9.2 A designated member of the board, or head of personnel, is responsible for co-ordinating activities to monitor staff views/attitudes.

A YES ☐ NO ☐ PROGRESS ☐

9.3 Surveys conducted to obtain staff views:

Notes for action planning:

Standard 9 : staff experience CONTINUED

9.3.1	have documented objectives	B	YES ☐	NO ☐	PROGRESS ☐
9.3.2	are based on a census or sample basis	B	YES ☐	NO ☐	PROGRESS ☐
9.3.3	ensure respondent confidentiality	B	YES ☐	NO ☐	PROGRESS ☐
9.3.4	examine areas which contribute towards a people-orientated culture	B	YES ☐	NO ☐	PROGRESS ☐
9.3.5	act as a benchmark against which improvements to the quality of working life is measured.	B	YES ☐	NO ☐	PROGRESS ☐

Guidance

Surveys administered by an independent organisation may overcome the staff's concern about confidentiality and help to improve response rates.

Staff surveys may be trust-wide or carried out in specific directorates, departments or services. Where the latter approach is taken there should be a schedule for surveying all directors/departments/services over a period of time.

HQS can help with suggested content for a brief questionnaire and/or organisations that can assist with survey administration and analysis.

9.4 Focus groups used to obtain staff views:

9.4.1	have documented objectives	B	YES ☐	NO ☐	PROGRESS ☐
9.4.2	ensure participant confidentiality	B	YES ☐	NO ☐	PROGRESS ☐
9.4.3	examine areas which contribute towards a people-oriented culture.	B	YES ☐	NO ☐	PROGRESS ☐

Notes for action planning:

Guidance

Over time a range of topics may be included, for example:

- *organisational values and objectives*
- *communication*
- *job design*
- *managerial style*
- *personal development*
- *working environment*
- *physical and mental health*
- *flexible working*
- *family friendly policies.*

Focus groups can be used to explore a wide range of topics with a vertical or cross section of staff to:

- *gain an understanding of staff views, attitudes and expectations*
- *identify relevant issues for inclusion in a questionnaire based survey*
- *prioritise action.*

The use of an independent facilitator may prompt more open discussion where staff have concerns about confidentiality.

9.5 Questionnaires used in staff surveys:

9.5.1 are developed in consultation with staff

9.5.2 are piloted prior to implementation

9.5.3 state how the results will be disseminated

9.5.4 are reviewed prior to repeat surveys.

Notes for action planning:

	YES	NO	PROGRESS
B	☐	☐	☐
B	☐	☐	☐
B	☐	☐	☐
B	☐	☐	☐

Guidance

Questionnaire design is not simple. Consider whether sufficient skills exist in-house relating to questionnaire design, sampling and analysis, or whether an independent organisation is used to assist the survey process.

9.6 Survey and/or focus group results are reviewed and action plans developed in response to the findings.

B YES ☐ NO ☐ PROGRESS ☐

Guidance

The value of obtaining staff views is often diminished because insufficient effort is given to who will respond to the information obtained. For example, it is useful as a first step to review the results in small groups, or by department. This provides the opportunity to:

- *prioritise action (for example, simple issues which can be dealt with quickly with little effort or resource, medium term issues which need co-ordination across departments and/or resources, and issues which need to be addressed by the whole organisation in the long-term)*
- *create action plans with individuals identified for taking issues forward*
- *agree a timetable to review progress.*

9.7 Key results of surveys, focus groups, and action plans are disseminated in appropriate detail to:

9.7.1 the board

A YES ☐ NO ☐ PROGRESS ☐

9.7.2 senior managers and heads of departments

B YES ☐ NO ☐ PROGRESS ☐

9.7.3 staff.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 9 : staff experience CONTINUED

Guidance

- *a report is included on the board agenda*
- *presentations are made, for example, to the medical, clinical audit, and health and safety committees*
- *bullet point summary is included in team brief or newsletter*
- *consideration is given to presenting a report to the recognised negotiation/consultation committee.*

9.8 Organisational changes made in response to staff views are widely publicised.

B YES ☐ NO ☐ PROGRESS ☐

Guidance:

For example, on noticeboards, team brief, newsletter and the annual report.

9.9 On termination of employment staff complete a questionnaire or exit interview.

A YES ☐ NO ☐ PROGRESS ☐

9.10 Aggregated information from exit questionnaires/interviews is used to identify:

9.10.1 problem issues

B YES ☐ NO ☐ PROGRESS ☐

9.10.2 training and development needs.

B YES ☐ NO ☐ PROGRESS ☐

Notes for action planning:

Standard 9 : staff experience

feedback sheet

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Thank you

Criteria	Comment	Criteria	Comment

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