HOW TO:
Organise and Run a Rapid Responsive Review: 2012/2013

National Quality Board

June 2012

This publication has been produced by the National Quality Team on behalf of the National Quality Board.

To find out more about The How To Guides please visit the NQB web site

http://www.dh.gov.uk/health/category/policy-areas/nhs/nqb/

or email parmjit.kaur@nqb.nhs.uk

Contents

The purpose of ‘How to’ guides

Recent failings in the health and social care system have highlighted the need for greater clarity about who is responsible for identifying and responding to failures in quality. The National Quality Board has addressed this through the publication of two reports

1. Review of early warning systems in the NHS (24 February 2010):-
   www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113020
2. Maintaining and improving quality during the transition: safety, effectiveness, experience (March 2011)
   www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125234

But if we are clearer about our roles and responsibilities, then we also need a more consistent approach to how these difficult judgements about quality are made and to provide the managers and clinicians who have to make them with more guidance and support. How should we judge whether a service is failing or not? What tools might be used to better understand the situation, and what action should be taken as a result?

As part of the SHA to SHA Cluster Handover Assurance Process run in 2011, we sought to understand from each region what the current ‘best practice’ operating model for key aspects of quality is in their area, with a view to encouraging adoption across the country. Rather than try and produce one overarching model, we have worked with the NHS and key stakeholders to produce a series of practical ‘How to’ guides that directly relate to the key issues that NHS staff have suggested that further guidance would be helpful. These documents and a range of other resources can be found on http://www.dh.gov.uk/health/category/policy-areas/nhs/nqb/. These guides are not set in stone: they represent our best understanding of the most effective way of responding to quality concerns, and we would welcome feedback and comment so that we can continue to incorporate any learning and experience into the operating model for quality.

Quality is complex. It is systemic: that is, the delivery of high quality care depends upon many different parts of the system working together. Therefore, the most important part of any operating model for quality in the NHS must be the culture and behaviours that our respective organisations adopt within and between ourselves.

Proposed Operating Principles

- The patient comes first – not the needs of any organisation or professional group
- Quality is everybody’s business – from the ward to the board; from the supervisory bodies to the Regulators, from the commissioners to primary care clinicians and managers
- If we have concerns, we speak out and raise questions without hesitation
- We listen in a systematic way to what our patients and our staff tell us about the quality of care
- If concerns are raised we listen and ‘go and look’
- We share our hard and soft intelligence on quality with others and actively look at the hard and soft intelligence on quality of others
- If we are not sure what to decide or do, then we seek advice from others
- Our behaviours and values will be consistent with the NHS Constitution

Summary

This is one of a number of 'How to' guides issued by the National Quality Board (NQB) which has been designed to help commissioners undertake a rapid appraisal of an organisation or service from a quality perspective. The approach and methodology is primarily designed for use in the acute setting but is sufficiently flexible for application across a range of other clinical and organisational environments such as intermediate care.

The guide is specifically for use in the current healthcare system but learning will be used as part of the design work underway to prepare for the changes to the NHS architecture and systems which are due to come into operation in April 2013.

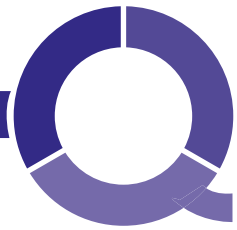
The operating principles are based on peer review although there is a real focus on scrutiny and critical appraisal by senior clinicians and managers. The methodology is centred on making sure that the concept of 'looking and seeing' dominates the process with patients actively involved.

The approach is not a 'catch-all' but will, I believe, prove a useful addition to established processes available to commissioners for measuring and assessing the quality of care provided for patients.

This straightforward approach to checking with patients and staff that the quality of care is as it should be is to be welcomed. Real time 'on site and near to the bedside' reviews of a type associated with the application of rapid responsive review, adds value in a way that other virtual exercises simply cannot achieve. By engaging patients and staff and listening carefully to what they have to say commissioners can tap into a rich source of information about the quality of services provided for patients.

Given that medical and nurse directors have a central role in assuring the quality of care provided for patients we trust that they will take an interest in, and apply, this 'How to' guide as part of their general approach to making sure that patients are well cared for and are safe.

Chapter one: Context



This guide has been developed to complement the work already undertaken by primary care trusts (commissioners) to assure themselves that the care provided for patients is acceptable. Although primary responsibility for the quality of care lies with the provider board and the Regulator has additional statutory duties, this guide is aimed at supporting commissioners to exercise their specific responsibilities with regard to the services they purchase. It also provides a structured and systematic approach to the delivery of a rapid responsive review and has been designed primarily for use in the acute sector. There is however, scope for application in other locations particularly intermediate care, inpatient elderly care facilities and similar clinical environments.

The use of a rapid responsive review should not be undertaken in isolation but seen as a key contributor to the broader assessment of services provided for patients. Essentially it should form part of the commissioner's 'tool box' for gaining assurance about standards of patient care.

What Is A Rapid Responsive Review?

A rapid responsive review is a form of rapid investigation which takes account of a broad range of data sources to inform the scope of enquiry. It is based on active engagement with clinical services, patients and staff to assess the standard of services provided for patients.

Chapter two: Introduction

The CQC is responsible for the registration of providers. It monitors compliance with essential levels of quality and safety[1] and undertakes scheduled, responsive and themed inspections of services, most of which are unannounced. The responsive inspections it undertakes are in response to information about concerns and risks, including potential quality failures. However SHAs and commissioners are responsible for enabling the provision of good quality of care through commissioning processes as reinforced in the *Operating Framework*[2]. This involves delivery of the national contract and associated performance measures[3], particularly the application of CQUINS[4]. On occasions, and in discussion with the CQC, SHAs/PCTs may conduct a rapid responsive review to establish whether there have been quality failures or unacceptable risks in respect of the quality of care being provided for patients.

In particular commissioners have a duty to ensure that they pursue a systematic approach to the assessment of patient safety and experience across all contracted providers. This is important not only for the board but also for the public.

The rapid responsive review methodology has been designed to assist both the SHA and commissioners to deliver against this level of responsibility and in so doing help assure themselves of the standard of services provided for patients.

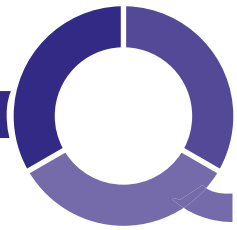
Although designed for use primarily in the acute sector the approach is easily applied to similar clinical settings such as intermediate care, inpatient care of the elderly or sub-acute /urgent care settings. Development of guidance and tools for use in mental health and nursing home provision are currently under consideration.

The guide explains the purpose of the rapid responsive review and sets out the methodology and processes to be followed in order to achieve a robust and valid review. It places emphasis on the need for board leadership, supported by a senior and experienced team. Application of the methodology must not be undertaken solely by senior or middle grade managers or clinicians (see chapter 3).

The guide should be considered carefully and advice sought from the SHA on the first application by commissioners.

1. CQC Essential Standards
2. The Operating Framework for the NHS in England 2012/13
3. Commissioning Outcome Framework
4. Guidance on the Standard NHS Contract for Acute Hospital Services 2012/13

Chapter three: Trigger for the use of the rapid responsive review



A rapid responsive review provides commissioners with a means by which they can carry out a structured and purposeful visit to a trust or other provider as part of their routine assurance monitoring of the quality of care being delivered. The process can also be used where issues have been raised that could potentially impact adversely on an aspect of the quality of care, including patient safety and/or experience. In essence a rapid responsive review can be used both on a planned basis and as an immediate response to a problem or crisis. Where the latter is the trigger, there should be a discussion with the CQC about whether a CQC led responsive inspection is the appropriate process or a commissioner led responsive review.

The commissioners must be clear about the justification for intervention in the form of a rapid responsive review. The decision to undertake a rapid responsive review should be made at board level and sponsored by the lead director for quality, usually the nurse or medical director. The chief executive would normally be involved at the decision making stage and endorse the process. Credibility of the process moving forward is dependent on board level sponsorship, the appointment of a lead director and the support of a senior and experienced team.

The rationale for undertaking a rapid responsive review must be based on a robust appraisal of both quantitative and qualitative data available about the trust/provider set against all available soft intelligence. Contact with the Care Quality Commission's regional director to discuss Quality Risk Profile (QRP) data, other intelligence as well as any current or planned CQC intervention is crucial at this stage. For foundation trusts, Monitor must also be consulted.

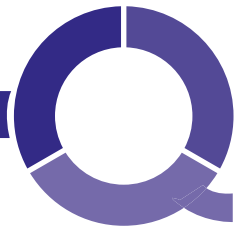
It is vital that an integrated dashboard on performance, including quality is considered. An example of the type of dashboard to be used is provided at Appendix 1.

From careful consideration of the core data and other intelligence the lead director should work to achieve a balanced and evidenced based view of the provider which can be both easily articulated and documented. The scope of the review and subsequent efficiency is dependent on reliable analysis of all available intelligence and data so it is important that the process is not unduly shortened or managed in haste.

It is also important at this stage that discussions take place between the chief executives of the PCT and trust / provider. This will encourage joint ownership of the rationale for the rapid responsive review and afford the trust/ provider chief executive the right of redress in the event that the commissioner's assessment of the situation is inaccurate or ill informed. It would be unfortunate if a rapid responsive review was launched on the grounds of flawed analysis, review and judgement.

Examples of Triggers for a Rapid Responsive Review (this is a list of examples and is not exhaustive)
Alarms or concerns arising from the examination of qualitative and quantitative data. For example, raised mortality rates, deteriorating infection profiles or concerning patient harm reports. Alternatively a worrying set of workforce metrics or credible soft intelligence which is not readily accounted for by the provider
When a concern about quality has been identified and acknowledged by provider and commissioner yet the mitigating actions to improve the situation are showing little signs of having an impact and patients continue to be at risk
Repeated failure to deliver agreed improvement plans
Trend data indicates potential or actual patient safety issues. For example, little or no improvement in performance and an unconvincing submission of evidence by the provider such that there is a breakdown in confidence that the provider has sufficient grip on the situation
Credible and material whistle blower feedback
Complaints about services provided for patients which suggest problems are not isolated and perhaps are more systemic
Heroic cost improvement plans (CIPs) which are focused on cost reduction through major workforce or service reductions. This might include a poor outcome to the quality impact assessment
Evident or suspected poor leadership and/ or governance, particularly clinical governance
Dramatic media exposure / covert reporting. For example of a type used to report on events at Winterbourne
Escalation of the number and type of minor concerns that begin to raise more fundamental questions of governance or competence of the provider to deliver a safe service
Highly critical independent service review reports which identify repetitive serious failures
Serious concerns raised by CQC, Monitor or professional bodies

Chapter four: Preparing for the visit



This section provides an overview of the steps to be taken to prepare for a rapid responsive review. It is not an exhaustive list and may need to be modified depending on local circumstances and the issues which prevail at the time. Any modification however, should not compromise the commitment and presence of board directors.

Establishing the reason for the review

As outlined in the previous section identifying the issues and concerns is an essential part of the process and sufficient time should be set aside at the outset to clarify why a rapid responsive review should be undertaken. To help ensure success, it is strongly recommended that the initial discussions are chaired by the chief executive with support from relevant board directors, notably the medical and nurse directors. To proceed otherwise would negate an important aspect of the review methodology – board level ownership and leadership.

The PCT chief executive should nominate a director with responsibility for quality, usually the nurse or medical director, to lead the review although the process should continue to be sponsored by the chief executive. The director will be responsible for signing off the data analysis, conclusions and scope of the Review. This process must be formally constituted and reported to the chief executive prior to submission to the board through established governance procedures of the commissioners. The director will provide leadership to the process and act as the formal link with the trust/provider under scrutiny.

It is also good practice and in keeping with the guidance – *Review of Early Warning Systems in the NHS*[3] that the CQC regional director is briefed by either the PCT chief executive or lead director. In the case involving a foundation trust, Monitor must also be briefed. This should be documented and regular communication with CQC and Monitor maintained. Intelligence from the CQC and Monitor should be taken into account and documented as part of the early assessment of available data. It is also advisable to invite CQC and Monitor representatives to join the Review. The detail of engagement should be agreed with the CQC and Monitor prior to launching the review and should respect and not compromise the statutory responsibilities of two Regulators.

Time should be spent at this stage;

- Populating and using a specific dashboard (see example at Appendix 1) which accounts for key performance indicators and quality metrics in the context of 'soft intelligence'. This should include a summation of the data analysis to help inform key lines of enquiry. This document will provide both the evidence base for moving forward as well as provide a record for any subsequent audits.
- Collating and reviewing background information to ensure that directors and members of the Visiting Team have a broad understanding and working knowledge of key indicators and the organisation under scrutiny. This would include a profile of the provider. Information not readily or routinely accessible to the commissioners should be obtained from the SHA, CQC or Monitor.

3. Review of early warning systems in the NHS, National Quality Board 2010

- Formulating an emerging issues list from analysis of the evidence. This might include a series of outstanding issues which require specialist analysis.
- Consulting with stakeholders such as the post graduate medical dean, local authority, specialised commissioning or Local Supervising Midwifery Authority Officer depending on the basis for considering rapid responsive review.
- Interpretation of soft intelligence as part of the overall assessment such that sufficient weight is given to the information.
- Formulating lines of enquiry. Suggested points of enquiry for use when engaging with the provider chief executive, medical and nurse directors are set out at Appendix 2.

Decision making should be balanced and easily justified. This will help ensure that the scope of the review remains focussed and purposeful. It will also inform;

1. The letter to the trust / provider chief executive
2. The composition of the Visiting Team
3. The basis for briefing the board and other stakeholders
4. The communications plan and fulfilment of the duty of candour
5. The approach to any patient confidentiality issues
6. The well being of staff involved with, or subject to, the review
7. The audit trail for future reference

The team

The Visiting Team must be led by an experienced, credible, influential and appropriately qualified board director, who holds responsibility for quality. Ideally this should be the medical or nurse director.

The Visiting Team should comprise senior and credible staff who have the respect of their peers and who have the gravitas and stature to perform the tasks expected of them. Deployment of junior to middle grade staff must be avoided since the review is something that is best done by people with a wealth of experience, knowledge of the service and the capability to handle difficult and often sensitive situations. It is strongly recommended that the lead director assures themselves that the assembled team is able to match the demands of the review. They should also be able to justify the team membership.

The behaviour expected of Visiting Team members should be made clear at the outset by the lead director. Professionalism and mature working styles, which are respectful of individuals and organisations, are essential. Moreover, they must be willing to uphold the values set out in the *NHS Constitution*[4]. Visiting Team members must also have the ability to critically appraise and interpret information, situations and conversations. Good judgement skills and the ability to engage with patients, carers and staff at all levels are essential pre-requisites.

Depending on the scope of the review consideration should be given to the inclusion of the post graduate medical dean or a member of their team. Other contributors might include;

- PCT director
- General Practitioners (lead commissioners)

4 NHS Constitution, Department of Health 2009

- Consultant Medical Staff*
- Senior Nurses / Midwives*
- Allied Health Professionals*
- Local Supervising Authority Midwifery Officer

*Drawn from provider services from outside the area under scrutiny

The PCT chief executive might also wish to involve SHA directors to form part of the team. In exceptional cases the SHA will insist that a member of SHA staff join the review. In addition the SHA must be notified by the commissioners as a matter of course of any rapid responsive reviews planned.

Expert contributors can be attracted from the Royal Colleges. Contributors must not be associated with the organisation under scrutiny and any potential conflict of interest must be formally considered and documented. A formal offer of indemnity should be made to all external contributors and appropriate records kept.

A dedicated administrator and note taker should be appointed. This individual should be capable of working with senior staff and be familiar with handling sensitive and confidential material.
Once constituted the team should receive a letter of confirmation from the lead director setting out the invitation, the scope of the review and the expectations placed up on them.

The lead director should then hold a briefing session for the team. Ideally this should occur in advance of the review but can be held on the day of the initial visit where time is of the essence. The session must be based on written evidence supplied to the team and a note made of the discussion.

Assurance visit checklist

	VISIT CHECKLIST	✓
1	Visit schedule – Plan for the day (outline provided at Appendix 3)	
2	Site map, address and contact details	
3	Copy of the letter to the provider chief executive	
4	Summary of the issues which have trigged the rapid responsive review	
5	Briefing material on performance including quality, workforce and other intelligence or relevant information	
6	Briefing on the application of the review methodology and the behaviours expected of the visiting team	
7	Check for consensus and understanding	

The lead director is responsible for ensuring compliance with the process and the ongoing consensus about the scope of the review. Any descent or disagreement must be addressed prior to engagement with the provider under scrutiny.

The team should be advised by the lead director of the action to be taken should they encounter a ‘hot issue’ such as a major patient safety issue, a verbal complaint, staff whistle blowing etc during the course of the visit.

This might involve for example;

- **An immediate safety issue is identified:** The team should intervene if appropriate and safe to do so. Otherwise they should notify the nurse/doctor in charge of the ward/department and if deemed extremely serious contact the nurse/medical director and take advice from the lead director.
- **A patient or carer raises a complaint:** Take details of the individual and seek assistance of the line manager for the area/matron to action in line with local policy.
- **A member of staff whistle blows:** listen to the staff member and arrange for their concerns to be documented and handled in line with local policy.
- **If there is a breach of confidentiality or press leak:** The SHA/commissioners/trust communications team should be immediately notified and work with the chief executive and lead director to manage the situation.

Care should be taken at all times to adhere to the Department of Health's two-part *Records Management: NHS Code of Practice* (Gateway Ref: 6295)[5] which is a guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in England. It is based on current legal requirements and professional best practice.

The guidelines contained in this code of practice apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the medium on which they are held.

Notification to the provider

Effective communication with the provider will help secure a successful and efficient review and preserve working relationships. The PCT chief executive should speak to the provider chief executive to discuss the proposed visit and explain the purpose and agree the process. Any disagreements at this point should be resolved before proceeding.

The PCT or provider chief executive should consult with the cluster chief executive and if matters are unable to be resolved consult the SHA.

The conversation between chief executives should be confirmed in writing by the PCT chief executive and include as a minimum a clear rationale for the Review with reference to the supporting evidence. The PCT chief executive must give 7 working days notification of the visit in writing unless there is a pressing need to move more quickly.

A timetable of the first visit should be sent to the trust/provider chief executive at least 5 days prior to the visit to allow the organisation to prepare effectively is provided at Appendix 3. A draft letter is provided in Appendix 4.

Only in exceptional circumstances, where the rapidity of the review prevents this period of notice will the two chief executives agree a shorter period of notice.

Administrative leads for both organisations should be confirmed at this stage. They will co-ordinate the visit logistics and provide relevant information, documentation and other briefing material.

The checklist overleaf is a summary of actions and clear rationale to assist the team in preparation for the enquiry. The list is not exhaustive.

5 Records Management and NHS code of practice

Checklist

ACTION	RATIONALE
CEO sponsorship and leadership.	Senior endorsement and ownership to help raise the profile of the review and ensure effective ownership by the board.
Appoint a lead director for quality	Secures senior leadership and contributes to board ownership.
Be clear about the reason for the rapid responsive review and the evidence used to identify the lines of enquiry/scope.	Evidence based approach. Enables good communication. Provides a record for future audit or formal enquiry.
Engage stakeholders as appropriate.	Partnership working. Balanced assessment of the situation and collective ownership of the process. Helps promote a positive and inclusive culture. Avoids surprises or revelations at a late stage in the process.
Select the team and ensure members are suitably qualified and experienced to undertake the task.	Provides assurance that the team has the experience and stature to fulfil the role.
Plan and execute the review on a formal and confidential basis.	Provides structure and confidence about the process. Provides evidence in the event of any challenge to the governance underpinning the planning and delivery of the review. Provides a formal record for future audit or enquiry.
Ensure record keeping and general administration is of a high standard and in line with best practice.	Secures reliable data accuracy/evidence base. Provides reliable document control and retrieval system.
Prepare a communication handling plan	Provides clarity in relation to any internal and external messages to be issued about the review. Supports and encourages collective communication amongst stakeholders to help maintain and promote public confidence. Enables reactive and proactive communications.
Appoint a lead administrator to help plan the logistics and delivery.	Enables reliable, timely and efficient systems to be put in place and to be maintained.
Feedback to team members and consider formal debriefing for the organisation under scrutiny.	Provides clarity about the findings and ensures consistency of message and an inclusive approach/openness. Supports ongoing dialogue about any remediation and associated performance monitoring requirements.

Chapter five: Announced visits

The plan for the day starts with a briefing for the Team conducted by the lead director. This is followed by formal discussions with key members of the trust/provider executive team, specifically;

- Chief Executive
- Director of Nursing
- Medical Director

An outline programme for the day is set out at Appendix 3.

This must be undertaken by the lead director supported by one or two directors usually the PCT director of nursing and medical director. It is important that the discussions are conducted between board directors, given the purpose and potential sensitivity of these discussions.

Possible lines of enquiry for meetings with the aforementioned directors are set out at Appendix 2.

In tandem with this, visits to clinical areas should be undertaken by selected team members to observe patient care and the environment. This is not the time for detailed questioning of staff. However it is the time for the team to gain an appreciation of systems and processes – what appears to be working well and what perhaps, is not working as well as it should. Appendix 5/6 provides a guide for this process and the associated feedback.

Following the concurrent processes described above, the Team should then meet to discuss their initial findings with the lead director. This discussion should be used to inform the approach to be taken for the afternoon visits (may also be used to inform the unannounced visits which follow – see chapter 6). The discussion should be noted and consensus reached. Specific issues and key lines of enquiry which require a more in-depth review should be confirmed at this stage. It is important that the lead director secures consensus among the visiting team before proceeding.

To undertake the more in depth review a suggested framework, *Energise for Excellence*, is provided at Appendix 7. The framework can be used to guide a discussion with clinical teams or the relevant sections used as an aide memoire where time is limited. The framework promotes areas for exploration with patients and staff, and has been designed to enable the rapid assimilation of quantitative and qualitative data. The assessment can be Red, Amber or Green (RAG) rated. That stated it is a guide and may require modification by the visiting team to reflect local circumstances.

The individual sections of the framework can be used to direct lines of enquiry for focus groups with staff and patients.

Information gathered from the clinical visits should not be used in isolation to form an immediate judgement about the clinical area or service. It must be triangulated against the original briefing for the enquiry and other data and feedback collected during the course of the review.

Focus group discussions with a variety of stakeholders should also conducted in the afternoon. These need to be led by members of the team. They should include:

- Patient groups
- Matrons/senior nurses and midwives
- Senior medical staff and clinicians in training, particularly doctors and nurses
- Managers
- Front line staff, including staff side representatives.

The Visiting Team need to meet for a final session at the end of the day to consider the outcome of the clinical visits, discussions and meetings undertaken. The template at Appendix 8 offers a guide to this process. The lead director must chair the discussion and ensure feedback is received from each member of the team. It is important that sufficient time is allocated to this part of the review.

A consensus on the outcome of the visit should be reached and any disagreement thoroughly considered and satisfactorily addressed. This discussion should be summarised and documented by the lead director to form the basis of the verbal feedback to the trust/provider chief executive that evening. This should include an overall assessment and findings of the visit together with a list of any 'hot issues' which require immediate action by the trust/provider chief executive. Good practice identified at the stage of preparation and during the course of the visit should also be flagged as part of the feedback (Appendix 9).

The trust/provider chief executive is expected to respond in writing to the initial feedback within 24 hours or sooner when 'hot issues' requiring immediate action has been reported. This should be done on a formal basis and the lead director is responsible for making sure that action taken is satisfactory and that no residual patient safety or experience issues remain unresolved.

The lead director is expected to write to the trust/provider chief executive confirming the substance of the feedback given. This should be within 24 hours of the visit and shared with the Team in confidence.

Chapter six: Unannounced visits

The Visiting Team should undertake a minimum of three unannounced visits within a week of the announced visit. This will assist with the assessment of information gleaned about the organisation. At least one of these visits must cover out of hours, for example during a staff handover period from days to night, Bank Holidays, night duty or weekend shifts.

Each visit should check that any 'hot issues' identified at the time of the announced visit have been rectified and that any previously identified patient safety and /or experience issues have been resolved. This should provide additional assurance but may prompt the need for further remedial action.

The visits should be conducted by at least two members of the original Visiting Team to ensure continuity. It is recommended that the reviewers work in pairs to assist with validation and quality of the assessment. Team members should be selected to best suit the key lines of review and one member nominated as the lead person.

The process

The Visiting Team members should notify the director on call for the trust/provider service at the point of arrival at the organisation. The director will be expected to facilitate access to the trust for the Visiting Team. There is no particular need for the on call director to accompany the team, but they should ensure that a senior member of staff on site acts as a guide to locate and gain access to clinical areas. The on call director must remain available to address any 'hot issues' spotted by the Visiting Team which require immediate action to safeguard patients.

The visit should span a minimum of 4-6 hours. This will allow time for a robust assessment to be completed. The tool (Appendix 7) can be used as an aide memoire to explore issues in detail, alongside the checklist for observational visits (Appendix 5).

The lead reviewer must provide high level feedback to the on-call director at the end of the visit. The feedback should be documented and shared with the lead director for the review within 24 hours. In the event of 'hot issues' having been identified the Visiting Team leader must ask the on-call director to take any immediate action deemed necessary and to confirm the position with the lead director for the review within 24 hours.

Chapter seven: Report and follow up

The lead director is responsible for preparing the letter within ten working days of the initial visit. Members of the Visiting Team should have had the opportunity to comment at the drafting stage.

The report should include any immediate action required together with a broader set of recommendations as deemed necessary. Good practice identified during the course of the preparation, assessment and as a result of the visits should also be included.

Once the position is clear the lead director is responsible for briefing the PCT chief executive, the SHA and CQC regional director and where appropriate Monitor. The communication plan should be finalised at this stage.

The trust/ provider chief executive should be given five working days to comment on the factual accuracy of the letter and respond to the lead director immediately following this. It is good practice for the lead director to discuss the letter with the trust/provider chief executive prior to the final letter being signed off which should occur within ten working days of the letter being issued. An action plan should be agreed subject to further discussions between the commissioner and the trust/provider chief executive on the performance management arrangements to be put in place.

Both commissioner and provider organisations should submit the letter and associated action plan to their boards, preferably in public unless there is a sound reason not to do so.

De-briefing sessions should be organised for both trust/provider staff and members of the Visiting Team. The optimal approach should be agreed with the parties concerned and organised by the lead director in collaboration with the trust/provider chief executive.

Ongoing monitoring

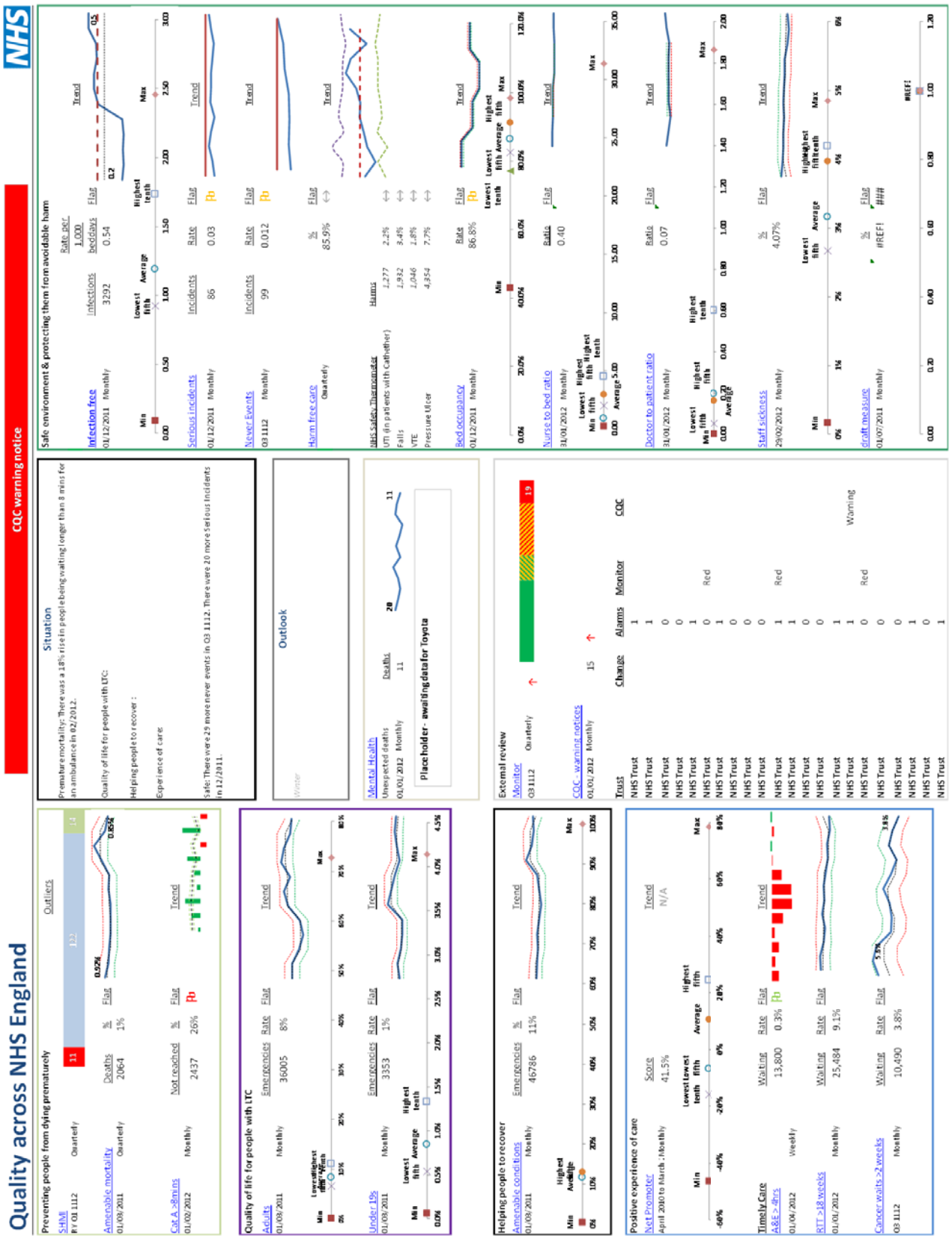
Once the review is complete, actions agreed and signed off by PCT commissioners and trust/provider boards; follow up should normally be coordinated through the routine Clinical Quality Review meetings between the commissioner and trust/provider. Exceptionally the SHA will adopt a lead role in managing the process and associated performance management.

To enable ongoing monitoring, there should be:

- Clearly documented actions with defined resource requirements, outcomes and timescales for progress reporting and completion.
- Agreement of the need and timescales for a follow up visit separate to those undertaken as part of routine Clinical Quality Review

The commissioner will also need to ensure that decisions made in relation to ongoing findings can be justified in public. As a performance measure and if sufficient progress has not been made the commissioner should repeat the review and consider what additional steps are required to safeguard patients.

Appendix one: Quality Dashboard



Appendix two: Suggested Lines of Enquiry to the Provider Chief Executive and Medical / Nurse Directors

Lines of Enquiry to Chief Executive

Theme	Hypothesis	Question	Evidence
Strategic	There is clarity in the organisation about the strategic direction for clinical services.	Does the trust have a clinical services strategy? If Yes: How is this being taken forward? If No: How are you managing without a strategy?	
Strategic	Nurse and medical directors demonstrate competence in the delivery of their respective roles specifically in relation to quality, patient safety and experience.	Do you have confidence in your nurse/medical director to lead on quality, patient safety and experience? Have you set specific objectives and how are these performance managed / appraised? Are there outcome measures? If no: what action are you taking to improve / clarify the situation?	
Patient Safety	Patient quality indicators are presented to the board on a regular basis	How is the board briefed on quality, safety and patient experience? What are your current clinical risks and how are you mitigating against them?	
Staffing	Staffing establishments are reviewed and adjusted to provide safe and effective care.	How confident are you that clinical staffing levels are adequate to ensure safe care? How do you judge this?	
Responsibility	Board considers external reports to ensure that they benchmark themselves against risk and mitigate as appropriate	Have you assessed the Trust's position against the finds\ recommendations set in the various reports relating to Mid Staffordshire NHS Foundation Trust and other failures such as Winterbourne? Is this type of appraisal formally considered by the board? If Yes: What was the outcome of the assessment? If No: Why not and are you proposing to complete an assessment?	

Theme	Hypothesis	Question	Evidence
General	The chief executive has a grip on quality.	What do you see as the biggest challenges in your trust relating to quality? What are you doing about them? Are there any concerns about patient safety and quality in general which you feel the Visiting Team should be made aware of at this early stage?	

Lines of Enquiry to Medical and Nurse Director

Theme	Hypothesis	Question	Evidence
Strategic	There is clarity in the organisation about the strategic direction for clinical services.	Does the board have a clinical strategy? If Yes: Obtain a copy and ask for an explanation of how it was developed and how it is being delivered? Where does nursing and midwifery fit it i.e. what contribution is it making? Similar question to the medical director? If No: ask what action is being taken to develop a strategy and how they lead clinical services currently in the absence of a formal strategy? What value set does the organisation have in relation to patient safety, quality of care and experience and are the nurse director and medical director working collaboratively to ensure these values are met? Are the roles and responsibilities of the nursing and medical directors clearly understood by the board in relation to the quality agenda? Are there any potential areas of confusion about which aspects of the portfolio they each lead?	

Theme	Hypothesis	Question	Evidence
Strategic	There is clarity on the strategic direction of the trust	Do the nursing and medical director have any difficulty engaging the board?	
Responsibility	It is clear who in the organisation is responsible for quality	Can you tell me who has overall responsibility for the quality & patient safety agenda is in your trust?	
Clinical Standards	Report goes to the board on a regular basis	Do you report clinical indicators of care to the board? If Yes: What do you report and how frequently? How was this regime of reporting and the content been agreed? Where is quality on the board agenda? Is there meaningful debate, discussion and decision making? Are you both challenged by the non executives? Give examples. Do your clinical staff attend the board, for example HCAI agenda?	
Patient Experience	Patient experience reports and progress on improvements are considered by the board	Who takes the lead for patient experience? What input did you have to the development of the patient experience strategy? What reports go to the board in relation to patient experience and how often? What is reported and how is the information triangulated against other quality indicators? What level of debate and discussion occurs in relation to patient experience? How do you become aware / involved if there are complex complaints relating to clinical care and ensure that systems are put in place to learn from these?	

Theme	Hypothesis	Question	Evidence
Patient Safety	Patient safety indicators are presented to the board on a regular basis	How do you ensure that key high level indicators are discussed and actions taken where trends are identified? Is the debate and discussion about HSMRs and associated data fields? What action is taken when rates are above acceptable reporting? How do you ensure that policy is in place to minimise risk and maintain standards in relation to HCAI agenda? How do you ensure that staff have the equipment they need to deliver care appropriately and is there a system in place for training? How do you use soft intelligence relating to quality, safety and patient experience? How do you ensure ward to board feedback on quality, safety and patient experience?	
Facilities	Patient environment is fit for purpose	Do you have a programme to ensure maintenance of the ward/department environments? What processes do you have in place to monitor the environment and assure yourself and the board that standards are acceptable?	
Staffing	Staffing establishments are reviewed and altered to provide safe and effective care.	Has the trust undertaken any recent staffing reviews to assess the appropriateness of current staffing levels and has this information been considered by the board? IF YES: What did the review(s) show? What actions did you take? Did you take the results to the board and where there any decisions made regarding investment requirements?	

Theme	Hypothesis	Question	Evidence
Staffing	Staffing establishments are reviewed and altered to provide safe and effective care. Staffing establishments are reviewed and altered to provide safe and effective care.	Alternatively: Have you undertaken an establishment review? If yes: When and how often do you do this? What tool do you use? What was the outcome? Was investment required and approved by the board? How did the establishment review link to the annual business planning process (service developments/reconfigurations planned)/ workforce & OD plan or contingencies for activity fluctuations?	
Staffing	The board is assured in relation to the quality of pre and post graduate education	Do you gather and use information from QA reports relating to the provision of pre and post graduate education?	
General	The medical and nurse directors have a grip on quality and are providing leadership for the agenda.	What do you see as the biggest challenges in relation to quality, patient safety and experience and what are you doing about them?	

Additional high level questions

1. Is there awareness at board level of the key issues relating to safety, experience and quality? This should reflect board discussions held and evidence on the trust/provider risk register? Ask for the risk register and a sample of board papers and minutes.

2. What is being done to tackle the risks?

3. Are there any blocks to progress and what evidence is organisational engagement? Is the staff side aware and contributing to problem resolution?

4. How is progress reviewed by the management team?

5. What is the view of other staff (clinical staff in particular)? Is there any apparent division between staff and management?

6. How would the trust describe its approach to governance issues – are the mechanisms widely known?

7. How are the Clinical Quality Review meetings with PCT commissioners viewed – are they systematic, comprehensive, taken seriously etc?

Appendix three: Suggested Timetable for Visit

Suggested Timetable for Visit to .....

Time	Visiting Team	Actions	Venue
08.00 - 09.00	Pre- meeting for Visiting Team	Alternatively: Have you undertaken an establishment review?	
09.00 - 10.00	Medical director/director of nursing/director of performance	Meeting with provider chief executive	
09.00 – 12.00	Clinical team members	Observational visits to clinical and other public areas. Possibly 'walk through' care pathway.	
10.00 - 11.30	Medical director/director of nursing	Meeting with staff and staff side representatives	
12.00 – 13.00	Visiting Team working lunch – sharing feedback from the observational visits and reflection	Reach consensus and agree lines of enquiry for the afternoon visits	
13.00 - 14.00	PCT commissioners nurse director and senior nurse Medical director, GP and other medical staff.	Meeting matrons/senior nurses/midwives Meeting with senior medical staff including trainees (consider two separate meetings running in parallel).	
Time	**PCT commissioners Team**	**Comment**	**Venue**
13.00 - 17.00	Nurse director/clinical members of the team	Visits to clinical areas	
14.30 - 16.00	Medical director/director of nursing/director of performance Senior nurse PCT commissioner/patient engagement lead	Visit to specific clinical areas or review services such as nutrition, infection prevention and control, complaints handling team etc (to be determined as part of the debate about lines of enquiry) Patients and carers group	

Time	Visiting Team	Comment	Venue
16.00 - 17.00	Medical director/director of nursing/director of performance	'Rapid fire' 1-1 meetings with key staff not included with any of the meetings e.g. clinical education lead for the trust.	
17.00 – 19.30	Visiting Team reflection and summing up		
19.30	**Lead director briefing to provider chief executive**		

Appendix four: Draft Letter to Provider Chief Executive

Our Ref:

Insert Date

Chief Executive

Dear xxxx

Commissioner Led Visit to XXXXXX Hospital

Further to the recent conversations, I am writing to confirm arrangements for the commissioner led visit to your trust on insert date.

As discussed the reason for the visit is the continued high HSMRs at the trust and the number of Never Events and patient harms reported on STEIS. You have briefed us thoroughly on the work you are doing to improve both mortality rates and patient safety but we felt it was important that we should arrange to see view services first hand by instigating a Rapid Responsive Review.

The Review will seek to undertake a rapid assessment of the trust's overall position on the provision and governance of clinical services particularly with regards to the emergency care pathway. This will include a particular assessment of patient safety and experience.

The visit will focus on:

- Leadership and governance arrangements within the trust for quality and safety issues
- A rapid review of the aforementioned clinical areas which will include:
    a) visiting the A&E and emergency admission wards
    b) meeting a cross-section of clinical staff to see and hear first-hand about the provision of patient services
    c) meeting a cross-section of patients and carers in the clinical setting and through the use of focus groups or similar meetings
    d) assessment of clinical staffing levels in those clinical areas visited
- Any issues/concerns raised through a number specific reports such as national reporting from Regulators, SUI reporting and actions taken, performance against key clinical indicators such as HCAIs, safe care harms, complaints data or coroner's reports
- Any other matters that arise out of the visit.

The Visiting Team will comprise;

- The PCT medical director and nurse and director of performance
- A&E consultant and acute physician from another trust outside of your locality
- Senior nurses from other trusts outside of your locality
- Clinical representatives from the PCT

I will aim to agree the timescales for the visit and programme with you within the next few days. In the meantime I should be grateful if you would let me have a point of contact by return to enable coordination between the PCT and your trust.

Should you require any further clarification please contact me direct.

Yours sincerely

Insert Name and Designation

Appendix five: Observational Visit – Checklist

Opportunity to speak to patients and their visitors (as appropriate) to seek their views about the service.

	Suggested areas to be observed	Comment
1	**Environment**	
	Is the environment fit for purpose?	
	Is the level of tidiness and cleanliness acceptable?	
	Is it safe?	
	Ambience – how does it feel?	
	Are sign posting and directions of an acceptable standard?	
	What appears to be working well/ what needs attention?	
	Any good practice?	
	Do staff and visitors appear to be adhering to hand washing and related infection prevention and control policies?	
	Is patient data stored confidentially?	
	Is the emergency equipment, for example, resuscitation trolley in good order with evidence of it having been checked in line with local policy?	
2	**Productive series applied**	
	Is productive series in evidence?	
	If so, is it safe and conducive to the provision of good patient care?	
	Do staff appear engaged with the philosophy of productive series?	
3	**Staffing**	
	Are staff welcoming and do they display appropriate attitudes and behaviours?	
	ID badges worn – is it easy to identify the staff by discipline?	
	Is the number of staff on duty appropriate for the environment and patient dependencies	

	Suggested areas to be observed	Comment
	Is there a nurse in charge and is he/she easily identifiable?	
	Are staff able to describe the purpose and function of the area, particularly with regard to the organisation and delivery of care?	
4	**Patients**	
	Do patients appear clean and well cared for?	
	Is privacy and dignity maintained at all times?	
	Is same sex accommodation available – i.e. same sex toilets and bathrooms, same sex bays	
	Are any patient safety concerns evident?	
	Does there appear to be a focus on food and nutrition?	
	Are care plans in place and current?	
	Are medication plans/prescription charts evident, in good order and stored correctly?	
	Does record keeping appear in order?	

Appendix six: Observational Visits - Initial Feedback Template

Feedback by: **Date:**

Overall Impression
General Comments:
Good Practice:
Immediate Risks (hot issues for urgent action now to protect patients / staff):
Issues / Concerns:
Issues for Further Consideration:

Appendix seven: Template for Clinical Visits / Prompts for Enquiry

Name of clinical area/ward	
Date	
Name of person(s) undertaking assessment	

Completion

In each section, consider whether as a clinical area response is compliant for each statement, and put a tick in the appropriate box by the side of each statement. Based on the responses given, a calculation will be made using the traffic light system to give an indication of the mechanisms that are in place to promote a high standard in the quality of care provided

Each section should be scored individually, which will give some indication where further development work may need to be targeted.

Colour	Score indicator	Score interpretation
Red	More than 5 "No" responses	Not compliant
Amber	2 to 5 "No" responses	Development work required – identify any immediate action required.
Green	2 or less "No" responses	Compliant but triangulation with other metrics required to ensure patients are safe and there is no requirement for immediate action.

1. Staffing -'Get Staffing Right'

"Staffing Levels are at a level that enables the clinical team to deliver safe and effective patient care"

No.	Criteria to be assessed	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
1	Review at least 6 duty rotas (prospective and retrospective) - If available scrutinise the electronic rostering system for standard reports. Where available review any material on patient dependancy/clinical staffing	N/A	N/A		N/A	
2	Guidelines for duty rotas – including annual leave, study leave are in place and being followed. The guideline should include uplift to meet agenda for change criteria	N/A			N/A	
3	Temporary staffing processes in place which facilitate the ability to meet minimum staffing levels Are processes clear to staff? Are they being applied in the interest of patient safety?	N/A			N/A	
4	Are non-registered staff supervised? Do they have their competencies signed off and are regular updates/training arrangements in place? New starters – what process is there and is it acceptable? Clinical supervision/preceptorship in place? Are student nurses and other trainees supernumerary and supported in their training?	N/A			N/A	

No.	Criteria to be assessed	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
5	Turnover / sickness levels – what is the rate? Is it excessive? Is staff absence having an adverse affect on patients or staff at work? Is sickness/absence being managed according to policy?	N/A			N/A	
6	What type of nursing model is implemented? How is nursing care organised/structured? e.g. team nursing, nurse in charge Is there an easily identifiable nurse in charge?		N/A			
7	Is there a satisfactory process in place to induct bank/agency Staff?					
8	Is the number of staff on duty today sufficient? If No: What has been/is being done about this?					
9	Are there regular visits by the matron to the ward/area – hourly, daily, weekly etc? What does the matron do when he/she visits?		N/A			
10	Is there a site management system in place and do staff understand it and use it to get support? Is there a clear mechanism for escalation of any concerns over a 24 hour period? Do staff feel supported?				N/A	
11	Whistle blowing policy in place and staff aware of how to raise concerns?				N/A	

No.	Criteria to be assessed	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
12	Staff are aware of policies and procedures regarding the safeguarding of vulnerable adults and children and know how to access them?	N/A			N/A	
13	Staff have attended mandatory training for the protection of vulnerable adults and children?	N/A			N/A	
14	Staff are trained/ participate in root cause analysis post serious incidents?	N/A			N/A	
15	Is there a clear record of all staff who have attended annual mandatory training (such as manual handling, resuscitation and fire)?	N/A		N/A	N/A	
16	Staff are aware of trust safety policies such as health & safety, violence & aggression, and lone working	N/A			N/A	
17	Agency & bank staff are subject to authentication and have their ID checked & validated	N/A			N/A	
18	Do staff know who the medical and nurse directors are? Do they see them regularly, e.g. on walk abouts? Raise similar questions about senior nurse and clinical director for the area.	N/A			N/A	

2. Patient Safety

"Staff are responsible for ensuring patients safety is maintained"

No.	Criteria	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
1	Are the medicine trolley(s) and individual patient drug lockers/drug cupboard locked and attached securely to a wall when not in use?		N/A	N/A	N/A	
2	All resuscitation equipment is clean, in date, easily accessible and a daily signed checking schedule is up to date?		N/A	N/A	N/A	
3	Equipment used for moving and handling patients is adequate, accessible, clean and maintained in good working order?		N/A	N/A	N/A	
4	All patients wear a clear and accurate identity band which complies with the trust's patient ID policy?		N/A	N/A	N/A	
5	There is a register of all equipment that is used in the clinical area/ward, which included serial numbers?	N/A		N/A	N/A	
6	There is a maintenance record in the clinical area/ward of when all equipment was last checked or serviced?	N/A		N/A	N/A	
7	For all equipment used in the clinical area/ward there is a maintained list of all staff trained in its use?	N/A		N/A	N/A	
8	If staff feel they need more equipment there is a process to access it?		N/A		N/A	

No.	Criteria	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
9	Staff know how to report an incident and have knowledge of the trust procedure on incident reporting?	N/A			N/A	
10	Staff receive feedback on incidents and actions that are required to prevent repetition?				N/A	
11	Staff understand what is meant by the term "serious incident" and are able to differentiate it from the general term "incident"?	N/A	N/A		N/A	
12	Staff know how to access "on-call" system for any work issues out of hours and escalation plan?	N/A			N/A	
13	Where appropriate, access to the clinical area/ward is strictly controlled?		N/A		N/A	
14	Patients are assessed on admission for their risk of harm, i.e. falling, using a validated assessment tool, pressure ulcers, VTE, infection?	N/A			N/A	
15	Risk assessments are repeated and actioned as appropriate during the care episode as required?	N/A			N/A	
16	Staff know what & how to record as part of the incident reporting process?	N/A			N/A	

3. Clinical – 'deliver care'

"Patients and Carers experience safe and effective clinical care, sensitive to their individual needs and preferences, that promotes high quality care for the patient"

No.	Criteria	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
1	There is evidence of essence of care/ or alternative audits and action plans to implement change as appropriate?	N/A			N/A	
2	There is evidence of high impact interventions for:- HCAI being implemented - Ask patients if staff wash hands High impact actions, care bundles, safety thermometer, intentional rounding, protected meal times – are they in evidence?					
3	What nursing care indicators are utilised and how are these shared and disseminated with staff, patients and relatives?					
4	The ward/ department has implemented the principles of releasing time to care (productive ward) and displays a dashboard of information?					
5	There is evidence to demonstrate that all care processes are actually documented, i.e. fluid balance charts, care plans, infusion pump charts and MEWs scoring system in place?				N/A	
6	Any information given to the patient is fully explained and understood?	N/A	N/A			

No.	Criteria	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
7	Planned care is agreed and decisions recorded with patients (and or relatives/carers) prior to treatment or care?	N/A				
8	The entrance to the care environment is obvious, sign posted clearly, safe, welcoming, easily reached and entered?		N/A	N/A	N/A	
9	"How it feels" – the environment feels pleasant, calm, secure, safe and reassuring?		N/A	N/A		
10	Furnishings (chairs, wall coverings, floors, carpets, doors etc) are all in good repair and have no stains or marks?		N/A	N/A	N/A	
11	The area is the appropriate temperature and where possible, has natural daylight and where appropriate lighting can be controlled by the patient?		N/A	N/A		
12	The area is free from inappropriate clutter (such as in exits, corridors, bathrooms, shower areas etc)?		N/A	N/A	N/A	
13	Linen and laundry segregation, storage and disposal are well managed and appropriate?		N/A	N/A	N/A	
14	Regular routines for cleaning and managing waste are in place that meet national standards?		N/A	N/A	N/A	
15	Telephones, calls, televisions, music, visitors and admissions are managed effectively to minimise disruption?		N/A	N/A		
16	There is signage on the clinical area/ward to notify patients, relatives and carers of facilities such as toilets, bathrooms, fire exits and directions to other services?			N/A	N/A	

No.	Criteria	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
17	There is an environmental risk assessment (safety check) of the patient's personal space that includes, such as, removal of obstructions to observations, sighting of hand gels, obstructions and clutter around the bed, and obstructions to prevent access to means of suicide etc?			N/A	N/A	
18	The patient's plan of care reflects their safety needs and documents that they have been given the opportunity to ask questions?	N/A		N/A		
19	Cleaning schedules are available and visible?			N/A		

4. Patient Experience

"The clinical area/ ward collects and acts upon feedback from Patients and Carers/Families" – take account of NICE quality standard on patient experience

No.	Criteria	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
1	There is adequate signage/maps/directions in the clinical area/ward to support effective communication to patients, relatives and carers?		N/A	N/A		
2	Staff introduce themselves to patients' relatives and carers?		N/A	N/A		
3	All staff wear an ID badge when on duty?		N/A	N/A	N/A	
4	Next of kin or principal carer is identified, agreed with the patient and the impact of care is assessed?	N/A				
5	Patients, relatives and carers know who to contact first if they have any questions regarding care?					
6	Does the ward get feedback in relation the annual patients' survey and is there a local action plan that is reported on? Or How does the ward get feedback and act on a variety of patient information to include annual surveys and real time feedback?	N/A			N/A	

No.	Criteria	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
7	Patients and or relatives/carers views are sought, listened to and acted upon from: e.g. Dr Foster patient tracker, local surveys, discussions and interviews, safety walkabouts, via releasing time to care programme?					
8	Is there evidence of thank you cards on the wards? How is feedback from patients collected?		N/A	N/A	N/A	
9	Do the ward staff manage patient complaints at a local level?		N/A	N/A	N/A	
10	Is information regarding the PALS service given to patients, relatives and or carers?	N/A	N/A			
11	There is information readily available for patients, relatives and or carers on how to make a complaint about the quality of care that is provided if needed?					
12	Do any of the ward staff participate in a patient experience group? e.g. support groups for the specialty or trust wide groups?	N/A	N/A		N/A	
13	Patient privacy is maintained by the use of curtains and screens?		N/A	N/A		
14	Permission is obtained before entering any private area, such as behind screen curtains, bathrooms and cubicles?		N/A			

No.	Criteria	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
15	Patients wear clothing that maintains modesty & dignity (such as their own clothes or hospital clothing)?		N/A	N/A		
16	Dignity & modesty is maintained for those patients moving between different care environments?		N/A	N/A		
17	Patients are protected from unwanted public view for example using curtains, screens, walls, clothes and covers?		N/A	N/A		
18	Patients are called by their preferred name, and this is documented?	N/A		N/A		
19	Patient call systems are answered in a timely manner?		N/A			
20	There is a "quiet" or private space available for patients to use, and patients are made aware of its availability?		N/A	N/A		
21	Precautions are taken to prevent information being shared inappropriately for example telephone conversations being overheard, computer screens being viewed and white boards being read?		N/A		N/A	
22	Procedures are in place for sending or receiving patient information for example hand-over procedures, consultant or teaching rounds, admission procedures, telephone calls, or breaking bad news?	N/A			N/A	

No.	Criteria	Evidenced by				Comments Observation
		Observation	Documentation	Staff views	Patient/carer /relative views	
23	Same sex facilities are provided, and there is access to segregated or age specific toilet and washing facilities?		N/A	N/A	N/A	
24	Staff are aware of their role in protecting patients' privacy & dignity?		N/A		N/A	
25	Staff are aware of individual patient cultural & religious beliefs and how it may change delivery of care?		N/A			
26	Patients look clean and cared for and are dressed in appropriate attire?		N/A	N/A		
27	Bed spaces are clean and tidy with items within easy reach of patients e.g. drinks/meals etc?		N/A	N/A		
28	Bathrooms and toilets, including commodes are clean and tidy?		N/A	N/A		
29	Information regarding the PALS service is given to patients, relatives and or carers?	N/A	N/A			

Appendix eight: Feedback Form for Observational and Clinical Visits

Feedback by: **Date:**

Area Visited:
General Comments:
Good Practice:
Immediate Risks (hot issues for urgent action now):
Issues / Concerns (to be addressed in the next 3 months):
Issues for Further Consideration:

Appendix nine: Immediate Feedback on Site Visit with Provider Chief Executive at end of day

Feedback by: **Date:**

Trust Wide Overall Impression	Key/Headline Points
General Comments:	
Good Practice:	
Immediate Risks (hot issues for urgent action):	
Issues / Concerns (to be addressed in the next month):	
Further Consideration (2-way Feedback /expectations when report ready/next steps /timescales):	
Comments to Note (including deadline dates agreed when report will be sent to Trust):