

Service Definition and Organisation Domain

Service Definition and Organisation - Achieving an integrated and patient-focused service requires a clear structure for leadership, management and accountability. This item ensures that the basic components of this are in place. Without these it will be impossible to deliver the Standards cost-effectively.

No.	Measure	Supporting information
1.1	There is a description of the extent of the service including all providers of care and remote services	<ul style="list-style-type: none"> • For Liver services the description should be drawn from the following menu: <ul style="list-style-type: none"> - Demographics & prevalence - Prevention elements - Early Identification mechanisms - Referral/consultation processes - Purpose and roles for parts of the service & individuals - Including specific treatment algorithms where relevant, e.g. hepatitis C, Hepatitis B, alcohol, transplant - Long term ongoing care processes - Objectives of clinical management, outcomes & their evaluation - End of Life Care processes
1.2	There is a description of the service for referrers, patients and their carers	

1.3	There is a clinical lead supported by a leadership team	<ul style="list-style-type: none"> • A leadership team is a group of individuals who work together as a leadership unit. One of these will be the overall leader and the other two leads will be from the main professional groups involved with the service • In the first instance this may be a hepatologist (defined as an appropriately trained clinician who spends >50% of face-to-face clinical time dealing with liver disease), or a gastroenterologist with an interest in Hepatology. Where neither exists (in >50% Trusts), a Gastroenterologist who is nominated to develop and improve this service (which would include the appointment of one of the above). • The leader however could be a manager, commissioner, spec nurse etc. but this is unlikely in the first round. The leader will need to form the team around them but we could help by specifying a minimum group: secondary care lead, primary care lead, CCG lead, specialist nurse (and practice nurse), public health person, Trust manager, patient rep & others as appropriate (e.g. prison healthcare, drugs worker, alcohol addiction specialist)
1.4	The roles and responsibilities of individuals in the leadership team are defined and the team is supported by a leadership and organisational structure with clear lines of accountability	<ul style="list-style-type: none"> • See 1.3 re concept of leadership team. Roles and responsibilities of the leadership team need to be clearly defined and taken from job plans
1.5	There is an agreed meetings structure to support the organisation and delivery of the service	<ul style="list-style-type: none"> • This relates to clear written terms of reference outlining the purpose of any meeting: who the chair is, what action points, etc. • The service should consider representation by patient groups
1.6	The relationships with relevant non-healthcare services, patient groups and services who share a common purpose are described	<ul style="list-style-type: none"> • Examples might be the prison service, drug and alcohol, homeless and social services
1.7	The leadership team has sufficient managerial, administrative and technical support (such as IT) to organise and deliver the service	<ul style="list-style-type: none"> • See 1.3 re concept of leadership team. For this measure we are looking at services that enable the leaders of the team to manage the service
1.8	The leadership team has timely and appropriate information on which to base decisions	<ul style="list-style-type: none"> • See 1.3 re concept of leadership team
1.9	There are processes in place to ensure effective communication	<ul style="list-style-type: none"> • The aim of the communication plan is to ensure that timely, accurate information leads to effective delivery and a clear understanding of the Liver Service through the following activities: <ul style="list-style-type: none"> ○ Promote the short- and long-term benefits of the Liver Service ○ Develop a process for consulting with stakeholders, including the

		<p>community, on the management and development of the Service</p> <ul style="list-style-type: none"> ○ Address risks that may arise if there is a lack of consistent and clear communication on the Liver Service with various stakeholder groups <ul style="list-style-type: none"> • This plan will be supported by a tactical plan that sets out in detail the activities, communications tools, timing and who/what will be responsible. This plan should use existing communications channels or establish new ones
1.10	The service reviews and defines its strategic and organisational objectives annually	<ul style="list-style-type: none"> • Cross references to most other items
1.11	There are systems in place to ensure staff are able to feedback in confidence on the service and the way it is led, and contribute to the development of the service	<ul style="list-style-type: none"> • Feedback from staff should be collected regularly and there should be ways in which staff can feedback concerns anonymously on an ad hoc basis
1.12	There is a service-wide Multi-Disciplinary Team meeting structure for complex cases/high risk groups	<ul style="list-style-type: none"> • There should be a meeting structure not just for clinical cases, but also to include education and research. To start with, this measure is about identifying and establishing service partnerships and liaisons
1.13	There is an annual report	<ul style="list-style-type: none"> • An annual report is a means of communicating but it is more than that: it is a summary of all the service has achieved, areas of difficulties and objectives for future year(s) • It should be communicated to all the key stakeholders, to those that provide the service and to senior management
1.14	The leadership team networks with other teams in other areas - both regionally and nationally - to share best practice and to help resolve service challenges	<ul style="list-style-type: none"> • See previous measures re leadership team

Patient Experience Domain

Patient Education and Information - This item ensures patients have relevant, high quality information in a form and place that suits their needs. This includes information about clinical conditions, service configuration, health promotion, discharge and aftercare information, but excludes information for individual patients such as treatment plans, clinic letters or results of investigations.

No.	Measure	Supporting Information
2.1	There are patient information materials in written and in electronic form for the principal clinical conditions, special groups and services	<ul style="list-style-type: none"> • Each patient fully understands their diagnosis and is supported with up to date information. • Information (leaflets) are provided and all information meets the NHS standards (language services) • Each service has information about all local and national support services, GRPs etc. • Each service provides detail to a national diary of information, education and support meetings
2.1	A review of information needs (including current national guidance, research studies and patient organisations) is conducted annually. This includes not just 'what information', but in what form and where information needs to be available (GP surgery, outpatients, ward etc.)	
2.3	There is patient involvement in the topics, content, choice and preparation of information materials	
2.4	There is a published timetable of educational opportunities for patient groups in collaboration, when appropriate, with patient organisations	<ul style="list-style-type: none"> • These educational opportunities may not be available locally but in the neighbouring area or at national level



2.5	Patient and patient representative feedback on the provision of information and education is collected at least once a year and considered when changes are made to the service(s)	<ul style="list-style-type: none"> E.g. clinic or postal survey at least once a year
2.6	Patients' frequently asked questions are incorporated into patient information materials	
2.7	Information materials comply with local and national guidelines	
2.8	Written information is available to patients in a variety of forms e.g. website and/or CD ROM	
2.9	There is an annual review of the information needs of 'hard to reach' groups	

Access and Choice - Access refers to what care patients have access to and in what time frame. Choice refers not just to choice of service, location or professional, but also to the opportunity to have active involvement in decisions that affect their care - so called 'Shared Decision Making' (SDM)

No.	Measure	Supporting Information
3.1	There is agreement with local and national commissioners what services are available to which group of patients. This includes the nature of the service, the way they are delivered (e.g. clinics, telephone, email) and in what time frames	<ul style="list-style-type: none"> For liver disease there is possibly a whole menu of services. People should concentrate on 'core' services and things they do well, and consider getting into networks of care for the rest. E.g. Core is referral for opinion & help with interpretation of LFTs; monitoring of people with chronic liver disease (with defined outcomes and aims) and surveillance of people with cirrhosis (HCC, varices, osteopenia & liver failure); and management of alcoholic liver disease. Network includes assessment & treatment for hepatitis C, chronic hepatitis B, liver transplant, addiction treatments (alcohol and drugs), obesity-NAFLD management, variceal hemorrhage and biliary disease management.



3.2	There are guidelines in place for services for which there is restricted access	
3.3	Based on 3.1 and 3.2 there is a description of the network of services available to patients, how services are accessed, and any restrictions to access	
3.4	Information materials include an explanation of what services patients have access to and what choices they have	
3.5	Annual audits and patient feedback demonstrate that patients have access to services when they require it and that they can exercise choice within agreed guidance. Shortfalls and unmet need are fed into the annual review of services (3.6)	
3.6	The provision of services is reviewed and agreed annually with commissioners, patient groups and providers of those services	
3.7	The principles of 'Shared Decision Making' (SDM) are made available to all members of the MPT	<ul style="list-style-type: none"> Shared Decision Making is a process in which patients, when they reach a decision crossroads in their health care, can review the treatment options available to them. With current clinical information, relevant to their particular condition, patients will be helped to work through any questions they may have, explore the options available, and take a treatment route which best suits their needs and expectations. http://www.rightcare.nhs.uk/index.php/shared-decision-making/
3.8	Annual audits of SDM are undertaken	
3.9	Audits of SDM are reviewed and actions to improve SDM are planned	
3.10	Audits of SDM indicate that actions taken to improve SDM have been successful	

Equity and Equality - This item ensures that the access to and quality of care are not affected by religion, ethnicity, gender or disability

No.	Measure	Supporting Information
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4.1	Service policies to meet the social, disability and cultural needs of patients are available	<ul style="list-style-type: none"> • There will be local policies on these issues in all health care providers. The service might choose to use one of the policies from one of these providers • Does the service have a policy to reach these socially deprived or disadvantaged groups?
4.2	Service delivery reflects service policies (as outlined in item 4.1)	
4.3	A demographic and/or language profile of the population served is available	
4.4	Patients' needs for item 4.1 are recorded as a part of the nursing assessment of patients admitted to hospital	
4.5	Resources exist to support patient communication needs appropriate to the demographic profile (e.g. interpreters, written information, language communication aids)	<ul style="list-style-type: none"> • The Department of Health has a number of communication aids available for download through the website to support patients who may be unable to communicate their symptoms: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4073230
4.6	The use of family and supporters as interpreters is discouraged unless it is the patient's choice to use them as interpreters (If patients exercise this choice it is documented in the patient's file)	<ul style="list-style-type: none"> • The reason the use of family or friends as interpreters is discouraged is because of the difficulty of being certain that the information transmitted to, or received from, the patient is complete and correct. Ultimately it is the patient's choice if they wish to use their family or friends as interpreters. If it is documented in the patient's file that the patient is happy to use a relative to interpret for them, then the answer to this measure will be Yes
4.7	All patients with communication needs are offered an interpreter, written information and/or telephone interpreting service appropriate to their needs	
4.8	The annual patient feedback report represents the different social groups accessing the service	<ul style="list-style-type: none"> • The service must draw evidence from several sources to determine the extent to which its service meets the expectations it has given its patients: patient panels, questionnaires, complaints, incident reviews, ad hoc suggestions, etc.

4.9	Feedback on the services provided is actively sought from different social groups using questionnaires, telephone interviews and/or focus groups	<ul style="list-style-type: none"> The service must make every effort to gather feedback from a wide range of patients accessing their services
4.10	Patient participation in planning and evaluating services is representative of the local population in terms of gender, ethnicity and disability	

Respect and Dignity - this item ensures patients are clear about how they should expect to be treated and whether those expectations are met.

No.	Measure	Supporting Information
5.1	The service has a patient charter for Respect and Dignity that includes patients' responsibilities	<ul style="list-style-type: none"> In England, some of patients' rights as an NHS patient are set out in the NHS constitution. You can see a copy of the constitution on the Department of Health website at: www.dh.gov.uk. The Handbook to the NHS constitution at www.dh.gov.uk gives a guide to patients' rights under the Constitution in England Services are encouraged to develop their own charter for liver services
5.2	There is a range of communication methods and materials that ensure patients are informed of the charter, what they should expect from the service and what their responsibilities are	
5.3	The methodology for assessing whether patients are treated with respect and dignity is agreed between the commissioners, the service providers and the relevant patient groups	<ul style="list-style-type: none"> This methodology includes at least two different methods for prospectively capturing feedback and a minimum of one assessment for each method per year To avoid duplicating effort it should include all relevant sources of information (collected by others) such as national and local patient surveys, complaints, compliments and incident reviews
5.4	The prospective assessments are completed and collated with other outputs (5.3), reviewed and actions are agreed and planned	
5.5	The outputs and planned actions (5.4) are disseminated to relevant parties	



5.6	There are systems in place to ensure that the planned actions arising from the review have been successful	
5.7	The charter (5.1) and supporting information (5.2) are reviewed and updated annually	



Clinical Quality Domain

Safety – Achievement of this item indicates that the service has processes in place to identify, respond to and learn from expected and unexpected adverse events.

No.	Measure	Supporting information
6.1	Key known adverse events are defined and available to all members of the service in electronic form	<ul style="list-style-type: none"> Improved safety is about reducing the expected and analysing both the expected and unexpected to reduce future risk The purpose of this item is agreed by the team and includes key measures pertinent to the service that will 'inform' safe practice. E.g. at a minimum this will mean unexpected mortality, or an unplanned admission resulting from the effect of treatment. This should include admissions under other teams or hospitals
6.2	There is a system for capturing and recording known adverse events described in 6.1	<ul style="list-style-type: none"> This is dependent on the items defined in 6.1 and there should be a nominated lead for it. We recommend that this is done on at least a monthly basis
6.3	The service adheres to the local process for acting on unexpected adverse events	
6.4	On the basis of 6.1-3 there is an annual review of current methods to reduce risk to patients and a plan agreed to minimize future risk	<ul style="list-style-type: none"> The process needs to be defined for liver patients with advanced disease, this should include defining the objective of treatment and consideration to EOLC scenarios
6.5	All adverse events are reviewed on a regular basis (at least 2x/year), and new methods of risk reduction and improvements to current methods are incorporated into the plan agreed in 6.4	
6.6	A process is in place for identifying and reviewing all unexpected deaths and unexpected readmissions within two days of discharge, and potential improvements to current methods are incorporated into the plan agreed in 6.4	



6.7	Actions on adverse events (expected and unexpected) incorporated into the risk reduction plan agreed in 6.4 are implemented within three months of being incorporated	
6.8	Auditable outcomes for actions on adverse events planned in 6.4 and 6.9 are identified and monitored, and actions are planned if objectives are not achieved	
6.9	Action is taken within a three month period if auditable outcomes for actions on adverse events or risk reduction improvements are not achieved	
6.10	Resource constraints for responding to adverse events or delivering risk reduction interventions are identified, placed on a 'risk register', and fed into the annual service planning process with commissioners	



Quality – This item determines whether the service is clear about what clinical conditions it is responsible for and assesses how well these conditions are managed

No.	Measure	Comments
7.1	There is agreement between the service team, relevant providers and commissioners on which conditions the service is responsible for	<p>Conditions might include:</p> <ul style="list-style-type: none"> • Alcohol related liver disease • (Acute Alcohol withdrawal) • (Identification of harmful drinkers in secondary care) • Chronic liver disease secondary to NAFLD • Hepatitis B • Hepatitis C • Variceal bleeding (TIPS) • Autoimmune liver disease • PBC • PSC • AIH • Haemochromatosis • HCC • NET • Biliary disease-ERCP • Acute liver failure
7.2	All national guidelines relevant to the conditions described in 7.1 are available to team members electronically, including associated key performance indicators and NICE quality standards	
7.3	There are written pathways/protocols with auditable outcomes for clinical conditions to support the use of investigations and treatments described in 7.1	<p>Protocols for all conditions should be available electronically on hospital internet</p> <p>Examples:</p> <ul style="list-style-type: none"> • <i>Clinical condition</i>; Hepatitis C • <i>Treatment</i>; as per protocol • <i>Auditable outcome</i> (SVR rate)



		<ul style="list-style-type: none"> • <i>Clinical condition</i>; Alcoholic liver disease • <i>Treatment</i>; as per protocol • <i>Auditable outcome</i>; % referred for liver transplant assessment (NICE recommendation)
7.4	The methodology for assessing whether patients are treated according to the local protocols and national guidelines is agreed between the commissioners, the service providers and the relevant patient groups.	<ul style="list-style-type: none"> • This includes all national Key Performance Indicators (KPIs) such as NICE quality standards and locally determined auditable outcomes, and other relevant sources of information (collected by others) such as complaints, compliments and incident reviews
7.5	Prospective assessments of Key Performance Indicators and auditable outcomes are completed and outputs are prepared for review	
7.6	The service participates in all relevant national audits	
7.7	Outputs from 7.5 are reviewed at least annually and actions plans are created to improve performance. The outputs and plans for action are disseminated to all relevant parties	
7.8	There is a patient register in place that is able to capture KPIs and auditable outcomes on a continuous basis	
7.9	Review of performance (local and national indicators) indicates that actions taken to improve performance have been successful	
7.10	There are regular Multi Professional Team (MPT) meetings to support the management of difficult clinical problems for which there is no clear evidence base	<p>Examples</p> <ul style="list-style-type: none"> • MPT Transplant assessment meeting • MPT HPB Cancer meeting • MPT Histopath meeting
7.11	Learning from MPT meetings feeds into the review of performance and is disseminated to the wider team	

Research and Innovation – This item determines the extent to which the service is aware of, and participates in, local and national research; and its capability to develop, measure the impact of and disseminate service innovations

No.	Measure	Comments
8.1	There is a register of regional and national research projects relevant to the service, which is updated at least twice a year	<ul style="list-style-type: none"> The team should know who the CLRN lead is for their specialty, and that their own service has a nominated lead), to plug into that http://www.crncc.nihr.ac.uk/about_us/ccrn
8.2	There is annual agreement between the service, hospital management, patient groups and commissioners on which local and national research projects the service will participate in. The agreement includes objectives for probity, patient-centredness and participation	
8.3	There is a register of nationally recommended service improvements and innovations, including interventions recommended by NICE	<ul style="list-style-type: none"> Service innovations in this context refers to new treatments or devices, and new ways of delivering the service such as new pathways or workforce models
8.4	There is annual agreement between the service, hospital management, patient groups and commissioners on which local and national service improvements and innovations will be adopted. This agreement includes a set of objectives for implementation	
8.5	Research governance policies and procedures are available electronically	
8.6	There is an individual or team responsible for ensuring that participation in research projects identified in 8.2 is not constrained by organisational issues	
8.7	There is an at least annual review of participation rates in research projects, uptake of service innovation and achievement of the objectives in 8.4	
8.8	Actions plans are created on the basis of the review (8.7) to improve participation and adoption rates for 8.2 and 8.4. Constraints on participation and adoption are fed into future planning	

8.9	There is participation in locally-led research networks	
8.10	The service assesses service innovations it has implemented and publishes the findings locally	
8.11	The service publishes evidence of service innovation within the knowledge management system of QuEST and/or in peer reviewed journals	
8.12	There is an annual report of participation in research and of uptake of service improvements and innovation	

Prevention – This item determines the extent to which the service is preventing disease burden

No.	Measure	Comments
9.1	There is a description of the ways in which disease burden can be reduced by reducing incidence, improving clinical outcomes and increasing safety	
9.2	There is an annual review of the local disease burden and possible interventions to reduce it. The interventions are ranked according to potential impact, difficulty of implementation and cost	
9.3	The interventions are mapped against the stakeholders needed to implement them	
9.4	On the basis of 9.1 and 9.2 the service, commissioners, local authority, patient groups and all other stakeholders in 9.3 annually agree and publish objectives (with timelines) for reducing disease burden in the 1-5 year time frame	
9.5	The stakeholders in 9.3 agree and implement a plan to achieve the objectives outlined in 9.4	
9.6	The objectives in 9.4 are reviewed annually	



9.7	Actions are agreed and implemented if objectives are not achieved	
9.8	Difficulties achieving objectives are fed into the annual reviews in 9.1-4	
9.9	The service publishes an annual report of progress reducing the burden of disease	



Boundaries of Care Domain

Self-Care - This item assesses the capability of a service to maximise the opportunity to enhance self-care. Self-care includes the actions people take for themselves to stay fit and maintain good physical and mental health, to meet social and psychological needs, prevent illness or accidents, to care for long-term conditions and to maintain health and wellbeing after an acute illness or discharge from hospital.

No.	Measure	Comments
10.1	There is a description of how the service encourages and supports self-care	<ul style="list-style-type: none"> • Examples include reading materials, diary including attendance & procedures, self-record, 'pledge-ambition'. • Who is the responsible lead for this, how often is it reviewed, how is it assessed?
10.2	There are processes in place, supported by educational materials, that make the options and process for self-care explicit to patients and their carers	<ul style="list-style-type: none"> • Website, written materials - e.g. list of web resources
10.3	There are processes and supporting materials that provide the patient with the information they need to self care	<ul style="list-style-type: none"> • Copy patient letters, formal care plan
10.4	All patients who self-care have a care plan agreed with the professionals responsible for their care	<ul style="list-style-type: none"> • Formal care plan reviewed annually: includes diagnosis, background, place on pathway, tests, treatment, agreed self-care
10.5	Patients who opt for self-care have ready and rapid access to advice and support when they need it. Ideally they have access to a 'patient navigator' who ensures patients can access what they need, when they need it	<ul style="list-style-type: none"> • Telephone (answerphone) & recoding system for notes, web access
10.6	There are policies and procedures in place for carers and case workers to support patients opting for self-care	<ul style="list-style-type: none"> • Self-care should be supported with GP agreements, patient agreement & permissions (for notes), named case workers or organisation- XR other



		item
10.7	Patients are made aware of, and have access to, local and national patient support groups	<ul style="list-style-type: none"> This should be a basic requirement. The service should List, access, descriptions/recommendations
10.8	Patients have access to their own records	<ul style="list-style-type: none"> Patients know they have a right to access, get copies of all correspondence, (incl results), electronic
10.9	Auditable outcomes for self-care, and methods to assess them, are agreed by relevant stakeholders	<ul style="list-style-type: none">
10.10	Auditable outcomes defined in 10.9 are measured and reviewed at least on an annual basis	<ul style="list-style-type: none"> This should feed into the annual section
10.11	Actions arising from review of auditable outcomes are agreed and implemented and incorporated into future planning: 10.1-4	<ul style="list-style-type: none"> Or reasons why not & plan of how to address these
10.12	There is evidence that actions defined in 10.11 have been implemented and have been successful	<ul style="list-style-type: none"> e.g. what progress has been made during previous year (or six months) to address the issues previously highlighted

***Interface Care* - This item assesses the service's capability to ensure that the patient is at the centre of care, that care is not compromised by boundaries or place of care, and that care is delivered efficiently by professionals and by their organisations**

No.	Measure	Comments
11.1	Each year stakeholders agree and define clinical pathways which are patient centred and describe the roles and responsibilities of both the organisations and the professionals involved in them	<ul style="list-style-type: none"> Requires nominated leads in each group, description of process & frequency of meetings, etc
11.2	There are policies and protocols in place for shared care	<ul style="list-style-type: none"> Knowledge of extent of problem: national & local data resource. Policy, algorithms, annually reviewed, performance measures and KPIs.

11.3	There are guiding principles for communicating and sharing information across professional and organisational boundaries, and processes in place that support these principles	<ul style="list-style-type: none"> Referral criteria (incl OB), Immuno guide, viral guide etc GP shared care
11.4	There are policies in place for managing the transition of care from paediatric to adult services	<ul style="list-style-type: none"> Understanding scale, nominated leads, process, frequency, literature
11.5	Auditable outcomes for care provided across professional and organisational boundaries, and methods to assess them (see measure 11.3), are agreed by relevant stakeholders	<ul style="list-style-type: none"> Basic numbers, exception reporting NB unplanned admissions
11.6	Auditable outcomes defined in 11.5 are measured and reviewed at least on an annual basis	
11.7	Actions arising from review of auditable outcomes are agreed and implemented	
11.8	There is evidence that actions defined in 11.7 have been implemented and have been successful	
11.9	Feedback from patients and evidence from auditable outcomes feeds into the annual review and definition described in 11.1	

Social Care - This item assesses the effectiveness of the involvement of non-healthcare providers, especially social care

No.	Measure	
12.1	All the relevant stakeholders agree a social care charter that makes it clear to patients and their carers what they might expect from non-healthcare providers	<ul style="list-style-type: none"> Patients' independence and choice are promoted through person centred assessment, care planning and review arrangements Assessment, care planning and review procedures take account of carers' needs, including risk assessment and identification of unmet

		<p>need</p> <ul style="list-style-type: none"> • Either the lead or a nominee from the team needs some liaison with CCG and HWBs for this to work. The over-arching reason is that liver disease outcomes are hugely linked to and are adversely affected by deprivation and other social factors such as ethnic isolation can have a deleterious effect
12.2	There is description of non-healthcare services, including how they are accessed	<ul style="list-style-type: none"> • In liver services this might be: <ul style="list-style-type: none"> ✓ Independent advocacy services ✓ Complaint procedure ✓ Social workers ✓ Benefits advice ✓ Spiritual support ✓ <i>HealthWatch</i> or equivalent organisation
12.3	There are processes in place, supported by educational materials, that make the options and process for social care explicit to patients and their carers	<ul style="list-style-type: none"> • There should be is a description of the services, including personnel and how it supports patients and supporters, including access to telephone/email advice both within and outside of office hours
12.4	There are policies and processes in place for managing patients with complex needs that require input from health and social care providers	<ul style="list-style-type: none"> • In liver services this might be an integrated S/W with MDT • A policy should ensure Multi-disciplinary meetings / case reviews with input from all local services take place to coordinate the care of patients with multiple long-term conditions and those with complex needs. The policy should cover at least: <ul style="list-style-type: none"> a. Indications for discussion b. Responsibility and arrangements for arranging and documenting these meetings c. Involvement of consultants and specialist staff d. Involvement of social care

12.5	There are policies in place for sharing information across professional and organisational boundaries	
12.6	Patients and carers are aware of guidelines for end of life care, services available and how to access them	
12.7	Monitoring and review arrangements are in place that maximise patient independence and provide the best outcomes	
12.8	Auditable outcomes for social care and the supporting charter, and methods to assess them, are agreed by relevant stakeholders	
12.9	Auditable outcomes defined in 12.8 are measured and reviewed at least on an annual basis	
12.10	Actions arising from review of the auditable outcomes in 12.9 are agreed and implemented	
12.11	There is evidence that actions defined in 12.10 have been implemented and have been successful	
12.12	Feedback from patients and evidence from auditable outcomes feeds into the annual review and definitions described in 12.1 and 12.2	

***Inpatient Care* – This item determines how well hospital care achieves excellent and cost-effective clinical outcomes for inpatients and daycases**

No.	Measure	Comments
13.1	The hospital and clinical teams review and agree each year what hospital facilities are required to deliver the service and where they are situated	

13.2	The hospital and clinical teams review and agree each year the leadership and constitution of the clinical teams required to deliver the service	
13.3	The hospital and clinical teams review and agree each year resource requirements for clinical teams that support the service	
13.4	There are protocols for treatments that can be administered as daycases	
13.5	There are policies in place that enable direct admission	
13.6	The hospital and clinical team agree auditable outcomes and performance indicators against which the hospital facilities, policies and processes can be assessed	
13.7	There are processes and supporting IT to monitor, record and review agreed performance criteria	
13.8	There is an annual review of performance measures, and action plans are created and implemented to improve the service	
13.9	Action plans are communicated to all members of the team	
13.10	Review of performance indicates that all agreed objectives have been achieved	
13.11	Review of performance identifies opportunities for improving effectiveness and/or efficiency, which are fed into the annual review in 13.8	
13.12	If there are resource constraints delivering the agreed objectives, they are fed into the annual planning process of 13.1-3	