NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)139

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday, 14 August 2025
Director Lead	Emma Sayner – Group Chief Financial Officer
Contact Officer / Author	Tom Myers – Group Director of Estates, Facilities and Development Thomas Doo - Head of Safety and Statutory Compliance
Title of Report	Premises Assurance Model 2024 – 2025 – Executive Summary
Executive Summary	The NHS Premises Assurance Model (PAM) is a mandatory management tool driven by NHS England and is designed to provide a nationally consistent approach to evaluating the premises performance through the co-ordinated approach across seven domains and comprising of self-assessment questions that provide the assessment structure. The Trust Board is requested to approve the HUTH and NLAG PAM report for 2024 – 2025
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Performance Estates and Finance CiC (July) Estates, Facilities and Development Governance Estates, Facilities and Development SMT
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Group Directorate of Estates, Facilities and Development

Annual PAM Reports

1st April 2024 to 31st March 2025

1.0 Executive summary

1.1 **Background** -

1.1.1 The NHS Premises Assurance Model (PAM) is a mandatory management tool driven by NHS E (NHS England) and is designed to provide a nationally consistent approach to evaluating the premises performance through the co-ordinated approach across seven domains and comprising of self-assessment questions that provide the assessment structure:

1. Safety Hard (Estates) – x22 assessment categories
2. Safety Soft (Facilities) – x10 assessment categories
3. Organisational Governance - x3 assessment categories
4. Patient Experience - x6 assessment categories
5. Effectiveness - x4 assessment categories
6. Efficiency - x5 assessment categories
7. Helipad – x1 assessment category*

* Tiered response levels with Yes/No qualifying questions

1.1.2 Additionally, there are two areas of the PAM which specifically look at Government Office documents and systems:

- FM Maturity (FMS 001: Management Services)
- FM Maturity (FMS 002: Asset Data) (optional last reporting year)

For each criterion, a self-assessment judgement is selected based on risk:

- Outstanding
- Good
- Requires minimal improvement.
- Requires moderate improvement.
- Inadequate
- Not Applicable

1.1.3 The submission is required to be completed by September 2025.

2.0 HUTH (Hull University Teaching Hospitals) Summary

2.1 There has been a slight increase in those rated as “Inadequate”, this is in relation to specifically Anti-Ligature and Safety in other Premises. These are currently being addressed but more progress is required in ensuring that services that are being

relocated are done so after Heads of Terms, and/or rental/leasing agreements have been confirmed.

2.2 In addition the SAQ (Standard Assessment Questions) for Decontamination has been considered as Not Applicable for this period as responsibility for this services was transferred into the care groups and outside of E,F& D. Also, the SAQ for Martyn's Law was not considered for the period stated as the legislation was not passed until late March 2025 and the SAQ set was not finally published until May 2025. This will, however, be included within the 2025-26 period.

3.0 NLaG (Northern Lincolnshire & Goole) Summary

3.1 For the Safety Hard there has been a slight increase in "outstanding" as the qualifying elements for this has been clarified by the National User Group. There has also been some movement from "good" to "requires minimal improvement" as there is a realignment within the E,F & D (Estates, Facilities & Development) Directorate as part of the Group working processes being implemented.

3.2 With the Safety Soft SAQ's there have been increases in both "outstanding" and "good" elements as the implementation of the National Standards progresses.

4.0 Recommendations

4.1 There are specific areas for each partner organisations which are detailed in the separate reports. However across the two organisations there are some common elements. These are:

- Fire Safety – appointment of a suitable Authorising Engineer(Fire) [AE(Fire)] due to be implemented in 25-26 period with a combined audit report to ensure a consistent approach. Resources available also need to be reviewed to ensure that processes are strengthened and the services are aligned across both organisations.
- Operational Management – there is a need to update the Computer Aided Facilities Management (CAFM) system across both organisations. This is due to be addressed within the 25-26 period as a tender across the Group is due to be completed and implemented within that period.

4.2 The independent review of PAM is currently different in each organisation and this may give rise to an inconsistent approach and level of assurance in some areas. However, this should be considered as how to address as part of the E,F&D restructure that will be implemented in 25-26.

4.3 The Trust Board is requested to approve the two organisational PAM reports for 2024-25

Estates and Facilities

Premises Assurance Model 2024-2025

End of Year Report

Hull University Teaching Hospitals NHS Trust

Contents

Purpose

The purpose of this report is to provide an end-of-year summary of the main findings when completing the mandatory NHSE 2024-25 Premises Assurance Model (PAM), which is required to have Trust Board[1] oversight/sign off.

Background Information

Regulated by NHSE, the PAM is a national, mandatory standardised approach to self-assessing assurance levels within Estates, Facilities & Development[2]. Through the coordinated engagement with both internal and external stakeholders, there are seven domains comprising of 53 self-assessment questions that provide the assessment structure:

1. Safety Hard (Estates) – x22 assessment categories
2. Safety Soft (Facilities) – x10 assessment categories
3. Organisational Governance - x3 assessment categories
4. Patient Experience - x6 assessment categories
5. Effectiveness - x4 assessment categories
6. Efficiency - x5 assessment categories
7. Helipad – x1 assessment category

Additionally, there are two areas of the PAM which specifically look at Government Office documents and systems:

- FM Maturity (FMS 001: Management Services)
- FM Maturity (FMS 002: Asset Data) (optional last reporting year)

Contained within each domain are:

- Self-assessment questions (SAQ's) which are answered through a series of sub-questions based on NHSE set criterion.
- National Metrics: a standardised method of determining levels of adherence to healthcare and government legislation requirements with regards to Estate and Facilities. The judgement metrics are:
    - Outstanding
    - Good
    - Requires Minimal Improvement
    - Requires Moderate Improvement
    - Inadequate
    - Not Applicable

The exception is the H1 domain, Helipad, which is piloting the YES/NO method of response coming away from the perspective style of rating. Although NLaG does not have a helipad and therefore does not answer this domain it is pertinent to note that it is anticipated that that the YES/NO methodology will feature in the whole collection if the pilot proves successful.

[1] 'Trust Board' is NHSE terminology, and the intent is that HUTH equivalent is the NHS Humber Health Partnership Cabinet act in the capacity of HUTH Board.

[2] Although categorised as *Estates, Facilities & Development* departments/services are assessed which do not sit within Estates, Facilities & Development in the structure of HUTH

Late May 2025, NHSE made Trusts aware of the final, yet unapproved SAQ definitions of the 2024/25 PAM. In addition to the Helipad feedback methodology change, it included two additional SAQ's, together with change of grouping for the BIM/PSTN SAQ being moved from the Safety Soft to the Safety Hard domain. The two new SAQ's are:

- SH20 Mortuaries
- SS10 Terrorism (Protection of Premises) Act 2025 – Martyn's Law

The view of the EF&D senior management team that the SAQ's have been provided beyond the end of March 2025 and therefore will only be considered in the 2025/26 submission and not addressed as part of the 2024/25 rating submission.

HUTH has undertaken the PAM since 2018/19, HUTH's Estates, Facilities & Development Directorate has actively engaged in the PAM self-assessment process with the EF&D Information & Governance team facilitating the process. Additionally, the Trust is represented at a national level consulting every quarter at the NHSE Premises Assurance User Group.

The PAM programme has only recently become a mandatory requirement appearing for the first time in the 2021 NHS Standard Contract.

Hull University Teaching Hospitals NHS Trust's PAM Model

HUTH's annual self-assessment usually commenced in November 2024 concluding early June 2025 with an annual report. The period between April and August enables internal and external reporting to be completed. The PAM sessions were conducted with the SAQ Leads and subject matter experts at facilitated workshops.

The existing model has been presented previously, and is deemed suitable for the organisation, resulting in transparent and credible assurances.

Inherently, the self-assessment process is a subjective process, and no physical evidence is collected. It is understood by the SAQ Leads that any external enquiries or audits would require production of any evidence to support their self-assessment ratings.

Additionally, national guidance such Health Technical Memorandums (HTM) and Trust policy requirements also inform the level of assurance for the operational teams.

The outcome of the PAM self-assessment process is presented at the EF&D Group Governance & Assurance meeting for approval, prior to seeking Board approval to submit the return to NHSE. It is intended that from the 2024/25 PAM all relevant actions will be discussed and progress towards completion will be monitored at the Technical/Operational Sub Groups. This integration with the Sub-Groups is evolving.

As the PAM is near the end of the 7th year of the current model and upon review, the delivery model is assessed as fit for purpose and delivers a meaningful self-assessment within the confines of the national mandated process. It should be

further noted that individual self-assessment questions are subject to scrutiny annually and may change.

2024-25 Estates and Facilities PAM Summary of Findings

The charts below capture the end of year comparisons that visually represents the judgements for the EF&D primary service provision (Hard and Soft FM) domains of Estates, Facilities & Development against each standardised question set. Appendix 1 provides the full data capture for each domain.

Graphical illustration of the displacement of judgements for both Estates (SH1 to SH22) (SH20 was not assessed; SH22 was identified as N/A)) and Facilities (SS1 to SS1.10 (SS10 removed)).

Figure 1 - Safety Hard - Comparison for 21/22 – 24/25 period

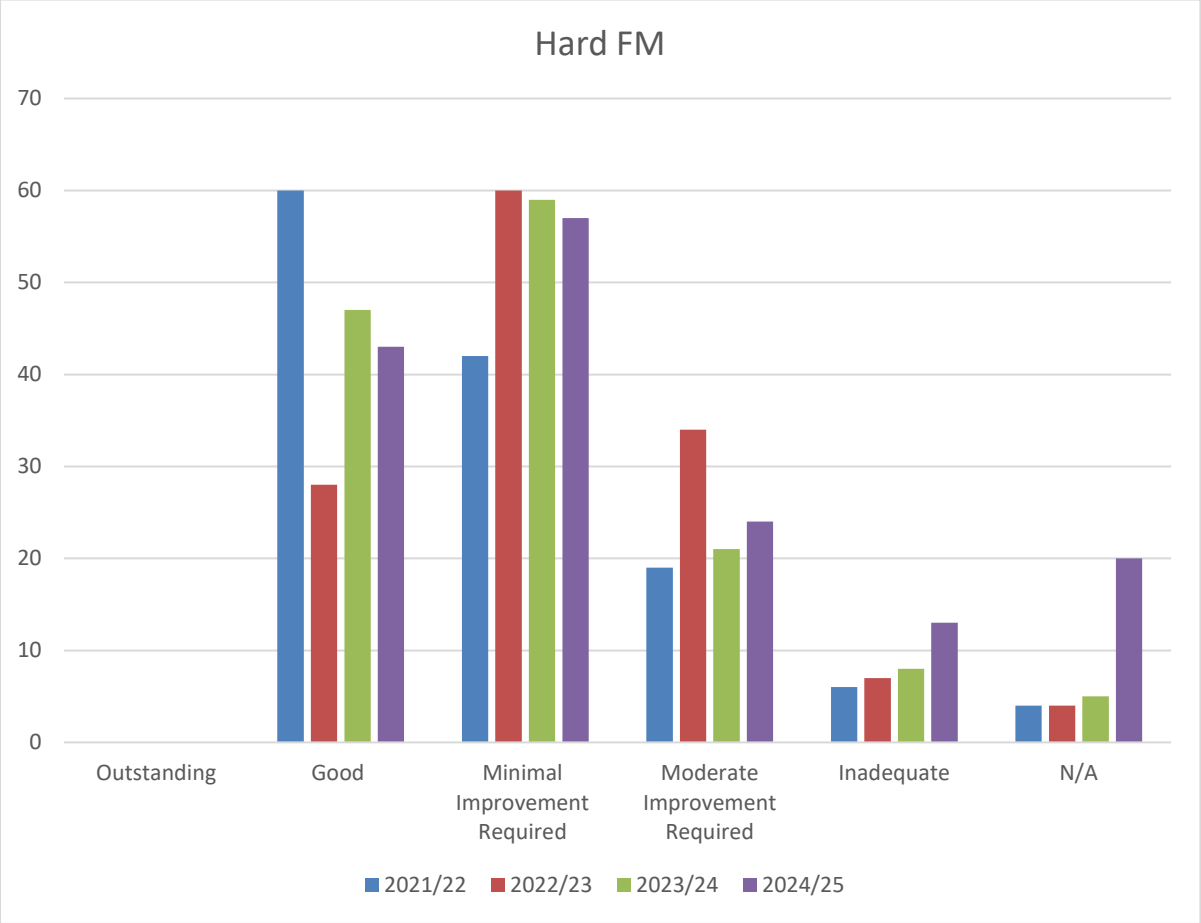


Figure 2 - Safety Soft - Comparison for 21/22 – 24/25 period

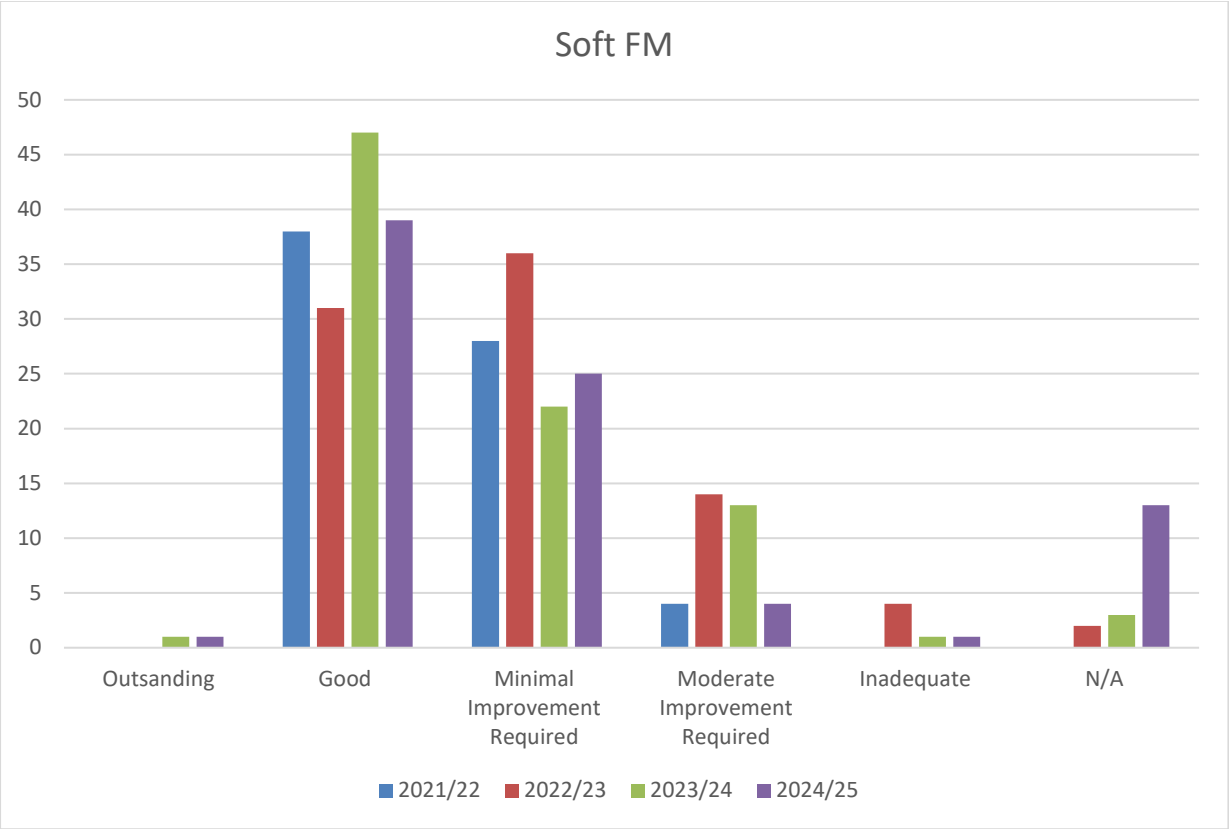


Figure 1 (Safety Hard) shows a slight decrease in the self-assessment rating of Good and Minimal Improvement Required. There has been an increase in the Moderate Improvement Required. There is an increase in the Inadequate rating that is due to the self-assessment of the Anti-Ligature SAQ with professional input from the Consultant Nurse (Mental Health). The variation is accredited to the evolving Group model and the evolving alignment of systems and processess between the South and North Bank Trusts.

There is one SAQ in the Safety Hard domain which has been been self-assesed as being Inadequate throughout. This is SH18 Safety in Other Premises. This is when HUTH operates out of premises not owned by the Trust and is typical of ‘outreach clinical services’. The weakness in assurance is considered an organisational issue and not solely isolated to EF&D. It has been self-assessed as part of the PAM as the Property Services resides within the EF&D directorate. The root cause is due mainly to Health Groups occupying facilities in other ‘landlord’s premises’, in order to deliver services close to the patient. However, this is invariably undertaken without any Heads of Terms, lease or rental agreement being put in place. This has the potential to put HUTH staff at risk, as they may be unaware of local procedures and arrangements, e.g. fire alarms and evacuation, health and safety arrangements, lone working, key handling, etc. Whilst some progress has been achieved it is considered not significant enough to change the PAM ratings.

The increase in the Not Applicable (N/A) ratings is attributable to, in the main, the S20 Mortuaries SAQ's which was not self-assessed in 2024/25 due the late inclusion and SH22 PSTN Shutdown, which was not assessed as this is seen as an IT lead.

For the Safety Soft (see figure 2) there has also been a change in the level of assurance provided, due mainly to the SS2 standard (Decontamination) now being considered N/A, as the delivery responsibility for the service is with the Care Groups. Additionally, SS10 Terrorism Prevention (Martyn's Law) has not been self-assessed in 2024/25 due the late inclusion.

The removal of the SS2 Decontamonation SAQ and the late inclusion of SS10 Terrorism Prevention (Martyn's Law), has impacted on the ratio of of the other PAM ratings for Safety Soft domain.

Figure 3 - 24/25 SAQ Outcome Safety Hard

	P&P	R&R	RA	Mtce	T&D	EPRR	Review
SH1	3	3	2	3	2	2	3
SH2	2	2	3	3	3	2	2
SH3	4	3	3	3	0	3	4
SH4	4	3	4	0	4	3	4
SH5	2	3	4	0	3	2	3
SH6	3	3	3	4	2	3	2
SH7	3	2	3	3	3	3	2
SH8	4	3	3	3	3	2	2
SH9	4	4	3	4	3	3	2
SH10	4	4	4	3	3	2	2
SH11	3	3	3	3	2	2	2
SH12	4	3	3	2	2	2	2
SH13	3	4	2	2	3	2	3
SH14	4	4	4	3	3	2	2
SH15	2	4	4	3	3	2	3
SH16	3	2	2	4	3	0	2
SH17	3	2	2	0	2	2	0
SH18	5	5	5	5	5	5	5
SH19	3	2	2	3	3	3	3
SH20	0	0	0	0	0	0	0
SH21	5	4	5	5	5	5	5
SH22	0	0	0	0	0	0	0
Average	3	3	3	3	3	3	3

Figure 4 - 24/25 SAQ Outcome Safety Soft

SS1	2	3	2	3	3	3	2
SS2	0	0	0	0	0	0	0
SS3	4	3	3	2	4	2	3
SS4	3	3	2	2	2	2	2
SS5	3	3	2	2	2	2	2
SS6	2	2	2	3	2	3	4
SS7	5	3	2	2	2	2	3
SS8	3	2	3	2	3	2	3
SS9	3	3	2	2	1	2	2
SS10	0	0	0	0	0	0	0
Average	3	2	2	2	2	2	2

Figures 3 and 4
Areas of Good Practice

- There has been an improvement on the general Estates & Facilities Management (SH1) domain.
- Electrical Systems (SH9) has also improved in a number of areas, in line with a number of other engineering disciplines.
- In the Safety Soft domain (SS1) Catering, has improved its ratings against the national standards and the increased framework requirements.
- The rating of Outstanding was recommended for the (SS9) Portering Services training and development process and the linking of Safe Systems of Work staff 'sign off'as read and understood. This maintains records for the Portering Service management team with embedded alerts when staff are about to expire.
- The Governance framework (G1) has decreased slightly whilst it is evident that there is a group wide monthly Governance & Assurance Group established, improved risk register identifying controls and gaps and actions to mitigate the risk. There is a transitional approach to the use and implementation of Group approved documentation.
- Patient Experience continues to self-assess in the lower ratings as this is historically strong on PALCE audits but not as robust on other patient feedback opportunities. The directorate is working with the Patient Experince lead to collect feedback on EF&D services and once this has become embedded, we will reach out to our nursing colleagues in order to understand if the ACE process offers further robustness to patient and staff feedback on EF&D services.

Key Areas for Improvements

- Safety in Other Premises (SH18) has remained as Inadequate throughout, for the second consecutive year. This is despite some works progressing in the year however it was considered not to impact on the current ratings. This is seen as a Trustwide risk and has been included on the Trust Operational Risk Register (Risk ID 4312).
- Asbestos Management (SH5) has deteriorated since the last annual review and is attributable to a number of issues, to the lack of information uploaded onto the Trust Asbestos Register and future process, completion of the robust risk assessment on the Asbestos Register and the inclusion of known asbestos abatement works on the Backlog Maintenance register.
- Fire Safety has also seen a slight deterioration, which is attributed to the appointment of an AE (Fire) conducting their initial audit. This has introduced a challenge into the current processes within the Fire Safety Team. Work is required to strengthen the team and the processes.
- Policies and procedural documents are required for all relevant SAQ areas in the Safety Hard and the Safety Soft domains.
- The review process in the Safety Hard and the Safety Soft domains are on the whole 'Good', consideration should be given to independent reviews. Currently some services reviews are conducted by the staff within the services, which does not demonstrate impartiality.

Conclusion

Completed in isolation of any verification process, the very nature of self-assessment is a subjective process at best. However, the EF&D Information and Governance team acts semi-independently of the main Estates, Facilities & Development departments and offer an element of impartiality that challenges the validity of the assessment judgements as part of the validation process. The team cannot be seen to be semi-independent of all services as it currently reports to the Head of Operational Estates.

Work was undertaken in 2024/25 to establish the policy frameworks within the EF&D directorate. An action plan was established and is the responsibility of service leads to deliver in 2025/26.

Further works were undertaken to determine the appointment of Authorised Engineer appointments across the Group. Alignmemt is being considered at the appointment stages of all new AE appointments and based upon capacity and experience there is an emphasis on joint appointments where appropriate.

Below are the report recommendations for improvement:

Recommendations

- Align, where practical all AE appointments across the Group.
- Strengthen the number of Policy and Procedural documents for all technical/operational services.
- Create comprehensive suite of Standard Operating Procedures (SOPs) for all disciplines.
- Consider how independent reviews/audits might be strengthened in areas where there is no external audits/monitoring.

- Strengthen the patient and staff feedback of EF&D services.

Mark Green
Head of Information & Governance

June 2025

Appendix

1 – National Premises Assurance Model SAQ Reference Worksheets


03.
PRN02003_ii_PAM SA

Instructions: NHS Premises Assurance Model 2023: Please also read the separate NHS PAM Guidance Document

Purpose and structure of this file	This file contains Self-Assessment Questions that help evaluate the way your organisation/site manages its estate and facilities in 5 Domains. Although the Safety Domain is notionally split between hard and soft Facility Management (FM) services some questions within the 'Combined and Hard FM' supply to both sections. These questions should be assessed across both hard and soft FM e.g. the SAQ relating to Health and Safety is within the 'Safety: Combined and Hard FM' but clearly applies to soft FM also. A number of other relevant sheets are also provided
How to complete it	The way to use this file is to fill in the 5 worksheets with yellow tabs, which include the domain self-assessment questions (SAQs). Year 1 | Year 2 | The assessment can be for one or two years if comparisons are required. **2023-24** | **2024-25** | ◄Use the drop down in the yellow boxes to alter the years where relevant Each SAQ contains several prompt questions. By answering the prompt questions, a result is automatically calculated for the SAQs and the domains. Please note it is not possible to give a rating to the SAQ directly, it has to be rated indirectly using the prompt questions or, alternatively, classified as not applicable. There are six possible responses for a prompt question: - Not applicable: this prompt question does not apply to your organisation/site. - Outstanding: compliant with no action plus evidence of high quality services and innovation. - Good: compliant no action required. - Requires minimal improvement: the impact on people who use services, visitors or staff is low. - Requires moderate improvement: the impact on people who use services, visitors or staff is medium. - Inadequate: action is required quickly - the impact on people who use services, visitors or staff is high.
Results	The "Summary' sheets show graphically the results of the NHS PAM self-assessment. - The 'summary' one shows the ratings at the domain level. It includes the average rating and the distribution of SAQ ratings for the 5 domains (i.e. the % of SAQs that obtain a rating of "Outstanding", the % of SAQs that obtain a rating of "Good", etc.) - The other 5 red 'Results' sheet detail the average rating and the distribution of the prompt questions ratings for each SAQ within the domain. This allows the user to see which SAQs are driving the results of the domains.

Annual Changes	**Annual changes may be required in line with updates to guidance and legislation, you can find an overview of the latest changes listed below.** **Changes for 2025:** **There has been updates to the HBN and HTM guidance, the links within the spreadsheet remains up to date, but please familiarise yourself with the latest publications:** **https://www.england.nhs.uk/estates/complete-list-of-publications-related-to-nhs-estates/** **Please also note there has been some technical bulletins published this year these can be found: https://www.england.nhs.uk/estates/netb/** **Safety Hard** **•Legislation & guidance updates – link provided** **•SH20 - Mortuary question added** **•SH22 – Addition of a question here (previously SS10 – BIM/PSTN)** **Safety Soft** **•Legislation and guidance updated (link provided)** **•The previous SS10 (BIM/PSTN) is now moved under safety hard as SS22, this question is also slightly updated within SS22.7.** **•There is a new SS10 - Terrorism (Protection of Premises) Act 2025** **•SS3 -guidance added: 9. NHS England » NHS clinical waste strategy** **Efficiency** **•F3 - Wording added - "(Please note - Building Standard is mandatory for certain projects)"** **•F5 Guidance updated - 8.Greener NHS » Delivering a net zero NHS, 9. NHS Estates Net Zero Carbon Delivery Plan Report, 10. Net Zero Guidance plan** **Effectiveness** **•E1 - Guidance updated - Greener NHS » Delivering a net zero NHS, . NHS Estates Net Zero Carbon Delivery Plan Report, . Net Zero Guidance plan** **•E2 - Evidence updated - 3. Refer to ICS infrastructure strategy guidance the guidance includes reference to local area energy plans and local nature recovery strategies, which will support town planning.** **•E4 - Guidance updated - 4. NHS Climate Change Risk Assessment tool, 5. Health and climate adaptation report 2025** **Governance** **•G1 - Guidance updated - 8. NHS England » Green plan guidance** **Helipad - This question has been replaced with a new set** **•Please note these questions appear in a different format to the rest of the current questions, with yes/no answers. The answers will be scored based on the assurance provided. This fits in with the approach to be taken next year.** **Contact details** **•Contact details requested for the appointed person regarding Terrorism (Protection of Premises) Act 2025.** **•Contact details requested for 'Food' and 'Linen and laundry'** **Online version of the SAQs:** **Please note due to year on year reporting within Tableau the new questions may be reflected with a different number.**

NHS Premises Assurance Model (NHS PAM)

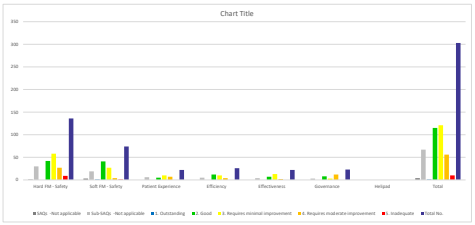
	Trust:
	Site Name:
	Year:

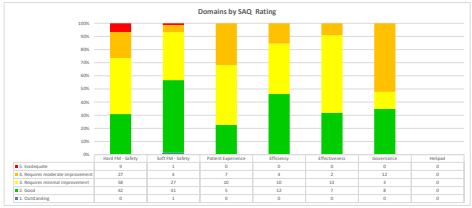
SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH1	Estates and Facilities Operational Management	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	Not applicable															0	0	
SH2	Design, Layout and Use of Premises	Hard FM - Safety	Applicable	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	Not applicable															0	0	
SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Document Management System in Place	2. Approval of documents	3. Review of documents	4: Availability of documents	5. Legibility of Documents	6: Document Control	7. Obsolescence	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH3	Estates and Facilities Document Management	Hard FM - Safety	Applicable	4. Requires moderate im	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	Not applicable	3. Requires minimal imp	4. Requires moderate im	Not applicable															0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	Maintenance	4. Training and Development	5. Resilience, Emergency & Business Continuity Planning	6. Review Process	7. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH4	Health & Safety at Work	Hard FM - Safety	Applicable	4. Requires moderate im	3. Requires minimal imp	4. Requires moderate improvement		4. Requires moderate im	3. Requires minimal imp	4. Requires moderate im	Not applicable															0	0	
SH5	Asbestos	Hard FM - Safety	Applicable	2. Good	3. Requires minimal imp	4. Requires moderate improvement		3. Requires minimal imp	2. Good	3. Requires minimal imp	Not applicable															0	0	
	Self Assessment Question (SAQ) Subject	Hard FM - Safety	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	9. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	
SH6	Medical Gas Systems	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	4. Requires moderate im	2. Good	3. Requires minimal imp	2. Good	Not applicable															0	0	
	Self Assessment Question (SAQ) Subject	Hard FM - Safety	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	
SH7	Natural Gas and specialist piped systems	Hard FM - Safety	Applicable	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH8	Water Safety Systems	Hard FM - Safety	Applicable	4. Requires moderate im	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	Not applicable															0	0	
SH9	Electrical Systems	Hard FM - Safety	Applicable	4. Requires moderate im	4. Requires moderate im	3. Requires minimal imp	4. Requires moderate im	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH10	Mechanical Systems and Equipment	Hard FM - Safety	Applicable	4. Requires moderate im	4. Requires moderate im	4. Requires moderate im	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	Not applicable															0	0	
SH11	Ventilation, Air Conditioning and Refrigeration Systems	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	Not applicable															0	0	
SH12	Lifts, Hoists and Conveyance Systems	Hard FM - Safety	Applicable	4. Requires moderate im	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SH13	Pressure Systems	Hard FM - Safety	Applicable	3. Requires minimal imp	4. Requires moderate im	2. Good	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	Not applicable															0	0	
	Self Assessment Question (SAQ) Subject		Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Governance	4. Enforcement	5. Risk Assessment	6. Maintenance	7. Training and Development	8. Resilience, Emergency & Business Continuity Planning	9. Review Process	10. Costed Action Plans															
SH14	Fire Safety	Hard FM - Safety	Applicable	4. Requires moderate im	4. Requires moderate im	2. Good	2. Good	4. Requires moderate im	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	Not applicable													0	0	
SH15	Medical Devices and Equipment	Hard FM - Safety	Applicable	2. Good	4. Requires moderate im	4. Requires moderate im	3. Requires minimal imp	3. Requires minimal imp	2. Good	3. Requires minimal imp	Not applicable															0	0	
SH16	Resilience, Emergency and Business Continuity Planning	Hard FM - Safety	Applicable	3. Requires minimal imp	2. Good	2. Good	4. Requires moderate im	3. Requires minimal improvement		2. Good	Not applicable															0	0	
SH17	Safety Alerts	Hard FM - Safety	Applicable	3. Requires minimal imp	2. Good	2. Good		Not applicable	2. Good	2. Good	Not applicable															0	0	
SH18	Externally supplied estate	Hard FM - Safety	Applicable	5. Inadequate	5. Inadequate	5. Inadequate	5. Inadequate	5. Inadequate	5. Inadequate	5. Inadequate	Not applicable															0	0	
SAQ No.19	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3.Contract Expiry	4. Risk Assessment	5. Maintenance	6. Contractor Compliance	7. Resilience, Emergency & Business Continuity Planning	8.. Review Process	9.. Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH19	Contractor Management for Soft and Hard FM services	Hard FM - Safety	Applicable	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	Not applicable														0	0	
SH20	Self Assessment Question (SAQ) Subject	Domain	Not applicable	1. Policy & Procedures	2. Security	3. Funeral Directors	4.HTA (Human Tissue A	5. Existing facilities	6. Future demand	7. Body transfer for Po	8. Entrances & Location	9. Care, safety and secu	10. Waste Management	11. Body storage & delivery point	12. PM with forensics	13. Waste disposal room	14. Costed action plan											
SH20	SH20	Hard FM - Safety	Not applicable	0	0	0	0	0	0	0	0	0	0	0	0	0	0											
SH21	SH21:The built environment: Reducing harm by ligature in practice.With regards to self-harm risks associated with the built environment, can the organisation evidence that they have taken consideration for the following:	Hard FM - Safety	Applicable	5. Inadequate	4. Requires moderate im	4. Requires moderate im	5. Inadequate	4. Requires moderate im	4. Requires moderate im	Not applicable																		
SAQ No.21	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Policy	2: Roles and Responsibilitie	3: Risk Assessment	4: Maintenance	5: Training	6: Review Process	7: Resilience	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH22	SH22:Estates IT and Building Information Management (BIM) systemsPlease confirm you I	Hard FM - Safety	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable															#REF!	#REF!	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8.Food Standards: Board Director	9.Food Standards: Strategy	10.Food Standards:Diatition	11.Food Standards: Safety Specialist	12.Food Standards: Workforce	13.Food Standards:Matrix	14.Food Standards: Waste	15.Food Standards: 24/7 Restaurant	16.Food Standards: 24/7 Café	17.Food Standards: 24/7 Vending machines	18.Food Standards: 24/7 Retail	19.Food Standards: Cold Vending	20. Food Standards: Smart Fridges	21.Food Standards: From home	22. Costed Action Plans	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS1	Catering services	Soft FM - Safety	Applicable	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	4. Requires moderate im	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	3. Requires minim	2. Good	2. Good	2. Good	3. Requires minim	Not applicable	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS2	Decontamination process	Soft FM - Safety	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable															0	0	
SS3	Waste and Recycling Management	Soft FM - Safety	Applicable	4. Requires moderate im	3. Requires minimal imp	3. Requires minimal imp	2. Good	4. Requires moderate im	2. Good	3. Requires minimal imp	Not applicable															0	0	
SAQ No.SS4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Cleaning Standards 2021: Star Ratings	9. Cleaning Standards 2021: Charter	10. Cleaning Standards 2021: Matrix	11.Cleaning Standards 2021: 95%	12: Costed Action Plans											Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS4	Cleanliness and Infection Control	Soft FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	3. Requires minimal imp	2. Good	Not applicable											0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS5	Laundry and Linen Services	Soft FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SS6	Security Management	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	4. Requires moderate im	Not applicable															0	0	
SS7	Transport Services	Soft FM - Safety	Applicable	5. Inadequate	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	3. Requires minimal imp	Not applicable															0	0	
SS8	Pest control	Soft FM - Safety	Applicable	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	Not applicable															0	0	
SS9	Portering services	Soft FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	1. Outstanding	2. Good	2. Good	Not applicable															0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Not applicable	1: Policy	2: Policy	3: Roles and Responsibilities	4. Roles and Responsibilities	5. Roles and Responsibilities	6. Risk Assessment - Enhanced Tier	7. Measures - Enhanced Tier	8. Training and Development	9. Training and Development - Enhanced Tier	10. Public Protection Procedures	11. Public Protection Measures	Capital cost to achieve compliance	Revenue consequences of achieving compliance										#REF!	#REF!	
SS10	SS10: With regard to the Terrorism (Protection of Premises) Act 2025, more commonly known as Martyn's Law can the organisation evidence the following?	Soft FM - Safety	Not applicable	Not applicable	#REF!	Not applicable	#REF!	Not applicable	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!												
SAQ No. P1	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Views and Experiences	2. Engagement	3. Staff Engagement	4. Prioritisation	5. Value	6: Costed Action Plans																	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P1	Engagement and involvement	Patient Experience	Applicable	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	4. Requires moderate im	4. Requires moderate im	Not applicable																	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. PLACE Assessment	2. Other Assessments	3. Cleaning Schedules	4. Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P2	Condition, appearance, maintenance and privacy and dignity perception	Patient Experience	Applicable	4. Requires moderate im	4. Requires moderate improvement		Not applicable																			0	0	
P3	Cleanliness	Patient Experience	Applicable	4. Requires moderate im	2. Good	2. Good	Not applicable																			0	0	
P4	Access and Car Parking	Patient Experience	Applicable	2. Good	3. Requires minimal improvement		Not applicable																			0	0	
P5	Grounds and Gardens	Patient Experience	Applicable	3. Requires minimal imp	3. Requires minimal improvement		Not applicable																			0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Regulation	3. Choice	4. Equality issues	5. Information	6. PLACE Assessment	7. Other Assessments	8. Legal Standards	9: Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P6	Catering services	Patient Experience	Applicable	3. Requires minimal imp	4. Requires moderate im	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	4. Requires moderate im	Not applicable														0	0	
SAQ No.F1	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Analysing Performance	2: Benchmarking	3: Costed Action Plans																				Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F1	Performance management	Efficiency	Applicable	3. Requires minimal imp	3. Requires minimal imp	Not applicable																				0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Business Planning	2: Estate Optimisation	3: Commercial Opportunities	4: Partnership working	5: New Technology	6: PFI and LIFT contracts	7: Other contracts	8. Property	9. Cost Improvement plans	10: Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F2	Improving efficiency - running	Efficiency	Applicable	3. Requires minimal imp	4. Requires moderate im	2. Good	2. Good	2. Good	2. Good	2. Good	3. Requires minimal imp	2. Good	Not applicable													0	0	
SAQ No. F3	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Capital Procurement.	2. Capital Project Management	3. Capital Procurement Efficiencies	4. Flexibility	5. Identification and disposal of surplus land	6: Net zero carbons	7: Costed Action Plans																Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F3	Improving efficiency - capital	Efficiency	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	Not applicable																0	0	
SAQ No.F4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Policy & Procedures	2: Review Process	3: Board Reporting & Contracting	4: Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F4	Financial controls	Efficiency	Applicable	2. Good	2. Good	2. Good	Not applicable																			0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Quality and Sustainability	2. Financial Pressure	3. Continuous Improvement	4. Quality Improvements	5. Recognition	6. Use of Information	7: Costed Action Plans																Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F5	Continuous improvement	Efficiency	Applicable	4. Requires moderate im	4. Requires moderate im	3. Requires minimal imp	3. Requires minimal imp	2. Good	4. Requires moderate im	Not applicable																0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Vision and Values	2. Strategy	3. Development	4. Vision and Values Understood	5. Strategy Understood	6. Progress	7: Costed Action Plans																Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E1	Vision and strategy	Effectiveness	Applicable	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	Not applicable																0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Local Planning	2. Neighbourhood Planning	3. Planning Control	4. Special Interests	5. Enforcement	6: Costed Action Plans																	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	
E2	Town planning	Effectiveness	Applicable	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	4. Requires moderate im	Not applicable																	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Disposal of land and property	2: Granting of Leases	3: Acquisition of land and property	4: Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E3	Land and Property management	Effectiveness	Applicable	2. Good	2. Good	2. Good	Not applicable																			0	0	
SAQ No.E4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Green Plan / Sustainability Strategy	2: Energy	3: Waste	4: Air Pollution	5.Travel & Transport	6.Water	7. Climate Change Adaptation	8. Procurement	9: Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E4	Sustainability	Effectiveness	Applicable	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	4. Requires moderate im	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	Not applicable														0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Framework	2. Roles	3. Partners	4. Framework	5: Assurance	6. Monitoring	7. Audit	8. Mitigation	9. Alignment	10: Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G1	Governance process	Governance	Applicable	4. Requires moderate im	4. Requires moderate im	2. Good	3. Requires minimal imp	2. Good	4. Requires moderate im	4. Requires moderate im	2. Good	3. Requires minimal imp	Not applicable													0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Effectiveness	2. Challenges	3. Visibility	4. Relationships	5. Respect	6. Behaviours.	7. Culture	8. Honesty.	9. Safety & Wellbeing	10. Healthier workplace	11. Collaboration	12: Costed Action Plans											Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G2	Leadership and culture	Governance	Applicable	2. Good	4. Requires moderate im	3. Requires minimal imp	4. Requires moderate im	4. Requires moderate im	4. Requires moderate im	4. Requires moderate im	4. Requires moderate im	4. Requires moderate im	2. Good	4. Requires moderate im	Not applicable											0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Professional advice	2. In-house advisors	3. External advisors	4: Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G3	Professional advice	Governance	Applicable	2. Good	2. Good	2. Good	Not applicable																			0	0	

SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Compliance Assessment and Policy Review: Adherence to CAP1256 and Downwash Helipad Considerations in the Trust	2: Roles and Responsibilities	3: Risk Assessment and Mitigation Strategies for Helipad and Estate	4: Resilience, Emergency & Business Continuity Planning	5: Risk assessment - Regulatory Differences between Ground-Based and Elevated Helipads	6: Resilience, Emergency & Business Continuity Planning	7: Review Process	8. Collaboration	10. Costed Action Plans																	
RIS	Helipad		Scored separate this year reflected in Tableau																										
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Confirmation of Safe Helipad Operations	2. How many primary HHLS does the trust have operating?	4. How many secondary HHLS does the trust utilise?	4. Who is the Accountable Manager (AM) for your HHLS?	5. AM Email address	6. AM Telephone number	7. AM Job Title	8. Hospital Operations Manual (HOM)	9. Risk Assessment and Mitigation Strategies for Helipad and Estates	10. Where Coast Guard Search and Rescue (SAR) landings take place on the HHLS.	11. Resilience, Emergency & Business Continuity Planning.	12: Review Process	13. Collaboration	9. Costed Action Plans	Capital cost to achieve desired improvements/outcomes										Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
FM MF	FM05	FM Maturity Framework																									#REF!	#REF!	
SAQ No.	Self Assessment Question (SAQ) Subject		Q1 - What level of location hierarchy is asset data captured against?	Q2 - Is there a consistent data specification aligned to the FM asset data standards (4.2)?	Q3 - How consistently is the data specification applied across the estate?	Q4 - What is the level of coverage of assets in the asset register data?	Q5 - How complete is the data captured against assets in the asset register?	Q6 - Is a full asset verification exercise required to update the asset register (5.1)?	Q7 - What regular sample surveys exist for on-going asset verification (5.2)?	Q8 - What processes are in place for change control/approvals for adding, removing or changing an asset (5.3)?	Q9 - What processes are in place for data quality checks (5.4)?	Q10 - What processes are in place for data update assurance (5.5)?	Q11 - What governance is in place to support data assurance and quality (5.6)?	Q12 - What level of documentation exists for the these data quality processes and governance (5.7)?	Q13 - Is the data contractually owned by the organisation (6.1)?	Q14 - What level of access does the organisation have to the data in the asset management systems (6.2)?	Q15 - What level of access management exists for controlling user privileges (6.3)?	Q16 - Do the asset management systems provide the flexibility to accommodate the data standards (7.1)?	Q17 - Do the asset management systems allow interoperability of asset data (7.2)?	Q18 - Does the asset management systems sync to a common data platform (7.3)?	Q19 - Do the systems meet data security requirements (7.4)?	Q20 - Do the systems meet data backup management requirements (7.5)?	Q21 - What types of management information reports and dashboards are used for FM asset data (8.1)?	Q22 - How does asset data inform decisions relating to contract management (8.2)?	Q23 - How does asset data inform decisions relating to mandatory and statutory compliance (8.3)?	Q24 - How does asset data inform decisions relating to Planned Preventative Maintenance (8.4)?	Q25 - How does asset data inform decisions relating to Investment Prioritisation (8.5)?	Q26 - What is the capacity of the teams working with asset data (9.1)?	
FM MF	FM02	FM Maturity Framework																									#REF!	#REF!	

Domain	SAQs -Not applicable	Sub-SAQs -Not applicable	1. Outstanding	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	5. Inadequate	Total No.
Hard FM - Safety	1	30	0	42	58	27	0	130
Soft FM - Safety	3	19	1	41	27	4	1	74
Patient Experience	0	4	0	5	10	7	0	22
Efficiency	0	1	0	12	10	4	0	26
Effectiveness	0	4	0	7	13	2	0	22
Governance	0	1	0	8	3	12	0	23
Helipad	0	0	0	0	0	0	0	0
Total	4	87	1	135	121	56	10	303

0





NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
◄◄ Back to instructions	

Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH1	**SH1: With regard to the Estates and Facilities Operational Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to the overall management of the E&F function and how specific technical areas (covered by separate SAQs) are managed, reported, escalated and reviewed in a consistent way	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; 2. CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. Health Building Note 00-08: The efficient management of healthcare estates and facilities 5. Health Building Note 00-08: Land and Property Appraisal - Available on the NHS Estates Collaboration Hub 6 A Risk-Based Methodology for establishing and Managing Backlog (NHS Estates 2004) 7. Monitor: The asset register and disposal of assets: guidance for providers of commissioner requested services 8. BS ISO 55000, 55001 & 55002: 2014 Asset Management 9 Quality Management System supported by the International Organisation for Standardisation ISO 9001 Quality Management System, or the current European Foundation for Quality Management (EFQM) Excellence Model criteria or equivalent. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/estates/health-building-notes/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/148143/Backlog_costing.pdf https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/guidance-and-support/ https://www.iso.org/standard/55088.Health Technical Memorandum https://www.iso.org/iso-9001-quality-management.Health Technical Memorandum Government Property Standard Launch 7th September 2022 Government Property Strategy 2022-2030 - GOV.UK (www.gov.uk) Government Asset Data Standard Launched Jan 2022 Government Function: Property - FMS 002: Asset Data (publishing.service.gov.uk) Government Facilities Management Standard Launched April 2022 Facilities Management Standard 001: Management and Services - GOV.UK (www.gov.uk)	
SH1	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH1	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH1	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH1	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH1	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH1	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH1	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH1	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
SH1	Capital cost to achieve compliance	£0	£0			
SH1	Revenue consequences of achieving compliance	£0	£0			
SH2	**SH2: With regard to the Design, Layout and Use of Premises [Functional suitability/Fitness for Purpose] can the organisation evidence the following in relation to functional suitability/?**	Applicable	Applicable	SH2: With regard to the Design, Layout and Use of Premises in relation to functional suitability can the organisation evidence the following? Critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs	1. Health and Social Care Act 2008 Regulations 14: and CQC guidance for providers on meeting the regulations - Regulations 10 and 15 (1) (c, d and f) 2. CQC guidance for providers on meeting the regulations - Regulations 10 and 15 (1) (c, d and f) 3. Land and property appraisal (2007 DH) 4. Equality Act 2010 5. 2010 to 2015 government policy: compassionate care in the NHS 6. Health Technical Memorandum 07-03 NHS Car parking management, environment and sustainability 7. Health Building Note 00-01 General design guidance for healthcare buildings 8. Health Building Note 00-08 Strategic framework for the efficient management of healthcare estates and facilities 9.. Health Building Note 00-02 Designing sanitary spaces 10. Building Regulations Parts M and K 11. Dementia design checklist 12. Health Building Note 08-02 Dementia friendly health and social care environments 13. NHSE Dementia assessment and improvement framework 14. Privacy and dignity report by the CNO into mixed sex accommodation in hospitals 15. Health Building Note 00-09 Infection control in the built environment 16. Secure by design 17. Net Zero Travel & Transport Strategy https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.england.nhs.uk/estates/other-guidance/ https://www.legislation.gov.uk/ukpga/2010/15/contents https://www.gov.uk/government/publications/2010-to-2015-government-policy-compassionate-care-in-the-nhs/2010-to-2015-government-policy-compassionate-care-in-the-nhs https://www.gov.uk/government/publications/nhs-car-parking-management-htm-07-03 https://www.england.nhs.uk/estates/health-building-notes/https://www.gov.uk/government/publications/guidance-on-the-design-and-layout-of-sanitary-spaces https://www.gov.uk/government/publications/consolidation-and-simplification-of-parts-m-k-and-n-of-the-building-regulations https://www.dementiaaction.org.uk/assets/0000/4336/dementia_friendly_environments_checklist.pdf https://www.england.nhs.uk/estates/health-building-notes/ https://improvement.nhs.uk/resources/dementia-assessment-and-improvement-framework/ NEW-Delivering_same_sex_accommodation_sep2019.pdf (england.nhs.uk) https://cfa.nhs.uk/resources/downloads/standards/Fraud_Standards_for_providers_2017-18.pdf https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment https://www.securedbydesign.com/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ For consideration: Protect legislation will be updated and released this year – Trusts should be prepared to self assess against threats of risk of your estate (i.e. minimising threats against the estate - reference 'Martins law' which is due to be released).	
SH2	**1. Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Estate strategy setting out current baseline, plans to address deficiencies including organisations risk management process/systems 4. Dementia strategy/policy 5. Privacy and dignity strategy/policy 6. Equality Act accessibility assessment 7. Local Authority approved travel plan 8. Security policy 9. Standard specification		
SH2	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. If technical expertise in-house - job descriptions, PDPs, TNA, training plans 5. If technical expertise outsourced - specification, qualifications and references. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandum's and other standards.		
SH2	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Six facet survey		
SH2	**4: Maintenance** Are relevant assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place;		
SH2	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. If technical expertise outsourced - appointment of qualified consultant or investment in training for staff in functional suitability issues (critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs) 4. If technical expertise in-house - PDP's, TNA, training plans, certificates of attendance/accreditation Purpose is to be able to identify levels of compliance to inform strategy/priority/investment		
SH2	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Plans in place if ward/unit is closed due to unacceptable levels of compliance - breech of 15 (1) (c, d and f) 6. Test reports/action plans 7. Escalation to relevant committees 8 Peer review outputs		
SH2	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Six facet survey; 4. Access audits; 5. Technical reports to cover critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs 6. Audit plan 7. Audit reports 8. Peer review output		
SH2	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
SH2	Capital cost to achieve compliance	£0	£0			
SH2	Revenue consequences of achieving compliance	£0	£0			
SH3	**SH3. With regard to Estates and Facilities Document Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers the coordination and control of the flow (storage, retrieval, processing, printing, copying, routing, distribution and disposal) of electronic and paper documents for Estates & Facilities documents in a secure and efficient manner.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 2. CQC Guidance for providers on meeting the regulations 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. BS EN 15221 Facilities Management 5. BS ISO 55000, 55001 & 55002: 2014 Asset Management 6. Quality Management System supported by the International Organisation for Standardisation ISO 9001 Quality Management System, or the current European Foundation for Quality Management (EFQM) Excellence Model criteria or equivalent. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://shop.bsigroup.com/ProductDetail?pid=000000000030206404 https://www.iso.org/standard/55088.html "https://www.iso.org/iso-9001-quality-management.html https://efqm.org/efqm-model/	
SH3	**1: Document Management System in Place** Does the Organisation have an effective and efficient document management system in place proportional to the level of complexity, hazards and risks concerned?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures		
SH3	**2: Approval of documents** Are documents approved for adequacy prior to issue?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH3	**3: Review of documents** Are documents reviewed and updated as necessary with changes identified?	3. Requires minimal improvement	3. Requires minimal improvement	1. Regular of policies and procedures to ensure implementation;		
SH3	**4: Availability of documents** Are all relevant versions of applicable documents available at points of use?	3. Requires minimal improvement	3. Requires minimal improvement	1. Review of document availability both in terms of policies/procedures as well as spot checks on availability;		
SH3	**5. Legibility of Documents** Are all relevant documents legible and readily identifiable?	Not applicable	Not applicable	1. Review of document availability both in terms of policies/procedures as well as spot checks on legibility;		
SH3	**6: Document Control** Are all internal and external documents identified and their distribution controlled?	3. Requires minimal improvement	3. Requires minimal improvement	1. Review of policies and procedures to ensure implementation;		
SH3	**7: Obsolescence** Is there a process to prevent the unintended use of obsolete documents and apply suitable identification to them if they are retained for any purpose?	4. Requires moderate improvement	4. Requires moderate improvement	1. Formal procedures in place to identify and replace obsolete documents; 2. Records of document replacement; 3. Review of documents replacement records to ensure completeness and accuracy;		
SH3	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
SH3	Capital cost to achieve compliance	£0	£0			
SH3	Revenue consequences of achieving compliance	£0	£0			
SH4	**SH4: With regard to Health & Safety at Work can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to overall H&S management. Most of the Safety SAQs will contain aspects of compliance with H&S legislation also e.g. risk assessments and COSHH assessments.	1. The Health and Safety at Work etc. Act 1974: The HSE with local authorities (and other enforcing authorities) is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment. 2. Management of Health and Safety at Work Regulations 1999 3. Leading health and safety at work: leadership actions for directors and board members INDG417(rev 1) - hse.gov.uk 4. Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended): Approved Code of Practice L186 - hse.gov.uk 5. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required. 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service. Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased. 7. CQC Provider Handbooks W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? 8.HBN 03-01 Adult mental health units: planning and design: https://www.england.nhs.uk/publication/adult-mental-health-units-planning-and-design-hbn-03-01/ 9.HBN 03-02 Facilities for child and adolescent mental health units: https://www.england.nhs.uk/publication/facilities-for-child-and-adolescent-mental-health-services-hbn-03-02/	
SH4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Evidence that H&S regulations are: - Understood by all teams involved - Applied by all teams involved - Systematically checked for compliance - Reported for exceptions 4. H&S Committee involvement - committee structure chart and terms of reference 5. Procedures to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities		
SH4	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:1. Adequate welfare facilities 4. COSHH assessments 5. Health and Safety audits / inspections (completed internal and examples of any external agency reports and associated action plans) 6. Plant and equipment are safe including maintenance, service and test reports 7. Safe arrangements for the use, handling, storage and transport of articles, materials and substances, 8. Safe access and egress.		
SH4	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Examples of completed risk assessments – including COSHH, DSE, stress etc.		
SH4	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records; 3. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports		
SH4	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. H&S information for staff 6. Copies of permits to work issued and documented procedures and training records for staff responsible for issue of permit to work 7. Copies of insurance and written schemes of inspection certificates 8. Evidence of compliance with all relevant published HBNs, CFPPs and Health technical Memorandum TMs 9. Meeting minutes 6. Documentation and procedures for Safe systems of work		
SH4	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	4. Requires moderate improvement	4. Requires moderate improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Incident reports and subsequence investigations including root cause analysis investigations 4. The ability to report on the regulatory requirements regarding safer wards (ligature). 5. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible rails/surface temperature) particularly when in relation to Mental health facilities and A&E wards.		
SH4	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
SH4	Capital cost to achieve compliance	£0	£0			
SH4	Revenue consequences of achieving compliance	£0	£0			
SH5	**SH5: With regard to Asbestos can the organisation evidence the following?**	Applicable	Applicable		1. Control of Asbestos Regulations 2012 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 3. CQC Guidance for providers on meeting the regulations 4. REACH (Registration, Evaluation, Authorisation and Restriction of Chemicals Regulations 2006). 5. HSE equipment and method series (em1 etc.) 6. HSE asbestos essentials task sheets (A1 etc.) https://www.legislation.gov.uk/uksi/2012/632/contents/made https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.hse.gov.uk/reach/ https://www.hse.gov.uk/pubns/guidance/emseries.htm https://www.hse.gov.uk/pubns/guidance/emseries.htm	
SH5	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Permits to work 4. Procedures to undertake work 5. Asbestos management plan 6. Asbestos register		
SH5	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Procedures to ensure staff and contractors have appropriate competencies, licences, professional indemnities and liability cover, also a record that these have been checked. 5. Permits to work 6. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards.		
SH5	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. A documented record of the location and condition of the asbestos containing materials - or materials which are presumed to contain asbestos. 5. Evidence of risk assessments relating to the potential exposure to fibres from the materials identified. 6. A plan that sets out in detail how the risks from these materials will be managed and how this has been actioned.		
SH5	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH5	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Evidence that reasonable steps have been taken to find out if there are materials containing asbestos in non-domestic premises, and if so, its amount, where it is and its condition. 6. Evidence that there is a period review of the plan and the arrangements in place to ensure that the plan remains relevant and up-to-date.		
SH5	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Evidence that information on the location and condition of the materials is provided to anyone who is liable to work on or disturb them 4. Active asbestos register 5. Significant findings from Authorising Engineer reports and action plans.		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH5	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH6	**SH6: With regard to Medical Gas Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum: 02-01: Medical gas pipeline systems 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 4. CQC Guidance for providers on meeting the regulations 5. CQC Provider Handbooks 6. Central Alert System - Organisations to familiarise themselves with this alert: https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103223 https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH6	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B. 2. The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system. 3. Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)		
SH6	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions. 3. Key relevant Objectives for the period:1. Permit to work 4. Approved persons 5. Authorised Persons 6. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards.		
SH6	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Organisation has a risk assessment as per section 6.6 of the HTM 02-01 3. Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the Health Technical Memorandum 02-01 (please indicated in the organisational evidence column the date of your last review)		
SH6	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B. 4. Are you sampling the air of the environment as minimum period at least annually. In relation to the frequency & sampling of the environment of nitrous oxide in the air are other considerations made, e.g., Seasonal impact, for example if the windows have been opened. 5. The organisation demonstrates compliance to COSHH, having a high level policy which outlines roles and responsibility and strategic documentation. 6. The organisation has proven testing methodology related to environmental sampling, seeking assurance of contracted laboratories upon their processes and any third party assurance of those laboratories, e.g., accreditation or certification		
SH6	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. The organisation has reviewed the skills and competencies of identified roles within the Health Technical Memorandum and has assurance of resilience for these functions; including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH6	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases; 2. The organisation has a clear escalation plan and processes for management of surge in oxygen demand either bulk or cylinder 3. Regular testing of Emergency response, business continuity plans and escalation plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH6	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports and action plans. 4. Audits to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities 5.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working		
SH6	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH7	**SH7: With regard to Natural Gas and specialist piped systems can the organisation evidence the following?**	Applicable	Applicable	See SAQ SH6 for Medical gas systems. This SAQ covers other gas installations and piped systems with specialist requirements such as high purity, compressed air negative pressure systems.	1. Gas Appliances (Safety) Regulations 1995 2. Gas Safety (Installations) & Use) Regulations 1998 3. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 5. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1995/1629/contents/made https://www.legislation.gov.uk/uksi/1998/2451/contents/made https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH7	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH7	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Approved persons, including employing a suitably qualified person where appropriate, i.e. "Gas Safe Registered" 5. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards. 6. Permit to work		
SH7	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH7	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH7	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH7	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH7	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Audits to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities 4. Quality Control Evidence 5.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working.		
SH7	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH8	**SH8: With regard to Water Safety Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 00: Policies and principles of healthcare engineering 2. Water Supply (Water Fittings) Regulations 1999 3. Defra's guidance to the Water Supply (Water Fittings) Regulations 4. HSE's Approved Code of Practice (ACoP) L8 (2013), HSG274 Parts 1, 2 and 3, Health Technical Memorandum 04-01: the control of legionella, hygiene, safe hot water, cold water and drinking water systems (Scheduled to be replaced in April 2016 by Health Technical Memorandum 04-01: Safe water in healthcare premises) 5. Notification of Cooling towers and Evaporative Condensers Regulations 1992 6. Health Technical Memorandum 04-01: Addendum Pseudomonas aeruginosa 7. Health Technical Memorandum 07-01: Water Management and Water Efficiency 8. Health Technical Memorandum 07-04: Water management and water efficiency – best practice advice for the healthcare sector 9. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 10. CQC Guidance for providers on meeting the regulations https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/uksi/1999/1148/contents/made https://www.legislation.gov.uk/uksi/1999/1148/contents/made https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/uksi/1992/2225/contents/made https://www.gov.uk/government/publications/hot-and-cold-water-supply-storage-and-distribution-systems-for-healthcare-premises https://www.gov.uk/government/publications/water-management-and-water-efficiency-best-practice-advice-for-the-healthcare-sector https://www.gov.uk/government/publications/water-management-and-water-efficiency-best-practice-advice-for-the-healthcare-sector https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH8	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Procedures to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities; 4. Water Safety Plans in place, including legionella written scheme 5. Action Plans, including their implementation 6. Control Measures and testing micro- organisms including Legionella and Pseudomonas 7. Organisations with boreholes must comply with the Private Water Supplies Regulations 2009		
SH8	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Water Safety Group with relevant advice and attendees		
SH8	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH8	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. HSE's Approved Code of Practice (ACoP) L8 (2013), HSG274 Parts 1, 2 and 3, Health Technical Memorandum 04-01: Safe Water in Health Care Premises		
SH8	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH8	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH8	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Reports to Infection Control Committee or other groups within the Governance Structure 4. Significant findings from Authorising Engineer reports and action plans. 5.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working		
SH8	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH9	**SH9: With regard to Electrical Systems can the organisation evidence the following?:**	Applicable	Applicable	This SAQ covers all aspects of electrical safety such as high and low voltage, switchgear, BMS, fire detection, communication, security, Lightening protection, PAT testing etc.	1. Electricity at Work Regulations 1989 (EAWR) 2. Electrical Equipment (safety) Regulations 1994 3. Electromagnetic Compatibility regulations 1992 4. Fuel and Electrical (Heating) (Control) (Amendment) Order 1980 5. Health Technical Memorandum 06-01: Electrical Services/Safety 6. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 7. Health Technical Memorandum 06-01: Electrical Services/Safety; 8. Health Technical Memorandum 06-02: Electrical Safety Guidance for Low Voltage Systems in healthcare premises 9. Health Technical Memorandum 06-03 Electrical safety guidance for high voltage systems in healthcare premises 10. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 11. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1989/635/contents/made https://www.legislation.gov.uk/uksi/1994/3260/contents/made https://www.legislation.gov.uk/uksi/1992/2372/contents/made https://www.legislation.gov.uk/uksi/1980/1013/made https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.gov.uk/government/publications/electrical-safety-guidance-for-high-voltage-systems-in-healthcare-premises https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH9	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of the policies and procedures through the ESG, or add separate bullet point for the ESG;		
SH9	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards and Authorised Persons appointed as recommended by Authorising Engineer.		
SH9	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. The Risk register should be developed and monitored by the ESG as per Health Technical Memorandum 06-01; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers;		
SH9	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Up to date asset register incorporated into CAFM system; 4. Quality control/Inspection records 5. Copies of test certificates/EC Declarations of Conformity 6. Records of inspections/thorough examinations 7. Written schemes of examination 8. Copies of insurance certificates/formal documentation from notified bodies		
SH9	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH9	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH9	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports;		
SH9	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH10	**SH10: With regard to Mechanical Systems and Equipment can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers work systems not included elsewhere e.g. space heating.(Equipment with a medical use is assessed under SH15). This also covers devices and equipment covered under LOLER and PUWER. Please use the guidance for further information (PUWER and LOLER) but some examples (not all) are: powered tugs and pallet trucks, temporary platforms, hop ups, fork lifts, cherry pickers, autoclaves, washer disinfectors, pneumatic tube systems, auto valets, lathes, presses, steam cleaners, diggers, tractors commercial lawn mowers.	1. Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) 2. Provision and Use of Work Equipment Regulations 1998 (PUWER) 3. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 5. CQC Guidance for providers on meeting the regulations https://www.hse.gov.uk/work-equipment-machinery/loler.htm https://www.hse.gov.uk/pubns/books/puwer.htm https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH10	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH10	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH10	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH10	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Copies of test certificates/EC Declarations of Conformity 5. Records of inspections/thorough examinations 6. Copies of insurance certificates/formal documentation from notified bodies 7. Written schemes of examination		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)

◄◄ Back to instructions

The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***

Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH10	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH10	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH10	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH10	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH11	**SH11: With regard to Ventilation, Air Conditioning and Refrigeration Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 03-01: Specialist Ventilation for Healthcare Premises 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 4. CQC Guidance for providers on meeting the regulations https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH11	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH11	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH11	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH11	**4: Maintenance** Are assets, equipment and plant adequately maintained?	4. Requires moderate improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Health Technical Memorandum 03-01 part B recommends: a. All ventilation plant should meet a minimum requirement in terms of the control of Legionella and safe access for inspection and maintenance. b. All ventilation plant should be inspected annually. c. The performance of all critical ventilation systems (such as those servicing operating suites) should be verified annually		
SH11	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH11	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH11	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports;		
SH11	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH12	**SH12: With regard to Lifts, Hoists and Conveyance Systems can the organisation evidence the following?**	Applicable	Applicable	Medical hoists and lifts are covered under SH15 Medical Devices and Equipment.	1. Lifts Regulations 1997 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health Technical Memorandum 08-02: Design and maintenance of lifts in the health sector - Lifts 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 5. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1997/831/contents/made https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.gov.uk/government/publications/guidance-concerning-the-planning-installation-and-operation-of-lifts-in-healthcare-buildings https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH12	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH12	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH12	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH12	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH12	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH12	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH12	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports;		
SH12	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH13	**SH13: With regard to Pressure Systems can the organisation evidence the following?**	Applicable	Applicable	Users can assess the specific requirements around Pressure Systems in this SAQ or within relevant SAQ with pressure systems e.g. medical gases. The approach used should be explained in the notes column.	1. Simple Pressure Vessels (Safety) Regulations 1991 2. Pressure Systems Safety Regulations 2000 (PSSR) 3. Pressure Equipment Regulations 1999 4. HSE Guidance Note PM5 1989 Automatically Controlled steam and hot water boilers now Safe Management of Industrial Steam and Hot Water Boilers HSE INDG436 2011 5. ACoP L122 Safety of Pressure Systems 6. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 8. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1991/2749/contents/made https://www.legislation.gov.uk/uksi/2000/128/contents/made https://www.legislation.gov.uk/uksi/1999/2001/contents/made https://www.hse.gov.uk/research/hsl_pdf/2005/cl05-11.pdf https://www.hse.gov.uk/pubns/books/l122.htm#:~:text=The%20Pressure%20Systems%20Safety%20Regulations,one%20of%20its%20component%20parts. https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH13	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH13	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH13	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH13	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH13	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH13	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH13	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH13	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH14	**SH14: With regard to Fire Safety can the organisation evidence the following?**	Applicable	Applicable	This SAQ assesses Fire Safety in its entirety including detection and alarm systems, sprinkler/water mist systems, fire damper operation etc. There may be some overlap with other SAQs, e.g. SH9 and SH11 that can be cross referred to avoid duplication	1. Regulatory Reform (Fire Safety) Order 2005 2. Management of Health and Safety at Work and Fire Precautions (Workplace) (Amendment) Regulations 2003 3. The Fire and Rescue Services Act 2004 4. Health and Safety (Training for Employment) Regulations 1990 5. Health and Safety at Work Act 1974 6. Management of Health and Safety at Work Regulations 1999 7. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 8. Safety Representatives and Safety Committees Regulations 1977 9. Building Regulations 2010 10. The Housing Act 2004 11. Health Technical Memorandum 05-01: Managing Healthcare Fire Safety 12. Health Technical Memorandum 05-02 Guidance in Support of Functional Provisions for Healthcare Premises 13. Health Technical Memorandum 05-03 Fire safety - Operational Provisions 14. HM Government – fire safety risk assessment: 'Means of Escape for Disabled People' 15. HM Government – fire safety risk assessment: 'Healthcare premises' 16. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 17. CQC Guidance for providers on meeting the regulations 18. Approved document B to the building regulations volume B2 19. Equality Act 2010 20. Regulation 38 – operating within the building on Fire Safety. 21.Estates Technical Bulletin - Risks of electrical batteries for the NHS estate 22. Building safety Act 2022 - https://www.legislation.gov.uk/ukpga/2022/30/contents/enacted https://www.legislation.gov.uk/uksi/2005/1541/contents/made https://www.legislation.gov.uk/uksi/2003/2457/contents/made https://www.legislation.gov.uk/ukpga/2004/21/pdfs/ukpga_20040021_en.pdf https://www.legislation.gov.uk/uksi/1990/1380/contents/made https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1995/3163/contents/made https://www.legislation.gov.uk/uksi/1977/500/contents/made https://www.legislation.gov.uk/uksi/2010/2214/contents/made https://www.legislation.gov.uk/ukpga/2004/34/contents https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.gov.uk/government/publications/fire-safety-risk-assessment-means-of-escape-for-disabled-people https://www.gov.uk/government/publications/fire-safety-risk-assessment-healthcare-premises https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1124736/Approved_Document_B__fire_safety__volume_2_-_Buildings_other_than_dwellings__2019_edition_incorporating_2020_and_2022_amendments.pdf https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.legislation.gov.uk%2Fuksi%2F2010%2F2214%2Fregulation%2F38%2Fmade&data=05%7C01%7Chayley.morris10%40nhs.net%7Cb384c2045c7e4f5597d808dbd3dc5eeb%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638336715661538052%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=2ovEsNorYbcyBWuK6wPkE4ZS8OzQ7hqQFjSxDfkW1Tk%3D&reserved=0 https://www.england.nhs.uk/long-read/nhs-estates-technical-bulletin-netb-risks-of-electrical-batteries-for-the-nhs-estate/ For consideration to relevant Trusts Building Safety Act 22	
SH14	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of protocols and procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site aligned to guidance; 2. Regular assessment of policies and procedures; 3. Local operating procedures in place including such items as contractors working on fire compartments		
SH14	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people, in compliance with relevant legislation and published guidance, with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH14	**3. Governance** Are there regular meetings of the fire safety committee, is there an external annual report by the authorising engineer (fire) is there an annual internal report to the Board	3. Requires minimal improvement	2. Good	1. Minutes of committee meetings 2. Annual AE report 3.Annual internal report		
SH14	**4. Enforcement** Has there been any enforcement of the fire safety order, either under articles 29, 30 and 31 of the fire safety order (alterations, enforcement or prohibition notice) or informal (notification of deficiencies) where no enforcement notices have been received, this should be scored as good.	2. Good	2. Good	1. Copies of FSO notices 2. Copies of notification of deficiencies		
SH14	**5: Risk Assessment** Have all areas of the premises had a fire risk assessment undertaken and regularly reviewed and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers where appropriate; 4. Fire Risk Assessments 5. Fire Safety Plans and Reviews 6. Compartmentalization drawings showing fire compartments and fire dampers		
SH14	**6 Maintenance** Are assets, equipment and plant necessary for fire safety maintained in an efficient state, efficient working order and good repair? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Risk based evidence backed planned preventative maintenance system in place e.g. fire alarm systems, fire doors, fire compartmentation, fire dampers, fire extinguishers; 3. Risk based methodology, quality control/Inspection records		
SH14	**7 Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records, incorporating specific evacuation training for staff with patient contact and evidence of this training.		
SH14	**8: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Plans for fire alarm mitigation in cases of system failure 6. Reduction of unwanted fire signals (both false alarms and spurious calls on the fire and rescue authority)		
SH14	**9: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures? (Note 1) Is the annual audit of fire safety and fire safety management undertaken, and the outcomes communicated to the Trust Board as outlined in HTM 05-01 section 7.14?	3. Requires minimal improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports; 4. Fire service audits; 5. Evacuation tests; 6. Fire risk assessment review frequency aligned to legislative requirements and risk.		
SH14	**10. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below .	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH15	**SH15: With regard to Medical Devices and Equipment can the organisation evidence the following?**	Applicable	Applicable	Decontamination is covered under SAQ SS1	1. Provision and Use of Work Equipment Regulations 1998 2. ACoP 22 Safe Use of work Equipment. 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. Medicines and Healthcare Products Regulatory Agency (MHRA) Guidance 5. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 6. CQC Guidance for providers on meeting the regulations https://www.hse.gov.uk/pubns/books/puwer.htm https://www.hse.gov.uk/pubns/books/l22.htm https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH15	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH15	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH15	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	4. Requires moderate improvement	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH15	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH15	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH15	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH15	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH15	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH16	**SH16: With regard to Resilience, Emergency and Business Continuity Planning can the organisation evidence the following?**	Applicable	Applicable	This SAQ looks at the overall approach to resilience, emergency and business continuity planning. This is in relation to estates and facilities	1. Civil Contingencies Act 2004 2. NHS Standard Contract; 3. Health Building note 00-07:Resilience planning for NHS facilities 30 April 2014: Guidance 4. NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework and Associated Guidance 5. ISO 22301:2014 'Business Continuity Management Systems' 6. ISO 22313:2012 'Business Continuity management Systems Guidance'. 7. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/2004/36/contents https://www.england.nhs.uk/nhs-standard-contract/ https://www.gov.uk/government/publications/resilience-planning-for-nhs-facilities https://www.england.nhs.uk/wp-content/uploads/2017/12/eprr-guidance-chart-v3.pdf https://shop.bsigroup.com/ProductDetail/?pid=000000000030292502 https://www.iso.org/standard/75107.html https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH16	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301; 2. The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board;		
SH16	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. The organisation's Estates and Facilities team is appropriately represented at the organisation's committee(s) which oversee Business Continuity and/or Emergency Preparedness; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH16	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH16	**4: Maintenance** Are assets, equipment and plant adequately maintained?	4. Requires moderate improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH16	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH16	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s); 2. Outputs of reviews and their inclusion in Action Plans;		
SH16	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH17	**SH17: With regard to the reporting of safety related issues and actioning of safety related alerts for estates and facilities issues can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to: 1. Reporting safety related incidents and accidents, 2. Ensuring corrective action is taken where notified in E&F safety alert system and similar.	1. National Framework for Reporting and Learning from Serious Incidents Requiring Investigation 2. Regulation 16 and 18 of the Care Quality Commission (Registration) Regulations 2009 3. Department of Health Never Events Policy Framework 4. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 5. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 6. CQC Guidance for providers on meeting the regulations 7.. Health and Care Act 2022 https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf https://www.cqc.org.uk/files/care-quality-commission-registration-regulations-2009 https://www.england.nhs.uk/patient-safety/revised-never-events-policy-and-framework/ https://www.hse.gov.uk/riddor/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH17	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH17	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Embedding bulletins into practice		
SH17	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH17	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	Not applicable	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH17	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH17	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Incident reports 4. Investigations		
SH17	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH18	**SH18: With regard to ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services can the organisation evidence the following?**	Applicable	Applicable	This SAQ mainly refers to ensuring rented (or similar) premises and related services are safe and suitable. Outsourced services will generally be considered under the relevant SAQ and Contractor management SH16. See the NHS PAM guidance for details on the PAM assessment for multiple small sites.	1. Health and Safety at Work Act 1974 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 3. CQC Guidance for providers on meeting the regulation 4. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH18	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	5. Inadequate	5. Inadequate	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH18	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)	5. Inadequate	5. Inadequate	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH18	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	5. Inadequate	5. Inadequate	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4.. A fire safety risk assessment has been undertaken and that a practice fire evacuation of the building has been undertaken		
SH18	**4: Maintenance** Are assets, equipment and plant adequately maintained?	5. Inadequate	5. Inadequate	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH18	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	5. Inadequate	5. Inadequate	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH18	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	5. Inadequate	5. Inadequate	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans;		
SH18	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	5. Inadequate	5. Inadequate	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Safe systems in place for electrical safety to include Portable Appliance Testing (PAT) testing 4. Control of Substances Hazardous to Health (COSHH) assessment has been undertaken and documented 5. Adequate security of the premises, e.g., panic alarms in the consulting rooms 6. A safe and effective system for storage of all waste 7. All staff are aware of their roles and responsibilities in the event of an emergency		
SH18	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH19	**SH19: With regard to Contractor Management for Soft and Hard FM services can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers using E&F contractors for a full range of services from maintenance and servicing to major construction, **both Hard and Soft FM**. It is about ensuring: competent contractors are appointed, adequately informed, instructed and trained, managed and supervised, co-ordinated and co-operate.	1. Health and Safety at Work etc. Act 1974 2. Construction (Design and Management) Regulations 3. HSE INDG368 4. Management of Health and Safety at Work Regulations 5. Legislation relevant to the service provided, as detailed in relevant SAQs. 6. Building Regulations 7. Planning Legislation including listed building consents 8. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 9. CQC Guidance for providers on meeting the regulations 10. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.hse.gov.uk/construction/cdm/2015/index.htm https://www.hse.gov.uk/pubns/indg368.htm https://www.legislation.gov.uk/uksi/1999/3242/contents/made Planning (Listed Buildings and Conservation Areas) Act 1990 (legislation.gov.uk) https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH19	**1: Policy** Does the organisation have a current and approved policy and if applicable, a set of underpinning set of procedures relating to contractor management.	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Preventative/corrective strategies; demonstration of documented process and procedure whereby non-compliance is identified and remediation strategies are developed and delivered.		
SH19	**2: Roles and Responsibilities** Does the Organisation have sufficient and appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood who are responsible for the management of contractors? Is there a named SRO and Trust representative for major contracts including PFI.	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH19	**3. Contract expiry** Does the Trust understand requirements and notice periods in respect of the expiry of major contracts (major or complex and whole contract period of £5mil or over) such as PFI and have plans in place to manage these and the transition of services.	2. Good	2. Good	1. Documented end dates for contracts and contractual requirements		
SH19	**4: Risk Assessment** Are contractors risk assessments and if applicable, method statements (RAMS) requested from the contractor(s) prior to works commencing and reviewed for their appropriateness?	3. Requires minimal improvement	3. Requires minimal improvement	1. Agreed allocation of risk is monitored; 2. Risks reviewed and included in local risk register; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers;		
SH19	**5: Maintenance** Does the organisation hold the necessary proof to demonstrate consistent contractor maintenance activities - for its contracted services.	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Documented evidence of audits and reviews to support compliance. 5. Auditing and inspecting the Contractors' work, ensuring that they comply with the contractual requirements on quality, Health and Safety, environmental and legislative requirements. 6. Managing communication between the Contracting Body and the Sub-Contractors;		
SH19	**6. Contractor Competence** With regards to the competence of the contractors - has the organisation checked that contractors are using suitably competent persons to carry out the contracted services?	3. Requires minimal improvement	3. Requires minimal improvement	1. Adequate insurance. 2. Performance monitoring against agreed Key Performance Indicators. 3. Evidence of professional qualifications and experience;		
SH19	**7: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Supplier Business Continuity and Disaster Recovery Plan.		
SH19	**8: Review Process** Is there a robust regular review process in place to manage the performance of contractors ensuring compliance to the agreed contract, relevant standards, policies and procedures?	3. Requires minimal improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Receiving, checking and authorising invoices for payment for additional services; 4. Monitoring Contractors' approach to rectifying defects; 5. Problem solving and dispute (prevention and) resolution where issues exist. 6. Establish and maintain appropriate records and information management systems to record and manage the performance of the Sub-Contractors;		
SH19	**9: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
SH20	**SH20: With regard to Mortuaries can the organisation evidence the following?** **Is your organisation responsible for the running or maintenance of one or more mortuaries? This includes Mortuaries in PFI or other out-sourced regimes.**	Not applicable	Not applicable	This SAQ relates to the overall management of the E&F function and how specific technical areas (covered by separate SAQs) are managed, reported, escalated and reviewed in a consistent way. If the answer to this question is "NA", the remainder of this SAQ does not need to be completed.	05/06/25: MG nil return as SAQ issued too late by NHSE.
SH20	**1: Policy & Procedures** The organisation has Policies and Procedures in place to deliver the requirements of HBN 16 01, including plans agreed with partner organisations to respond to "Excess death events" and "mass fatality events.	Not applicable		1. Policy and procedures relevant to Mortuary services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
SH20	**2: Security** For all mortuary and post-mortem facilities, are: • All parts of the facility that are only used during the day protected out of hours by an intruder alarm system, to either BS 4737 or BS EN 50518 as appropriate. • All points of ingress and egress from the facility, including body storage and receiving areas, even if temporary, covered by high-definition CCTVs. These should be equipped with a pan and tilt facility and be capable of producing high-quality images in low levels of light. Positioning of cameras should be determined with care, selecting optimum positioning for maximum field of coverage. Monitors should be sited at a location that is permanently staffed whilst the facility is in use. • All entrances, work areas and other sensitive spaces should be protected wherever possible by passive security, plus one of the variety of electronic access control systems available. • Visitors and funeral directors only gain access to the mortuary after operating an audio/video intercom at the appropriate entrance. • All CCTV provided in mortuary facilities capable of being isolated if required.	Not applicable		1. Risk assessment of Mortuary security. 2. Design and approval of Mortuary security system, including procedures for us and maintenance.	
SH20	**3. Funeral Directors** Agreed plans and protocols are in place to work with funeral directors to ensure a timely turnaround of the deceased and also to establish protocols including for remote sites.	Not applicable		1. Authorised plans and protocols agreed by all Funeral Directors using the Mortuary.	
SH20	**4. HTA (Human Tissue Authority)** Do all of the organisations meet the Human Tissue Authority (HTA) regulatory standards and professional guidance for mortuaries requiring licensing by the HTA. Where HTA licenses do not apply to a facility, do they meet their standards and guidance?	Not applicable		1. Copies of HTA licenses.	
SH20	**5. Existing facilities** Where facilities do not currently meet the appropriate standards and guidance, are plans in place for them to be upgraded? Is this upgraded funded?"	Not applicable		1. Analysis of current situation and future plans agreed by the Board.	
SH20	**6. Future demand** Does the organisations long-term permanent storage meet their forecasts for predictable peaks in a resilient manner?	Not applicable		1. Analysis of current situation and future plans agreed by the Board.	
SH20	**7. Body transfer for Post Mortems (PMs)** Are protocols in place to ensure all bodies from non HTA licensed facilities are transferred to licensed facilities within seven days where a post mortem is required.	Not applicable		1. Copies of Body transfer protocols.	

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM) ◄◄ Back to instructions	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH20	**8. Entrances & Location** Do all the facilities used by the organisations for body storages provide: • A dedicated entrance into the mortuary for the deceased which is not shared with visitors; • A staff entry either combined with the visitors' entrance or deceased entrance for smaller facilities (depending on the size of the facility, staff numbers and operational model); • For larger facilities separate entrances, creating a more serene ambience for bereaved visitors; • Entrances not in close proximity to each other, and the entrance for the deceased should not be seen from the visitors' entrance.	Not applicable		1. Policy and procedures relevant to Mortuary services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH20	**9. Care, safety and security** Are all entry points at all facilities always: • Controlled by staff, for example through video/audio intercoms • Access-controlled through a digital system for staff, for example swipe card, fob or other intelligent solution, with visitors escorted when in the facility • Providing mortuary and other NHS Trust managers with the ability to regularly audit matters such as access arrangements, CCTV and trends. • Have active surveillance of each entrance and the body store area provided both within the mortuary facility and to an appropriate, constantly staffed area, for example a Trust security hub. Such equipment should be located so as to comply with data protection legislation. In addition, can the active surveillance measures be isolated and turned off in cases of extreme public interest.	Not applicable		1. Policy and procedures relevant to Mortuary services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH20	**10. Waste management** In all mortuaries and post-mortem facilities, are: • A sluice or sluices for material suitable for direct discharge to drains provided, subject to the consent of the appropriate water authority ; • Adequate secure storage and ventilation of no fewer than six air changes per hour for material in bags, packages or drums awaiting removal for appropriate treatment and disposal; • Direct access to a disposal hold for waste produced during procedures.	Not applicable		1. Trust Waste plan.		
SH20	**11. Body storage & delivery point** For all rooms where bodies are stored: • Are storage temperatures in line with the following requirements: - refrigerated storage should be 4–6°C for storage of less than 30 days or necessary to preserve the body's integrity - freezer storage should be at –20°C if stored for over 30 days (or sooner – depending on the condition of the body). • Are all the above fridges and freezers continuously monitored, with alarms located locally within the mortuary and these alarms linked to the estates and/or switchboard function to allow for 24/7 observation. • Are appropriate "cold store rooms" provided for people with excess weight who exceed normal expectations, to remain on trolleys in order to minimise unnecessary handling of the bodies.	Not applicable		1. Protocols for the regular measurement of body store temperatures including methodology for doing so and how records and reviewed and checked.		
SH20	**12. PM with forensics** For post-mortem room designated or used for criminal forensic examinations, are the following facilities provided: • An observation room, with two-way audio/visual communication • Audiovisual recording and two-way communication to a large meeting • Additional office accommodation/hot desks for other agencies • An additional area around the postmortem table for additional staff and equipment • Ceiling mounted white screens for photography • UV light and blackout screens for DNA work • Additional and secure storage for items such as evidence or equipment	Not applicable		1. Policy and procedures relevant to Mortuary services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH20	**13. Waste disposal room** For all facilities: • Are policies in place for the safe disposal of used items in accordance with current legislation and NHS guidance, for example COSHH and HTM 07-01 – 'Safe and sustainable management of healthcare waste'. • Is a secured waste disposal room provided, with adequate space for the temporary storage of securely packed, segregated, recycled refuse and dirty linen bags (appropriately colour-coded, labelled and carrying identifiable location source tags), with easy access from both the dirty utility room and externally, for their collection by the waste management company. If the waste disposal room is located directly off the post-mortem room, is: • Waste and dirty linen generated in the post-mortem suite placed in the correct container or bag, complete with identification labels and source tags, within the post-mortem suite before being deposited in the disposal hold • Air movement controlled in the whole post-mortem suite • Entry controlled to the post-mortem suite and mortuary, and the means by which unauthorised movement is prevented. • Disposal areas organised so that clinical waste, linen and domestic waste are not mixed together, including waste recycling segregation prior to collection.	Not applicable		1. Trust Waste plan.		
SH20	**14: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable				
SH20	Capital cost to achieve compliance	£0	£0			
SH20	Revenue consequences of achieving compliance	£0	£0			
SH21	**SH21:The built environment: Reducing harm by ligature in practice.With regards to self-harm risks associated with the built environment, can the organisation evidence that they have taken consideration for the following:**	Applicable	Applicable			
SH21	**1: Policy** The Trust has a policy in place which specifically relates to ligature and can evidence it is being followed in line with the CQC guidance?	3. Requires minimal improvement	5. Inadequate			
SH21	**2: Roles and Responsibilities** The trust has reviewed and specified the key roles, responsibilities and competencies for those who are accountable for safety covering ligature assessments?	4. Requires moderate improvement	4. Requires moderate improvement			
SH21	**3: Risk Assessment** Has a full risk assessment been completed	4. Requires moderate improvement	4. Requires moderate improvement			
SH21	**4: Maintenance** Does the organisation hold the necessary proof to demonstrate consistent contractor maintenance activities - for its contracted services.	5. Inadequate	5. Inadequate			
SH21	**5: Contractor Compliance** Where contractors are used for fixture and fittings they should be adequately qualified to ensure the specific ligature risks have been identified if applicable	4. Requires moderate improvement	4. Requires moderate improvement			
SH21	**6: Review Process** Is there a robust, regular review process in place to manage the performance of contractors ensuring compliance to the agreed contract, relevant standards, policies and procedures?	4. Requires moderate improvement	4. Requires moderate improvement			
SH21	**7: Costed Action Plans If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.**	Not applicable	Not applicable			
SH21	Capital cost to achieve compliance	£0	£0			
SH21	Revenue consequences of achieving compliance	£0	£0			
SH22	**SH22:Estates IT and Building Information Management (BIM) systems** **Please confirm you have a plan for your trusts to engage with their current providers of telecoms services who will be able to assist them in identifying their Public Switch Telephone Network services. Once this has been completed, trusts need decide how best these services should be replaced or removed.** **The systems that need to be considered include:** **• Plant alarms;** **• Staff Attack Systems;** **• Security Alarms;** **• Lockdown/Access Control intercoms;** **• Car Park Barriers;** **• Catering freezers & fridges;** **• Pathology & Blood freezers and fridges;** **• Fire alarm auto dial;** **• Lift emergency calls;** **• Building Management Systems (BMS) alarms (oxygen, gas shut out, fuel alarms (leak and level), ventilation, generator etc);** **• Fax machines;** **• Credit card terminals.** **The PSTN situation is discussed at your Local Resilience Forums (LRF) and therefore we suggest you link with your Trust EPRR lead who will be able to assist with the wider work being undertaken by LRF partners, to identify any potential interdependencies within your Trust.**	Applicable	Not applicable	Please note this question was previously SS10 and has now been moved under Safety hard as SH22	05/06/25: MG nil return as SAQ issued too late by NHSE. 1 .Public Health Act 1961 2. Health and Safety at Work Act 1974 3. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/ukpga/Eliz2/9-10/64/contents https://www.legislation.gov.uk/ukpga/1974/40 https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH22	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	Not applicable	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH22	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	Not applicable	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SH22	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	Not applicable	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH22	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	Not applicable	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH22	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	Not applicable	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Process for monitoring operators handling of calls for quality purposes		
SH22	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	Not applicable	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Business continuity procedures in place in case of fire or other emergency to maintain service including standby operating facilities located on individual sites 6. Loss of service plans including bleeps and mobile phones. 7. Robust call out procedures tested over all sites monthly with table top exercises.		
SH22	**7. Technology replacement plan & Review process** Is there a technology migration plan in place for removal of service/infrastructure reliance on PSTN and ISDN by January 2027? When answering this sub-question, "Not Applicable" should only apply where no PSTN connections have ever existed within your organisation. If you have completed migration, please use "Outstanding".	2. Good	Not applicable	1. Identified services reliant on PSTN within your organisation? 2. Have an appropriate replacement solution identified with your provider that ensures continuity of service? 3. Is there a plan in place with your provider to migrate services away from PSTN? 4. Has the identified plan been executed to migrate services to replacement solution? 5 Annual reviews of standards, policies and procedures documented; 6 Outputs of reviews and their inclusion in Action Plans; 7. KPIs on performance including call pick up times		
SH22	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
SH22	Capital cost to achieve compliance	£0	£0			
SH22	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Safety Domain (Soft FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS1	**SS1: With regard to Catering Services can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers the safety aspects of catering and food with SAQ PE4 looking at patient feedback on food. Note: This applies to all food sources on-site including commercial and charitable outlets.		
SS1	**1: Policy & Procedures** Does the Organisation have a current, approved Policy, Food Safety Management System and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS1	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS1	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? Has the organisation documented all processes and procedures in an approved HACCP document?	2. Good	2. Good	1. Food Standards Agency ratings and Nonmental Health Officer reports. 2. Risks reviewed and included in local risk register; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers; 5. Nutritional screening programme identifying patients at risk from malnutrition and dehydration. 6. Allergens screening		
SS1	**4: Maintenance** Are assets, equipment and plant adequately maintained, regularly and monitored to ensure equipment relating to temperature control is functioning correctly?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS1	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements including level 2 hygiene for all food handlers and HACCP at the appropriate level for supervisors and Managers?	4. Requires moderate improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS1	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS1	**7: Review Process** Is there a robust regular review process to assure compliance and effectiveness of relevant standards, policies and procedures which includes sampling and testing where required?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS1	8. **Food Standards (No.1)** Organisations should have a designated board director responsible for food (nutrition and safety) and report on compliance with the healthcare food and drink standards at board level as a standing agenda item.	4. Requires moderate improvement	2. Good	1. Documented and readily available		
SS1	9. **Food Standards (No.2)** Organisations should have a food and drink strategy.	4. Requires moderate improvement	4. Requires moderate improvement	1. Documented and readily available		
SS1	10. **Food Standards (No.3)** Organisations should consider the level of input from a named food service dietitian to ensure choices are appropriate.	3. Requires minimal improvement	3. Requires minimal improvement	1. Documented and readily available 2. Minutes of nutritional steering group available 3. Name and details of dietitian from contacts page 4. Documented evidence of dietitian involvement in menu engineering		
SS1	11. **Food standards (No. 4)** Organisations should nominate a food safety specialist and this person should chair a food safety group	2. Good	2. Good	1. Documented and readily available 2. Minutes of food safety group available 3. Evidence of food safety audit management and safety system .4 A food safety group, to include relevant leads should be set up, this should also pick up outcomes from environmental health inspections. 5.Mandatory training should include an appropriate level of food hygiene training for all employees working with and serving food, this should be completed at least once every 3 years.		
SS1	12. **Food Standards (No.5)** Organisations invest in a high calibre workforce, improved staffing and recognise the complex knowledge and skills required by chefs and food service teams in the provision of safe food and drink services, including training report, matrices or other evidence of chef, catering and nurse training including L2 food safety.	3. Requires minimal improvement	3. Requires minimal improvement	1. Documented and readily available training matrices' and training programme 2. available on ESR		
SS1	13 **Food Standards (No.6)** Organisations are able to demonstrate that they have an established training matrix and a learning and development programme for all staff involved in healthcare food and drink services.	3. Requires minimal improvement	3. Requires minimal improvement	1. Documented and readily available training matrices' and training programme 2. available on ESR		

1. Food Hygiene (England) Regulations 2006.
2. Control of Substances Hazardous to Health 2002
3.Food Safety Act 1990.(Amended Regulations 2004)
4. HSG (96) 20 -Management of Food Hygiene & Food Services in the National Health Service.
5. NHS Code of Practice for the manufacture, distribution and supply of food, ingredients and food related products.
6. Regulation EC 852/2004 on the hygiene of foodstuffs.
7. Food Service at Ward Level with Healthcare food and Beverage Service Standards – a guide to ward level services – 2007
8. Compliance with Healthcare Commission Core Standard 14 (Food)
9. Health Act 2006 Code of Practice for Prevention and Control of Health Care Associated Infections (Department of Health 2006) revised January 2008
10. Food Safety(England) Regulations 2005
11. Food Safety (Temperature Control) Regulations 1995
12..CQC Guidance for providers on meeting the regulations
13. Fire Hazards have been considered for any catering service
14. NHS 10 Key Characteristics of Good Nutrition and Hydration
15. British Dietetic Association's Nutrition and Hydration Digest
16. British Dietetic Association guidelines
17. The MUST Toolkit (Malnutrition Universal Screening Tool)
18. National standards for healthcare food and drink
19. Food Review

.https://www.legislation.gov.uk/uksi/2006/14/contents/made
https://www.hse.gov.uk/coshh/
https://www.legislation.gov.uk/uksi/2004/2990/contents/made
https://www.legislation.gov.uk/eur/2004/852/contents
https://www.cqc.org.uk/guidance-providers/regulationsenforcement/regulation-14-meeting-nutritional-hydration-needs
https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance
https://www.legislation.gov.uk/uksi/2005/2059/contents/made
https://www.legislation.gov.uk/uksi/1995/2200/contents/made
https://www.cqc.org.uk/guidance-providers/regulations
https://www.england.nhs.uk/estates/health-technical-memoranda/
https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics/
https://www.bda.uk.com/specialist-groups-and-branches/food-services-specialist-group/nutrition-and-hydration-digest.html
https://www.bda.uk.com/professional/practice/practice_guidance/home
https://www.bapen.org.uk/screening-and-must/must/must-toolkit/the-must-itself
https://www.bapen.org.uk/must-and-self-screening/must-toolkit/
https://www.england.nhs.uk/long-read/national-standards-for-healthcare-food-and-drink/
.https://www.gov.uk/government/publications/independent-review-of-nhs-hospital-food

Guidance for Food Standard no 8. - If patient/staff/visitors are not present 24/7, approach this question as having a food provision for 100% of the time they are on site.
If the type of food service is not present within your trust, put not applicable, however you cannot put not applicable for all 7 Food Standard No. 8 questions as you should be working to provide a 24/7 offering for your staff of one of these types of food service
If your trust operates 24/7 services but the food provision operates only daytime hours, the maximum score should be requires minimal improvement

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Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
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SS1	14.**Food Standards (No. 7)** Organisations are able to monitor, manage and actively reduce their food waste from production waste, plate waste and unserved meals, a full waste strategy including food waste	2. Good	2. Good	1. Documented and readily available 2. Evidence provided of involvement of waste management measurements and systems 3. Evidence food is included within waste management strategy 4. Completed ERIC return inline with this		
SS1	15.**Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a 24 hour restaurant.	2. Good	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**16.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a 24 hour café	2. Good	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**17.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a hot vending services.	2. Good	3. Requires minimal improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**18.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have retail services	3. Requires minimal improvement	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**19.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have cold vending	2. Good	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**20.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have smart fridges	2. Good	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**21.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have staff provision for storage and heating of food brought from home.	2. Good	3. Requires minimal improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**22: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS2	**SS2: With regard to Decontamination Processes can the organisation evidence the following?**	Applicable	**Not applicable**	Management, operation and maintenance of decontamination equipment and processes covering the decontamination of surgical equipment, linen, dental equipment and flexible endoscopes. As set out in the HTM 01 Suite 01-06		
SS2	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	Not applicable	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Quality manual and supporting processes.		
SS2	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	Not applicable	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. Trust management structure for decontamination 5. Appointment letter for AE, job descriptions e.g. decontamination lead, SSD manager, Endoscopy Unit decontamination team 6. Appointment letter for AP(D) 7. Evidence of employing appropriately qualified experienced people in key roles as identified in the HTMs and other standards.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations15(1) All premises and equipment used by the service provider must be—15(1)(d) properly used,15(1)(e) properly maintained 2. CQC Guidance for providers on meeting the regulations15(1) All premises and equipment used by the service provider must be—15(1)(d) properly used,15(1)(e) properly maintained, and 3. Health Technical Memorandum01-01A, B, C, D, E 4. Health Technical Memorandum01-04A 5. Health Technical Memorandum01-05 6. Health Technical Memorandum01-06A, B, C, D, E; 7. ISO 9001 8. ISO13485 9. Estate/MHRA alerts 10. Medical Devices Directive. 11. Revision to the Medical Devices Directive. 12. CQC Guidance about compliance. - Guidance about compliance Essential standards of quality and safety 13. GS1 coding. 14. NHS Operating Framework 15. Medical Devices Regulations (MDR) 2002. 16. BS EN ISO 13485.	
SS2	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	Not applicable	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		

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SS2	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	Not applicable	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Validation reports for washer disinfectors and drying cabinets. 5. Permits to work for service engineers. Service contracts. PPM dockets and maintenance instructions 6. Permit to work system	17. Executive Letter EL(98)5. 18. Decontamination Services Agreement. 19. In-vitro Diagnostic Devices Directive. 20. Kirby, E., Dickinson, J., Vassey, M., Dennis, M., Cornwall, M., Mcleod N. et al. (2012). Bioassay stunnex L. 21. IHEEM AE(D) register. 22. Institute of Decontamination Sciences (IDSc). 23. Institute of Healthcare Engineering and Estate Management (IHEEM). 24. ESAC-Pr report. 25. MHRA's 'Managing medical devices: guidance for healthcare and social services organisations' 26. MHRA 'Medical devices: conformity assessment and the CE mark'. 27. BSG Guidance for flexible endoscopy 28. JAG Guidance for endoscopy 29. BS EN ISO 15883 (washers – surgical and endo) 30. BS EN ISO 285 (sterilizers) 31. BS EN ISO 14662 (drying cabinets endo) https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations NHS England » Health technical memoranda NHS England » Health technical memoranda NHS England » Health technical memoranda NHS England » Health technical memoranda ISO - ISO 9000 family — Quality management https://shop.bsigroup.com/ProductDetail?pid=000000000030353196&creative=435401337506&keyword=&matchtype=b&network=g&device=c&gclid=Cj0KCQjwhb36BRCfARIsAKcXh6GMNUjeSJRKxBsGuwxpkqp_2sQxy7VOg8DODJbCx0VtfiaOupLFzQaAoDMEALw_wcB https://www.cas.mhra.gov.uk/Home.aspx https://www.gov.uk/guidance/medical-devices-conformity-assessment-and-the-ce-mark https://www.gov.uk/government/consultations/consultation-on-the-future-regulation-of-medical-devices-in-the-united-kingdom https://services.cqc.org.uk/sites/default/files/gac_-_dec_2011_update.pdf https://www.gs1.org/standards/barcodes https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13 https://www.legislation.gov.uk/uksi/2002/618/contents/made https://shop.bsigroup.com/products/medical-devices-quality-management-systems-requirements-for-regulatory-purposes/tracked-changes https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/376918/Guidance_on_the_In_Vitro_Diagnostic_Medical_Devices_Directive.pdf http://eprints.gla.ac.uk/75539/1/75539.pdf https://www.iheem.org.uk/IHEEM-Authorising-Engineer-Decontamination-Register https://www.idsc-uk.co.uk/ https://www.iheem.org.uk/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271414/Frequently_asked_questions.pdf https://www.gov.uk/government/publications/managing-medical-devices https://www.gov.uk/guidance/medical-devices-conformity-assessment-and-the-ce-mark https://www.bsg.org.uk/clinical-resource/guidance-on-decontamination-of-equipment-for-gastrointestinal-endoscopy-2017-edition/ https://www.thejag.org.uk/ https://shop.bsigroup.com/ProductDetail?pid=000000000030353196&creative=386044230705&keyword=iso13485&matchtype=b&network=g&device=c&gclid=Cj0KCQjw-uH6BRDQARIsAI3I-UebTMtTTunz4BVFa_wZGh4Z4faiqjOB6iywmYHF2wdlVHKQL0EPDNkaAseTEALw_wcB https://shop.bsigroup.com/ProductDetail/?pid=000000000030278677#:~:text=It%20specifies%20requirements%20and%20the,of%20at%20least%2060%20l. https://www.iso.org/standard/55290.html	
SS2	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	Not applicable	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records; 3. Training needs analysis, staff training matrix for SSD/Endoscopy and Estates Teams. Specialist training with external providers. Scope cleaning training 4. Competency documents for endoscopy technicians 5. Competency documents for contractors required to work on decontamination equipment 6. Agency staff - if used include matrix of assessment of competency etc?	
SS2	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	Not applicable	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Business Continuity plans for SSD and Endoscopy Unit. 6. Test reports for efficacy of plans. 7. Training records for staff following testing	
SS2	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	Not applicable	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Internal and external audit reports 4. Use of ISO 9001 and ISO13485 can be incorporated into evidence 5. AE audit of Trust policy and processes 6. IHEEM JAG audit report and certificate 7. Significant findings from Authorising Engineer reports and action plans.	
SS2	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS3	**SS3: With regard to Waste and Recycling Management can the organisation evidence the following?**	Applicable	Applicable	The scope of this SAQ may gross over into Effectiveness Question E4 (SDMP)		
SS3	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS3	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		

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SS3	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS3	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. Waste Electrical and Electronic Equipment Regulations 2006 2. Pollution Prevention and Control (England and Wales) Regulations 2000 3. Environment Act 1995 4. Environmental Protection Act 1990 5. Health Technical Memorandum 07-01; Safe Management of Healthcare Waste 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 7. CQC Guidance for providers on meeting the regulations 8. CQC Provider Handbooks 9. NHS England » NHS clinical waste strategy https://www.legislation.gov.uk/uksi/2006/3289/contents/made https://www.legislation.gov.uk/uksi/2000/1973/contents/made https://www.legislation.gov.uk/ukpga/1995/25/contents https://www.legislation.gov.uk/ukpga/1990/43/contents https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf https://www.england.nhs.uk/estates/nhs-clinical-waste-strategy/	
SS3	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	4. Requires moderate improvement	4. Requires moderate improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS3	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS3	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS3	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS4	**SS4: With regard to Cleanliness and Infection Control applying to Premises and Facilities can the organisation evidence the following ?**	Applicable	Applicable	This SAQ covers the safety aspects of cleaning and infection control. SAQ PE3 looks at patient feedback relating to cleanliness.		
SS4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS4	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. 4. Framework of responsibility at trust level, linking into departmental responsibilities.		
SS4	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS4	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS4	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Use of NHS England Cleaning Manual	1. Health and Care Act 2022 2. (Health Building Note 00-09) Infection control in the built environment 3. Association of Healthcare Cleaning Professionals (AHCP) (2009) Colour Coding Hospital Cleaning Materials and Equipment: Safer Practice Notice 15 4.National infection prevention and control manual (NIPCM) for England 5. Health Building Note 04-01) Adult in-patient facilities: planning and design	

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SS4	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	6.. CQC Guidance for providers on meeting the regulations 7. CQC Provider Handbooks 8. National Standards of Healthcare Cleanliness 2021 9. NHS Cleaning Manual (on the E+F hub since 2021, to be published on web March 2024) 1. https://www.legislation.gov.uk/ukpga/2022/31/contents 2.. https://www.england.nhs.uk/publication/infection-control-in-the-built-environment-hbn-00-09/ 3.. https://www.ahcp.co.uk/wp-content/uploads/NRLS-0949-Healthcare-clea-ng-manual-2009-06-v1.pdf 4. https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/ 5.. https://www.england.nhs.uk/publication/adult-in-patient-facilities-planning-and-design-hbn-04-01/ 6&7. https://www.cqc.org.uk/guidance-providers/regulations 8.. https://www.england.nhs.uk/publication/national-standards-of-healthcare-cleanliness-2021/ 9. Hub not yet published	(For SS8 and 9 - Although the mandatory requirement is to display in patient facing areas, a Trust may choose to display in other areas so this is capturing evidence where trusts are improving standards for staff - it is best prac tice to share this information wider)
SS4	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS4	**8. Cleaning Standards 2021** Can you evidence that Star ratings are Displayed in patient facing areas?	2. Good	2. Good	1. Audit evidence 2. Publicly displayed and available		
SS4	**9. Cleaning Standards 2021** **As a minimum has 95% of the estate achieved a star rating of 4* or above, following their technical audits, in FR categories 1 – 4?**	2. Good	2. Good	1. Documented and readily available 2. Publicly displayed and available 3. Reviewed annually		
SS4	**10. Cleaning Standards 2021** **Have you undertaken efficacy audits in a minimum of 95% in each FR categories 1 – 4?**	4. Requires moderate improvement	3. Requires minimal improvement	1. Audit evidence 2. Reported to Board quarterly		
SS4	**11. Cleaning Standards 2021** **Do you have evidence that audits scoring 3* stars or below are following an escalation and review process?**	2. Good	2. Good	1. Audit evidence 2. Reported to Board quarterly		
SS4	**12: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS5	**SS5: With regard to Laundry and Linen Services can the organisation evidence the following?**	Applicable	Applicable	There may be some cross over with this SAQ and SS4.		
SS5	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS5	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS5	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS5	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. (HTM 01-04) Decontamination of linen for health and social care 2. Department of Health Uniforms and workwear: Guidance on uniform and workwear policies for NHS employers 2020 3. Immunisation against infectious disease: 'The Green Book' 4. HSE (1999) Management of Health and Safety at Work Regulations. London: Stationery Office 5.. HSE (2002) Control of Substances Hazardous to Health Regulations. London: Stationery Office- Health and Care Act 2022 6.. CQC Guidance for providers on meeting the regulations 7. CQC Provider Handbooks 8.. The Textile Services Association 1 .https://www.england.nhs.uk/publication/decontamination-of-linen-for-health-and-social-care-htm-01-04/ 2. https://www.england.nhs.uk/publication/uniforms-and-workwear-guidance-for-nhs-employers/ 3. https://www.gov.uk/government/collections/immunisation-against	
SS5	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Training matrix available		

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◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS5	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans;	3. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book 4.. https://www.hse.gov.uk/pubns/hsc13.pdf 5. https://www.hse.gov.uk/coshh/ 6https://www.legislation.gov.uk/ukpga/2022/31/contents 7. https://www.cqc.org.uk/guidance-providers/regulations 8. https://tsa-uk.org/healthcare/	
SS5	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS5	**8. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS6	**SS6: With regard to Security Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates only to the Physical Security infrastructure and labour related to the security of NHS facilities and not fraud or cybersecurity.		
SS6	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Identified and allocated resources are stipulated in the policy 4. The organisation has in place a security management strategy as a standalone document or as part of a policy statement. 5. Evidence of a Security Policy, Violence and Aggression Policy, 6. Procedure for the dissemination of key and vital information e.g. security alerts. The organisation has clear policies and procedures in place for the security of all medicines and controlled drugs.	1. Counter-Terrorism and Border Security Act 2019 2. National Counter Terrorism Security Office guidance 3.Human Rights Act 1998 4. Criminal Procedure and Investigations Act 1996 5.. Guidance from the Surveillance Commissioners Office 6.. General Data Protection Regulations 2018 7.. Criminal Justice and Immigration Act 2008 8.. Criminal Law Act 1967 9.. Following the principle of NHS Protect - Standards for providers 2017-18 Fraud, bribery and corruption 10. Health and Safety at work act 19741. 11. Updated - NHSE National Contract 22/23 Service condition 24 – counter fraud (previously 'Protect')- NHS Requirements | Government Functional Standards | NHS Counter Fraud Authority (cfa.nhs.uk) .12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 13. CQC Provider Handbooks 14. Martyn's Law (currently under consultation - it is important to be aware of updates) https://www.legislation.gov.uk/ukpga/1996/25/contents https://www.legislation.gov.uk/ukpga/2019/3/contents/enacted https://www.gov.uk/government/latest?departments%5B%5D=national-counter-terrorism-security-office https://www.npcc.police.uk/ https://www.legislation.gov.uk/ukpga/1998/42/contents	
SS6	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. Board nominated executive with the responsibility for overseeing security management 5. Nominated Qualified and Accredited Security Management Specialist to oversee and undertake the delivery of the full range of security management work - external/internal. 6. Evidence of internal (including capital development) and external liaison and involvement in local and national groups and with agency partners also to be included in job descriptions.		
SS6	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Risks identified include those related to; -Violent and aggressive individuals - Premises suitability - Lone working arrangements. - Evidence of Security assessment programme		
SS6	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Evidence of security involvement in new builds. 5. Evidence of a managed and maintained security access control system		

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SS6	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Evidence of the promotion of security awareness via multiple mediums 4. Evidence of tiered security training commensurate with duties based on a training needs analysis which is monitored, evaluated and reviewed as needed. 5. Demonstration of staff training in relation to incident reporting	https://www.legislation.gov.uk/ukpga/1996/25/contents https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/786444/Guide_to_the_Regulation_of_Surveillance.pdf https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted https://www.legislation.gov.uk/ukpga/2008/4/contents https://www.legislation.gov.uk/ukpga/1967/58/contents https://cfa.nhs.uk/resources/downloads/standards/Fraud_Standards_for_providers_2017-18.pdf https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fcfa.nhs.uk%2Fgovernment-functional-standard%2FNHS-requirements&data=05%7C02%7Chayley.morris10%40nhs.net%7C8a406c7e22d942e9aabc08dc1bec2ccc%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638415948376320929%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=0wnDVJjTpnmL0RVCYtj1eczCmOtHPHDkLtQm5T1jQQE%3D&reserved=0 https://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf https://www.protectuk.police.uk/martyns-law/martyns-law-overview-and-what-you-need-know	
SS6	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Evidence of plans as required by the security standards; - Planning for Lockdowns; - Planning for child abductions;		
SS6	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	4. Requires moderate improvement	4. Requires moderate improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Demonstration that risks identified through assessment are sufficiently funded to enable mitigation and response 4. Annual report to board in relation to security management 5. Evidence of work plan and ongoing review and update of plan 6. Evidence that incidents where harm or injury occur or had the potential to occur are sufficiently followed up and investigated including where appropriate support being provided to victims.		
SS6	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS7	**SS7: With regard to Transport Services and access arrangements can the organisation evidence the following?**	Applicable	Applicable	SAQ covers fleet management and transport of goods and services on and between sites. It excludes patient transport apart from the management of taxi services. Related patient experience is covered in SAQ P5. Access arrangements may also be covered under SH2. This includes car parking.		
SS7	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	5. Inadequate	5. Inadequate	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS7	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS7	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS7	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. Health Technical Memorandum 07-03: Transport Management and Car Parking 2. Building Research Establishment BRE - BREEAM Travel Plan documentation. 3. Net Zero Travel & Transport Strategy	
SS7	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:	https://www.england.nhs.uk/estates/health-technical-memoranda/ https://kb.breeam.com/knowledgebase/transport-assessments-and-transport-statements/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ https://energysavingtrust.org.uk/wp-content/uploads/2020/10/EST0018-001-EV-Guide-for-Fleet-Manager-WEB.pdf https://www.r-e-a.net/wp-content/uploads/2020/03/Updated-UK-EVSE-	

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SS7	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	Procurement-Guide.pdf	
SS7	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS7	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS8	**SS8: With regard to Pest Control can the organisation evidence the following?**	Applicable	Applicable			
SS8	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;. 3. Preventative/corrective strategies; demonstration of documented process and procedure whereby non-compliance is identified and remediation strategies are developed and delivered.		
SS8	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS8	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS8	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/inspection records	1.Public Health Act 1961 2.Control of Pollution Act 1974 3. Health and Safety at Work Act 1974 4. The Poisons Act 1972 5. The Control of Substances Hazardous to Health Regulation 1988 6. Control of Pesticides Regulations 1986 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 8. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/ukpga/Eliz2/9-10/64/contents https://www.legislation.gov.uk/ukpga/1974/40 https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/ukpga/1972/66 https://www.legislation.gov.uk/uksi/1988/1657/contents/made https://www.legislation.gov.uk/uksi/1986/1510/contents/made https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SS8	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS8	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS8	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Records of pest infestation, COSHH data sheets for pesticides, records of bait placement etc. 4. Documented evidence of audits and reviews to support compliance.		

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SS8	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS9	**SS9: with regard Portering Services can the organisation evidence the following?**	Applicable	Applicable	In line with local organisational portfolio for this area.		
SS9	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Patient transfer policy. 4. Infection control procedures and training.		
SS9	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS9	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Risk assessments for injury from needles and exposure to harmful substances and bodily fluids		
SS9	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Training matrix available	1. Health & Safety at Work Act 1974 2. Management of Health & Safety at Work Regulations 1988 3. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1988/1222/contents/made https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf To note we are working on guidance for portering which will be available for reference next year, covering: - Service strategy (workforce) - Technology and equipment - Policy - Working with clinical teams	
SS9	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	1. Outstanding	1. Outstanding	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Manual handling training		
SS9	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS9	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Evidence of patient involvement and feedback. 4. Patient Feedback considered and actioned		
SS9	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Patient Experience Domain	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
◄◄ Back to instructions	

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P1	**P1: With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?**	Applicable	Applicable	P1 replicates the CQC Provider handbooks KLOE R4 and assesses your processes for patient involvement, compliments and complaints	
P1	**1. Views and Experiences** Are people's views and experiences gathered and acted on to shape and improve the services and culture?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Review of the Patient Led Assessment of the Care Environment (PLACE) results and implementation of the outcomes;	
P1	**2. Engagement** Are people who use services, those close to them and their representatives actively engaged and involved in decision making?	3. Requires minimal improvement	3. Requires minimal improvement	1. Engagement process and methodology 2. Friends and Family Test 3. Patient Advice and Liaison Service (PALS)	1. Data Protection Act 1998 2. Freedom of Information Act 2000 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: 4. CQC Guidance for providers on meeting the regulations 5. CQC Provider Handbooks 6. NHS England Transforming Participation in Health and Care – September 2013 7. The Kings Fund Research Paper; Patient Engagement and Involvement 8. The Kings Fund Research Paper; The Quality of Patient Engagement and Involvement in Primary Care 2010 https://www.legislation.gov.uk/ukpga/1998/29/contents https://www.legislation.gov.uk/ukpga/2000/36/contents https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf https://www.england.nhs.uk/2013/09/trans-part/ https://www.kingsfund.org.uk/projects/gp-inquiry/patient-engagement-involvement https://www.kingsfund.org.uk/projects/gp-inquiry/patient-engagement-involvement
P1	**3. Staff Engagement** Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?	3. Requires minimal improvement	3. Requires minimal improvement	1. Surveys and questionnaires 2. Focus Groups 3. Engagement feedback influencing services developments and improvements	
P1	**4. Prioritisation** Do leaders prioritise the participation and involvement of people who use services and staff?	4. Requires moderate improvement	4. Requires moderate improvement	1. Governance and process for dealing with feedback	
P1	**5. Value** Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?	4. Requires moderate improvement	4. Requires moderate improvement	1. Adherence to confidentiality policy 2. Feedback to stakeholders and patients	
P1	**6: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

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◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P2	**P2: With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on condition, appearance, maintenance and P&D. Safety aspects are dealt with in the safety domain.	
P2	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.	3. Requires minimal improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services 7evelopments and improvements 8. Adherence to confidentiality policy 9. Feedback to stakeholders and patients 10. Complaints Procedure 11. Diversity considerations	1. NHS England: Delivering same sex accommodation guidance. Responsibility transferred to NHSE/I in 2017 .The DHSC guidance was revised and published in 2019. 2. Patient Led Assessments of the Care Environment (PLACE). 3. Health Ombudsman 'Care and Compassion' report 4. National In-patient survey 5. Commission for dignity in Care for older people 'delivering dignity' report 6. Patient Association guidance and advice 7. Joint Committee on Human Rights 'The Human Rights of Older People in healthcare' 8. CQC Provider Handbooks https://improvement.nhs.uk/resources/delivering-same-sex-accommodation/ https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/ https://www.ombudsman.org.uk/publications/care-and-compassion https://www.cqc.org.uk/publications/surveys/surveys https://www.nhsconfed.org/resources/2012/06/delivering-dignity-securing-dignity-in-care-for-older-people-in-hospitals-and-care#:~:text=hospitals%20and%20care-,Delivering%20Dignity%3A%20Securing%20dignity%20in%20care%20for,people%20in%20hospitals%20and%20care&text=Delivering%20Dignity%20is%20the%20final,underlying%20causes%20of%20poor%20care. https://publications.parliament.uk/pa/jt200607/jtselect/jtrights/156/156i.pdf https://www.patients-association.org.uk/Pages/FAQs/Category/policy https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf
P2	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?	3. Requires minimal improvement	4. Requires moderate improvement	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Monthly reporting of breaches of mixed-sex accommodation guidance 6. Meetings and dialogue with CQC identifying improvements	
P2	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P3	**P3: With regard to ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on cleanliness. Safety aspects of cleanliness are covered in the safety domain.	
P3	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to cleanliness for all relevant sites and published a local improvement plan.	2. Good	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 9. Diversity considerations	
P3	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the cleanliness and is action taken on the results?	3. Requires minimal improvement	2. Good	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Meetings and dialogue with CQC identifying improvements	1. Health and Social Care Information Centre: Patient Led Assessments of the Care Environment (PLACE) https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/
P3	**3. Cleaning Schedules** Are Cleaning Schedules publicly available?	3. Requires minimal improvement	2. Good	1. Reviews of policy stating where schedules are available compared with actual checking of availability.	
P3	**4: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

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P4	**P4: with regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with access and car parking. Safety SAQ SS7 covers car park management and access arrangements	1.. NHS patient visitor and staff car parking principles 2022 2. Health Technical Memorandum 07-03 (2006): NHS car parking management 3. Car Parking Code of Practice 4. Healthcare Travel Cost Scheme https://www.gov.uk/government/publications/nhs-patient-visitor-and-staff-car-parking-principles https://www.england.nhs.uk/estates/health-technical-memoranda/Private Parking Code of Practice - GOV.UK (www.gov.uk) https://www.nhs.uk/nhs-services/help-with-health-costs/healthcare-travel-costs-scheme-htcs/
P4	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to access and car parking for all relevant sites and published a local improvement plan.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 10. Diversity considerations	
P4	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	4. Requires moderate improvement	3. Requires minimal improvement	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Meetings and dialogue with CQC identifying improvements	
P4	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		
P5	**P5: With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to Grounds and Gardens can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with access and car parking. Safety SAQ SS7 covers car park management and access arrangements	1. The Occupiers Liability Act 1957 (amended 1984) 2. The Health and Safety at Work Act 1974 3. The Management of health and safety at Work Regulations 1999 4. Provision and Use of Work Equipment Regulations 1998 5. Control of Substances Hazardous to Health (COSHH) Regulations 2002 6. Personnel Protective Equipment at Work Regulations 1992 7. Management of Health and Safety at Work Regulation 1999 approved code of practice 8. Workplace, Health, Safety and Welfare Regulations 1992 approved code of practice and guidance 9. Work Equipment Provision and use of Work Equipment Regulations 1998 10. First Aid at Work, Health and Safety Regulations 1981 11. Hand-Arm Vibration 12. Corporate Manslaughter and Corporate Homicide Act 2007 13. RIDDOR 2013 RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 14. Working at Height Regulations 2005 15. BS ISO 15799:2003 Soil quality - guidance on eco-toxicological characterization ofsoils and soil materials 16. BS 3882:1994 Specification for topsoil 17. BS 6031:1981 Code of practice for earthworks 18. BS 7562-4:1992 Planning, design and installation of irrigation schemes guide to water resources 19. BS 4428:1989 guide of practice for general landscape operations (excluding hard surfaces) AMD 6784 20. BS 3882:1994 specification for topsoil and AMD 9338 21. BS 3936-1:1992 Nursery stock specification for trees and shrubs 22. BS 3936-5:1985 nursery stock specification for poplars and willows 23. BS 3936-10:1990 nursery stock specification for ground cover plants 24.BS 7370-3:1991 grounds maintenance recommendations for maintenance •
P5	**1. PLACE Assessment** The organisation has completed the PLACE External areas assessment relating to Grounds and Gardens for all relevant sites and published a local improvement plan.	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 10. Diversity considerations 11. The local improvement plan is included within the Green Plan.	

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Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P5	**2. Other Assessments** Is there a system/process, additional to PLACE External areas assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	2. Good	3. Requires minimal improvement	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Monthly reporting of breaches of mixed-sex accommodation guidance 6. Meetings and dialogue with CQC identifying improvements	25. BS 3998:1989 recommendations for tree work and AMD 6549 Horticulture 26. BS EN 12579:2000 Soil improvers and growing media - sampling 27. BS EN 13037:2000 Soil improvers and growing media - determination of pH Turf 28. BS 3969:1998 Recommendations for turf for general purposes 39. BS 4428:1989 Code of practice for general landscape operations14 (excluding hard surfaces). 30. Horticultural Trades Association guidelines on plant handling and establishment 31. BS 1129 Specification for portable timber ladders, steps, trestles and lightweight stagings British Standards Institution •BS 2037 Specification for portable aluminium ladders, steps, trestles and lightweight stagings British Standards Institution 32. BS EN 131 Ladders (Specification for terms, types, functional sizes; Specification for requirements, testing, marking; User instructions; Single or multiple hinge-joint ladders) British Standards Institute https://www.legislation.gov.uk/ukpga/1984/3 https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1998/2306/contents/made https://www.legislation.gov.uk/uksi/2002/2677/regulation/7/made https://www.legislation.gov.uk/uksi/1992/2966/contents/made https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1992/3004/contents/made https://www.legislation.gov.uk/uksi/1998/2306/contents/made https://www.legislation.gov.uk/uksi/1981/917/regulation/3/made https://www.hse.gov.uk/vibration/hav/ https://www.legislation.gov.uk/ukpga/2007/19/contents https://www.hse.gov.uk/riddor/ https://www.legislation.gov.uk/uksi/2005/735/contents/made https://www.iso.org/standard/29085.html https://shop.bsigroup.com/ProductDetail/?pid=000000000001382025#:~:text=BS%203882%3A1994%20specifies%20requirements,in%20situ%20topsoil%20or%20subsoil. https://shop.bsigroup.com/ProductDetail/?pid=000000000000078031 https://shop.bsigroup.com/ProductDetail?pid=000000000000285806 https://shop.bsigroup.com/ProductDetail?pid=000000000000198326 https://shop.bsigroup.com/ProductDetail/?pid=000000000001382025 https://shop.bsigroup.com/ProductDetail?pid=000000000000262241 https://shop.bsigroup.com/ProductDetail/?pid=000000000000151386 https://shop.bsigroup.com/ProductDetail?pid=000000000000209042 https://shop.bsigroup.com/ProductDetail?pid=000000000000238150 https://shop.bsigroup.com/ProductDetail/?pid=000000000000194564 https://shop.bsigroup.com/ProductDetail/?pid=000000000030006469 https://standardsdevelopment.bsigroup.com/projects/1992-06005#/section https://shop.bsigroup.com/ProductDetail?pid=000000000030260283 https://shop.bsigroup.com/ProductDetail?pid=000000000000198326 https://hta.org.uk/ https://shop.bsigroup.com/ProductDetail/?pid=000000000001635045 https://landingpage.bsigroup.com/LandingPage/Series?UPI=BS%20EN%20131
P5	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
P5	Capital cost to achieve compliance	£0	£0		
P5	Revenue consequences of achieving compliance	£0	£0		

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P6	**P6: How does your organisation/site ensure that NHS catering standards are provided effectively and efficiently?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with Catering Services and also complying with Regulation 14. Safety aspects of food and catering are dealt with in the safety domain.	
P6	**1. Policy & Procedures** Does the organisation have in place a policy for healthcare catering which is aligned to current National Standards for Healthcare Catering which has been reviewed via an MDT process within the last 3 years?	4. Requires moderate improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Internal structure to consider and action feedback 4. Adherence to confidentiality policy 5. Feedback to stakeholders and patients 6. Complaints Procedure 7. Benchmarking, KPIs and peer comparison process 8. Meetings and dialogue with CQC identifying improvements 9. Public/patient information e.g. handbooks, pre visit information	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 2. CQC Guidance for providers on meeting the regulations 3. National Specifications for healthcare cleanliness 2007 4. PAS:5748 5. NHS Estates (2000) Reducing food Waste in the NHS Department of Health. Better Hospital Food 6. Hospital Catering Association – Protected Mealtimes 7. Council of Europe Resolution food and nutritional Care in hospitals NHS England – 10 Key Characteristics of Good Nutritional Care in Hospitals 2006 8. Food Service at Ward Level with Healthcare food and Beverage Service Standards – a guide to ward level services – 2009 9. Water for Health – Hydration Best Practice Toolkit for Hospitals and Healthcare 10. NHS Executive 'Hospital catering delivering a quality service.' 11. NHS Code of Practice for the manufacture, distribution and supply of food, ingredients and food related products. 12. Improving Nutritional Care – a joint action plan from the department of health and nutrition summit stakeholders 13. HCA Ward Service guide 14. British Dialectic Association Improving Outcomes through Food and Beverage Services Nutritional & Hydration digest "15. Sustainable procurement: the GBS for food and catering services Official Government Buying Standards (GBS) for food and catering services" 16. NHS Standards Contract 17.The NHS Hospital Food Review 2020 18. British Association for Parenteral and Enteral Nutrition - Malnutrition Screening Tool 19. Public Health England - Healthier and More Sustainable Catering Nutrition Principles 20. A Toolkit to Support the Development of a Hospital Food and Drink Strategy 21. CQC Provider Handbooks https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.gov.uk/government/news/hospital-cleaning-revised-specification-published https://www.bsigroup.com/en-GB/about-bsi/media-centre/press-releases/2014/december/Standard-for-providing-a-clean-and-safe-hospital-environment-is-revised/ Reducing waste in the NHS: an overview of the literature and challenges for the nursing profession - PubMed (nih.gov) http://www.hospitalcaterers.org/publications/ https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics/ http://www.hospitalcaterers.org/publications/ https://www.choiceforum.org/docs/dohplan.pdf http://www.hospitalcaterers.org/publications/ https://www.bda.uk.com/uploads/assets/c24296fe-8b4d-4626-aeebb6cf2d92fccb/NutritionHydrationDigest.pdf https://www.gov.uk/government/publications/sustainable-procurement-the-gbs-for-food-and-catering-services https://www.england.nhs.uk/nhs-standard-contract/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/929234/independent-review-of-nhs-hospital-food-report.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/523049/Hospital_Food_Panel_May_2016.pdf https://www.malnutritionselfscreening.org/self-screening.html https://www.gov.uk/government/publications/healthier-and-more-sustainable-catering-a-toolkit-for-serving-food-to-adults https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499745/Toolkit_Feb_16.pdf https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf
P6	**2. Regulation** Does the organisation have a food and drink strategy as defined in the NHS Standard Contract	4. Requires moderate improvement	4. Requires moderate improvement	1. Review of relevant Policies and Procedures. 2. Nutritional screening programme identifying patient at risk from malnutrition and dehydration	
P6	**3. Choice** The organisation provides a choice of nutritious and appetising food and hydration, in sufficient quantities to meet patients needs	4. Requires moderate improvement	3. Requires minimal improvement	1. Review of relevant Policies and Procedures.	
P6	**4. Equality issues** Food and hydration meets any reasonable requirements arising from Equality issues e.g. from a patients religious or cultural background	2. Good	2. Good	1. Diversity considerations as set out in Policies and Procedures.	
P6	**5. Information** Patients have accessible information about meals and the arrangements for mealtimes, access to snacks and drinks throughout the day and night and to have mealtimes that are reasonably spaced and at appropriate times.	3. Requires minimal improvement	3. Requires minimal improvement	1. Patient, visitor and staff charter	
P6	**6. Patient Led Assessment of the Care Environment (PLACE) Assessment** The organisation has completed the PLACE assessment relating to catering services for all relevant sites and published a local improvement plan.	2. Good	2. Good	1. Completed PLACE assessments reviewed and actioned; 2. PLACE training records	
P6	**7. Other Assessments** Is there a system/process in place, additional to PLACE assessments, to measure patients satisfaction with the service provided and is action taken on the results?	3. Requires minimal improvement	3. Requires minimal improvement	1. Engagement process and methodology 2. Surveys and questionnaires 3. Focus Groups 4. Engagement feedback influencing services developments and improvements	
P6	**8. Legal Standards** Has the organisation complied with the estates related legally binding standards as detailed in the NHS Standard Contract	4. Requires moderate improvement	4. Requires moderate improvement	1. Review of policies and procedures to ensures compliance.	
P6	**9: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
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P1	**P1: With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?**	
P1	**1. Views and Experiences** Are people's views and experiences gathered and acted on to shape and improve the services and culture?	
P1	**2. Engagement** Are people who use services, those close to them and their representatives actively engaged and involved in decision making?	
P1	**3. Staff Engagement** Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?	
P1	**4. Prioritisation** Do leaders prioritise the participation and involvement of people who use services and staff?	
P1	**5. Value** Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?	
P1	**6: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
	Capital cost to achieve compliance Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P2	**P2: With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?**	
P2	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.	
P2	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?	
P2	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
	Capital cost to achieve compliance Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P3	**P3: With regard to ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?**	
P3	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to cleanliness for all relevant sites and published a local improvement plan.	
P3	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the cleanliness and is action taken on the results?	
P3	**3. Cleaning Schedules** Are Cleaning Schedules publicly available?	
P3	**4: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
	Capital cost to achieve compliance	
	Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P4	**P4: with regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?**	
P4	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to access and car parking for all relevant sites and published a local improvement plan.	
P4	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	
P4	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
	Capital cost to achieve compliance Revenue consequences of achieving compliance	
P5	**P5: With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to Grounds and Gardens can your organisation evidence the following?**	
P5	**1. PLACE Assessment** The organisation has completed the PLACE External areas assessment relating to Grounds and Gardens for all relevant sites and published a local improvement plan.	

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P5	**2. Other Assessments** Is there a system/process, additional to PLACE External areas assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	
P5	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
P5	Capital cost to achieve compliance	
P5	Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P6	**P6: How does your organisation/site ensure that NHS catering standards are provided effectively and efficiently?**	
P6	**1. Policy & Procedures** Does the organisation have in place a policy for healthcare catering which is aligned to current National Standards for Healthcare Catering which has been reviewed via an MDT process within the last 3 years?	
P6	**2. Regulation** Does the organisation have a food and drink strategy as defined in the NHS Standard Contract	
P6	**3. Choice** The organisation provides a choice of nutritious and appetising food and hydration, in sufficient quantities to meet patients needs	
P6	**4. Equality issues** Food and hydration meets any reasonable requirements arising from Equality issues e.g. from a patients religious or cultural background	
P6	**5. Information** Patients have accessible information about meals and the arrangements for mealtimes, access to snacks and drinks throughout the day and night and to have mealtimes that are reasonably spaced and at appropriate times.	
P6	**6. Patient Led Assessment of the Care Environment (PLACE) Assessment** The organisation has completed the PLACE assessment relating to catering services for all relevant sites and published a local improvement plan.	
P6	**7. Other Assessments** Is there a system/process in place, additional to PLACE assessments, to measure patients satisfaction with the service provided and is action taken on the results?	
P6	**8. Legal Standards** Has the organisation complied with the estates related legally binding standards as detailed in the NHS Standard Contract	
P6	**9: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
	Capital cost to achieve compliance Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F1	**F1: With regard to having a well-managed approach to performance management of the estate and facilities operations can the organisation evidence the following?**	Applicable	Applicable	HBN 00-08 Part A Section 2	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 3. Developing an Estate Strategy 4. Estates Return Information Collection 5. Patient Lead Assessments of the Care Environment (PLACE) 6. In patient Survey 7. NHS Premises Assurance Model Metrics Dashboard - RICS Real Estate 8. ISO 55000/01/02 Asset Management 2004 ISO 55000:2014 Asset management — Overview, principles and terminology" Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/ https://nhssurveys.org/surveys/survey/02-adults-inpatients/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.iso.org/standard/55088.html	
F1	**1: Analysing Performance** A process in place to analyse estates and facilities services and costs and if these continue to meet clinical and organisational needs?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
F1	**2: Benchmarking** A process in place to regularly benchmark estates and facilities costs?	3. Requires minimal improvement	3. Requires minimal improvement	1. Ongoing review of costs on a consistent basis that measures progress against established baseline position 2. Benchmarking including the use of metrics and KPIs from suitable sources including: - Estates Return Information Collection (ERIC) - Contract/Service Level agreement KPIs - Estate Strategy KPIs - Energy and sustainability targets - Cost Improvement Plan targets - NHS Model Hospital		
F1	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F2	**F2: With regard to having a well-managed approach to improved efficiency in running estates and facilities services can the organisation evidence the following and is this in line with the ICS infrastructure strategy?**	Applicable	Applicable	HBN 00-08 Part A Section 3	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 - The efficient management of healthcare estates and facilities Health Building Note 00-08 Part B: Supplementary information for Part A 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Premises Assurance Model Metrics 6. ISO 55000/01/02 Asset Management 2004 Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.england.nhs.uk/estates/health-building-notes/ https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://improvement.nhs.uk/resources/model-hospital/ https://www.iso.org/standard/55088.html	
F2	**1: Business Planning** An effective and efficient estate and facilities business planning process in place?	4. Requires moderate improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Business plans.		
F2	**2: Estate Optimisation** An effective and efficient process in place to ensure estate optimisation and space utilisation?	4. Requires moderate improvement	4. Requires moderate improvement	1. Space utilisation studies and monitoring of usage. 2. Response to NHS Long Term Plan of reduction to 30% non clinical space.		
F2	**3: Commercial Opportunities** An effective and efficient process in place to identify and maximise benefits from commercial opportunities from land and property that support the main business of the NHS ?	2. Good	2. Good	1. Market testing and cost benchmarking of contracts. 2. Land and property sale receipts. 3. Commercial Strategy or agreements such as letting of space for retail use.		
F2	**4: Partnership working** An effective and efficient process in place to investigate and implement improvements through partnership working?	2. Good	2. Good	1. Partnership Working, i.e. One Public Estate		
F2	**5: New Technology** An effective and efficient process in place to maximise the benefits from new technologies?	2. Good	2. Good	1. New Technology and Innovation - examples of product design or system implementation 2. IT strategy.		
F2	**6: PFI and LIFT contracts** An effective and efficient process in place to achieve value for money from existing PFI and LIFT contracts?	2. Good	2. Good	1. Date and outcome of PFI/PPP reviews and next steps.		
F2	**7: Other contracts** An effective and efficient process in place to achieve value for money from existing other contracts?	2. Good	2. Good	1. Market testing and cost benchmarking of contracts.		
F2	**8. Property** An effective and efficient process in place to record and managing property interest and leases held	3. Requires minimal improvement	3. Requires minimal improvement	1. Asset/Estate Terrier		
F2	**9. Cost Improvement plans** A robust methodology for identifying the delivery and implications of cost improvement plans	2. Good	2. Good	1. Regular and accurate submission of CIPs 2. Monitoring of progress of delivery		
F2	**10. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F3	**F3: With regard to improved efficiencies in capital procurement, refurbishments and land management can the organisation evidence the following?**	Applicable	Applicable	HBN 00-08 Part A Section 4.0	1. Health Building Note 00-08, The efficient management of healthcare estates and facilities Health Building Note 00-08 Part B: Supplementary information for Part A 2. NHS Model Health System 3. Estates Return Information Collection (ERIC) 4. Building Cost information Service 5. Government Construction Strategy 6. ProCure22/ProCure23 guidance 7. Naylor Review: 8. Lord Carter Review: 9. NHS Long Term Plan: 10. NHS Net Zero Building Standard 11. Estates Net Zero Carbon Delivery Plan (NZCDP) 1. https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 2. https://model.nhs.uk/ 3. https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection 4. https://www.rics.org/uk/products/data-products/bcis-construction/ 5. https://www.gov.uk/government/publications/government-construction-strategy 6. https://procure22.nhs.uk/ and https://procure22.nhs.uk/p23/ 7. https://www.gov.uk/government/publications/naylor-review-government-response#:~:text=The%20Naylor%20review%20was%20a,response%20capitalises%20on%20those%20opportunities. 8. https://www.gov.uk/government/publications/productivity-in-nhs-hospitals 9. https://www.longtermplan.nhs.uk/ 10. https://www.england.nhs.uk/publication/nhs-net-zero-building-standard/ 11. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117	
F3	**1. Capital Procurement** Capital procurement and refurbishment projects progressed in line with local standing orders and financial instructions and relevant procurement guidance, HM Treasury and DHSC and NHSE guidance.	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
F3	**2. Capital project management** Processes and procedures that ensure there are robust processes for the management of projects during construction including change control and lessons learnt/benefits realisation once projects are completed.	2. Good	3. Requires minimal improvement	1. Project governance documentation in line with capital management 2. Track how many projects are delivered on time or late and track that these were delivered within budget 3. Lessons learnt/benefits realisation and evidence of applying learning to subsequent projects		
F3	**3.. Capital Procurement Efficiencies** Capital procurement and refurbishment projects that actively seek efficiency such as through cost benchmarking, Building Information Modelling and repeatable designs?	2. Good	2. Good	1. Ongoing review of costs on a consistent basis that measures progress against established baseline position		
F3	**4. Flexibility** Capital procurement and refurbishment projects that actively seek flexible designs to accommodate changes in services?	2. Good	3. Requires minimal improvement	1. Consideration of innovative design and building options e.g. "New for Old".		
F3	**5. Identification and disposal of surplus land** An effective and efficient process for the identification and disposal of surplus land?	2. Good	3. Requires minimal improvement	1. Benchmarking including the use of metrics and KPIs from suitable sources 2. Surplus land identified in Annual Surplus Land Return, STP/ICS Estate Strategy, and EPIMS and shared through One Public Estate.		
F3	**6.Net Zero Carbon** Do the Capital Procurement Capital procurement and refurbishment projects include plans to meet national NHS net zero carbon targets?	2. Good	3. Requires minimal improvement	1. Site Level Heat decarbonisation plans (targets in Delivering a Net Zero NHS report and heat decarbonisation requirement within Green Plan Guidance) 2. The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects (Please note - Building Standard is mandatory for certain projects)		
F3	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
	Revenue consequences of achieving compliance	£0	£0			
F4	**F4: With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services can the organisation evidence the following?**	Applicable	Applicable			
F4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	1. Health Building Note 00-08 - The efficient management of healthcare estates and facilities 2. NHS Standing Financial Instructions -These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by us. 3. Audit Commission Report 2004 - Achieving first-class financial management in the NHS 4. The Public Contracts Regulations 2015 5. The Bribery Act 2010 - Guidance (publishing.service.gov.uk) 6. Leading the fight against NHS Fraud, organisational strategy 2017-2020 -Standards for NHS Providers 2020-21 Fraud, bribery and corruption January 2020 7. HFMA Finance training modules https://www.england.nhs.uk/estates/health-building-notes/https://www.england.nhs.uk/publication/standing-financial-instructions/ http://www.wales.nhs.uk/documents/FinanceinNHS_Report.pdf https://www.legislation.gov.uk/uksi/2015/102/contents/made https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832011/bribery-act-2010-guidance.pdf https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Providers_2020_v1.3.pdf https://www.hfma.org.uk/online-learning/bitesize-courses/detail/nhs-finance https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2F	
F4	**2: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	1. Internal Audits 2. Financial controls and scheme of delegation 3. Business Case procedure and Capital regime		
F4	**3. Board reporting and contracting** Is there comprehensive and regular reporting relating to estates and facilities services to the trust board highlighting performance, risks and issues. Are contracts in place for all estates and facilities services, documenting requirements with appropriate ability to terminate or manage poor performance and defined change control arrangements.	3. Requires minimal improvement	2. Good	1. Board reports 2. Do you have robust change control and review of costs 3. Contracts in place for all services with appropriate provisions for cost control and service incentivisation		
F4	**4: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
	Revenue consequences of achieving compliance	£0	£0			
F5	**F5: With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation evidence the following?**	Applicable	Applicable	SAQ taken from CQC KLOE W5. Prompt 6 can be cross referred to SAQ F1 and Patient Experience SAQs		
F5	**1. Quality and Sustainability** When considering developments to estates and facilities services or efficiency changes (including derogations from standards and guidance), is the impact on quality and sustainability and net zero carbon targets assessed, understood and monitored, before, during and after the development?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Action from surveys and feedback. 4. Backlog Risk Assessment, impact assessment and mitigation and action plan.	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 The efficient management of healthcare estates and facilities 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Model Health System 6. Department of Health Built Environment Key Performance Indicators (KPIs) 7. ISO 55000/01/02 Asset Management 2004 8.Greener NHS » Delivering a net zero NHS 9. NHS Estates Net Zero Carbon Delivery Plan Report 10. Net Zero Guidance plan Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://model.nhs.uk/ https://improvement.nhs.uk/resources/model-hospital/ https://www.gov.uk/government/statistics/key-performance-indicators https://www.iso.org/standard/55088.html https://www.hfma.org.uk/online-learning/bitesize-courses/detail/nhs-finance https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fgreenernhs%2Fa-net-zero-nhs%2F&data=05%7C02%https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 https://future.nhs.uk/connect.ti/Estates_and_Facilities_Hub/view?objectId=155202117 https://www.england.nhs.uk/long-read/green-plan-guidance/ https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/ https://www.england.nhs.uk/long-read/green-plan-guidance/	
F5	**2. Financial Pressure** Are there examples of where financial pressures have negatively affected estates and facilities services?	3. Requires minimal improvement	4. Requires moderate improvement	1. Estates Incidents impacting on clinical care- ERIC returns, & feedback to EFM Division to NHS England and NHS Improvement.		
F5	**3. Continuous Improvement** Do leaders and staff strive for continuous learning, improvement and innovation?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risk Assessments and Registers 2. Derogations documented with clinical impact assessment and clinical sign-off. 3. Training and Development plans and records.		
F5	**4. Quality Improvements** Are staff focused on continually improving the quality of estates and facilities services?	3. Requires minimal improvement	3. Requires minimal improvement	1. Regular assessments of quality outputs e.g. PLACE scores; 2. Inclusion of quality assessments in Costed Action Plans.		
F5	**5. Recognition** Are improvements to quality and innovation recognised and rewarded?	2. Good	2. Good	1. Staff suggestion scheme. 2. Staff awards and recognition.		
F5	**6. Use of Information** Is information used proactively to improve estates and facilities services?	4. Requires moderate improvement	4. Requires moderate improvement	1. Use of design evaluation tools.		
F5	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
E1	**E1: With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation evidence the following and is this inline with the ICS infrastructure strategy?**	Applicable	Applicable	SAQ is taken from CQC KLOE W1 and covers the estates and other related strategies as described in HBN 00-08 Part B section 2. Prompt 3 can be linked to SAQ PE1. Operational management is covered in SAQ S01	
E1	**1. Vision and Values** A clear vision and a set of values, with quality and safety the top priority?	2. Good	2. Good	1. Estates Strategy and related documents;	1. Developing an Estate Strategy document 2. Health Building Note 00-08 The efficient management of healthcare estates and facilities 3. Health building Note 00-08The efficient management of healthcare estates and facilities (part A): Land and Property Appraisal 4. Strategic Health Asset Planning & Evaluation (SHAPE) tool 5. RICS UK Commercial Real Estate Agency Standards. 6. RICS Guidance Notes- Real Estate disposal and acquisition. 7. Assets in Action 8. Healthcare providers: asset register and disposal of asset 9. Strategy development: a toolkit for NHS providers 10. Developing strategy What every trust board member should know 11..Greener NHS » Delivering a net zero NHS 12. NHS Estates Net Zero Carbon Delivery Plan Report 13. Net Zero Guidance plan https://www.gov.uk/government/publications/developing-an-estate-strategy https://www.england.nhs.uk/estates/health-building-notes/ https://shapeatlas.net/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency-1st-edition-rics.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144216/Assets_in_Action.pdf https://www.gov.uk/government/publications/healthcare-providers-asset-register-and-disposal-of-assets https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers https://www.gov.uk/government/publications/strategy-development-a-guide-for-nhs-foundation-trust-boards https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F% https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/ https://www.england.nhs.uk/long-read/green-plan-guidance/
E1	**2. Strategy** A robust, realistic strategy for achieving the priorities and delivering good quality estates and facilities services?	3. Requires minimal improvement	3. Requires minimal improvement	1. Documentary evidence relevant to the prompt questions e.g. document articulating the vision such as mission statement	
E1	**3. Development** The vision, values and strategy has been developed with staff and other stakeholders?	3. Requires minimal improvement	3. Requires minimal improvement	1. Regular discussions/meetings/exchanges with interested parties; 2. Integration of these discussions into Strategies and Visions/Values;	
E1	**4. Vision and Values Understood** Staff know and understand what the vision and values are?	3. Requires minimal improvement	2. Good	1. Feedback from staff to quantify their understanding of visions, values and strategy e.g. staff survey results;	
E1	**5. Strategy Understood** Staff know and understand the strategy and their role in achieving it?	3. Requires minimal improvement	3. Requires minimal improvement	1. Feedback from staff to quantify their understanding of visions, values and strategy e.g. staff survey results;	
E1	**6. Progress** Progress against delivering the strategy is monitored and reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	2. Staff, Patient and stakeholder engagement and feedback 2. Analysis of relevant complaints;	
E1	**7: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Effectiveness Domain ◄◄ Back to instructions	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
E2	**E2: With regard to having a well-managed approach to town planning can the organisation evidence the following?**	Applicable	Applicable	SAQ measures compliance with HBN 00-08 Part B Section 3.0.	
E2	**1. Local Planning** An effective and efficient process to participate in Local Planning matters?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
E2	**2. Neighbourhood Planning** An effective and efficient process to participate in Neighbourhood planning matter?	2. Good	2. Good	1. Involvement in town planning issues. 2. Appropriate action when land and/or property is subject to compulsory purchase powers or potential or actual applications for registering as a town or village green	
E2	**3. Planning Control** An effective and efficient process to participate in planning control process?	3. Requires minimal improvement	3. Requires minimal improvement	1. Involvement in town planning issues 2. Trusts should be engaged with their ICBs regaridng the local plan process. ICBs, alongside NHSE, are statutory consultees on local plans (but not planning applications). 3. Refer to ICS infrastructure strategy guidance the guidance includes reference to local area energy plans and local nature recovery strategies, which will support town planning.	1. Health Building Note 00-08: The efficient management of healthcare estates and facilities 2. Health building Note 00-08:The efficient management of healthcare estates and facilities - Part A Land and Property Appraisal 3. Health Technical Memorandum 05 Fire code 4. Estates Net Zero Carbon Delivery Plan 5.Health Technical Memorandum 07-02 6. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/estates/health-building-notes https://www.england.nhs.uk/estates/health-building-notes/ https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/
E2	**4. Special Interests** An effective and efficient process to manage special interests (e.g. conservation areas, listed buildings etc.) ?	2. Good	2. Good	1. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings 2. Preventing third parties gaining inappropriate rights over land and property 3. Management of easement agreements 4. Management of tenancy and other contractual arrangements 5. Where non-NHS facilities are used for NHS patients, that policies to ensure NHS standards regarding the built environment are adopted and implemented	
E2	**5. Enforcement** An effective and efficient process to deal with any enforcement procedures served on the organisation?	4. Requires moderate improvement	4. Requires moderate improvement	1. Has there been any enforcement actions from the Local Planning Authority in the year and, if so, whether these have been satisfactorily resolved	
E2	**6: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Effectiveness Domain ◄◄ Back to instructions	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
E3	**E3: with regard to having a well-managed robust approach to management of land and property can the organisation evidence the following?**	Applicable	Applicable	SAQ measures compliance with HBN 00-08 Part B Section 4.0 to 8.0	
E3	**1: Disposal of land and property** An effective and efficient process for the disposal of freehold/leasehold land and property?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3 Evidence of a short and long term estate strategy supporting clinical, financial and investment objectives. 4. Evidence of optimising utilisation of accommodation across the estate, the Sustainability and Transformation Partnership and Integrated Care Organisation footprint and with One Public Estate partners. 5. Evidence of masterplans for large sites which identify areas for retention, development and disposal 6. Involvement of District Valuer 7. Demonstration of re-investment of income. 8. Maintenance of an up-to-date and accurate property asset register 9. All statutory obligations to be identified and met 10. Preventing third parties gaining inappropriate rights over land and property 11. Management of easement agreements 12. Appropriate action when land and/or property is subject to compulsory purchase powers or potential or actual applications for registering as a town or village green 13. Where non-NHS facilities are used for NHS patients, that policies to ensure NHS standards regarding the built environment are adopted and implemented 14. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings	1. Health Building Note 00-08 - The efficient management of healthcare estates and facilities 2. Health Building Note 00-08: The efficient management of healthcare estates and facilities - Part A Land and Property Appraisal 3. RICS UK Commercial Real Estate Agency Standards. 4. RICS Guidance Notes- Real Estate disposal and acquisition. 5. Assets in Action 6. Real estate management - 3rd edition, October 2016" 7. Healthcare providers: asset register and disposal of asset 8. Estates Net Zero Carbon Delivery Plan https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/estates/health-building-notes/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency-1st-edition-rics.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144216/Assets_in_Action.pdf https://shapeatlas.net/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/real-estate-management-3rd-edition-rics.pdf https://www.gov.uk/government/publications/healthcare-providers-asset-register-and-disposal-of-assets
E3	**2: Granting of Leases** An effective and efficient process for the granting of leases?	2. Good	2. Good	1. Management of leases, tenancy and other contractual arrangements	
E3	**3: Acquisition of land and property** An effective and efficient process for the acquisition of freehold/leasehold land and property?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3 Evidence of a short and long term estate strategy supporting clinical, financial and investment objectives. 4. Evidence of optimising utilisation of accommodation across the estate, the Sustainability and Transformation Partnership and Integrated Care Organisation footprint and with One Public Estate partners. 5. Evidence of masterplans for large sites which identify areas for retention, development and disposal 6. Involvement of District Valuer 7. Maintenance of an up-to-date and accurate property asset register 8. All statutory obligations to be identified and met 9. Preventing third parties retaining inappropriate rights over land and property 10. Management of easement agreements 11. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings 12. Consideration of mandatory energy efficiency ratings.	
E3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Effectiveness Domain ◄◄ Back to instructions	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
E4	**E4: With regard to having a suitable Sustainability approach in place and being actioned.**	Applicable	Applicable		
E4	**1: Green Plan / Sustainability Strategy** Has your Green Plan been approved by Board and submitted to the ICS / ICB	2. Good	3. Requires minimal improvement	1. The Green Plan / Sustainability Strategies published on the Trust's website and has been updated within the last 3 years 2. The organisation tracks its progress using the Green Plan Support Tool 3. The Green Plan / Sustainability Strategy names an executive lead for sustainability 4. The Green Plan / Sustainability Strategy states progress against carbon emission reduction targets in line with the 'Delivering a net zero NHS report' 5. Alignment with STP/ICS estates strategy; 6. Green Plan is published on the Trust's website & has been updated within the last 3 years 7. Green plan states progress against carbon emission reduction targets in line with national NHS net zero targets.	1.Greener NHS » Delivering a net zero NHS 2. NHS Estates Net Zero Carbon Delivery Plan Report 3. Net Zero Guidance plan 4. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ 1.https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 2.https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/ 3. https://www.england.nhs.uk/long-read/green-plan-guidance/ 4. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117
E4	**2: Energy** Is your energy usage, including heat, managed to fully deliver sustainability and effectiveness, and includes plans to meet national NHS net zero carbon targets?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has evidence of TM44 Air Conditioning System Assessments 2. Organisations which qualify for the EU Emissions Trading Scheme (EUETS) have an EUETS assessor and can demonstrate relevant annual reporting systems 3. Organisations with Combined (Cooling) Heat and Power Plant (CHP/CCHP) have a CHP Quality Assurance (CHPQA) Certificate for Climate Change Levy (CCL) exemption for each unit installed 4. The organisation has a current energy efficiency policy 6. Evidence that utility bills are checked and validated before payment 7. The organisation has rolled out smart metering across the estate, or has a programme to roll out within the next 3 years 9. Monthly meter readings are taken and recorded, and automated readings validated physically 10. The organisation employs a dedicated (spends > 50% of their time working on energy management activities) energy manager / responsible person for energy 11. The Organisation is compliant to HTM 07-02; Making Energy work in Healthcare 12. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex. 13. Site Level Heat decarbonisation plans (targets in Delivering a Net Zero NHS report and heat decarbonisation requirement within Green Plan Guidance)	1. CIBSE TM44 : Inspection of Air Conditioning Systems 2. EU Emissions Trading System 3. Combined Heat and Power Quality Assurance Programme 4. Making energy work in healthcare (Health Technical Memorandum 07-02) 5. ISO 50001 Energy Management 6. Estates Net Zero Carbon Delivery Plan (NZCDP) 7. NZCDP Technical annex 1. https://www.cibse.org/AirConditioning_1 2. https://ec.europa.eu/clima/policies/ets_en 3. https://www.gov.uk/guidance/chpqa-guidance-notes 4. https://www.england.nhs.uk/estates/health-technical-memoranda/ 5. https://www.iso.org/iso-50001-energy-management.html 6. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 7. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=151919557#
E4	**3: Waste** Are effective systems in place to minimise waste production and effectively dispose of it?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has a current waste management and minimisation policy 2. The organisation's Dangerous Goods Safety Advisor (DGSA) has reported within the last 12 months 3. The organisation can evidence completion of Pre-acceptance Audits? 4. The Trust can demonstrate processes to fulfil their Duty of Care for waste 5. The organisation holds regular contract review meetings 6. The organisation can evidence record receipt and review of monthly progress reports 7. The organisation holds regular operational meetings 8. The organisation conducts monthly independent audits of the service 9. The organisation maintains statutory waste records (disposal notes, destruction certificates) and compliance audits 10. The organisation can evidence staff waste 11. The organisation employs a dedicated (spends > 50% of their time working on waste management activities) waste manager / responsible person for waste 12. The organisation is compliant with HTM 07-01; Safe Management of Healthcare Waste 13. The organisation is compliant with the Clinical Waste Strategy 14. The organisation is compliant with the 20:20:60 split of Alternative Treatment, Incineration (clinical waste) and Offensive Waste volume	1. HTM 07-01; Safe Management of Healthcare Waste 2. NHS Clinical Waste Strategy 1. https://www.england.nhs.uk/publication/management-and-disposal-of-healthcare-waste-htm-07-01/ 2. https://www.england.nhs.uk/publication/nhs-clinical-waste-strategy/

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
E4	**4: Air Pollution** Does your Trust have policies and procedures in place to control air pollution and an overview of these procedures is included within the Green Plan?	2. Good	3. Requires minimal improvement	1.The organisation has completed the Clean Air Hospitals Framework Tool 2.The organisation has a Clean Air policy including anti-idling 3.The organisation has an action plan for tackling air pollution from its buildings 4. The organisation has an action plan for tackling air pollution from its own vehicles and those that visit the organisation's site(s) 5.The organisation keeps an FGAS register 6.The organisation has a plan for migrating to Zero Emission Vehicles 7. The organisation has an action plan to meet air pollution targets in the Long Term Plan	1. Clean Air Hospital Framework 2. Fluorinated gas (F gas): guidance for users, producers and traders 3. NHS Long Term Plan https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/air-pollution/ https://www.globalactionplan.org.uk/clean-air-hospital-framework/ https://www.gov.uk/government/collections/fluorinated-gas-f-gas-guidance-for-users-producers-and-traders
E4	**5.: Travel & Transport** Can the organisation evidence an effective and efficient process to ensure staff commuting, patient & visitor travel, and the organisation's own fleet are sustainable and meet the relevant guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. The organisation has a sustainable travel plan. 2. Zero emissions vehicles are integrated into procurement practices - in-line with Net Zero Travel & Transport strategy. 3. A staff travel survey is completed at least every 24 months. 4. The organisation has a parking policy covering staff, patient & visitor travel. 5. The organisation provides secure bike storage, changing facilities and good quality on and off-site walking and cycling routes. 6. The organisation considers sustainable transport, flexible working and route planning/optimisation in its business travel (or similar) policy. 7. The organisation reports to the Greener NHS Fleet Data Collection	1. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ 2. Health Technical Memorandum 07-03 NHS Car parking management, environment and sustainability 3. Delivering a Net Zero NHS https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/ https://energysavingtrust.org.uk/wp-content/uploads/2020/10/EST0018-001-EV-Guide-for-Fleet-Manager-WEB.pdf https://www.r-e-a.net/wp-content/uploads/2020/03/Updated-UK-EVSE-Procurement-Guide.pdf
E4	**6.: Water** Are water services efficiently and effectively delivered?	3. Requires minimal improvement	3. Requires minimal improvement	1.The organisation has a water efficiency policy 2.Monthly meter readings are taken and recorded, and automated readings validated physically 3. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex.	1. Estates Net Zero Carbon Delivery Plan (NZCDP) 2. NZCDP Technical annex 1. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 2. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=151919557
E4	**7.: Climate Change Adaptation** Are risk assessments of the effects of climate change risk assessment and mitigation action implemented and include references to overheating, flooding and extreme weather events?	4. Requires moderate improvement	3. Requires minimal improvement	1.The organisation has a climate change adaptation risk assessment on the Trust risk register 2.The organisation reports on estate related events, such as extreme weather events including flooding, heatwave and cold winter events 3. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex.	1. Estates Net Zero Carbon Delivery Plan (NZCDP) 2. HBN 00-07 Resilience planning for the healthcare estate 3. Flood Risk Toolkit 4. NHS Climate Change Risk Assessment tool 5. Health and climate adaptation report 2025 1. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 2. https://www.england.nhs.uk/publication/resilience-planning-for-nhs-facilities-hbn-00-07/ 3. https://tabanalytics.data.england.nhs.uk/#/views/FloodRiskToolkit/TitlePage?=null&:iid=3 4.https://www.england.nhs.uk/publication/climate-adaptation-resources/ 5.https://www.england.nhs.uk/publication/health-and-climate-adaptation-reports/
E4	**8.: Procurement** Is all relevant procurement consistent with NHS England's net zero and sustainable procurement policies?	3. Requires minimal improvement	3. Requires minimal improvement	1.The organisation takes account of the NHS Net Zero Supplier Roadmap and reports against compliance with this through the quarterly Greener NHS data collection. 2.The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects.	1. NHS Net Zero Supplier Roadmap 2. Greener NHS quarterly data collection 3. Applying net zero and social value in the procurement of NHS goods and services (building on PPN06/20) 4. Carbon reduction plan and net zero commitment requirements for the procurement of NHS goods, services and works (aligning to PPN06/21) 5. Evergreen Sustainable Supplier Assessment 6. NHS Net Zero Building Standard 1. https://www.england.nhs.uk/greenernhs/get-involved/suppliers/ 2. https://future.nhs.uk/sustainabilitynetwork/view?objectID=40822960 3. https://www.england.nhs.uk/greenernhs/publication/applying-net-zero-and-social-value-in-the-procurement-of-nhs-goods-and-services/ 4. https://www.england.nhs.uk/long-read/carbon-reduction-plan-requirements-for-the-procurement-of-nhs-goods-services-and-works/ 5. https://www.england.nhs.uk/nhs-commercial/central-commercial-function-ccf/evergreen/ 6. https://www.england.nhs.uk/publication/nhs-net-zero-building-standard/
E4	**9: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
E4	Capital cost to achieve compliance	£0	£0		
E4	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Effectiveness Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
E1	**E1: With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation evidence the following and is this inline with the ICS infrastructure strategy?**	
E1	**1. Vision and Values** A clear vision and a set of values, with quality and safety the top priority?	
E1	**2. Strategy** A robust, realistic strategy for achieving the priorities and delivering good quality estates and facilities services?	
E1	**3. Development** The vision, values and strategy has been developed with staff and other stakeholders?	
E1	**4. Vision and Values Understood** Staff know and understand what the vision and values are?	
E1	**5. Strategy Understood** Staff know and understand the strategy and their role in achieving it?	
E1	**6. Progress** Progress against delivering the strategy is monitored and reviewed?	
E1	**7: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	
	Capital cost to achieve compliance	
	Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Effectiveness Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
E2	**E2: With regard to having a well-managed approach to town planning can the organisation evidence the following?**	
E2	**1. Local Planning** An effective and efficient process to participate in Local Planning matters?	
E2	**2. Neighbourhood Planning** An effective and efficient process to participate in Neighbourhood planning matter?	
E2	**3. Planning Control** An effective and efficient process to participate in planning control process?	
E2	**4. Special Interests** **A**n effective and efficient process to manage special interests (e.g. conservation areas, listed buildings etc.) ?	
E2	**5. Enforcement** **A**n effective and efficient process to deal with any enforcement procedures served on the organisation?	
E2	**6: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	
	Capital cost to achieve compliance	
	Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Effectiveness Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
E3	**E3: with regard to having a well-managed robust approach to management of land and property can the organisation evidence the following?**	
E3	**1: Disposal of land and property** An effective and efficient process for the disposal of freehold/leasehold land and property?	
E3	**2: Granting of Leases** An effective and efficient process for the granting of leases?	
E3	**3: Acquisition of land and property** An effective and efficient process for the acquisition of freehold/leasehold land and property?	
E3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance? Capital cost to achieve compliance Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Effectiveness Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
E4	**E4: With regard to having a suitable Sustainability approach in place and being actioned.**	
E4	**1: Green Plan / Sustainability Strategy** Has your Green Plan been approved by Board and submitted to the ICS / ICB	
E4	**2: Energy** Is your energy usage, including heat, managed to fully deliver sustainability and effectiveness, and includes plans to meet national NHS net zero carbon targets?	
E4	**3: Waste** Are effective systems in place to minimise waste production and effectively dispose of it?	

NHS Premises Assurance Model: Effectiveness Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
E4	**4: Air Pollution** Does your Trust have policies and procedures in place to control air pollution and an overview of these procedures is included within the Green Plan?	
E4	**5.: Travel & Transport** Can the organisation evidence an effective and efficient process to ensure staff commuting, patient & visitor travel, and the organisation's own fleet are sustainable and meet the relevant guidance?	
E4	**6.: Water** Are water services efficiently and effectively delivered?	
E4	**7.: Climate Change Adaptation** Are risk assessments of the effects of climate change risk assessment and mitigation action implemented and include references to overheating, flooding and extreme weather events?	
E4	**8.: Procurement** Is all relevant procurement consistent with NHS England's net zero and sustainable procurement policies?	
E4	**9: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	
E4	Capital cost to achieve compliance	
E4	Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Governance Domain	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
G1	**G1. With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed, can the organisation evidence the following?**	Applicable	Applicable	SAQ is taken from CQC KLOE W2.	
G1	**1. Framework** There is an effective governance framework to support the delivery of the Estates and Facilities strategy and good quality services?	3. Requires minimal improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
G1	**2. Roles** Staff are clear about their roles and understand what they are accountable for?	4. Requires moderate improvement	4. Requires moderate improvement	1. Governance Structure 2. Annual Plan/Programme Board 3. Structure chart 4. Committee terms of reference and minutes	
G1	**3. Partners** Working arrangements with partners and third party providers, e.g. PFI, are effectively managed?	2. Good	2. Good	1. Local sustainability and transformation partnership plans	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 2. CQC Guidance for providers on meeting the regulations 2. NHS Constitution and Handbook to the NHS Constitution 3. NHS Long Term Plan 4. Quality Governance in the NHS 5. Gov.uk - Quality governance in the NHS - A guide for provider boards 6. Monitor Code of Governance for Foundation Trusts 7. NHS TDA Delivering High Quality Care 8. NHS England » Green plan guidance 9. Monitor: Risk Assessment Framework for NHS Foundation Trusts 10. HSE five steps to risk assessment - INDG163 (rev 4) 06/11 11. Developing strategy What every trust board member should know 12. Modern Slavery Act 2015 13. Public Services (Social Value) Act 2012 https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england https://www.longtermplan.nhs.uk/ https://www.gov.uk/government/publications/quality-governance-in-the-nhs-a-guide-for-provider-boards https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance Foreword: https://www.england.nhs.uk/wp-content/uploads/2013/10/keogh-qual-ltr.pdfhttps://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F% https://www.england.nhs.uk/long-read/green-plan-guidance/ https://www.gov.uk/government/publications/risk-assessment-framework-raf https://www.hse.gov.uk/pubns/INDG163.pdf https://www.gov.uk/government/publications/strategy-development-a-guide-for-nhs-foundation-trust-boards https://www.legislation.gov.uk/ukpga/2015/30/contents/enacted https://www.legislation.gov.uk/ukpga/2012/3/enacted
G1	**4. Framework** The governance framework and management systems are regularly reviewed and improved?	2. Good	3. Requires minimal improvement	1.Estate Strategy 2 Standing Orders	
G1	**5: Assurance** There are comprehensive assurance system and service performance measures, which are reported and monitored, and action taken to improve performance	3. Requires minimal improvement	2. Good	1. Evidence of walkarounds 2. Signed-of processes and procedures documentation, including risk register. 3. Signed-off roles and responsibilities documentation.	
G1	**6. Monitoring** There are effective arrangements in place to ensure that the information used to monitor, report (including regional and national data collections) and manage quality and performance is accurate, valid, reliable, timely and relevant (including PFI and non PFI costs).	4. Requires moderate improvement	4. Requires moderate improvement	1. Audit reports, peer and external reviews.	
G1	**7. Audit** There is a systematic programme of internal audit, which is used to monitor quality and systems to identify where action should be taken?	4. Requires moderate improvement	4. Requires moderate improvement	1. Surveillance Programme 2. Audit Programme	
G1	**8. Mitigation** There are robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	2. Good	2. Good	1. Job descriptions and training records for risk management. 2. Corporate, current risk register in place, with an identifiable owner. 3. Signed-off risk management strategy by the Board	
G1	**9. Alignment** There is alignment between the recorded risks and what people say is 'on their worry list'?	3. Requires minimal improvement	3. Requires minimal improvement	4. Evidence risks are passed into corporate risk register and actions taken, do not simply disappear without action	
G1	**10: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
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NHS Premises Assurance Model: Governance Domain	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.
◄◄ Back to instructions	

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G2	**G2: With regard to ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services can the organisation evidence the following?**	Applicable	Applicable	SAQ is taken from CQC KLOE W3.	
G2	**1. Effectiveness** Leaders have the skills, knowledge, experience and integrity that they need and have the capacity, capability, and experience to lead effectively – both when they are appointed and on an ongoing basis.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Job specification and competencies	
G2	**2. Challenges** Leaders understand the challenges to good quality estates and facilities services and can identify the actions needed to improve.	4. Requires moderate improvement	4. Requires moderate improvement	1. Local and national staff surveys and feedback	
G2	**3. Visibility** Leaders are visible and approachable.	3. Requires minimal improvement	3. Requires minimal improvement	1. Organograms and structure charts	
G2	**4. Relationships** Leaders encourage appreciative, supportive relationships among staff.	4. Requires moderate improvement	4. Requires moderate improvement	1. Local and national staff surveys and feedback	
G2	**5. Respect** Staff feel respected and valued.	4. Requires moderate improvement	4. Requires moderate improvement	1. Local and national staff surveys and feedback	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 2. CQC Guidance for providers on meeting the regulations 3. CQC Regulation 20: Duty of candour (FS) 4. NHS Long Term Plan 5. Conduct for NHS Managers 6. NHS Constitution and Handbook to the NHS Constitution 7. NHS complaints procedure in England SN / SP / 5401 24.01.14 "8. ISO 10002:2004 Quality management — Customer satisfaction — Guidelines for complaints handling in organizations" 9. NHS whistleblowing procedures in England SN06490 13.12.13 10. Public Interest Disclosure Act 1998 https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour https://www.longtermplan.nhs.uk/ https://www.nhsemployers.org/~/media/Employers/Documents/Recruit/Code_of_conduct_for_NHS_managers_2002.pdf https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england https://www.england.nhs.uk/contact-us/complaint/ https://www.iso.org/standard/35539.html https://www.england.nhs.uk/ourwork/whistleblowing/ https://www.gov.uk/government/publications/the-public-interest-disclosure-act
G2	**6. Behaviours** Action is taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority.	2. Good	4. Requires moderate improvement	1. Performance reviews 2. Local and national staff surveys and feedback	
G2	**7. Culture** Is the culture centred on the needs and experience of people who use services?	4. Requires moderate improvement	4. Requires moderate improvement	1. Local and national staff surveys and feedback 2.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working	
G2	**8. Honesty** The culture encourages candour, openness and honesty.	4. Requires moderate improvement	4. Requires moderate improvement	1. Local and national staff surveys and feedback	
G2	**9. Safety & Wellbeing** There is a strong emphasis on promoting the safety, health and wellbeing of staff.	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Job specification and competencies	
G2	**10. Healthier workplace** Promoting a healthier NHS workplace through cutting access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
G2	**11. Collaboration** Staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality estates and facilities services.	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
G2	**12: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
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◄◄ Back to instructions	

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G3	**G3: With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services can the organisation evidence the following?**	Applicable	Applicable		
G3	**1. Professional advice** The organisation has adequately identified its requirements for Estates and Facilities related professional advice?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
G3	**2. In-house advisors** Where Estates and Facilities related professional advice is provided in house mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate pre-employment checks?	2. Good	2. Good	1. Documented list of advisors 2. Transparent process to appoint suitable advisors 3. Suitable qualifications and experience of advisors	
G3	**3. External advisors** Where Estates and Facilities related professional advice is provided externally mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate skills and knowledge?	3. Requires minimal improvement	2. Good	1. Documented list of advisors 2. Transparent process to appoint suitable advisors 3. Suitable qualifications and experience of advisors	
G3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
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NHS Premises Assurance Model: Governance Domain		
◄◄ Back to instructions		
Ref.	**SAQ/Prompt Questions**	**Comments**
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
G1	**G1. With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed, can the organisation evidence the following?**	
G1	**1. Framework** There is an effective governance framework to support the delivery of the Estates and Facilities strategy and good quality services?	
G1	**2. Roles** Staff are clear about their roles and understand what they are accountable for?	
G1	**3. Partners** Working arrangements with partners and third party providers, e.g. PFI, are effectively managed?	
G1	**4. Framework** The governance framework and management systems are regularly reviewed and improved?	
G1	**5: Assurance** There are comprehensive assurance system and service performance measures, which are reported and monitored, and action taken to improve performance	
G1	**6. Monitoring** There are effective arrangements in place to ensure that the information used to monitor, report (including regional and national data collections) and manage quality and performance is accurate, valid, reliable, timely and relevant (including PFI and non PFI costs).	
G1	**7. Audit** There is a systematic programme of internal audit, which is used to monitor quality and systems to identify where action should be taken?	
G1	**8. Mitigation** There are robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
G1	**9. Alignment** There is alignment between the recorded risks and what people say is 'on their worry list'?	
G1	**10: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	
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◄◄ Back to instructions		
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G2	**3. Visibility** Leaders are visible and approachable.	
G2	**4. Relationships** Leaders encourage appreciative, supportive relationships among staff.	
G2	**5. Respect** Staff feel respected and valued.	
G2	**6. Behaviours** Action is taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority.	
G2	**7. Culture** Is the culture centred on the needs and experience of people who use services?	
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◄◄ Back to instructions		
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G3	**G3: With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services can the organisation evidence the following?**	
G3	**1. Professional advice** The organisation has adequately identified its requirements for Estates and Facilities related professional advice?	
G3	**2. In-house advisors** Where Estates and Facilities related professional advice is provided in house mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate pre-employment checks?	
G3	**3. External advisors** Where Estates and Facilities related professional advice is provided externally mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate skills and knowledge?	
G3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	
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◄◄ Back to instructions

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H1	**Confirmation of Safe Helipad Operations** The Trust must demonstrate that it has established processes to ensure the safe and efficient operation of its helipad in accordance with CAP 1264 guidance **1. Does your NHS organisation have a Hospital Helipad Landing Sites (HHLS)? If the answer is "No", then no further answers on this Domain are required. If the answer is "Yes" all the SAQ below must be answered.**		Yes		https://www.caa.co.uk/our-work/publications/documents/content/cap1264/
H1	**2. How many primary HHLS does the trust have operating?** (Primary HHLS are directly controlled by the NHS organisation).		1		
H1	**3. How many secondary HHLS does the trust utilise?** (Secondary HHLS are those not directly controlled by the NHS organisation, but used regularly.)		1		
H1	**4. Who is the Accountable Manager (AM) for your HHLS? -** Name		David May	Job Description and annual appraisal.	
H1	**5. AM Email address**		davidmay1@nhs.net		
H1	**6. AM Telephone number**		01482 468011		
H1	**7. AM Job Title**		Deputy Head of Facilities (Logistics)		
H1	**8. Hospital Operations Manual (HOM)** Do you have an up-to-date and approved HOM for all your sites? It is owned by the Accountable Manager (AM) and can be delegated to the HHLS Responsible Person (RP) where required and sets the standards, procedures and best practise of the Heliports Operation and Maintenance		Yes		CAP 1264 Chapter 1 HOM Template provided by NHS England.
H1	**9. Risk Assessment and Mitigation Strategies for Helipad and Estates** Is there an up-to-date Risk Assessment in place, undertaken by a competent person alongside the Responsible Person/Accountable Manager? HHLS Risk Assessment be carried out annually or sooner if a reportable incident or near miss occurs.		Yes	Risk assessment and related documentation.	CAP 1264 Chapter 3.
H1	**10. Where Coast Guard Search and Rescue (SAR) landings take place on the HHLS.** Have you provided a signed letter from your Chief Executive confirming responsibility for the safety of the site in the appropriate format?		no		NHS England
H1	**11. Resilience, Emergency & Business Continuity Planning.** Are the HHLS integrated into the Organisation's resilience, emergency, business continuity and escalation plans both for the organisation itself and for the region?		Yes		
H1	**12: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?		no		
H1	**13. Collaboration** Has the organisation in undertaking the risk assessment processes collaborated with helipad users, fire and rescue services re pre-determined site attendance and police with regard to safety & security (in particular terrorism threat) and staff members whose role includes receiving patients from/transferring a patient to, a helicopter.		Yes		
H1	**14. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.		no	Detailed Action Plans: Outlining investments needed for compliance with the NHS Premises Assurance Model (PAM), including specific steps, timelines, and responsible parties. Financial Documentation and Risk Assessments: Detailed cost estimates and risk assessments for areas needing improvement. Board and Committee Escalation Evidence: Documentation showing board-level awareness and action plan discussions. Budget Inclusion Proof and Prior Investment. Assessment: Evidence of budgetary allocation for actions and analysis of the impact of previous investments. Compliance Tracking and Stakeholder Communication: Systems for monitoring action plan progress and evidence of stakeholder engagement. Legal and Regulatory Compliance Documents: References to documents guiding NHS helipad operations and safety standards.	

H1	Capital cost to achieve desired improvements/outcomes		no	Capital Cost Analysis and Legislative Alignment. Legal and Regulatory Compliance Documents: References to documents guiding NHS helipad operations and safety standards. Post-Implementation Review Plan: Outline for evaluating helipad performance and impact after implementation. Revenue Implications of NHS Helipad Improvements Cost-Benefit Analysis and Comparative Case Studies: Financial analysis of improvements and case studies from similar healthcare facilities. Regulatory Compliance and Projected Revenue Impact Reports: Documentation on compliance with laws and projected revenue changes. Stakeholder Feedback and Performance Metrics: Input from various stakeholders and clear metrics for evaluating improvement outcomes. Risk Analysis and Sustainability Assessments: Financial risk identification and assessments of long term sustainability.	
H1	Revenue consequences of achieving desired improvements/outcomes		no		

To Replace the below

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H1	**H1. Confirmation of Safe Helipad Operations and Evidencing Planning and Implementation Practices: Can the organisation confirm they have processes in place to safely maintain the operation of their helipad?** **The Trust must demonstrate that it has established processes to ensure the safe and efficient operation of its helipad.** **This includes evidencing the planning and implementation of the helipad, with clearly defined responsibilities about quality, performance, and risk management.** **The organisation should also be able to evidence the planning and implementation of a helipad with clear responsibilities for quality, performance and risks, can the organisation evidence the following?**	Not applicable	Not applicable	•**Documented Safety Protocols and Procedures** These documents should detail safety protocols for helipad operations, including emergency procedures, maintenance schedules, and guidelines for safe landings and take-offs. •**Maintenance Records** Regular helipad maintenance is essential. Logs and records must show consistent inspections and upkeep to required standards. •**Training Records of Personnel** Ensure all helipad personnel, ground staff, and emergency teams, are trained and qualified. Training records must confirm staff adherence to current safety practices and procedures. •**Risk Assessment Documentation** Evidence must show regular risk assessments for helipad operations, identifying and mitigating potential hazards. •**Quality and Performance Monitoring Records** Documentation should demonstrate the monitoring and evaluation of helipad operations, including incident logs, response times, and corrective actions taken. •**Certifications and Compliance Reports** Any relevant certifications or compliance reports that show the helipad meets national and international safety standards. •**Operational Guidelines and Manuals** Comprehensive operational manuals outlining procedures and responsibilities for safe helipad operation. •**Emergency Response Plans** Documentation of emergency response plans, including coordination with local emergency services and contingency plans for various emergency scenarios. •**Feedback and Incident Reports** Records of user feedback and incident reports for the helipad, including follow-up actions taken. •**Insurance and Liability Documents** Proof of appropriate insurance coverage and liability protections related to helipad operations. **CAA training should be undertaken Hospital Helipad – Aviation Awareness | Training Course by the UK CAA (caainternational.com)**	
H1	1. Compliance Assessment and Policy Review: Adherence to CAP1264 and Downwash Helipad Considerations in the Trust: Policy, Procedures and Compliance: Is the organisation compliant and does the organisation have a current, approved policy and an underpinning set of procedures that comply with CAP1264? The Trust should have a responsible person able to demonstrate and a documented evidence/policy in relation to Downwash helipad factors and considerations within the Trust.	Not applicable	1. Outstanding	CAP1264 Compliance and Operations: The Trust must have documentation proving its helipad design and operations comply with CAP1264 standards. This includes assessing the helipad's layout, safety features, and protocols. Approved Helipad Policy: A regularly reviewed helipad policy, in line with CAP1264 guidelines, should be established. It should encompass emergency procedures, maintenance, and staff training. Documented Evidence/Policy for Downwash Considerations: Downwash Factors Records and analyses are needed to manage helicopter downwash, a key safety concern in helipad design and operations, in accordance with CAP1264. Responsibility and Documentation Appoint a responsible person or team knowledgeable in CAP1264 to oversee helipad operations. Their role includes managing documentation related to downwash, including risk assessments, mitigation strategies, and staff training. Regular Audits and Reviews Conduct frequent audits to ensure the Trust's helipad policies and procedures remain compliant with CAP1264. These should review downwash management and adapt to changes in helicopter technology or operational practices.	

H1	2. Roles and Responsibilities Ensuring Qualified Personnel and Clear Governance Does the Organisation have appropriately qualified, trained, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? When developing the policy and procedures have you consulted with internal and external stakeholders? The Trust should have a responsible person and a documented evidence/policy in relation to general helipad factors and considerations within the Trust.	Not applicable	1. Outstanding	Governance Structure Documentation This should outline the overarching framework within which helipad operations are conducted. It includes details on decision making processes, accountability and how different roles within the organisation contribute to helipad management. Organisational Structure Chart This chart should visually represent the hierarchy and reporting lines relevant to helipad operations. It clarifies who is responsible for what, ensuring that roles and responsibilities are clearly defined and understood. Post Profiles and Training Records Detailed job descriptions for each role involved in helipad operations, along with records of individual training, are crucial. These profiles should include specific qualifications, competencies, and experience required for each position. Training records prove that staff members have been adequately trained for their roles. Evidence of Training and Development Documentation should be provided to show that all staff involved in helipad operations have received proper training. This includes training that meets safety, technical, and quality requirements. Evidence may include certificates, course completion records, and ongoing professional development logs. Specific Training Certifications For instance, the CAA training for Hospital Helipad - Aviation Awareness. This specialised training, offered by the UK Civil Aviation Authority (CAA), ensures that staff is aware of aviation-specific considerations and safety practices related to helipad operations. To ensure comprehensive compliance, the Trust should have a designated responsible person who can present and manage these documents. This individual should be well-versed in the operational aspects of the helipad and the regulatory environment. They should also be capable of liaising with both internal and external stakeholders to ensure that all policies and procedures are up-to-date, effective, and widely understood. Regular consultations with stakeholders, including emergency services, aviation experts, and hospital staff, are vital for maintaining a safe and efficient helipad operation.	
H1	3. Risk Assessment and Mitigation Strategies for Helipad and Estates In relation to this, has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	Not applicable	Documented Risk Assessment Report This should include a comprehensive risk assessment of the helipad and surrounding estate. The report should detail identified risks, the likelihood of occurrence, potential impact, and the scoring methodology used to prioritise risks. Mitigation Strategies and Implementation Evidence Documentation should be provided showing the specific risk mitigation strategies that have been applied. This could include engineering controls, procedural changes, training programs, or any other relevant measures. Evidence of implementation might include records of changes made, training completed, or equipment installed. Regular Review and Update Records Compliance requires not just a one-time assessment but ongoing monitoring and reassessment of risks. Documentation should show how often the risk assessment is reviewed and updated and how new risks or changes in the environment are incorporated. Alignment with Civil Aviation Authority Standards Evidence should be presented that the organisation's risk assessment and mitigation strategies are in line with the Civil Aviation Authority's Standards for helicopter landing areas at hospitals, as detailed in CAP 1264. This might include a comparative analysis or a compliance checklist. Audit and Inspection Reports Regular audits or inspections of the helipad and related facilities can provide evidence of compliance. These reports should detail the findings of the audits, any non-compliances identified, and how these were addressed. Incident and Accident Records Records of any incidents or accidents related to the helipad should be maintained. This includes how these incidents were investigated and what measures were taken to prevent recurrence. Stakeholder Consultation Records Documentation of consultations with stakeholders, including hospital staff, emergency services, and aviation experts, can provide evidence of a thorough and inclusive risk assessment process. Training Record Evidence of training provided to relevant staff in helipad operations and safety can demonstrate commitment to risk mitigation. Emergency Response Plan A documented emergency response plan specific to helipad operations should be available, detailing procedures for various potential emergencies.	
	4. Risk assessment - Regulatory Differences between Ground-Based and Elevated Helipads When conducting fire risk assessments and ensuring compliance with relevant guidelines for NHS helipads, please confirm the Trust understands the distinct regulatory considerations for ground-based and elevated helipads.		5. Inadequate	Ground-Based Helipads Accessibility: Ground-based helipads typically offer easier access to emergency services and fire-fighting equipment. This accessibility needs to be factored into the risk assessment and mitigation strategies. Surrounding Environment The assessment must consider the immediate environment around the helipad, including the types of surfaces (grass, concrete, etc.) and nearby structures or natural features that might influence fire risk. Elevated Helipads (such as on rooftops) Structural Integrity Elevated helipads require careful assessment of the building's structural integrity to support the helipad's weight, especially during fire emergencies. Evacuation Routes Special attention must be given to evacuation routes and emergency access, as elevated helipads may present more challenges in these areas compared to ground-based helipads. Wind and Weather Conditions Elevated helipads are more exposed to wind and other weather elements, which can impact fire behaviour. This must be considered in the fire risk assessment. Fire Suppression System Due to their location, elevated helipads may require specialised fire suppression systems that are effective at higher elevations and in potentially limited spaces. In both cases, the NHS Trust should ensure compliance with the Civil Aviation Authority's standards (CAP 1264) and incorporate specific guidelines for each type of helipad into their overall fire risk management strategy. Regular training, emergency drills, and clear documentation are crucial components of this strategy, regardless of the helipad type.	Possible updates to follow 2023/24

H1	5. NHS Helipad Fire Risk Assessment and Compliance Guidelines Has there been a specific fire risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? Has this assessment taken into account the helipad and the potential healthcare buildings in its curtilage In addition the Trust should have a responsible person and a documented evidence/policy in relation to Fire risk regarding helipad factors and considerations within the Trust.	Not applicable	Not applicable	Specific Fire Risk Assessment for the Helipad Area The NHS Trust should conduct a thorough fire risk assessment specifically for the helipad area. This assessment should consider all potential fire hazards associated with helicopter operations, including fuel, electrical systems, and potential ignition sources. The assessment should also consider the unique characteristics of the helipad, such as its location, size, and proximity to healthcare buildings and other infrastructure. Regular Review and Update of the Fire Risk Assessment The fire risk assessment should not be a one-time activity. It needs to be regularly reviewed and updated to reflect any changes in the operating environment, new helicopter models, or changes in surrounding infrastructure. Regular reviews ensure that any new risks are identified and mitigated promptly. Risk Mitigation Strategies Based on the findings of the fire risk assessment, the Trust should implement appropriate risk mitigation strategies. These might include fire suppression systems, emergency response plans, and safety protocols for fuel handling and storage. The effectiveness of these mitigation strategies should be regularly tested and evaluated. Documentation and Policy The Trust should maintain comprehensive documentation of the fire risk assessment process, including the findings, decisions made, and actions taken. This documentation serves as evidence of compliance with relevant guidelines and legislation. There should also be a clear policy outlining the responsibilities and procedures related to fire risk management at the helipad. Responsibility and Training The Trust should designate a responsible person or team to oversee fire safety at the helipad. This individual or team should have the necessary training and expertise in fire risk management and helicopter operations. Regular training and drills should be conducted for all staff involved in helipad operations to ensure they are aware of fire risks and know how to respond in an emergency. Compliance with Civil Aviation Authority Standards The Trust's risk assessment and mitigation strategies should take into account the relevant sections of the Civil Aviation Authority's Standards for helicopter landing areas at hospitals, outlined in CAP 1264. This includes ensuring that the design, operation, and maintenance of the helipad meet the safety standards set by the Civil Aviation Authority.
H1	6. Resilience, Emergency & Business Continuity Planning Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff in relation to helipad and the estate.	Not applicable	2. Good	Business Continuity Audit Reports for Helipads: These reports analyse an organization's capacity to maintain operations amidst major disruptions like natural disasters or cyber attacks, with a focus on helipad operations and continuity measures. Trust's Incident Response Plan for Helipads: A detailed plan outlining response procedures for incidents impacting the helipad, including emergency medical situations and natural disasters. Committee/Group Terms of Reference: Document detailing the responsibilities of the committee overseeing the helipad's emergency and business continuity plans, including test frequency, scope, and review processes. Corporate Risk Register for Helipad Operations: A comprehensive list of risks related to helipad operations, detailing the nature, likelihood, impact, and mitigation measures for each risk, regularly updated and maintained by an assigned owner. Board-Approved Risk Management Strategy: A strategy document outlining the approach to managing helipad risks, aligning with the organization's broader risk management policies, and subject to periodic review. Board-Signed Incident Response and Business Continuity Plans: Documents detailing emergency response and continuity strategies for the helipad, indicating organizational commitment to preparedness and safety. Stakeholder Collaboration in Risk Assessment and Meeting Records: Documentation evidencing collaboration with stakeholders, including helipad users, emergency services, and staff, in risk assessment processes, and minutes from meetings discussing safety, security, and operational procedures. Compliance Tracking and Stakeholder Communication: Systems for monitoring action plan progress and evidence of stakeholder engagement.
H1	7: Review Process Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	1. Outstanding	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Receiving, checking and authorising invoices for payment for additional services; 4. Monitoring Contractors' approach to rectifying defects; 5. Problem solving and dispute (prevention and) resolution where issues exist. 6. Establish and maintain appropriate records and information management systems to record and manage the performance of the Sub-Contractors; 7. The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working' 8. The ability to report on the regulatory requirements regarding safer wards (ligature). 9. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible rails/surface temperature) particularly when in relation to Mental health facilities and A&E wards.
H1	8. Collaboration Has the organisation in undertaking the risk assessment processes collaborated with helipad users, fire and rescue services re pre-determined site attendance and police with regard to safety & security (in particular terrorism threat) and staff members whose role includes receiving patients from/transferring a patient to, a helicopter	Not applicable	3. Requires minimal improvement	1. Working with relevant organisations to ensure best practice is followed. 2. Consider external sites being used
H1	9. Costed Action Plans If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Not applicable	1. Outstanding	Detailed Action Plans: Outlining investments needed for compliance with the NHS Premises Assurance Model (PAM), including specific steps, timelines, and responsible parties. Financial Documentation and Risk Assessments: Detailed cost estimates and risk assessments for areas needing improvement. Board and Committee Escalation Evidence: Documentation showing board-level awareness and action plan discussions. Budget Inclusion Proof and Prior Investment Assessment: Evidence of budgetary allocation for actions and analysis of the impact of previous investments. Compliance Tracking and Stakeholder Communication: Systems for monitoring action plan progress and evidence of stakeholder engagement. Legal and Regulatory Compliance Documents: References to documents guiding NHS helipad operations and safety standards.
H1	Capital cost to achieve desired improvements/outcomes	£0	£0	Capital Cost Analysis and Legislative Alignment Detailed Cost-Benefit Analysis: Breakdown of costs and benefits of helipad improvements, including patient care and operational efficiency. Post-Implementation Review Plan: Outline for evaluating helipad performance and impact after implementation. Revenue Implications of NHS Helipad Improvements

Ref.	Revenue consequences of achieving desired improvements/outcomes	£0	£0	Cost-Benefit Analysis and Comparative Case Studies: Financial analysis of improvements and case studies from similar healthcare facilities. Regulatory Compliance and Projected Revenue Impact Reports: Documentation on compliance with laws and projected revenue changes. Stakeholder Feedback and Performance Metrics: Input from various stakeholders and clear metrics for evaluating improvement outcomes. Risk Analysis and Sustainability Assessments: Financial risk identification and assessments of long term sustainability.	

This one!

Facilities Management (FM) Maturity

This section has been added as part of a wider Government estate process, NHSE Trusts are asked to support the wider property function across government

			Scoring	**1**	**2**	**3+**		
Integrated	**Integrated Leadership**	Q1 How integrated is facilities management - Soft Services?	**3+**	Soft services is devolved around the organisation without a central "controlling mind".	A central team exists that manage a range of core buildings directly but are not fully integrated	Soft services is integrated with a clear centre of expertise with delivery coordinated centrally		
			Scoring	1	2	3+		
		Q2. How integrated is facilities management - Hard Services?	**3+**	Hard services is devolved around the organisation without a central "controlling mind".	A central team exists that manage a range of core buildings directly but are not fully integrated	Hard services is integrated with a clear centre of expertise with delivery coordinated centrally		
			Scoring	1	2	3+		
		Q3. How integrated is Property Leadership?	**3+**	FM works in a silo, reactive to demand with little engagement with wider property leadership	FM links in some what with construction, design and asset management teams, but gaps remain.	leadership across the wider property function is integrated and aligned. Total cost of ownership is considered and understood across all aspects of asset lifecycle.		
	CAFM		**Scoring**	1	2	3	4	5
		Q4. How integrated are your FM Management IT Systems?	**3**	No CAFM, basic spreadsheets or similar used to monitor and manage FM.	Several systems in use, e.g. asset management system, CAFM, finance system, supplier system. Limited or no integration. Multiple versions of the truth.	A combination of systems are used between departments and suppliers, but a recognised master system is in place, showing one version of the truth.	An integrated CAFM is in use holding all but financial data, which is held in corporate finance system.	Organisation has a single, integrated CAFM system holding a single version of the truth, with other key systems feeding into a master system.
			Scoring	1	2	3	4	5
Collaborative	**Partnership & Transparency**	Q5 - How closely does FM management work with the FM delivery organisation(s)?	**3**	Minimal, adversarial relationship	Weekly or monthly meeti	Regular, joint meetings held taking both a backwards look at performance and a forward look at opportunity for improvement and upcoming changes	Genuine partnership, both sides work in an open and honest way to improve service delivery, built on trust. Very little discussion on poor performance or penalties.	A fully open and trusting relationship, working both ways to improve performance and value
			Scoring	1	2	3+		
		Q6 - How strategic and effective are supplier relationships?	**3+**	Supplier relationships are transactional only.	A supplier relationship model (SRM) is in place (See CCS)	Open and honest conversations about what can be done both sides to improve outcomes. Service plans are jointly developed with each party inputting to one another. Topics such as profit, overheads, investment and supplier sustainability are openly discussed. An effective SRM model is in place.		
			Scoring	1	2	3+		
		Q7 - How transparent is FM delivery between the management organisation and delivery organisation?	**3+**	No transparency regarding performance or cost.	Data held by supplier but	Organisation has real time access to key data in a transparent and open way and is regularly audited.		
			Scoring	1	2	3+		
		Q8 - Does the FM team collaborate outside of the management organisation?	**3+**	Little engagement with wider government departments, occasional attendance at events or key meetings.	Actively involved in cross	In addition to formal cross gov groups, work closely with equals and leadership in other government departments to share best practice and go develop solutions, driving continuous improvement and innovation.		
			Scoring	1	2	3	4+	

Delivery Excellence	Compliance	Q9 - How effective is your hard compliance management approach?	3	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.	Able to evidence compliance on high risk items (Asbestos, Water, Fixed Wiring, Fire, Gas, Lifts). Wider compliance held client side but regularly validated with robust QA.	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated through robust QA.	
			Scoring	1	2	3	4+	5
		Q10 - How effective is your soft compliance management approach?	3	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.	Able to evidence compliance on high risk items (security, risk assessments, data). Wider compliance held client side but regularly validated with robust QA.	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated through robust QA.	
			Scoring	1	2	3+		
	Standards and Best Practice	Q11 - How well standardised is FM management in line with industry best practice? (E.g. ISO)	3+	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.	Use of some industry standards, but less maturity on other aspects	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		
			Scoring	1	2	3+		
		Q12 - How well standardised is FM delivery in line with industry best practice? (E.g. SFG20, CCS)	3+	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.	Use of some industry standards, such as SFG20 but less maturity on other aspects.	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		
			Scoring	1	2	3+		
	Defined Roles	Q13 - How well defined are FM roles and responsibilities within Hard Services?	3+	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		
			Scoring	1	2	3+		
		Q14 - How well defined are FM roles and responsibilities within Soft Services?	3+	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		
			Scoring	1	2	3	4+	
	Enabling	Q15 - How flexible is FM to changing business needs?	3	FM works on fixed price c	Part fixed, part variable a	Work in partnership with suppliers to continually improve support for changing business objectives.	Supplier is engaged in the organisations service and strategy planning and understands their role. They work in partnership to proactively deliver change.	
			Scoring	1	2	3	4+	

Strategic	**FM Strategy**	Q16 -How strategic is FM?	**3**	No FM strategy or service plan. FM is delivered in a reactive way.	Basic FM strategy and ser	FM Strategy in place, con	Long-term vision of what good FM looks like and how to get there. Consideration for external impact (e.g. sustainability) fully embedded into delivery model with robust monitoring and reporting in place. Horizon scanning undertaken including strategic risk management. Strategy fully aligned with aims and values of department/	
			Scoring	1	2	3		
	Governance	Q17 -Do you have effective FM governance in place?	**3**	No management/minimal management. Risk poorly allocated.	Following recognised governance, for example RICS Public sector asset management guide or functional standard on governance.	Clear, best in class and effective governance arrangements in place. Understood by organisation with clear roles and responsibilities.		
			Scoring	1		3	4+	
Intelligent	**Intelligent Client**	Q18 -Do you have a clear definition and recognised Intelligent client function?	**3**	The ICF is dispersed without a clear, recognised function.		A recognised intelligent client function is in place, with defined roles and responsibilities, recognised by the wider organisation and has the capabilities and capacity required to be effective.	A highly effective ICF is in place with it's value recognised at an organisational level.	
			Scoring	1	2	3+		
		Q19 - Is an effective client department in place?	**3+**	No recognisable client department, a number of individuals within the organisation may be responsible for various aspects	An identifiable client department is in place, acting as a conduit between the wider organisation and the delivery organisations to maximise value.	A strong and effective client department is in place, with centralised oversight of all aspects of FM.		
				1	2	3+		
	Control Levers	Q20 -How well do you understand the levers to improve performance?	**3+**	A basic understanding of levers available in the contract, primarily performance failure driven	A good understanding of commercial, financial and quality control levers and their impact of performance	Regular, demonstrable use of all types of control levers to drive continuous improvement		
			Scoring	1	2	3+		
	Management structure	Q21 - Is there sufficient management, capability and capacity to be effective? Are roles clear?	**3+**	Unclear roles and responsibilities, disjoined management with FM and property spread over multiple departments, devolved FM model - no "corporate landlord".	A defined, central FM team undertaking most FM duties, but with some aspects still devolved.	Clearly defined roles and responsibilities, appropriate capacity and capability to effectively discharge duties in a timely manner. Centralised "Centre of expertise" and an effective corporate landlord in place.		
			Scoring	1	2	3+		
	Forward Planning	Q22 - How proactive is FM service delivery in your organisation?	**3+**	Reactive works only, failure driven.	Short term planning - next financial year only.	Accurate condition data driving an FMR based on risk and asset criticality, long term view and whole life costing.		

Facilities Management (FM) Maturity

This section has been added as part of a wider Government estate process, NHSE Trusts are asked to support the wider property function across government

Data Structure	**Hierarchy**		**Scoring**	1	2	3+		
		Q1 - What level of location hierarchy is asset data captured against?	**3+**	Asset level data is captured against the site and building it is in.	Asset level data is captured against the site, building, floor and location it is in.	Asset level data is captured against the site, building, floor, location and system it is in.		
	Data Specification		**Scoring**	1	2	3	4	5
		Q2 - Is there a consistent data specification aligned to the FM asset data standards (4.2)?	**3**	No defined data specification for FM asset data.	Defined data specification for FM asset data is not aligned to the data standard (4.2.1).	Defined data specification for FM asset data is consistently aligned to the data standard (4.2.1).	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and inconsistently aligned to 'non-core' fields (4.2.2).	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and 'non-core' fields (4.2.2).
			Scoring	1	2	3+		
		Q3 - How consistently is the data specification applied across the estate?	**3+**	No defined data specification for FM asset data.	The data specification is inconsistently applied across the estate.	The data specification is consistently applied across the estate.		
	Coverage and Completeness		**Scoring**	1	2	3+		
		Q4 - What is the level of coverage of assets in the asset register data?	**3+**	The asset data covers some assets in some estates.	The asset data covers all assets in some estates but only some assets in other estates.	The asset data covers all assets in all estates.		
			Scoring	1	2	3	4	5
		Q5 - How complete is the data captured against assets in the asset register?	**3**	Data is not captured against assets for the 'core fields' in the data standard (4.2.1).	Data is captured against some assets for the 'core fields' in the data standard (4.2.1).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and some assets for the 'non-core fields' in the data standard (4.2.2).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and all assets for the 'non-core fields' in the data standard (4.2.2).
	Audit		**Scoring**	1	2	3+		
		Q6 - Is a full asset verification exercise required to update the asset register (5.1)?	**3+**	Data is out of date or incomplete and requires a full asset verification exercise.	Data is out of date or incomplete for parts of the estate and requires a targeted asset verification exercise.	Data is up to date and complete. An asset verification exercise is not currently required.		
			Scoring	1	2	3	4	5
		Q7 - What regular sample surveys exist for on-going asset verification (5.2)?	**3**	No / limited sample surveys.	Inconsistent and ad-hoc sample surveys for some of the estates.	Consistent and regular sample surveys for all estates. There is a defined methodology to logically work through the all estates over time.	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in some parts of the estate.	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in all estates.
			Scoring	1	2	3	4	5
		Q8 - What processes are in place for change control/approvals for adding, removing or changing an asset (5.3)?	**3**	No / limited processes in place.	Inconsistent processes exist covering some parts of the estate.	Consistent processes exist covering all estates with clear responsibilities for approvals and tracking of changes.	Partially automated processes with frequent updates to change log.	Automated processes across all estates with close to real-time updates to change log.
			Scoring	1	2	3	4	5

Data Assurance & Quality	**Data Quality Control**	Q9 - What processes are in place for data quality checks (5.4)?	**3**	No / limited processes in place.	Inconsistent and ad-hoc processes exist using basic checks covering some parts of the estate.	Consistent and regular processes exist using checks based on business rules covering all estates.	Partially automated processes using data quality check algorithms and data quality dashboards.	Automated processes using real-time data quality check algorithms, business rules, quality control dashboards and user feedback.
			Scoring	1	2	3	4	5
		Q10 - What processes are in place for data update assurance (5.5)?	**3**	No / limited processes in place.	Inconsistent and ad-hoc processes exist using minimal data quality checks covering some parts of the estate.	Consistent and regular processes exist using verification tools and update logs covering all estates.	Partially automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering parts of the estate.	Automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering all estates.
			Scoring	1	2	3	4	5
	Governance	Q11 - What governance is in place to support data assurance and quality (5.)?	3	No / limited governance / informal group for asset data quality.	A dedicated asset data-quality governance group/board exists but meets on an irregular basis or without the required attendees.	A dedicated asset data-quality governance group/board exists, which meets regularly with all the relevant attendees.	Along with the dedicated asset data quality governance group/board, there are additional sub-working groups with the suppliers.	Along with the dedicated asset data quality governance group/board, there are additional sub-working groups with suppliers and cross-organisational governance board/group.
			Scoring	1	2	3+		
		Q12 - What level of documentation exists for the these data quality processes and governance (5.6)?	**3+**	No / limited documented items for processes and governance.	Some documentation exists related to processes and governance which are applied on an ad-hoc basis across some parts of the estate.	Consistent documentation exists which the organisation applies for these processes and the governance across all estates. This documentation is reviewed and updated on a regular basis.		
Data Ownership and Access			**Scoring**	1	2	3+		
	Ownership	Q13 - Is the data contractually owned by the organisation (6.1)?	**3+**	The organisation does not contractually own the data.	The organisation contractually owns the data for some data stores/parts of estate.	The organisation contractually owns the data for all estates.		
	Accessibility		**Scoring**	1	2	3	4	5
		Q14 - What level of access does the organisation have to the data in the asset management systems (6.2)?	**3**	No / limited access to the data (e.g. data extracts requested via email to FM provider).	Access to some data tables/extracts across some data stores/parts of the estate.	Access to all data tables/extracts across all data stores/all estates and manually extract the required data.	The ability to access data in via desktop tool or automated APIs for some data stores/parts of estate.	The ability to access data in data in via desktop tool or automated APIs for all data stores/all estates.
			Scoring	1	2	3+		
		Q15 - What level of access management exists for controlling user privileges (6.3)?	**3+**	No / limited access management privileges.	Some access management privileges exist across some data stores/parts of the estate. These are inconsistently applied.	Access management privileges exist across all data stores/all estates. These are consistently applied and tightly controlled.		
			Scoring	1	2	3+		
	Flexibility	Q16 - Do the asset management systems provide the flexibility to accommodate the data standards (7.1)?	**3+**	Systems with limited flexibility to accommodate the data standards.	Systems with some flexibility to partially accommodate the data standards for some data stores/parts of the estate.	Systems with flexibility to fully accommodate the data standards for all data stores/all estates.		

Data Systems	**Interoperability**		**Scoring**	1	2	3+		
		Q17 - Do the asset management systems allow interoperability of asset data (7.2)?	**3+**	Systems with limited interoperability between systems.	Systems with some interoperability between some systems and data is not transferable in COBie format.	Systems with interoperability between all systems and data is transferable in COBie format.		
			Scoring	1	2	3	4	5
		Q18 - Does the asset management systems sync to a common data platform (7.3)?	**3**	No common data platform exist.	Common data platform exists but data from some data stores/parts of the estate are stored. Data sources are updated on an ad-hoc basis.	Common data platform exists where data from all data stores/all estates are stored. Data sources are updated on a regular basis.	Common data platform exists where data from all data stores/all estates are aggregated using desktop tools and databases. Data sources are updated frequently.	Common data platform exists where data from all data stores/all estates are aggregated using automated APIs (applications). Data sources are updated in real-time.
	Management		**Scoring**	1	2	3+		
		Q19 - Do the systems meet data security requirements (7.4)?	**3+**	No systems meet minimum requirements across any estate.	Some of the systems meet data security requirements across some data stores/parts of the estate.	All systems meet data security requirements across all estates.		
			Scoring	1	2	3+		
		Q20 - Do the systems meet data backup management requirements (7.5)?	**3+**	No systems meet minimum requirements across any estate.	Some of the systems meet data backup management requirements across some data stores/parts of the estate. Backup processes are ad-hoc.	All systems meet data backup management requirements. Backup processes are on a regular basis.		
Data Usage	**Management Information**		**Scoring**	1	2	3	4	5
		Q21 - What types of management information reports and dashboards are used for FM asset data (8.1)?	**3**	No / ad hoc reporting and dashboarding to support the use of FM asset data.	Inaccurate reports generated from data gathered point in time.	Standard reporting and interactive dashboards generated regularly with reliable processing and calculations.	Standard reporting and interactive dashboards generated from frequently updated data via robust data pipelines.	Ability to create bespoke customisable reports to answer the latest business questions.
	Insights		**Scoring**	1	2	3	4	5
		Q22 - How does asset data inform decisions relating to contract management (8.2)?	**3**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5
		Q23 - How does asset data inform decisions relating to mandatory and statutory compliance (8.3)?	**3**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5
		Q24 - How does asset data inform decisions relating to Planned Preventative Maintenance (8.4)?	**3**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5

		Q25 - How does asset data inform decisions relating to Investment Prioritisation (8.5)?	**3**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
Team Capacity and Capability			**Scoring**	1	2	3	4	5
	Capacity	Q26 - What is the capacity of the teams working with asset data (9.1, 9.2)?	**3**	No dedicated teams/informal teams.	Dedicated team exists within the organisation covering some parts of the estate. Individuals do not have assigned responsibilities and accountabilities.	Dedicated team exists within the organisation covering some parts of the estate. Individuals have clear with responsibilities and accountabilities. Identified individuals with responsibilities and accountabilities to manage, monitor and generate required reports/insights from FM asset data.	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers.	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers and cross-organisational data team.
			Scoring	1	2	3	4	5
	Capability	Q27 - What is the capability of the teams working with asset data (9.3)?	**3**	No dedicated personnel/informal teams.	Team with some FM and data/technical understanding.	Team with good FM and data/technical understanding. Ability to extract, transform, load and report data to generate required reports and insights.	Team with the ability to create robust and repeatable data processes along interactive dashboard to support in generating insights.	Team with the ability to use predictive and prescriptive analytical techniques used to create forward-looking insights.
	Training		**Scoring**	1	2	3	4	5
		Q28 - What training is provided for teams working with asset data (9.4)?	**3**	No / limited training provided.	Inconsistent and ad-hoc pieces of training exist focusing on basic understanding and only the necessary parts of the processes. They are partially in line with the Government Property Profession career framework.	Consistent and regular pieces of training exist focusing on all the necessary processes. They are in line with the Government Property Profession career framework.	Frequent pieces of training focusing on better understanding and upskilling in extended processes and tools used within the organisation.	Frequent pieces of training focusing on upskilling in advanced analytical and automation skills.
			Scoring	1	2	3+		
		Q29 - What training materials exists relating to asset data (9.5)?	**3+**	No training and guidance material for asset data and processes.	Some training and guidance material exist related to asset data and processes covering some parts of the estate. These are reviewed and referred to on an ad-hoc basis.	Consistent training and guidance material exist covering onboarding, quality and audit processes, etc. for all estates. These are reviewed and referred to on regular basis.		
			Scoring	1	2	3	4	5
		Q30 - What knowledge sharing exists relating to asset data (9.6)?	**3**	No / limited knowledge sharing in place.	Some knowledge sharing exists within the organisation and some irregular knowledge sharing exists between organisations.	Consistent knowledge sharing exists between different organisations on a regular basis.	Consistent knowledge sharing exists between different organisations on a regular basis. Some knowledge sharing with suppliers on an irregular basis.	Consistent knowledge sharing exists between different organisations. Consistent knowledge sharing with suppliers on a regular basis.

Section	Area	Question	Add Details
All	Contact details	1. **Identify Lead for:** Insert name for board representative	Emma Sayner,, Chief Financial Officer
All		1.a Insert contact details	emma.sayner@nhs.net
Linen and laundry	Contact details	2. **Identify Lead for linen and laundry:** Insert name of board representative and contact details	Tom Myers, Group Director of Estates, Facilities & Development tom.myers2@nhs.net
Linen and laundry	Contact details	3. **Identify Lead for linen and laundry:** Insert name of competent persons and contact details	Caroline Gorman, Hotel Services Manager caroline.gorman2@nhs.net
Linen and laundry	Contact details	3. **Identify Lead for linen and laundry:** Insert name of authorised persons and contact details	Zara Ridge, Head of Facilities zara.ridge@nhs.net
Food	Contact details	1. Identify Lead for food: Insert name for board representative and contact details	Emma Sayner,, Chief Financial Officer emma.sayner@nhs.net
Food	Contact details	2. Identify Lead for food: Insert name for Competent Persons and contact details	Michael James michael.james17@nhs.net
Food	Contact details	2. **Identify Lead for:** Insert name of catering dietitian	Unappointed.
Food	Contact details	2a. Contact details of the dietitian	N/A.
Food	Contact details	2b Indicate if this is in house in-house, from an FM provider or an external contract (including NHS Supply Chain)	N/A.
Food	Contact details	3. **Identify Lead for:** Organisations must nominate a food safety specialist. Provide details of person or company supplying service	Mark Richardson, RFS Consulting
Medical Gas	Contact details	4. Medical gas committee: Board Executive responsible for medical gasses	Tom Myers, Group Director of Estates, Facilities & Development
Medical Gas	Contact details	5. Authorised Engineer	Unappointed, out to tender
Medical Gas	Contact details	6. Authorised Person	Neil Kaye, Head of Engineering
Terrorism (Protection of Premises) Act 2025	Contact details	Please provide contact details; name, job title and contact email, of the appointed Accountable Officer in relation to this	N/A
Terrorism (Protection of Premises) Act 2026	Contact details	Please provide contact details; name, job title and contact email, of the organisation's Board appointed Designated Individual(s) for relevant premises?	N/A

NHS PAM Safety Prompt Question Guidance Sheets	◄◄ Back to instructions

Introduction

This sheet supplements the 'generic' prompt questions contained within NHS PAM safety domain. It provides key references from the following documents that users should consider when undertaking their assessment of the relevant prompts:
1. Health and Safety Executive publication HSG 65 'Managing for health and safety'
2. The Care Quality Commission Provider Handbooks Appendix A 'Key Lines of Enquiry'
3. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Associated CQC guidance

Extracts from HSG 65 primarily relate to H&S regulations so may not be strictly relevant in all instance. However the advice may still be useful. HSG 65 'Managing for health and safety' is available from: http://www.hse.gov.uk/pubns/priced/hsg65.pdf.
Similarly some references from the regulations and CQC guidance, particularly around training and development, may relate primarily to clinical and clinical support staff but again they still may be useful.

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

1.1 HSG 65 page 21:

Policies should be designed to meet legal requirements, prevent health and safety problems, and enable you to respond quickly where difficulties arise or new risks are introduced.

1.2 Regulations and CQC Guidance

15(1)d
• The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used.

15(1)d&e
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.

1.3 Regulations and CQC Guidance	CQC KLOE
15(1)d • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.	S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff?
17(2)(e) Where relevant, the provider should also seek and act on the views of external bodies such as fire, environmental health, royal colleges and other bodies who provide best practice guidance relevant to the service provided.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

2.1 HSG 65

HSG 65 page 11)
The Management of Health and Safety at Work Regulations 1999 require employers to put in place arrangements to control health and safety risks. As a minimum, you should have the processes and procedures required to meet the legal requirements, including:
■ ensuring there is adequate and appropriate supervision in place;
■ access to competent health and safety advice, for example see the Occupational Safety and Health Consultants Register (OSHCR) at www.hse.gov.uk/oshcr;

HSG 65 page 17:
The competence of individuals is vital, whether they are employers, managers, supervisors, employees or contractors, especially those with safety-critical roles (such as plant maintenance engineers). It ensures they recognise the risks in their activities and can apply the right measures to control and manage those risks.

2.2 Regulations and CQC Guidance

15(1)d&e
• Providers must make sure that staff and others who operate the equipment are trained to use it appropriately.

18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

2.4 Regulations and CQC Guidance	CQC KLOE
18(1) Guidance: Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards).	E3.1. Do staff have the right qualifications, skills, knowledge and experience to do their job when they start their employment, take on new responsibilities and on a continual basis?

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

3.1 HSG

HSG 65 Page 27)
What the law says on assessing risks
The law states that a risk assessment must be 'suitable and sufficient', i.e. it should show that:
■ a proper check was made;
■ you asked who might be affected;
■ you dealt with all the obvious significant risks, taking into account the number of people who could be involved;
■ the precautions are reasonable, and the remaining risk is low;
■ you involved your workers or their representatives in the process.
The level of detail in a risk assessment should be proportionate to the risk and appropriate to the nature of the work. Insignificant risks can usually be ignored, as can risks arising from routine activities associated with life in general, unless the work activity compounds or significantly alters those risks.
Your risk assessment should only include what you could reasonably be expected to know – you are not expected to anticipate unforeseeable risks.

HSG 65 page 14)
Leaders, at all levels, need to understand the range of health and safety risks in their part of the organisation and to give proportionate attention to each of them. This applies to the level of detail and effort put into assessing the risks, implementing controls, supervising and monitoring.

HSG 65 page 13)
The risk profile of an organisation informs all aspects of the approach to leading and managing its health and safety risks.

HSG 65 page 13)
Every organisation will have its own risk profile. This is the starting point for determining the greatest health and safety issues for the organisation. In some businesses the risks will be tangible and immediate safety hazards, whereas in other organisations the risks may be health-related and it may be a long time before the illness becomes apparent.

3.2 Regulations and CQC Guidance

15(1)c: • Any alterations to the premises or the equipment that is used to deliver care and treatment must be made in line with current legislation and guidance. Where the guidance cannot be met, the provider should have appropriate contingency plans and arrangements to mitigate the risks to people using the service.

17(2)(b)
Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.

17(2)(b)
Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.

17(2)(b)
Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.

17(2)(b)
Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate.
Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.

17(2)(b)
Note: In this regulation, 'others' includes anyone who may be put at risk through the carrying on of a regulated activity, such as staff, visitors, tradespeople or students.

3.3 Regulations and CQC Guidance	CQC KLOE
15(1)d&e • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required. 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;	S4.4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing? W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?

4: Maintenance
Are assets, equipment and plant adequately maintained?

4.1 Regulations and CQC Guidance

15(1)d
• Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.

15(1)d&e
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

5.1 HSG 65

HSG 65 page 11) The Management of Health and Safety at Work Regulations 1999 require employers to put in place arrangements to control health and safety risks. As a minimum, you should have the processes and procedures required to meet the legal requirements, including:
■ ensuring there is adequate and appropriate supervision in place;
■ access to competent health and safety advice, for example see the Occupational Safety and Health Consultants Register (OSHCR) at www.hse.gov.uk/oshcr;

3.2 Regulations and CQC Guidance

18(2) Persons employed by the service provider in the provision of a regulated activity must
18(2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

Providers must ensure that they have an induction programme that prepares staff for their role. It is expected that providers that employ healthcare assistants and social care support workers should follow the Care Certificate standards to make sure new staff are supported, skilled and assessed as competent to carry out their roles.

Where appropriate, staff must be supervised until they can demonstrate required/acceptable levels of competence to carry out their role unsupervised.

Staff should receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained.
Other mandatory training, as defined by the provider for their role.

Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support.

Other learning and development opportunities required to enable them to fulfil their role. This includes first aid training for people working in the adult social care sector.

All learning and development and required training completed should be monitored and appropriate action taken quickly when training requirements are not being met.

Other mandatory training, as defined by the provider for their role.

Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support.

Other learning and development opportunities required to enable them to fulfil their role. This includes first aid training for people working in the adult social care sector.

All learning and development and required training completed should be monitored and appropriate action taken quickly when training requirements are not being met.

18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and
Providers must support staff to obtain appropriate further qualifications that would enable them to continue to perform their role.
Providers must not act in a way that prevents or limits staff from obtaining further qualifications that are appropriate to their role.
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and
Providers must support staff to obtain appropriate further qualifications that would enable them to continue to perform their role.
Providers must not act in a way that prevents or limits staff from obtaining further qualifications that are appropriate to their role.

4.3 Regulations and CQC Guidance	CQC KLOE
Training, learning and development needs of individual staff members must be carried out at the start of employment and reviewed at appropriate intervals during the course of employment. Staff must be supported to undertake training, learning and development to enable them to fulfil the requirements of their role.	E3.2. How are the learning needs of staff identified? E3.3. Do staff have appropriate training to meet their learning needs? E3.4. Are staff encouraged and given opportunities to develop?
Staff should be supported to make sure they are can participate in: Statutory training.	S3.2. Do staff receive effective mandatory training in the safety systems, processes and practices?
Staff should receive regular appraisal of their performance in their role from an appropriately skilled and experienced person and any training, learning and development needs should be identified, planned for and supported.	E3.5. What are the arrangements for supporting and managing staff? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.) E3.6. How is poor or variable staff performance identified and managed? How are staff supported to improve?

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

6.1 CQC KLOE

S5.2. What arrangements are in place to respond to emergencies and major incidents? How often are these practised and reviewed?

S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing?

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

7.1 Regulations and CQC Guidance

17(2)(f)
Providers must ensure that their audit and governance systems remain effective.

7.2 Regulations and CQC Guidance	CQC KLOE
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).

8: Costed Action Plans
If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?

References to risk assessment and management are details under prompt 3 above

8: Scoring
Scoring should be based on the following:

	Self-assessment rating	% to score in given area
	Not applicable: This prompt question does not apply to the trust e.g. Mental Health trusts do not use Medical Gases;	
	Outstanding: Compliant with no action required, plus evidence of high-quality services and innovation. This Score is likely to be rarely applied.	100%
	Good: compliant no action required.	85% or above
	Requires minimal improvement: The impact on people who use services, visitors or staff is low.	66% to 85%
	Requires moderate improvement: The impact on people who use services, visitors or staff is medium.	45% to 65%
	Inadequate	45% or less

NHS Premises Assurance Model 2016

◄◄ Back to instructions	
This sheet shows the relationship and link between the NHS PAM SAQs and: 1. Relevant parts of the 'Health and Social Care Act 2008 (Regulated Activities) Regulations 2014' 2. Associated CQC guidance to providers on meeting the Regulations 3. CQC provider Handbooks Annex A: Key Lines of Enquiry	
Regulations (bold text) **CQC Guidance** (non-bold text), **CQC KLOE** (bold italics)	**PAM Ref.**
Regulation 14: Meeting nutritional and hydration needs (FS)	
CQC KLOE: E1.4. How are people's nutrition and hydration needs assessed and met?	
14(1) The nutritional and hydration needs of service users must be met.	SS1
Providers must include people's nutrition and hydration needs when they make an initial assessment of their care, treatment and support needs and in the ongoing review of these. The assessment and review should include risks related to people's nutritional and hydration needs. Providers should have a food and drink strategy that addresses the nutritional needs of people using the service.	
14(2) Paragraph 1 applies where— **(a) care or treatment involves—** **the provision of accommodation by the service provider, or** **an overnight stay for the service user on premises used by the service for the purposes of carrying on a regulated activity, or** **(b) the meeting of the nutritional or hydration needs of service users is part of the arrangements made for the provision of care or treatment by the service provider.**	SS1
Providers must meet people's nutrition or hydration needs wherever an overnight stay is provided as part of the regulated activity or where nutrition or hydration are provided as part of the arrangements made for the person using the service.	
14(3) But paragraph (1) does not apply to the extent that the meeting of such nutritional or hydration needs would— **(a) result in a breach of regulation 11, or** **(b) not be in the service user's best interests**	NA
14(4)(a) receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health,	
Nutrition and hydration assessments must be carried out by people with the required skills and knowledge. The assessments should follow nationally recognised guidance and identify, as a minimum: requirements to sustain life, support the agreed care and treatment, and support ongoing good health dietary intolerances, allergies, medication contraindications how to support people's good health including the level of support needed, timing of meals, and the provision of appropriate and sufficient quantities of food and drink.	SS1 should demonstrate following the Nutrition & hydration assessment but assessment is not part of PAM
Nutrition and hydration needs should be regularly reviewed during the course of care and treatment and any changes in people's needs should be responded to in good time. A variety of nutritious, appetising food should be available to meet people's needs and be served at an appropriate temperature. When the person lacks capacity, they must have prompts, encouragement and help to eat as appropriate.	SS1
Where a person is assessed as needing a specific diet, this must be provided in line with that assessment. Nutritional and hydration intake should be monitored and recorded to prevent unnecessary dehydration, weight loss or weight gain. Action must be taken without delay to address any concerns. Staff must follow the most up-to-date nutrition and hydration assessment for each person and take appropriate action if people are not eating and drinking in line with their assessed needs. Staff should know how to determine whether specialist nutritional advice is required and how to access and follow it.	NA
Water must be available and accessible to people at all times. Other drinks should be made available periodically throughout the day and night and people should be encouraged and supported to drink. Arrangements should be made for people to receive their meals at a different time if they are absent or asleep when their meals are served. Snacks or other food should be available between meals for those who prefer to eat 'little and often'.	SS1

14(4)(b) receipt by a service user of parenteral nutrition and dietary supplements when prescribed by a health care professional,	NA
14(4)(c) the meeting of any reasonable requirements of a service user for food and hydration arising from the service user's preferences or their religious or cultural background, and	
People should be able to make choices about their diet. People's religious and cultural needs must be identified in their nutrition and hydration assessment, and these needs must be met. If there are any clinical contraindications or risks posed because of any of these requirements, these should be discussed with the person, to allow them to make informed choices about their requirements. When a person has specific dietary requirements relating to moral or ethical beliefs, such as vegetarianism, these requirements must be fully considered and met. Every effort should be made to meet people's preferences, including preference about what time meals are served, where they are served and the quantity.	SS1
14(4)(d) if necessary, support for a service user to eat or drink	NA
Regulation 15: Premises and equipment (FS)	
15(1) All premises and equipment used by the service provider must be— 15(1)(a) clean,	
CQC KLOE S3.5. How are standards of cleanliness and hygiene maintained?	
• Premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance.	
• Premises and equipment should be visibly clean and free from odours that are offensive or unpleasant.	
• Providers should: o Use appropriate cleaning methods and agents. o Operate a cleaning schedule appropriate to the care and treatment being delivered from the premises or by the equipment. o Monitor the level of cleanliness. o Take action without delay when any shortfalls are identified. o Make sure that staff with responsibility for cleaning have appropriate training.	Safety SAQ SS4
• Domestic, clinical and hazardous waste and materials must be managed in line with current legislation and guidance.	
CQC KLOE S3.9. Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.)	Safety SAQ SS3
15(1) All premises and equipment used by the service provider must be— 15(1)(b) secure,	Safety SAQ SS6
• Security arrangements must make sure that people are safe while receiving care, including:	
CQC KLOES3.4. Are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures?	Safety SAQ SS6
o Protecting personal safety, which includes restrictive protection required in relation to the Mental Capacity Act 2005 and Mental Health Act 1983. This includes the use of window restrictors or locks on doors, which are used in a way that protects people using the service when lawful and necessary, but which does not restrict the liberty of other people using the service.	Safety SAQ SS6
CQC KLOE E1.7. Are the rights of people subject to the Mental Health Act (MHA) protected and do staff have regard to the MHA Code of Practice?	
o Protecting personal property and/or money.	
o Providing appropriate access to and exit from protected or controlled areas.	
o Not inadvertently restricting people's movements.	
o Providing appropriate information about access and entry when people who use the service are unable to come and go freely and when people using a service move from the premises as part of their care and treatment.	
o Using the appropriate level of security needed in relation to the services being delivered. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Guidance for providers on meeting the regulations March 2015 57	Safety SAQ SS6

• If any form of surveillance is used for any purpose, the provider must make sure that this is done in the best interests of people using the service, while remaining mindful of their responsibilities for the safety of their staff. Any surveillance should be operated in line with current guidance. Detailed guidance on the use of surveillance is available on CQC's website.	
15(1) All premises and equipment used by the service provider must be— 15(1)(c) suitable for the purpose for which they are being used,	Safety SAQ SH2
Premises must be fit for purpose in line with statutory requirements and should take account of national best practice.	
CQC KLOE S3.7. Does the design, maintenance and use of facilities and premises keep people safe?	
• Premises must be suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time. There must be sufficient equipment to provide the service.	Safety SAQ SH2 & SH15
• Adequate support facilities and amenities must be provided where relevant to the service being provided. This includes sufficient toilets and bathrooms for the number of people using the service, adequate storage space, adequate seating and waiting space.	Safety SAQ SH2
• People's needs must be taken into account when premises are designed, built, maintained, renovated or adapted. Their views should also be taken into account when possible.	Patient Experience SAQ P1
• People should be able to easily enter and exit premises and find their way around easily and independently. If they can't, providers must make reasonable adjustments in accordance with the Equality Act 2010 and other current legislation and guidance.	Safety SAQ SH2 & Patient Experience SAQ P6
• Any alterations to the premises or the equipment that is used to deliver care and treatment must be made in line with current legislation and guidance. Where the guidance cannot be met, the provider should have appropriate contingency plans and arrangements to mitigate the risks to people using the service.	Safety SAQ SH2
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
The premises and equipment used to deliver care and treatment must meet people's needs and, where possible, their preferences. This includes making sure that privacy, dignity and confidentiality are not compromised.	Safety SAQ SH2
• Reasonable adjustments must be made when providing equipment to meet the needs of people with disabilities, in line with requirements of the Equality Act 2010.	Safety SAQ SH15
15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and	Safety prompt questions 1,4 & 7 for each technical area e.g. electrical safety
• Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.	
CQC KLOE S3.7. Does the design, maintenance and use of facilities and premises keep people safe? S3.8. Does the maintenance and use of equipment keep people safe?	
• The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used.	Safety SAQ SH2 & SH15
• Any change of use of premises and/or equipment should be informed by a risk assessment and providers must make appropriate alterations to premises and equipment where reasonably practical. Where this is not possible, providers should have appropriate contingency plans and arrangements to mitigate the risks to people using the service. Alterations must be in line with current legislation and guidance.	Safety SAQ SH2
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required.	SH4 & safety SAQ prompt 3
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures.	Safety SAQ SH1 & Safety SAQ prompt 4

• Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration.	Safety SAQ SH1 & Safety SAQ prompt 4
S3.8. Does the maintenance and use of equipment keep people safe?	
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.	Safety SAQ SH15
S3.8. Does the maintenance and use of equipment keep people safe?	
• Providers must make sure that staff and others who operate the equipment are trained to use it appropriately.	Safety SAQ SH15 & Safety SAQ prompt 2&5
15(1) All premises and equipment used by the service provider must be— 15(1)(f) appropriately located for the purpose for which they are being used.	
• When planning the location of premises, providers must take into account the anticipated needs of the people who will use the service and they should ensure easy access to other relevant facilities and the local community.	Patient Experience SAQ P1
• Facilities should be appropriately located to suit the accommodation that is being used. This includes short distances between linked facilities, sufficient car parking that is clearly marked and reasonably close, and good access to public transport.	Safety SAQ SH2
Equipment must be accessible at all times to meet the needs of people using the service. This means it must be available when needed, or obtained in a reasonable time so as not to pose a risk to the person using the service. Equipment includes chairs, beds, clinical equipment, and moving and handling equipment.	Safety SAQ SH15
S3.8. Does the maintenance and use of equipment keep people safe?	
15(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.	
• Providers must comply with guidance from the Department of Health about the prevention and control of infections: Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance.	Safety SAQ SS4
S3.6. Are reliable systems in place to prevent and protect people from a healthcare-associated infection?	
• Where applicable, premises must be cleaned or decontaminated in line with current legislation and guidance, and equipment must be cleaned, decontaminated and/or sterilised in line with current legislation and guidance and manufacturers' instructions. Equipment must be cleaned or decontaminated after each use and between use by different people who use the service.	Safety SAQ SS4
• Ancillary services belonging to the provider, such as kitchens and laundry rooms, which are used for or by people who use the service, must be used and maintained in line with current legislation and guidance. People using the service and staff using the equipment should be trained to use it or supervised/risk assessed as necessary.	Safety SAQ SS1, SS4 & SH10
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• Multiple use equipment and devices must be cleaned or decontaminated between use. Single use and single person devices must not be re-used or shared. All staff must understand the risk to people who use services if they do not adhere to this.	Safety SAQ SS2 & SS4
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
Regulation 16: Receiving and acting on complaints (FS)	Patient Exp SAQ P1
R4. How are people's concerns and complaints listened and responded to and used to improve the quality of care?	
16(1) Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.	P1

People must be able to make a complaint to any member of staff, either verbally or in writing. All staff must know how to respond when they receive a complaint. Unless they are anonymous, all complaints should be acknowledged whether they are written or verbal. Complainants must not be discriminated against or victimised. In particular, people's care and treatment must not be affected if they make a complaint, or if somebody complains on their behalf. Appropriate action must be taken without delay to respond to any failures identified by a complaint or the investigation of a complaint. Information must be available to a complainant about how to take action if they are not satisfied with how the provider manages and/or responds to their complaint. Information should include the internal procedures that the provider must follow and should explain when complaints should/will be escalated to other appropriate bodies. Where complainants escalate their complaint externally because they are dissatisfied with the local outcome, the provider should cooperate with any independent review or process.	P1
16(2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.	P1
Information and guidance about how to complain must be available and accessible to everyone who uses the service. It should be available in appropriate languages and formats to meet the needs of the people using the service. Providers must tell people how to complain, offer support and provide the level of support needed to help them make a complaint. This may be through advocates, interpreter services and any other support identified or requested. When complainants do not wish to identify themselves, the provider must still follow its complaints process as far as possible. Providers must have effective systems to make sure that all complaints are investigated without delay. This includes: Undertaking a review to establish the level of investigation and immediate action required, including referral to appropriate authorities for investigation. This may include professional regulators or local authority safeguarding teams. Making sure appropriate investigations are carried out to identify what might have caused the complaint and the actions required to prevent similar complaints. When the complainant has identified themselves, investigating and responding to them and where relevant their family and carers without delay.	P1
Providers should monitor complaints over time, looking for trends and areas of risk that may be addressed. Staff and others who are involved in the assessment and investigation of complaints must have the right level of knowledge and skill. They should understand the provider's complaints process and be knowledgeable about current related guidance. Consent and confidentiality must not be compromised during the complaints process unless there are professional or statutory obligations that make this necessary, such as safeguarding. Complainants, and those about whom complaints are made, must be kept informed of the status of their complaint and its investigation, and be advised of any changes made as a result. Providers must maintain a record of all complaints, outcomes and actions taken in response to complaints. Where no action is taken, the reasons for this should be recorded. Providers must act in accordance with Regulation 20: Duty of Candour in respect of complaints about care and treatment that have resulted in a notifiable safety incident.	P1
16(3) The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of— **(a) complaints made under such complaints system,** **(b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and** **(c) any other relevant information in relation to such complaints as the Commission may request.**	P1

CQC can ask providers for information about a complaint; if this is not provided within 28 days of our request, it may be seen as preventing CQC from taking appropriate action in relation to a complaint or putting people who use the service at risk of harm, or of receiving care and treatment that has, or is, causing harm. The 28-day period starts the day after the request is received.	P1
Regulation 17: Good governance (FS)	
W2.6. Are there comprehensive assurance system and service performance measures, which are reported and monitored, and is action taken to improve performance ***S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff?*** ***W2. Does the governance framework ensure that responsibilities are clear and that quality, performance and risks are understood and managed?***	The NHS PAM is designed to be used as a system that meets this requirement
17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. Providers must operate effective systems and processes to make sure they assess and monitor their service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended). The provider must have a process in place to make sure this happens at all times and in response to the changing needs of people who use the service.	
The system must include scrutiny and overall responsibility at board level or equivalent.	Governance domain
17(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—	
17(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); ***S3.3. Is implementation of safety systems, processes and practices monitored and improved when required?*** 1. Providers must have systems and processes such as regular audits of the service provided and must assess, monitor and improve the quality and safety of the service. The audits should be baselined against Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and should, where possible, include the experiences people who use the service. The systems and processes should be continually reviewed to make sure they remain fit for purpose. Fit for purpose means that: systems and processes enable the provider to identify where quality and/or safety are being compromised and to respond appropriately and without delay. providers have access to all necessary information.	The NHS PAM is designed to be used as a system that meets this requirement
17(2)(a) 2. Information should be up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated and appropriate action taken. ***W2.7. Are there effective arrangements in place to ensure that the information used to monitor and manage quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?*** ***W5.6. How is information used proactively to improve care?***	G1.7
17(2)(a) 3. Providers should have effective communication systems to ensure that people who use the service, those who need to know within the service and, where appropriate, those external to the service, know the results of reviews about the quality and safety of the service and any actions required following the review.	NA
17(2)(a) 4. Providers should actively seek the views of a wide range of stakeholders, including people who use the service, staff, visiting professionals, professional bodies, commissioners, local groups, members of the public and other bodies, about their experience of, and the quality of care and treatment delivered by the service. Providers must be able to show how they have: analysed and responded to the information gathered, including taking action to address issues where they are raised, and used the information to make improvements and demonstrate that they have been made ***W4. How are people who use the service, the public and staff engaged and involved?***	Patient Experience SAQ P1
Providers must seek professional/expert advice as needed and without delay to help them to identify and make improvements.	Governance SAQ G3

17(2)a Providers must monitor progress against plans to improve the quality and safety of services, and take appropriate action without delay where progress is not achieved as expected.	PE domain and action plan prompt under each SAQ
Subject to statutory consent and applicable confidentiality requirements, providers must share relevant information, such as information about incidents or risks, with other relevant individuals or bodies. These bodies include safeguarding boards, coroners, and regulators. Where they identify that improvements are needed these must be made without delay.	Safety SAQ SH17
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	Safety SAQ prompt Question 1
E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).	
17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;	Safety SAQ prompt question 3 & G1.9 & G1.10
S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff? ***S4.4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively?*** ***S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing?***	
17(2)(b) Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.	
17(2)(b) Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.	
17(2)(b) Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.	
17(2)(b) Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.	
17(2)(b) Note: In this regulation, 'others' includes anyone who may be put at risk through the carrying on of a regulated activity, such as staff, visitors, tradespeople or students.	
17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;	NA
17(2)(d) maintain securely such other records as are necessary to be kept in relation to— **(i) persons employed in the carrying on of the regulated activity, and** **(ii) the management of the regulated activity;**	
Records relating to people employed and the management of regulated activities must be created, amended, stored and destroyed in accordance with current legislation and guidance.	
Records relating to people employed must include information relevant to their employment in the role including information relating to the requirements under Regulations 4 to 7 and Regulation 19 of this part (part 3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This applies to all staff, not just newly appointed staff. Providers must observe data protection legislation about the retention of confidential personal information.	

Records relating to the management of regulated activities means anything relevant to the planning and delivery of care and treatment. This may include governance arrangements such as policies and procedures, service and maintenance records, audits and reviews, purchasing, action plans in response to risk and incidents.	Safety SAQ SH3
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
Records must be kept secure at all times and only accessed, amended or destroyed by people who are authorised to do so.	
Information in all formats must be managed in line with current legislation and guidance.	
Systems and processes must support the confidentiality of people using the service and not contravene the Data Protection Act 1998.	
17(2)(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;	Patient Experience SAQ P1
17(2)(e) Providers should actively encourage feedback about the quality of care and overall involvement with them. The feedback may be informal or formal, written or verbal. It may be from people using the service, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies.	
17(2)(e) All feedback should be listened to, recorded and responded to as appropriate. It should be analysed and used to drive improvements to the quality and safety of services and the experience of engaging with the provider.	
17(2)(e) Improvements should be made without delay once they are identified, and the provider should have systems in place to communicate how feedback has led to improvements.	
17(2)(e) Where relevant, the provider should also seek and act on the views of external bodies such as fire, environmental health, royal colleges and other bodies who provide best practice guidance relevant to the service provided.	
17(2)(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).	Safety SAQ prompt question 7, SAQ G1.8 & G1.4
17(2)(f) Providers must ensure that their audit and governance systems remain effective.	
17(3) The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—-	NA
Regulation 18: Staffing (FS)	see also 'prompt guidance sheet'
18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.	Safety SAQ prompt question 2: See 'prompt guidance sheet'
S4.1. How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available?	
18(2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,	Safety SAQ prompt question 5: See 'prompt guidance sheet'
S3.2. Do staff receive effective mandatory training in the safety systems, processes	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to	
Regulation 19: Fit and proper persons employed (FS)	NA
Regulation 20: Duty of candour (FS)	**G2.9**

Northern Lincolnshire and Goole NHS Foundation Trust

Estates and Facilities

Premises Assurance Model 2024-2025

End of Year Report

Northern Lincolnshire & Goole NHS Foundation Trust

Working in partnership:
Hull University Teaching Hospitals NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust

United by Compassion:
Driving for Excellence

Contents

Purpose

The purpose of this report is to provide an end-of-year summary of the main findings of completing the mandatory NHSE 2024-25 Premises Assurance Model (PAM), which is required to have Trust Board oversight/sign off.

Background Information

Regulated by NHSE, the PAM is a national, mandatory standardised approach to self-assessing assurance levels within Estates, Facilities[1] and Development (EF&D). Through the coordinated engagement with both internal and external stakeholders, there are seven domains comprising of 53 self-assessment categories that provide the assessment structure:

1. Safety Hard (Estates) – x22 assessment categories
2. Safety Soft (Facilities) – x10 assessment categories
3. Patient Experience – x6 assessment categories
4. Efficiency - x5 assessment categories
5. Effectiveness - x4 assessment categories
6. Governance – x3 assessment categories
7. Helipad – x1 assessment categories

Additionally, there are a small number of new sections for 2024-25 of the assurance model which specifically look at:

- FM Maturity (FMS 001: Management Services)
- FM Maturity (FMS 002: Asset Data) (optional last reporting year)

Contained within each domain are:

- Self-assessment questions (SAQ's) which are answered through a series of sub-questions based on NHSE set criterion.
- National Metrics: a standardised method of determining levels of adherence to healthcare and government legislation requirements regarding Estates, Facilities and Development. The judgement metrics are:
    - *Outstanding*
    - *Good*
    - *Requires Minimal Improvement*
    - *Requires Moderate Improvement*
    - *Inadequate*
    - *Not Applicable*

[1] Although categorised as *Estates and Facilities,* departments/services are assessed which do not sit within Estates and Facilities in the structure of NLaG.

The exception is the H1 domain, Helipad, which is piloting the YES/NO method of response coming away from the perspective style of rating. Although Northern Lincolnshire & Goole (NLaG) does not have a helipad and therefore does not answer this domain it is pertinent to note that it is anticipated that the YES/NO methodology will feature in the whole collection if the pilot proves successful.

Late May 2025, NHSE made Trusts aware of the final, yet unapproved SAQ definitions of the 2024/25 PAM. In addition to the Helipad feedback methodology change, it included two additional SAQ's, together with a change of grouping for the BIM/PSTN SAQ being moved from the Safety Soft to the Safety Hard domain. The two new SAQ's are:

- SH20 Mortuaries
- SS10 Terrorism (Protection of Premises) Act 2025 – Martyn's Law

The view of the EF&D senior management team is that because the SAQ's have been provided beyond the end of March 2025 they will therefore only be considered in the 2025/26 submission and not addressed as part of the 2024/25 rating submission.

NLaG was one of the first voluntary adopters of PAM and for the past 10 years, NLaG's EF&D Directorate has actively engaged in the PAM self-assessment process with the E&F Safety and Statutory Compliance team facilitating the process. Additionally, the Trust is represented at a national level, consulting every quarter at the NHSE Premises Assurance Model development steering group.

The PAM programme has only recently become a mandatory requirement, appearing for the first time in the 2021 NHS Standard Contract.

Northern Lincolnshire and Goole NHS Foundation Trust's PAM Model

NLaG's annual self-assessment commences each September and concludes at the end of March in the following calendar year. The period between April and August enables internal and external reporting to be completed.

The existing model has been presented previously, and is deemed suitable for the organisation, resulting in transparent and credible assurances.

This model was devised to best utilise the significant resources required to complete a 360° self-assessment. Therefore, a full stakeholder review is conducted every other year with a management desk-top review being carried out in the interim years.

Inherently, the self-assessment process is a subjective process therefore, underpinning this process is an annual programme of internal auditing activities conducted by the EF&D Safety and Statutory Compliance team. Utilising the PAM

Safety Hard (Estates) and Safety Soft (Facilities) self-assessment categories; a risk-based approach is employed to direct auditing activities to maximise targeted resource allocation. The primary objective is to determine assurance levels from suggested evidence provided by EF&D departments as to their justifications of:

- Not Applicable (grey)
- Inadequate *(red)* [<45%]
- Requires Moderate Improvement *(amber)* [45-65%]
- Requires Minimal Improvement *(yellow)* [66-85%]
- Good *(green)* [>85%]
- Outstanding *(blue)* [100%]

Additionally, national guidance such as Health Technical Memorandums (HTM) and Trust policy requirements also inform the audit scope for their operational accuracy. Findings of internal audit reports are summarised each month at the EF&D Governance meeting group along with PAM completion progress as well as the progress made against improvement actions that are identified from each self-assessment session.

As the PAM is near the end of the 7th year of the current model and upon review, the delivery model is assessed as fit for purpose and delivers a meaningful self-assessment within the confines of the national mandated process.

2024-25 Estates and Facilities PAM Summary of Findings

The charts below capture the end of year comparisons that visually represents the judgements for the EF&D primary service provision (Hard and Soft FM) domains of EF&D against each standardised question set. Appendix 1 provides the full data capture for each domain.

Graphical illustration of the displacement of judgements for both Estates (SH1 to SH22) (SH20 was not assessed; SH22 was identified as N/A)) and Facilities (SS1 to SS1.10 (SS10 removed)).

Figure 1 - Safety Hard - Comparison for 2021 - 24 period

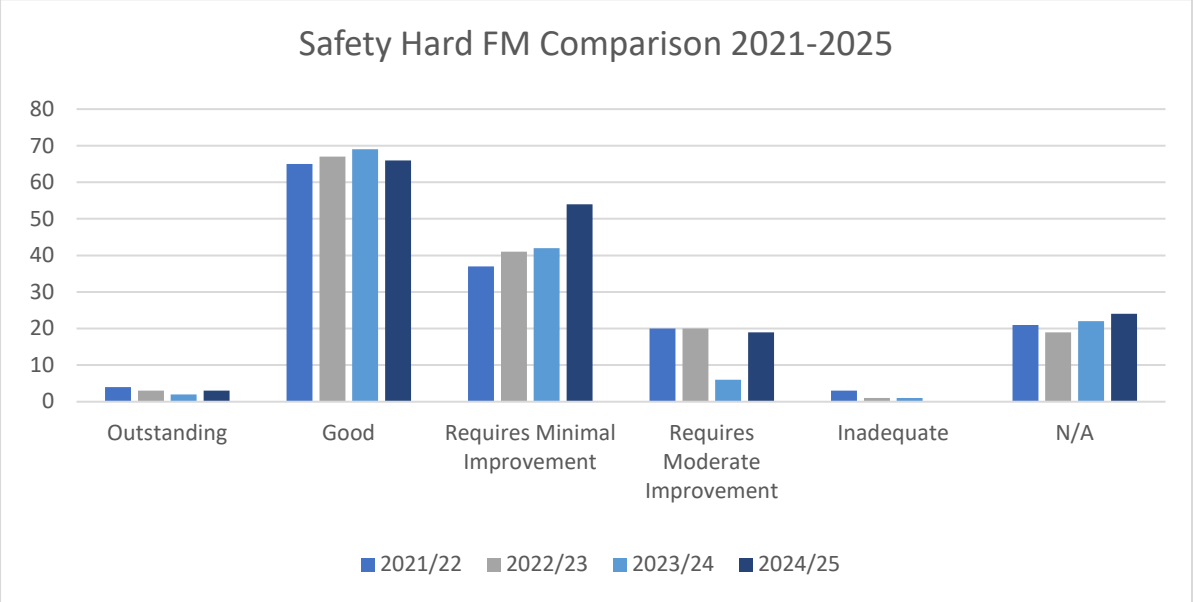
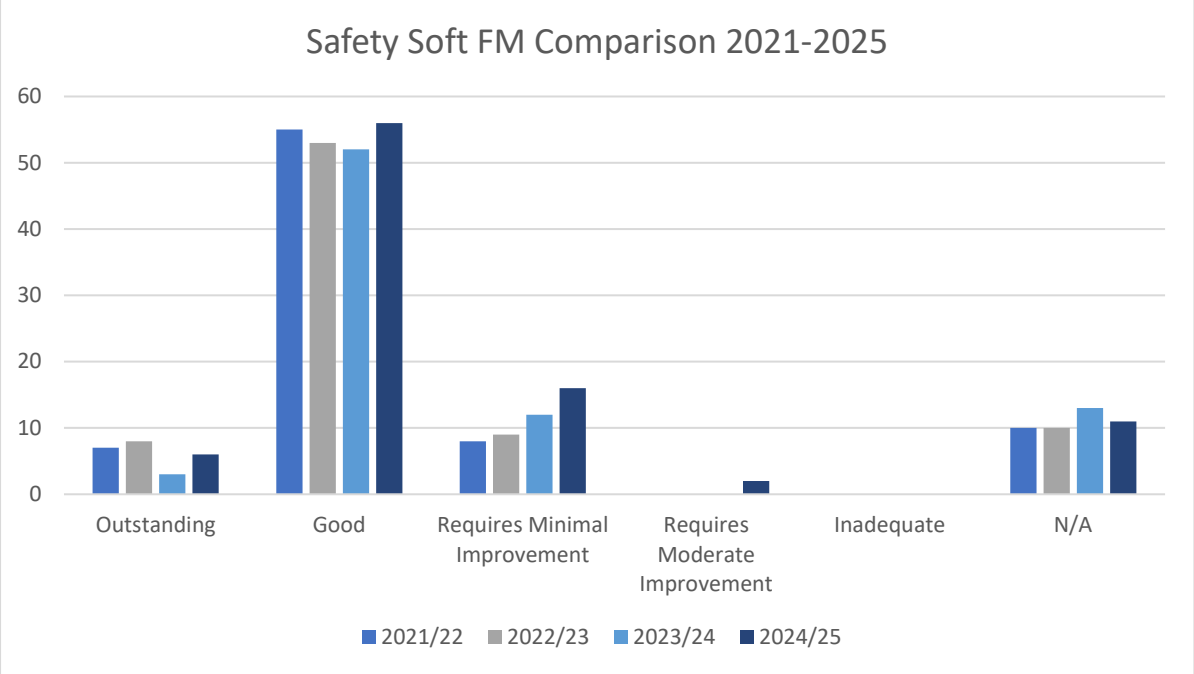


Figure 2 - Safety Soft - Comparison for 2021-24 period



For Safety Hard (figure 1) shows a slight increase in “outstanding” from the previous year as the criteria for this has been further clarified by the National User Group and this is reflected in the trend seen. The number of “good” has seen a decrease from the previous years, “requires minimal improvement” has also seen an increase in trend consecutively over the last 4 years, this has been mainly attributed to the Directorate realigning its objectives as a Group structure with Hull University Teaching Hosptial as well as varying opinions from individuals from the multi-stakeholder workshops. For those requiring moderate improvement, there is an increase compared to the previous year. The “inadequate” rating has seen a downwards trend compared to previous years as the domain leads work through actions identified in previous years.

For Safety Soft (figure 2) there has been an increase in “outstanding” and “good” from the previous year. This is due to a number of elements including the introduction of National Standards requiring additional input which have now yet been implemented. There has however been an increase in requires “minimal” and “moderate” improvement this year, this is attributed to SS1 food standard SAQ querying if the Trust has 24/7 retail and restaurant catering facilities which is currently not part of the Trusts overall objectives.

Figure 3 - 24/25 SAQ Outcome Safety Hard

	Policy	R & R	RA	Maint	T&D	EPRR	Review	*Average*
SH1	3	2	2	4	3	3	2	***3***
SH2	3	3	3	3	3	3	2	***3***
SH3	3	2	2	2	2	2	2	***2***
SH4	3	3	3	NA	2	2	2	***3***
SH5	2	2	2	NA	2	2	2	***2***
SH6	3	3	2	2	2	3	2	***2***
SH7	3	3	2	2	2	4	3	***3***
SH8	2	3	2	3	3	3	2	***3***
SH9	3	3	2	4	3	3	2	***3***
SH10	4	4	3	3	4	3	2	***3***
SH11	2	2	3	2	3	4	2	***3***
SH12	2	3	2	2	3	2	2	***2***
SH13	3	3	3	4	3	3	3	***3***
SH14	3	3	3	4	4	4	2	***3***
SH15	2	3	2	2	2	NA	2	***2***
SH16	2	2	2	3	2	NA	2	***2***
SH17	2	2	2	2	2	2	2	***2***
SH18	1	1	2	3	2	3	2	***2***
SH19	2	3	2	3	NA	2	2	***2***
SH20	NA	NA	NA	NA	NA	NA	NA	
SH21	3	3	2	NA	NA	NA	3	***3***
SH22	NA	NA	NA	NA	NA	NA	NA	
Average	***3***	***3***	***2***	***3***	***3***	***3***	***2***	

Figure 4 - 24/25 SAQ Outcome Safety Soft

	Policy	R & R	RA	Maint	T&D	EPRR	Review	*Average*
SS1	2	2	1	3	3	2	2	***2***
SS2	2	3	2	2	2	2	2	***2***
SS3	1	2	2	1	3	2	3	***2***
SS4	2	2	2	2	2	2	2	***2***
SS5	2	3	2	3	2	2	3	***2***
SS6	1	2	2	2	2	2	2	***2***
SS7	2	2	3	2	2	2	2	***2***
SS8	2	3	2	3	3	3	2	***3***
SS9	2	2	2	2	2	2	2	***2***
SS10	NA	NA	NA	NA	NA	NA	NA	
Average	***2***	***2***	***2***	***2***	***2***	***2***	***2***	

Figures 3 and 4 show the scoring for each SAQ within the different domains and the average scores for the entire domain. This shows which element in each domain needs to be improved. Those with a score of 4 or above should be seen as priority to address.

Key Considerations

- This year was a full-stakeholder review, the coming year will see the domain lead review recommence as per the embedded cycle.
- Some SAQs have been updated, or introduced, which has seen a limited change in terms of year-on-year comparison.
- Maintenance in Safety Hard (Estates) is improving as full asset reviews have been undertaken over the past number of years and work is well underway to implement a new asset management system and Planned Preventative Maintenance (PPM) regime as part of the Directorates Computer Aided Facilities Management (CAFM) upgrade strategy which will give considerably more accurate reporting.

Areas of Good Practice

- Generally, there has been a slight shift to the positive in Safety Hard.
- SH15 (Medical Devices) has seen a minor improvement from the last annual review where maintenance has moved from *Inadequate* to *Requires Moderate Improvement* with a supported business case for additional staffing.
- SH8 (Water Safety Systems) has also improved in a number of areas, in line with a number of other engineering disciplines.
- SS1 (Catering), SS3 (Waste) and SS4 (Cleanliness) have all seen improvement this year, which is attributed to a slight drop in previous year(s) due to the release of relevent guidance/standards in those areas in the recent years, and work being undertaken to implement new practices, which are now well underway, or already fully embedded.
- Mature review process and monitoring processes are continuing to be undertaken across all sector specialisms supported by dedicated EF&D internal auditing programme and risk and governance provision.

Key Areas for Improvement

- SH1 (Operational Management) has seen a downwards trend from the previous year that has been mainly attributed to the need to update the computer aided facilities management system (CAFM), this is being addressed as part of the CAFM Project Board with a view to procure a new Group wide system by the end of 2025.
- SH2 (Design, Layout and Use of Premises) has deteriorated since the last annual review which is attributed to a number of issues such as the need for training in some areas, the need for Capital Project Management policies to be implemented and the challenges with interfacing new projects with existing legacy maintenance issues.
- SH14 (Fire Safety) has also seen a decline from the previous year, this has been attributed to the need to address the findings relevant to the Trust from the Grenfell enquiry and the continued monitoring of the performance of the GDH Fire alarm (Risk 3361)
- SS8 (Pest Control) has declined from *Good* to *Requires Minimal improvement*, this was mainly attributed to concerns highlighted around the maintenance of areas that could allow ingress of pests such as drainage systems and that there is no formal business continuity plan in place.

Conclusion

Completed in isolation of any verification process, the very nature of self-assessment is a subjective process at best. However, the EF&D Safety and Statutory Compliance Department acts independently of the main EF&D Departments and offer an impartiality that challenges the validity of the assessment judgements as part of the validation and auditing process. There is therefore a level of assurance that standardisation across all Self-Assessment Questions (SAQs) due to standardisation provided by the facilitators; some of whom are either actively, or recently involved with other Trusts' PAM process.

The Estates department and its Safety Hard assessment are continuing to work with ageing infrastructure resulting in a mixed judgement of "*Good*" and "*Requires Minor Improvement*" across the Estates provision.

The Facilities department and its Safety Soft assessment continue to benefit from longevity of key roles being in post for a sustained period, bringing with them the accompanying knowledge and experience. There is a clear overall judgement of 'Good' assurance levels across the Facilities provision.

Recommendations

- Complete the current implementation of a Group Estates asset data-capture to improve asset management and maintenance with progress monitored through the Estates meeting structure ***(action continued from previous reports)***
- Assign PPMs to all Estates Assets, to ensure compliance with statutory obligations. ***(action continued from previous reports)*.**
- Create comprehensive suite of Standard Operating Procedures (SOPs) for all engineering disciplines. Water SOPs have recently been reviewed, however some areas, such as MGPSs remain in need of attention[2].
- Align, where practical, all Authorised Engineer appointments across the Group.

Thomas Doo
Head of Safety and Statutory Compliance

Appendix 1 Premises Assurance Model SAQ

PRN02003_ii_PAM SAQs 2024_25 V3 20

[2] SOPs feature at safety groups/sub-groups for oversight.

appendix 1

Instructions: NHS Premises Assurance Model 2023: Please also read the separate NHS PAM Guidance Document

Purpose and structure of this file	This file contains Self-Assessment Questions that help evaluate the way your organisation/site manages its estate and facilities in 5 Domains. Although the Safety Domain is notionally split between hard and soft Facility Management (FM) services some questions within the 'Combined and Hard FM' supply to both sections. These questions should be assessed across both hard and soft FM e.g. the SAQ relating to Health and Safety is within the 'Safety: Combined and Hard FM' but clearly applies to soft FM also. A number of other relevant sheets are also provided
How to complete it	The way to use this file is to fill in the 5 worksheets with yellow tabs, which include the domain self-assessment questions (SAQs). Year 1 | Year 2 | The assessment can be for one or two years if comparisons are required. **2023-24** | **2024-25** | ◀Use the drop down in the yellow boxes to alter the years where relevant Each SAQ contains several prompt questions. By answering the prompt questions, a result is automatically calculated for the SAQs and the domains. Please note it is not possible to give a rating to the SAQ directly, it has to be rated indirectly using the prompt questions or, alternatively, classified as not applicable. There are six possible responses for a prompt question: - Not applicable: this prompt question does not apply to your organisation/site. - Outstanding: compliant with no action plus evidence of high quality services and innovation. - Good: compliant no action required. - Requires minimal improvement: the impact on people who use services, visitors or staff is low. - Requires moderate improvement: the impact on people who use services, visitors or staff is medium. - Inadequate: action is required quickly - the impact on people who use services, visitors or staff is high.
Results	The "Summary' sheets show graphically the results of the NHS PAM self-assessment. - The 'summary' one shows the ratings at the domain level. It includes the average rating and the distribution of SAQ ratings for the 5 domains (i.e. the % of SAQs that obtain a rating of "Outstanding", the % of SAQs that obtain a rating of "Good", etc.) - The other 5 red 'Results' sheet detail the average rating and the distribution of the prompt questions ratings for each SAQ within the domain. This allows the user to see which SAQs are driving the results of the domains.

Annual Changes	**Annual changes may be required in line with updates to guidance and legislation, you can find an overview of the latest changes listed below.** **Changes for 2025:** **There has been updates to the HBN and HTM guidance, the links within the spreadsheet remains up to date, but please familiarise yourself with the latest publications:** **https://www.england.nhs.uk/estates/complete-list-of-publications-related-to-nhs-estates/** **Please also note there has been some technical bulletins published this year these can be found: https://www.england.nhs.uk/estates/netb/** **Safety Hard** **•Legislation & guidance updates – link provided** **•SH20 - Mortuary question added** **•SH22 – Addition of a question here (previously SS10 – BIM/PSTN)** **Safety Soft** **•Legislation and guidance updated (link provided)** **•The previous SS10 (BIM/PSTN) is now moved under safety hard as SS22, this question is also slightly updated within SS22.7.** **•There is a new SS10 - Terrorism (Protection of Premises) Act 2025** **•SS3 -guidance added: 9. NHS England » NHS clinical waste strategy** **Efficiency** **•F3 - Wording added - "(Please note - Building Standard is mandatory for certain projects)"** **•F5 Guidance updated - 8.Greener NHS » Delivering a net zero NHS, 9. NHS Estates Net Zero Carbon Delivery Plan Report, 10. Net Zero Guidance plan** **Effectiveness** **•E1 - Guidance updated - Greener NHS » Delivering a net zero NHS, . NHS Estates Net Zero Carbon Delivery Plan Report, . Net Zero Guidance plan** **•E2 - Evidence updated - 3. Refer to ICS infrastructure strategy guidance the guidance includes reference to local area energy plans and local nature recovery strategies, which will support town planning.** **•E4 - Guidance updated - 4. NHS Climate Change Risk Assessment tool, 5. Health and climate adaptation report 2025** **Governance** **•G1 - Guidance updated - 8. NHS England » Green plan guidance** **Helipad - This question has been replaced with a new set** **•Please note these questions appear in a different format to the rest of the current questions, with yes/no answers. The answers will be scored based on the assurance provided. This fits in with the approach to be taken next year.** **Contact details** **•Contact details requested for the appointed person regarding Terrorism (Protection of Premises) Act 2025.** **•Contact details requested for 'Food' and 'Linen and laundry'** **Online version of the SAQs:** **Please note due to year on year reporting within Tableau the new questions may be reflected with a different number.**

NHS Premises Assurance Model (NHS PAM)

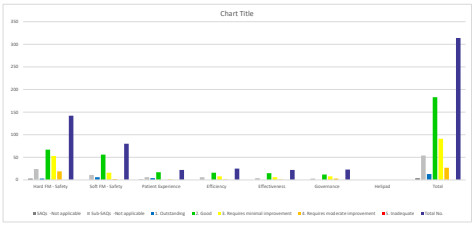
	Trust:	Northern Lincolnshire and Goole NHS Foundation Trust
	Site Name:	Northern Lincolnshire and Goole NHS Foundation Trust
	Year:	2024/2025

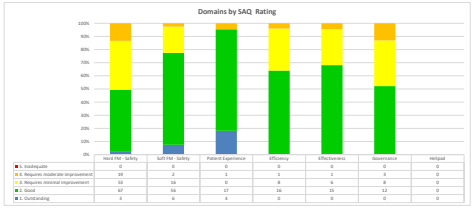
SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH1	Estates and Facilities Operational Management	Hard FM - Safety	Applicable	2. Good	2. Good	2. Good	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH2	Design, Layout and Use of Premises	Hard FM - Safety	Not applicable	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Document Management System in Place	2. Approval of documents	3. Review of documents	4: Availability of documents	5. Legibility of Documents	6: Document Control	7. Obsolescence	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH3	Estates and Facilities Document Management	Hard FM - Safety	Applicable	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	Maintenance	4. Training and Development	5. Resilience, Emergency & Business Continuity Planning	6. Review Process	7. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH4	Health & Safety at Work	Hard FM - Safety	Not applicable	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal improvement		2. Good	2. Good	2. Good	Not applicable															0	0	
SH5	Asbestos	Hard FM - Safety	Applicable	2. Good	2. Good	2. Good		2. Good	2. Good	2. Good	Not applicable															0	0	
	Self Assessment Question (SAQ) Subject	Hard FM - Safety	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	9. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	
SH6	Medical Gas Systems	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	3. Requires minimal imp	2. Good	Not applicable															0	0	
	Self Assessment Question (SAQ) Subject	Hard FM - Safety	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	
SH7	Natural Gas and specialist piped systems	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	4. Requires moderate in	3. Requires minimal imp	Not applicable															0	0	
SH8	Water Safety Systems	Hard FM - Safety	Applicable	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH9	Electrical Systems	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH10	Mechanical Systems and Equipment	Hard FM - Safety	Applicable	4. Requires moderate in	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	4. Requires moderate in	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH11	Ventilation, Air Conditioning and Refrigeration Systems	Hard FM - Safety	Applicable	2. Good	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	4. Requires moderate in	2. Good	Not applicable															0	0	
SH12	Lifts, Hoists and Conveyance Systems	Hard FM - Safety	Applicable	2. Good	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	2. Good	2. Good	Not applicable															0	0	
SH13	Pressure Systems	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	Not applicable															0	0	
	Self Assessment Question (SAQ) Subject		Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Governance	4. Enforcement	5. Risk Assessment	6. Maintenance	7. Training and Development	8. Resilience, Emergency & Business Continuity Planning	9. Review Process	10. Costed Action Plans															
SH14	Fire Safety	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	4. Requires moderate in	4. Requires moderate in	4. Requires moderate in	2. Good	Not applicable													0	0	
SH15	Medical Devices and Equipment	Hard FM - Safety	Applicable	2. Good	3. Requires minimal imp	4. Requires moderate in	4. Requires moderate in	2. Good	2. Good	2. Good	Not applicable															0	0	
SH16	Resilience, Emergency and Business Continuity Planning	Hard FM - Safety	Applicable	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good		2. Good	Not applicable															0	0	
SH17	Safety Alerts	Hard FM - Safety	Applicable	2. Good	2. Good	2. Good		2. Good	2. Good	2. Good	Not applicable															0	0	
SH18	Externally supplied estate	Hard FM - Safety	Applicable	1. Outstanding	1. Outstanding	1. Outstanding	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	Not applicable															0	0	
SAQ No.19	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3.Contract Expiry	4. Risk Assessment	5. Maintenance	6. Contractor Compliance	7. Resilience, Emergency & Business Continuity Planning	8.. Review Process	9.. Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH19	Contractor Management for Soft and Hard FM services	Hard FM - Safety	Applicable	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	2. Good	2. Good	Not applicable														0	0	
SH20	Self Assessment Question (SAQ) Subject	Domain	Applicable	1. Policy & Procedures	2. Security	3. Funeral Directors	4 HTA (Human Tissue A	5. Existing facilities	6. Future demand	7. Body transfer for Po	8. Entrances & Locatior	9. Care, safety and secu	10. Waste Management	11. Body storage & delivery point	12. PM with forensics	13. Waste disposal room	14. Costed action plan											
SH20	SH20	Hard FM - Safety	Applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable											
SH21	SH21:The built environment: Reducing harm by ligature in practice.With regards to self-harm risks associated with the built environment, can the organisation evidence that they have taken consideration for the following:	Hard FM - Safety	Not applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable	Not applicable	3. Requires minimal imp	Not applicable																		
SAQ No.21	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Policy	2: Roles and Responsibilitie	3: Risk Assessment	4: Maintenance	5: Training	6: Review Process	7: Resilience	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH22	SH22:Estates IT and Building Information Management (BIM) systemsPlease confirm you l	Hard FM - Safety	5. Inadequate	4. Requires moderate in	4. Requires moderate in	4. Requires moderate in	4. Requires moderate in	4. Requires moderate in	Not applicable	4. Requires moderate in	Not applicable															#REF!	#REF!	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8.Food Standards: Board Director	9.Food Standards: Strategy	10.Food Standards:Diatition	11.Food Standards: Safety Specialist	12.Food Standards: Workforce	13.Food Standards:Matrix	14.Food Standards: Waste	15.Food Standards: 24/7 Restaurant	16.Food Standards: 24/7 Café	17.Food Standards: 24/7 Vending machines	18.Food Standards: 24/7 Retail	19.Food Standards: Cold Vending	20. Food Standards: Smart Fridges	21.Food Standards: From home	22. Costed Action Plans	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS1	Catering services	Soft FM - Safety	Applicable	2. Good	2. Good	1. Outstanding	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	3. Requires minimal imp	2. Good	2. Good	4. Requires moderate in	3. Requires minim	3. Requires minim	4. Requires moder	2. Good	Not applicable	2. Good	Not applicable	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS2	Decontamination process	Soft FM - Safety	Applicable	2. Good	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SS3	Waste and Recycling Management	Soft FM - Safety	Applicable	1. Outstanding	2. Good	2. Good	1. Outstanding	3. Requires minimal imp	2. Good	3. Requires minimal imp	Not applicable															0	0	
SAQ No.SS4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Cleaning Standards 2021: Star Ratings	9. Cleaning Standards 2021: Charter	10. Cleaning Standards 2021: Matrix	11.Cleaning Standards 2021: 95%	12: Costed Action Plans											Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS4	Cleanliness and Infection Control	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	1. Outstanding	1. Outstanding	2. Good	2. Good	Not applicable											0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS5	Laundry and Linen Services	Soft FM - Safety	Applicable	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	Not applicable															0	0	
SS6	Security Management	Soft FM - Safety	Applicable	1. Outstanding	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SS7	Transport Services	Soft FM - Safety	Applicable	2. Good	2. Good	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SS8	Pest control	Soft FM - Safety	Applicable	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SS9	Portering services	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable	1: Policy	1.2: Policy	1.3: Policy	2 Roles & Responsibilities	3 Roles & Responsibilities																		#REF!	#REF!	
SS10	SS10: With regard to the Terrorism (Protection of Premises) Act 2025, more commonly known as Martyn's Law can the organisation evidence the following?	Soft FM - Safety	Applicable	Not applicable	11	6	requires improvement	good				0	0	0	0	0												
SAQ No. P1	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Views and Experiences	2. Engagement	3. Staff Engagement	4. Prioritisation	5. Value	6: Costed Action Plans																	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P1	Engagement and involvement	Patient Experience	Not applicable	2. Good	2. Good	4. Requires moderate in	2. Good	2. Good	Not applicable																	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. PLACE Assessment	2. Other Assessments	3. Cleaning Schedules	4. Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P2	Condition, appearance, maintenance and privacy and dignity perception	Patient Experience	Applicable	2. Good	2. Good		Not applicable																			0	0	
P3	Cleanliness	Patient Experience	Applicable	2. Good	2. Good	1. Outstanding	Not applicable																			0	0	
P4	Access and Car Parking	Patient Experience	Applicable	1. Outstanding	1. Outstanding		Not applicable																			0	0	
P5	Grounds and Gardens	Patient Experience	Applicable	2. Good	2. Good		Not applicable																			0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Regulation	3. Choice	4. Equality issues	5. Information	6. PLACE Assessment	7. Other Assessments	8. Legal Standards	9: Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P6	Catering services	Patient Experience	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	1. Outstanding	2. Good	Not applicable														0	0	
SAQ No.F1	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Analysing Performance	2: Benchmarking	3: Costed Action Plans																				Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F1	Performance management	Efficiency	Applicable	2. Good	2. Good	Not applicable																				0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Business Planning	2: Estate Optimisation	3: Commercial Opportunities	4: Partnership working	5: New Technology	6: PFI and LIFT contracts	7: Other contracts	8. Property	9. Cost Improvement plans	10: Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F2	Improving efficiency - running	Efficiency	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	4. Requires moderate in	Not applicable	2. Good	2. Good	3. Requires minimal imp	Not applicable													0	0	
SAQ No. F3	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Capital Procurement.	2. Capital Project Management	3. Capital Procurement Efficiencies	4. Flexibility	5. Identification and disposal of surplus land	6: Net zero carbons	7: Costed Action Plans																Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F3	Improving efficiency - capital	Efficiency	Applicable	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable																0	0	
SAQ No.F4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Policy & Procedures	2: Review Process	3: Board Reporting & Contracting	4: Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F4	Financial controls	Efficiency	Applicable	2. Good	2. Good	2. Good	Not applicable																			0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Quality and Sustainability	2. Financial Pressure	3. Continuous Improvement	4. Quality Improvements	5. Recognition	6. Use of Information	7: Costed Action Plans																Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F5	Continuous improvement	Efficiency	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	Not applicable																0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Vision and Values	2. Strategy	3. Development	4. Vision and Values Understood	5. Strategy Understood	6. Progress	7: Costed Action Plans																Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E1	Vision and strategy	Effectiveness	Applicable	2. Good	2. Good	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	Not applicable																0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Local Planning	2. Neighbourhood Planning	3. Planning Control	4. Special Interests	5. Enforcement	6: Costed Action Plans																	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	
E2	Town planning	Effectiveness	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable																	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Disposal of land and property	2: Granting of Leases	3: Acquisition of land and property	4: Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E3	Land and Property management	Effectiveness	Applicable	2. Good	2. Good	2. Good	Not applicable																			0	0	
SAQ No.E4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Green Plan / Sustainability Strategy	2: Energy	3: Waste	4: Air Pollution	5.Travel & Transport	6.Water	7. Climate Change Adaptation	8. Procurement	9: Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E4	Sustainability	Effectiveness	Applicable	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	4. Requires moderate in	2. Good	Not applicable														0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Framework	2. Roles	3. Partners	4. Framework	5: Assurance	6. Monitoring	7. Audit	8. Mitigation	9. Alignment	10: Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G1	Governance process	Governance	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	Not applicable													0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Effectiveness	2. Challenges	3. Visibility	4. Relationships	5. Respect	6. Behaviours.	7. Culture	8. Honesty.	9. Safety & Wellbeing	10. Healthier workplace	11. Collaboration	12: Costed Action Plans											Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G2	Leadership and culture	Governance	Applicable	3. Requires minimal imp	2. Good	2. Good	2. Good	4. Requires moderate in	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	2. Good	4. Requires moderate in	2. Good	Not applicable											0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Professional advice	2. In-house advisors	3. External advisors	4: Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G3	Professional advice	Governance	Applicable	2. Good	2. Good	2. Good	Not applicable																			0	0	

SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Compliance Assessment and Policy Review: Adherence to CAP1284 and Downwash Helipad Considerations in the Trust	2: Roles and Responsibilities	3: Risk Assessment and Mitigation Strategies for Helipad and Estate	4: Resilience, Emergency & Business Continuity Planning	5: Risk assessment - Regulatory Differences between Ground-Based and Elevated Helipads	6: Resilience, Emergency & Business Continuity Planning	7: Review Process	8. Collaboration	10. Costed Action Plans																	
RS	Updated	Helipad	Scored separate this year reflected in Tableau																										
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Confirmation of Safe Helipad Operations	2. How many primary HHLS does the trust have operating?	4. How many secondary HHLS does the trust utilise?	4. Who is the Accountable Manager (AM) for your HHLS?	5. AM Email address	6. AM Telephone number	7. AM Job Title	8. Hospital Operations Manual (HOM)	9. Risk Assessment and Mitigation Strategies for Helipad and Estates	10. Where Coast Guard Search and Rescue (SAR) landings take place on the HHLS.	11. Resilience, Emergency & Business Continuity Planning.	12: Review Process	13. Collaboration	9. Costed Action Plans	Capital cost to achieve desired improvements/outcomes									Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
FM MF	Hub04	FM Maturity Framework																									#REF!	#REF!	
SAQ No.	Self Assessment Question (SAQ) Subject		Q1 - What level of location hierarchy is asset data captured against?	Q2 - Is there a consistent data specification aligned to the FM asset data standards (4.2)?	Q3 - How consistently is the data specification applied across the estate?	Q4 - What is the level of coverage of assets in the asset register data?	Q5 - How complete is the data captured against assets in the asset register?	Q6 - Is a full asset verification exercise required to update the asset register (5.1)?	Q7 - What regular sample surveys exist for on-going asset verification (5.2)?	Q8 - What processes are in place for change control/approvals for adding, removing or changing an asset (5.3)?	Q9 - What processes are in place for data quality checks (5.4)?	Q10 - What processes are in place for data update assurance (5.5)?	Q11 - What governance is in place to support data assurance and quality (5.6)?	Q12 - What level of documentation exists for the these data quality processes and governance (5.7)?	Q13 - Is the data contractually owned by the organisation (6.1)?	Q14 - What level of access does the organisation have to the data in the asset management systems (6.2)?	Q15 - What level of access management exists for controlling user privileges (6.3)?	Q16 - Do the asset management systems provide the flexibility to accommodate the data standards (7.1)?	Q17 - Do the asset management systems allow interoperability of asset data (7.2)?	Q18 - Does the asset management systems sync to a common data platform (7.3)?	Q19 - Do the systems meet data security requirements (7.4)?	Q20 - Do the systems meet data backup management requirements (7.5)?	Q21 - What types of management information reports and dashboards are used for FM asset data (8.1)?	Q22 - How does asset data inform decisions relating to contract management (8.2)?	Q23 - How does asset data inform decisions relating to mandatory and statutory compliance (8.3)?	Q24 - How does asset data inform decisions relating to Planned Preventative Maintenance (8.4)?	Q25 - How does asset data inform decisions relating to Investment Prioritisation (8.5)?	Q26 - What is the capacity of the teams working with asset data (9.1)?	
FM MF	Hub02	FM Maturity Framework																									#REF!	#REF!	

Domain	SAQs -Not applicable	Sub-SAQs -Not applicable	1. Outstanding	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	5. Inadequate	Total No.
Hard FM - Safety	3	24	3	67	53	38	0	142
Soft FM - Safety	0	11	6	56	16	2	0	80
Patient Experience	1	4	4	17	0	1	0	22
Efficiency	0	6	0	16	8	1	0	25
Effectiveness	0	4	0	10	6	1	0	21
Governance	0	1	0	12	8	1	0	23
Helipad	0	0	0	0	0	0	0	0
Total	4	54	13	180	91	27	0	314

0





NHS Premises Assurance Model: Safety Domain (Combined and Hard FM) ◄◄ Back to instructions	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "inadequate" the whole of the Safety Domain will be rated as "inadequate".**

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH1	**SH1: With regard to the Estates and Facilities Operational Management can the organisation evidence the following?**	Not applicable	Applicable	This SAQ relates to the overall management of the E&F function and how specific technical areas (covered by separate SAQs) are managed, reported, escalated and reviewed in a consistent way	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; 2. CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. Health Building Note 00-08: The efficient management of healthcare estates and facilities 5. Health Building Note 00-08: Land and Property Appraisal - Available on the NHS Estates Collaboration Hub 6 A Risk-Based Methodology for establishing and Managing Backlog (NHS Estates 2004) 7. Monitor: The asset register and disposal of assets: guidance for providers of commissioner requested services 8. BS ISO 55000, 55001 & 55002: 2014 Asset Management 9 Quality Management System supported by the International Organisation for Standardisation ISO 9001 Quality Management System, or the current European Foundation for Quality Management (EFQM) Excellence Model criteria or equivalent. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/estates/health-building-notes/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/148143/Backlog_costing.pdf https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/guidance-and-support/ https://www.iso.org/standard/55088.Health Technical Memorandum https://www.iso.org/iso-9001-quality-management.Health Technical Memorandum Government Property Standard Launch 7th September 2022 Government Property Strategy 2022-2030 - GOV.UK (www.gov.uk) Government Asset Data Standard Launched Jan 2022 Government Function: Property - FMS 002: Asset Data (publishing.service.gov.uk) Government Facilities Management Standard Launched April 2022 Facilities Management Standard 001: Management and Services - GOV.UK (www.gov.uk)	
SH1	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH1	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH1	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH1	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	2. Good	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH1	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH1	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH1	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH1	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH2	**SH2: With regard to the Design, Layout and Use of Premises [Functional suitability/Fitness for Purpose] can the organisation evidence the following in relation to functional suitability/?**	Not applicable	Not applicable	SH2: With regard to the Design, Layout and Use of Premises in relation to functional suitability can the organisation evidence the following? Critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs	1. Health and Social Care Act 2008 Regulations 14: and CQC guidance for providers on meeting the regulations - Regulations 10 and 15 (1) (c, d and f) 2. CQC guidance for providers on meeting the regulations - Regulations 10 and 15 (1) (c, d and f) 3. Land and property appraisal (2007 DH) 4. Equality Act 2010 5. 2010 to 2015 government policy: compassionate care in the NHS 6. Health Technical Memorandum 07-03 NHS Car parking management, environment and sustainability 7. Health Building Note 00-01 General design guidance for healthcare buildings 8. Health Building Note 00-08 Strategic framework for the efficient management of healthcare estates and facilities 9.. Health Building Note 00-02 Designing sanitary spaces 10. Building Regulations Parts M and K 11. Dementia design checklist 12. Health Building Note 08-02 Dementia friendly health and social care environments 13. NHSE Dementia assessment and improvement framework 14. Privacy and dignity report by the CNO into mixed sex accommodation in hospitals 15. Health Building Note 00-09 Infection control in the built environment 16. Secure by design 17. Net Zero Travel & Transport Strategy https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.england.nhs.uk/estates/other-guidance/ https://www.legislation.gov.uk/ukpga/2010/15/contents https://www.gov.uk/government/publications/2010-to-2015-government-policy-compassionate-care-in-the-nhs/2010-to-2015-government-policy-compassionate-care-in-the-nhs https://www.gov.uk/government/publications/nhs-car-parking-management-htm-07-03 https://www.england.nhs.uk/estates/health-building-notes/https://www.gov.uk/government/publications/guidance-on-the-design-and-layout-of-sanitary-spaces https://www.gov.uk/government/publications/consolidation-and-simplification-of-parts-m-k-and-n-of-the-building-regulations https://www.dementiaaction.org.uk/assets/0000/4336/dementia_friendly_environments_checklist.pdf https://www.england.nhs.uk/estates/health-building-notes/ https://improvement.nhs.uk/resources/dementia-assessment-and-improvement-framework/ NEW-Delivering_same_sex_accommodation_sep2019.pdf (england.nhs.uk) https://cfa.nhs.uk/resources/downloads/standards/Fraud_Standards_for_providers_2017-18.pdf https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment https://www.securedbydesign.com/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ For consideration: Protect legislation will be updated and released this year – Trusts should be prepared to self assess against threats of risk of your estate (i.e. minimising threats against the estate - reference 'Martins law' which is due to be released).	
SH2	**1. Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Estate strategy setting out current baseline, plans to address deficiencies including organisations risk management process/systems 4. Dementia strategy/policy 5. Privacy and dignity strategy/policy 6. Equality Act accessibility assessment 7. Local Authority approved travel plan 8. Security policy 9. Standard specification		
SH2	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. If technical expertise in-house - job descriptions, PDPs, TNA, training plans 5. If technical expertise outsourced - specification, qualifications and references. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards.		
SH2	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Six facet survey		
SH2	**4: Maintenance** Are relevant assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place;		
SH2	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. If technical expertise outsourced - appointment of qualified consultant or investment in training for staff in functional suitability issues (critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs) 4. If technical expertise in-house - PDP's, TNA, training plans, certificates of attendance/accreditation Purpose is to be able to identify levels of compliance to inform strategy/priority/investment		
SH2	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Plans in place if ward/unit is closed due to unacceptable levels of compliance - breech of 15 (1) (c, d and f) 6. Test reports/action plans 7. Escalation to relevant committees 8. Peer review outputs		
SH2	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Six facet survey; 4. Access audits; 5. Technical reports to cover critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs 6. Audit plan 7. Audit reports 8. Peer review output		
SH2	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH3	**SH3. With regard to Estates and Facilities Document Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers the coordination and control of the flow (storage, retrieval, processing, printing, copying, routing, distribution and disposal) of electronic and paper documents for Estates & Facilities documents in a secure and efficient manner.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 2. CQC Guidance for providers on meeting the regulations 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. BS EN 15221 Facilities Management 5. BS ISO 55000, 55001 & 55002: 2014 Asset Management 6. Quality Management System supported by the International Organisation for Standardisation ISO 9001 Quality Management System, or the current European Foundation for Quality Management (EFQM) Excellence Model criteria or equivalent. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://shop.bsigroup.com/ProductDetail?pid=000000000030206404 https://www.iso.org/standard/55088.html "https://www.iso.org/iso-9001-quality-management.html https://efqm.org/efqm-model/	
SH3	**1: Document Management System in Place** Does the Organisation have an effective and efficient document management system in place proportional to the level of complexity, hazards and risks concerned?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures		
SH3	**2: Approval of documents** Are documents approved for adequacy prior to issue?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH3	**3: Review of documents** Are documents reviewed and updated as necessary with changes identified?	3. Requires minimal improvement	2. Good	1. Regular of policies and procedures to ensure implementation;		
SH3	**4: Availability of documents** Are all relevant versions of applicable documents available at points of use?	3. Requires minimal improvement	2. Good	1. Review of document availability both in terms of policies/procedures as well as spot checks on availability;		
SH3	**5. Legibility of Documents** Are all relevant documents legible and readily identifiable?	2. Good	2. Good	1. Review of document availability both in terms of policies/procedures as well as spot checks on legibility;		
SH3	**6: Document Control** Are all internal and external documents identified and their distribution controlled?	2. Good	2. Good	1. Review of policies and procedures to ensure implementation;		
SH3	**7: Obsolescence** Is there a process to prevent the unintended use of obsolete documents and apply suitable identification to them if they are retained for any purpose?	3. Requires minimal improvement	2. Good	1. Formal procedures in place to identify and replace obsolete documents; 2. Records of document replacement; 3. Review of documents replacement records to ensure completeness and accuracy;		
SH3	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH4	**SH4: With regard to Health & Safety at Work can the organisation evidence the following?**	Applicable	Not applicable	This SAQ relates to overall H&S management. Most of the Safety SAQs will contain aspects of compliance with H&S legislation also e.g. risk assessments and COSHH assessments.	1. The Health and Safety at Work etc. Act 1974: The HSE with local authorities (and other enforcing authorities) is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment. 2. Management of Health and Safety at Work Regulations 1999 3. Leading health and safety at work: leadership actions for directors and board members INDG417(rev 1) - hse.gov.uk 4. Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended): Approved Code of Practice L186 - hse.gov.uk 5. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required. 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service. Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased. 7. CQC Provider Handbooks W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? 8.HBN 03-01 Adult mental health units: planning and design: https://www.england.nhs.uk/publication/adult-mental-health-units-planning-and-design-hbn-03-01/ 9.HBN 03-02 Facilities for child and adolescent mental health units: https://www.england.nhs.uk/publication/facilities-for-child-and-adolescent-mental-health-services-hbn-03-02/	
SH4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Evidence that H&S regulations are: - Understood by all teams involved - Applied by all teams involved - Systematically checked for compliance - Reported for exceptions 4. H&S Committee involvement - committee structure chart and terms of reference 5. Procedures to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities		
SH4	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:1. Adequate welfare facilities 4. COSHH assessments 5. Health and Safety audits / inspections (completed internal and examples of any external agency reports and associated action plans) 6. Plant and equipment are safe including maintenance, service and test reports 7. Safe arrangements for the use, handling, storage and transport of articles, materials and substances, 8. Safe access and egress.		
SH4	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Examples of completed risk assessments – including COSHH, DSE, stress etc.		
SH4	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records; 3. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports		
SH4	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. H&S information for staff 6. Copies of permits to work issued and documented procedures and training records for staff responsible for issue of permit to work 7. Copies of insurance and written schemes of inspection certificates 8. Evidence of compliance with all relevant published HBNs, CFPPs and Health technical Memorandum TMs 9. Meeting minutes 6. Documentation and procedures for Safe systems of work		
SH4	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Incident reports and subsequence investigations including root cause analysis investigations 4. The ability to report on the regulatory requirements regarding safer wards (ligature). 5. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible rails/surface temperature) particularly when in relation to Mental health facilities and A&E wards.		
SH4	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
SH4	Capital cost to achieve compliance	£0	£0			
SH4	Revenue consequences of achieving compliance	£0	£0			
SH5	**SH5: With regard to Asbestos can the organisation evidence the following?**	Applicable	Applicable		1. Control of Asbestos Regulations 2012 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 3. CQC Guidance for providers on meeting the regulations 4. REACH (Registration, Evaluation, Authorisation and Restriction of Chemicals Regulations 2006). 5. HSE equipment and method series (em1 etc.) 6. HSE asbestos essentials task sheets (A1 etc.) https://www.legislation.gov.uk/uksi/2012/632/contents/made https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.hse.gov.uk/reach/ https://www.hse.gov.uk/pubns/guidance/emseries.htm https://www.hse.gov.uk/pubns/guidance/emseries.htm	
SH5	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Permits to work 4. Procedures to undertake work 5. Asbestos management plan 6. Asbestos register		
SH5	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Procedures to ensure staff and contractors have appropriate competencies, licences, professional indemnities and liability cover, also a record that these have been checked. 5. Permits to work 6. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards.		
SH5	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. A documented record of the location and condition of the asbestos containing materials - or materials which are presumed to contain asbestos. 5. Evidence of risk assessments relating to the potential exposure to fibres from the materials identified. 6. A plan that sets out in detail how the risks from these materials will be managed and how this has been actioned.		
SH5	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH5	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Evidence that reasonable steps have been taken to find out if there are materials containing asbestos in non-domestic premises, and if so, its amount, where it is and its condition. 6. Evidence that there is a period review of the plan and the arrangements in place to ensure that the plan remains relevant and up-to-date.		
SH5	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Evidence that information on the location and condition of the materials is provided to anyone who is liable to work on or disturb them 4. Active asbestos register 5. Significant findings from Authorising Engineer reports and action plans.		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)

◄◄ Back to instructions

The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***

Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH5	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH6	**SH6: With regard to Medical Gas Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum: 02-01: Medical gas pipeline systems 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 4. CQC Guidance for providers on meeting the regulations 5. CQC Provider Handbooks 6. Central Alert System - Organisations to familiarise themselves with this alert: https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103223 https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH6	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B. 2. The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system. 3. Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)		
SH6	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions. 3. Key relevant Objectives for the period:1. Permit to work 4. Approved persons 5. Authorised Persons 6. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards.		
SH6	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Organisation has a risk assessment as per section 6.6 of the HTM 02-01 3. Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the Health Technical Memorandum 02-01 (please indicated in the organisational evidence column the date of your last review)		
SH6	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B. 4. Are you sampling the air of the environment as minimum period at least annually. In relation to the frequency & sampling of the environment of nitrous oxide in the air are other considerations made, e.g., Seasonal impact, for example if the windows have been opened. 5. The organisation demonstrates compliance to COSHH, having a high level policy which outlines roles and responsibility and strategic documentation. 6. The organisation has proven testing methodology related to environmental sampling, seeking assurance of contracted laboratories upon their processes and any third party assurance of those laboratories, e.g., accreditation or certification		
SH6	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. The organisation has reviewed the skills and competencies of identified roles within the Health Technical Memorandum and has assurance of resilience for these functions; including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH6	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases; 2. The organisation has a clear escalation plan and processes for management of surge in oxygen demand either bulk or cylinder 3. Regular testing of Emergency response, business continuity plans and escalation plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH6	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports and action plans. 4. Audits to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities 5.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working		
SH6	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH7	**SH7: With regard to Natural Gas and specialist piped systems can the organisation evidence the following?**	Applicable	Applicable	See SAQ SH6 for Medical gas systems. This SAQ covers other gas installations and piped systems with specialist requirements such as high purity, compressed air negative pressure systems.	1. Gas Appliances (Safety) Regulations 1995 2. Gas Safety (Installations) & Use) Regulations 1998 3. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 5. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1995/1629/contents/made https://www.legislation.gov.uk/uksi/1998/2451/contents/made https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH7	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH7	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Approved persons, including employing a suitably qualified person where appropriate, i.e. "Gas Safe Registered" 5. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards. 6. Permit to work		
SH7	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH7	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH7	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH7	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	4. Requires moderate improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH7	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Audits to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities 4. Quality Control Evidence 5.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working.		
SH7	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH8	**SH8: With regard to Water Safety Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 00: Policies and principles of healthcare engineering 2. Water Supply (Water Fittings) Regulations 1999 3. Defra's guidance to the Water Supply (Water Fittings) Regulations 4. HSE's Approved Code of Practice (ACoP) L8 (2013), HSG274 Parts 1, 2 and 3, Health Technical Memorandum 04-01: the control of legionella, hygiene, safe hot water, cold water and drinking water systems (Scheduled to be replaced in April 2016 by Health Technical Memorandum 04-01: Safe water in healthcare premises) 5. Notification of Cooling towers and Evaporative Condensers Regulations 1992 6. Health Technical Memorandum 04-01: Addendum Pseudomonas aeruginosa 7. Health Technical Memorandum 07-01: Water Management and Water Efficiency 8. Health Technical Memorandum 07-04: Water management and water efficiency – best practice advice for the healthcare sector 9. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 10. CQC Guidance for providers on meeting the regulations https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/uksi/1999/1148/contents/made https://www.legislation.gov.uk/uksi/1999/1148/contents/made https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/uksi/1992/2225/contents/made https://www.gov.uk/government/publications/hot-and-cold-water-supply-storage-and-distribution-systems-for-healthcare-premises https://www.gov.uk/government/publications/water-management-and-water-efficiency-best-practice-advice-for-the-healthcare-sector https://www.gov.uk/government/publications/water-management-and-water-efficiency-best-practice-advice-for-the-healthcare-sector https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH8	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Procedures to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities; 4. Water Safety Plans in place, including legionella written scheme 5. Action Plans, including their implementation 6. Control Measures and testing micro- organisms including Legionella and Pseudomonas 7. Organisations with boreholes must comply with the Private Water Supplies Regulations 2009		
SH8	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Water Safety Group with relevant advice and attendees		
SH8	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH8	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. HSE's Approved Code of Practice (ACoP) L8 (2013), HSG274 Parts 1, 2 and 3, Health Technical Memorandum 04-01: Safe Water in Health Care Premises		
SH8	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH8	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH8	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Reports to Infection Control Committee or other groups within the Governance Structure 4. Significant findings from Authorising Engineer reports and action plans. 5.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working		
SH8	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH9	**SH9: With regard to Electrical Systems can the organisation evidence the following?:**	Applicable	Applicable	This SAQ covers all aspects of electrical safety such as high and low voltage, switchgear, BMS, fire detection, communication, security, Lightening protection, PAT testing etc.	1. Electricity at Work Regulations 1989 (EAWR) 2. Electrical Equipment (safety) Regulations 1994 3. Electromagnetic Compatibility regulations 1992 4. Fuel and Electrical (Heating) (Control) (Amendment) Order 1980 5. Health Technical Memorandum 06-01: Electrical Services/Safety 6. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 7. Health Technical Memorandum 06-01: Electrical Services/Safety; 8. Health Technical Memorandum 06-02: Electrical Safety Guidance for Low Voltage Systems in healthcare premises 9. Health Technical Memorandum 06-03 Electrical safety guidance for high voltage systems in healthcare premises 10. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 11. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1989/635/contents/made https://www.legislation.gov.uk/uksi/1994/3260/contents/made https://www.legislation.gov.uk/uksi/1992/2372/contents/made https://www.legislation.gov.uk/uksi/1980/1013/made https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.gov.uk/government/publications/electrical-safety-guidance-for-high-voltage-systems-in-healthcare-premises https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH9	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of the policies and procedures through the ESG, or add separate bullet point for the ESG;		
SH9	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards and Authorised Persons appointed as recommended by Authorising Engineer.		
SH9	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. The Risk register should be developed and monitored by the ESG as per Health Technical Memorandum 06-01; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers;		
SH9	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Up to date asset register incorporated into CAFM system; 4. Quality control/Inspection records 5. Copies of test certificates/EC Declarations of Conformity 6. Records of inspections/thorough examinations 7. Written schemes of examination 8. Copies of insurance certificates/formal documentation from notified bodies		
SH9	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH9	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH9	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports;		
SH9	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH10	**SH10: With regard to Mechanical Systems and Equipment can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers work systems not included elsewhere e.g. space heating.(Equipment with a medical use is assessed under SH15). This also covers devices and equipment covered under LOLER and PUWER. Please use the guidance for further information (PUWER and LOLER) but some examples (not all) are: powered tugs and pallet trucks, temporary platforms, hop ups, fork lifts, cherry pickers, autoclaves, washer disinfectors, pneumatic tube systems, auto valets, lathes, presses, steam cleaners, diggers, tractors commercial lawn mowers.	1. Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) 2. Provision and Use of Work Equipment Regulations 1998 (PUWER) 3. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 5. CQC Guidance for providers on meeting the regulations https://www.hse.gov.uk/[illegible] https://www.hse.gov.uk/[illegible] https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH10	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH10	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH10	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH10	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Copies of test certificates/EC Declarations of Conformity 5. Records of inspections/thorough examinations 6. Copies of insurance certificates/formal documentation from notified bodies 7. Written schemes of examination		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "inadequate" the whole of the Safety Domain will be rated as "inadequate".**
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH10	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	4. Requires moderate improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH10	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH10	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH10	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH11	**SH11: With regard to Ventilation, Air Conditioning and Refrigeration Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 03-01: Specialist Ventilation for Healthcare Premises 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 4. CQC Guidance for providers on meeting the regulations https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH11	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH11	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH11	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH11	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Health Technical Memorandum 03-01 part B recommends: a. All ventilation plant should meet a minimum requirement in terms of the control of Legionella and safe access for inspection and maintenance. b. All ventilation plant should be inspected annually. c. The performance of all critical ventilation systems (such as those servicing operating suites) should be verified annually		
SH11	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH11	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	4. Requires moderate improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH11	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports;		
SH11	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH12	**SH12: With regard to Lifts, Hoists and Conveyance Systems can the organisation evidence the following?**	Applicable	Applicable	Medical hoists and lifts are covered under SH15 Medical Devices and Equipment.	1. Lifts Regulations 1997 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health Technical Memorandum 08-02: Design and maintenance of lifts in the health sector - Lifts 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 5. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1997/831/contents/made https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.gov.uk/government/publications/guidance-concerning-the-planning-installation-and-operation-of-lifts-in-healthcare-buildings https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH12	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH12	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH12	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH12	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH12	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH12	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH12	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports;		
SH12	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH13	**SH13: With regard to Pressure Systems can the organisation evidence the following?**	Applicable	Applicable	Users can assess the specific requirements around Pressure Systems in this SAQ or within relevant SAQ with pressure systems e.g. medical gases. The approach used should be explained in the notes column.	1. Simple Pressure Vessels (Safety) Regulations 1991 2. Pressure Systems Safety Regulations 2000 (PSSR) 3. Pressure Equipment Regulations 1999 4. HSE Guidance Note PM5 1989 Automatically Controlled steam and hot water boilers now Safe Management of Industrial Steam and Hot Water Boilers HSE INDG436 2011 5. ACoP L122 Safety of Pressure Systems 6. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 8. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1991/2749/contents/made https://www.legislation.gov.uk/uksi/2000/128/contents/made https://www.legislation.gov.uk/uksi/1999/2001/contents/made https://www.hse.gov.uk/research/hsl_pdf/2005/cl05-11.pdf https://www.hse.gov.uk/pubns/books/l122.htm#:~:text=The%20Pressure%20Systems%20Safety%20Regulations,one%20of%20its%20component%20parts. https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH13	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH13	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH13	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	4. Requires moderate improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH13	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH13	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH13	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH13	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH13	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH14	**SH14: With regard to Fire Safety can the organisation evidence the following?**	Applicable	Applicable	This SAQ assesses Fire Safety in its entirety including detection and alarm systems, sprinkler/water mist systems, fire damper operation etc. There may be some overlap with other SAQs, e.g. SH9 and SH11 that can be cross referred to avoid duplication	1. Regulatory Reform (Fire Safety) Order 2005 2. Management of Health and Safety at Work and Fire Precautions (Workplace) (Amendment) Regulations 2003 3. The Fire and Rescue Services Act 2004 4. Health and Safety (Training for Employment) Regulations 1990 5. Health and Safety at Work Act 1974 6. Management of Health and Safety at Work Regulations 1999 7. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 8. Safety Representatives and Safety Committees Regulations 1977 9. Building Regulations 2010 10. The Housing Act 2004 11. Health Technical Memorandum 05-01: Managing Healthcare Fire Safety 12. Health Technical Memorandum 05-02 Guidance in Support of Functional Provisions for Healthcare Premises 13. Health Technical Memorandum 05-03 Fire safety - Operational Provisions 14. HM Government – fire safety risk assessment: 'Means of Escape for Disabled People' 15. HM Government – fire safety risk assessment: 'Healthcare premises' 16. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 17. CQC Guidance for providers on meeting the regulations 18. Approved document B to the building regulations volume B2 19. Equality Act 2010 20. Regulation 38 – operating within the building on Fire Safety. 21.Estates Technical Bulletin - Risks of electrical batteries for the NHS estate 22. Building safety Act 2022 - https://www.legislation.gov.uk/ukpga/2022/30/contents/enacted https://www.legislation.gov.uk/uksi/2005/1541/contents/made https://www.legislation.gov.uk/uksi/2003/2457/contents/made https://www.legislation.gov.uk/ukpga/2004/21/pdfs/ukpga_20040021_en.pdf https://www.legislation.gov.uk/uksi/1990/1380/contents/made https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1995/3163/contents/made https://www.legislation.gov.uk/uksi/1977/500/contents/made https://www.legislation.gov.uk/uksi/2010/2214/contents/made https://www.legislation.gov.uk/ukpga/2004/34/contents https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.gov.uk/government/publications/fire-safety-risk-assessment-means-of-escape-for-disabled-people https://www.gov.uk/government/publications/fire-safety-risk-assessment-healthcare-premises https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1124736/Approved_Document_B__fire_safety__volume_2_-_Buildings_other_than_dwellings__2019_edition_incorporating_2020_and_2022_amendments.pdf https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.legislation.gov.uk%2Fuksi%2F2010%2F2214%2Fregulation%2F38%2Fmade&data=05%7C01%7Chayley.morris10%40nhs.net%7Cb384c2045c7e4f5597d808dbd3dc5eeb%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638336715661538052%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=2ovEsNorYbcyBWuK6wPkE4ZS8OzQ7hqQFjSxDfkW1Tk%3D&reserved=0 https://www.england.nhs.uk/long-read/nhs-estates-technical-bulletin-netb-risks-of-electrical-batteries-for-the-nhs-estate/ For consideration to relevant Trusts Building Safety Act 22	
SH14	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of protocols and procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site aligned to guidance; 2. Regular assessment of policies and procedures; 3. Local operating procedures in place including such items as contractors working on fire compartments		
SH14	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people, in compliance with relevant legislation and published guidance, with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH14	**3. Governance** Are there regular meetings of the fire safety committee, is there an external annual report by the authorising engineer (fire) is there an annual internal report to the Board	2. Good	2. Good	1. Minutes of committee meetings 2. Annual AE report 3.Annual internal report		
SH14	**4. Enforcement** Has there been any enforcement of the fire safety order, either under articles 29, 30 and 31 of the fire safety order (alterations, enforcement or prohibition notice) or informal (notification of deficiencies) where no enforcement notices have been received, this should be scored as good.	3. Requires minimal improvement	2. Good	1. Copies of FSO notices 2. Copies of notification of deficiencies		
SH14	**5: Risk Assessment** Have all areas of the premises had a fire risk assessment undertaken and regularly reviewed and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers where appropriate; 4. Fire Risk Assessments 5. Fire Safety Plans and Reviews 6. Compartmentalization drawings showing fire compartments and fire dampers		
SH14	**6 Maintenance** Are assets, equipment and plant necessary for fire safety maintained in an efficient state, efficient working order and good repair? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Risk based evidence backed planned preventative maintenance system in place e.g. fire alarm systems, fire doors, fire compartmentation, fire dampers, fire extinguishers; 3. Risk based methodology, quality control/Inspection records		
SH14	**7 Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records, incorporating specific evacuation training for staff with patient contact and evidence of this training.		
SH14	**8: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	4. Requires moderate improvement	4. Requires moderate improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Plans for fire alarm mitigation in cases of system failure 6. Reduction of unwanted fire signals (both false alarms and spurious calls on the fire and rescue authority)		
SH14	**9: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures? (Note 1) Is the annual audit of fire safety and fire safety management undertaken, and the outcomes communicated to the Trust Board as outlined in HTM 05-01 section 7.14?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports; 4. Fire service audits; 5. Evacuation tests; 6. Fire risk assessment review frequency aligned to legislative requirements and risk.		
SH14	**10. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below .	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH15	**SH15: With regard to Medical Devices and Equipment can the organisation evidence the following?**	Applicable	Applicable	Decontamination is covered under SAQ SS1	1. Provision and Use of Work Equipment Regulations 1998 2. ACoP 22 Safe Use of work Equipment. 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. Medicines and Healthcare Products Regulatory Agency (MHRA) Guidance 5. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 6. CQC Guidance for providers on meeting the regulations https://www.hse.gov.uk/pubns/books/puwer.htm https://www.hse.gov.uk/pubns/books/l22.htm https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH15	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH15	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH15	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH15	**4: Maintenance** Are assets, equipment and plant adequately maintained?	5. Inadequate	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH15	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH15	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH15	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH15	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH16	**SH16: With regard to Resilience, Emergency and Business Continuity Planning can the organisation evidence the following?**	Applicable	Applicable	This SAQ looks at the overall approach to resilience, emergency and business continuity planning. This is in relation to estates and facilities	1. Civil Contingencies Act 2004 2. NHS Standard Contract; 3. Health Building note 00-07:Resilience planning for NHS facilities 30 April 2014: Guidance 4. NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework and Associated Guidance 5. ISO 22301:2014 'Business Continuity Management Systems' 6. ISO 22313:2012 'Business Continuity management Systems Guidance'. 7. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/2004/36/contents https://www.england.nhs.uk/nhs-standard-contract/ https://www.gov.uk/government/publications/resilience-planning-for-nhs-facilities https://www.england.nhs.uk/wp-content/uploads/2017/12/eprr-guidance-chart-v3.pdf https://shop.bsigroup.com/ProductDetail/?pid=000000000030292502 https://www.iso.org/standard/75107.html https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH16	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301; 2. The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board;		
SH16	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. The organisation's Estates and Facilities team is appropriately represented at the organisation's committee(s) which oversee Business Continuity and/or Emergency Preparedness; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH16	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH16	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH16	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH16	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s); 2. Outputs of reviews and their inclusion in Action Plans;		
SH16	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH17	**SH17: With regard to the reporting of safety related issues and actioning of safety related alerts for estates and facilities issues can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to: 1. Reporting safety related incidents and accidents, 2. Ensuring corrective action is taken where notified in E&F safety alert system and similar.	1. National Framework for Reporting and Learning from Serious Incidents Requiring Investigation 2. Regulation 16 and 18 of the Care Quality Commission (Registration) Regulations 2009 3. Department of Health Never Events Policy Framework 4. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 5. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 6. CQC Guidance for providers on meeting the regulations 7.. Health and Care Act 2022 https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf https://www.cqc.org.uk/files/care-quality-commission-registration-regulations-2009 https://www.england.nhs.uk/patient-safety/revised-never-events-policy-and-framework/ https://www.hse.gov.uk/riddor/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH17	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH17	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Embedding bulletins into practice		
SH17	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH17	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH17	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH17	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Incident reports 4. Investigations		
SH17	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH18	**SH18: With regard to ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services can the organisation evidence the following?**	Applicable	Applicable	This SAQ mainly refers to ensuring rented (or similar) premises and related services are safe and suitable. Outsourced services will generally be considered under the relevant SAQ and Contractor management SH16. See the NHS PAM guidance for details on the PAM assessment for multiple small sites.	1. Health and Safety at Work Act 1974 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 3. CQC Guidance for providers on meeting the regulation 4. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH18	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	1. Outstanding	1. Outstanding	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH18	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)	1. Outstanding	1. Outstanding	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH18	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	1. Outstanding	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4.. A fire safety risk assessment has been undertaken and that a practice fire evacuation of the building has been undertaken		
SH18	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH18	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH18	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans;		
SH18	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Safe systems in place for electrical safety to include Portable Appliance Testing (PAT) testing 4. Control of Substances Hazardous to Health (COSHH) assessment has been undertaken and documented 5. Adequate security of the premises, e.g., panic alarms in the consulting rooms 6. A safe and effective system for storage of all waste 7. All staff are aware of their roles and responsibilities in the event of an emergency		
SH18	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH19	**SH19: With regard to Contractor Management for Soft and Hard FM services can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers using E&F contractors for a full range of services from maintenance and servicing to major construction, **both Hard and Soft FM**. It is about ensuring: competent contractors are appointed, adequately informed, instructed and trained, managed and supervised, co-ordinated and co-operate.	1. Health and Safety at Work etc. Act 1974 2. Construction (Design and Management) Regulations 3. HSE INDG368 4. Management of Health and Safety at Work Regulations 5. Legislation relevant to the service provided, as detailed in relevant SAQs. 6. Building Regulations 7. Planning Legislation including listed building consents 8. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 9. CQC Guidance for providers on meeting the regulations 10. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.hse.gov.uk/construction/cdm/2015/index.htm https://www.hse.gov.uk/pubns/indg368.htm https://www.legislation.gov.uk/uksi/1999/3242/contents/made Planning (Listed Buildings and Conservation Areas) Act 1990 (legislation.gov.uk) https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH19	**1: Policy** Does the organisation have a current and approved policy and if applicable, a set of underpinning set of procedures relating to contractor management.	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Preventative/corrective strategies; demonstration of documented process and procedure whereby non-compliance is identified and remediation strategies are developed and delivered.		
SH19	**2: Roles and Responsibilities** Does the Organisation have sufficient and appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood who are responsible for the management of contractors? Is there a named SRO and Trust representative for major contracts including PFI.	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH19	**3. Contract expiry** Does the Trust understand requirements and notice periods in respect of the expiry of major contracts (major or complex and whole contract period of £5mil or over) such as PFI and have plans in place to manage these and the transition of services.	Not applicable	3. Requires minimal improvement	1. Documented end dates for contracts and contractual requirements		
SH19	**4: Risk Assessment** Are contractors risk assessments and if applicable, method statements (RAMS) requested from the contractor(s) prior to works commencing and reviewed for their appropriateness?	2. Good	2. Good	1. Agreed allocation of risk is monitored; 2. Risks reviewed and included in local risk register; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers;		
SH19	**5: Maintenance** Does the organisation hold the necessary proof to demonstrate consistent contractor maintenance activities - for its contracted services.	2. Good	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Documented evidence of audits and reviews to support compliance. 5. Auditing and inspecting the Contractors' work, ensuring that they comply with the contractual requirements on quality, Health and Safety, environmental and legislative requirements. 6. Managing communication between the Contracting Body and the Sub-Contractors;		
SH19	**6. Contractor Competence** With regards to the competence of the contractors - has the organisation checked that contractors are using suitably competent persons to carry out the contracted services?	2. Good	2. Good	1. Adequate insurance. 2. Performance monitoring against agreed Key Performance Indicators. 3. Evidence of professional qualifications and experience;		
SH19	**7: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Supplier Business Continuity and Disaster Recovery Plan.		
SH19	**8: Review Process** Is there a robust regular review process in place to manage the performance of contractors ensuring compliance to the agreed contract, relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Receiving, checking and authorising invoices for payment for additional services; 4. Monitoring Contractors' approach to rectifying defects; 5. Problem solving and dispute (prevention and) resolution where issues exist. 6. Establish and maintain appropriate records and information management systems to record and manage the performance of the Sub-Contractors;		
SH19	**9: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH20	**SH20: With regard to Mortuaries can the organisation evidence the following?** **Is your organisation responsible for the running or maintenance of one or more mortuaries? This includes Mortuaries in PFI or other out-sourced regimes.**	Not applicable	Applicable	This SAQ relates to the overall management of the E&F function and how specific technical areas (covered by separate SAQs) are managed, reported, escalated and reviewed in a consistent way. If the answer to this question is "NA", the remainder of this SAQ does not need to be completed.		
SH20	**1: Policy & Procedures** The organisation has Policies and Procedures in place to deliver the requirements of HBN 16 01, including plans agreed with partner organisations to respond to "Excess death events" and "mass fatality events.	Not applicable	Not applicable	1. Policy and procedures relevant to Mortuary services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH20	**2: Security** For all mortuary and post-mortem facilities, are: • All parts of the facility that are only used during the day protected out of hours by an intruder alarm system, to either BS 4737 or BS EN 50518 as appropriate. • All points of ingress and egress from the facility, including body storage and receiving areas, even if temporary, covered by high-definition CCTVs. These should be equipped with a pan and tilt facility and be capable of producing high-quality images in low levels of light. Positioning of cameras should be determined with care, selecting optimum positioning for maximum field of coverage. Monitors should be sited at a location that is permanently staffed whilst the facility is in use. • All entrances, work areas and other sensitive spaces should be protected wherever possible by passive security, plus one of the variety of electronic access control systems available. • Visitors and funeral directors only gain access to the mortuary after operating an audio/video intercom at the appropriate entrance. • All CCTV provided in mortuary facilities capable of being isolated if required.	Not applicable	Not applicable	1. Risk assessment of Mortuary security. 2. Design and approval of Mortuary security system, including procedures for us and maintenance.		
SH20	**3. Funeral Directors** Agreed plans and protocols are in place to work with funeral directors to ensure a timely turnaround of the deceased and also to establish protocols including for remote sites.	Not applicable	Not applicable	1. Authorised plans and protocols agreed by all Funeral Directors using the Mortuary.		
SH20	**4. HTA (Human Tissue Authority)** Do all of the organisations meet the Human Tissue Authority (HTA) regulatory standards and professional guidance for mortuaries requiring licensing by the HTA. Where HTA licenses do not apply to a facility, do they meet their standards and guidance?	Not applicable	Not applicable	1. Copies of HTA licenses.		
SH20	**5. Existing facilities** Where facilities do not currently meet the appropriate standards and guidance, are plans in place for them to be upgraded? Is this upgraded funded?"	Not applicable	Not applicable	1. Analysis of current situation and future plans agreed by the Board.		
SH20	**6. Future demand** Does the organisations long-term permanent storage meet their forecasts for predictable peaks in a resilient manner?	Not applicable	Not applicable	1. Analysis of current situation and future plans agreed by the Board.		
SH20	**7. Body transfer for Post Mortems (PMs)** Are protocols in place to ensure all bodies from non HTA licensed facilities are transferred to licensed facilities within seven days where a post mortem is required.	Not applicable	Not applicable	1. Copies of Body transfer protocols.		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH20	**8. Entrances & Location** Do all the facilities used by the organisations for body storages provide: • A dedicated entrance into the mortuary for the deceased which is not shared with visitors; • A staff entry either combined with the visitors' entrance or deceased entrance for smaller facilities (depending on the size of the facility, staff numbers and operational model); • For larger facilities separate entrances, creating a more serene ambience for bereaved visitors; • Entrances not in close proximity to each other, and the entrance for the deceased should not be seen from the visitors' entrance.	Not applicable	Not applicable	1. Policy and procedures relevant to Mortuary services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH20	**9. Care, safety and security** Are all entry points at all facilities always: • Controlled by staff, for example through video/audio intercoms • Access-controlled through a digital system for staff, for example swipe card, fob or other intelligent solution, with visitors escorted when in the facility • Providing mortuary and other NHS Trust managers with the ability to regularly audit matters such as access arrangements, CCTV and trends. • Have active surveillance of each entrance and the body store area provided both within the mortuary facility and to an appropriate, constantly staffed area, for example a Trust security hub. Such equipment should be located so as to comply with data protection legislation. In addition, can the active surveillance measures be isolated and turned off in cases of extreme public interest.	Not applicable	Not applicable	1. Policy and procedures relevant to Mortuary services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH20	**10. Waste management** In all mortuaries and post-mortem facilities, are: • A sluice or sluices for material suitable for direct discharge to drains provided, subject to the consent of the appropriate water authority ; • Adequate secure storage and ventilation of no fewer than six air changes per hour for material in bags, packages or drums awaiting removal for appropriate treatment and disposal; • Direct access to a disposal hold for waste produced during procedures.	Not applicable	Not applicable	1. Trust Waste plan.		
SH20	**11. Body storage & delivery point** For all rooms where bodies are stored: • Are storage temperatures in line with the following requirements: - refrigerated storage should be 4–6°C for storage of less than 30 days or necessary to preserve the body's integrity - freezer storage should be at –20°C if stored for over 30 days (or sooner – depending on the condition of the body). • Are all the above fridges and freezers continuously monitored, with alarms located locally within the mortuary and these alarms linked to the estates and/or switchboard function to allow for 24/7 observation. • Are appropriate "cold store rooms" provided for people with excess weight who exceed normal expectations, to remain on trolleys in order to minimise unnecessary handling of the bodies.	Not applicable	Not applicable	1. Protocols for the regular measurement of body store temperatures including methodology for doing so and how records and reviewed and checked.		
SH20	**12. PM with forensics** For post-mortem room designated or used for criminal forensic examinations, are the following facilities provided: • An observation room, with two-way audio/visual communication • Audiovisual recording and two-way communication to a large meeting • Additional office accommodation/hot desks for other agencies • An additional area around the postmortem table for additional staff and equipment • Ceiling mounted white screens for photography • UV light and blackout screens for DNA work • Additional and secure storage for items such as evidence or equipment	Not applicable	Not applicable	1. Policy and procedures relevant to Mortuary services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH20	**13. Waste disposal room** For all facilities: • Are policies in place for the safe disposal of used items in accordance with current legislation and NHS guidance, for example COSHH and HTM 07-01 – 'Safe and sustainable management of healthcare waste'. • Is a secured waste disposal room provided, with adequate space for the temporary storage of securely packed, segregated, recycled refuse and dirty linen bags (appropriately colour-coded, labelled and carrying identifiable location source tags), with easy access from both the dirty utility room and externally, for their collection by the waste management company. If the waste disposal room is located directly off the post-mortem room, is: • Waste and dirty linen generated in the post-mortem suite placed in the correct container or bag, complete with identification labels and source tags, within the post-mortem suite before being deposited in the disposal hold • Air movement controlled in the whole post-mortem suite • Entry controlled to the post-mortem suite and mortuary, and the means by which unauthorised movement is prevented. • Disposal areas organised so that clinical waste, linen and domestic waste are not mixed together, including waste recycling segregation prior to collection.	Not applicable	Not applicable	1. Trust Waste plan.		
SH20	**14: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable			
SH20	Capital cost to achieve compliance	£0	£0			
SH20	Revenue consequences of achieving compliance	£0	£0			
SH21	**SH21:The built environment: Reducing harm by ligature in practice.With regards to self-harm risks associated with the built environment, can the organisation evidence that they have taken consideration for the following:**	Not applicable	Not applicable			
SH21	**1: Policy** The Trust has a policy in place which specifically relates to ligature and can evidence it is being followed in line with the CQC guidance?	Not applicable	3. Requires minimal improvement			
SH21	**2: Roles and Responsibilities** The trust has reviewed and specified the key roles, responsibilities and competencies for those who are accountable for safety covering ligature assessments?	Not applicable	3. Requires minimal improvement			
SH21	**3: Risk Assessment** Has a full risk assessment been completed	Not applicable	2. Good			
SH21	**4: Maintenance** Does the organisation hold the necessary proof to demonstrate consistent contractor maintenance activities - for its contracted services.	Not applicable	Not applicable			
SH21	**5: Contractor Compliance** Where contractors are used for fixture and fittings they should be adequately qualified to ensure the specific ligature risks have been identified if applicable.	Not applicable	Not applicable			
SH21	**6: Review Process** Is there a robust, regular review process in place to manage the performance of contractors ensuring compliance to the agreed contract, relevant standards, policies and procedures?	Not applicable	3. Requires minimal improvement			
SH21	**7: Costed Action Plans If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.**	Not applicable	Not applicable			
SH21	Capital cost to achieve compliance	£0	£0			
SH21	Revenue consequences of achieving compliance	£0	£0			
SH22	**SH22:Estates IT and Building Information Management (BIM) systems** **Please confirm you have a plan for your trusts to engage with their current providers of telecoms services who will be able to assist them in identifying their Public Switch Telephone Network services. Once this has been completed, trusts need decide how best these services should be replaced or removed.** **The systems that need to be considered include:** **• Plant alarms;** **• Staff Attack Systems;** **• Security Alarms;** **• Lockdown/Access Control intercoms;** **• Car Park Barriers;** **• Catering freezers & fridges;** **• Pathology & Blood freezers and fridges;** **• Fire alarm auto dial;** **• Lift emergency calls;** **• Building Management Systems (BMS) alarms (oxygen, gas shut out, fuel alarms (leak and level), ventilation, generator etc);** **• Fax machines;** **• Credit card terminals.** **The PSTN situation is discussed at your Local Resilience Forums (LRF) and therefore we suggest you link with your Trust EPRR lead who will be able to assist with the wider work being undertaken by LRF partners, to identify any potential interdependencies within your Trust.**	Applicable	5. Inadequate	Please note this question was previously SS10 and has now been moved under Safety hard as SH22		
SH22	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH22	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SH22	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH22	**4: Maintenance** Are assets, equipment and plant adequately maintained?	Not applicable	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1 .Public Health Act 1961 2. Health and Safety at Work Act 1974 3. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/ukpga/Eliz2/9-10/64/contents https://www.legislation.gov.uk/ukpga/1974/40 https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH22	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	Not applicable	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records; 3. Process for monitoring operators handling of calls for quality purposes		
SH22	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	4. Requires moderate improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Business continuity procedures in place in case of fire or other emergency to maintain service including standby operating facilities located on individual sites 6. Loss of service plans including bleeps and mobile phones. 7. Robust call out procedures tested over all sites monthly with table top exercises.		
SH22	**7. Technology replacement plan & Review process** Is there a technology migration plan in place for removal of service/infrastructure reliance on PSTN and ISDN by January 2027? When answering this sub-question, "Not Applicable" should only apply where no PSTN connections have ever existed within your organisation. If you have completed migration, please use "Outstanding".	3. Requires minimal improvement	Not applicable	1. Identified services reliant on PSTN within your organisation? 2. Have an appropriate replacement solution identified with your provider that ensures continuity of service? 3. Is there a plan in place with your provider to migrate services away from PSTN? 4. Has the identified plan been executed to migrate services to replacement solution? 5 Annual reviews of standards, policies and procedures documented; 6 Outputs of reviews and their inclusion in Action Plans; 7. KPIs on performance including call pick up times		
SH22	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
SH22	Capital cost to achieve compliance	£0	£0			
SH22	Revenue consequences of achieving compliance	£0	£0			

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SS1	**SS1: With regard to Catering Services can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers the safety aspects of catering and food with SAQ PE4 looking at patient feedback on food. Note: This applies to all food sources on-site including commercial and charitable outlets.		
SS1	**1: Policy & Procedures** Does the Organisation have a current, approved Policy, Food Safety Management System and an underpinning set of procedures that comply with relevant legislation and published guidance?	1. Outstanding	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS1	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS1	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? Has the organisation documented all processes and procedures in an approved HACCP document?	3. Requires minimal improvement	1. Outstanding	1. Food Standards Agency ratings and Nonmental Health Officer reports. 2. Risks reviewed and included in local risk register; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers; 5. Nutritional screening programme identifying patients at risk from malnutrition and dehydration. 6. Allergens screening		
SS1	**4: Maintenance** Are assets, equipment and plant adequately maintained, regularly and monitored to ensure equipment relating to temperature control is functioning correctly?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS1	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements including level 2 hygiene for all food handlers and HACCP at the appropriate level for supervisors and Managers?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS1	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	1. Food Hygiene (England) Regulations 2006. 2. Control of Substances Hazardous to Health 2002 3.Food Safety Act 1990.(Amended Regulations 2004) 4. HSG (96) 20 -Management of Food Hygiene & Food Services in the National Health Service. 5. NHS Code of Practice for the manufacture, distribution and supply of food, ingredients and food related products. 6. Regulation EC 852/2004 on the hygiene of foodstuffs. 7. Food Service at Ward Level with Healthcare food and Beverage Service Standards – a guide to ward level services – 2007 8. Compliance with Healthcare Commission Core Standard 14 (Food) 9. Health Act 2006 Code of Practice for Prevention and Control of Health Care Associated Infections (Department of Health 2006) revised January 2008 10. Food Safety(England) Regulations 2005 11. Food Safety (Temperature Control) Regulations 1995 12..CQC Guidance for providers on meeting the regulations 13. Fire Hazards have been considered for any catering service 14. NHS 10 Key Characteristics of Good Nutrition and Hydration 15. British Dietetic Association's Nutrition and Hydration Digest 16. British Dietetic Association guidelines 17. The MUST Toolkit (Malnutrition Universal Screening Tool) 18. National standards for healthcare food and drink 19. Food Review .https://www.legislation.gov.uk/uksi/2006/14/contents/made https://www.hse.gov.uk/coshh/ https://www.legislation.gov.uk/uksi/2004/2990/contents/made https://www.legislation.gov.uk/eur/2004/852/contents https://www.cqc.org.uk/guidance-providers/regulationsenforcement/regulation-14-meeting-nutritional-hydration-needs https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance https://www.legislation.gov.uk/uksi/2005/2059/contents/made https://www.legislation.gov.uk/uksi/1995/2200/contents/made https://www.cqc.org.uk/guidance-providers/regulations https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics/ https://www.bda.uk.com/specialist-groups-and-branches/food-services-specialist-group/nutrition-and-hydration-digest.html https://www.bda.uk.com/professional/practice/practice_guidance/home https://www.bapen.org.uk/screening-and-must/must/must-toolkit/the-must-itself https://www.bapen.org.uk/must-and-self-screening/must-toolkit/ https://www.england.nhs.uk/long-read/national-standards-for-healthcare-food-and-drink/ .https://www.gov.uk/government/publications/independent-review-of-nhs-hospital-food	
SS1	**7: Review Process** Is there a robust regular review process to assure compliance and effectiveness of relevant standards, policies and procedures which includes sampling and testing where required?	1. Outstanding	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS1	8. **Food Standards (No.1)** Organisations should have a designated board director responsible for food (nutrition and safety) and report on compliance with the healthcare food and drink standards at board level as a standing agenda item.	3. Requires minimal improvement	2. Good	1. Documented and readily available		
SS1	9. **Food Standards (No.2)** Organisations should have a food and drink strategy.	2. Good	2. Good	1. Documented and readily available		
SS1	10. **Food Standards (No.3)** Organisations should consider the level of input from a named food service dietitian to ensure choices are appropriate.	2. Good	2. Good	1. Documented and readily available 2. Minutes of nutritional steering group available 3. Name and details of dietitian from contacts page 4. Documented evidence of dietitian involvement in menu engineering		
SS1	11. **Food standards (No. 4)** Organisations should nominate a food safety specialist and this person should chair a food safety group	2. Good	2. Good	1. Documented and readily available 2. Minutes of food safety group available 3. Evidence of food safety audit management and safety system .4 A food safety group, to include relevant leads should be set up, this should also pick up outcomes from environmental health inspections. 5.Mandatory training should include an appropriate level of food hygiene training for all employees working with and serving food, this should be completed at least once every 3 years.		
SS1	12. **Food Standards (No.5)** Organisations invest in a high calibre workforce, improved staffing and recognise the complex knowledge and skills required by chefs and food service teams in the provision of safe food and drink services, including training report, matrices or other evidence of chef, catering and nurse training including L2 food safety.	2. Good	3. Requires minimal improvement	1. Documented and readily available training matrices' and training programme 2. available on ESR		
SS1	13 **Food Standards (No.6)** Organisations are able to demonstrate that they have an established training matrix and a learning and development programme for all staff involved in healthcare food and drink services.	2. Good	2. Good	1. Documented and readily available training matrices' and training programme 2. available on ESR		

Guidance for Food Standard no 8. - If patient/staff/visitors are not present 24/7, approach this question as having a food provision for 100% of the time they are on site.
If the type of food service is not present within your trust, put not applicable, however you cannot put not applicable for all 7 Food Standard No. 8 questions as you should be working to provide a 24/7 offering for your staff of one of these types of food service
If your trust operates 24/7 services but the food provision operates only daytime hours, the maximum score should be requires minimal improvement

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SS1	14.**Food Standards (No. 7)** Organisations are able to monitor, manage and actively reduce their food waste from production waste, plate waste and unserved meals, a full waste strategy including food waste	2. Good	2. Good	1. Documented and readily available 2. Evidence provided of involvement of waste management measurements and systems 3. Evidence food is included within waste management strategy 4. Completed ERIC return inline with this		
SS1	15.**Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a 24 hour restaurant.	3. Requires minimal improvement	4. Requires moderate improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**16.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a 24 hour café	3. Requires minimal improvement	3. Requires minimal improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**17.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a hot vending services.	3. Requires minimal improvement	3. Requires minimal improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**18.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have retail services	3. Requires minimal improvement	4. Requires moderate improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**19.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have cold vending	3. Requires minimal improvement	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**20.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have smart fridges	3. Requires minimal improvement	Not applicable	1. Documented and readily available with analysis of why this is appropriate		
SS1	**21.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have staff provision for storage and heating of food brought from home.	2. Good	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**22: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	2. Good	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS2	**SS2: With regard to Decontamination Processes can the organisation evidence the following?**	Applicable	Applicable	Management, operation and maintenance of decontamination equipment and processes covering the decontamination of surgical equipment, linen, dental equipment and flexible endoscopes. As set out in the HTM 01 Suite 01-06		
SS2	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Quality manual and supporting processes.		
SS2	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. Trust management structure for decontamination 5. Appointment letter for AE, job descriptions e.g. decontamination lead, SSD manager, Endoscopy Unit decontamination team 6. Appointment letter for AP(D) 7. Evidence of employing appropriately qualified experienced people in key roles as identified in the HTMs and other standards.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations15(1) All premises and equipment used by the service provider must be—15(1)(d) properly used,15(1)(e) properly maintained 2. CQC Guidance for providers on meeting the regulations15(1) All premises and equipment used by the service provider must be—15(1)(d) properly used,15(1)(e) properly maintained, and 3. Health Technical Memorandum01-01A, B, C, D, E 4. Health Technical Memorandum01-04A 5. Health Technical Memorandum01-05 6. Health Technical Memorandum01-06A, B, C, D, E; 7. ISO 9001 8. ISO13485 9. Estate/MHRA alerts 10. Medical Devices Directive. 11. Revision to the Medical Devices Directive. 12. CQC Guidance about compliance. - Guidance about compliance Essential standards of quality and safety 13. GS1 coding. 14. NHS Operating Framework 15. Medical Devices Regulations (MDR) 2002. 16. BS EN ISO 13485.	
SS2	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		

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SS2	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Validation reports for washer disinfectors and drying cabinets. 5. Permits to work for service engineers. Service contracts. PPM dockets and maintenance instructions 6. Permit to work system	17. Executive Letter EL(98)5. 18. Decontamination Services Agreement. 19. In-vitro Diagnostic Devices Directive. 20. Kirby, E., Dickinson, J., Vassey, M., Dennis, M., Cornwall, M., Mcleod N. et al. (2012). Bioassay stunnex L. 21. IHEEM AE(D) register. 22. Institute of Decontamination Sciences (IDSc). 23. Institute of Healthcare Engineering and Estate Management (IHEEM). 24. ESAC-Pr report. 25. MHRA's 'Managing medical devices: guidance for healthcare and social services organisations' 26. MHRA 'Medical devices: conformity assessment and the CE mark'. 27. BSG Guidance for flexible endoscopy 28. JAG Guidance for endoscopy 29. BS EN ISO 15883 (washers – surgical and endo) 30. BS EN ISO 285 (sterilizers) 31. BS EN ISO 14662 (drying cabinets endo) https://www.legislation.gov.uk/ukdsi/2014/97801111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations NHS England » Health technical memoranda NHS England » Health technical memoranda NHS England » Health technical memoranda NHS England » Health technical memoranda ISO - ISO 9000 family — Quality management https://shop.bsigroup.com/ProductDetail?pid=000000000030353196&creative=435401337506&keyword=&matchtype=b&network=g&device=c&gclid=Cj0KCQjwhb36BRCfARIsAKcXh6GMNUjeSJRKxBsGuwxpkqp_2sQxy7VOg8DODJbCx0VtfiaOupLFzQaAoDMEALw_wcB https://www.cas.mhra.gov.uk/Home.aspx https://www.gov.uk/guidance/medical-devices-conformity-assessment-and-the-ce-mark https://www.gov.uk/government/consultations/consultation-on-the-future-regulation-of-medical-devices-in-the-united-kingdom https://services.cqc.org.uk/sites/default/files/gac_-_dec_2011_update.pdf https://www.gs1.org/standards/barcodes https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13 https://www.legislation.gov.uk/uksi/2002/618/contents/made https://shop.bsigroup.com/products/medical-devices-quality-management-systems-requirements-for-regulatory-purposes/tracked-changes https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/376918/Guidance_on_the_In_Vitro_Diagnostic_Medical_Devices_Directive.pdf http://eprints.gla.ac.uk/75539/1/75539.pdf https://www.iheem.org.uk/IHEEM-Authorising-Engineer-Decontamination-Register https://www.idsc-uk.co.uk/ https://www.iheem.org.uk/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271414/Frequently_asked_questions.pdf https://www.gov.uk/government/publications/managing-medical-devices https://www.gov.uk/guidance/medical-devices-conformity-assessment-and-the-ce-mark https://www.bsg.org.uk/clinical-resource/guidance-on-decontamination-of-equipment-for-gastrointestinal-endoscopy-2017-edition/ https://www.thejag.org.uk/ https://shop.bsigroup.com/ProductDetail?pid=000000000030353196&creative=386044230705&keyword=iso13485&matchtype=b&network=g&device=c&gclid=Cj0KCQjw-uH6BRDQARIsAI3I-UebTMtTTunz4BVFa_wZGh4Z4faiqjOB6iywmYHF2wdlVHKQL0EPDNkaAseTEALw_wcB https://shop.bsigroup.com/ProductDetail/?pid=000000000030278677#:~:text=It%20specifies%20requirements%20and%20the,of%20at%20least%2060%20l. https://www.iso.org/standard/55290.html	
SS2	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records; 3. Training needs analysis, staff training matrix for SSD/Endoscopy and Estates Teams. Specialist training with external providers. Scope cleaning training 4. Competency documents for endoscopy technicians 5. Competency documents for contractors required to work on decontamination equipment 6. Agency staff - if used include matrix of assessment of competency etc?		
SS2	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Business Continuity plans for SSD and Endoscopy Unit. 6. Test reports for efficacy of plans. 7. Training records for staff following testing		
SS2	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Internal and external audit reports 4. Use of ISO 9001 and ISO13485 can be incorporated into evidence 5. AE audit of Trust policy and processes 6. IHEEM JAG audit report and certificate 7. Significant findings from Authorising Engineer reports and action plans.		
SS2	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS3	**SS3: With regard to Waste and Recycling Management can the organisation evidence the following?**	Applicable	Applicable	The scope of this SAQ may gross over into Effectiveness Question E4 (SDMP)		
SS3	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	1. Outstanding	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS3	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		

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SS3	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS3	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	1. Outstanding	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. Waste Electrical and Electronic Equipment Regulations 2006 2. Pollution Prevention and Control (England and Wales) Regulations 2000 3. Environment Act 1995 4. Environmental Protection Act 1990 5. Health Technical Memorandum 07-01; Safe Management of Healthcare Waste 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 7. CQC Guidance for providers on meeting the regulations 8. CQC Provider Handbooks 9. NHS England » NHS clinical waste strategy https://www.legislation.gov.uk/uksi/2006/3289/contents/made https://www.legislation.gov.uk/uksi/2000/1973/contents/made https://www.legislation.gov.uk/ukpga/1995/25/contents https://www.legislation.gov.uk/ukpga/1990/43/contents https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf https://www.england.nhs.uk/estates/nhs-clinical-waste-strategy/	
SS3	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS3	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS3	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS3	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS4	**SS4: With regard to Cleanliness and Infection Control applying to Premises and Facilities can the organisation evidence the following ?**	Applicable	Applicable	This SAQ covers the safety aspects of cleaning and infection control. SAQ PE3 looks at patient feedback relating to cleanliness.		
SS4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS4	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. 4. Framework of responsibility at trust level, linking into departmental responsibilities.		
SS4	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS4	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS4	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Use of NHS England Cleaning Manual	1. Health and Care Act 2022 2. (Health Building Note 00-09) Infection control in the built environment 3. Association of Healthcare Cleaning Professionals (AHCP) (2009) Colour Coding Hospital Cleaning Materials and Equipment: Safer Practice Notice 15 4.National infection prevention and control manual (NIPCM) for England 5. Health Building Note 04-01) Adult in-patient facilities: planning and design	

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◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS4	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	6.. CQC Guidance for providers on meeting the regulations 7. CQC Provider Handbooks 8. National Standards of Healthcare Cleanliness 2021 9. NHS Cleaning Manual (on the E+F hub since 2021, to be published on web March 2024) 1. https://www.legislation.gov.uk/ukpga/2022/31/contents 2.. https://www.england.nhs.uk/publication/infection-control-in-the-built-environment-hbn-00-09/ 3.. https://www.ahcp.co.uk/wp-content/uploads/NRLS-0949-Healthcare-clea-ng-manual-2009-06-v1.pdf 4. https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/ 5.. https://www.england.nhs.uk/publication/adult-in-patient-facilities-planning-and-design-hbn-04-01/ 6&7. https://www.cqc.org.uk/guidance-providers/regulations 8.. https://www.england.nhs.uk/publication/national-standards-of-healthcare-cleanliness-2021/ 9. Hub not yet published	(For SS8 and 9 - Although the mandatory requirement is to display in patient facing areas, a Trust may choose to display in other areas so this is capturing evidence where trusts are improving standards for staff - it is best prac tice to share this information wider)
SS4	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS4	**8. Cleaning Standards 2021** Can you evidence that Star ratings are Displayed in patient facing areas?	1. Outstanding	1. Outstanding	1. Audit evidence 2. Publicly displayed and available		
SS4	**9. Cleaning Standards 2021** **As a minimum has 95% of the estate achieved a star rating of 4* or above, following their technical audits, in FR categories 1 – 4?**	2. Good	1. Outstanding	1. Documented and readily available 2. Publicly displayed and available 3. Reviewed annually		
SS4	**10. Cleaning Standards 2021** **Have you undertaken efficacy audits in a minimum of 95% in each FR categories 1 – 4?**	2. Good	2. Good	1. Audit evidence 2. Reported to Board quarterly		
SS4	**11. Cleaning Standards 2021** **Do you have evidence that audits scoring 3* stars or below are following an escalation and review process?**	2. Good	2. Good	1. Audit evidence 2. Reported to Board quarterly		
SS4	**12: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS5	**SS5: With regard to Laundry and Linen Services can the organisation evidence the following?**	Applicable	Applicable	There may be some cross over with this SAQ and SS4.		
SS5	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS5	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS5	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS5	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. (HTM 01-04) Decontamination of linen for health and social care 2. Department of Health Uniforms and workwear: Guidance on uniform and workwear policies for NHS employers 2020 3. Immunisation against infectious disease: 'The Green Book' 4. HSE (1999) Management of Health and Safety at Work Regulations. London: Stationery Office 5.. HSE (2002) Control of Substances Hazardous to Health Regulations. London: Stationery Office- Health and Care Act 2022 6.. CQC Guidance for providers on meeting the regulations 7. CQC Provider Handbooks 8.. The Textile Services Association 1 .https://www.england.nhs.uk/publication/decontamination-of-linen-for-health-and-social-care-htm-01-04/ 2. https://www.england.nhs.uk/publication/uniforms-and-workwear-guidance-for-nhs-employers/ 3. https://www.gov.uk/government/collections/immunisation-against	
SS5	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	1. Outstanding	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Training matrix available		

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Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS5	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans;	3. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book 4.. https://www.hse.gov.uk/pubns/hsc13.pdf 5. https://www.hse.gov.uk/coshh/ 6https://www.legislation.gov.uk/ukpga/2022/31/contents 7. https://www.cqc.org.uk/guidance-providers/regulations 8. https://tsa-uk.org/healthcare/	
SS5	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS5	**8. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS6	**SS6: With regard to Security Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates only to the Physical Security infrastructure and labour related to the security of NHS facilities and not fraud or cybersecurity.		
SS6	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	1. Outstanding	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Identified and allocated resources are stipulated in the policy 4. The organisation has in place a security management strategy as a standalone document or as part of a policy statement. 5. Evidence of a Security Policy, Violence and Aggression Policy, 6. Procedure for the dissemination of key and vital information e.g. security alerts. The organisation has clear policies and procedures in place for the security of all medicines and controlled drugs.		
SS6	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. Board nominated executive with the responsibility for overseeing security management 5. Nominated Qualified and Accredited Security Management Specialist to oversee and undertake the delivery of the full range of security management work - external/internal. 6. Evidence of internal (including capital development) and external liaison and involvement in local and national groups and with agency partners also to be included in job descriptions.	1. Counter-Terrorism and Border Security Act 2019 2. National Counter Terrorism Security Office guidance 3.Human Rights Act 1998 4. Criminal Procedure and Investigations Act 1996 5.. Guidance from the Surveillance Commissioners Office 6.. General Data Protection Regulations 2018 7.. Criminal Justice and Immigration Act 2008 8.. Criminal Law Act 1967 9.. Following the principle of NHS Protect - Standards for providers 2017-18 Fraud, bribery and corruption 10. Health and Safety at work act 19741. 11. Updated - NHSE National Contract 22/23 Service condition 24 – counter fraud (previously 'Protect')- NHS Requirements | Government Functional Standards | NHS Counter Fraud Authority (cfa.nhs.uk) .12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 13. CQC Provider Handbooks 14. Martyn's Law (currently under consultation - it is important to be aware of updates)	
SS6	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Risks identified include those related to; -Violent and aggressive individuals - Premises suitability - Lone working arrangements. - Evidence of Security assessment programme		
SS6	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Evidence of security involvement in new builds. 5. Evidence of a managed and maintained security access control system	https://www.legislation.gov.uk/ukpga/1996/25/contents https://www.legislation.gov.uk/ukpga/2019/3/contents/enacted https://www.gov.uk/government/latest?departments%5B%5D=national-counter-terrorism-security-office https://www.npcc.police.uk/ https://www.legislation.gov.uk/ukpga/1998/42/contents	

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS6	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Evidence of the promotion of security awareness via multiple mediums 4. Evidence of tiered security training commensurate with duties based on a training needs analysis which is monitored, evaluated and reviewed as needed. 5. Demonstration of staff training in relation to incident reporting	https://www.legislation.gov.uk/ukpga/1996/25/contents https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/786444/Guide_to_the_Regulation_of_Surveillance.pdf https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted https://www.legislation.gov.uk/ukpga/2008/4/contents https://www.legislation.gov.uk/ukpga/1967/58/contents https://cfa.nhs.uk/resources/downloads/standards/Fraud_Standards_for_providers_2017-18.pdf https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fcfa.nhs.uk%2Fgovernment-functional-standard%2FNHS-requirements&data=05%7C02%7Chayley.morris10%40nhs.net%7C8a406c7e22d942e9aabc08dc1bec2ccc%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638415948376320929%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=0wnDVJjTpnmL0RVCYtj1eczCmOtHPHDkLtQm5T1jQQE%3D&reserved=0 https://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf https://www.protectuk.police.uk/martyns-law/martyns-law-overview-and-what-you-need-know	
SS6	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Evidence of plans as required by the security standards; - Planning for Lockdowns; - Planning for child abductions;		
SS6	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Demonstration that risks identified through assessment are sufficiently funded to enable mitigation and response 4. Annual report to board in relation to security management 5. Evidence of work plan and ongoing review and update of plan 6. Evidence that incidents where harm or injury occur or had the potential to occur are sufficiently followed up and investigated including where appropriate support being provided to victims.		
SS6	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS7	**SS7: With regard to Transport Services and access arrangements can the organisation evidence the following?**	Applicable	Applicable	SAQ covers fleet management and transport of goods and services on and between sites. It excludes patient transport apart from the management of taxi services. Related patient experience is covered in SAQ P5. Access arrangements may also be covered under SH2. This includes car parking.		
SS7	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS7	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS7	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS7	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. Health Technical Memorandum 07-03: Transport Management and Car Parking 2. Building Research Establishment BRE - BREEAM Travel Plan documentation. 3. Net Zero Travel & Transport Strategy	
SS7	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:	https://www.england.nhs.uk/estates/health-technical-memoranda/ https://kb.breeam.com/knowledgebase/transport-assessments-and-transport-statements/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ https://energysavingtrust.org.uk/wp-content/uploads/2020/10/EST0018-001-EV-Guide-for-Fleet-Manager-WEB.pdf https://www.r-e-a.net/wp-content/uploads/2020/03/Updated-UK-EVSE-	

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS7	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	Procurement-Guide.pdf	
SS7	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS7	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS8	**SS8: With regard to Pest Control can the organisation evidence the following?**	Applicable	Applicable			
SS8	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;. 3. Preventative/corrective strategies; demonstration of documented process and procedure whereby non-compliance is identified and remediation strategies are developed and delivered.		
SS8	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS8	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS8	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/inspection records	1.Public Health Act 1961 2.Control of Pollution Act 1974 3. Health and Safety at Work Act 1974 4. The Poisons Act 1972 5. The Control of Substances Hazardous to Health Regulation 1988 6. Control of Pesticides Regulations 1986 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 8. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/ukpga/Eliz2/9-10/64/contents https://www.legislation.gov.uk/ukpga/1974/40 https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/ukpga/1972/66 https://www.legislation.gov.uk/uksi/1988/1657/contents/made https://www.legislation.gov.uk/uksi/1986/1510/contents/made https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SS8	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS8	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS8	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Records of pest infestation, COSHH data sheets for pesticides, records of bait placement etc. 4. Documented evidence of audits and reviews to support compliance.		

NHS Premises Assurance Model: Safety Domain (Soft FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS8	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS9	**SS9: with regard Portering Services can the organisation evidence the following?**	Applicable	Applicable	In line with local organisational portfolio for this area.		
SS9	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Patient transfer policy. 4. Infection control procedures and training.		
SS9	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS9	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Risk assessments for injury from needles and exposure to harmful substances and bodily fluids		
SS9	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Training matrix available	1. Health & Safety at Work Act 1974 2. Management of Health & Safety at Work Regulations 1988 3. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1988/1222/contents/made https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf To note we are working on guidance for portering which will be available for reference next year, covering: - Service strategy (workforce) - Technology and equipment - Policy - Working with clinical teams	
SS9	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Manual handling training		
SS9	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS9	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Evidence of patient involvement and feedback. 4. Patient Feedback considered and actioned		
SS9	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Patient Experience Domain	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P1	**P1: With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?**	Applicable	Not applicable	P1 replicates the CQC Provider handbooks KLOE R4 and assesses your processes for patient involvement, compliments and complaints	
P1	**1. Views and Experiences** Are people's views and experiences gathered and acted on to shape and improve the services and culture?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Review of the Patient Led Assessment of the Care Environment (PLACE) results and implementation of the outcomes;	
P1	**2. Engagement** Are people who use services, those close to them and their representatives actively engaged and involved in decision making?	2. Good	2. Good	1. Engagement process and methodology 2. Friends and Family Test 3. Patient Advice and Liaison Service (PALS)	1. Data Protection Act 1998 2. Freedom of Information Act 2000 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: 4. CQC Guidance for providers on meeting the regulations 5. CQC Provider Handbooks 6. NHS England Transforming Participation in Health and Care – September 2013 7. The Kings Fund Research Paper; Patient Engagement and Involvement 8. The Kings Fund Research Paper; The Quality of Patient Engagement and Involvement in Primary Care 2010 https://www.legislation.gov.uk/ukpga/1998/29/contents https://www.legislation.gov.uk/ukpga/2000/36/contents https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf https://www.england.nhs.uk/2013/09/trans-part/ https://www.kingsfund.org.uk/projects/gp-inquiry/patient-engagement-involvement https://www.kingsfund.org.uk/projects/gp-inquiry/patient-engagement-involvement
P1	**3. Staff Engagement** Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?	3. Requires minimal improvement	4. Requires moderate improvement	1. Surveys and questionnaires 2. Focus Groups 3. Engagement feedback influencing services developments and improvements	
P1	**4. Prioritisation** Do leaders prioritise the participation and involvement of people who use services and staff?	2. Good	2. Good	1. Governance and process for dealing with feedback	
P1	**5. Value** Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?	2. Good	2. Good	1. Adherence to confidentiality policy 2. Feedback to stakeholders and patients	
P1	**6: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

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◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P2	**P2: With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on condition, appearance, maintenance and P&D. Safety aspects are dealt with in the safety domain.	1. NHS England: Delivering same sex accommodation guidance. Responsibility transferred to NHSE/I in 2017 .The DHSC guidance was revised and published in 2019. 2. Patient Led Assessments of the Care Environment (PLACE). 3. Health Ombudsman 'Care and Compassion' report 4. National In-patient survey 5. Commission for dignity in Care for older people 'delivering dignity' report 6. Patient Association guidance and advice 7. Joint Committee on Human Rights 'The Human Rights of Older People in healthcare' 8. CQC Provider Handbooks https://improvement.nhs.uk/resources/delivering-same-sex-accommodation/ https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/ https://www.ombudsman.org.uk/publications/care-and-compassion https://www.cqc.org.uk/publications/surveys/surveys https://www.nhsconfed.org/resources/2012/06/delivering-dignity-securing-dignity-in-care-for-older-people-in-hospitals-and-care#:~:text=hospitals%20and%20care-,Delivering%20Dignity%3A%20Securing%20dignity%20in%20care%20for,people%20in%20hospitals%20and%20care&text=Delivering%20Dignity%20is%20the%20final,underlying%20causes%20of%20poor%20care. https://publications.parliament.uk/pa/jt200607/jtselect/jtrights/156/156i.pdf https://www.patients-association.org.uk/Pages/FAQs/Category/policy https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf
P2	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services 7evelopments and improvements 8. Adherence to confidentiality policy 9. Feedback to stakeholders and patients 10. Complaints Procedure 11. Diversity considerations	
P2	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?	2. Good	2. Good	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Monthly reporting of breaches of mixed-sex accommodation guidance 6. Meetings and dialogue with CQC identifying improvements	
P2	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

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Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P3	**P3: With regard to ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on cleanliness. Safety aspects of cleanliness are covered in the safety domain.	
P3	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to cleanliness for all relevant sites and published a local improvement plan.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 9. Diversity considerations	
P3	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the cleanliness and is action taken on the results?	2. Good	2. Good	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Meetings and dialogue with CQC identifying improvements	1. Health and Social Care Information Centre: Patient Led Assessments of the Care Environment (PLACE) https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/
P3	**3. Cleaning Schedules** Are Cleaning Schedules publicly available?	2. Good	1. Outstanding	1. Reviews of policy stating where schedules are available compared with actual checking of availability.	
P3	**4: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

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◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P4	**P4: with regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with access and car parking. Safety SAQ SS7 covers car park management and access arrangements	1.. NHS patient visitor and staff car parking principles 2022 2. Health Technical Memorandum 07-03 (2006): NHS car parking management 3. Car Parking Code of Practice 4. Healthcare Travel Cost Scheme https://www.gov.uk/government/publications/nhs-patient-visitor-and-staff-car-parking-principles https://www.england.nhs.uk/estates/health-technical-memoranda/Private Parking Code of Practice - GOV.UK (www.gov.uk) https://www.nhs.uk/nhs-services/help-with-health-costs/healthcare-travel-costs-scheme-htcs/
P4	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to access and car parking for all relevant sites and published a local improvement plan.	2. Good	1. Outstanding	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 10. Diversity considerations	
P4	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	2. Good	1. Outstanding	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Meetings and dialogue with CQC identifying improvements	
P4	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		
P5	**P5: With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to Grounds and Gardens can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with access and car parking. Safety SAQ SS7 covers car park management and access arrangements	1. The Occupiers Liability Act 1957 (amended 1984) 2. The Health and Safety at Work Act 1974 3. The Management of health and safety at Work Regulations 1999 4. Provision and Use of Work Equipment Regulations 1998 5. Control of Substances Hazardous to Health (COSHH) Regulations 2002 6. Personnel Protective Equipment at Work Regulations 1992 7. Management of Health and Safety at Work Regulation 1999 approved code of practice 8. Workplace, Health, Safety and Welfare Regulations 1992 approved code of practice and guidance 9. Work Equipment Provision and use of Work Equipment Regulations 1998 10. First Aid at Work, Health and Safety Regulations 1981 11. Hand-Arm Vibration 12. Corporate Manslaughter and Corporate Homicide Act 2007 13. RIDDOR 2013 RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 14. Working at Height Regulations 2005 15. BS ISO 15799:2003 Soil quality - guidance on eco-toxicological characterization ofsoils and soil materials 16. BS 3882:1994 Specification for topsoil 17. BS 6031:1981 Code of practice for earthworks 18. BS 7562-4:1992 Planning, design and installation of irrigation schemes guide to water resources 19. BS 4428:1989 guide of practice for general landscape operations (excluding hard surfaces) AMD 6784 20. BS 3882:1994 specification for topsoil and AMD 9938 21. BS 3936-1:1992 Nursery stock specification for trees and shrubs 22. BS 3936-5:1985 nursery stock specification for poplars and willows 23. BS 3936-10:1990 nursery stock specification for ground cover plants 24.BS 7370-3:1991 grounds maintenance recommendations for maintenance •
P5	**1. PLACE Assessment** The organisation has completed the PLACE External areas assessment relating to Grounds and Gardens for all relevant sites and published a local improvement plan.	Not applicable	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 10. Diversity considerations 11. The local improvement plan is included within the Green Plan.	

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◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P5	**2. Other Assessments** Is there a system/process, additional to PLACE External areas assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	3. Requires minimal improvement	2. Good	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Monthly reporting of breaches of mixed-sex accommodation guidance 6. Meetings and dialogue with CQC identifying improvements	25. BS 3998:1989 recommendations for tree work and AMD 6549 Horticulture 26. BS EN 12579:2000 Soil improvers and growing media - sampling 27. BS EN 13037:2000 Soil improvers and growing media - determination of pH Turf 28. BS 3969:1998 Recommendations for turf for general purposes 39. BS 4428:1989 Code of practice for general landscape operations14 (excluding hard surfaces). 30. Horticultural Trades Association guidelines on plant handling and establishment 31. BS 1129 Specification for portable timber ladders, steps, trestles and lightweight stagings British Standards Institution •BS 2037 Specification for portable aluminium ladders, steps, trestles and lightweight stagings British Standards Institution 32. BS EN 131 Ladders (Specification for terms, types, functional sizes; Specification for requirements, testing, marking; User instructions; Single or multiple hinge-joint ladders) British Standards Institute https://www.legislation.gov.uk/ukpga/1984/3 https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1998/2306/contents/made https://www.legislation.gov.uk/uksi/2002/2677/regulation/7/made https://www.legislation.gov.uk/uksi/1992/2966/contents/made https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1992/3004/contents/made https://www.legislation.gov.uk/uksi/1998/2306/contents/made https://www.legislation.gov.uk/uksi/1981/917/regulation/3/made https://www.hse.gov.uk/vibration/hav/ https://www.legislation.gov.uk/ukpga/2007/19/contents https://www.hse.gov.uk/riddor/ https://www.legislation.gov.uk/uksi/2005/735/contents/made https://www.iso.org/standard/29085.html https://shop.bsigroup.com/ProductDetail/?pid=000000000001382025#:~:text=BS%203882%3A1994%20specifies%20requirements,in%20situ%20topsoil%20or%20subsoil. https://shop.bsigroup.com/ProductDetail/?pid=000000000000078031 https://shop.bsigroup.com/ProductDetail?pid=000000000000285806 https://shop.bsigroup.com/ProductDetail?pid=000000000000198326 https://shop.bsigroup.com/ProductDetail/?pid=000000000001382025 https://shop.bsigroup.com/ProductDetail?pid=000000000000262241 https://shop.bsigroup.com/ProductDetail/?pid=000000000000151386 https://shop.bsigroup.com/ProductDetail?pid=000000000000209042 https://shop.bsigroup.com/ProductDetail?pid=000000000000238150 https://shop.bsigroup.com/ProductDetail/?pid=000000000000194564 https://shop.bsigroup.com/ProductDetail/?pid=000000000030006469 https://standardsdevelopment.bsigroup.com/projects/1992-06005#/section https://shop.bsigroup.com/ProductDetail?pid=000000000030260283 https://shop.bsigroup.com/ProductDetail?pid=000000000000198326 https://hta.org.uk/ https://shop.bsigroup.com/ProductDetail/?pid=000000000001635045 https://landingpage.bsigroup.com/LandingPage/Series?UPI=BS%20EN%20131
P5	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
P5	Capital cost to achieve compliance	£0	£0		
P5	Revenue consequences of achieving compliance	£0	£0		

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◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P6	**P6: How does your organisation/site ensure that NHS catering standards are provided effectively and efficiently?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with Catering Services and also complying with Regulation 14. Safety aspects of food and catering are dealt with in the safety domain.	
P6	**1. Policy & Procedures** Does the organisation have in place a policy for healthcare catering which is aligned to current National Standards for Healthcare Catering which has been reviewed via an MDT process within the last 3 years?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Internal structure to consider and action feedback 4. Adherence to confidentiality policy 5. Feedback to stakeholders and patients 6. Complaints Procedure 7. Benchmarking, KPIs and peer comparison process 8. Meetings and dialogue with CQC identifying improvements 9. Public/patient information e.g. handbooks, pre visit information	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 2. CQC Guidance for providers on meeting the regulations 3. National Specifications for healthcare cleanliness 2007 4. PAS:5748 5. NHS Estates (2000) Reducing food Waste in the NHS Department of Health. Better Hospital Food 6. Hospital Catering Association – Protected Mealtimes 7. Council of Europe Resolution food and nutritional Care in hospitals NHS England – 10 Key Characteristics of Good Nutritional Care in Hospitals 2006 8. Food Service at Ward Level with Healthcare food and Beverage Service Standards – a guide to ward level services – 2009 9. Water for Health – Hydration Best Practice Toolkit for Hospitals and Healthcare 10. NHS Executive 'Hospital catering delivering a quality service.' 11. NHS Code of Practice for the manufacture, distribution and supply of food, ingredients and food related products. 12. Improving Nutritional Care – a joint action plan from the department of health and nutrition summit stakeholders 13. HCA Ward Service guide 14. British Dialectic Association Improving Outcomes through Food and Beverage Services Nutritional & Hydration digest "15. Sustainable procurement: the GBS for food and catering services Official Government Buying Standards (GBS) for food and catering services" 16. NHS Standards Contract 17.The NHS Hospital Food Review 2020 18. British Association for Parenteral and Enteral Nutrition - Malnutrition Screening Tool 19. Public Health England - Healthier and More Sustainable Catering Nutrition Principles 20. A Toolkit to Support the Development of a Hospital Food and Drink Strategy 21. CQC Provider Handbooks https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.gov.uk/government/news/hospital-cleaning-revised-specification-published https://www.bsigroup.com/en-GB/about-bsi/media-centre/press-releases/2014/december/Standard-for-providing-a-clean-and-safe-hospital-environment-is-revised/ Reducing waste in the NHS: an overview of the literature and challenges for the nursing profession - PubMed (nih.gov) http://www.hospitalcaterers.org/publications/ https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics/ http://www.hospitalcaterers.org/publications/ https://www.choiceforum.org/docs/dohplan.pdf http://www.hospitalcaterers.org/publications/ https://www.bda.uk.com/uploads/assets/c24296fe-8b4d-4626-aeebb6cf2d92fccb/NutritionHydrationDigest.pdf https://www.gov.uk/government/publications/sustainable-procurement-the-gbs-for-food-and-catering-services https://www.england.nhs.uk/nhs-standard-contract/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/929234/independent-review-of-nhs-hospital-food-report.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/523049/Hospital_Food_Panel_May_2016.pdf https://www.malnutritionselfscreening.org/self-screening.html https://www.gov.uk/government/publications/healthier-and-more-sustainable-catering-a-toolkit-for-serving-food-to-adults https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499745/Toolkit_Feb_16.pdf https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf
P6	**2. Regulation** Does the organisation have a food and drink strategy as defined in the NHS Standard Contract	2. Good	2. Good	1. Review of relevant Policies and Procedures. 2. Nutritional screening programme identifying patient at risk from malnutrition and dehydration	
P6	**3. Choice** The organisation provides a choice of nutritious and appetising food and hydration, in sufficient quantities to meet patients needs	2. Good	2. Good	1. Review of relevant Policies and Procedures.	
P6	**4. Equality issues** Food and hydration meets any reasonable requirements arising from Equality issues e.g. from a patients religious or cultural background	2. Good	2. Good	1. Diversity considerations as set out in Policies and Procedures.	
P6	**5. Information** Patients have accessible information about meals and the arrangements for mealtimes, access to snacks and drinks throughout the day and night and to have mealtimes that are reasonably spaced and at appropriate times.	2. Good	2. Good	1. Patient, visitor and staff charter	
P6	**6. Patient Led Assessment of the Care Environment (PLACE) Assessment** The organisation has completed the PLACE assessment relating to catering services for all relevant sites and published a local improvement plan.	2. Good	2. Good	1. Completed PLACE assessments reviewed and actioned; 2. PLACE training records	
P6	**7. Other Assessments** Is there a system/process in place, additional to PLACE assessments, to measure patients satisfaction with the service provided and is action taken on the results?	2. Good	1. Outstanding	1. Engagement process and methodology 2. Surveys and questionnaires 3. Focus Groups 4. Engagement feedback influencing services developments and improvements	
P6	**8. Legal Standards** Has the organisation complied with the estates related legally binding standards as detailed in the NHS Standard Contract	Not applicable	2. Good	1. Review of policies and procedures to ensures compliance.	
P6	**9: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P1	**P1: With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?**	
P1	**1. Views and Experiences** Are people's views and experiences gathered and acted on to shape and improve the services and culture?	
P1	**2. Engagement** Are people who use services, those close to them and their representatives actively engaged and involved in decision making?	
P1	**3. Staff Engagement** Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?	
P1	**4. Prioritisation** Do leaders prioritise the participation and involvement of people who use services and staff?	
P1	**5. Value** Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?	
P1	**6: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
	Capital cost to achieve compliance Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P2	**P2: With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?**	
P2	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.	
P2	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?	
P2	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
	Capital cost to achieve compliance Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P3	**P3: With regard to ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?**	
P3	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to cleanliness for all relevant sites and published a local improvement plan.	
P3	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the cleanliness and is action taken on the results?	
P3	**3. Cleaning Schedules** Are Cleaning Schedules publicly available?	
P3	**4: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
	Capital cost to achieve compliance	
	Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P4	**P4: with regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?**	
P4	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to access and car parking for all relevant sites and published a local improvement plan.	
P4	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	
P4	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
	Capital cost to achieve compliance Revenue consequences of achieving compliance	
P5	**P5: With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to Grounds and Gardens can your organisation evidence the following?**	
P5	**1. PLACE Assessment** The organisation has completed the PLACE External areas assessment relating to Grounds and Gardens for all relevant sites and published a local improvement plan.	

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P5	**2. Other Assessments** Is there a system/process, additional to PLACE External areas assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	
P5	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
P5	Capital cost to achieve compliance	
P5	Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Patient Experience Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P6	**P6: How does your organisation/site ensure that NHS catering standards are provided effectively and efficiently?**	
P6	**1. Policy & Procedures** Does the organisation have in place a policy for healthcare catering which is aligned to current National Standards for Healthcare Catering which has been reviewed via an MDT process within the last 3 years?	
P6	**2. Regulation** Does the organisation have a food and drink strategy as defined in the NHS Standard Contract	
P6	**3. Choice** The organisation provides a choice of nutritious and appetising food and hydration, in sufficient quantities to meet patients needs	
P6	**4. Equality issues** Food and hydration meets any reasonable requirements arising from Equality issues e.g. from a patients religious or cultural background	
P6	**5. Information** Patients have accessible information about meals and the arrangements for mealtimes, access to snacks and drinks throughout the day and night and to have mealtimes that are reasonably spaced and at appropriate times.	
P6	**6. Patient Led Assessment of the Care Environment (PLACE) Assessment** The organisation has completed the PLACE assessment relating to catering services for all relevant sites and published a local improvement plan.	
P6	**7. Other Assessments** Is there a system/process in place, additional to PLACE assessments, to measure patients satisfaction with the service provided and is action taken on the results?	
P6	**8. Legal Standards** Has the organisation complied with the estates related legally binding standards as detailed in the NHS Standard Contract	
P6	**9: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	
	Capital cost to achieve compliance Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F1	**F1: With regard to having a well-managed approach to performance management of the estate and facilities operations can the organisation evidence the following?**	Applicable	Applicable	HBN 00-08 Part A Section 2	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 3. Developing an Estate Strategy 4. Estates Return Information Collection 5. Patient Lead Assessments of the Care Environment (PLACE) 6. In patient Survey 7. NHS Premises Assurance Model Metrics Dashboard - RICS Real Estate 8. ISO 55000/01/02 Asset Management 2004 ISO 55000:2014 Asset management — Overview, principles and terminology" Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/ https://nhssurveys.org/surveys/survey/02-adults-inpatients/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.iso.org/standard/55088.html	
F1	**1: Analysing Performance** A process in place to analyse estates and facilities services and costs and if these continue to meet clinical and organisational needs?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
F1	**2: Benchmarking** A process in place to regularly benchmark estates and facilities costs?	Not applicable	2. Good	1. Ongoing review of costs on a consistent basis that measures progress against established baseline position 2. Benchmarking including the use of metrics and KPIs from suitable sources including: - Estates Return Information Collection (ERIC) - Contract/Service Level agreement KPIs - Estate Strategy KPIs - Energy and sustainability targets - Cost Improvement Plan targets - NHS Model Hospital		
F1	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	2. Good	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F2	**F2: With regard to having a well-managed approach to improved efficiency in running estates and facilities services can the organisation evidence the following and is this in line with the ICS infrastructure strategy?**	Applicable	Applicable	HBN 00-08 Part A Section 3	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 - The efficient management of healthcare estates and facilities Health Building Note 00-08 Part B: Supplementary information for Part A 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Premises Assurance Model Metrics 6. ISO 55000/01/02 Asset Management 2004 Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.england.nhs.uk/estates/health-building-notes/ https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://improvement.nhs.uk/resources/model-hospital/ https://www.iso.org/standard/55088.html	
F2	**1: Business Planning** An effective and efficient estate and facilities business planning process in place?	Not applicable	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Business plans.		
F2	**2: Estate Optimisation** An effective and efficient process in place to ensure estate optimisation and space utilisation?	Not applicable	3. Requires minimal improvement	1. Space utilisation studies and monitoring of usage. 2. Response to NHS Long Term Plan of reduction to 30% non clinical space.		
F2	**3: Commercial Opportunities** An effective and efficient process in place to identify and maximise benefits from commercial opportunities from land and property that support the main business of the NHS ?	Not applicable	2. Good	1. Market testing and cost benchmarking of contracts. 2. Land and property sale receipts. 3. Commercial Strategy or agreements such as letting of space for retail use.		
F2	**4: Partnership working** An effective and efficient process in place to investigate and implement improvements through partnership working?	Not applicable	2. Good	1. Partnership Working, i.e. One Public Estate		
F2	**5: New Technology** An effective and efficient process in place to maximise the benefits from new technologies?	Not applicable	4. Requires moderate improvement	1. New Technology and Innovation - examples of product design or system implementation 2. IT strategy.		
F2	**6: PFI and LIFT contracts** An effective and efficient process in place to achieve value for money from existing PFI and LIFT contracts?	Not applicable	Not applicable	1. Date and outcome of PFI/PPP reviews and next steps.		
F2	**7: Other contracts** An effective and efficient process in place to achieve value for money from existing other contracts?	Not applicable	2. Good	1. Market testing and cost benchmarking of contracts.		
F2	**8. Property** An effective and efficient process in place to record and managing property interest and leases held	Not applicable	2. Good	1. Asset/Estate Terrier		
F2	**9. Cost Improvement plans** A robust methodology for identifying the delivery and implications of cost improvement plans	Not applicable	3. Requires minimal improvement	1. Regular and accurate submission of CIPs 2. Monitoring of progress of delivery		
F2	**10. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F3	**F3: With regard to improved efficiencies in capital procurement, refurbishments and land management can the organisation evidence the following?**	Applicable	Applicable	HBN 00-08 Part A Section 4.0	1. Health Building Note 00-08, The efficient management of healthcare estates and facilities Health Building Note 00-08 Part B: Supplementary information for Part A 2. NHS Model Health System 3. Estates Return Information Collection (ERIC) 4. Building Cost information Service 5. Government Construction Strategy 6. ProCure22/ProCure23 guidance 7. Naylor Review: 8. Lord Carter Review: 9. NHS Long Term Plan: 10. NHS Net Zero Building Standard 11. Estates Net Zero Carbon Delivery Plan (NZCDP) 1. https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 2. https://model.nhs.uk/ 3. https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection 4. https://www.rics.org/uk/products/data-products/bcis-construction/ 5. https://www.gov.uk/government/publications/government-construction-strategy 6. https://procure22.nhs.uk/ and https://procure22.nhs.uk/p23/ 7. https://www.gov.uk/government/publications/naylor-review-government-response#:~:text=The%20Naylor%20review%20was%20a,response%20capitalises%20on%20those%20opportunities. 8. https://www.gov.uk/government/publications/productivity-in-nhs-hospitals 9. https://www.longtermplan.nhs.uk/ 10. https://www.england.nhs.uk/publication/nhs-net-zero-building-standard/ 11. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117	
F3	**1. Capital Procurement** Capital procurement and refurbishment projects progressed in line with local standing orders and financial instructions and relevant procurement guidance, HM Treasury and DHSC and NHSE guidance.	Not applicable	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
F3	**2. Capital project management** Processes and procedures that ensure there are robust processes for the management of projects during construction including change control and lessons learnt/benefits realisation once projects are completed.	Not applicable	2. Good	1. Project governance documentation in line with capital management 2. Track how many projects are delivered on time or late and track that these were delivered within budget 3. Lessons learnt/benefits realisation and evidence of applying learning to subsequent projects		
F3	**3.. Capital Procurement Efficiencies** Capital procurement and refurbishment projects that actively seek efficiency such as through cost benchmarking, Building Information Modelling and repeatable designs?	Not applicable	2. Good	1. Ongoing review of costs on a consistent basis that measures progress against established baseline position		
F3	**4. Flexibility** Capital procurement and refurbishment projects that actively seek flexible designs to accommodate changes in services?	Not applicable	2. Good	1. Consideration of innovative design and building options e.g. "New for Old".		
F3	**5. Identification and disposal of surplus land** An effective and efficient process for the identification and disposal of surplus land?	Not applicable	2. Good	1. Benchmarking including the use of metrics and KPIs from suitable sources 2. Surplus land identified in Annual Surplus Land Return, STP/ICS Estate Strategy, and EPIMS and shared through One Public Estate.		
F3	**6.Net Zero Carbon** Do the Capital Procurement Capital procurement and refurbishment projects include plans to meet national NHS net zero carbon targets?	Not applicable	2. Good	1. Site Level Heat decarbonisation plans (targets in Delivering a Net Zero NHS report and heat decarbonisation requirement within Green Plan Guidance) 2. The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects (Please note - Building Standard is mandatory for certain projects)		
F3	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
	Revenue consequences of achieving compliance	£0	£0			
F4	**F4: With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services can the organisation evidence the following?**	Applicable	Applicable			
F4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	1. Health Building Note 00-08 - The efficient management of healthcare estates and facilities 2. NHS Standing Financial Instructions -These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by us. 3. Audit Commission Report 2004 - Achieving first-class financial management in the NHS 4. The Public Contracts Regulations 2015 5. The Bribery Act 2010 - Guidance (publishing.service.gov.uk) 6. Leading the fight against NHS Fraud, organisational strategy 2017-2020 -Standards for NHS Providers 2020-21 Fraud, bribery and corruption January 2020 7. HFMA Finance training modules https://www.england.nhs.uk/estates/health-building-notes/https://www.england.nhs.uk/publication/standing-financial-instructions/ http://www.wales.nhs.uk/documents/FinanceinNHS_Report.pdf https://www.legislation.gov.uk/uksi/2015/102/contents/made https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832011/bribery-act-2010-guidance.pdf https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Providers_2020_v1.3.pdf https://www.hfma.org.uk/online-learning/bitesize-courses/detail/nhs-finance https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2F	
F4	**2: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Internal Audits 2. Financial controls and scheme of delegation 3. Business Case procedure and Capital regime		
F4	**3. Board reporting and contracting** Is there comprehensive and regular reporting relating to estates and facilities services to the trust board highlighting performance, risks and issues. Are contracts in place for all estates and facilities services, documenting requirements with appropriate ability to terminate or manage poor performance and defined change control arrangements.	Not applicable	2. Good	1. Board reports 2. Do you have robust change control and review of costs 3. Contracts in place for all services with appropriate provisions for cost control and service incentivisation		
F4	**4: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
	Revenue consequences of achieving compliance	£0	£0			
F5	**F5: With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation evidence the following?**	Applicable	Applicable	SAQ taken from CQC KLOE W5. Prompt 6 can be cross referred to SAQ F1 and Patient Experience SAQs		
F5	**1. Quality and Sustainability** When considering developments to estates and facilities services or efficiency changes (including derogations from standards and guidance), is the impact on quality and sustainability and net zero carbon targets assessed, understood and monitored, before, during and after the development?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Action from surveys and feedback. 4. Backlog Risk Assessment, impact assessment and mitigation and action plan.	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 The efficient management of healthcare estates and facilities 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Model Health System 6. Department of Health Built Environment Key Performance Indicators (KPIs) 7. ISO 55000/01/02 Asset Management 2004 8.Greener NHS » Delivering a net zero NHS 9. NHS Estates Net Zero Carbon Delivery Plan Report 10. Net Zero Guidance plan Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://model.nhs.uk/ https://improvement.nhs.uk/resources/model-hospital/ https://www.gov.uk/government/statistics/key-performance-indicators https://www.iso.org/standard/55088.html https://www.hfma.org.uk/online-learning/bitesize-courses/detail/nhs-finance https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fgreenernhs%2Fa-net-zero-nhs%2F&data=05%7C02%https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 https://future.nhs.uk/connect.ti/Estates_and_Facilities_Hub/view?objectId=155202117 https://www.england.nhs.uk/long-read/green-plan-guidance/ https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/ https://www.england.nhs.uk/long-read/green-plan-guidance/	
F5	**2. Financial Pressure** Are there examples of where financial pressures have negatively affected estates and facilities services?	3. Requires minimal improvement	3. Requires minimal improvement	1. Estates Incidents impacting on clinical care- ERIC returns, & feedback to EFM Division to NHS England and NHS Improvement.		
F5	**3. Continuous Improvement** Do leaders and staff strive for continuous learning, improvement and innovation?	2. Good	2. Good	1. Risk Assessments and Registers 2. Derogations documented with clinical impact assessment and clinical sign-off. 3. Training and Development plans and records.		
F5	**4. Quality Improvements** Are staff focused on continually improving the quality of estates and facilities services?	2. Good	3. Requires minimal improvement	1. Regular assessments of quality outputs e.g. PLACE scores; 2. Inclusion of quality assessments in Costed Action Plans.		
F5	**5. Recognition** Are improvements to quality and innovation recognised and rewarded?	2. Good	2. Good	1. Staff suggestion scheme. 2. Staff awards and recognition.		
F5	**6. Use of Information** Is information used proactively to improve estates and facilities services?	2. Good	3. Requires minimal improvement	1. Use of design evaluation tools.		
F5	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
E1	**E1: With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation evidence the following and is this inline with the ICS infrastructure strategy?**	Applicable	Applicable	SAQ is taken from CQC KLOE W1 and covers the estates and other related strategies as described in HBN 00-08 Part B section 2. Prompt 3 can be linked to SAQ PE1. Operational management is covered in SAQ S01	
E1	**1. Vision and Values** A clear vision and a set of values, with quality and safety the top priority?	2. Good	2. Good	1. Estates Strategy and related documents;	1. Developing an Estate Strategy document 2. Health Building Note 00-08 The efficient management of healthcare estates and facilities 3. Health building Note 00-08The efficient management of healthcare estates and facilities (part A): Land and Property Appraisal 4. Strategic Health Asset Planning & Evaluation (SHAPE) tool 5. RICS UK Commercial Real Estate Agency Standards. 6. RICS Guidance Notes- Real Estate disposal and acquisition. 7. Assets in Action 8. Healthcare providers: asset register and disposal of asset 9. Strategy development: a toolkit for NHS providers 10. Developing strategy What every trust board member should know 11..Greener NHS » Delivering a net zero NHS 12. NHS Estates Net Zero Carbon Delivery Plan Report 13. Net Zero Guidance plan https://www.gov.uk/government/publications/developing-an-estate-strategy https://www.england.nhs.uk/estates/health-building-notes/ https://shapeatlas.net/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency-1st-edition-rics.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144216/Assets_in_Action.pdf https://www.gov.uk/government/publications/healthcare-providers-asset-register-and-disposal-of-assets https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers https://www.gov.uk/government/publications/strategy-development-a-guide-for-nhs-foundation-trust-boards https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F% https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/ https://www.england.nhs.uk/long-read/green-plan-guidance/
E1	**2. Strategy** A robust, realistic strategy for achieving the priorities and delivering good quality estates and facilities services?	3. Requires minimal improvement	2. Good	1. Documentary evidence relevant to the prompt questions e.g. document articulating the vision such as mission statement	
E1	**3. Development** The vision, values and strategy has been developed with staff and other stakeholders?	2. Good	3. Requires minimal improvement	1. Regular discussions/meetings/exchanges with interested parties; 2. Integration of these discussions into Strategies and Visions/Values;	
E1	**4. Vision and Values Understood** Staff know and understand what the vision and values are?	2. Good	2. Good	1. Feedback from staff to quantify their understanding of visions, values and strategy e.g. staff survey results;	
E1	**5. Strategy Understood** Staff know and understand the strategy and their role in achieving it?	3. Requires minimal improvement	2. Good	1. Feedback from staff to quantify their understanding of visions, values and strategy e.g. staff survey results;	
E1	**6. Progress** Progress against delivering the strategy is monitored and reviewed?	2. Good	3. Requires minimal improvement	2. Staff, Patient and stakeholder engagement and feedback 2. Analysis of relevant complaints;	
E1	**7: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Effectiveness Domain ◄◄ Back to instructions	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
E2	**E2: With regard to having a well-managed approach to town planning can the organisation evidence the following?**	Applicable	Applicable	SAQ measures compliance with HBN 00-08 Part B Section 3.0.	
E2	**1. Local Planning** An effective and efficient process to participate in Local Planning matters?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
E2	**2. Neighbourhood Planning** An effective and efficient process to participate in Neighbourhood planning matter?	2. Good	2. Good	1. Involvement in town planning issues. 2. Appropriate action when land and/or property is subject to compulsory purchase powers or potential or actual applications for registering as a town or village green	
E2	**3. Planning Control** An effective and efficient process to participate in planning control process?	2. Good	2. Good	1. Involvement in town planning issues 2. Trusts should be engaged with their ICBs regaridng the local plan process. ICBs, alongside NHSE, are statutory consultees on local plans (but not planning applications). 3. Refer to ICS infrastructure strategy guidance the guidance includes reference to local area energy plans and local nature recovery strategies, which will support town planning.	1. Health Building Note 00-08: The efficient management of healthcare estates and facilities 2. Health building Note 00-08:The efficient management of healthcare estates and facilities - Part A Land and Property Appraisal 3. Health Technical Memorandum 05 Fire code 4. Estates Net Zero Carbon Delivery Plan 5.Health Technical Memorandum 07-02 6. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/estates/health-building-notes https://www.england.nhs.uk/estates/health-building-notes/ https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/
E2	**4. Special Interests** **A**n effective and efficient process to manage special interests (e.g. conservation areas, listed buildings etc.) ?	2. Good	2. Good	1. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings 2. Preventing third parties gaining inappropriate rights over land and property 3. Management of easement agreements 4. Management of tenancy and other contractual arrangements 5. Where non-NHS facilities are used for NHS patients, that policies to ensure NHS standards regarding the built environment are adopted and implemented	
E2	**5. Enforcement** **A**n effective and efficient process to deal with any enforcement procedures served on the organisation?	2. Good	2. Good	1. Has there been any enforcement actions from the Local Planning Authority in the year and, if so, whether these have been satisfactorily resolved	
E2	**6: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Effectiveness Domain ◄◄ Back to instructions	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
E3	**E3: with regard to having a well-managed robust approach to management of land and property can the organisation evidence the following?**	Applicable	Applicable	SAQ measures compliance with HBN 00-08 Part B Section 4.0 to 8.0	
E3	**1: Disposal of land and property** An effective and efficient process for the disposal of freehold/leasehold land and property?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3 Evidence of a short and long term estate strategy supporting clinical, financial and investment objectives. 4. Evidence of optimising utilisation of accommodation across the estate, the Sustainability and Transformation Partnership and Integrated Care Organisation footprint and with One Public Estate partners. 5. Evidence of masterplans for large sites which identify areas for retention, development and disposal 6. Involvement of District Valuer 7. Demonstration of re-investment of income. 8. Maintenance of an up-to-date and accurate property asset register 9. All statutory obligations to be identified and met 10. Preventing third parties gaining inappropriate rights over land and property 11. Management of easement agreements 12. Appropriate action when land and/or property is subject to compulsory purchase powers or potential or actual applications for registering as a town or village green 13. Where non-NHS facilities are used for NHS patients, that policies to ensure NHS standards regarding the built environment are adopted and implemented 14. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings	1. Health Building Note 00-08 - The efficient management of healthcare estates and facilities 2. Health Building Note 00-08: The efficient management of healthcare estates and facilities - Part A Land and Property Appraisal 3. RICS UK Commercial Real Estate Agency Standards. 4. RICS Guidance Notes- Real Estate disposal and acquisition. 5. Assets in Action 6. Real estate management - 3rd edition, October 2016" 7. Healthcare providers: asset register and disposal of asset 8. Estates Net Zero Carbon Delivery Plan https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/estates/health-building-notes/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency-1st-edition-rics.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144216/Assets_in_Action.pdf https://shapeatlas.net/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/real-estate-management-3rd-edition-rics.pdf https://www.gov.uk/government/publications/healthcare-providers-asset-register-and-disposal-of-assets
E3	**2: Granting of Leases** An effective and efficient process for the granting of leases?	2. Good	2. Good	1. Management of leases, tenancy and other contractual arrangements	
E3	**3: Acquisition of land and property** An effective and efficient process for the acquisition of freehold/leasehold land and property?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3 Evidence of a short and long term estate strategy supporting clinical, financial and investment objectives. 4. Evidence of optimising utilisation of accommodation across the estate, the Sustainability and Transformation Partnership and Integrated Care Organisation footprint and with One Public Estate partners. 5. Evidence of masterplans for large sites which identify areas for retention, development and disposal 6. Involvement of District Valuer 7. Maintenance of an up-to-date and accurate property asset register 8. All statutory obligations to be identified and met 9. Preventing third parties retaining inappropriate rights over land and property 10. Management of easement agreements 11. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings 12. Consideration of mandatory energy efficiency ratings.	
E3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
E4	**E4: With regard to having a suitable Sustainability approach in place and being actioned.**	Applicable	Applicable		
E4	**1: Green Plan / Sustainability Strategy** Has your Green Plan been approved by Board and submitted to the ICS / ICB	2. Good	2. Good	1. The Green Plan / Sustainability Strategies published on the Trust's website and has been updated within the last 3 years 2. The organisation tracks its progress using the Green Plan Support Tool 3. The Green Plan / Sustainability Strategy names an executive lead for sustainability 4. The Green Plan / Sustainability Strategy states progress against carbon emission reduction targets in line with the 'Delivering a net zero NHS report' 5. Alignment with STP/ICS estates strategy; 6. Green Plan is published on the Trust's website & has been updated within the last 3 years 7. Green plan states progress against carbon emission reduction targets in line with national NHS net zero targets.	1.Greener NHS » Delivering a net zero NHS 2. NHS Estates Net Zero Carbon Delivery Plan Report 3. Net Zero Guidance plan 4. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ 1.https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 2.https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/ 3. https://www.england.nhs.uk/long-read/green-plan-guidance/ 4. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117
E4	**2: Energy** Is your energy usage, including heat, managed to fully deliver sustainability and effectiveness, and includes plans to meet national NHS net zero carbon targets?	2. Good	3. Requires minimal improvement	1. The organisation has evidence of TM44 Air Conditioning System Assessments 2. Organisations which qualify for the EU Emissions Trading Scheme (EUETS) have an EUETS assessor and can demonstrate relevant annual reporting systems 3. Organisations with Combined (Cooling) Heat and Power Plant (CHP/CCHP) have a CHP Quality Assurance (CHPQA) Certificate for Climate Change Levy (CCL) exemption for each unit installed 4. The organisation has a current energy efficiency policy 6. Evidence that utility bills are checked and validated before payment 7. The organisation has rolled out smart metering across the estate, or has a programme to roll out within the next 3 years 9. Monthly meter readings are taken and recorded, and automated readings validated physically 10. The organisation employs a dedicated (spends > 50% of their time working on energy management activities) energy manager / responsible person for energy 11. The Organisation is compliant to HTM 07-02; Making Energy work in Healthcare 12. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex. 13. Site Level Heat decarbonisation plans (targets in Delivering a Net Zero NHS report and heat decarbonisation requirement within Green Plan Guidance)	1. CIBSE TM44 : Inspection of Air Conditioning Systems 2. EU Emissions Trading System 3. Combined Heat and Power Quality Assurance Programme 4. Making energy work in healthcare (Health Technical Memorandum 07-02) 5. ISO 50001 Energy Management 6. Estates Net Zero Carbon Delivery Plan (NZCDP) 7. NZCDP Technical annex 1. https://www.cibse.org/AirConditioning_1 2. https://ec.europa.eu/clima/policies/ets_en 3. https://www.gov.uk/guidance/chpqa-guidance-notes 4. https://www.england.nhs.uk/estates/health-technical-memoranda/ 5. https://www.iso.org/iso-50001-energy-management.html 6. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 7. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=151919557#
E4	**3: Waste** Are effective systems in place to minimise waste production and effectively dispose of it?	2. Good	2. Good	1. The organisation has a current waste management and minimisation policy 2. The organisation's Dangerous Goods Safety Advisor (DGSA) has reported within the last 12 months 3. The organisation can evidence completion of Pre-acceptance Audits? 4. The Trust can demonstrate processes to fulfil their Duty of Care for waste 5. The organisation holds regular contract review meetings 6. The organisation can evidence record receipt and review of monthly progress reports 7. The organisation holds regular operational meetings 8. The organisation conducts monthly independent audits of the service 9. The organisation maintains statutory waste records (disposal notes, destruction certificates) and compliance audits 10. The organisation can evidence staff waste 11. The organisation employs a dedicated (spends > 50% of their time working on waste management activities) waste manager / responsible person for waste 12. The organisation is compliant with HTM 07-01; Safe Management of Healthcare Waste 13. The organisation is compliant with the Clinical Waste Strategy 14. The organisation is compliant with the 20:20:60 split of Alternative Treatment, Incineration (clinical waste) and Offensive Waste volume	1. HTM 07-01; Safe Management of Healthcare Waste 2. NHS Clinical Waste Strategy 1. https://www.england.nhs.uk/publication/management-and-disposal-of-healthcare-waste-htm-07-01/ 2. https://www.england.nhs.uk/publication/nhs-clinical-waste-strategy/

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
E4	**4: Air Pollution** Does your Trust have policies and procedures in place to control air pollution and an overview of these procedures is included within the Green Plan?	3. Requires minimal improvement	3. Requires minimal improvement	1.The organisation has completed the Clean Air Hospitals Framework Tool 2.The organisation has a Clean Air policy including anti-idling 3.The organisation has an action plan for tackling air pollution from its buildings 4. The organisation has an action plan for tackling air pollution from its own vehicles and those that visit the organisation's site(s) 5.The organisation keeps an FGAS register 6.The organisation has a plan for migrating to Zero Emission Vehicles 7. The organisation has an action plan to meet air pollution targets in the Long Term Plan	1. Clean Air Hospital Framework 2. Fluorinated gas (F gas): guidance for users, producers and traders 3. NHS Long Term Plan https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/air-pollution/ https://www.globalactionplan.org.uk/clean-air-hospital-framework/ https://www.gov.uk/government/collections/fluorinated-gas-f-gas-guidance-for-users-producers-and-traders
E4	**5.: Travel & Transport** Can the organisation evidence an effective and efficient process to ensure staff commuting, patient & visitor travel, and the organisation's own fleet are sustainable and meet the relevant guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has a sustainable travel plan. 2. Zero emissions vehicles are integrated into procurement practices - in-line with Net Zero Travel & Transport strategy. 3. A staff travel survey is completed at least every 24 months. 4. The organisation has a parking policy covering staff, patient & visitor travel. 5. The organisation provides secure bike storage, changing facilities and good quality on and off-site walking and cycling routes. 6. The organisation considers sustainable transport, flexible working and route planning/optimisation in its business travel (or similar) policy. 7. The organisation reports to the Greener NHS Fleet Data Collection	1. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ 2. Health Technical Memorandum 07-03 NHS Car parking management, environment and sustainability 3. Delivering a Net Zero NHS https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/ https://energysavingtrust.org.uk/wp-content/uploads/2020/10/EST0018-001-EV-Guide-for-Fleet-Manager-WEB.pdf https://www.r-e-a.net/wp-content/uploads/2020/03/Updated-UK-EVSE-Procurement-Guide.pdf
E4	**6.: Water** Are water services efficiently and effectively delivered?	Not applicable	3. Requires minimal improvement	1.The organisation has a water efficiency policy 2.Monthly meter readings are taken and recorded, and automated readings validated physically 3. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex.	1. Estates Net Zero Carbon Delivery Plan (NZCDP) 2. NZCDP Technical annex 1. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 2. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=151919557
E4	**7.: Climate Change Adaptation** Are risk assessments of the effects of climate change risk assessment and mitigation action implemented and include references to overheating, flooding and extreme weather events?	4. Requires moderate improvement	4. Requires moderate improvement	1.The organisation has a climate change adaptation risk assessment on the Trust risk register 2.The organisation reports on estate related events, such as extreme weather events including flooding, heatwave and cold winter events 3. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex.	1. Estates Net Zero Carbon Delivery Plan (NZCDP) 2. HBN 00-07 Resilience planning for the healthcare estate 3. Flood Risk Toolkit 4. NHS Climate Change Risk Assessment tool 5. Health and climate adaptation report 2025 1. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 2. https://www.england.nhs.uk/publication/resilience-planning-for-nhs-facilities-hbn-00-07/ 3. https://tabanalytics.data.england.nhs.uk/#/views/FloodRiskToolkit/TitlePage?=null&:iid=3 4.https://www.england.nhs.uk/publication/climate-adaptation-resources/ 5.https://www.england.nhs.uk/publication/health-and-climate-adaptation-reports/
E4	**8.: Procurement** Is all relevant procurement consistent with NHS England's net zero and sustainable procurement policies?	3. Requires minimal improvement	2. Good	1.The organisation takes account of the NHS Net Zero Supplier Roadmap and reports against compliance with this through the quarterly Greener NHS data collection. 2.The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects.	1. NHS Net Zero Supplier Roadmap 2. Greener NHS quarterly data collection 3. Applying net zero and social value in the procurement of NHS goods and services (building on PPN06/20) 4. Carbon reduction plan and net zero commitment requirements for the procurement of NHS goods, services and works (aligning to PPN06/21) 5. Evergreen Sustainable Supplier Assessment 6. NHS Net Zero Building Standard 1. https://www.england.nhs.uk/greenernhs/get-involved/suppliers/ 2. https://future.nhs.uk/sustainabilitynetwork/view?objectID=40822960 3. https://www.england.nhs.uk/greenernhs/publication/applying-net-zero-and-social-value-in-the-procurement-of-nhs-goods-and-services/ 4. https://www.england.nhs.uk/long-read/carbon-reduction-plan-requirements-for-the-procurement-of-nhs-goods-services-and-works/ 5. https://www.england.nhs.uk/nhs-commercial/central-commercial-function-ccf/evergreen/ 6. https://www.england.nhs.uk/publication/nhs-net-zero-building-standard/
E4	**9: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
E4	Capital cost to achieve compliance	£0	£0		
E4	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Effectiveness Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
E1	**E1: With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation evidence the following and is this inline with the ICS infrastructure strategy?**	
E1	**1. Vision and Values** A clear vision and a set of values, with quality and safety the top priority?	
E1	**2. Strategy** A robust, realistic strategy for achieving the priorities and delivering good quality estates and facilities services?	
E1	**3. Development** The vision, values and strategy has been developed with staff and other stakeholders?	
E1	**4. Vision and Values Understood** Staff know and understand what the vision and values are?	
E1	**5. Strategy Understood** Staff know and understand the strategy and their role in achieving it?	
E1	**6. Progress** Progress against delivering the strategy is monitored and reviewed?	
E1	**7: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	
	Capital cost to achieve compliance	
	Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Effectiveness Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
E2	**E2: With regard to having a well-managed approach to town planning can the organisation evidence the following?**	
E2	**1. Local Planning** An effective and efficient process to participate in Local Planning matters?	
E2	**2. Neighbourhood Planning** An effective and efficient process to participate in Neighbourhood planning matter?	
E2	**3. Planning Control** An effective and efficient process to participate in planning control process?	
E2	**4. Special Interests** **A**n effective and efficient process to manage special interests (e.g. conservation areas, listed buildings etc.) ?	
E2	**5. Enforcement** **A**n effective and efficient process to deal with any enforcement procedures served on the organisation?	
E2	**6: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	
	Capital cost to achieve compliance	
	Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Effectiveness Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
E3	**E3: with regard to having a well-managed robust approach to management of land and property can the organisation evidence the following?**	
E3	**1: Disposal of land and property** An effective and efficient process for the disposal of freehold/leasehold land and property?	
E3	**2: Granting of Leases** An effective and efficient process for the granting of leases?	
E3	**3: Acquisition of land and property** An effective and efficient process for the acquisition of freehold/leasehold land and property?	
E3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance? Capital cost to achieve compliance Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Effectiveness Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
E4	**E4: With regard to having a suitable Sustainability approach in place and being actioned.**	
E4	**1: Green Plan / Sustainability Strategy** Has your Green Plan been approved by Board and submitted to the ICS / ICB	
E4	**2: Energy** Is your energy usage, including heat, managed to fully deliver sustainability and effectiveness, and includes plans to meet national NHS net zero carbon targets?	
E4	**3: Waste** Are effective systems in place to minimise waste production and effectively dispose of it?	

NHS Premises Assurance Model: Effectiveness Domain

◄◄ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
E4	**4: Air Pollution** Does your Trust have policies and procedures in place to control air pollution and an overview of these procedures is included within the Green Plan?	
E4	**5.: Travel & Transport** Can the organisation evidence an effective and efficient process to ensure staff commuting, patient & visitor travel, and the organisation's own fleet are sustainable and meet the relevant guidance?	
E4	**6.: Water** Are water services efficiently and effectively delivered?	
E4	**7.: Climate Change Adaptation** Are risk assessments of the effects of climate change risk assessment and mitigation action implemented and include references to overheating, flooding and extreme weather events?	
E4	**8.: Procurement** Is all relevant procurement consistent with NHS England's net zero and sustainable procurement policies?	
E4	**9: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	
E4	Capital cost to achieve compliance	
E4	Revenue consequences of achieving compliance	

NHS Premises Assurance Model: Governance Domain	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
G1	**G1. With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed, can the organisation evidence the following?**	Applicable	Applicable	SAQ is taken from CQC KLOE W2.	
G1	**1. Framework** There is an effective governance framework to support the delivery of the Estates and Facilities strategy and good quality services?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
G1	**2. Roles** Staff are clear about their roles and understand what they are accountable for?	2. Good	3. Requires minimal improvement	1. Governance Structure 2. Annual Plan/Programme Board 3. Structure chart 4. Committee terms of reference and minutes	
G1	**3. Partners** Working arrangements with partners and third party providers, e.g. PFI, are effectively managed?	2. Good	2. Good	1. Local sustainability and transformation partnership plans	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 2. CQC Guidance for providers on meeting the regulations 2. NHS Constitution and Handbook to the NHS Constitution 3. NHS Long Term Plan 4. Quality Governance in the NHS 5. Gov.uk - Quality governance in the NHS - A guide for provider boards 6. Monitor Code of Governance for Foundation Trusts 7. NHS TDA Delivering High Quality Care 8. NHS England » Green plan guidance 9. Monitor: Risk Assessment Framework for NHS Foundation Trusts 10. HSE five steps to risk assessment - INDG163 (rev 4) 06/11 11. Developing strategy What every trust board member should know 12. Modern Slavery Act 2015 13. Public Services (Social Value) Act 2012 https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england https://www.longtermplan.nhs.uk/ https://www.gov.uk/government/publications/quality-governance-in-the-nhs-a-guide-for-provider-boards https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance Foreword: https://www.england.nhs.uk/wp-content/uploads/2013/10/keogh-qual-ltr.pdfhttps://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F% https://www.england.nhs.uk/long-read/green-plan-guidance/ https://www.gov.uk/government/publications/risk-assessment-framework-raf https://www.hse.gov.uk/pubns/INDG163.pdf https://www.gov.uk/government/publications/strategy-development-a-guide-for-nhs-foundation-trust-boards https://www.legislation.gov.uk/ukpga/2015/30/contents/enacted https://www.legislation.gov.uk/ukpga/2012/3/enacted
G1	**5: Assurance** There are comprehensive assurance system and service performance measures, which are reported and monitored, and action taken to improve performance	2. Good	3. Requires minimal improvement	1. Evidence of walkarounds 2. Signed-of processes and procedures documentation, including risk register. 3. Signed-off roles and responsibilities documentation.	
G1	**6. Monitoring** There are effective arrangements in place to ensure that the information used to monitor, report (including regional and national data collections) and manage quality and performance is accurate, valid, reliable, timely and relevant (including PFI and non PFI costs).	2. Good	2. Good	1. Audit reports, peer and external reviews.	
G1	**7. Audit** There is a systematic programme of internal audit, which is used to monitor quality and systems to identify where action should be taken?	2. Good	3. Requires minimal improvement	1. Surveillance Programme 2. Audit Programme	
G1	**8. Mitigation** There are robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	2. Good	2. Good	1. Job descriptions and training records for risk management. 2. Corporate, current risk register in place, with an identifiable owner. 3. Signed-off risk management strategy by the Board	
G1	**9. Alignment** There is alignment between the recorded risks and what people say is 'on their worry list'?	2. Good	3. Requires minimal improvement	4. Evidence risks are passed into corporate risk register and actions taken, do not simply disappear without action	
G1	**10: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Governance Domain	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
G2	**G2: With regard to ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services can the organisation evidence the following?**	Applicable	Applicable	SAQ is taken from CQC KLOE W3.	
G2	**1. Effectiveness** Leaders have the skills, knowledge, experience and integrity that they need and have the capacity, capability, and experience to lead effectively – both when they are appointed and on an ongoing basis.	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Job specification and competencies	
G2	**2. Challenges** Leaders understand the challenges to good quality estates and facilities services and can identify the actions needed to improve.	2. Good	2. Good	1. Local and national staff surveys and feedback	
G2	**3. Visibility** Leaders are visible and approachable.	3. Requires minimal improvement	2. Good	1. Organograms and structure charts	
G2	**4. Relationships** Leaders encourage appreciative, supportive relationships among staff.	2. Good	2. Good	1. Local and national staff surveys and feedback	
G2	**5. Respect** Staff feel respected and valued.	3. Requires minimal improvement	4. Requires moderate improvement	1. Local and national staff surveys and feedback	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 2. CQC Guidance for providers on meeting the regulations 3. CQC Regulation 20: Duty of candour (FS) 4. NHS Long Term Plan 5. Conduct for NHS Managers 6. NHS Constitution and Handbook to the NHS Constitution 7. NHS complaints procedure in England SN / SP / 5401 24.01.14 "8. ISO 10002:2004 Quality management — Customer satisfaction — Guidelines for complaints handling in organizations" 9. NHS whistleblowing procedures in England SN06490 13.12.13 10. Public Interest Disclosure Act 1998 https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour https://www.longtermplan.nhs.uk/ https://www.nhsemployers.org/~/media/Employers/Documents/Recruit/Code_of_conduct_for_NHS_managers_2002.pdf https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england https://www.england.nhs.uk/contact-us/complaint/ https://www.iso.org/standard/35539.html https://www.england.nhs.uk/ourwork/whistleblowing/ https://www.gov.uk/government/publications/the-public-interest-disclosure-act
G2	**6. Behaviours** Action is taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority.	3. Requires minimal improvement	4. Requires moderate improvement	1. Performance reviews 2. Local and national staff surveys and feedback	
G2	**7. Culture** Is the culture centred on the needs and experience of people who use services?	2. Good	3. Requires minimal improvement	1. Local and national staff surveys and feedback 2.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working	
G2	**8. Honesty** The culture encourages candour, openness and honesty.	2. Good	3. Requires minimal improvement	1. Local and national staff surveys and feedback	
G2	**9. Safety & Wellbeing** There is a strong emphasis on promoting the safety, health and wellbeing of staff.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Job specification and competencies	
G2	**10. Healthier workplace** Promoting a healthier NHS workplace through cutting access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff.	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
G2	**11. Collaboration** Staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality estates and facilities services.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
G2	**12: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

NHS Premises Assurance Model: Governance Domain	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2023-24	2024-25	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
G3	**G3: With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services can the organisation evidence the following?**	Applicable	Applicable		
G3	**1. Professional advice** The organisation has adequately identified its requirements for Estates and Facilities related professional advice?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
G3	**2. In-house advisors** Where Estates and Facilities related professional advice is provided in house mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate pre-employment checks?	2. Good	2. Good	1. Documented list of advisors 2. Transparent process to appoint suitable advisors 3. Suitable qualifications and experience of advisors	
G3	**3. External advisors** Where Estates and Facilities related professional advice is provided externally mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate skills and knowledge?	2. Good	2. Good	1. Documented list of advisors 2. Transparent process to appoint suitable advisors 3. Suitable qualifications and experience of advisors	
G3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
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NHS Premises Assurance Model: Governance Domain		
◄◄ Back to instructions		
Ref.	**SAQ/Prompt Questions**	**Comments**
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
G1	**G1. With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed, can the organisation evidence the following?**	
G1	**1. Framework** There is an effective governance framework to support the delivery of the Estates and Facilities strategy and good quality services?	
G1	**2. Roles** Staff are clear about their roles and understand what they are accountable for?	
G1	**3. Partners** Working arrangements with partners and third party providers, e.g. PFI, are effectively managed?	
G1	**4. Framework** The governance framework and management systems are regularly reviewed and improved?	
G1	**5: Assurance** There are comprehensive assurance system and service performance measures, which are reported and monitored, and action taken to improve performance	
G1	**6. Monitoring** There are effective arrangements in place to ensure that the information used to monitor, report (including regional and national data collections) and manage quality and performance is accurate, valid, reliable, timely and relevant (including PFI and non PFI costs).	
G1	**7. Audit** There is a systematic programme of internal audit, which is used to monitor quality and systems to identify where action should be taken?	
G1	**8. Mitigation** There are robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
G1	**9. Alignment** There is alignment between the recorded risks and what people say is 'on their worry list'?	
G1	**10: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	
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NHS Premises Assurance Model: Governance Domain		
◄◄ Back to instructions		
Ref.	**SAQ/Prompt Questions**	**Comments**
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
G2	**G2: With regard to ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services can the organisation evidence the following?**	
G2	**1. Effectiveness** Leaders have the skills, knowledge, experience and integrity that they need and have the capacity, capability, and experience to lead effectively – both when they are appointed and on an ongoing basis.	
G2	**2. Challenges** Leaders understand the challenges to good quality estates and facilities services and can identify the actions needed to improve.	
G2	**3. Visibility** Leaders are visible and approachable.	
G2	**4. Relationships** Leaders encourage appreciative, supportive relationships among staff.	
G2	**5. Respect** Staff feel respected and valued.	
G2	**6. Behaviours** Action is taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority.	
G2	**7. Culture** Is the culture centred on the needs and experience of people who use services?	
G2	**8. Honesty** The culture encourages candour, openness and honesty.	
G2	**9. Safety & Wellbeing** There is a strong emphasis on promoting the safety, health and wellbeing of staff.	
G2	**10. Healthier workplace** Promoting a healthier NHS workplace through cutting access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff.	
G2	**11. Collaboration** Staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality estates and facilities services.	
G2	**12: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	
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NHS Premises Assurance Model: Governance Domain		
◄◄ Back to instructions		
Ref.	**SAQ/Prompt Questions**	**Comments**
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
G3	**G3: With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services can the organisation evidence the following?**	
G3	**1. Professional advice** The organisation has adequately identified its requirements for Estates and Facilities related professional advice?	
G3	**2. In-house advisors** Where Estates and Facilities related professional advice is provided in house mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate pre-employment checks?	
G3	**3. External advisors** Where Estates and Facilities related professional advice is provided externally mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate skills and knowledge?	
G3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	
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◄◄ Back to instructions

How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

Ref.	SAQ/Prompt Questions SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	2023-24 Rate the prompt question by using the drop down menus in the columns below	2024-25 Rate the prompt question by using the drop down menus in the columns below	Evidence (examples listed below) Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	Relevant guidance and legislation The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
H1	**Confirmation of Safe Helipad Operations** The Trust must demonstrate that it has established processes to ensure the safe and efficient operation of its helipad in accordance with CAP 1264 guidance **1. Does your NHS organisation have a Hospital Helipad Landing Sites (HHLS)? If the answer is "No", then no further answers on this Domain are required. If the answer is "Yes" all the SAQ below must be answered.**		Yes		https://www.caa.co.uk/our-work/publications/documents/content/cap1264/
H1	**2. How many primary HHLS does the trust have operating?** (Primary HHLS are directly controlled by the NHS organisation).		1		
H1	**3. How many secondary HHLS does the trust utilise?** (Secondary HHLS are those not directly controlled by the NHS organisation, but used regularly.)		1		
H1	**4. Who is the Accountable Manager (AM) for your HHLS? -** Name		Free Text	Job Description and annual appraisal.	
H1	**5. AM Email address**		Free Text		
H1	**6. AM Telephone number**		Free Text		
H1	**7. AM Job Title**		Free Text		
H1	**8. Hospital Operations Manual (HOM)** Do you have an up-to-date and approved HOM for all your sites? It is owned by the Accountable Manager (AM) and can be delegated to the HHLS Responsible Person (RP) where required and sets the standards, procedures and best practise of the Heliports Operation and Maintenance		Yes		CAP 1264 Chapter 1 HOM Template provided by NHS England.
H1	**9. Risk Assessment and Mitigation Strategies for Helipad and Estates** Is there an up-to-date Risk Assessment in place, undertaken by a competent person alongside the Responsible Person/Accountable Manager? HHLS Risk Assessment be carried out annually or sooner if a reportable incident or near miss occurs.		no	Risk assessment and related documentation.	CAP 1264 Chapter 3.
H1	**10. Where Coast Guard Search and Rescue (SAR) landings take place on the HHLS.** Have you provided a signed letter from your Chief Executive confirming responsibility for the safety of the site in the appropriate format?		no		NHS England
H1	**11. Resilience, Emergency & Business Continuity Planning.** Are the HHLS integrated into the Organisation's resilience, emergency, business continuity and escalation plans both for the organisation itself and for the region?		no		
H1	**12: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?		no		
H1	**13. Collaboration** Has the organisation in undertaking the risk assessment processes collaborated with helipad users, fire and rescue services re pre-determined site attendance and police with regard to safety & security (in particular terrorism threat) and staff members whose role includes receiving patients from/transferring a patient to, a helicopter.		no		
H1	**Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.		no	Detailed Action Plans: Outlining investments needed for compliance with the NHS Premises Assurance Model (PAM), including specific steps, timelines, and responsible parties. Financial Documentation and Risk Assessments: Detailed cost estimates and risk assessments for areas needing improvement. Board and Committee Escalation Evidence: Documentation showing board-level awareness and action plan discussions. Budget Inclusion Proof and Prior Investment. Assessment: Evidence of budgetary allocation for actions and analysis of the impact of previous investments. Compliance Tracking and Stakeholder Communication: Systems for monitoring action plan progress and evidence of stakeholder engagement. Legal and Regulatory Compliance Documents: References to documents guiding NHS helipad operations and safety standards.	

H1	Capital cost to achieve desired improvements/outcomes		no	Capital Cost Analysis and Legislative Alignment. Legal and Regulatory Compliance Documents: References to documents guiding NHS helipad operations and safety standards. Post-Implementation Review Plan: Outline for evaluating helipad performance and impact after implementation. Revenue Implications of NHS Helipad Improvements Cost-Benefit Analysis and Comparative Case Studies: Financial analysis of improvements and case studies from similar healthcare facilities. Regulatory Compliance and Projected Revenue Impact Reports: Documentation on compliance with laws and projected revenue changes. Stakeholder Feedback and Performance Metrics: Input from various stakeholders and clear metrics for evaluating improvement outcomes. Risk Analysis and Sustainability Assessments: Financial risk identification and assessments of long term sustainability.	
H1	Revenue consequences of achieving desired improvements/outcomes		no		

To Replace the below

◄◄ Back to instructions	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
H1	**H1. Confirmation of Safe Helipad Operations and Evidencing Planning and Implementation Practices: Can the organisation confirm they have processes in place to safely maintain the operation of their helipad?** **The Trust must demonstrate that it has established processes to ensure the safe and efficient operation of its helipad.** **This includes evidencing the planning and implementation of the helipad, with clearly defined responsibilities about quality, performance, and risk management.** **The organisation should also be able to evidence the planning and implementation of a helipad with clear responsibilities for quality, performance and risks, can the organisation evidence the following?**	Not applicable	Not applicable	•**Documented Safety Protocols and Procedures** These documents should detail safety protocols for helipad operations, including emergency procedures, maintenance schedules, and guidelines for safe landings and take-offs. •**Maintenance Records** Regular helipad maintenance is essential. Logs and records must show consistent inspections and upkeep to required standards. •**Training Records of Personnel** Ensure all helipad personnel, ground staff, and emergency teams, are trained and qualified. Training records must confirm staff adherence to current safety practices and procedures. •**Risk Assessment Documentation** Evidence must show regular risk assessments for helipad operations, identifying and mitigating potential hazards. •**Quality and Performance Monitoring Records** Documentation should demonstrate the monitoring and evaluation of helipad operations, including incident logs, response times, and corrective actions taken. •**Certifications and Compliance Reports** Any relevant certifications or compliance reports that show the helipad meets national and international safety standards. •**Operational Guidelines and Manuals** Comprehensive operational manuals outlining procedures and responsibilities for safe helipad operation. •**Emergency Response Plans** Documentation of emergency response plans, including coordination with local emergency services and contingency plans for various emergency scenarios. •**Feedback and Incident Reports** Records of user feedback and incident reports for the helipad, including follow-up actions taken. •**Insurance and Liability Documents** Proof of appropriate insurance coverage and liability protections related to helipad operations. **CAA training should be undertaken Hospital Helipad – Aviation Awareness | Training Course by the UK CAA (caainternational.com)**	
H1	1. Compliance Assessment and Policy Review: Adherence to CAP1264 and Downwash Helipad Considerations in the Trust: Policy, Procedures and Compliance: Is the organisation compliant and does the organisation have a current, approved policy and an underpinning set of procedures that comply with CAP1264? The Trust should have a responsible person able to demonstrate and a documented evidence/policy in relation to Downwash helipad factors and considerations within the Trust.	Not applicable	1. Outstanding	CAP1264 Compliance and Operations: The Trust must have documentation proving its helipad design and operations comply with CAP1264 standards. This includes assessing the helipad's layout, safety features, and protocols. Approved Helipad Policy: A regularly reviewed helipad policy, in line with CAP1264 guidelines, should be established. It should encompass emergency procedures, maintenance, and staff training. Documented Evidence/Policy for Downwash Considerations: Downwash Factors Records and analyses are needed to manage helicopter downwash, a key safety concern in helipad design and operations, in accordance with CAP1264. Responsibility and Documentation Appoint a responsible person or team knowledgeable in CAP1264 to oversee helipad operations. Their role includes managing documentation related to downwash, including risk assessments, mitigation strategies, and staff training. Regular Audits and Reviews Conduct frequent audits to ensure the Trust's helipad policies and procedures remain compliant with CAP1264. These should review downwash management and adapt to changes in helicopter technology or operational practices.	

H1	2. Roles and Responsibilities Ensuring Qualified Personnel and Clear Governance Does the Organisation have appropriately qualified, trained, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? When developing the policy and procedures have you consulted with internal and external stakeholders? The Trust should have a responsible person and a documented evidence/policy in relation to general helipad factors and considerations within the Trust.	Not applicable	1. Outstanding	Governance Structure Documentation This should outline the overarching framework within which helipad operations are conducted. It includes details on decision making processes, accountability and how different roles within the organisation contribute to helipad management. Organisational Structure Chart This chart should visually represent the hierarchy and reporting lines relevant to helipad operations. It clarifies who is responsible for what, ensuring that roles and responsibilities are clearly defined and understood. Post Profiles and Training Records Detailed job descriptions for each role involved in helipad operations, along with records of individual training, are crucial. These profiles should include specific qualifications, competencies, and experience required for each position. Training records prove that staff members have been adequately trained for their roles. Evidence of Training and Development Documentation should be provided to show that all staff involved in helipad operations have received proper training. This includes training that meets safety, technical, and quality requirements. Evidence may include certificates, course completion records, and ongoing professional development logs. Specific Training Certifications For instance, the CAA training for Hospital Helipad - Aviation Awareness. This specialised training, offered by the UK Civil Aviation Authority (CAA), ensures that staff is aware of aviation-specific considerations and safety practices related to helipad operations. To ensure comprehensive compliance, the Trust should have a designated responsible person who can present and manage these documents. This individual should be well-versed in the operational aspects of the helipad and the regulatory environment. They should also be capable of liaising with both internal and external stakeholders to ensure that all policies and procedures are up-to-date, effective, and widely understood. Regular consultations with stakeholders, including emergency services, aviation experts, and hospital staff, are vital for maintaining a safe and efficient helipad operation.	
H1	3. Risk Assessment and Mitigation Strategies for Helipad and Estates In relation to this, has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	Not applicable	Documented Risk Assessment Report This should include a comprehensive risk assessment of the helipad and surrounding estate. The report should detail identified risks, the likelihood of occurrence, potential impact, and the scoring methodology used to prioritise risks. Mitigation Strategies and Implementation Evidence Documentation should be provided showing the specific risk mitigation strategies that have been applied. This could include engineering controls, procedural changes, training programs, or any other relevant measures. Evidence of implementation might include records of changes made, training completed, or equipment installed. Regular Review and Update Records Compliance requires not just a one-time assessment but ongoing monitoring and reassessment of risks. Documentation should show how often the risk assessment is reviewed and updated and how new risks or changes in the environment are incorporated. Alignment with Civil Aviation Authority Standards Evidence should be presented that the organisation's risk assessment and mitigation strategies are in line with the Civil Aviation Authority's Standards for helicopter landing areas at hospitals, as detailed in CAP 1264. This might include a comparative analysis or a compliance checklist. Audit and Inspection Reports Regular audits or inspections of the helipad and related facilities can provide evidence of compliance. These reports should detail the findings of the audits, any non-compliances identified, and how these were addressed. Incident and Accident Records Records of any incidents or accidents related to the helipad should be maintained. This includes how these incidents were investigated and what measures were taken to prevent recurrence. Stakeholder Consultation Records Documentation of consultations with stakeholders, including hospital staff, emergency services, and aviation experts, can provide evidence of a thorough and inclusive risk assessment process. Training Record Evidence of training provided to relevant staff in helipad operations and safety can demonstrate commitment to risk mitigation. Emergency Response Plan A documented emergency response plan specific to helipad operations should be available, detailing procedures for various potential emergencies.	
	4. Risk assessment - Regulatory Differences between Ground-Based and Elevated Helipads When conducting fire risk assessments and ensuring compliance with relevant guidelines for NHS helipads, please confirm the Trust understands the distinct regulatory considerations for ground-based and elevated helipads.		5. Inadequate	Ground-Based Helipads Accessibility: Ground-based helipads typically offer easier access to emergency services and fire-fighting equipment. This accessibility needs to be factored into the risk assessment and mitigation strategies. Surrounding Environment The assessment must consider the immediate environment around the helipad, including the types of surfaces (grass, concrete, etc.) and nearby structures or natural features that might influence fire risk. Elevated Helipads (such as on rooftops) Structural Integrity Elevated helipads require careful assessment of the building's structural integrity to support the helipad's weight, especially during fire emergencies. Evacuation Routes Special attention must be given to evacuation routes and emergency access, as elevated helipads may present more challenges in these areas compared to ground-based helipads. Wind and Weather Conditions Elevated helipads are more exposed to wind and other weather elements, which can impact fire behaviour. This must be considered in the fire risk assessment. Fire Suppression System Due to their location, elevated helipads may require specialised fire suppression systems that are effective at higher elevations and in potentially limited spaces. In both cases, the NHS Trust should ensure compliance with the Civil Aviation Authority's standards (CAP 1264) and incorporate specific guidelines for each type of helipad into their overall fire risk management strategy. Regular training, emergency drills, and clear documentation are crucial components of this strategy, regardless of the helipad type.	Possible updates to follow 2023/24

H1	5. NHS Helipad Fire Risk Assessment and Compliance Guidelines Has there been a specific fire risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? Has this assessment taken into account the helipad and the potential healthcare buildings in its curtilage In addition the Trust should have a responsible person and a documented evidence/policy in relation to Fire risk regarding helipad factors and considerations within the Trust.	Not applicable	Not applicable	Specific Fire Risk Assessment for the Helipad Area The NHS Trust should conduct a thorough fire risk assessment specifically for the helipad area. This assessment should consider all potential fire hazards associated with helicopter operations, including fuel, electrical systems, and potential ignition sources. The assessment should also consider the unique characteristics of the helipad, such as its location, size, and proximity to healthcare buildings and other infrastructure. Regular Review and Update of the Fire Risk Assessment The fire risk assessment should not be a one-time activity. It needs to be regularly reviewed and updated to reflect any changes in the operating environment, new helicopter models, or changes in surrounding infrastructure. Regular reviews ensure that any new risks are identified and mitigated promptly. Risk Mitigation Strategies Based on the findings of the fire risk assessment, the Trust should implement appropriate risk mitigation strategies. These might include fire suppression systems, emergency response plans, and safety protocols for fuel handling and storage. The effectiveness of these mitigation strategies should be regularly tested and evaluated. Documentation and Policy The Trust should maintain comprehensive documentation of the fire risk assessment process, including the findings, decisions made, and actions taken. This documentation serves as evidence of compliance with relevant guidelines and legislation. There should also be a clear policy outlining the responsibilities and procedures related to fire risk management at the helipad. Responsibility and Training The Trust should designate a responsible person or team to oversee fire safety at the helipad. This individual or team should have the necessary training and expertise in fire risk management and helicopter operations. Regular training and drills should be conducted for all staff involved in helipad operations to ensure they are aware of fire risks and know how to respond in an emergency. Compliance with Civil Aviation Authority Standards The Trust's risk assessment and mitigation strategies should take into account the relevant sections of the Civil Aviation Authority's Standards for helicopter landing areas at hospitals, outlined in CAP 1264. This includes ensuring that the design, operation, and maintenance of the helipad meet the safety standards set by the Civil Aviation Authority.
H1	6. Resilience, Emergency & Business Continuity Planning Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff in relation to helipad and the estate.	Not applicable	2. Good	Business Continuity Audit Reports for Helipads: These reports analyse an organization's capacity to maintain operations amidst major disruptions like natural disasters or cyber attacks, with a focus on helipad operations and continuity measures. Trust's Incident Response Plan for Helipads: A detailed plan outlining response procedures for incidents impacting the helipad, including emergency medical situations and natural disasters. Committee/Group Terms of Reference: Document detailing the responsibilities of the committee overseeing the helipad's emergency and business continuity plans, including test frequency, scope, and review processes. Corporate Risk Register for Helipad Operations: A comprehensive list of risks related to helipad operations, detailing the nature, likelihood, impact, and mitigation measures for each risk, regularly updated and maintained by an assigned owner. Board-Approved Risk Management Strategy: A strategy document outlining the approach to managing helipad risks, aligning with the organization's broader risk management policies, and subject to periodic review. Board-Signed Incident Response and Business Continuity Plans: Documents detailing emergency response and continuity strategies for the helipad, indicating organizational commitment to preparedness and safety. Stakeholder Collaboration in Risk Assessment and Meeting Records: Documentation evidencing collaboration with stakeholders, including helipad users, emergency services, and staff, in risk assessment processes, and minutes from meetings discussing safety, security, and operational procedures. Compliance Tracking and Stakeholder Communication: Systems for monitoring action plan progress and evidence of stakeholder engagement.
H1	7: Review Process Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	1. Outstanding	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Receiving, checking and authorising invoices for payment for additional services; 4. Monitoring Contractors' approach to rectifying defects; 5. Problem solving and dispute (prevention and) resolution where issues exist. 6. Establish and maintain appropriate records and information management systems to record and manage the performance of the Sub-Contractors; 7. The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working' 8. The ability to report on the regulatory requirements regarding safer wards (ligature). 9. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible rails/surface temperature) particularly when in relation to Mental health facilities and A&E wards.
H1	8. Collaboration Has the organisation in undertaking the risk assessment processes collaborated with helipad users, fire and rescue services re pre-determined site attendance and police with regard to safety & security (in particular terrorism threat) and staff members whose role includes receiving patients from/transferring a patient to, a helicopter	Not applicable	3. Requires minimal improvement	1. Working with relevant organisations to ensure best practice is followed. 2. Consider external sites being used
H1	9. Costed Action Plans If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Not applicable	1. Outstanding	Detailed Action Plans: Outlining investments needed for compliance with the NHS Premises Assurance Model (PAM), including specific steps, timelines, and responsible parties. Financial Documentation and Risk Assessments: Detailed cost estimates and risk assessments for areas needing improvement. Board and Committee Escalation Evidence: Documentation showing board-level awareness and action plan discussions. Budget Inclusion Proof and Prior Investment Assessment: Evidence of budgetary allocation for actions and analysis of the impact of previous investments. Compliance Tracking and Stakeholder Communication: Systems for monitoring action plan progress and evidence of stakeholder engagement. Legal and Regulatory Compliance Documents: References to documents guiding NHS helipad operations and safety standards.
H1	Capital cost to achieve desired improvements/outcomes	£0	£0	Capital Cost Analysis and Legislative Alignment Detailed Cost-Benefit Analysis: Breakdown of costs and benefits of helipad improvements, including patient care and operational efficiency. Post-Implementation Review Plan: Outline for evaluating helipad performance and impact after implementation. Revenue Implications of NHS Helipad Improvements

Ref.	Revenue consequences of achieving desired improvements/outcomes	£0	£0	Cost-Benefit Analysis and Comparative Case Studies: Financial analysis of improvements and case studies from similar healthcare facilities. Regulatory Compliance and Projected Revenue Impact Reports: Documentation on compliance with laws and projected revenue changes. Stakeholder Feedback and Performance Metrics: Input from various stakeholders and clear metrics for evaluating improvement outcomes. Risk Analysis and Sustainability Assessments: Financial risk identification and assessments of long term sustainability.	

This one!

Facilities Management (FM) Maturity

This section has been added as part of a wider Government estate process, NHSE Trusts are asked to support the wider property function across government

			Scoring	**1**	**2**	**3+**		
Integrated	**Integrated Leadership**	Q1 How integrated is facilities management - Soft Services?	**2**	Soft services is devolved around the organisation without a central "controlling mind".	A central team exists that manage a range of core buildings directly but are not fully integrated	Soft services is integrated with a clear centre of expertise with delivery coordinated centrally		
			Scoring	1	2	3+		
		Q2. How integrated is facilities management - Hard Services?	**2**	Hard services is devolved around the organisation without a central "controlling mind".	A central team exists that manage a range of core buildings directly but are not fully integrated	Hard services is integrated with a clear centre of expertise with delivery coordinated centrally		
			Scoring	1	2	3+		
		Q3. How integrated is Property Leadership?	**2**	FM works in a silo, reactive to demand with little engagement with wider property leadership	FM links in some what with construction, design and asset management teams, but gaps remain.	leadership across the wider property function is integrated and aligned. Total cost of ownership is considered and understood across all aspects of asset lifecycle.		
	CAFM		**Scoring**	1	2	3	4	5
		Q4. How integrated are your FM Management IT Systems?	**2**	No CAFM, basic spreadsheets or similar used to monitor and manage FM.	Several systems in use, e.g. asset management system, CAFM, finance system, supplier system. Limited or no integration. Multiple versions of the truth.	A combination of systems are used between departments and suppliers, but a recognised master system is in place, showing one version of the truth.	An integrated CAFM is in use holding all but financial data, which is held in corporate finance system.	Organisation has a single, integrated CAFM system holding a single version of the truth, with other key systems feeding into a master system.
			Scoring	1	2	3	4	5
Collaborative	**Partnership & Transparency**	Q5 - How closely does FM management work with the FM delivery organisation(s)?	**1**	Minimal, adversarial relationship	Weekly or monthly meeti	Regular, joint meetings held taking both a backwards look at performance and a forward look at opportunity for improvement and upcoming changes	Genuine partnership, both sides work in an open and honest way to improve service delivery, built on trust. Very little discussion on poor performance or penalties.	A fully open and trusting relationship, working both ways to improve performance and value
			Scoring	1	2	3+		
		Q6 - How strategic and effective are supplier relationships?	**1**	Supplier relationships are transactional only.	A supplier relationship model (SRM) is in place (See CCS)	Open and honest conversations about what can be done both sides to improve outcomes. Service plans are jointly developed with each party inputting to one another. Topics such as profit, overheads, investment and supplier sustainability are openly discussed. An effective SRM model is in place.		
			Scoring	1	2	3+		
		Q7 - How transparent is FM delivery between the management organisation and delivery organisation?	**2**	No transparency regarding performance or cost.	Data held by supplier but	Organisation has real time access to key data in a transparent and open way and is regularly audited.		
			Scoring	1	2	3+		
		Q8 - Does the FM team collaborate outside of the management organisation?	**1**	Little engagement with wider government departments, occasional attendance at events or key meetings.	Actively involved in cross	In addition to formal cross gov groups, work closely with equals and leadership in other government departments to share best practice and go develop solutions, driving continuous improvement and innovation.		
			Scoring	1	2	3	4+	

Delivery Excellence	Compliance	Q9 - How effective is your hard compliance management approach?	2	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.	Able to evidence compliance on high risk items (Asbestos, Water, Fixed Wiring, Fire, Gas, Lifts). Wider compliance held client side but regularly validated with robust QA.	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated through robust QA.	
			Scoring	1	2	3	4+	5
		Q10 - How effective is your soft compliance management approach?	2	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.	Able to evidence compliance on high risk items (security, risk assessments, data). Wider compliance held client side but regularly validated with robust QA.	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated through robust QA.	
			Scoring	1	2	3+		
	Standards and Best Practice	Q11 - How well standardised is FM management in line with industry best practice? (E.g. ISO)	2	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.	Use of some industry standards, but less maturity on other aspects	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		
			Scoring	1	2	3+		
		Q12 - How well standardised is FM delivery in line with industry best practice? (E.g. SFG20, CCS)	2	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.	Use of some industry standards, such as SFG20 but less maturity on other aspects.	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		
			Scoring	1	2	3+		
	Defined Roles	Q13 - How well defined are FM roles and responsibilities within Hard Services?	2	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		
			Scoring	1	2	3+		
		Q14 - How well defined are FM roles and responsibilities within Soft Services?	2	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		
			Scoring	1	2	3	4+	
	Enabling	Q15 - How flexible is FM to changing business needs?	2	FM works on fixed price c	Part fixed, part variable a	Work in partnership with suppliers to continually improve support for changing business objectives.	Supplier is engaged in the organisations service and strategy planning and understands their role. They work in partnership to proactively deliver change.	
			Scoring	1	2	3	4+	

Strategic	**FM Strategy**	Q16 -How strategic is FM?	**2**	No FM strategy or service plan. FM is delivered in a reactive way.	Basic FM strategy and ser	FM Strategy in place, con	Long-term vision of what good FM looks like and how to get there. Consideration for external impact (e.g. sustainability) fully embedded into delivery model with robust monitoring and reporting in place. Horizon scanning undertaken including strategic risk management. Strategy fully aligned with aims and values of department/	
			Scoring	1	2	3		
	Governance	Q17 -Do you have effective FM governance in place?	**2**	No management/minimal management. Risk poorly allocated.	Following recognised governance, for example RICS Public sector asset management guide or functional standard on governance.	Clear, best in class and effective governance arrangements in place. Understood by organisation with clear roles and responsibilities.		
			Scoring	1		3	4+	
Intelligent	**Intelligent Client**	Q18 -Do you have a clear definition and recognised Intelligent client function?	**1**	The ICF is dispersed without a clear, recognised function.		A recognised intelligent client function is in place, with defined roles and responsibilities, recognised by the wider organisation and has the capabilities and capacity required to be effective.	A highly effective ICF is in place with it's value recognised at an organisational level.	
			Scoring	1	2	3+		
		Q19 - Is an effective client department in place?	**2**	No recognisable client department, a number of individuals within the organisation may be responsible for various aspects	An identifiable client department is in place, acting as a conduit between the wider organisation and the delivery organisations to maximise value.	A strong and effective client department is in place, with centralised oversight of all aspects of FM.		
				1	2	3+		
	Control Levers	Q20 -How well do you understand the levers to improve performance?	**1**	A basic understanding of levers available in the contract, primarily performance failure driven	A good understanding of commercial, financial and quality control levers and their impact of performance	Regular, demonstrable use of all types of control levers to drive continuous improvement		
			Scoring	1	2	3+		
	Management structure	Q21 - Is there sufficient management, capability and capacity to be effective? Are roles clear?	**2**	Unclear roles and responsibilities, disjoined management with FM and property spread over multiple departments, devolved FM model - no "corporate landlord".	A defined, central FM team undertaking most FM duties, but with some aspects still devolved.	Clearly defined roles and responsibilities, appropriate capacity and capability to effectively discharge duties in a timely manner. Centralised "Centre of expertise" and an effective corporate landlord in place.		
			Scoring	1	2	3+		
	Forward Planning	Q22 - How proactive is FM service delivery in your organisation?	**1**	Reactive works only, failure driven.	Short term planning - next financial year only.	Accurate condition data driving an FMR based on risk and asset criticality, long term view and whole life costing.		

Facilities Management (FM) Maturity

This section has been added as part of a wider Government estate process, NHSE Trusts are asked to support the wider property function across government

Data Structure	**Hierarchy**		**Scoring**	1	2	3+		
		Q1 - What level of location hierarchy is asset data captured against?	**3+**	Asset level data is captured against the site and building it is in.	Asset level data is captured against the site, building, floor and location it is in.	Asset level data is captured against the site, building, floor, location and system it is in.		
	Data Specification		**Scoring**	1	2	3	4	5
		Q2 - Is there a consistent data specification aligned to the FM asset data standards (4.2)?	**3**	No defined data specification for FM asset data.	Defined data specification for FM asset data is not aligned to the data standard (4.2.1).	Defined data specification for FM asset data is consistently aligned to the data standard (4.2.1).	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and inconsistently aligned to 'non-core' fields (4.2.2).	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and 'non-core' fields (4.2.2).
			Scoring	1	2	3+		
		Q3 - How consistently is the data specification applied across the estate?	**3+**	No defined data specification for FM asset data.	The data specification is inconsistently applied across the estate.	The data specification is consistently applied across the estate.		
Data Assurance & Quality	**Coverage and Completeness**		**Scoring**	1	2	3+		
		Q4 - What is the level of coverage of assets in the asset register data?	**3+**	The asset data covers some assets in some estates.	The asset data covers all assets in some estates but only some assets in other estates.	The asset data covers all assets in all estates.		
			Scoring	1	2	3	4	5
		Q5 - How complete is the data captured against assets in the asset register?	**3**	Data is not captured against assets for the 'core fields' in the data standard (4.2.1).	Data is captured against some assets for the 'core fields' in the data standard (4.2.1).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and some assets for the 'non-core fields' in the data standard (4.2.2).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and all assets for the 'non-core fields' in the data standard (4.2.2).
	Audit		**Scoring**	1	2	3+		
		Q6 - Is a full asset verification exercise required to update the asset register (5.1)?	**3+**	Data is out of date or incomplete and requires a full asset verification exercise.	Data is out of date or incomplete for parts of the estate and requires a targeted asset verification exercise.	Data is up to date and complete. An asset verification exercise is not currently required.		
			Scoring	1	2	3	4	5
		Q7 - What regular sample surveys exist for on-going asset verification (5.2)?	**3**	No / limited sample surveys.	Inconsistent and ad-hoc sample surveys for some of the estates.	Consistent and regular sample surveys for all estates. There is a defined methodology to logically work through the all estates over time.	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in some parts of the estate.	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in all estates.
	Data Quality Control		**Scoring**	1	2	3	4	5
		Q8 - What processes are in place for change control/approvals for adding, removing or changing an asset (5.3)?	**3**	No / limited processes in place.	Inconsistent processes exist covering some parts of the estate.	Consistent processes exist covering all estates with clear responsibilities for approvals and tracking of changes.	Partially automated processes with frequent updates to change log.	Automated processes across all estates with close to real-time updates to change log.
			Scoring	1	2	3	4	5
		Q9 - What processes are in place for data quality checks (5.4)?	**3**	No / limited processes in place.	Inconsistent and ad-hoc processes exist using basic checks covering some parts of the estate.	Consistent and regular processes exist using checks based on business rules covering all estates.	Partially automated processes using data quality check algorithms and data quality dashboards.	Automated processes using real-time data quality check algorithms, business rules, quality control dashboards and user feedback.

			Scoring	1	2	3	4	5
		Q10 - What processes are in place for data update assurance (5.5)?	**3**	No / limited processes in place.	Inconsistent and ad-hoc processes exist using minimal data quality checks covering some parts of the estate.	Consistent and regular processes exist using verification tools and update logs covering all estates.	Partially automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering parts of the estate.	Automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering all estates.
	Governance		**Scoring**	1	2	3	4	5
		Q11 - What governance is in place to support data assurance and quality (5.)?	3	No / limited governance / informal group for asset data quality.	A dedicated asset data-quality governance group/board exists but meets on an irregular basis or without the required attendees.	A dedicated asset data-quality governance group/board exists, which meets regularly with all the relevant attendees.	Along with the dedicated asset data quality governance group/board, there are additional sub-working groups with the suppliers.	Along with the dedicated asset data quality governance group/board, there are additional sub-working groups with suppliers and cross-organisational governance board/group.
			Scoring	1	2	3+		
		Q12 - What level of documentation exists for the these data quality processes and governance (5.6)?	**3+**	No / limited documented items for processes and governance.	Some documentation exists related to processes and governance which are applied on an ad-hoc basis across some parts of the estate.	Consistent documentation exists which the organisation applies for these processes and the governance across all estates. This documentation is reviewed and updated on a regular basis.		
Data Ownership and Access	**Ownership**		**Scoring**	1	2	3+		
		Q13 - Is the data contractually owned by the organisation (6.1)?	**3+**	The organisation does not contractually own the data.	The organisation contractually owns the data for some data stores/parts of estate.	The organisation contractually owns the data for all estates.		
	Accessibility		**Scoring**	1	2	3	4	5
		Q14 - What level of access does the organisation have to the data in the asset management systems (6.2)?	**3**	No / limited access to the data (e.g. data extracts requested via email to FM provider).	Access to some data tables/extracts across some data stores/parts of the estate.	Access to all data tables/extracts across all data stores/all estates and manually extract the required data.	The ability to access data in via desktop tool or automated APIs for some data stores/parts of estate.	The ability to access data in data in via desktop tool or automated APIs for all data stores/all estates.
			Scoring	1	2	3+		
		Q15 - What level of access management exists for controlling user privileges (6.3)?	**3+**	No / limited access management privileges.	Some access management privileges exist across some data stores/parts of the estate. These are inconsistently applied.	Access management privileges exist across all data stores/all estates. These are consistently applied and tightly controlled.		
	Flexibility		**Scoring**	1	2	3+		
		Q16 - Do the asset management systems provide the flexibility to accommodate the data standards (7.1)?	**3+**	Systems with limited flexibility to accommodate the data standards.	Systems with some flexibility to partially accommodate the data standards for some data stores/parts of the estate.	Systems with flexibility to fully accommodate the data standards for all data stores/all estates.		
			Scoring	1	2	3+		
		Q17 - Do the asset management systems allow interoperability of asset data (7.2)?	**3+**	Systems with limited interoperability between systems.	Systems with some interoperability between some systems and data is not transferable in COBie format.	Systems with interoperability between all systems and data is transferable in COBie format.		
			Scoring	1	2	3	4	5

Data Systems	**Interoperability**	Q18 - Does the asset management systems sync to a common data platform (7.3)?	**3**	No common data platform exist.	Common data platform exists but data from some data stores/parts of the estate are stored. Data sources are updated on an ad-hoc basis.	Common data platform exists where data from all data stores/all estates are stored. Data sources are updated on a regular basis.	Common data platform exists where data from all data stores/all estates are aggregated using desktop tools and databases. Data sources are updated frequently.	Common data platform exists where data from all data stores/all estates are aggregated using automated APIs (applications). Data sources are updated in real-time.
			Scoring	1	2	3+		
	Management	Q19 - Do the systems meet data security requirements (7.4)?	**3+**	No systems meet minimum requirements across any estate.	Some of the systems meet data security requirements across some data stores/parts of the estate.	All systems meet data security requirements across all estates.		
			Scoring	1	2	3+		
		Q20 - Do the systems meet data backup management requirements (7.5)?	**3+**	No systems meet minimum requirements across any estate.	Some of the systems meet data backup management requirements across some data stores/parts of the estate. Backup processes are ad-hoc.	All systems meet data backup management requirements. Backup processes are on a regular basis.		
Data Usage	**Management Information**		**Scoring**	1	2	3	4	5
		Q21 - What types of management information reports and dashboards are used for FM asset data (8.1)?	**3**	No / ad hoc reporting and dashboarding to support the use of FM asset data.	Inaccurate reports generated from data gathered point in time.	Standard reporting and interactive dashboards generated regularly with reliable processing and calculations.	Standard reporting and interactive dashboards generated from frequently updated data via robust data pipelines.	Ability to create bespoke customisable reports to answer the latest business questions.
	Insights		**Scoring**	1	2	3	4	5
		Q22 - How does asset data inform decisions relating to contract management (8.2)?	**3**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5
		Q23 - How does asset data inform decisions relating to mandatory and statutory compliance (8.3)?	**3**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5
		Q24 - How does asset data inform decisions relating to Planned Preventative Maintenance (8.4)?	**3**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5
		Q25 - How does asset data inform decisions relating to Investment Prioritisation (8.5)?	**3**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5

Team Capacity and Capability	**Capacity**	Q26 - What is the capacity of the teams working with asset data (9.1, 9.2)?	**3**	No dedicated teams/informal teams.	Dedicated team exists within the organisation covering some parts of the estate. Individuals do not have assigned responsibilities and accountabilities.	Dedicated team exists within the organisation covering some parts of the estate. Individuals have clear with responsibilities and accountabilities. Identified individuals with responsibilities and accountabilities to manage, monitor and generate required reports/insights from FM asset data.	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers.	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers and cross-organisational data team.
			Scoring	1	2	3	4	5
	Capability	Q27 - What is the capability of the teams working with asset data (9.3)?	**3**	No dedicated personnel/informal teams.	Team with some FM and data/technical understanding.	Team with good FM and data/technical understanding. Ability to extract, transform, load and report data to generate required reports and insights.	Team with the ability to create robust and repeatable data processes along interactive dashboard to support in generating insights.	Team with the ability to use predictive and prescriptive analytical techniques used to create forward-looking insights.
			Scoring	1	2	3	4	5
	Training	Q28 - What training is provided for teams working with asset data (9.4)?	**3**	No / limited training provided.	Inconsistent and ad-hoc pieces of training exist focusing on basic understanding and only the necessary parts of the processes. They are partially in line with the Government Property Profession career framework.	Consistent and regular pieces of training exist focusing on all the necessary processes. They are in line with the Government Property Profession career framework.	Frequent pieces of training focusing on better understanding and upskilling in extended processes and tools used within the organisation.	Frequent pieces of training focusing on upskilling in advanced analytical and automation skills.
			Scoring	1	2	3+		
		Q29 - What training materials exists relating to asset data (9.5)?	**3+**	No training and guidance material for asset data and processes.	Some training and guidance material exist related to asset data and processes covering some parts of the estate. These are reviewed and referred to on an ad-hoc basis.	Consistent training and guidance material exist covering onboarding, quality and audit processes, etc. for all estates. These are reviewed and referred to on regular basis.		
			Scoring	1	2	3	4	5
		Q30 - What knowledge sharing exists relating to asset data (9.6)?	**3**	No / limited knowledge sharing in place.	Some knowledge sharing exists within the organisation and some irregular knowledge sharing exists between organisations.	Consistent knowledge sharing exists between different organisations on a regular basis.	Consistent knowledge sharing exists between different organisations on a regular basis. Some knowledge sharing with suppliers on an irregular basis.	Consistent knowledge sharing exists between different organisations. Consistent knowledge sharing with suppliers on a regular basis.

Section	Area	Question
All	Contact details	1. **Identify Lead for:** Insert name for board representative
All		1.a Insert contact details
Linen and laundry	Contact details	2. **Identify Lead for linen and laundry:** Insert name of board representative and contact details
Linen and laundry	Contact details	3. **Identify Lead for linen and laundry:** Insert name of competent persons and contact details
Linen and laundry	Contact details	3. **Identify Lead for linen and laundry:** Insert name of authorised persons and contact details
Food	Contact details	1. Identify Lead for food: Insert name for board representative and contact details
Food	Contact details	2. Identify Lead for food: Insert name for Competent Persons and contact details
Food	Contact details	2. **Identify Lead for:** Insert name of catering dietitian
Food	Contact details	2a. Contact details of the dietitian
Food	Contact details	2b Indicate if this is in house in-house, from an FM provider or an external contract (including NHS Supply Chain)
Food	Contact details	3. **Identify Lead for:** Organisations must nominate a food safety specialist. Provide details of person or company supplying service
Medical Gas	Contact details	4. Medical gas committee: Board Executive responsible for medical gasses
Medical Gas	Contact details	5. Authorised Engineer
Medical Gas	Contact details	6. Authorised Person
Terrorism (Protection of Premises) Act 2025	Contact details	Please provide contact details; name, job title and contact email, of the appointed Accountable Officer in relation to this

Add Details
Emma Sayner, Chief Financial Officer
emma.sayner@nhs.net
Tom Myers, Group Director of Estates, Facilities & Development tom.myers2@nhs.net
Karl Cliff, Facilities Services Manager SGH & GDH, karl.cliff@nhs.net, Michelle Smith, Facilities Service Manager DPOW, michelle.smith18@nhs.net
Kieth Fowler, Associate Director Of Facilities Services and Sustainability, keithfowler@nhs.net
Emma Sayner, Chief Financial Officer emma.sayner@nhs.net
Kieth Fowler, Associate Director Of Facilities Services and Sustainability, keithfowler@nhs.net
Unappointed
N/A
N/A
Mark Richardson, RFS Consulting
Tom Myers, Group Director of Estates, Facilities & Development
Mark Milne HAC Medical Gas
Gareth Scott, Senior Estates Manager
N/A

NHS PAM Safety Prompt Question Guidance Sheets	◄◄ Back to instructions

Introduction

This sheet supplements the 'generic' prompt questions contained within NHS PAM safety domain. It provides key references from the following documents that users should consider when undertaking their assessment of the relevant prompts:
1. Health and Safety Executive publication HSG 65 'Managing for health and safety'
2. The Care Quality Commission Provider Handbooks Appendix A 'Key Lines of Enquiry'
3. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Associated CQC guidance

Extracts from HSG 65 primarily relate to H&S regulations so may not be strictly relevant in all instance. However the advice may still be useful. HSG 65 'Managing for health and safety' is available from: http://www.hse.gov.uk/pubns/priced/hsg65.pdf.
Similarly some references from the regulations and CQC guidance, particularly around training and development, may relate primarily to clinical and clinical support staff but again they still may be useful.

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

1.1 HSG 65 page 21:

Policies should be designed to meet legal requirements, prevent health and safety problems, and enable you to respond quickly where difficulties arise or new risks are introduced.

1.2 Regulations and CQC Guidance

15(1)d
• The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used.

15(1)d&e
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.

1.3 Regulations and CQC Guidance	CQC KLOE
15(1)d • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.	S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff?
17(2)(e) Where relevant, the provider should also seek and act on the views of external bodies such as fire, environmental health, royal colleges and other bodies who provide best practice guidance relevant to the service provided.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

2.1 HSG 65

HSG 65 page 11)
The Management of Health and Safety at Work Regulations 1999 require employers to put in place arrangements to control health and safety risks. As a minimum, you should have the processes and procedures required to meet the legal requirements, including:
■ ensuring there is adequate and appropriate supervision in place;
■ access to competent health and safety advice, for example see the Occupational Safety and Health Consultants Register (OSHCR) at www.hse.gov.uk/oshcr;

HSG 65 page 17:
The competence of individuals is vital, whether they are employers, managers, supervisors, employees or contractors, especially those with safety-critical roles (such as plant maintenance engineers). It ensures they recognise the risks in their activities and can apply the right measures to control and manage those risks.

2.2 Regulations and CQC Guidance

15(1)d&e
• Providers must make sure that staff and others who operate the equipment are trained to use it appropriately.

18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

2.4 Regulations and CQC Guidance	CQC KLOE
18(1) Guidance: Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards).	E3.1. Do staff have the right qualifications, skills, knowledge and experience to do their job when they start their employment, take on new responsibilities and on a continual basis?

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

3.1 HSG

HSG 65 Page 27)
What the law says on assessing risks
The law states that a risk assessment must be 'suitable and sufficient', i.e. it should show that:
■ a proper check was made;
■ you asked who might be affected;
■ you dealt with all the obvious significant risks, taking into account the number of people who could be involved;
■ the precautions are reasonable, and the remaining risk is low;
■ you involved your workers or their representatives in the process.
The level of detail in a risk assessment should be proportionate to the risk and appropriate to the nature of the work. Insignificant risks can usually be ignored, as can risks arising from routine activities associated with life in general, unless the work activity compounds or significantly alters those risks.
Your risk assessment should only include what you could reasonably be expected to know – you are not expected to anticipate unforeseeable risks.

HSG 65 page 14)
Leaders, at all levels, need to understand the range of health and safety risks in their part of the organisation and to give proportionate attention to each of them. This applies to the level of detail and effort put into assessing the risks, implementing controls, supervising and monitoring.

HSG 65 page 13)
The risk profile of an organisation informs all aspects of the approach to leading and managing its health and safety risks.

HSG 65 page 13)
Every organisation will have its own risk profile. This is the starting point for determining the greatest health and safety issues for the organisation. In some businesses the risks will be tangible and immediate safety hazards, whereas in other organisations the risks may be health-related and it may be a long time before the illness becomes apparent.

3.2 Regulations and CQC Guidance

15(1)c: • Any alterations to the premises or the equipment that is used to deliver care and treatment must be made in line with current legislation and guidance. Where the guidance cannot be met, the provider should have appropriate contingency plans and arrangements to mitigate the risks to people using the service.

17(2)(b)
Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.

17(2)(b)
Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.

17(2)(b)
Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.

17(2)(b)
Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate.
Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.

17(2)(b)
Note: In this regulation, 'others' includes anyone who may be put at risk through the carrying on of a regulated activity, such as staff, visitors, tradespeople or students.

3.3 Regulations and CQC Guidance	CQC KLOE
15(1)d&e • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required. 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;	S4.4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing? W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?

4: Maintenance
Are assets, equipment and plant adequately maintained?

4.1 Regulations and CQC Guidance

15(1)d
• Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.

15(1)d&e
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

5.1 HSG 65

HSG 65 page 11) The Management of Health and Safety at Work Regulations 1999 require employers to put in place arrangements to control health and safety risks. As a minimum, you should have the processes and procedures required to meet the legal requirements, including:
■ ensuring there is adequate and appropriate supervision in place;
■ access to competent health and safety advice, for example see the Occupational Safety and Health Consultants Register (OSHCR) at www.hse.gov.uk/oshcr;

3.2 Regulations and CQC Guidance

18(2) Persons employed by the service provider in the provision of a regulated activity must
18(2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

Providers must ensure that they have an induction programme that prepares staff for their role. It is expected that providers that employ healthcare assistants and social care support workers should follow the Care Certificate standards to make sure new staff are supported, skilled and assessed as competent to carry out their roles.

Where appropriate, staff must be supervised until they can demonstrate required/acceptable levels of competence to carry out their role unsupervised.

Staff should receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained.
Other mandatory training, as defined by the provider for their role.

Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support.

Other learning and development opportunities required to enable them to fulfil their role. This includes first aid training for people working in the adult social care sector.

All learning and development and required training completed should be monitored and appropriate action taken quickly when training requirements are not being met.

Other mandatory training, as defined by the provider for their role.

Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support.

Other learning and development opportunities required to enable them to fulfil their role. This includes first aid training for people working in the adult social care sector.

All learning and development and required training completed should be monitored and appropriate action taken quickly when training requirements are not being met.

18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and
Providers must support staff to obtain appropriate further qualifications that would enable them to continue to perform their role.
Providers must not act in a way that prevents or limits staff from obtaining further qualifications that are appropriate to their role.
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and
Providers must support staff to obtain appropriate further qualifications that would enable them to continue to perform their role.
Providers must not act in a way that prevents or limits staff from obtaining further qualifications that are appropriate to their role.

4.3 Regulations and CQC Guidance	CQC KLOE
Training, learning and development needs of individual staff members must be carried out at the start of employment and reviewed at appropriate intervals during the course of employment. Staff must be supported to undertake training, learning and development to enable them to fulfil the requirements of their role.	E3.2. How are the learning needs of staff identified? E3.3. Do staff have appropriate training to meet their learning needs? E3.4. Are staff encouraged and given opportunities to develop?
Staff should be supported to make sure they are can participate in: Statutory training.	S3.2. Do staff receive effective mandatory training in the safety systems, processes and practices?
Staff should receive regular appraisal of their performance in their role from an appropriately skilled and experienced person and any training, learning and development needs should be identified, planned for and supported.	E3.5. What are the arrangements for supporting and managing staff? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.) E3.6. How is poor or variable staff performance identified and managed? How are staff supported to improve?

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

6.1 CQC KLOE

S5.2. What arrangements are in place to respond to emergencies and major incidents? How often are these practised and reviewed?

S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing?

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

7.1 Regulations and CQC Guidance

17(2)(f)
Providers must ensure that their audit and governance systems remain effective.

7.2 Regulations and CQC Guidance	CQC KLOE
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).

8: Costed Action Plans
If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?

References to risk assessment and management are details under prompt 3 above

8: Scoring
Scoring should be based on the following:

	Self-assessment rating	% to score in given area
	Not applicable: This prompt question does not apply to the trust e.g. Mental Health trusts do not use Medical Gases;	
	Outstanding: Compliant with no action required, plus evidence of high-quality services and innovation. This Score is likely to be rarely applied.	100%
	Good: compliant no action required.	85% or above
	Requires minimal improvement: The impact on people who use services, visitors or staff is low.	66% to 85%
	Requires moderate improvement: The impact on people who use services, visitors or staff is medium.	45% to 65%
	Inadequate	45% or less

NHS Premises Assurance Model 2016

◄◄ Back to instructions	
This sheet shows the relationship and link between the NHS PAM SAQs and: 1. Relevant parts of the 'Health and Social Care Act 2008 (Regulated Activities) Regulations 2014' 2. Associated CQC guidance to providers on meeting the Regulations 3. CQC provider Handbooks Annex A: Key Lines of Enquiry	
Regulations (bold text) **CQC Guidance** (non-bold text), **CQC KLOE** (bold italics)	**PAM Ref.**
Regulation 14: Meeting nutritional and hydration needs (FS)	
CQC KLOE: E1.4. How are people's nutrition and hydration needs assessed and met?	
14(1) The nutritional and hydration needs of service users must be met.	SS1
Providers must include people's nutrition and hydration needs when they make an initial assessment of their care, treatment and support needs and in the ongoing review of these. The assessment and review should include risks related to people's nutritional and hydration needs. Providers should have a food and drink strategy that addresses the nutritional needs of people using the service.	
14(2) Paragraph 1 applies where— **(a) care or treatment involves—** **the provision of accommodation by the service provider, or** **an overnight stay for the service user on premises used by the service for the purposes of carrying on a regulated activity, or** **(b) the meeting of the nutritional or hydration needs of service users is part of the arrangements made for the provision of care or treatment by the service provider.**	SS1
Providers must meet people's nutrition or hydration needs wherever an overnight stay is provided as part of the regulated activity or where nutrition or hydration are provided as part of the arrangements made for the person using the service.	
14(3) But paragraph (1) does not apply to the extent that the meeting of such nutritional or hydration needs would— **(a) result in a breach of regulation 11, or** **(b) not be in the service user's best interests**	NA
14(4)(a) receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health,	
Nutrition and hydration assessments must be carried out by people with the required skills and knowledge. The assessments should follow nationally recognised guidance and identify, as a minimum: requirements to sustain life, support the agreed care and treatment, and support ongoing good health dietary intolerances, allergies, medication contraindications how to support people's good health including the level of support needed, timing of meals, and the provision of appropriate and sufficient quantities of food and drink.	SS1 should demonstrate following the Nutrition & hydration assessment but assessment is not part of PAM
Nutrition and hydration needs should be regularly reviewed during the course of care and treatment and any changes in people's needs should be responded to in good time. A variety of nutritious, appetising food should be available to meet people's needs and be served at an appropriate temperature. When the person lacks capacity, they must have prompts, encouragement and help to eat as appropriate.	SS1
Where a person is assessed as needing a specific diet, this must be provided in line with that assessment. Nutritional and hydration intake should be monitored and recorded to prevent unnecessary dehydration, weight loss or weight gain. Action must be taken without delay to address any concerns. Staff must follow the most up-to-date nutrition and hydration assessment for each person and take appropriate action if people are not eating and drinking in line with their assessed needs. Staff should know how to determine whether specialist nutritional advice is required and how to access and follow it.	NA
Water must be available and accessible to people at all times. Other drinks should be made available periodically throughout the day and night and people should be encouraged and supported to drink. Arrangements should be made for people to receive their meals at a different time if they are absent or asleep when their meals are served. Snacks or other food should be available between meals for those who prefer to eat 'little and often'.	SS1

14(4)(b) receipt by a service user of parenteral nutrition and dietary supplements when prescribed by a health care professional,	NA
14(4)(c) the meeting of any reasonable requirements of a service user for food and hydration arising from the service user's preferences or their religious or cultural background, and	
People should be able to make choices about their diet. People's religious and cultural needs must be identified in their nutrition and hydration assessment, and these needs must be met. If there are any clinical contraindications or risks posed because of any of these requirements, these should be discussed with the person, to allow them to make informed choices about their requirements. When a person has specific dietary requirements relating to moral or ethical beliefs, such as vegetarianism, these requirements must be fully considered and met. Every effort should be made to meet people's preferences, including preference about what time meals are served, where they are served and the quantity.	SS1
14(4)(d) if necessary, support for a service user to eat or drink	NA
Regulation 15: Premises and equipment (FS)	
15(1) All premises and equipment used by the service provider must be— 15(1)(a) clean,	
CQC KLOE S3.5. How are standards of cleanliness and hygiene maintained?	
• Premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance.	
• Premises and equipment should be visibly clean and free from odours that are offensive or unpleasant.	
• Providers should: o Use appropriate cleaning methods and agents. o Operate a cleaning schedule appropriate to the care and treatment being delivered from the premises or by the equipment. o Monitor the level of cleanliness. o Take action without delay when any shortfalls are identified. o Make sure that staff with responsibility for cleaning have appropriate training.	Safety SAQ SS4
• Domestic, clinical and hazardous waste and materials must be managed in line with current legislation and guidance.	
CQC KLOE S3.9. Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.)	Safety SAQ SS3
15(1) All premises and equipment used by the service provider must be— 15(1)(b) secure,	Safety SAQ SS6
• Security arrangements must make sure that people are safe while receiving care, including:	
CQC KLOES3.4. Are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures?	Safety SAQ SS6
o Protecting personal safety, which includes restrictive protection required in relation to the Mental Capacity Act 2005 and Mental Health Act 1983. This includes the use of window restrictors or locks on doors, which are used in a way that protects people using the service when lawful and necessary, but which does not restrict the liberty of other people using the service.	Safety SAQ SS6
CQC KLOE E1.7. Are the rights of people subject to the Mental Health Act (MHA) protected and do staff have regard to the MHA Code of Practice?	
o Protecting personal property and/or money.	
o Providing appropriate access to and exit from protected or controlled areas.	
o Not inadvertently restricting people's movements.	
o Providing appropriate information about access and entry when people who use the service are unable to come and go freely and when people using a service move from the premises as part of their care and treatment.	
o Using the appropriate level of security needed in relation to the services being delivered. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Guidance for providers on meeting the regulations March 2015 57	Safety SAQ SS6

• If any form of surveillance is used for any purpose, the provider must make sure that this is done in the best interests of people using the service, while remaining mindful of their responsibilities for the safety of their staff. Any surveillance should be operated in line with current guidance. Detailed guidance on the use of surveillance is available on CQC's website.	
15(1) All premises and equipment used by the service provider must be— 15(1)(c) suitable for the purpose for which they are being used,	Safety SAQ SH2
Premises must be fit for purpose in line with statutory requirements and should take account of national best practice.	
CQC KLOE S3.7. Does the design, maintenance and use of facilities and premises keep people safe?	
• Premises must be suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time. There must be sufficient equipment to provide the service.	Safety SAQ SH2 & SH15
• Adequate support facilities and amenities must be provided where relevant to the service being provided. This includes sufficient toilets and bathrooms for the number of people using the service, adequate storage space, adequate seating and waiting space.	Safety SAQ SH2
• People's needs must be taken into account when premises are designed, built, maintained, renovated or adapted. Their views should also be taken into account when possible.	Patient Experience SAQ P1
• People should be able to easily enter and exit premises and find their way around easily and independently. If they can't, providers must make reasonable adjustments in accordance with the Equality Act 2010 and other current legislation and guidance.	Safety SAQ SH2 & Patient Experience SAQ P6
• Any alterations to the premises or the equipment that is used to deliver care and treatment must be made in line with current legislation and guidance. Where the guidance cannot be met, the provider should have appropriate contingency plans and arrangements to mitigate the risks to people using the service.	Safety SAQ SH2
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
The premises and equipment used to deliver care and treatment must meet people's needs and, where possible, their preferences. This includes making sure that privacy, dignity and confidentiality are not compromised.	Safety SAQ SH2
• Reasonable adjustments must be made when providing equipment to meet the needs of people with disabilities, in line with requirements of the Equality Act 2010.	Safety SAQ SH15
15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and	Safety prompt questions 1,4 & 7 for each technical area e.g. electrical safety
• Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.	
CQC KLOE S3.7. Does the design, maintenance and use of facilities and premises keep people safe? S3.8. Does the maintenance and use of equipment keep people safe?	
• The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used.	Safety SAQ SH2 & SH15
• Any change of use of premises and/or equipment should be informed by a risk assessment and providers must make appropriate alterations to premises and equipment where reasonably practical. Where this is not possible, providers should have appropriate contingency plans and arrangements to mitigate the risks to people using the service. Alterations must be in line with current legislation and guidance.	Safety SAQ SH2
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required.	SH4 & safety SAQ prompt 3
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures.	Safety SAQ SH1 & Safety SAQ prompt 4

• Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration.	Safety SAQ SH1 & Safety SAQ prompt 4
S3.8. Does the maintenance and use of equipment keep people safe?	
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.	Safety SAQ SH15
S3.8. Does the maintenance and use of equipment keep people safe?	
• Providers must make sure that staff and others who operate the equipment are trained to use it appropriately.	Safety SAQ SH15 & Safety SAQ prompt 2&5
15(1) All premises and equipment used by the service provider must be— 15(1)(f) appropriately located for the purpose for which they are being used.	
• When planning the location of premises, providers must take into account the anticipated needs of the people who will use the service and they should ensure easy access to other relevant facilities and the local community.	Patient Experience SAQ P1
• Facilities should be appropriately located to suit the accommodation that is being used. This includes short distances between linked facilities, sufficient car parking that is clearly marked and reasonably close, and good access to public transport.	Safety SAQ SH2
Equipment must be accessible at all times to meet the needs of people using the service. This means it must be available when needed, or obtained in a reasonable time so as not to pose a risk to the person using the service. Equipment includes chairs, beds, clinical equipment, and moving and handling equipment.	Safety SAQ SH15
S3.8. Does the maintenance and use of equipment keep people safe?	
15(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.	
• Providers must comply with guidance from the Department of Health about the prevention and control of infections: Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance.	Safety SAQ SS4
S3.6. Are reliable systems in place to prevent and protect people from a healthcare-associated infection?	
• Where applicable, premises must be cleaned or decontaminated in line with current legislation and guidance, and equipment must be cleaned, decontaminated and/or sterilised in line with current legislation and guidance and manufacturers' instructions. Equipment must be cleaned or decontaminated after each use and between use by different people who use the service.	Safety SAQ SS4
• Ancillary services belonging to the provider, such as kitchens and laundry rooms, which are used for or by people who use the service, must be used and maintained in line with current legislation and guidance. People using the service and staff using the equipment should be trained to use it or supervised/risk assessed as necessary.	Safety SAQ SS1, SS4 & SH10
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• Multiple use equipment and devices must be cleaned or decontaminated between use. Single use and single person devices must not be re-used or shared. All staff must understand the risk to people who use services if they do not adhere to this.	Safety SAQ SS2 & SS4
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
Regulation 16: Receiving and acting on complaints (FS)	Patient Exp SAQ P1
R4. How are people's concerns and complaints listened and responded to and used to improve the quality of care?	
16(1) Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.	P1

People must be able to make a complaint to any member of staff, either verbally or in writing. All staff must know how to respond when they receive a complaint. Unless they are anonymous, all complaints should be acknowledged whether they are written or verbal. Complainants must not be discriminated against or victimised. In particular, people's care and treatment must not be affected if they make a complaint, or if somebody complains on their behalf. Appropriate action must be taken without delay to respond to any failures identified by a complaint or the investigation of a complaint. Information must be available to a complainant about how to take action if they are not satisfied with how the provider manages and/or responds to their complaint. Information should include the internal procedures that the provider must follow and should explain when complaints should/will be escalated to other appropriate bodies. Where complainants escalate their complaint externally because they are dissatisfied with the local outcome, the provider should cooperate with any independent review or process.	P1
16(2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.	P1
Information and guidance about how to complain must be available and accessible to everyone who uses the service. It should be available in appropriate languages and formats to meet the needs of the people using the service. Providers must tell people how to complain, offer support and provide the level of support needed to help them make a complaint. This may be through advocates, interpreter services and any other support identified or requested. When complainants do not wish to identify themselves, the provider must still follow its complaints process as far as possible. Providers must have effective systems to make sure that all complaints are investigated without delay. This includes: Undertaking a review to establish the level of investigation and immediate action required, including referral to appropriate authorities for investigation. This may include professional regulators or local authority safeguarding teams. Making sure appropriate investigations are carried out to identify what might have caused the complaint and the actions required to prevent similar complaints. When the complainant has identified themselves, investigating and responding to them and where relevant their family and carers without delay.	P1
Providers should monitor complaints over time, looking for trends and areas of risk that may be addressed. Staff and others who are involved in the assessment and investigation of complaints must have the right level of knowledge and skill. They should understand the provider's complaints process and be knowledgeable about current related guidance. Consent and confidentiality must not be compromised during the complaints process unless there are professional or statutory obligations that make this necessary, such as safeguarding. Complainants, and those about whom complaints are made, must be kept informed of the status of their complaint and its investigation, and be advised of any changes made as a result. Providers must maintain a record of all complaints, outcomes and actions taken in response to complaints. Where no action is taken, the reasons for this should be recorded. Providers must act in accordance with Regulation 20: Duty of Candour in respect of complaints about care and treatment that have resulted in a notifiable safety incident.	P1
16(3) The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of— **(a) complaints made under such complaints system,** **(b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and** **(c) any other relevant information in relation to such complaints as the Commission may request.**	P1

CQC can ask providers for information about a complaint; if this is not provided within 28 days of our request, it may be seen as preventing CQC from taking appropriate action in relation to a complaint or putting people who use the service at risk of harm, or of receiving care and treatment that has, or is, causing harm. The 28-day period starts the day after the request is received.	P1
Regulation 17: Good governance (FS)	
W2.6. Are there comprehensive assurance system and service performance measures, which are reported and monitored, and is action taken to improve performance ***S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff?*** ***W2. Does the governance framework ensure that responsibilities are clear and that quality, performance and risks are understood and managed?***	The NHS PAM is designed to be used as a system that meets this requirement
17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. Providers must operate effective systems and processes to make sure they assess and monitor their service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended). The provider must have a process in place to make sure this happens at all times and in response to the changing needs of people who use the service.	
The system must include scrutiny and overall responsibility at board level or equivalent.	Governance domain
17(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—	
17(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); ***S3.3. Is implementation of safety systems, processes and practices monitored and improved when required?*** 1. Providers must have systems and processes such as regular audits of the service provided and must assess, monitor and improve the quality and safety of the service. The audits should be baselined against Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and should, where possible, include the experiences people who use the service. The systems and processes should be continually reviewed to make sure they remain fit for purpose. Fit for purpose means that: systems and processes enable the provider to identify where quality and/or safety are being compromised and to respond appropriately and without delay. providers have access to all necessary information.	The NHS PAM is designed to be used as a system that meets this requirement
17(2)(a) 2. Information should be up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated and appropriate action taken. ***W2.7. Are there effective arrangements in place to ensure that the information used to monitor and manage quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?*** ***W5.6. How is information used proactively to improve care?***	G1.7
17(2)(a) 3. Providers should have effective communication systems to ensure that people who use the service, those who need to know within the service and, where appropriate, those external to the service, know the results of reviews about the quality and safety of the service and any actions required following the review.	NA
17(2)(a) 4. Providers should actively seek the views of a wide range of stakeholders, including people who use the service, staff, visiting professionals, professional bodies, commissioners, local groups, members of the public and other bodies, about their experience of, and the quality of care and treatment delivered by the service. Providers must be able to show how they have: analysed and responded to the information gathered, including taking action to address issues where they are raised, and used the information to make improvements and demonstrate that they have been made ***W4. How are people who use the service, the public and staff engaged and involved?***	Patient Experience SAQ P1
Providers must seek professional/expert advice as needed and without delay to help them to identify and make improvements.	Governance SAQ G3

17(2)a Providers must monitor progress against plans to improve the quality and safety of services, and take appropriate action without delay where progress is not achieved as expected.	PE domain and action plan prompt under each SAQ
Subject to statutory consent and applicable confidentiality requirements, providers must share relevant information, such as information about incidents or risks, with other relevant individuals or bodies. These bodies include safeguarding boards, coroners, and regulators. Where they identify that improvements are needed these must be made without delay.	Safety SAQ SH17
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	Safety SAQ prompt Question 1
E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).	
17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;	Safety SAQ prompt question 3 & G1.9 & G1.10
S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff? ***S4.4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively?*** ***S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing?***	
17(2)(b) Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.	
17(2)(b) Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.	
17(2)(b) Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.	
17(2)(b) Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.	
17(2)(b) Note: In this regulation, 'others' includes anyone who may be put at risk through the carrying on of a regulated activity, such as staff, visitors, tradespeople or students.	
17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;	NA
17(2)(d) maintain securely such other records as are necessary to be kept in relation to— **(i) persons employed in the carrying on of the regulated activity, and** **(ii) the management of the regulated activity;**	
Records relating to people employed and the management of regulated activities must be created, amended, stored and destroyed in accordance with current legislation and guidance.	
Records relating to people employed must include information relevant to their employment in the role including information relating to the requirements under Regulations 4 to 7 and Regulation 19 of this part (part 3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This applies to all staff, not just newly appointed staff. Providers must observe data protection legislation about the retention of confidential personal information.	

Records relating to the management of regulated activities means anything relevant to the planning and delivery of care and treatment. This may include governance arrangements such as policies and procedures, service and maintenance records, audits and reviews, purchasing, action plans in response to risk and incidents.	Safety SAQ SH3
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
Records must be kept secure at all times and only accessed, amended or destroyed by people who are authorised to do so.	
Information in all formats must be managed in line with current legislation and guidance.	
Systems and processes must support the confidentiality of people using the service and not contravene the Data Protection Act 1998.	
17(2)(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;	Patient Experience SAQ P1
17(2)(e) Providers should actively encourage feedback about the quality of care and overall involvement with them. The feedback may be informal or formal, written or verbal. It may be from people using the service, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies.	
17(2)(e) All feedback should be listened to, recorded and responded to as appropriate. It should be analysed and used to drive improvements to the quality and safety of services and the experience of engaging with the provider.	
17(2)(e) Improvements should be made without delay once they are identified, and the provider should have systems in place to communicate how feedback has led to improvements.	
17(2)(e) Where relevant, the provider should also seek and act on the views of external bodies such as fire, environmental health, royal colleges and other bodies who provide best practice guidance relevant to the service provided.	
17(2)(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).	Safety SAQ prompt question 7, SAQ G1.8 & G1.4
17(2)(f) Providers must ensure that their audit and governance systems remain effective.	
17(3) The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—-	NA
Regulation 18: Staffing (FS)	see also 'prompt guidance sheet'
18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.	Safety SAQ prompt question 2: See 'prompt guidance sheet'
S4.1. How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available?	
18(2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,	Safety SAQ prompt question 5: See 'prompt guidance sheet'
S3.2. Do staff receive effective mandatory training in the safety systems, processes	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to	
Regulation 19: Fit and proper persons employed (FS)	NA
Regulation 20: Duty of candour (FS)	**G2.9**