Cheshire and Wirral Partnership NHS
NHS Foundation Trust

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The management of internal and external recommendations policy

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Type of document	Policy
Target audience	All CWP staff
Document purpose	This document sets out a framework for the process of how internal recommendations resulting from Trust investigations and learning are analysed, implemented and used to improve/enhance practice and sets out a process of how external sources of information are received, reviewed, considered and, if appropriate, implemented in the context of the services provided by the Trust.

Document consultation	Clinical Service Units, Performance and Compliance Sub committee (PCSC), Company Secretary, Clinical Governance Department	
Approving meeting	Quality Committee	19-Sep-12
Ratification	Document Quality Group (DQG)	13-Nov-12
Original issue date	Nov-07	
Implementation date	Nov-12	

CWP documents to be read in conjunction with	FR1 CP58	Integrated governance framework NICE publication management

Training requirements	There **are no** specific training requirements for this document.

Financial resource implications	Yes - Action plans developed as a result of this process may have financial implications, which will be addressed as part of the action planning process.

Equality Impact Assessment (EIA)

Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
• Race	No	
• Ethnic origins (including gypsies and travellers)	No	
• Nationality	No	
• Gender	No	
• Culture	No	
• Religion or belief	No	
• Sexual orientation including lesbian, gay and bisexual people	No	
• Age	No	
• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		

Is the impact of the document likely to be negative? • If so can the impact be avoided? • What alternatives are there to achieving the document without the impact? • Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.		

If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact.

For advice in respect of answering the above questions, please contact the human resource department.

Was a full impact assessment required?	No	No
What is the level of impact?	Low	

Document change history

Changes made with rationale and impact on practice
1. Full document review in line with NHSLA level 3 2. Review of policy in line with 2012/2013 standards and removal of best practice guidance.

External references

References
1.

Monitoring compliance with the processes outlined within this document

Please state how this document will be monitored. If the document is linked to the NHSLA accreditation process, please complete the monitoring section below.			NHSLA standard 1.6 – Dealing with external recommendations specific to the organisation			
Minimum requirement to be monitored NB the standards in bold below are assessed at level 2/3 NHSLA accreditation	Process for monitoring e.g. audit	Responsible individual / group	Frequency of monitoring	Responsible individual / group for review of results	Responsible individual / group / for development of action plan	Responsible individual / group for monitoring of action plan and Implementation
a) Process for reviewing external recommendations specific to the organisation (pilot)	Report	Head of Performance and Information	Twice per year	PCSC	PCSC	PCSC
b) Process for reporting on external recommendations specific to the organisation. (pilot)	Report	Head of Performance and Information	Twice per year	PCSC	PCSC	PCSC
c) How action plans are developed as a result of external recommendations	**Report**	**Head of Performance and Information**	**Twice per year**	**PCSC**	**PCSC**	**PCSC**
d) How action plans are followed up	**Report**	**Head of Performance and Information**	**Twice per year**	**PCSC**	**PCSC**	**PCSC**
e) How the organisation monitors compliance with all of the above	As above	As above	As above	As above	As above	As above

Content

1. Introduction

The Trust is committed to reviewing internal and external recommendations to learn lessons, comply with best practice and utilise recommendations when planning and reviewing clinical effectiveness, thus enhancing safety and improving clinical care. Recommendations from internal investigations and sources such as incidents, complaints, claims, and clinical audit, are utilised internally to improve quality of care.

Recommendations from external sources, such as the Care Quality Commission, National Patient Safety Agency and National Institute for Health & Clinical Excellence, Monitor, Internal and External Auditors etc., are examples of such external sources that are regularly reviewed. In addition there are a number of serious case reviews published nationally which will need to be considered in line with this policy such as Francis Enquiry report.

This document sets out the process of how internal and external sources of information are received, reviewed, considered and, where appropriate, implemented.

2. Process for reviewing internal and external recommendations specific to the organisation

To ensure that internal and external documents, guidance and recommendations are received, disseminated, reviewed, considered and, if appropriate, implemented, a process has been developed, which is described in appendix 1 of this document.

The internal or external document/report will be distributed to the Chief Executive or relevant Executive Director, General Manager or Head of service who will ensure that the recommendations are reviewed, considered and where appropriate enacted by the services delivered by the Trust. Such recommendations will also drive future service improvement and delivery plans and will support the development of future care pathways in services. The recommendations will be disseminated through either the corporate governance structure or within the clinical service line governance structure dependant upon the impact of the report.

Specific duties and responsibilities for the management of internal and external recommendations are detailed in section 5 of this document. Nominated / appointed individuals have a responsibility to follow the process for receipt, review, consideration, implementation and monitoring as outlined in appendix 1. Action plans must be developed and recorded in accordance with the processes outlined within the policy.

3. Process for reporting internal and external recommendations specific to the organisation

The Trust will develop an action plan in response to any internal or external issue or recommendation that requires improvements to be made or learning communicated as appropriate. Where the internal or external issue or recommendation does not highlight any recommendations or learning then no action plan will be developed.

As detailed in the introduction, the issues or recommendations may be identified through a variety of sources. The source determines the management level at which any actions will be commissioned, i.e. Executive Directors, Associate / Deputy Directors (or equivalent), General Managers, or Heads of Service (or equivalent).

For clinical service unit applicable / level action plans, the action plan registration process will identify the relevant Deputy Director of Operations as the lead for the action plan with delegated responsibility for the implementation of the actions to the relevant General Manager and Clinical Director. Quality committee will be the monitoring meeting.

For Trustwide applicable or Trust level action plans, the action plan registration process will identify the relevant meeting in the governance structure responsible for monitoring the action plan and therefore the corresponding lead therefore, the Chair of the sub committee, committee, or Board level meeting as appropriate.

4. How action plans are developed and followed up

An action plan is completed by the nominated lead to address gaps between current and recommended practice. This may include identification of resources that may be required and associated risks. The action plan is registered via the Trust Action Plan registration point on the intranet.

Any action plans developed as a result of external recommendations will be reported to Quality Committee and any risks identified in the report are allocated an appropriate risk grading and added to the corporate risk register as appropriate.

The executive or nominated operational lead ensures the action plan is added to the action plan tracker and ensures that the action plan is implemented.

The summary of the action plan tracker is monitored by the Quality Committee at every meeting.

The Action plan tracker will be maintained by Head of Performance and Information:

- The nominated / appointed operational lead is responsible for ensuring that each individual action plan is included within the nominated Trust committee / sub-committee / group business cycle within the governance structure by notifying the chair of the relevant committee / sub-committee / group;
- The operational lead for the appropriate action plan will ensure that the action plan is included within the responsible committee / sub committee / group business cycle;
- The business cycle of the responsible committee / sub-committee / group is reviewed / updated by its own committee at each of its own meetings.

The learning outcomes from external agency visits are communicated to the Board either directly through the dissemination of the external report or via receipt of the Quality Committee minutes.

Learning outcomes from both internal and external sources are communicated to CWP Services via one or more of the following:

- Learning from Experience Report;
- Trust Quality Report;
- Intranet site information;
- Briefings emailed to applicable staff groups;
- By discussion at Trust wide or local meetings.

CWP also responds to recommendations following reviews carried out by external agencies.

5. Duties and responsibilities

5.1 Chief Executive

As accountable officer, the Chief Executive has overall responsibility to ensure that any internal or external recommendations / requirements, derived from incidents, complaints, claims, clinical audit and any external recommendations/requirements from external agencies, derived from visits, inspections, accreditations or mandates / reports / guidance issued, are received, reviewed, considered and, if appropriate, implemented within the Trust and included with the corporate risk register and / or assurance framework if appropriate.

The Chief Executive has delegated responsibilities within an executive director's portfolio framework. The portfolio framework can be reviewed at any given time by the chief executive in response to internal / external requirements.

5.2 Executive Directors

- Executive Directors have responsibility, within their delegated portfolios, to ensure that any recommendations / requirements from internal sources derived from incidents, complaints, claims, and clinical audit are managed appropriately and that any external recommendations / requirements from external agencies, derived from visits, inspections, accreditations or mandates / reports / guidance issued, are received, reviewed, considered and, if appropriate, are implemented within the Trust;
- Executive Directors must appoint appropriate operational lead(s) to determine whether to ensure that any internal recommendations / requirements, derived from incidents, complaints, claims, and clinical audit are managed appropriately and whether the external requirements are applicable to the Trust and, if applicable, support them to conduct a Trust gap analysis;
- Executive Directors have responsibility for ensuring that any risks highlighted as a result of reviews are registered on the appropriate risk register and / or corporate risk register via the Clinical Governance Department as appropriate;
- Dependent on the actual high level enquiry, the Executive Lead allocates co-ordination of the enquiry to the appropriate senior manager and / or the Head of Performance and Information;
- If applicable, ensuring that the action plan is added to the action plan tracker and is implemented.

5.3 Operational leads / senior managers

- Operational leads **/** senior managers must support the Executive Director to ensure that applicable recommendations or requirements from external agencies, derived from visits, inspections, accreditations or mandates / reports / guidance issued are being addressed within the Trust;
- Operational Lead will consider the appropriateness of forwarding the action plan to one or more corporate or clinical service unit meetings for review. It is the responsibility of the Operational Lead(s) to ensure that action plans are maintained to ensure implementation of the recommendations;
- Operational Lead will ensure that the action plan is included on meeting agenda for agreement, included on their associated business cycle and rated as per Trust Integrated Governance Framework, and review dates are scheduled and monitored;
- If applicable, ensuring that the action plan is added to the action plan tracker and is implemented.

5.4 Board of Directors (BOD)

- Responsible for receiving learning outcomes from external agency visits.

5.5 Quality Committee

- For Clinical Service Unit applicable / level action plans the Quality Committee will have overall responsibility for monitoring;
- Will receive any action plans developed as a result of external recommendations,
- Will be responsible for receiving the action plan tracker.

5.6 Committee / Sub Committee Chairs

- The chairs of relevant committees / sub committees have a responsibility to ensure that any actions are monitored within the committee structure and that operational leads are held accountable for the delivery.

5.7 Clinical Governance Department

- The Clinical Governance Department will ensure that any risks identified by the appropriate Executive Director as a result of the review, consideration and implementation of internal / external recommendations and requirements, is included on the corporate risk register;

- The Clinical Governance Department will ensure that all new risks and updates to the corporate risk register are provided to the Board and Committees regularly, as per Trust Integrated Governance Framework.

5.8 Head of Performance and Information

- The Head of Performance and Information is responsible for ensuring the action plan tracker is maintained and reported to the Quality Committee;
- Dependent on the actual high level enquiry, the Executive Lead allocates co-ordination of enquiry to the appropriate Senior Manager and / or the Head of Performance and Information.

5.9 Compliance Manager

- The Compliance Manager is responsible for ensuring recommendations from external reviews are linked to the relevant compliance requirements for CQC and NHSLA;
- Compliance Manager is responsible for monitoring and reporting on the implementation of the risk management standards described in the policy.

Appendix 1 - Process for receipt, review, consideration, implementation and monitoring of external recommendations