NHS
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NHS Trust

Management of External Recommendations Policy

Document Author: Head of Clinical Effectiveness and Governance

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V 1.1	6/4/18	Head of Clinical Effectiveness Governance	D	Minor amendments and new template
V 2.0	April 2018	Risk Team	A	Policy Approved at April TMG
V2.1	5/6/ 20	Head of Clinical Effectiveness & Governance	D	Minor amendments to roles and change from Mortality review to Learning from deaths
V2.2	July 20	Head of Clinical Effectiveness & Governance	D	Policy for approval to TMG reviewed July 20 at CGG
V3	August 2020	Head of Clinical Effectiveness & Governance	A	Approved at TMG
A = Approved D = Draft				
Document Author = Jacqui Crossley, Head of Clinical Governance & Effectiveness				

Procedure for the Management of JRCALC Guidance
Procedure for the Management of NICE Guidance
Procedure for the Management of National Confidential Enquiries/Inquiries

Staff Summary

1	The Trust will adopt the best available locally/nationally agreed practice/recommendations relevant to its business.
2	The Policy identifies likely sources (but not limited to) where external recommendations/guidelines are likely to be received from.
3	The Policy identifies nominated job roles/groups who will receive external recommendations/guidance.
4	The Clinical Governance Group (CGG) will be the Trust group that reviews and actions external recommendations/guidance through a standing agenda item.
5	The nominated job roles/groups identified within point 3 above will be responsible for identifying the respective recommendations/ guidance to the CGG and for the coordination of any subsequent action plans with the relevant personnel/departments concerned under the direction of the CGG.
6	The CGG will sign off action plans and monitor implementation of the plans.
7	Where it is decided recommendations/guidance is not to be implemented the CGG will fully document the reasons why including the process taken to arrive at the decision. This decision will be reviewed at pre-identified periods to ensure there are no changes in circumstances.
8	Recommendations/guidance is anticipated to be received from but not limited to NICE, Prevention of Future Deaths, National Confidential Inquiry Reports, CQC, UK Ambulance Service Clinical Practice Guidelines, CAS & MRHA / Medical Devices Alerts, Medical Director Letters, Mortality Review, National Reports and Recommendations (e.g. Francis Report).

1. Introduction

1.1.1 The vision of the Trust is to provide an Ambulance Service which is continuously improving patient care, high performing, always learning and delivers value for money. In achieving this vision and the Trusts stated values, the Trust has a duty to limit the potential risk of harm to patients, potential patients and members of staff and the public. The Trust will therefore adopt the best available nationally or locally agreed practice and recommendations; this policy identifies the process through which this will occur.

1.1.2 This policy brings together a number of other external recommendation policies including JRCALC, NCPOD, NICE.

2.0 Purpose/Scope

2.1 The findings from external inspections, assessments, reviews and clinical guidelines are an important and valuable source of learning and guidance, in order to improve the quality of care and the safety of staff, patients and others affected by the activities of the Trust. Appendix 1 identifies likely external recommendations covered within this policy.

2.1.1 Providing this process to coordinate and evaluate the identified areas specific to the Trust benefit the Trust by allowing potential gaps in assurance to be identified and addressed and by ensuring best clinical practice is followed so that the Trust can achieve its purpose and uphold its Vision and Values.

3.0 Process

3.1 Identification of External Agencies

3.1.1 External agencies and likely sources of recommendations/guidance have been identified (but not limited to) and documented. Appendix 1 identifies the likely source of the recommendation/guidance and describes subsequent internal steps to be taken to review, implement where deemed relevant and monitor progress. The source of recommendations will be reviewed on a quarterly basis by the CGG or through a nominated CGG member and updated where necessary.

3.2 Initial Assessment and Formulation of Action Plans

3.2.1 The relevant nominated individual/group receiving the recommendations/guidance (Appendix 2) will perform an initial assessment on their identified subject area and document findings on the relevant form (Appendix 3). It is envisaged the initial assessment will be comprehensive enough to identify likely impact and consequences to the Trust for either accepting or declining the recommendation/guidance.

3.2.2 The documented assessment will be discussed at the next CGG meeting under the standing agenda item. The CGG will be the group with responsibility for reviewing and identifying whether the recommendations/guidance is to be implemented or not. Where it is deemed relevant to be implemented an action plan will be formulated by the identified individuals (Appendix 2) and taken back to the CGG for approval prior to implementation.

3.3 Review of Progress against the Action Plan

3.3.1 The nominated lead manager will be responsible for ensuring that all identified actions arising from the agreed action plan are delivered within the requisite timescales, and that any risks arising during implementation are recorded on the appropriate risk register.

3.3.2 The CGG will monitor progress against the developed action plan, ensuring that the plan is discussed, updated and formally acknowledged. The CGG report to the Trust Management Group (TMG) The TMG will consider whether the measures taken are sufficient and appropriate, and that adequate assurance has been provided that action plans are being effectively monitored. If necessary, the TMG may recommend that the measures are reviewed, developed and strengthened.

3.4 Process for documenting any decisions not to implement External Recommendations/Guidance

3.4.1 Where it has been identified by the nominated group/individual upon receipt (Appendix 3) and agreed by the CGG that recommendations/guidance are not applicable, or where no further action is required, this will be documented by the CGG and reported via the existing committee/internal control reporting arrangements. Any decision made will be reviewed in light of changes or provision of new services, when they occur, which may lead to previous decisions being revoked. The CGG will retain responsibility for this action/monitoring.

3.5 Organisational Learning

3.5.1 The TMG facilitates organisational learning and improvement arising from external agency assessments, inspections, reviews, recommendations/guidance, through the delegation of specific actions to its members. Learning from external recommendations/guidance will be managed via established governance arrangements.

3.6 Variations to the Process

3.6.1 It is acknowledged the occasions may arise whereby immediate action is required following an external recommendation/guidance. In these circumstances, relevant action will be taken by the respective directorate who is primarily impacted upon by the recommendation/guidance. This will be then reported to the CGG at the earliest opportunity.

4.0 Training expectations for staff

4.1 Training is delivered as specified within the Trust Training Needs Analysis (TNA) and the responsibility of the YAS Education Academy.

5.0 Implementation Plan

5.1 The latest approved version of this Policy will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

6.0 Monitoring compliance with this Policy

6.1 The CGG will ensure an annual audit of the Management of External Recommendations Policy occurs. The findings of the audit will be taken to the TMG for consideration and action, as appropriate.

6.1.1

Standard	Monitor
Process	The CGG will be responsible for ensuring the identified process occurs and will agree and monitor developed action plans. The CGG will ensure regular review of decisions made not to implement recommendations/guidance and take appropriate action in any change of circumstances. The CGG will ensure the sources of recommendations/guidance are reviewed on a quarterly basis. The nominated job roles/groups will be responsible for initially receiving recommendations/guidance, recording initial findings and forwarding to the CGG.
Managing Variations	The CGG will monitor any variations to the process and ensure full documentation is made regarding any variations.

7.0 References

7.1 An Organisation-wide Document for Dealing with External Recommendations Specific to the Organisation London: Stationary Office. Available at www.nhsla.com

8.0 Appendixes

8.1 Appendix 1 – Management of External Recommendations Identification and Action

8.1.1 Appendix 2 – Management of External Recommendations Process

8.1.2 Appendix 3 – Assessment template

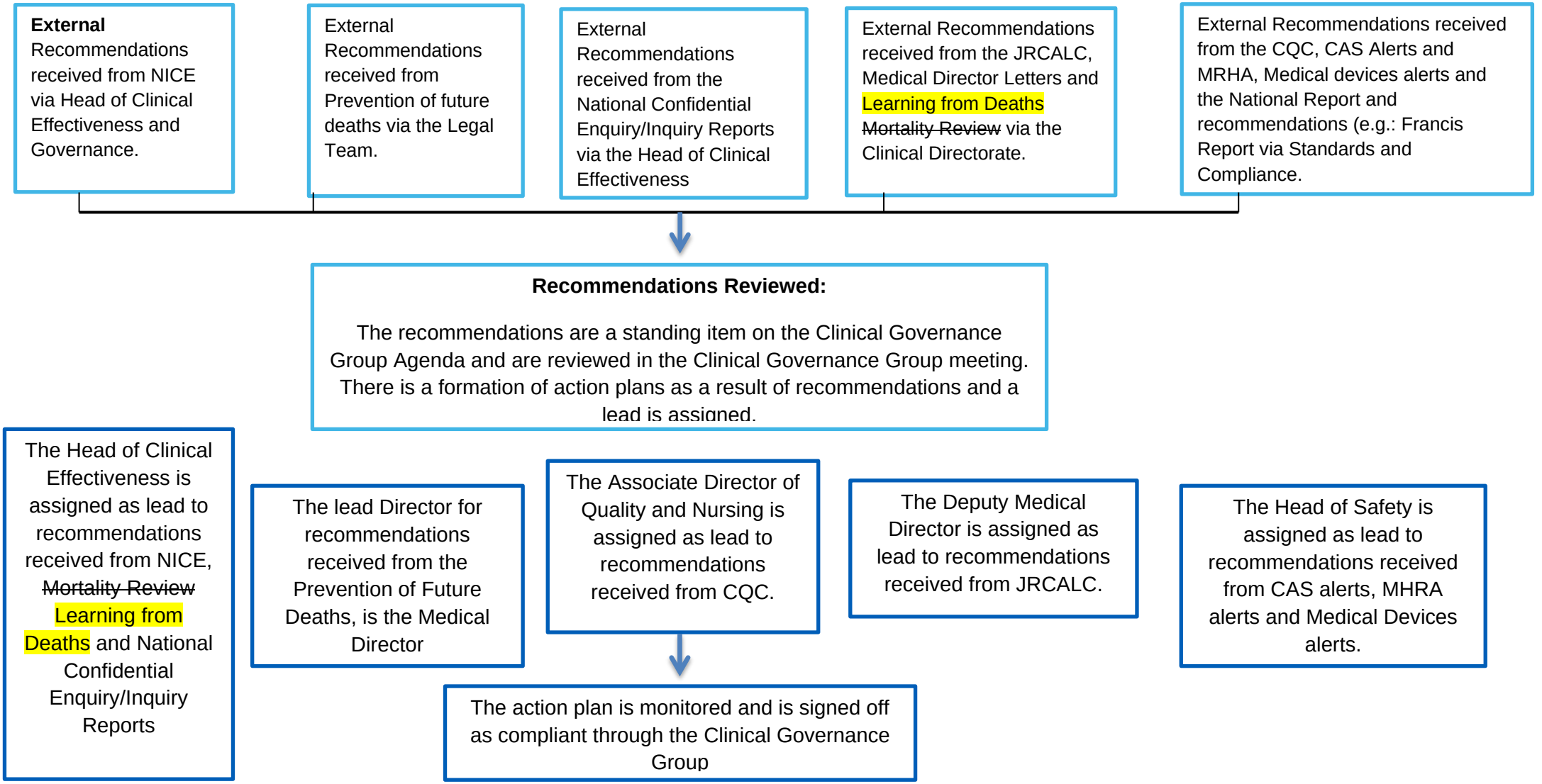
8.1.3 Appendix 4 – Definitions

8.1.4 Appendix 5 – Roles & Responsibilities

Appendix 1 - Management of External Recommendations Policy and Policy Identification and Action

Recommendation source	Entry Point into YAS	Reviewing Committee	Review of Recommendation	Formation of action plan lead	Sign off of action plan	Monitoring of action plan and compliance sign off
NICE	Clinical Directorate ~~CEM removed~~	Clinical Governance Group	Standing item of CGG	Head of Clinical Effectiveness	Clinical Governance Group	Clinical Governance Group
Prevention of future deaths	Legal Team	Clinical Governance Group	Standing item of CGG	Clinical Safety Improvement Group	Clinical Governance Group	Clinical Governance Group
National Confidential Enquiry/ Inquiry Reports	Medical Director	Clinical Governance Group	Standing item of CGG	Head of Clinical Effectiveness	Clinical Governance Group	Clinical Governance Group
CQC	Standards and Compliance Directorate	Clinical Governance Group	Standing item of CGG	Associate Director Quality and Nursing	Clinical Governance Group	Clinical Governance Group
JRCALC	Clinical Directorate	Clinical Governance Group	Standing item of CGG	Deputy Medical Director	Clinical Governance Group	Clinical Governance Group
CAS Alerts and MRHA	Standard and Compliance	Clinical Governance Group	Standing item of CGG	Head of Safety	Clinical Governance Group	Clinical Governance Group
Medical devices Alerts	Standard and Compliance	Clinical Governance Group	Standing item of CGG	Head of Safety	Clinical Governance Group	Clinical Governance Group
Medical Director Letters	Clinical Directorate	Clinical Governance Group	Standing item of CGG	Medical Director	Clinical Governance Group	Clinical Governance Group
~~Mortality Review~~ Learning from Deaths	Clinical Directorate	Clinical Governance Group	Standing item of CGG	Head of Clinical Effectiveness	Clinical Governance Group	Clinical Governance Group
National Report & recommendations (e.g. Francis Report)	Standard and Compliance	Clinical Governance Group	Standing item of CGG	Associate Director Quality and Nursing	Clinical Governance Group	Clinical Governance Group

Appendix 2 - Management of External Recommendations Process



Appendix 3 - Assessment template

Date	Source	Outline of recommendation	Mandatory or statutory	Relevance to YAS (Y/N)	If not why not?	If Yes, outline reasons	Resulting actions	Lead	Date completed	Signed off

Appendix 4 - Definitions

External Agency
An external agency in the context of this policy is an organisation that has a legitimate interest in the Trust and with whom the Trust is expected or requested to co-operate (e.g. CQC, Monitor, HM Coroner).

Inspection
An inspection is, most generally, an organised examination or formal evaluation exercise. The results are usually compared to specified requirements and standards for determining whether the activity is in line with these targets.

Assessment
There are numerous types of assessment. The assessment by general agencies is primarily an educational assessment, which is the process of documenting knowledge, skills and attitudes.

Review
To examine with an eye or to critique or correct.

Recommendation
A recommendation serves to recommend something or induce acceptance.

Internal Control
Internal control is defined as a process affected by an organisation's structure, work and authority flows, people and management information systems. It is designed to help an organisation accomplish specific goals or objectives.

Assurance
A positive declaration intended to give confidence.

Appendix 5 – Roles and Responsibilities

Trust Board

The Trust Board is responsible for ensuring that effective systems are in place for responding to external agency assessments, inspections and reviews. The Trust Board seeks assurance regarding the Trust's response to external agency recommendations, through the Chief Executive and the Executive Director of Standards and Compliance.

Trust Management Group

The Trust Management Group (TMG) accepts responsibility, delegated from the Trust Board, for scrutinising the Trust's plans to respond to recommendations from external agencies, ensuring these are fit for purpose, are delivered to timescale and that associated risks are effectively managed. The TMG facilitates organisational learning and improvement arising from external agency assessments, inspections and reviews, through the delegation of specific actions to its members.

Clinical Governance Group

The Clinical Governance Group (CGG) is responsible for identifying, collating, reviewing and deciding whether the recommendations/guidance is to be accepted or declined. The CGG are also responsible for the formulation of action plans and their implementation and monitoring. The CGG will also monitor changes in Trust/external circumstances which may result in previous decisions being reviewed. The CGG will also review the source of recommendations/guidance to incorporate any additional areas not previously identified.

Chief Executive

The Chief Executive is ultimately accountable for the implementation of the process for managing and responding to external agency assessments, inspections and reviews. As the Accountable Officer the Chief Executive provides the Trust Board with assurance regarding the Trust's response to external agency recommendations.

Executive Director of Standards & Compliance

The Executive Director of Standards & Compliance has responsibility for ensuring a schedule of review dates is maintained and disseminated as appropriate. The Director has responsibility for ensuring that adequate arrangements are in place to manage external agency assessments, inspections and reviews. The Director has responsibility ensuring an appropriate system is in place to manage risks arising from external recommendations and for providing the Trust Executive and Trust Board with assurance on this process.

Associate Directors for Quality and Risk & Safety

The Associate Directors for Quality and Risk & Safety have delegated responsibility from the Executive Director of Standards & Compliance for:

- Maintaining a schedule of review dates (inspections, assessments, etc.)
- Reviewing and providing a summary briefing of external recommendations received into the organisation, highlighting any areas identified for immediate action to the TMG
- On receipt of the report following the specific external agency inspection, assessment or review, ensuring that all the information included in the report is accurate
- Ensuring that all external recommendations received into the Trust are recorded on an electronic system, disseminated, reported to and discussed by the TMG
- Ensuring that electronic system(s) recording data relevant to external agency assessments, inspections and reviews is kept up to date
- Developing a report and an action to address any recommendations
- Ensuring action plans are reviewed and evaluated by the TMG
- Ensuring that the organisation-wide risk register is populated with risks identified from external visits and recommendations

Nominated Managers/Groups

Nominated managers/Groups will have delegated responsibility for developing an action plan (either as a separate piece of work, or as part of existing management plans), delivering the necessary actions to timescale, identifying any risks arising from the recommendations and ensuring these are recorded on the appropriate risk register. Nominated managers/groups are also required to report on the delivery of action plans and the management of risks to the CGG.

Quality & Risk Co-Ordinators

Quality & Risk Co-Ordinators work within the Standards and Compliance Directorate, to support the overall quality and risk management arrangements within the Trust. The co-ordinators manage a forward planning system to ensure that arrangements are in place for all anticipated external agency assessments, inspections and reviews. They also co-ordinate the recording of subsequent recommendations and action plans.