Somerset Partnership NHS
NHS Foundation Trust

EXTERNAL RECOMMENDATIONS (MANAGEMENT OF) POLICY

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Title of originator/author:	Head of Corporate Governance
Title of responsible committee/group:	Clinical Governance Group Regulation Governance Group
Date issued:	**October 2012**
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Relevant Staff Groups:	Staff involved in coordinating the response to National recommendations and visits by external agencies.

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DOCUMENT CONTROL

Reference Number AL/Oct/12/ERP	**Version** 3	**Status** Final	**Author** Head of Corporate Governance
Amendments	Amended following the reviewed NHSLA Risk Management Standards January 2012.		
Document objectives: To set out the processes by which the Trust ensures a robust system for the identification, distribution, evaluation, implementation and monitoring of recommendations arising from external assessments, reviews, reports & guidance			
Intended recipients: Staff involved in coordinating the response to National recommendations and visits by external agencies.			
Committee/Group Consulted: Regulation Governance and Clinical Governance Groups.			
Monitoring arrangements and indicators: See section 8			
Training/resource implications: Training requirements arising from external recommendations are identified and documented in action plans. These are referred to the Head of Training for inclusion in the workforce training plan for all necessary staff (qualified, unqualified, other clinical staff, bank, agency and contractual staff).			

Approving body and date	Regulation Governance Group / Clinical Governance Group	Date: August 2012 Date: September 2012
Formal Impact Assessment	Impact Part 1	Date: September 2012
Clinical Audit Standards	NO	Not Applicable
Ratification Body and date	Senior Managers Business Group	Date: October 2012
Date of issue	**October 2012**	
Review date	**September 2015**	
Contact for review	Head of Corporate Governance	
Lead Director	Director of Governance and Corporate Development	

CONTRIBUTION LIST Key individuals involved in developing the document

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CONTENTS

1. INTRODUCTION

1.1 The Care Quality Commission and the NHS Litigation Authority expect Trusts to comply with all recommendations from external agencies and will expect evidence to show that there is a robust process for its management within the Trust.

1.2 As such, the Trust must ensure a systematic approach when responding to the recommendations and requirements arising from external agency visits, inspections and accreditations. It must have an auditable process for reviewing, considering and implementing the advice from relevant best practice guidance and enquiries.

1.3 The processes that this document describes are seen as part of the Trust's internal control systems and aims to provide assurance to the Executive Team and ultimately the Trust Board, who need, wherever possible, to make use of the work of the many external reviewers and to ensure the whole process is efficient. The Trust is keen to ensure that it learns from inspections and is committed to ensuring that the required improvements are made.

1.4 The policy will minimise the burden on the organisation by reducing duplication and will allow potential gaps to be identified and addressed.

1.5 It will ensure that:

- A suitable individual is nominated to coordinate and report on any reviews carried out by external agencies to the appropriate Trust committees.
- A schedule of review dates is maintained.
- Action Plans are developed, within agreed timescales, as a result of reviews to facilitate the implementation of recommendations.
- Compliance with implementation of recommendations is monitored and reviewed.
- Where deficiencies occur these will be escalated to the relevant committee for scrutiny and action planning to rectify any deficiencies.
- Where relevant a decision may be made to add the risk of non-compliance to the Risk Register.

2. PURPOSE & SCOPE

2.1 This policy applies to all Trust staff and applies whenever an external agency inspects the Trust. There are a number of external agencies that review and/or inspect the Trust. Reviews and inspections may be at service, directorate or corporate level.

2.2 All external agencies that visit the Trust where a response is expected should come under the remit of this document. Where there is any doubt, advice should be sought from the Director of Governance and Corporate Development.

2.3 Reviews, reports and guidance issued nationally, from which the Trust may identify recommendations and best practice, include but are not limited to the following:

- National Confidential Enquiries (NCEs);
- National Institute for Health and Clinical Effectiveness (NICE);
- Department of Health Central Alerting System (CAS);
- Care Quality Commission (CQC);
- Local Involvement Networks (LINks) / Healthwatch;
- Equality and Human Rights Commission;
- Health and Safety Executive;
- Environmental Health Department; and
- National Patient Safety reviews.

2.4 This procedure applies to all staff including temporary, locum, bank, agency and contracted staff when working for the Trust in any capacity.

3. DUTIES AND RESPONSIBLITIES

3.1 The overall responsibility for ensuring that the Trust takes account of external recommendations and best practice guidance rests with the **Board of Directors.**

3.2 The **Director of Governance and Corporate Development** is the Chair of the Regulation Governance Group and will monitor overall compliance with this policy.

3.3 The **Director of Nursing and Patient Safety** is the Chair of the Clinical Governance Group and is responsible for monitoring compliance with clinical standards and recommendations arising from external reviews.

3.4 The **Trust's Equality and Diversity Lead** is the Chair of the Equality and Diversity Group who have been charged with responsibility for the development and implementation of recommendations made by the Equality and Human Rights Commission.

3.5 The **Head of Patient Safety** is the **Central Alert Systems Liaison Officer** for the Trust and has responsibility for distributing CAS Alerts and monitoring action.

3.6 The **Clinical Governance Group** has responsibility for monitoring compliance with this policy in respect of **National Confidential Enquiries**, **NICE Guidance** and the **Central Alerting System (CAS).**

3.7 The **Mental Health Act Group** is responsible for monitoring compliance with this policy with regards to the **Care Quality Commission** where the inspections/recommendations are related to the Mental Health Act.

3.8 The **Clinical and Social Care Effectiveness Group** is responsible for considering all NICE Guidance and reviewing the relevance to the Trust.

3.9 The Trust has a number of Governance groups (or sub groups) that take a lead in implementing and monitoring the action plans resulting from external recommendations and best practice guidance as required. Details of the Trust's governance structure (including governance sub groups) can be found at Appendix A.

3.10 The **Head of Clinical Effectiveness and Research** has responsibility for the dissemination of audit results and ensuring that these are used to improve the quality of patient care and to provide assurance of compliance with national guidance (NICE) and best practice.

3.11 **The Head of Corporate Services** has responsibility to ensure compliance with recommendations arising from Health and Safety inspections and for co-ordinating action plans in response to Rule 43 judgements.

3.12 All **Trust staff,** whether health and social care practitioners or administrative staff who support them are responsible for ensuring they comply with this policy/procedure.

3.13 With the exception of NICE guidance, action plans developed in response to external recommendations should follow a standardised template. This template is provided at Appendix D.

4 EXPLANATIONS OF TERMS USED

4.1 **External body or agency:** An organisation that has an official advisory or regulatory role concerning the corporate and professional activities of NHS Trusts, or which otherwise has statutory rights to regulate, visit, audit or inspect the Trust's premises and/or review and inspect its processes, whether in the Trust's capacity as an employer, provider of healthcare, or as a statutory public body. This includes police investigatory visits. The external bodies and agencies who may inspect the Trust are numerous and it is difficult to define an exhaustive list.

4.2 **Accreditation:** This encompasses audit and review activities of both internal and external bodies that are required to deliver Board Assurance. Accreditation provides assurance that services delivered by the Trust are fit-for-purpose and are achieving the intended results in accordance with the Trust's strategies, policies and procedures.

4.3 **Inspection:** An examination of a property or service to confirm that it meets the required standards. The Trust is required to cooperate with certain mandated inspections.

4.4 **'Other' Visit:** for the purpose of this policy, this encompasses any external agency visits, inspections and accreditations other than those of Internal and External Audit.

4.5 **Central Alerting System (CAS**): the Department of Health's approved method of disseminating all safety alerts to Trusts.

4.6 **Environmental Health Department**: the local authority department responsible for protecting the health of the community and improving the environment; in particular compliance with food safety legislation within food businesses.

4.7 **Health and Safety Executive (HSE)**: provides advice, guidance, regulations and inspections to protect people against risks to health or safety arising out of work activities.

4.8 **Healthcare Quality Improvement Partnership** (HQIP) are responsible for the management and commissioning of the Clinical Outcome Review Programmes (also known as Confidential Enquiries), previously the responsibility of the National Patient Safety Agency (NPSA)

4.9 **Care Quality Commission (CQC)**: the independent regulator for health and social care in England, which promotes continuous improvement in the services provided by the NHS and other health and social care organisations and investigates serious service failures in the NHS. The Care Quality Commission also provide a safeguard for people who are detained in hospital under the powers of the Mental Health Act 1983, advising on policy and best practice and monitoring the legality of detention and the protection of individuals' human rights. This role was formerly undertaken by the Mental Health Act Commission.

4.10 **National Confidential Inquiries (NCI)**: nationally co-ordinated studies in which clinicians confidentially review practice on a given topic, the results of which are then brought together to provide a national picture and develop recommendations which are disseminated by HQIP.

4.11 **National Institute for Health and Clinical Excellence (NICE)**: the independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

4.12 **Equality and Human Rights Commission** The Equality and Human Rights Commission champions equality and human rights for all, working to eliminate discrimination, reduce inequality, protect human rights and to build good relations, ensuring that everyone has a fair chance to participate in society.

4.13 **High Level Inquiries:** any published inquiry with recommendations for implementation nationally e.g. Shipman Inquiry, Healthcare Commission Investigation into Mid Staffordshire NHS Foundation Trust and Care Quality Commission Investigation into West London Mental Health NHS Trust.

5. PROCESSES

5.1 A number of different processes exist in order to support the identification, distribution, evaluation, implementation and monitoring of recommendations arising from external assessments, reviews, reports and guidance.

5.2 Clinical Outcome Review Programmes/National Confidential Inquiries (NCI)

There are four clinical outcome review programmes commissioned by HQIP on behalf of the Department of Health:

- Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

- Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH – University of Manchester)
- Child Health programme: Royal College of Paediatrics and Child Health (RCPCH)
- Maternal, Newborn and Infant programme: MBRRACE-UK

5.3 The only programme requiring submissions by clinicians in the Trust is the National Confidential Inquiry into Suicide and Homicide for people with Mental Illness.

- Requests for data are sent to the Research team who complete the data request form.
- The data form is returned to the NCI who forward Questionnaires to the appropriate clinician, for patients who had been seen by Mental Health Services in the Trust within 12 months of the incident.
- The Clinician is requested to complete the Questionnaire and return directly to the NCI. Clinicians with any concerns regarding the completion of these Questionnaires may contact the Research Team (located within the trusts Headquarters at Mallard Court) for advice.

5.4 The publication of a NCI report is identified via the weekly Department of Health bulletin. This bulletin is provided to the Trust's Chief Executive who will identify an appropriate Manager or Governance Group to review its relevance to the Trust.

5.5 The action taken is dependent on the report, however the following principles apply:

- a senior manager is identified for each relevant **NCI** who is responsible for reviewing the NCI, evaluating its applicability to the Trust, and coordinating any required action;
- the identified senior manager conducts an organisational gap analysis and draws up an action plan;
- the action plan is presented to the **Clinical Governance Group** and implemented;
- the **Integrated Governance Committee** will receive a progress report which will be monitored by the Trust Audit Committee;
- where service developments are identified, these are referred to the Trust Executive team for action;
- any risk issues are identified and included on the **Corporate Risk Register**.

NICE Guidance

5.6 The publication of all NICE guidance on the fourth Wednesday of each month is monitored by the Head of Clinical Effectiveness & Research and its relevance to the Trust evaluated.

5.7 A process chart outlining the implementation of NICE guidance is shown at Appendix B.

5.8 All Heads of Services are advised of new guidance and asked to confirm relevance and nominate a lead person/group where assessment of current compliance is required.

5.9 The identified lead/group completes a NICE Compliance Assessment form using the proforma shown at Appendix C, including identifying actions required in order to implement the NICE guidance.

5.10 At the next **Clinical and Social Care Effectiveness Group** meeting, all guidance issued by NICE is reviewed and the relevance to the Trust ratified.

5.11 Where service developments are identified, these are referred to the Trust Executive team for action.

5.12 Where the Trust is unable to fully implement **NICE guidance** because of resource/commissioning issues, these areas of concern are reported to the Trusts Clinical Governance Group and Integrated Governance Committee. Where appropriate these are also included within the **Corporate Risk Register.**

5.13 A record of all NICE guidance and implementation progress is maintained by the Head of Clinical Effectiveness & Research and monitored by the **Clinical and Social Care Effectiveness Group**.

Central Alerting System (CAS)

5.14 The Central Alerting System (CAS) brings together Chief Medical Officer's (CMO's) bulletins Public Health Link (PHL) and the Safety Alert Broadcast System (SABS). It enables alerts and urgent patient safety specific guidance to be accessed at any time.

5.15 Safety alerts, emergency alerts, drug alerts, Dear Doctor letters and Medical Device Alerts are available on the CAS website. They are issued on behalf of the Medicines and Healthcare products Regulatory Agency (MHRA), the NHS Commissioning Board Special Health Authority (who provide the key functions and expertise for patient safety previously developed by the National Patient Safety Agency), and the Department of Health.

5.16 When a safety alert is received from CAS it is sent to the Safety Alert Bulletin (SABS) Administrator via Outlook. It includes information about the alert, such as alert details, action deadline, and a hyperlink to a PDF file showing the alert in more detail and a hyperlink to the alert on the CAS website.

5.17 The SABS Administrator will, on receipt, forward all safety alerts to the Head of Patient Safety.

5.18 The Head of Patient Safety will review each safety alert and agree the appropriate distribution.

5.19 The Trust SABS Administrator will distribute the safety alert, as agreed by the Head of Patient Safety, via the DATIX system. This will record when recipients have viewed it.

5.20 If required, recipients of the safety alert notice can cascade the information to other members of their teams/service.

5.21 Staff members are required to provide feedback on each alert, advising of the action they have taken to ensure compliance. Staff members are required to record their response onto DATIX.

5.22 DATIX will display a list of staff who have been sent the alert and will also highlight where a response has become overdue.

5.23 On receipt of staff respones, it is the responsibility for the SABS Adminstrator to update and close the alert on the SABS Website. This must be completed by the Safety Alert Response due date to ensure that Somerset Partnership is compliant.

5.24 Compliance against safety alerts is monitored by the Head of Patient Safety and reported monthly to the Clinical Governance Group.

Care Quality Commission (CQC) – Mental Health Act Reviews

5.25 All services provided by the Trust are registered with the CQC . The Director of Governance and Corporate Development is the Trusts 'nominated individual'. In line with guidance issued by the CQC, the nominated individual is employed as a director and is responsible for supervising the management of the carrying on of the regulated activity by the Trust.

5.26 Each of the Trust's Mental Health wards are registered with the CQC to detain patients under the Mental Health Act. In line with registration requirements each ward should be inspected by a Mental Health Act Commissioner from CQC at least once every 18 months. These visits are usually unannounced. Section 120 of The Mental Health Act (MHA) grants MHA Commissioners the power to visit and interview in private patients detained under the MHA, and to require the production of and inspect any records relating to the detention or treatment of any person who is or has been detained.

5.27 Following the review, a report is compiled by the MHA Commissioner highlighting any issues requiring the Trust to take action. The report is issued to the Trust's nominated individual (Director of Governance and Corporate Development), who is responsible for the coordination of the Trust's response. The response must be completed within the timescale requested by the MHA Commissioner (usually within a month of receipt, or more rapidly for urgent situations). The Trust's response is recorded on the template provided by the CQC.

5.28 MHA Commissioner reports and the Trust's responses are monitored at the Mental Health Act Group, as part of its standing agenda items. The group monitor the implementation of the action plan six monthly (as a minimum) and report identified risks by completing the DATIX Risk Reporting form in accordance with the Risk Management Policy and Procedure. New Significant Risks will be discussed at the Regulation Governance Group for possible inclusion on the Corporate Risk Register.

5.29 MHA Commissioners also occasionally carry out inspections of how patients subject to Community Treatment Orders are treated. These visits are more likely to be planned and announced, and the MHA Commissioner will expect cooperation from the Trust in arranging the interviews with such patients, and to facilitate access to their notes. The MHA Commissioner will produce a written report after a CTO visit, and this will be received by the Trust and dealt with in the same way as detailed above.

Care Quality Commission (CQC) – Planned and Responsive Reviews:

5.30 All services provided by the Trust are registered with the Care Quality Commission. The Director of Governance and Corporate Development is the Trusts 'nominated individual'. In line with guidance issued by the CQC, the nominated individual is employed as a director and is responsible for supervising the management of the carrying on of the regulated activity by the Trust.

5.31 All planned and responsive reviews undertaken by the CQC are notified to the Director of Governance and Corporate Development.

5.32 Following inspection, details of the findings and any subsequent improvement actions are formally notified by the CQC in a compliance report sent to the Director of Governance and Corporate Development.

5.33 An action plan to address improvement actions is developed by the relevant members of the Executive Team and is formally notified to the CQC within 14 days of receipt of the draft inspection report.

5.34 Action plans developed in response to a CQC inspection are subject to ongoing monitoring via the Regulation Governance Group, Integrated Governance Committee and Board of Directors (as required).

LETTERS ISSUED BY THE CORONER UNDER RULE 43

5.35 Rule 43 (as amended by the Coroners Amendment Rules 2008) provides that if, at an inquest into a person's death, a coroner hears evidence that "gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future; and in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances," the coroner may report the circumstances to whoever may be able to take remedial action.

5.36 Under the powers of Rule 43:

- a statutory duty is placed on organisations receiving reports from Coroners to respond within 56 days. Failure to respond in time will prompt the Coroner to chase the organisation and continued failure to engage with the Coroner will prompt an adverse report to the Government and general publication;

- there is no obligation to act upon the Coroner's recommendations but the response must indicate what action has been taken or what is proposed. If no action is proposed an explanation must be given;

- Coroners *must* share reports and responses with those, including bereaved families, assigned the status of 'interested persons'. The Coroner *may* send a copy of the report and response to any other person or organisation with an interest;

- the Coroner must file a copy of his report and the response with the Government (Lord Chancellor);

- the Lord Chancellor may publish the report and response or a summary thereof. The Lord Chancellor may share the report and response to any other person or organisation considered to have an interest; and

- reports and responses are centrally collated so that any trends can be identified, monitored and lessons learned can be shared widely.

5.37 Any patient death which is considered by the Coroner and subject to a formal inquest will be reviewed under the provisions of the Serious Incidents Requiring Investigation (SIRI) Policy to identify if a full Serious Incident Review is necessary.

5.38 Any letter issued by the Coroner under Rule 43 will be notified to the Director of Governance and Corporate Development who will ensure that an acknowledgment is sent to the Coroner within 7 days.

5.39 A full investigation in to the incident will be undertaken (if not already completed) in line with the SIRI Policy and the incident and outcome will be recorded on the Strategic Executive Information System (StEIS).

5.40 An action plan to address improvement actions will be developed by the relevant members of the Executive Team and presented to the SIRI Review Group.

5.41 The Director of Governance and Corporate Development will ensure that a full response to the Coroner is prepared for signature by the Chief Executive within 56 days of receipt of the Rule 43 letter, and copies are sent to anyone identified by the coroner.

5.42 Action plans developed in response to a Rule 43 letter are subject to ongoing monitoring via the SIRI Review Group, Clinical Governance Group, Integrated Governance Committee and Board of Directors (as required).

5.43 The process for the review of recommendations arising from NHSLA Solicitors Risk Management Reports is outlined within the Trust's Claims Handling Policy.

Other External Inspections and Accreditation Visits

5.44 Other external inspections and accreditation visits specific to the Trust may arise, such as **Health and Safety Executive inspections, Environmental Health Department food** and **hygiene inspections** and **service specific accreditation.**

5.45 The action taken is dependent on the nature of the inspection/ accreditation visit; however the following principles apply:

- a **senior manager** is identified to take responsibility for facilitating the visit, and coordinating the provision of required documentary evidence, interviews and resources;
- where the inspection/accreditation visit includes subsequent reviews, the identified lead will maintain a schedule of review dates and ensure the Trust is prepared for future visits;
- any recommendations arising from the inspection/accreditation visit will be considered by the appropriate governance group;
- the identified lead will conduct an organisational gap analysis and draw up an action plan;
- the action plan will be monitored by the appropriate governance group at least six monthly;
- any service developments identified are referred to the Trust Executive team for action;
- where the Trust is unable to fully implement the recommendations because of resource/commissioning issues, these areas of concern will be reported to the Regulation Governance Group.

6. TRAINING REQUIREMENTS

6.1 Training requirements arising from external recommendations are identified and documented in action plans. These are referred to the Learning and Development Manager for inclusion in the workforce training plan for all necessary staff (qualified, unqualified, other clinical staff, bank, agency and contractual staff).

7. EQUALITY IMPACT ASSESSMENT

All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Trusts Equality and Diversity Lead who will then actively respond to the enquiry

8. MONITORING COMPLIANCE AND EFFECTIVENESS

8.1 In addition to the monitoring detailed within sections three and five of this document, the effectiveness of these procedures is monitored by the Trust Integrated Governance Committee via quarterly reports from the Trusts Clinical, Regulation and Caldicott and Information Governance Groups.

8.2 Staff are made aware of good practice, external recommendations and lessons learned through internal communications including 'From the Exec' (a monthly internal newsletter) and the SPICE (Somerset Partnership: Improving Clinical Effectiveness) newsletter.

9. COUNTER FRAUD

9.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

10 RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

The standards and outcomes which inform this procedural document are as follows:

Section	Outcome	
Quality and management	16	Assessing and monitoring the quality of service provision

Relevant National Requirements

Department of Health initiatives

NICE and other clinical guidance

NHSLA Risk Management Standards 2012-2013 for NHS Providers of Acute, Community or Mental Health and Learning Disability Services and Non-NHS Providers of NHS Care.

11. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

11.1 Acknowledgements

Care Quality Commission, Essential Standards of Quality and Safety, March 2010

11.2 Cross reference to other procedural documents

Clinical Audit Policy
Development & Management of Procedural Documents
Learning Development and Mandatory Training Policy
Risk Management Policy and Procedure
Mandatory Training Matrix (Training Needs Analysis)
Serious Incidents Requiring Investigation Policy
Claims Handling Policy

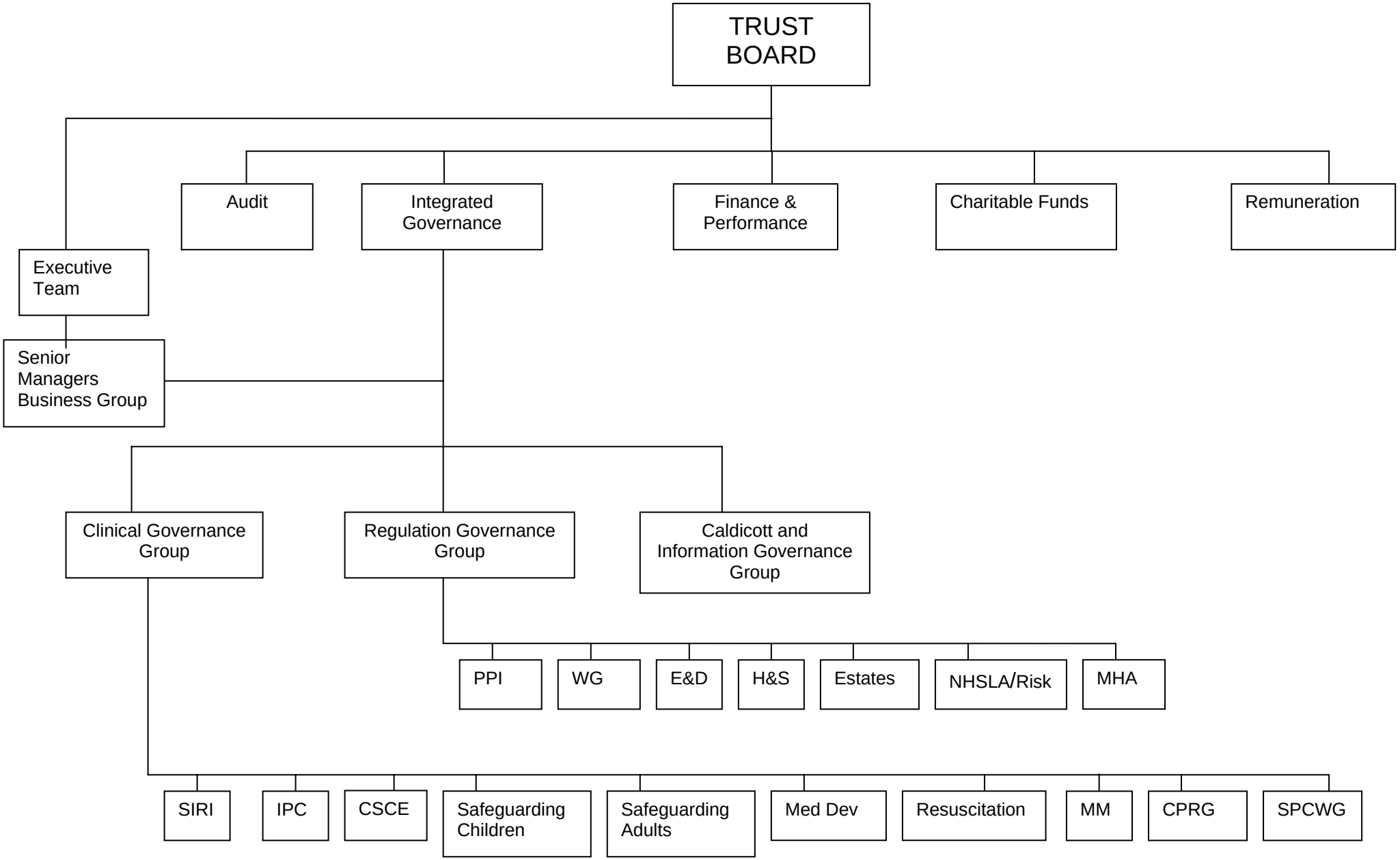
All current policies and procedures are accessible to all staff on the Trust intranet (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet (within Policies and Procedures).

12. APPENDICES

12.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A	Trust Governance Structure
Appendix B	NICE Implementation Flowchart
Appendix C	NICE Compliance Assessment Form
Appendix D	Action Plan Template

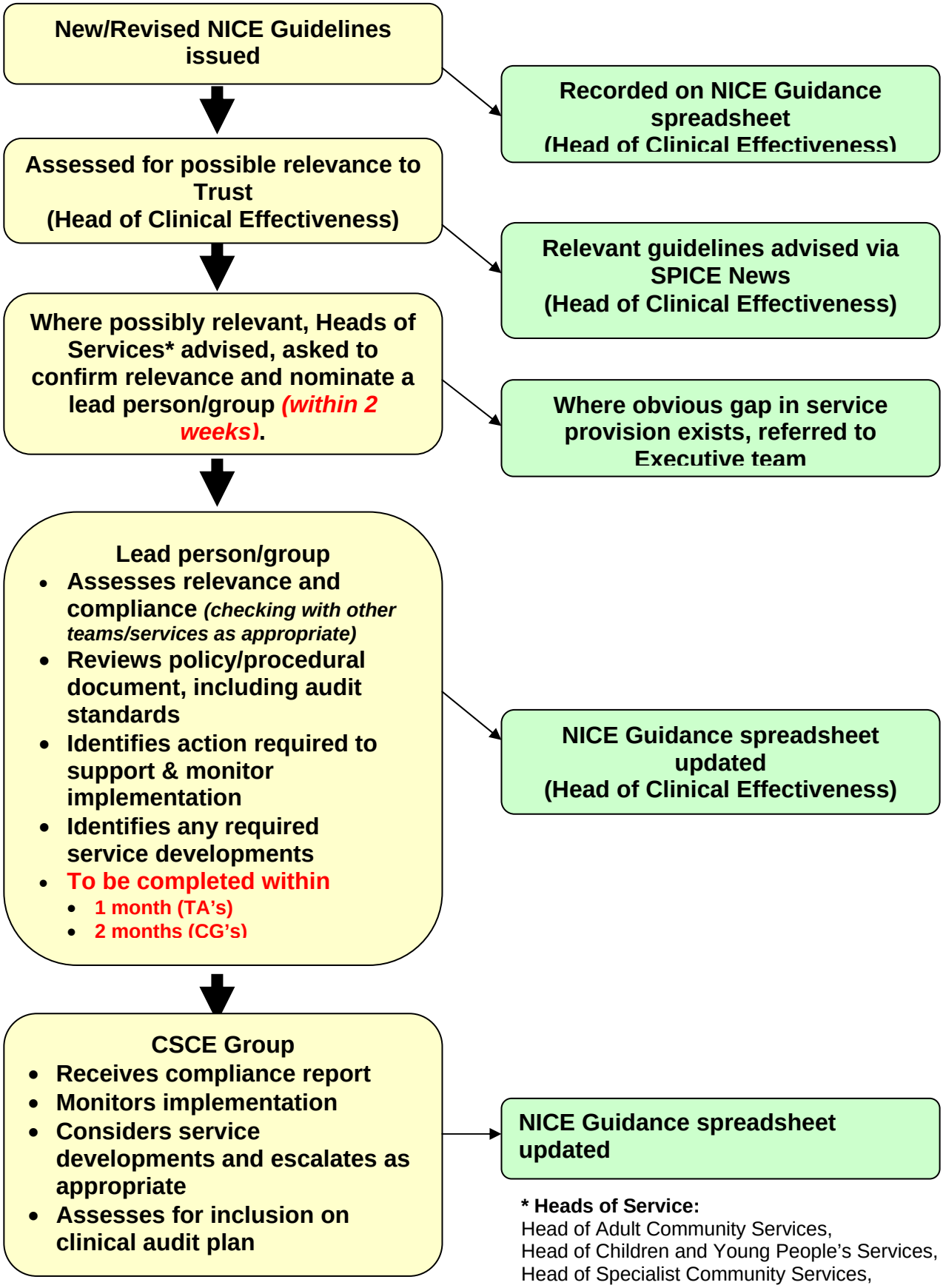
Appendix A


TRUST BOARD
Audit
Integrated Governance
Finance & Performance
Charitable Funds
Remuneration
Executive Team
Senior Managers Business Group
Clinical Governance Group
Regulation Governance Group
Caldicott and Information Governance Group
PPI
WG
E&D
H&S
Estates
NHSLA/Risk
MHA
SIRI
IPC
CSCE
Safeguarding Children
Safeguarding Adults
Med Dev
Resuscitation
MM
CPRG
SPCWG

LEGEND

PPI	Patient and Public Involvement
WG	Workforce Governance
E&D	Equality and Diversity
H&S	Health and Safety and Security Management
MHA	Mental Health Act
SIRI	Serious Incident Requiring Investigation
IPC	Infection Prevention and Control
CSCE	Clinical and Social Care Effectiveness
Med Dev	Medical Devices
MM	Medicines Management
CPRG	Clinical Policy Review Group
SPCWG	Safer Patient Care Working Group

Appendix B



*** Heads of Service:**
Head of Adult Community Services,
Head of Children and Young People's Services,
Head of Specialist Community Services,
Head of Community Services Programmes,
Head of Adult MH Community Services,
Head of Older Person's MH and LD Services,
Head of MH Inpatient Services.
Medical Director
Operational Directors (CH and MH/LD)
Chief Pharmacist

Appendix C

NICE Guidance Compliance Assessment Form

NICE Ref No: **NICE Guidance Title:**

Date Published:

Reviewed By: **Job Role:**

Date of Review: **Review Updated:**

Overall Level of Compliance: *(please tick one box)*

Not Relevant		Partial Compliance	
Full Compliance		Non Compliance	

Key Priorities for Implementation: *(include **all** key priorities identified by NICE, and then assess status; add/remove rows as required)*

No.	Key Priority	Applicable Services	Status (0-3)	Evidence
1				
2				
3				
4				
5				

No.	Key Priority	Applicable Services	Status (0-3)	Evidence
6				
7				
8				
9				
10				

Other Service-specific Implementation: *(Ref: = relevant NICE guidance paragraph number; add/remove rows as required)*

Ref.	Area of Guidance	Applicable Services	Status (0-3)	Evidence

Status descriptions

0 Not relevant
1 Current practice is judged to be already compliant and no action required
2 Compliance is compatible with existing resources but a change of practice is needed to comply
3 Current practice is judged to be non-compliant and action is required to implement the guidance

Action plan: *(add an action for all key priorities/other service-specific areas of guidance with a Status of 2 or 3; use the "No./Ref." column to cross reference all actions to the appropriate key priority/other service-specific area of guidance; each action may be cross referenced to one or more key priority/other service-specific area of guidance"; add/remove rows as required)*

No./ Ref.	Action required	Person Responsible	Target date	Progress to date	Date completed

Appendix D

ACTION PLAN TEMPLATE

Immediate Actions						
Item	**Action Required**	**Lead Responsibility**	**Target Date for Completion**	**Progress and Comments**	**RAG Rating**	

Key to RAG Rating

- double green achieved;
- green/amber work is in progress in line with target date;
- amber/amber initial work has commenced appropriate to target date;
- amber/red minimal or no work has commenced in this area due to the long lead time;
- red/red actions have not been achieved by the target date.