EXTERNAL AGENCY VISITS INSPECTIONS ACCREDITATION NATIONAL CONFIDENTIAL ENQUIRIES AND HIGH LEVEL ENQUIRIES (Management of)

NGH-PO-505

Ratified By:	Procedural Documents Group
Date Ratified:	December 2013 Chair App Oct 2010
Version No:	1.4
Supercedes Document No:	NGH-PO-250 (2009) Responding to External Inspections and NGH-PO-253(2009) Best Practice National Confidential Enquiries.
Previous versions ratified by (group & date)	Not applicable
Date(s) Reviewed:	December 2013
Next Review Date:	December 2016
Responsibility for Review:	Quality Assurance Manager
Contributors:	Governance Facilitators Clinical Effectiveness and Audit Manager/ Deputy Medical Director.

NHSLA POLICY

CONTENTS

Version Control Summary

Version	Date	Author	Status	Comment
1.4	December 2013	Jackie Dodds	Governance Manager (interim)	Chair Approved

SUMMARY

This policy provides a documented process for preparing and responding to recommendations and requirements arising from external agency visits, inspections and accreditations specific to the organisation and National Confidential Enquiries (NCE) /Enquiries are taken into account, implemented and monitored.

External Agency Visits, Inspections and Accreditations specific to the organisation

National Confidential Enquiries/High level Enquiries

Executive Director

Identifies Lead committee and nominated lead

Nominated Lead

Providing a summary briefing of the initial findings of the specific external agency inspection, review, accreditation, National Confidential/ High Level Enquiry to the identified committee/group, highlighting any areas identified as being high risk or of media interest;

On receipt of the report following the specific external agency visit, inspection or accreditation, ensure that all information in the report is accurate;

Carry out gap analysis and risk assessment for activities identified in the report recommendations and, as appropriate, enter on the risk register;

Write report and action plan to address any recommendations made. Report is to be given to the lead committee who will determine the frequency of monitoring of progress with the action plan.

Lead Committee

Review and approve recommendations and monitor actions. Ensure areas of moderate or high risk have been put on Directorate risk register and escalated to Executive Director.

1. INTRODUCTION

This Policy outlines the Trust's process which provides good co-ordination and evaluation of the work of External Agency Inspections, Accreditations, National Confidential Enquiries and Inspections. It will allow potential gaps in assurance to be identified and addressed. It forms part of the organisations control system and provides assurance to the Audit and the Clinical Quality and Effectiveness Group (CQEG).

2. PURPOSE

The purpose of this policy is to provide a framework within which;

- The outcomes of external reviews, inspections, accreditations and enquiries are reviewed and monitored by relevant board committees and sub committees.
- Action Plans are developed in response to recommendations are monitored by relevant board committees and sub committees.
- Assurances received are recorded against the assurance framework
- Risks identified are assessed and recorded on the risk register.
- To enable the organisation to comply with NHS Litigation Authority standards 1.7 (Responding to external recommendations specific to the organisation) and 5.9 (Best Practice National Conferential Enquiries and Inquiries).

3. SCOPE

This policy applies to staff at NGH, managers and health professionals who are identified leads and contacts for the professional and regulatory bodies.

4. COMPLIANCE STATEMENTS

Equality & Diversity

This policy has been designed to support the Trust's effort to promote Equality and Human Rights in the work place and has been assessed for any adverse impact using the Trust's Equality Impact assessment tool as required by the Trust's Equality and Human Rights Strategy. It is considered to be compliant with equality legislation and to uphold the implementation of Equality and Human Rights in practice.

NHS Constitution

The contents of this document incorporates the NHS Constitution and sets out the rights, to which, where applicable, patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with the responsibilities which, where applicable, public, patients and staff owe to one another. The foundation of this document is based on the Principals and Values of the NHS along with the Vision and Values of Northampton General Hospital NHS Trust.

5. DEFINITIONS

External agency	An organisation that is outside the management structure of the Northampton Hospital NHS Trust.
Inspection	An on-site visit to examine systems, interview staff and / or review documentation. This may also involve an off-site review of documentation by an external agency.
Accreditation	Assessment against a defined set of criteria with a minimum standard defined to achieve overall compliance.
National Confidential Enquiry	NCEPOD's purpose is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, and by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.
Compliance	The requirements of a standard or report recommendation required to be met in order to achieve accreditation. Partial compliance implies that the requirement has not been met but there is some progress
Internal Control	A process within an organisation designed to provide reasonable assurance regarding the achievement of primary objectives.

6. ROLES & RESPONSIBILITIES

Individual responsibilities.

Management of the Trust's participation in external assessments, and requests for reports (with action plans) dealing with any recommendations and/or in-year compliance with external agency requirements is delegated from the Chief executive jointly to the Medical Director and Director of Nursing, Midwifery and Patient Services, who share strategic leadership responsibility for Risk Management and Governance. These executive leads have further delegated responsibility to key managers and individuals.

Role	Responsibility
Chief Executive	To ensure overall accountability for compliance with the processes set out within this policy- The CEO will delegate this role to the directors with a responsibility of governance (Medical Director and Director of Patient and Nursing services) – where there is not a predetermined lead they will be responsible for appointing one.
Deputy Director of Nursing/ Governance	Overall accountability for implementation with the processes set out within this policy.
Quality Assurance Manager	Overall responsibility for facilitation implementation and monitoring compliance out with this policy and reporting to CQEG; Liaise with the delegated leads to ensure external visits are coordinated by Maintain of a schedule of review dates (external agency visits, inspections and accreditations); Inform relevant committees of their responsibilities for monitoring and review of reports and actions plans in association with this policy Update Performance accelerator ensuring scheduled dates and reminders are generated. Ensure the Trust wide risk register is populated with accepted risks associated with inspections and reviews.
Executive Directors/ Directorate Managers.	Responsible for; Inform the Deputy Director Of Nursing and Governance of any scheduled, unscheduled or impromptu external visits. All notification must include details of; • Scope, location, date and time, duration, dates and number of those visiting, expected report date. • Inform the chair of relevant sub committees.

Role	Responsibility
Trust Board	For receiving reports/minutes from IHGC and relevant sub committees and taking appropriate action to support any issues with compliance.
Integrated Healthcare Governance Committee (IHGC)	Receive reports by exception from executive leads or their nominated Lead and relevant sub committees. Highlight to the Trust Board potential non compliance or other potential risks that the organisation is unable to mitigate
Clinical Quality and Effectiveness Group (CQEG)	CQEG will serve as Lead committee for the purpose of receiving internal reports concerning matters related to external agencies requirements and recommendations by exception. In particular the CQEG will ensure progress with action plans and management of risks identified by Trust leads. Other specialist Sub-Groups and Committees may be involved by the Trust Lead to assist with the development of action plans and identification of clinical risk, organisational risk, financial risk or other risks. This committee will also escalate any significant risks that cannot be resolved within the required timescales to the IHGC.
Directorate Governance Committee/ Lead committee	Accountable for evaluating the results of **service specific reviews and accreditations** and developing and monitoring action plans to respond to relevant recommendations. Each outstanding partial or non-compliance will be risk assessed by the nominated lead to identify any additional controls required to allow the Trust to become compliant. All areas of non-compliance with a risk score >= 12 will be entered onto a Directorate risk register or the Trust risk register if appropriate or compliance affects more than one directorate. Where a specialist sub-committee or Group makes a recommendation that the Trust remain non-compliant, this should be formally approved by the Integrated Healthcare Governance Committee. Where the Trust Integrated Healthcare Governance Committee agrees to remain non-compliant with certain recommendations these must be brought to the attention of the risk management team for addition onto the risk register.
Executive Director Leads	They will be delegated responsibility by Trust board for external reviews, inspections and accreditations that fall under their areas of direct accountability. Accountabilities include: • Ensuring data requested by external organisations is

Role	Responsibility
	validated and returned within the required deadlines. ▪ Identification of future assessments requirements/dates, for example, by the use of the Concordat scheduling tool[1], and appropriate delegation of responsibility for maintaining a central register of documents related to external agency visits and requirements. ▪ Mapping external agency requirements to ensure efficient, cost effective collation of compliance evidence, and other information between Trust Leads. ▪ Appointment of Trust leads to manage collation of evidence for external agencies, the dissemination of recommendations, the preparation of any action plans and in-year compliance reports required. Executive leads must ensure nominated lead are aware of their responsibilities. ▪ Management of any external media communications in conjunction with the Trust's communication officer. ▪ Maintenance of the Trust Risk register, through the Risk Management team, to ensure recording of high level compliance risks arising from external agencies, reviews, inspections, reports and standard requirements and appropriate in-year monitoring of any related action plans at Board and Directorate levels.
Trust lead (for individual assessments / reports)- These will be appointed by an executive lead. This individual may be nominated by virtue of their position (e.g. Directorate Manager for the service area under review) or as part of their job description (e.g. lead clinician for the individual specialty	Duties would include: Ensure where appropriate, that any electronically held system(s) recording data relevant to external agency visits, inspections and accreditations is kept up to date; Manage collation of in-year compliance evidence, horizon-scanning, submission of information, internal report preparation and the provision of data relevant to any agency specific audit and will disseminate information resulting from any review, visit or report. Maintaining action plans to implement any recommendations made as a result of reviews; Co-ordinating all aspects associated with meeting the requirements of external agencies will ensure that information about the assessment processes is shared with other staff in particular concerning forthcoming site visits and assessments, and later the details of any report received. Information may be

[1] (http://www.concordat.org.uk/homepage.cfm).

Role	Responsibility
	disseminated at Directorate Governance meetings within local team meetings. Delegate aspect as appropriate to other individuals but the lead will retain overall operational responsibility for the in-year management processes. In particular, the Trust lead will be responsible for the accuracy of the information contained in any report or submission made to the external agency and should ensure that the Executive Lead Directors have approved the response before despatch. Following completion of an external assessment, review or publication on a national confidential enquiry/inquiry the Trust lead will prepare a summary report (Appendix 2) to be presented to the relevant trust committee outlining the initial findings including any areas identified as being high risk or of potential media interest and requiring further action. Ensuring action plans are reviewed regularly and evaluated by the nominated committee/group Ensure that there is auditable evidence of compliance with the external agency requirements for which they are responsible. Ensure that any high level risk is reported and appropriately recorded on the Trust's Risk Register. Notify the lead Director of of any compliance concern that may affect the Trust in the event of a spot-check site inspection. The Director will expect an action plan to be prepared and will liaise with others to ensure appropriate action is taken. There is often an interval between the initial assessment and the published report (occasionally over six months). The Trust lead and other relevant individuals should therefore use this time to address, where possible, any areas identified as high risk or of media interest. On receipt of any external agency report, the Trust lead should ensure that all information included in the report is accurate and highlight any areas of potential adverse media interest to Director of Nursing, Midwifery and Patient Services/Medical Director Following publication, a report should be drawn up which lists the Trust's compliance against the recommendations of the report (Example in Appendix 2) and where there are areas of partial or non-compliance that have to be addressed, an action plan and regular progress report(s) should be provided to the lead committee. Compliance with recommendations, especially where this involves a change in practice, should be considered when developing services and audit programmes.

7. SUBSTANTIVE CONTENT

7.1. Process for nominating and appointing an individual to coordinate and report on any external inspections, reviews and National Confidential Enquiries

7.1.1 The Chief Executive will usually be contacted first to advise the organisation of a pending external review, inspection or accreditation visit or publication of a National Confidential Enquiries or High Level Enquiry. If information comes through another route, the Chief Executive should be advised immediately of the intended review.

The Chief executive will advise the Executive Directors responsible for governance (Director of Nursing, Midwifery and Patient Services and Medical Director) in the first instance.

7.1.2 Leads may be nominated by virtue of position for planned reviews and inspections Where a lead has not already been identified the Executive Director will delegate responsibility to a chair of a relevant sub-committee or nominate a lead- they will then inform the Quality Assurance Manager.

7.1.3 For inspections and reviews or National confidential or high level enquiries that are service specific and/or possibly recurrent the clinical director and Directorate Manger will be the joint nominated lead. They are at liberty to delegate key task to other staff but must remain accountable.

7.2. Process for maintaining a schedule of review dates

7.2.1 All external reviews, accreditations and inspections that are planned will be logged on an annual schedule of review dates. The live schedule will be stored on the governance shared drive. Executive Directors will inform the Quality Assurance Manager of Corporate reviews and Directorate leads will inform the Directorates Governance Facilitators/Quality Managers of localised inspections reviews and accreditations. They will in turn log this on the live schedule.

7.3. Process for ensuring organisation responds to requests for data.

7.3.1 Organisations are often subject to request for data as part of national confidential or high level enquiries. Any requests from an external organisation for data should be directed to the Executive Director who is accountable for the data being requested. They are responsible for ensuring the data is validated and returned within the required deadlines. The nominated lead (see 7.1) will collate and organise the collection of the data and before submission it will be approved by the Executive Director.

7.4. Process for identifying and disseminating relevant documents (National Confidential/High Level Enquires)

7.4.1 The Deputy Medical Director will be responsible for identifying National Confidential. Executive Directors will be responsible for identifying High Level enquiries which are relevant to the organisation.

7.4.2 Once the document has been identified the Deputy Medical Director/Executive Director will be disseminated to the nominated lead identify the most appropriate committee within the organisation to monitor compliance.

7.5 Process for undertaking a organisation gap analysis

7.5.1 The nominated lead once they will undertake a gap analysis by reviewing the report to determine compliance within the organisation. The nominated lead will submit this report using appendix 3 to the relevant committee within 2 months where at all possible. Any decision not to implement national confidential enquiry recommendations will be documented in the report and approved by the committee the report is presented to. Reports will be stored on the Governance NAS drive under External reviews.

7.6 Process for maintaining and monitoring action plans to implement recommendations as a result of a review.

7.6.1 Recommendations and actions are recorded in the report by the nominated lead and submitted to the lead committee for approval. Once agreed and approved as relevant to the organisation, the actions proposed are agreed and a review date is agreed by the committee. The review date will be added to the schedule of external review by the nominated lead or they will inform the Quality Assurance Manager/ Compliance Manager. The nominated lead will monitor the progress of the action plan and update the committee at interval specified by that committee or by exception.

7.7 Process for ensuring that Trust risk register is populated with risks identified

7.7.1 When the nominated lead reports the gap analysis to the lead committee they will agree if any gaps need to go on the directorate or corporate risk register.

8 IMPLEMENTATION & TRAINING

The Deputy Director of Nursing and Governance will have overall responsibility for the implementation of this policy. On ratification the Quality Assurance Manager will inform all lead committees of their responsibilities as set out in this policy.

External review accreditation/inspections and response to National Confidential/High Level Enquiries will be a core agenda item on all lead committees.

Nominated leads will be supported by the Quality Assurance Manager and the governance team to understand their responsibilities and to develop high quality reports.

The Governance team will set up a file named external inspection and review under each Directorate on the NGH shared Governance Drive.

9 MONITORING & REVIEW

Dealing with External Recommendations specific to the organisation

Minimum policy requirement to be monitored	Process for monitoring	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
Process for reviewing external recommendations specific to the organisation	Undertake a gap analysis by reviewing the report to determine compliance within the organisation	Nominated lead	As required	Nominated lead/relevant committee	Nominated lead	Nominated lead/relevant committee
Process for reporting on external recommendations specific to the organisation	Report findings to relevant committee	Nominated lead	As required	Nominated lead/relevant committee	Nominated lead	Nominated lead/relevant committee
	Gaps recorded on relevant risk register	Nominated lead	As required	Nominated lead/relevant committee	Nominated lead	Nominated lead/relevant committee
How action plans are developed as a result of external recommendations	Actions are recorded in the report identified in 'c' above.	Nominated lead	As required	Nominated lead/relevant committee	Nominated lead	Nominated lead/relevant committee
How action plans are followed up	Reports made on progress of implementation of actions	Nominated lead	As required	Nominated lead/relevant committee	Nominated lead	Nominated lead/relevant committee
How the organization monitors compliance with all of the above	All external reviews, accreditations and inspections are logged on to the live schedule of reviews	Quality Assurance Manager	Quarterly	Quality Assurance Manager/CQEG	Quality Assurance Manager	Quality Assurance Manager/CQEG

NHSLA POLICY

10 REFERENCES & ASSOCIATED DOCUMENTATION

Audit Commission (n.d) NHS Audit 2008/09: Key lines of enquiry for auditors' local evaluation assessment: NHS Trusts. [online]. London: Audit Commission. Available from:http://archive.auditcommission.gov.uk/auditcommission/sitecollectiondocuments/Downloads/ALEKLOEs0809NHStrusts.pdf [Accessed 17th January 2014]

Care Quality Commission (2010) Guidance about compliance: essential standards of quality and safety. [online]. London: Care Quality Commission. Available from: http://www.cqc.org.uk/content/essential-standards-quality-and-safety [Accessed 17th January 2014].

Department of Health (2003) Building the assurance framework: a practical guide for NHS Boards. London: DH.

Department of Health (2002) Assurance: The Board Agenda. London: DH
Health and Safety Commission (2004) A strategy for workplace health and safety in Great Britain to 2010 and beyond. [online]. London: Health and Safety Executive. Available from: http://www.hse.gov.uk/aboutus/strategiesandplans/strategy.htm [Accessed 17th January 2014]

HM Treasury (2013) Audit and risk assurance committee handbook. [online]. London: HM Treasury. Available from: https://www.gov.uk/government/publications/audit-committee-handbook [Accessed 17th January 2014]

Monitor Compliance Framework 2007 **the latest Monitor compliance framework on their website is 2013/14 but this has now been replaced by the risk assessment framework in October 2013.

Associated documents:

Northampton General Hospital (2013) Risk management. NGH-SY-426.Northampton: NGHT

Northampton General Hospital (2010) Policy on development and control of Procedural Documents. NGH-PO-001. Northampton: NGHT

Appendix 1 EXAMPLE- Report Template Following External Agency Visits, Inspections, Accreditations, National Confidential and High Level Enquires.

Title	
Summary- Provide a synopsis of the inspection/ review/ accreditation or report.	
Gap Analysis- Identify potential gaps within the organisation and document recommendations below. (National Confidential/High level enquiries only)	
Date (of inspection/review/ publication of report)	
Lead Committee	
Lead Director	
Nominated Lead	
Review Date	

Recommendation	**Compliant** **Part Met** **Not met**	**Actions required/ Or document decision no to implement**	**Lead responsible**	**Timescale**	**Assurance**	**Risk** **Low** **Moderate** **High**

External Agency Visits Inspections Accreditations National Confidential Enquiries and High Level Enq
#NGH-PO-505

Business Area
Governance

Person Responsible
Sue Cross

Created
16th January, 2014

Last Review
1st January, 2014

Status
Complete

Next Review
n/a

Screening Data

Name, job title, department and telephone number of the person completing this Equality Impact Assessment

Sue Cross
on behalf of Governance
NGH
Ext 3439

What is the title and number of this policy/procedure/guideline?

Management of;
External Agency Visits Inspections
Accreditations National Confidential Enquiries and High Level Enquires
NGH-PO-505

What are the main aims, objectives or purpose of this policy/procedure/guideline?

2.1 The purpose of this policy is to provide a framework within which;
â€¢
The outcomes of external reviews, inspections, accreditations and enquiries are reviewed and monitored by relevant board committees and sub committees.
â€¢
Action Plans are developed in response to recommendations are monitored by relevant board committees and sub committees.
â€¢
Assurances received are recorded against the assurance framework
â€¢
Risks identified are assessed and recorded on the risk register.
â€¢
To enable the organisation to comply with NHS Litigation Authority standards 1.7 (Responding to external recommendations specific to the organisation) and 5.9 (Best Practice National Conferential Enquiries and Inquiries).

Who is intended to benefit from this policy/procedure/guideline?

This policy applies to staff at NGH, managers and health professionals who are identified leads and contacts for the professional and regulatory bodies.

Is this a Trustwide, Directorate only or Department only policy/procedure/guideline?

Trustwide

Who is responsible for the implementation of the policy/procedure/guideline?

Quality Assurance Manager
Ext 4005

Recommend this EA for Full Impact Analysis?

No

Comments

For staff only

Rate this EA

Low

Organisation Sign-off Data

If the policy is implemented what is the potential risk of it having an adverse effect on equality?

Low Risk - probably will not have an adverse effect on equality

If the policy is implemented what is the potential of it having a positive effect on equality and relations?

Low Potential - probably will not promote equality or good relations

If the potential for risk or positive effect occurred what would be the potential number of people it effected?

A low number of people would be affected

Based on the answers to questions 1 - 3 will this policy promote equality and diversity?

No

Do you have any additional comments or observations about the policy?

No impact

How will the results of the Equality Impact Assessment will be published?

With the policy on the Trust intranet

Have you completed any Action Boxes with recommended actions or changes for completion?

No

If 'Yes' please print off an action plan report along with a copy of the Equality Impact Assessment report to the policy/procedure/guidelines owner, and record below who it has been sent to

If 'No' please print off a copy of the Equality Impact Assessment report to the policy/procedure/guidelines owner, and record below who it has been sent to

Will be uploaded with the Policy and can be seen in the procedural document on the intranet

Please give details of the monitoring arrangements

See section 9 of the policy

Comments

None

Outstanding Actions

No outstanding actions

Northampton General Hospital NHS
NHS Trust

FORM 1a- RATIFICATION FORM - FOR COMPLETION BY DOCUMENT LEAD Note: Delegated ratification groups may use alternative ratification documents approved by the procedural document groups.	
DOCUMENT DETAILS	
Document Name:	External Agency Visits Inspections Accreditations National Confidential Enquiries and High Level Enquires
Is the document new?	No
If yes a new number will be allocated by Governance	N/A
If No - quote old Document Reference Number	NGH-PO-505
This Version Number:	**Version: 1.4**
Date originally ratified:	October 2010
Date reviewed:	December 2013
Date of next review: a 3 year date will be given unless you specify different	**December 2016 (3 Years)**
If a Policy has the document been Equality & Diversity Impact Assessed? (please attach the electronic copy)	Yes
DETAILS OF NOMINATED LEAD	
Full Name:	Jackie Dodds
Job Title:	Governance Manager (Interim)
Directorate:	Medical Directorate
Email Address:	Jackie.dodds@ngh.nhs.uk
Ext No:	4005
DOCUMENT IDENTIFICATION	
Keywords: **please give up to 10 –** to assist a search on intranet	Inspection, inspector, National Confidential Enquiries, Accreditations

GROUPS WHO THIS DOCUMENT WILL AFFECT?
(please highlight the Directorates below who will need to take note of this updated / new policy)

Anaesthetics & Critical Care	Gynaecology	Medicine
Child Health	Haematology	Nursing & Patient Services
Corporate Affairs	Head & Neck - inc Ophthalmology	Obstetrics
Diagnostics	Human Resources	Oncology
Facilities	Infection Control	Planning & Development
Finance	Information Governance	Trauma & Orthopaedics
General Surgery		**Trust wide**

TO BE DISSEMINATED TO: NB – if Trust wide document it should be electronically disseminated to Head Nurses/ Dm's and CD's .List below all additional ways you as document lead intend to implement this policy such as; as presentations at groups, forums, meetings, workshops, The Point, Insight, newsletters, training etc below:

Where	When	Who

Northampton General Hospital NHS
NHS Trust

FORM 2 - RATIFICATION FORM to be completed by the document lead

Please Note: Document will not be uploaded onto the intranet without completion of this form

CONSULTATION PROCESS

NB: You MUST request and record a response from those you consult, even if their response requires no changes. Consider Relevant staff groups that the document affects/ will be used by, Directorate Managers, Head of Department ,CDs, Head Nurses , NGH library regarding References made, Staff Side (Unions), HR Others please specify

Name, Committee or Group Consulted	Date Policy Sent for Consultation	Amendments requested?	Amendments Made - Comments

Existing document only - FOR COMPLETION BY DOCUMENT LEAD

Have there been any significant changes to this document? *if no you do not need to complete a consultation process*		YES / NO
Sections Amended:	YES / NO	**Specific area amended within this section**
Re-formatted into current Trust format	YES / NO	
Summary/ Introduction/Purpose	YES / NO	
Scope	YES / NO	
Definitions	YES / NO	
Roles and responsibilities	YES / NO	
Substantive content	YES / NO	
Monitoring	YES / NO	
Refs & Assoc Docs	YES / NO	
Appendices	YES / NO	

FORM 3- RATIFICATION FORM (FOR PROCEDURAL DOCUMENTS GROUP USE ONLY) **Read in conjunction with FORM 2**			
Document Name:	External Agency Visits Inspections Accreditations National Confidential Enquiries and High Level Enquires	**Document No:**	**NGH-PO-505**
Overall Comments from PDG re the Policy			

	YES / NO / NA	Recommendations	Recommendations completed
Consultation Do you feel that a reasonable attempt has been made to ensure relevant expertise has been used?	Yes		
Title -Is the title clear and unambiguous?	Yes		
Is it clear whether the document is a strategy, policy, protocol, guideline or standard?	Yes		
Summary Is it brief and to the point?	Yes		
Introduction Is it brief and to the point?	Yes		
Purpose Is the purpose for the development of the document clearly stated?	Yes		
Scope -Is the target audience clear and unambiguous?	Yes		
Compliance statements – is it the latest version	Yes		
Definitions –is it clear what definitions have been used in the	Yes		
Roles & Responsibilities Do the individuals listed understand about their role in managing and implementing the policy?	Yes		
Substantive Content is the Information presented clear/concise and sufficient ?	Yes		
Implementation & Training – is it clear how this will procedural document will be implemented and what training is required?	Yes		
Monitoring & Review (policy only) -Are you satisfied that the information given will in fact monitor compliance with the policy?	Yes		
References & Associated Documentation / **Appendices**- are these up to date and in Harvard Does the information provided provide a clear evidence base? Are the reference provided using Harvard Referencing format?	Yes		
Are the keywords relevant	Yes		

Name of Ratification Group **Chair Approval**	Ratified **Yes**	Date of Meeting: **December 2013**