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Policy for the Management of External Agency Visits, Inspections and Accreditations v4.0

Document reference:	POL 036
Document Type:	Policy
Version:	4.0
Purpose:	To set out the principles and framework for the management of external agency visits, inspections and accreditations; including the monitoring of outcomes and any subsequent action plans.
Responsible Directorate:	Safety and Governance
Executive Sponsor:	David Burbridge, Director of Corporate Affairs
Document Author:	Patient Safety and Clinical Governance Lead
Approved by:	Board
Date Ratified:	24/07/2017
Review Date:	24/07/2020
Related Controlled documents	Risk Management Policy and Strategy Health and Safety Policies and Procedures Information Governance Policy Clinical Guidelines Policy Claims Management Policy Management of safety alerts received via the central alert system procedure
Relevant External Standards/ Legislation	Care Quality Commission standards
Target Audience:	All staff involved in External Agency Visits
Further information:	Patient Safety and Clinical Governance Lead

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Version History

Version No.	Date of Release	Document Author	Amendment made
2.0	February 2011	Safety and Governance Team	Update policy ratified by Director of Safety and Governance
2.1	August 2012	Compliance manager	Addition of attachment for communications of unannounced visits
2.2	Sep 2012	Safety and Governance Senior Team	Agreement on rule 43 process
3.0	Dec 2012	Head Nurses	Agreement on process for escalation of unannounced visits
4.0	TBC	Safety and Governance	New template. Alignment with UHB. Updating of Committee names.

Summary of changes from last version:

- The policy has been transferred to the new Trust policy template
- Where possible the HEFT policy has been aligned with the University Hospital Birmingham policy
- Group/Committee names have been updated to reflect the changes in structure

Table of Contents

1. Policy Statement

The purpose of this policy is to ensure the appropriate co-ordination and evaluation of external recommendations arising from external agency visits, inspections, accreditations and peer review/assessment, allowing potential gaps in assurance to be identified and addressed. The Patient Safety Group (PSG) will monitor that action plans are in place.

This document ensures that:

- Key staff involved in the preparation, management and follow up of such reviews are identified and aware of their responsibilities
- Recommendations made by external agencies are implemented within a specified time frame
- Implementation of recommendations is monitored through a formal reporting and reviewing process

2. Scope

This policy applies to all external agency visits, inspections and accreditations in which the Trust participates as outlined below. This is not an exhaustive list.

- NHS Improvement
- Care Quality Commission (CQC)
- NHS Resolution
- Health and Safety Executive
- MHRA
- General Pharmaceutical Council
- United Kingdom Accreditation Service (UKAS) Laboratories
- Health Watch
- Human Tissue Authority
- Radioactive Immunoassay Inspections Environmental Agency (RIA)
- Commissioners reviews
- Health Education England
- Royal Colleges (Commissioned Reviews)
- West Midlands Quality Review Service (WMQRS)*
- NHS CFMS(Counter fraud services)
- PLACE (Patient Led Assessment of Care Environment)
- Environment Agency

The policy does not cover:

- Participation in national clinical audit activity, or national confidential enquiries, these are covered by separate policy documents
- Work undertaken by the Trust's external and internal auditors

3. Definitions

External Agency An organisation that has a legitimate interest in the organisation and with whom the organisation is expected or requested to co-operate (e.g. Care Quality Commission, NHS Resolution, peer review, Clinical Commissioning Groups.

Accreditation Accreditation refers to an external peer assessment process to accurately assess the Trust's level of performance in relation to established standards and to implement ways to improve.

Inspection Inspection refers to an evaluation exercise to check whether the Trust is meeting national and local performance or quality and safety standards, legislative and professional requirements, and the needs of service users. Inspections can be planned or unannounced. An unannounced inspection is thought to give inspectors a real-time picture of the process or area being inspected.

Peer review/assessment Evaluation of professional work by others working in the same field

4. Policy Framework

The following details the procedure for the identification, preparation/support and review of external visits. It also includes the process for the review of recommendations and development and monitoring of action plans following external reviews.

4.1 Nominating a Lead for Specific Visits

The appropriate Divisional Director must ensure that each Directorate appoints a nominated lead for external visits with key areas of accountability and responsibility as outlined in the policy.

4.2 Identification of External Visits

- Nominated Leads for coordinating external visits must inform the Safety and Governance Directorate of th e visit by completing the external visit form which can be obtained from the Trust Intranet under (E) for External Visits. The completed form must be sent to the Safety and Governance Directorate via External Agency Visits generic email address.
- The Safety and Governance Directorate will keep a central register of External Agency visits identifying those that are open, closed and superseded.
- The Safety and Governance Directorate will also keep a register for each Division and a Corporate register, including details on the status of action planning. The divisional and corporate spreadsheets will be reviewed by exception by the Patient Safety Group.
- When an unannounced visit or inspection takes place the Safety and Governance Directorate will add the visit to the Register of External Visits.

4.3 Preparation for the Visit

The requirements of the external organisation undertaking the visit should be determined through communication with that organisation, reading guidance provided by the organisation and understanding statutory requirements. In particular, there is a need to ascertain:

- What the purpose of the visit is and how it will be conducted, including what the format of the visit will be and who the inspectors should report to when entering the hospital.
- What locations they wish to visit.
- Who the inspectors wish to meet and interview.
- What facilities the inspectors will require. This may include offices, meeting rooms, access to Information Technology (IT) equipment or documentation.
- Develop an agenda.

4.4 Preparing Staff

- All staff must be honest and truthful with inspectors.

- Some inspectors will be enforcing officers and have powers similar to the police (HSE inspectors for example). They have a right to reasonable access to all areas and in extreme cases can close down services.
- Staff should be aware of these powers and be supported by the Trust in understanding what will be required of them during the review (the responsibility for preparing for an inspection remains with the Nominated Lead responsible for that area).This may necessitate briefing sessions, training and policy review. Staff to be interviewed as part of the visit should be briefed and supported in this process.

4.5 Collection of Data and Evidence

- The Trust may be expected to produce evidence of compliance with standards or statutory requirements during an external agency visit; this is usually in the form of documentation.

- The Trust must comply with the external organisation's requirements for format of evidence (i.e. hard copy or electronic evidence), and the timeliness of information available to them (i.e. supporting evidence might need to be submitted in advance of the visit, on the day or afterwards).

- A list of information provided to external assessors must be sent to the Safety and Governance Directorate. Any information governance requirements need to be addressed prior to the release of information with the Information Governance Lead.

4.6 Process for Reviewing External Recommendations and Developing Action Plans

- All formal reports must be copied to the Safety and Governance Directorate.
- Where actions are required the Nominated Lead is responsible for creating an action plan, updating that action plan and providing a copy to the Safety and Governance Directorate.
- Where significant risks are identified the risk will need to be recorded on a risk register and reported following the risk register process.
- The Nominated Lead must update the Safety and Governance Directorate on the progress with the outcome of the visit and any action plans developed to meet recommendations.

4.7 Process for Ensuring Actions Plans are followed up

- Action plans and recommendations should be tracked at the appropriate Directorate Governance Meetings by the Nominated Lead and Clinical Director. The actions will be reported and monitored at the Divisional Governance Meetings until completed.
- Progress with action plans will be included in the Quarterly Directorate and Divisional Quality Governance Reports.
- Action plans are approved and closed by the Patient Safety Group.

- The Patient Safety Group Chair or the nominated Deputy and is responsible for monitoring the Register of External Visits ensuring action plans and updates on visits are recorded in the Register.

5. Role and Responsibilities

5.1 Safety and Governance Directorate

The Safety & Governance Directorate will ensure that:

- All external visits are recorded on the Trust Central Database
- Action plans are developed in response to recommendations
- Details of external visits and progress with action plans are included in the Divisional Quality Governance reports
- A quality report is provided to the Audit Committee, usually on a quarterly basis.

5.2 Divisional Directors

The Divisional Director must ensure that each Directorate appoints a nominated lead for external visits with key areas of accountability and responsibility.

5.3 Divisional Management Team

The Divisional Management team are responsible for monitoring progress against all actions developed following external visits at the Divisional Governance meetings.

5.4 Clinical Directors

Individual Clinical Directors are responsible for ensuring that action plans and recommendations are tracked at the Directorate Governance Meetings

5.5 Nominated Lead

- Acting as the primary point of contact with the external agency visit, co-ordinating the preparation for, and the conduct of, the visit and maintaining a positive relationship prior to, during, and following the visit through regular communication.
- Keeping the Safety and Governance Directorate, Clinical Director, Medical or Nursing Director and/or assuring committee/group, up to date with progress.
- Identifying any potential risks to the visit process which may hinder the Trust's ability to comply with external requirements or progress any subsequent recommendations.
- Ensuring that systems are in place to provide evidence of compliance with standards relevant to the visit.
- Providing the Safety and Governance Directorate and assuring committee/group with a summary of initial feedback received from the visit and a copy of the formal report, action plans to implement any recommendations where shortfalls have been identified and, where necessary, any risks associated with non-implementation.
- Ensuring that any risks are included on the appropriate risk register and escalated through the Trust according to the Risk Management Policy.

- Ensure that action plans and are presented and progress reviewed at the Directorate Governance Meetings.

5.6 Guideline and Compliance Advisor

- Maintaining a central database of planned or unplanned visits.
- Provide advice on the development and monitoring of the action plan.
- Maintaining a Divisional and Corporate database of planned or unplanned visits, including the progress of action plans developed.
- Providing updates of action plans developed following external visits, and progress against the actions in the Quarterly Directorate and Divisional Quality Governance Reports.
- Oversee and monitor the implementation of this policy.

5.7 Senior Governance Facilitator

- Providing advice on the development and monitoring of action plans.
- Providing advice and support in relation to the escalation of any risks following any visit.

6. Training

There are no specific training requirements attached to this policy but advice and guidance is provided by the Safety and Governance Directorate.

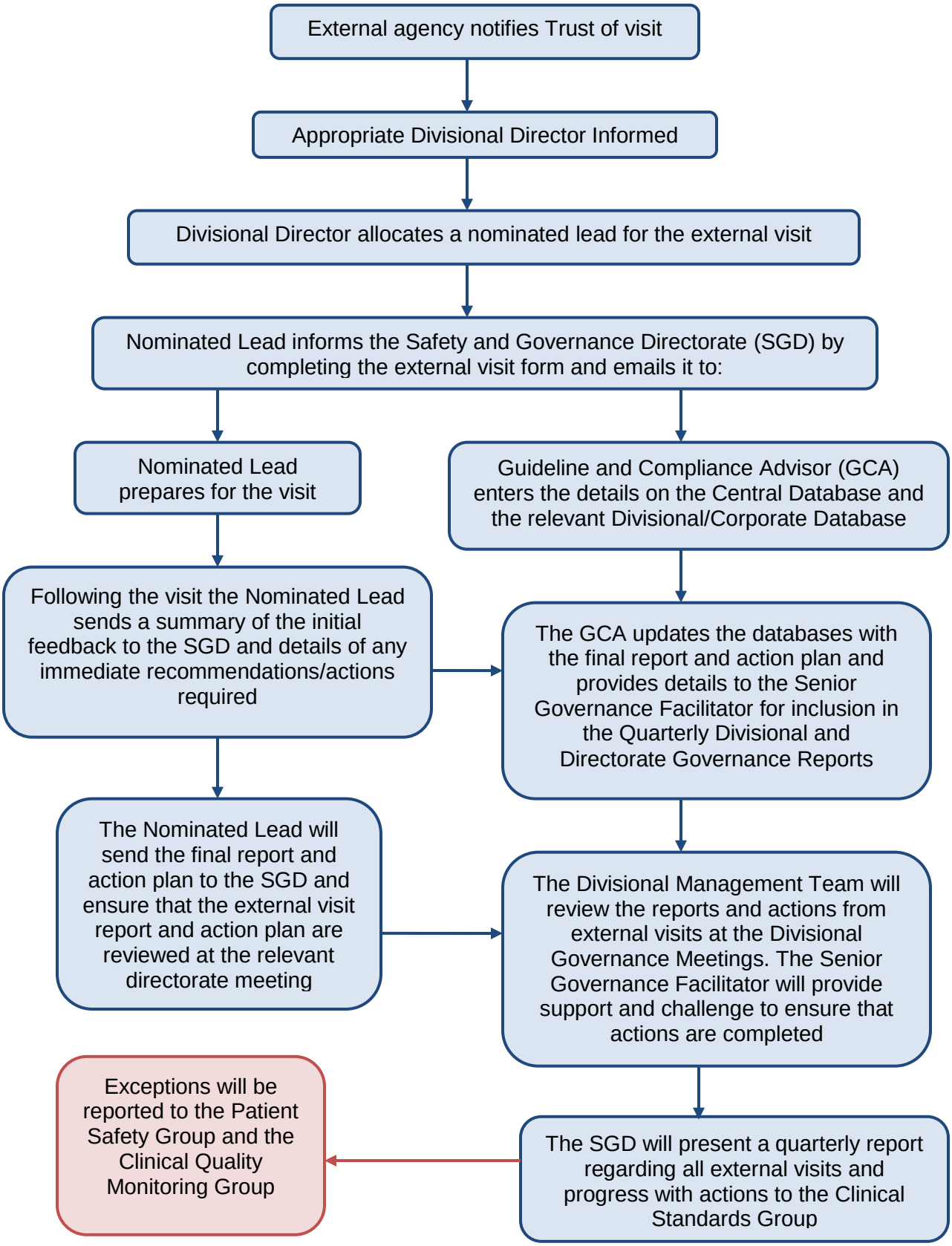
7. Monitoring Matrix

See **Appendix A**

Appendix A – Monitoring Matrix

MONITORING OF IMPLEMENTATION	MONITORING LEAD	REPORTED TO PERSON/GROUP	MONITORING PROCESS	MONITORING FREQUENCY
All external visits are recorded on the Trust Central Database	Guideline and Compliance Advisor	Clinical Standards Group (CSG) and Clinical Quality Monitoring Group (CQMG)	Report presented to Patient Safety Group and CQMG	Quarterly
Action plans are developed in response to recommendations from external visits and progress monitored. Both clinical and corporate visits are escalated to the appropriate Divisional Director.	Appropriate Divisional Director	Clinical Standards Group (CSG) and Clinical Quality Monitoring Group (CQMG). Also reported in to Patient Safety Group.	Development of action plan and evidence of review at Divisional Quality and Safety/Governance meetings.	Monthly

Appendix B - Planned External Visits Process Flow Chart



Appendix C - Unannounced External Visits Process Flow Chart