NHS
University Hospitals of
Derby and Burton
NHS Foundation Trust

TRUST POLICY FOR THE MANAGEMENT OF EXTERNAL AGENCY VISITS, INSPECTIONS, AND ACCREDITATIONS

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Version / Amendment History	Version	Date	Author	Reason	
	1.0	Sept 08	A. Lambourne	New policy – NHSLA requirement	
	2.0	Jan 18	Justine Fitzjohn	Review and Minor amendments	
	3.0	Nov 22	Deb Price	Review and minor amendments	

Intended Recipients:
All clinical staff, Executive Directors, Associate Directors, Trust Board and Heads of Nursing, Heads of Services.

Training and Dissemination:
Support will be given to relevant Executive Directors, Associate Directors and Appointed Leads by the Trust Secretary or their nominee. Staff informed via the Intranet.

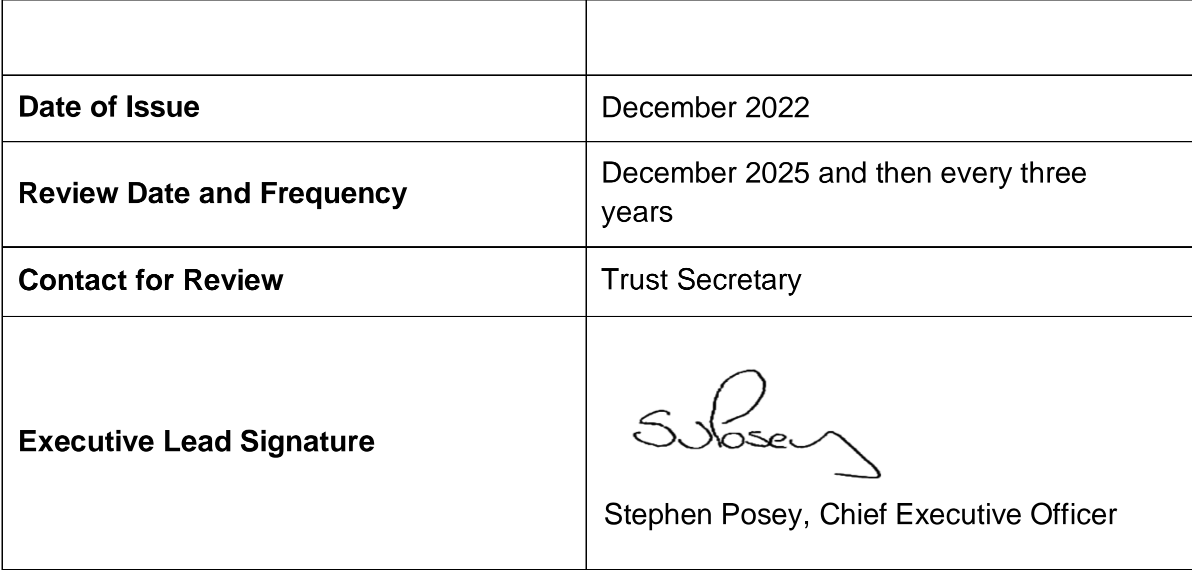
To be read in conjunction with:
None.

In consultation with and Date:
Trust Delivery Group – November 2022

EIRA stage One Completed Yes

stage Two Completed No – Not Applicable

Approving Body and Date Approved	Trust Delivery Group - January 2021 Minor amendments approved by Chief Executive 08.12.2022

Date of Issue	December 2022
Review Date and Frequency	December 2025 and then every three years
Contact for Review	Trust Secretary
Executive Lead Signature	 Stephen Posey, Chief Executive Officer

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TRUSTT POLICY FOR THE MANAGEMENT OF EXTERNAL AGENCY VISITS, INSPECTIONS AND ACCREDITATIONS

1. INTRODUCTION

The Care Quality Commission (CQC), NHS England (NHSE)and other organisations such as the Health & Safety Executive expect Trusts to comply with all recommendations they make from visits and will expect evidence to show there is a robust process for its management within the Trust. This Policy reflects best practice and aims to deliver a consistent approach to the implementation, monitoring and review of recommendations from visits.

2. PURPOSE AND OUTCOMES

This Policy outlines the process for the coordination and evaluation of all external agency visits to the Trust. Any external agency visits including Peer Reviews, Inspections and Accreditations are to be included. The Policy describes the reporting and action planning to achieve the implementation of recommendations following these reviews.

The Trust will have in place a centrally held, internally audited, record of all external visits, inspections, accreditations and peer reviews, which are kept, updated and monitored within specific timescales.

This Policy describes the formal review and reporting processes which includes specified timescales and the identification of Nominated Leads who will manage the implementation and review of recommendations.

It will ensure that:

- The Trust Secretary or their nominee must be advised of all such visits to the Trust and will record any visits carried out on a corporate database ensuring that the Executive Lead or their nominee reports the visit to the appropriate Trust Committee.

- Executive Directors or their nominees will ensure action plans are developed, within agreed timescales, as a result of reviews to facilitate the implementation of recommendations. This will be monitored through the action plan tracker linked to the external visits central database

- Compliance with implementation of recommendations will be monitored and reviewed at Quality Assurance Committee or any other relevant designated Committee.

- Where deficiencies occur this will be escalated to the Executive Leadership Team or other appropriate Committee for scrutiny and action planning to rectify any deficiencies.

- Where it has been agreed that the Trust will not implement recommendations the reasons will be noted and any identified and agreed risks will be added to the Trust Risk Register.

3. DEFINITIONS USED

External Agencies – External agencies and organisations which undertake assessments of the Trust systems and processes against a set of standards e.g. CQC, NHSE, NHSI, and HSE.

Peer Review – The objective evaluation of the performance of a professional or technical service by qualified experts in the same field.

Accreditation – Audit and review by internal and external bodies, which are required to deliver assurance to the Trust Board that the services being delivered by the Trust are fit for purpose and achieving the desired outcomes as laid down by Trust strategies and policies.

Inspection – A visit from an external body to ensure the Trust is meeting statutory requirements e.g. CQC, NHS Resolution, , Fire Service, Health and Safety Executive, Environmental Health Agency.

Internal Controls – The instigation of an Internal review of systems and processes to improve service quality or safety e.g. Audit, Serious Untoward Incident or Complaint investigations.

4. KEY RESPONSIBILITIES/DUTIES

4.1 Trust Board

The Trust Board is responsible for assuring that services delivered by the Trust are fit for purpose and of a high quality as outlined in all relevant local and national standards.

4.2 Quality Assurance Committee

The Quality Assurance Committee has the overarching responsibility for the management and reporting of this process. The Committee will receive reports on all visits to the Trust which will include those areas where the Trust was non-compliant and where any required actions remain outstanding.

Where necessary the Quality Assurance Committee will request a further report from the Executive Lead or their nominee then determine whether any specific matter should be reported to the Trust Board.

4.3 Chief Executive

The Chief Executive has the ultimate responsibility for the process of managing and responding to these visits and enquiries effectively, efficiently and for the appropriate delegation of responsibilities.

4.4 Executive Directors

The Executive Directors have specific responsibility for ensuring that all external visits are notified to the Trust Secretary directly and via reports to the Quality Assurance Committee additionally monitoring / reviewing the outcomes from all external visits through the relevant governance committees.

4.5 Appointed Lead

An individual will be nominated / appointed by the relevant Executive Director to facilitate organisational learning and improvement as a result of these visits. Relevant information will be disseminated throughout the Trust via the Intranet and other communication channels as appropriate. The appointed lead will be responsible for verifying the identification of the external visitor(s) and informing the relevant department(s) of their attendance.

4.6 Directorate Clinical Governance Committees / Structures

These Committees / Groups are responsible for collating and agreeing reports for Directorate specific reviews to report to the Quality Assurance Committee and will:

- Review summary reports and consider if the identified actions are adequate and appropriate to address the recommendations.
- Produce details of all Action Plans arising from the visits and will highlight any outstanding issues, deficiencies or areas of non-compliance.
- Ensure action plans are consolidated to avoid duplication
- Report to the Trust Secretary or their nominee to ensure that the external visits database can be updated and monitored effectively.

4.7 Trust Secretary

The Trust Secretary or their nominee is responsible for:

- The maintenance of a database on which relevant information relating to the visits will be held including:
    - Organisation Visiting
    - Lead Director
    - Issues identified
    - Risks identified and action taken
    - Link to national recommendations or guidance

- Providing a quarterly report for the Quality Assurance Committee based on the information retained in the database.

5. PROCESS FOR THE MANAGEMENT OF EXTERNAL VISIT

There are three stages within the process, all of which require actions from this with key responsibilities / duties identified in section 4.

5.1 Stage 1 Notification of Visits and Action Planning

The Executive Directors or their nominees have the direct responsibility for advising the Trust Secretary or their nominee of any forthcoming visits. Reporting will be e mail which will be sent to the Trust Secretary or their nomineewho will keep a schedule of visits.

5.2 Stage 2 Appointing a Nominated Lead

The relevant Executive Directors must agree a Nominated Lead as soon as possible after the visit has been notified / agreed.

The Nominated Lead must:

- Provide a summary of the initial findings of the specific external agency visit, peer review, inspection or accreditation to the relevant committee, highlighting any areas of high risk or potential media interest.

- Ensure that when a final report is received that the accuracy of information detailed is checked.

- Advise the Trust Secretary or their nominee regarding which Committee / Group had reviewed the visit report, what actions had been agreed and the timescales for completion.

5.3 Stage 3 Action Planning

Executive Leads and Associate Directors must agree the final report which must include which Directorate / Trust Group will be responsible for implementing action plans and ensure that copies of action plans and progress reports are available within the agreed timescales.

5.4 Issues of Deficiencies / Non-Compliance

Where there are deficiencies or issues of non-compliance these must be highlighted on the database and in the report to the Quality Assurance Committee. Dependent on the level of non-compliance and the potential impact the decision may be made to add a risk to the Trust or Directorate Risk Register.

6. MONITORING COMPLIANCE AND EFFECTIVENESS

Monitoring Requirement:	The process for maintaining action plans to implement any recommendations made as a result of reviews.
Monitoring Method:	Review of progress against action plans drawn up in response to formal reports from external agencies.
Report prepared by:	Trust Secretary or their nominee
Monitoring Report presented to:	Quality Assurance Committee
Frequency of Report	Quarterly