University Hospitals of Leicester NHS
NHS Trust

External Agency Visits and Recommendations UHL Policy

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Version Control and Summary of Changes

Version	Date	Comment (description change and amendments)
Version V5	Nov. 2021	Appendix B-Schedule of External Visits Account Management removed. No longer relevant. Names of Authors/Responsible individual updated.

INTRODUCTION

1.0 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 their management within the Trust. This reflects best practice and shows a consistent approach to the implementation, monitoring and review of recommendations and will assist in the achievement of the corporate objectives of a safe, high quality service.

1.1 This policy outlines the process for the coordination and evaluation of all external agency visits to the Trust. This includes Peer Reviews, Inspections and Accreditations. The policy describes the reporting and action planning to achieve the implementation of recommendations following these reviews.

1.2 The Trust is also required to ensure that there is a centrally held schedule of all external agency visits, inspections, accreditations and a peer review, which is kept updated and monitored within specific timescales.

1.3 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.

1.4 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.

2.0 OBJECTIVES

2.1 The purpose of this policy is to ensure there is a clear and consistent approach for the management of external agency visits, inspections, accreditations and reviews across the Trust. The policy will minimise the burden on the organisation by reducing duplication and will allow potential gaps to be identified and addressed.

2.2 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.
- Where it has been agreed that the Trust will not implement recommendations the identified and agreed risks will be added to the Trust Risk Register.

2.3 To provide clarity a flow diagram is provided in Appendix A outlining the steps to follow for the reporting and monitoring of external visits.

3.0 SCOPE

3.1 This policy applies to all Trust staff and applies whenever an external agency inspects the Trust for the purposes of accreditation. There are a number of external agencies that review, inspect and accredit UHL. These reviews may be at Clinical Management Group (CMG) or corporate level.

3.2 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 Quality Governance.

4.0 DEFINITIONS

4.1 Although not an exhaustive list the following are included within the scope:

External Agencies	External agencies and organisations which undertake assessments of the Trust systems and processes against a set of standards e.g. the Care Quality Commission and the Human Tissue Authority.
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. Fire Service, Health and Safety Executive, Environment Agency.

Internal Control	Internal control refers to the Trust's systems for reviewing its services, practices, risks and other aspects of performance to achieve organisational objectives. This includes review by auditors (internal and external).
Inquest Findings	HM Coroners have a remit to make reports to prevent future deaths. On receipt of a Regulation 28 letter, a written response must be submitted by the Trust within 56 days or an agreed extension period.

5.0 ROLES AND RESPONSIBILITIES

5.1 Chief Executive

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

5.2 Chief Nurse

(a) The Chief Nurse shall be the Executive Director responsible for this policy and shall ensure that the Board is informed of all matters of importance in this area.

(b) The Chief Nurse will delegate to the Director of Quality Governance operational delivery of this policy.

5.3 Director of Quality Governance (DCQ)

The Director of Quality Governance is responsible for:

(a) The maintenance of a schedule on which relevant information relating to the visits will be held. This will include responses from Nominated Leads, Action Plans, timeframes and review dates.

(b) Ensuring action plans are reviewed and evaluated by the nominated committee/group. The frequency of review will be dependent upon the outcome of the visit and level of risk posed. The frequency of monitoring the action plans will be captured on the schedule of external visits.

(c) Liaising with the nominated/appointed lead for each specific external agency visit, inspection or accreditation.

(d) Ensuring that the organisation-wide risk register is populated with risks identified from external agency visits, inspections and accreditations.

(e) Ensuring that a Nominated Lead is agreed with the relevant Executive/CMG Director and that they receive appropriate notification and support to carry out the duties involved.

(f) Ensuring relevant feedback from the relevant Executive/CMG Director to each Nominated Lead.

(g) Ensuring dissemination of relevant information from reports to all areas to facilitate learning and improvements that result from these reviews.

(h) Providing regular reports to the Executive Quality Board.

(i) Providing a quarterly report to Quality Assurance Committee on forthcoming visits and non-compliances.

5.4 Executive Directors

(a) An Executive Director will be the nominated lead for each visit and will be supported by a senior member of the Trust (SRO). Appendix B provides a non- exhaustive list of visits and the corresponding Executive Lead. He/she will have the key responsibility for advising the Director of Quality Governance of all planned visits to the Trust as far in advance as possible.

(b) He/she will be responsible for reporting unplanned visits as soon as possible to the Director of Quality Governance.

(c) Following reviews the Executive Director (or nominated individual) will also address any issues of non-compliance directly with the Nominated Lead and will ensure further action planning to identify and address deficiencies.

5.5 Nominated/Appointed Lead to Facilitate the Visit

(a) Where visits are planned in advance an individual will be nominated/appointed by an Executive Director to lead/facilitate the visit.

(b) He/she will:

- Act as primary point of contact with the external agency and maintain a relationship prior to and following the visit.
- Ensure any operational requirements of the visit are met including collation of evidence of compliance with standards relevant to the visit.
- On receipt of the report following the specific external agency visit, inspection or accreditation, ensure that all the information included in the report is accurate.
- Provide a summary briefing of the initial findings of the specific external agency visit to the Director of Quality Governance and identified committee/group highlighting any areas identified as being high risk or of media interest.
- Carry out risk assessments for activities identified in the report recommendations and, as appropriate, enter on the risk register in line with the UHL Risk Management Policy.

- Develop a report and an action plan to address any recommendations made. This report is to be given to the appropriate group/committee who will determine the frequency of monitoring of progress against the action plan.
- Inform the Director of Quality Governance of impending visits, summary of results and progress with action plan.

6.0 PROCESS FOR THE MANAGEMENT OF EXTERNAL VISITS

6.1 There are 5 stages within the process, all of which require actions from those with key responsibilities/duties identified.

6.2 Stage 1 Notification of Visits

6.2.1 The Director of Quality Governance will populate a schedule of external visits planned for the financial year with details of review dates and this will be presented to a number of Committees on a monthly/quarterly basis.

6.2.2 The Executive Directors have the direct responsibility for advising the Director of Quality Governance of any forthcoming visits.

6.3 Stage 2 Appointing a Nominated Lead

6.3.1 The relevant Executive Director must appoint a Nominated Lead as soon as possible after review dates have been decided.

6.4 Stage 3 Preparing for External Agency Visit

6.4.1 The Nominated Lead(s) will be responsible for liaising with the relevant personnel from the external body and for ensuring that all relevant staff are involved in the necessary preparation and for the visit itself.

6.4.2 The Nominated Lead needs to ascertain

- the purpose of the visit and how it will be conducted
- The format of the visit, who inspectors should report to and produce an agenda/timetable if necessary
- Find out who the inspectors want to meet/interview, what locations they wish to visit and what equipment is needed (e.g. rooms, IT)

6.5 Stage 4 Reporting Findings and Recommendations

6.5.1 On receipt of a report following an external agency visit, it should be checked for factual accuracy and this should be confirmed by the Accountable Executive Lead, Committee or Group.

6.5.2 The Executive Quality Board and other relevant executive committees must then be informed of the key findings and recommendations arising from the visit. This must be arranged in conjunction with the Director of Quality Governance

6.5.3 The accountable executive lead, Committee or Group must ensure that areas for improvement and aspects of good practice that have been identified are shared in the organisation through the use of appropriate forums and established communication channels. This includes reporting the outcome to the Director of Quality Governance who will update this information on the schedule of external visits.

6.6 Stage 5 Action Plan Development and Approval

6.6.1 Actions arising from visits will be managed by the clinical / corporate team visited through use of the Trust format action plan (Appendix C).

6.6.2 Action plans should be discussed and approved at an appropriate clinical and / or corporate meeting.

6.6.3 Action plans must clearly state:

- The point requiring actions and how it related to the report (e.g. by reference or page number). Action points should be sufficiently specific in order to avoid the use of terms such as 'ongoing' or 'in progress' in the resolution of the action point.
- The post holder (and their name) responsible for action
- The target date for completion of the action point
- RAG rating

6.6.4 As the action plan develops it must be updated with progress on each action point, stating 'no action' where none has occurred. Where the target date changes this must be clearly shown by scoring through the original date.

6.6.5 Where actions are completed the action plan should state date of completion and include information as to where, and from whom, evidence for completion of action can be obtained, and what form this evidence takes.

6.6.7 The Director of Quality Governance may request a copy of an action plan, to ascertain its status at any time.

6.6.8 Where there are deficiencies or issues of non-compliance these must be highlighted in the Director of Quality Governance's report to the Executive Quality Board. A decision will need to be made whether to add the risk of non-compliance to the Risk Register.

7.0 POPULATING THE RISK REGISTER

7.1 Any risk identified as part of the review should be assessed and entered on the risk register. This will include, but need not be limited to, non-compliances identified as part of an external visit or accreditation.

7.2 These risks will be entered on the risk register by the nominated individual from the clinical / corporate team.

7.3 These risks will be subject to review in line with the Trust's UHL Risk Management Policy.

8.0 REPORTING TO COMMISSIONERS

8.1 The Director of Quality Governance will notify the Commissioners 'real time' of visits by the CQC.

9.0 MONITORING COMPLIANCE AND EFFECTIVENESS WITH THE POLICY AND KEY PERFORMANCE INDICATORS

In terms of monitoring the following will take place:

9.1 Process for nominating/appointing a suitable individual(s) to co-ordinate and report on any reviews carried out by external agencies.

On an annual basis the schedule will be reviewed by the Director of Quality Governance to determine if the relevant information has been completed identifying who the lead officer is. Feedback on the above will be reported to the Executive Quality Board.

9.2 Process for maintaining a schedule of review dates.

On an annual basis the schedule will be reviewed by the Director of Quality Governance to determine dates of reviews are captured and results reported to Executive Quality Board.

9.3 Process for maintaining action plans to implement any recommendations made as a result of reviews.

On an annual basis the schedule will be reviewed by the Director of Quality Governance to determine if information is complete in respect of details of action plans. In addition the Director of Quality Governance will, on an annual basis, take a random sample of action plans to review for completeness/implementation.

9.4 Process for ensuring that the organisation wide risk register is populated with risks identified from reviews.

The CMG boards will ensure that risks identified are entered onto the risk register and reviewed in line with the risk management policy.

10.0 EQUALITY IMPACT ASSESSMENT

10.1 An equality impact assessment screening tool has been completed for this policy. Authors and approvers of action plans need to ensure that actions take full account of the prevailing requirements in relation to Equality Impact Assessments.

11.0 PROCESS FOR REVIEW OF THIS DOCUMENT

11.1 This policy will be reviewed every three years.

11.2 Where the revised document contains significant changes the revised document will be circulated for comment. All revised documents will be approved by the Policy and Guideline Committee.

12.0 VERSION CONTROL AND ARCHIVING

12.1 This document will be uploaded onto the Trust's Policy & Guideline Library (PAGL) and will be available for access by staff. The policy is also accessible via the Trust's Freedom of Information publication scheme on the external website.

13.0 CONTACT DETAILS

13.1 The Director of Quality Governance can be contacted on 0116 258 3381 becky.obrien@uhl-tr.nhs.uk

Steps to follow for the reporting and monitoring of external visits

Organisation is notified of external visit:-

Responsibility of Nominated/Appointed Lead

Inform Director of Quality Governance

Prepare for visit

Visit Occurs

On receipt of the report ensure that all the information included in the report is accurate

Provide a summary report of initial findings to Director of Quality Governance and relevant committee/group, highlighting any areas of high risk

Develop a report and action plan to address any recommendations made and send to the Director of Quality Governance and relevant committee/group.
The committee/group to determine the frequency of monitoring of progress against the action plan

Any risk identified should be assessed and entered on the risk register

Action plan must be updated with progress on each action point and the Director of Quality Governance and relevant committee/group informed

Responsibility of Director of Quality Governance

Add to external agency visits schedule

Monitoring of action plans and updating schedule of progress

Ensuring that the risk register is populated with any risks identified

Ensuring dissemination of relevant information from reports to all areas to facilitate learning and improvements

Provide report to Executive Quality Board

Provide a quarterly report to Quality Assurance Committee on forthcoming visits and non-compliances

TRUST ACTION PLAN TEMPLATE

Appendix B

DATE OF VISIT:	**DATE OF LATEST REVIEW:**	**DATE OF NEXT REVIEW:**	**MONITORING COMMITTEE:**
EXECUTIVE LEAD:		**OPERATIONAL LEAD:**	

Ref	Area for Improvement	Action to be taken	Risks to Delivery	Lead for Action	Action Completion Deadline	Progress RAG	Progress update/comment