Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title:	**Management of and Responses to External Agency Visits, Inspections and Accreditations Policy**
Version:	**5**
Reference Number:	**CO057**

Scope:

This policy applies to all managers and health professionals who are identified leads and contacts for the professional and regulatory bodies for both external and internal scrutiny.

Purpose:

The purpose of this document is to describe visits and reports from external organisations that make recommendations to the Trust. It outlines the Trust's philosophy and a systematic approach to the management of, and response to these visits, receipt of reports and their resulting recommendations.

Requirement for Policy

Good Governance, Best Practice

Keywords:

Visits, Inspections, CQC, External Visitors

Supersedes:

Version 4

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NHSLA changed to NHS Resolution

Changes to examples of external organisations

Owner:

Head of Corporate Governance – Karen Byrne

Individual(s) & group(s) involved in the Development:

This document has been developed in collaboration with the following interested parties:

- Karen Byrne
- Richard Cliff

Individual(s) & group(s) involved in the Consultation:	
The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: • Legal Team	
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Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
CL122	Safeguarding Families
Policy Associated Documents:	
Other external documentation/resources to which this policy relates:	

CQC Regulations This guideline supports the following CQC regulations:	
Regulation 17	Good Governance

Contents Page

1. INTRODUCTION

There are many external organisations that regulate, audit, inspect or review elements of health and social care in England. This policy has been developed to enable the Trust to manage and respond to such visits, inspections and procedures.

This policy will support best practice in integrated governance and will ensure a systematic and consistent approach to the implementation, monitoring and review of recommendations from external regulatory bodies.

Examples of some of the sources of external assurance and scrutiny include:

- Academy of Medical Royal Colleges
- Care Quality Commission
- General Medical Council
- NHS Counter Fraud and Security Management System
- NHS England
- OFSTED
- Post Graduate Medical Education Training Board
- Quality Assurance Agency for Higher Education
- The Department of Health

(NB. This list is indicative, but not exhaustive)

This policy outlines the Trust's philosophy and a systematic approach to the management of, and response to these visits, receipt of reports and their resulting recommendations.

2. SCOPE

This applies to visits from external organisations that make recommendations to the Trust. These visits could be for numerous reasons including:

- Regular inspection to assess the Trust's standards.
- Inspection to assess statutory compliance.
- Arranged visit to award accreditation to the Trust.
- Repeat visits to assess the Trust's progress following previous visits.
- Random visits to assess the Trust's standards.
- In response to incidents or accidents.
- In response to complaints by the public or staff
- To undertake or in response to audits or surveys
- At the request of the Trust as a monitoring or auditing tool.

This policy outlines a systematic approach to allow the Trust to plan and respond to the recommendations and requirements of external organisations.

The recommendations made could be:

- Statutory in that failure to comply would result in prosecution.
- Mandatory in that failure to comply could result in other consequences.
- Advisory in that the Trust will need to decide on compliance based on the risk.

3. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

Chief Executive

All reports will ultimately be received by the Chief Executive who will delegate leadership to the appropriate Director. The Lead Director may in turn nominate a Lead Officer

Role of the Designated Lead Director

The designated Lead director or nominated Lead Officer will:

- Confirm when inspections are scheduled to take place.
- Identify the appropriate committee/group within the Trust structure that will be responsible for the monitoring of the Trust performance and the response to the external organisation.
- Make reports to the appropriate committee/group. Significant risks and assurances will be reported through the Executive Team, who will agree the appropriate action/s.
- Maintain a positive relationship with the external organisation and act as a primary point of contact.

Managing Directors

Will be responsible for facilitating visits to service areas.

4. PROCESS FOR MANAGING THE VISIT/INSPECTION

4.1 Stage 1 – Identifying External Organisations

It is important for the Trust to identify all the organisations that may visit. This will include local visits to specialist departments as well as Trust inspections.

In each case the Lead Director/Lead Officer for the review must be determined.

4.2 Stage 2 – Scheduling Visits

Many of the organisations retain the right to make unannounced visits and inspections. It is therefore important that the external organisations are aware of the identity and contact details for the Lead Officer.

Some unannounced visits can be anticipated, for example following a serious accident, incident or adverse press interest. The Head of Corporate Governance should notify the Executive Directors when this is likely and prepare as if it were scheduled.

4.3 Stage 3 – Planning for Visits

Research

The nominated Lead Officer will determine what will be required by the external organisation through dialogue with the organisation, reading guidance provided by the organisation, understanding statutory requirements and from their own knowledge and expertise.

The Lead Officer will ascertain:

- What the purpose of the visit is and how it will be conducted
- Who the inspectors wish to meet and interview
- What locations they wish to visit
- What facilities the inspectors will require. This could be offices, meeting rooms, equipment, documentation etc.

Preparing Staff

The Lead Officer will communicate with key staff, ensuring that they understand what is required of them (the responsibility for preparing for an inspection remains with Trust managers but they will be advised and supported by the Lead Officer). This may require briefing sessions, training, policy development, etc. Staff to be interviewed should be briefed and supported.

The Trust has a policy of openness and all staff should be honest and truthful with inspections. 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 can interview staff under caution. In extreme cases they can bring individual prosecutions and close down services. It is essential that they are treated with respect and due deference.

Staff should be aware of these powers and will be supported by the Trust in meeting their obligations.

Collection of Data and Evidence

Often the Trust will be expected to produce evidence of compliance with standards or statutory requirements. This is usually in the form of documentation. The Lead Officer and local manager will determine who will lead on the collection and presentation of this documentation. The external organisation may have preferences as to format.

Progress Reporting

The Lead Officer will report to the Lead Director and the appropriate committee/group on progress in preparing for the visit. Additionally, this will be reported through the Trust wide Quality Group.

4.4 Stage 4 – Managing the Visits and Inspections

The Trust welcomes the feedback from inspections and visits, so will engage fully in the process. The Lead Officer will manage the visit so that it is a positive experience for all involved.

The inspector, where appropriate, should be met by the Chief Executive or Lead Director to demonstrate the Trusts commitment. The Lead Officer will escort the inspector and ensure the Trust meets their needs. Hospitality requirements will be arranged.

4.5 Stage 5 – Feedback from Visits and Inspections

Following a visit the Trust will receive feedback from the external organisation. Initially this may be verbal feedback given at the conclusion of the visit. Senior Managers will be available to receive this feedback. It will be recorded by the Lead Officer who will produce a brief report on all aspects of the visit.

The Trust may receive a written order from the external organisation that must be complied with immediately (a HSE inspector may issue an enforcement notice for example). These must be acted on by the Lead Officer and the Lead Director immediately. The Executive Team and Board will need to be informed as soon as possible. This will be the responsibility of the Lead Director.

The external organisation will provide a written report shortly after the visit. This report will need to be presented to the relevant committee/group and reported to the Board. The Lead Director and the Medical Director will be responsible for making this decision.

4.6 Stage 6 – Assessment of Recommendations

Some recommendations must be addressed quickly and completely (where the Trust is found to be non-compliant with statutory instruments, for example). Other recommendations may be advisory and the Trust has some discretion on how it interprets the recommendation. In these cases the recommendation needs to be understood and assessed.

The Lead Officer will produce a list of the recommendations and ensure, through dialogue with the inspector, that each recommendation is understood.

The recommendations will be developed into an action plan. For each recommendation the risk associated with not complying with the recommendation must be determined. The priority and resources committed will be proportional to the risk. Any risk identified will be assessed, utilising the Trust Risk Assessment Tool and submitted to the Risk Register. The recommendations and the associated risks will be monitored through the Trust Wide Quality Group.

4.7 Stage 7 – Development of an Action Plan

The Lead Officer will produce a list of the recommendations and develop them into an action plan.

These action plans must include:

- The source of the recommendation and any associated risk. This could be a reference to the visit or inspection.
- The Directorate responsible for meeting the recommendation and any associated risk.
- A description of the recommendation and any associated risk.
- The uncontrolled risk score. This is the risk if the Trust takes no action.

- Gaps (what is currently in place and absent). The gaps will be replaced by clear actions as the plan is developed.
- Present control measures. This is what we have already achieved.
- Actions will migrate to the control measures list as they are completed.
- Each action must have an individual identified as the lead for its completion.
- Each action must have a target completion date.
- There must be a current risk rating where appropriate. This is the risk score with new control measures in place. There must also be an indication as to whether the residual risk is acceptable. If a risk is accepted this must be agreed by the appropriate Director.
- The committee/group, individual or body that will monitor the action and give the Board assurance that it has been completed.

All unmitigated risks should be placed on the Trust's Risk Register. This should be completed by the manager of the department that owns the risk who also will be the individual identified as the lead for recommendation and completion. For example HSE improvement notices are placed on the risk register.

4.8 Stage 8 – Monitoring the Action Plan and Board Assurance

The action plan will be presented to the appropriate committee/group by the Lead Officer. The committee/group will monitor the plan, ensure its completion and make reports through the Quality Group to the Board. If an action cannot be completed due to lack of resource the risk must be considered at the Quality Group and then at Board level for either the resources to be identified or the risk accepted.

4.9 Stage 9 – Feedback to the External Organisation

It is important that the Lead Officer maintains a dialogue with the external organisation to assure them that their recommendations are being addressed.
Regular feedback on progress shows the Trusts commitment and may prevent an unannounced visit.

When the action plan has been completed and all the recommendations addressed, the Lead Officer will ensure that the external organisation is informed. Letters may be signed by the Chief Executive or a Director to further demonstrate the Trusts commitment. It is important that this correspondence is retained and reported to the relevant committee.

4.10 Stage 10 – Record Keeping

As failure to respond correctly to some external organisations may lead to prosecution it is important that a corporate file is maintained and retained as an evidence record. It should include all correspondence and extracts from the minutes of meetings. These files will be the responsibility of the Lead Officer.

5. EDUCATION AND TRAINING

The Lead Officers must have the competence, skills and knowledge required in order to best represent the Trust with external organisations. Managers and staff may need some basic information, instruction, training and support before visits.

6. IMPLEMENTATION PLAN

The accountabilities of Directors will be determined through the implementation of the Trust's Strategy. From this the Lead Director for each external organisation will be identified. The Lead Directors will nominate the Lead Officers and identify the appropriate committees/groups.

The Lead Officer will follow this policy and report to the relevant committee/group on their visit and inspection schedule. The relevant committees/groups will include their responsibilities for external visits into their terms of reference and work plans.

7. REVISION AND IMPROVEMENT OF THE POLICY / MONITORING

Trust performance with respect to visits and inspections will be monitored by the Quality Group on a monthly basis. As the nature of visits from different external organisations is diverse, performance will be assessed on a case by case basis by the relevant committee. The Head of Corporate Governance will maintain a database of visits, action plans and outcomes reports.

8. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy.

9. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

10. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

11. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

12. MONITORING

The effective application of this policy, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

13. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

14. REFERENCES

The Trusts strategies, policies and guidance are held on the Intranet and can be accessed by all staff through the Trust's Intranet site.

Freedom of Information Act (2000)

Equality Act 2010