Mid Essex Hospital Services NHS
NHS Trust

Management of external agency visits, inspections, accreditations and inquest findings	**Type: Policy** **Register No: 08067** **Status: Public**

Developed in response to:	Best practice
Contributes to CQC Regulations:	12, 17

Consulted With	**Post/Committee/Group**	**Date**
Hilary Bowring	Associate Chief Nurse	27th April 2016
Spencer Humphrys	Associate Director of Operations	27th April 2016
Natalie Butt	Associate Director of Operations	27th April 2016
Mags Farley	Director of Operations	27th April 2016
James Day	Trust Board Secretary	27th April 2016
Carin Charlton	Director of Strategy and Corporate Services	27th April 2016
Peter Davis	Deputy Medical Director	27th April 2016
Professionally Approved By	Cathy Geddes, Chief Nurse	6th May 2016

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Author/Contact for Information	Matthew Grantham, Quality & Compliance Manager
Policy to be followed by (target staff)	All staff
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Related Trust Policies (to be read in conjunction with)	Risk Management Policy Implementation of National Guidance Policy Clinical Audit Strategy & Policy Claims Handling Policy and Procedure Policy

Document Review History

Version No	**Reviewed by**	**Issue Date**
1.0	Helen Clarke	7 October 2010
2.0	Helen Clarke amendments to section 7 - monitoring, update form, insertion of review tool	17th May 2011
2.1	Helen Clarke -amendments to include Coroner's Rule 43 process	24 January 2011
2.2	Helen Clarke - review to take account of changes to NHSLA criteria	29th August 2012
3.0	Helen Clarke	27 September 2012
4.0	Matthew Grantham	25th May 2016
4.1	Helen Clarke – 6 month extension due to MSE harmonisation	20th June 2019

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1.0 Purpose

1.1 As a statutory public body, the Trust is subject to numerous external agency reviews that assess and inspect various aspects of its services.

1.2 The purpose of this policy is to ensure that there is a co-ordinated and consistent approach for managing and responding to external agency reviews specific to the Trust.

1.3 The process ensures that:

- appropriate leads are identified for reviews undertaken by external agencies
- a central schedule of review dates is maintained
- recommendations specific to the organisation are reviewed and reported appropriately
- where possible, the Trust complies with recommendations made following external agency review
- highlighting key risks on the Risk Assurance Framework (RAF)

1.4 Examples of the external agencies that may issue recommendations specific to the organisation are listed in Appendix 1.

1.5 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

2.0 Scope

2.1 This policy applies to all staff employed by the Trust involved in the management of reviews by external agencies.

2.2 The policy applies to all those reviews sought or imposed upon the Trust by external agencies, inspections and accreditations including HM Coroner.

2.3 This policy does not include the process of self-assessment against defined standards or the Internal and External Audit Programme that reports direct to the Audit Committee.

2.4 For guidance on responding to national recommendations that are not specific to the organisation refer to the Implementation of National Guidance Policy.

2.5 For guidance on the management of national clinical audit refer to the Clinical Audit Strategy and Policy.

2.6 For guidance on the management of Solicitors Risk Management Reports refer to the Claims Handling Policy and Procedure Policy.

3.0 Definitions

3.1 External Agency

3.1.1 For the purposes of this policy, an external agency refers to any organisation which has an advisory or regulatory role concerning the corporate or professional activities of the Trust or which has a statutory right to visit, audit or inspect the Trust's premises or activities.

3.2 External Agency Review

3.2.1 External agency review includes all formal visits, inspections, peer reviews, assessments and accreditations undertaken by recognised third parties. Such visits may be for a variety of reasons including:

- regular or random inspection to assess Trust standards
- inspection to assess statutory compliance
- arranged visit to award accreditation to the Trust
- repeat visits to assess the Trusts progress following previous visits
- in response to incidents or accidents
- at the request of the Trust as a monitoring tool

3.2.2 As a result of a visit by such a body, a report is normally produced which identifies any deficiencies and makes recommendations for improvement. These recommendations may be:

- statutory, such that failure to comply would result in prosecution
- mandatory, such that failure to comply could result in other consequences
- advisory, such that the Trust will need to decide on appropriate action

3.3 Accreditation

3.3.1 Accreditation provides independent certification from a recognised external agency that the Trust has achieved a level of compliance with defined standards. For the purposes of this policy, it does not include self-assessment standards.

3.4 Inspection

3.4.1 Inspection describes the role of statutory bodies to assess and report on the performance of the Trust.

3.5 Internal Control

3.5.1 Internal control refers to the Trust's systems for reviewing its services, practices, risks and other aspects of performance to achieve organisational objectives.

4.0 Responsibilities

4.1 Chief Executive and Board of Directors

4.1.1 The Chief Executive and Board of Directors are responsible for ensuring systems and processes are in place within the organisation to support effective governance. This includes ensuring the implementation of an effective process for managing and responding to recommendations and requirements from external agency reviews within an agreed timeframe.

4.1.2 Where external bodies directly contact the Chief Executive with notification of a planned visit, the Chief Executive will identify an Accountable Executive Director to oversee the visit. Executive leads will be identified according to their key areas of accountability and responsibility.

4.2 Executive Director Lead

4.2.1 The accountable Executive Director will nominate a lead who will act as a primary point of contact with the external agency and lead on the operational aspects of the visit.

4.2.2 The Executive Director Lead will, with the nominated lead, ensure that any planned or unannounced external agency visits within their area are registered centrally on the schedule of visits.

4.2.3 The Executive Director Lead will nominate a committee or group to oversee progress with a planned visit and review outcome reports.

4.2.4 The Executive Director Lead will be responsible for ensuring that the Executive Team and Board of Directors, are informed and kept up to date with the external agencies visit requirements and Trust progress against meeting them.

4.2.5 Where significant risks to the Trust are identified, the Executive Director Lead must ensure the risk(s) appears on the appropriate Risk Assurance Framework (RAF).

4.3 Nominated Lead

4.3.1 The Nominated Lead will be a person with expertise in the area subject to the external review. This Nominated Lead will be responsible for:

- acting as a primary point of contact with the external agency and maintaining a positive relationship with them prior to and following the visit through regular communication

- ensuring any operational requirements of the visit are met including collation of evidence of compliance with standards relevant to the visit

- keeping the Executive Director Lead up to date with progress, identifying any potential risks to the review process which may hinder the Trust's ability to comply with external requirements or progress any subsequent recommendations

- providing the nominated group and Executive Director Lead with a summary of any initial feedback from the external agency review highlighting any areas identified as being of high risk or media interest

- ensuring the accuracy of the information contained within the external agency review report and discussing any inaccuracies with the identified Executive Director Lead to agree an appropriate response

- providing feedback to appropriate individuals, departments and the nominated group providing the latter with a copy of the formal report when it is issued by the external agency

- responding to the visit findings, which may include the development of a formal action plan to address any agreed recommendations

- undertake a risk assessment where significant non compliances exist and escalating these to the Executive Director Lead and nominated group ensuring significant risks are added to the appropriate risk assurance framework

- provide regular updates to the nominated group

- notify the Quality and Compliance Manager of any planned visits and completing and submitting relevant paperwork pertaining to the visit so that the External Agency Visits Register can be maintained.

4.4 Quality and Compliance Manager

4.4.1 The Quality and Compliance Manager will:

- maintain an up to date electronic register to include a schedule of external review dates and details of all external reviews specific to the Trust including the respective Nominated Lead and committee

- provide quarterly updates on planned visits and concerns to the Clinical Governance Group

- undertake an annual review of the effectiveness of this policy

4.5 Nominated Committee / Group for each specific external agency review

4.5.1 The nominated group is responsible for:

- overseeing plans for the external agency review
- reviewing the recommendations arising from external agency review
- reviewing the draft action plan and considering whether the identified actions and timescales for implementation are appropriate and adequate
- determining the frequency of, and undertaking regular review of, progress with implementation
- consider the risks associated with any non compliances and ensure these are escalated to the Executive Director Lead and recorded on the appropriate Risk Assurance Framework
- where a specific committee / group is not identified, the nominated group will be the relevant directorate / department governance meeting

4.6 Directorate Governance Meetings (DGM)

4.6.1 The DGM will monitor the process reviewing and acting on recommendations from external agency reviews and receive the findings of the annual review of compliance with the policy requirements and monitor progress with any required actions.

4.6.2 The DGM will receive updates from the Quality and Compliance Manager regarding planned visits, reports and recommendations and escalate any significant risks to the Board of Directors.

5.0 Key Requirements for an External Agency Review

5.1 Scheduling Visits

5.1.1 It is important for the Trust to identify all the external agencies that may visit. This will include local visits to specialist departments, such as Clinical Peer Reviews, as well as Trust-wide inspections. A schedule of external agency visits is maintained by the Quality and Compliance Manager within the Clinical Effectiveness Team.

5.1.2 The schedule will be distributed on a monthly basis for update by the nominated leads and to each Directorate within the directorate governance meetings.

5.2 Planning for Visits

5.2.1 It is important that the Trust prepares for a visit to maximise its value and minimise any adverse consequences. In planning for the visit, it is important to

determine what will be required by the external agency through dialogue and review of guidance or statutory requirements.

5.2.2 In particular, there is a need to ascertain:

- what the purpose of the visit is and how it will be conducted
- the format of the day, who the inspectors should report to when entering the hospital – consider developing an agenda and providing hospitality
- who the inspectors wish to meet and interview
- what locations they wish to visit
- what facilities the inspectors will require. This may include an office, meeting rooms, access to IT, equipment or access to Trust documents

5.3 Preparing Staff

5.3.1 All staff must be honest and truthful with inspectors. Some inspectors, such as those representing the Health and Safety Executive, will be enforcing officers and have powers similar to the police. They have a right to reasonable access to all areas and in extreme cases can close services. Staff should be aware of these powers and will be supported by the Trust in understanding what is required of them during the review. Staff to be interviewed as part of the visit will be briefed and supported in this process.

5.4 Unannounced visits

5.4.1 The CQC could arrive unannounced at any time to inspect the Trust, see appendix 3 for the management process for CQC unannounced visits.

5.4.2 The Executive Director Lead or Nominated Lead should ensure that all relevant staff are alerted to the visit and that the central register of external agency visits is updated to reflect any unannounced visits that occur.

5.4.3 To confirm the identity of a CQC Inspector, genuine CQC inspectors carry ID badges that include:

- a photograph of the inspector on the front.
- a copy of their warrant on the reverse.
- the signature of the CQC Chief Executive David Behan (older ID badges may have the signature of Cynthia Bower).

5.4.4 If staff are unsure about the identity of an inspector, contact the CQC Enquiries Team on 03000 616161. The CQC team can check the inspector's details before they are allowed on Trust premises**.**

5.5 Feedback from External Agency Visits

5.5.1 Following a visit the Trust will receive feedback from the external agency. Initially this may take the form of verbal feedback given at the conclusion of the visit. Where this is the case, Senior Managers, ideally the identified Executive Director Lead and the Nominated Lead must be available to receive and note this feedback.

5.5.2 Formal feedback is often received sometime after the visit in the form of a written report. In some instances the Trust is given a limited timescale to comment on the final report and recommendations, or identify factual inaccuracies. Wherever possible, the Trust should engage in this process and welcome the opportunity to feedback to the external agency.

5.5.3 The Quality & Compliance Manager is the nominated person to receive formal feedback from CQC inspection visits.

5.6 Reviewing and Reporting on External Recommendations

5.6.1 In many cases an external agency visit will result in a number of recommendations for the Trust to action. Some recommendations must be addressed quickly and completely, for example where the Trust is found to be non-compliant with statutory requirements and an improvement notice issued. These must be acted on immediately and the Executive Team and Trust Board must be informed as soon as possible.

5.6.2 Other recommendations may be advisory and the Trust has some discretion on how it interprets the recommendations.

5.6.3 The Nominated Lead must submit the report or a summary of the findings to the nominated group for review.

5.6.4 A summary of the findings will presented within the Directorate Governance Meetings (DGM's) and the Clinical Governance Group (CCG).

5.6.5 Where the Trust is non compliant with agreed recommendations and this represents a significant risk, this must be added to the directorate or department Risk Assurance Framework (RAF) in accordance with the Risk Management Strategy and Policy.

5.6.6 In some cases, the Trust may choose to accept the risk and not fully meet the recommendation. There should be documentary evidence of any response recorded in the minutes of the nominated group. Where non-action creates a risk, this should be added on to the Risk Assurance Framework (RAF).

5.6.7 Preventing Future Death Reports (formerly Coroners Rule 43 letters) are received by the Chief Executive Officer who appoints Chief Medical Officer to identify a named lead to review and develop the Trust response within 56 days. The Chief Medical officer will also nominate a group to review the Preventing Future Death reports. The Trust response and progress with any identified

actions will then be recorded on the DATIX system against the original DATIX investigation.

5.6.8 Please complete Part 1 of the External Agency Review Update Form (appendix 4) and return to the Quality & Compliance Manager.

5.6.9 Refer to the flowchart (Appendix 2) for dealing with external recommendations specific to the organisation.

5.7 Action Plan Development and Follow-up

5.7.1 All recommendations agreed by the relevant Trust committee or group must be developed into an action plan. For each recommendation there should be:

- a description of the recommendation
- clear actions to address the gaps
- an individual identified as the lead for implementation of identified actions
- a target completion date

5.7.2 The action plan will be approved by the nominated Executive Lead / Trust group and updates provided at an agreed frequency.

5.7.3 It is good practice that following a visit, dialogue with the external agency is maintained to assure them that their recommendations are being addressed.

5.7.4 When the action plan has been implemented and all the recommendations addressed, the nominated group should consider whether to formally inform the external agency.

5.7.5 Upon completion of the action plan notification to the DGM and CGG will be provided.

5.7.6 Please complete Part 2 of the External Agency Review Update Form (appendix 4) and return to the Quality & Compliance Manager.

5.7.7 Refer to the flowchart (Appendix 2) for dealing with external recommendations specific to the organisation.

6.0 Maintaining a Schedule of Visits and Monitoring Implementation of Actions to Address Recommendations

6.1 The schedule of external agency visits is maintained by the Quality and Compliance Manager. This is circulated for update on a monthly basis to nominated leads and Executive Directors.

6.2 Following receipt of a report, leads are required to complete Part 1 of the External Agency Review Update Form external visit update form and return it the Quality and Compliance Manager (see Appendix 4).

6.3 Progress with action plans developed in response to external agency reviews is monitored by the nominated group and the responsible Executive Director Lead on an individual basis.

6.4 Once the action plan has been implemented, the Quality and Compliance Manager should be notified and part 2 of the External Agency Review Update Form should be completed by the Nominated Lead and resubmitted (Appendix 4).

7.0 Monitoring Policy Compliance

7.1 An annual review will be undertaken by the Quality and Compliance Manager to assess the effectiveness of this policy. This will include assessment of the following key performance indicators:

- schedule of external agency visits updated monthly
- executive Lead Director, Nominated Lead and / or nominated group identified for each review
- external agency report submitted to, and recommendations reviewed
- action plan developed where indicated and approved by Executive Lead / group
- implementation of actions monitored by nominated group
- Risk Assurance Framework (RAF) updated if indicated

7.2 The audit findings will be reported to the Clinical Governance Group and Directorate Governance meetings by exception, actions developed to address any key concerns.

7.4 The findings will be reported to the Executive Team and nominated leads for information and action where indicated.

8.0 Communication & Implementation

8.1 The policy will be launched in the Trust's Staff Focus newsletter and made available to staff on the Trust's intranet site and website.

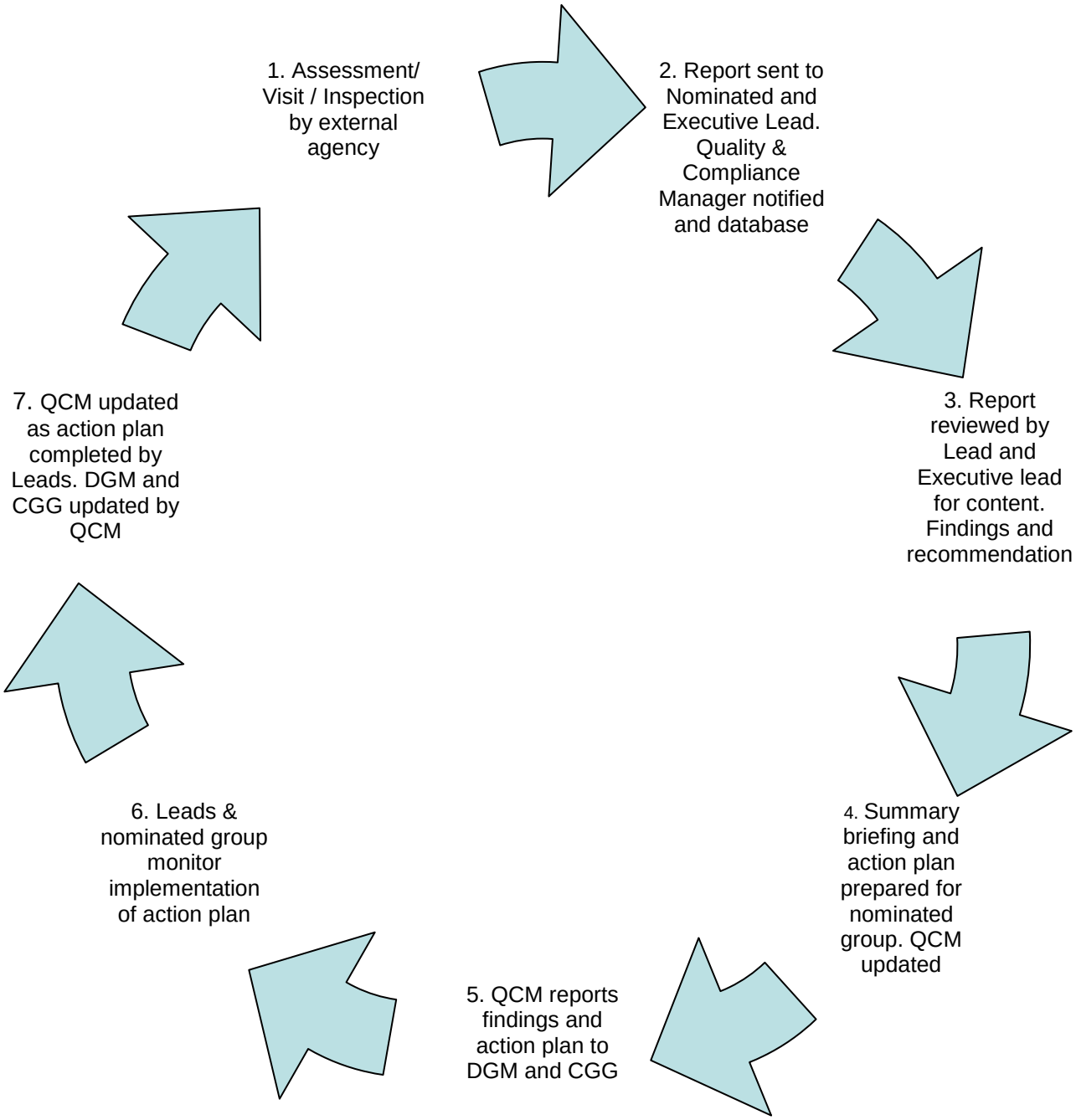
8.2 The policy will be sent to all Executive Directors, Clinical Directors, Heads of Nursing, Heads of Department and nominated leads.

Appendix 1 List of External Agencies

The list is not intended to be exhaustive

Academy of Royal Colleges
Audit Commission
Cancer Peer Review
Care Quality Commission
Conference of Postgraduate Medical Deans
Counter Fraud and Security Management Service
Department of Health
Environment Agency
Fire Authorities
Health and Safety Executive
Human Tissue Authority
Information Commissioners Office
HM Coroner
Joint Agency Review
London & South East England Burn Network
Medicines and Healthcare products Regulatory Agency
NHS Litigation Authority
NHS Protect
NHS Confederation
NHS Health and Social Care Information Centre
NHS Improvement
Patient Environment Action Teams
Postgraduate Medical Education and Training Board
Quality Assurance Agency
UK Accreditation Service

Appendix 2 Flowchart for Dealing with External Recommendations Specific to the Organisation



Please note: *progress reported to the Quality & Compliance Manager (QCM) using the update from (appendix 3)

Appendix 3 - Management Process for Care Quality Commission (CQC) unannounced visits

Management Process for Care Quality Commission (CQC) unannounced visits

The CQC could arrive unannounced at any of the Trust's services at any time. This guidance describes key contacts and actions to be taken when inspectors arrive on site. Inspectors should always introduce themselves and show their identification. If they do not present their identification, please do ask to see it.

During Normal Hours

At Reception or on arrival to the Ward

- Confirm the inspector's identity;
- Clarify which areas they wish to visit, notify the **Lead Nurse(s)** for the areas and request they escort the Inspectors to the Corporate offices;
- **Reception / Nurse in Charge to notify the Switchboard that the CQC ARE ON SITE;**
    - **Switchboard to notify;**
        - **Corporate Office;**
        - **Senior managers via pager alert using the internal incident contact list;**
- The **Lead nurse / Nurse In Charge** to;
    - Ensure patients are made aware of what is taking place (if appropriate);
    - Accompany the inspector(s) to the ward or area they wish to visit;
    - Ensure that the inspector(s) has/have a suitable place to work;
    - Note any concerns raised and email the CEO and Executive Directors with details;
- Members of the senior management team will respond to and manage any immediate concerns raised by the Inspectors; and
- **If the CQC request hard copies of any documents / records, this request should be noted and directed to Quality & Compliance Manager, the point of contact for all data submissions**. **Inspectors should not be provided with hard copies of documentation other than through the primary data contact.**

Out of Hours / Bank Holiday

At Reception or on arrival to the Ward:

- Confirm the inspector's identity;
- Clarify which areas they wish to visit, alert the **Clinical Operations Manager** and request they escort the Inspectors to the area;
- **Clinical Operations Manager to notify the Switchboard that the CQC ARE ON SITE;**
    - **Switchboard to notify;**
        - **General On call manager;**
        - **Executive On call;**
        - **Estates On call;**
- **The General On Call manager should;**
    - Attend the site;
    - Be briefed by Clinical Operational Manager;
    - Ensure the Inspector(s) has/have the required resources;
    - Ensure that patients are made aware of what is taking place (if appropriate);
    - Ensure any immediate concerns raised by the Inspectors have been responded to and managed;
    - The **on call manager** should note the Inspectors initial findings and email the **CEO and Executive Directors with details**; and
    - **If the a request is made for hard copies of any records / documentation, the request should be noted and addressed in normal hours by xxx.**

Contacts Flowchart in normal hours

CQC arrive at reception or ward
Inspectors should be directed to Corporate office

Reception / Nurse in Charge to alert **switchboard** – stating the **CQC are on site**

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Switchboard to alert:
- ✓ **Corporate Office** on ext 4442
- ✓ **Lead Nurse** for the area
- ✓ **Senior managers via pager alert (internal incident distribution list)**

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Corporate Office to alert
- ✓ **Executive Directors**
- ✓ **Clinical Directors for area**

Contacts out of hours

CQC arrive at reception or ward
Reception / Nurse in charge to alert **switchboard** – stating the **CQC are on site**

↓

Switchboard to alert:
- ✓ **Clinical Operations Manager**
- ✓ **On call Manager**
- ✓ **Executive on call**
- ✓ **Estates on Call**
- ✓ **HoM & Supervisor on Call**

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Appendix 4 External Agency Review Update Form

Part 1 of this update form should be completed by the nominated lead after receipt and review of the external agency report.
Please return to Matthew Grantham, via email matthew.grantham@meht.nhs.uk.

PART 1 – to be completed following review of report by the nominated group			
External Agency name:		**Date of Visit:**	
Purpose / scope of review:			
Directorate / Speciality:			
Nominated Lead:		**Date Report received:**	
Nominated Executive Lead:			
Nominated Committee / group:			

1. Has the report been reviewed by the nominated lead?	Yes / No
2a. Has a summary / the report been reviewed by the nominated group?	Yes / No
2b. Please record the date of this meeting	
3. Have recommendations for the Trust been made within the report?	Yes / No
If no to 3, no further action is required. Please return this form to Matthew Grantham	
4. Have recommendations for the Trust been made within the report?	Yes / No
5. Please attach/embed i) Recommendations findings generated by visit ii) Summary / detail below key actions / risks to the Trust	
Please embed documents here or summarise actions / risks	
6. Have these key actions / risks been escalated to the Executive Lead?	Yes / No / NA
7a. Has an action plan with identified leads and defined timescales been developed to address recommendations made within the report?	Yes / No
7b. Has this action plan been reviewed / approved by the nominated group?	Yes / No
7c. At what frequency will the nominated group receive updates?	
8. Have any identified risks been added to the appropriate Risk Assurance Framework? **If no, please give rationale**	Yes / No / NA
9 What is the identified completion date for the all actions?	
Please return by email to matthew.grantham@meht.nhs.uk	

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Part 2 of this update form should be completed by the nominated lead after closing of the actions to address findings/recommendations following an external agency report. Please return to the Matthew Grantham, via email matthew.grantham@meht.nhs.uk.			
PART 2 – UPDATE to be completed following closure of action plan			
External Agency name:		**Date of Visit:**	
Purpose / scope of review:			
Directorate / Speciality:			
Nominated Lead:		**Date Report received:**	
Nominated Executive Lead:			
Nominated Committee / group:			
1. Has the action plan been fully implemented?			Yes / No
2. Has the action plan been fully implemented by the identified completion date?			Yes / No / NA
3. Were updates provided to the nominated group at the identified frequency?			Yes / No
4. Has the nominated group and Executive Lead approved action plan for closure			Yes / No
5. Have the identified risks been updated on the appropriate Risk Assurance Framework?			Yes / No
7. Please attach/embed the completed action plan to this form			*Embed document here*
Comments:			
Please return by email to matthew.grantham@meht.nhs.uk			