Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

External Accreditation, Regulation and Quality Assurance Management Policy

POLICY

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			X
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Position of Person able to provide Further Guidance/Information	Director of Nursing Quality & Governance		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Not Applicable	*Not Applicable*

CONTENTS

APPENDICIES

1.0 INTRODUCTION

The policy aims to provide a clearly articulated process that provides appropriate coordination, evaluation and oversight of the work emanating from external agency visits, inspections and accreditation. Visits are opportunities for staff to highlight the good work of the Trust and promote a positive environment for patients and staff.

The policy sets out the process to ensure that all recommendations made following visits are implemented within a specified time scale, that they are monitored following their implementation, and that there is a formal reporting and reviewing process.

The policy will assist in reducing overlap and allow potential gaps in assurance to be identified and addressed.

2.0 POLICY STATEMENT

The policy will ensure that there is a centrally held record of all external agency visits, inspections and accreditations together with their reports, and remedial action plans. This central record will be kept up to date and will be regularly monitored. Information relating to the preparation for, and outcome of, external agency visits, inspections and accreditations will be shared with the appropriate Trust committees in a timely manner thereby creating the appropriate level of “Executive line of sight”.

3.0 DEFINITIONS/ ABBREVIATIONS

3.1. Definitions

Accreditation	The act of certifying that an institution maintains suitable standards
External Agency	An agency located outside of the Trust
Inspection	A formal evaluation technique, in which requirements are examined in detail by a person, or group from outside the organization to assess against specified standards and identify potential problems.

3.2. Abbreviations

PSC	Patient Safety Committee
CQC	Care Quality Commission
DoH	Department of Health
TMB	Trust Management Board
NHS LA	NHS Litigation Authority
GSU	Governance Support Unit
QC	Quality Committee

4.0 ROLES AND RESPONSIBILITIES

4.1 Responsibilities of the Board of Directors

The process described within this policy, if adhered to, will provide assurance to the Board of Directors that the system designed to manage external agency visits, inspections and accreditations is working effectively and minimises the risk to the organisation from any failures to fully implement the recommendations of previous external agency visits, inspections or accreditations.
The process described by this policy will provide a line of sight for the Board of Directors of the outcomes of all external agency visits, inspections or accreditations as follows:

- The initial verbal feedback from all external agency visits, inspections or accreditations will be received by the Board of Directors in the Library section of its agenda and by exception as an actual agenda item.
- The final report from all external agency visits, inspections or accreditations and the remedial action plan will be received by the Board of Directors in the Library section of its agenda and by exception as an actual agenda item.

Further assurance, if required, may be obtained by commissioning the Executive Medical Director to validate the implementation of certain external agency recommendations.

4.2 Responsibilities of the Chief Executive

The Chief Executive is ultimately responsible for the process of managing and responding to external agency visits, inspections and accreditations effectively and efficiently. This responsibility is delegated to the following committees and nominated individuals:

4.3 Responsibilities of Executive Sponsor (Executive Medical Director)

The Executive Sponsor is the owner of the process and will support the implementation of this policy at Corporate Level

4.4 Responsibilities of the Director of Nursing Quality & Governance

The Director of Nursing Quality & Governance is the appointed lead for the implementation of this policy supported by the Executive Sponsor. Responsibilities are:

- Providing information to the Executive Medical Director on external agencies which may visit/inspect or accredit the Trust, ensuring:
    - nominated leads or deputies have been identified;
    - the accountable committees they report to have been identified
    - the database where the information is stored has been identified; access requirements to are identified as appropriate;
    - logging of evidence relating to the external agency visit, inspection or accreditation onto a central resource (e.g. final report and remedial action plan).
    - access requirements to the Trust's web enabled risk register are identified;
    - ensure the communications team is notified as soon as required
- Informing the Executive Medical Director of all planned and unannounced visits notified to the Director of Nursing Quality & Governance as soon as notification is received
- Support Trust Leads with implementation of this policy

4.5 Responsibilities of Trust Leads (or a named designated deputy)

The Trust Lead for a specific external agency visit, inspection or accreditation (or their deputy) may be nominated / appointed by virtue of their position. As Trust Lead for an external agency visit, inspection or accreditation this responsibility should form part of their roles and responsibilities e.g. lead individual for the service being reviewed.

If notification arrives centrally, of any new accreditation, visit or inspection a Trust Lead will be nominated via the Executive Medical Director/ in liaison with the Director of Nursing Quality & Governance and the Senior Management Team within the Division. The Trust Leads / deputies are responsible for:

- Ensuring that the Director of Nursing Quality & Governance is notified immediately upon receipt of acknowledgement of a proposed visit, inspection or accreditation.
- Ensuring the Executive Medical Director/ Director of Nursing Quality & Governance is notified as soon as possible after an unannounced visit and for recording this on the central resource.
- Preparing the organisation for a visit, inspection or accreditation as highlighted within section 7 of the policy including the provision of a self-assessment highlighting any areas of potential non-compliance for presentation to the Accountable Committee / Group PSC.
- Ensuring evidence is robust as highlighted within section 7 of the policy.
- Providing a summary report of the initial findings arising from the specific external agency visit, inspection or accreditation to the Accountable Committee / Group; Executive Team Meeting and PSC highlighting any areas identified as being high risk or of media interest.
- Where appropriate, 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.
- Carrying out / ensuring methods of risk assessments are completed for activities identified in the report's recommendations and, as appropriate, enter on the risk register.
- Developing an action plan (containing responsibilities and timescales) to address any recommendations made in the external agency's report. This report and action plan must be presented to the Accountable Committee who will determine the frequency of monitoring of progress with the action plan. The report and action plan must also be presented to Quality Committee as well as being sent to the Trust Management Board.
- Ensuring clear communication with the Director of Nursing Quality & Governance over action plan progress, reports, risks or concerns and communications from or with external agencies.

5.0 APPROVAL

This document has been approved by Patient Safety Committee

6.0 DOCUMENT REQUIREMENTS

The following section will set out the process to manage the visit, inspection or accreditation giving guidance on the various stages.

6.1 Identification of External Organisations

The organisation will identify all those external agencies undertaking a visit, inspection or accreditation; this also includes local inspections for specialist services as well as organisational inspections. The details of all external agency visits, inspections and accreditations will be included on the central resource and recorded upon the electronic “External Agency Visits” calendar managed by the Director of Nursing Quality & Governance. The information on the central resource will be reviewed on a 6 monthly basis to ensure it is accurate.

6.2 Scheduling Visits

Director of Nursing Quality & Governance will maintain and update a schedule of visits identified by Trust Leads or nominated deputies. This schedule will be stored on an electronic calendar managed by the Director of Nursing Quality & Governance and details recorded upon a central resource
The Corporate Services directorate will be informed of any unannounced visits by the Trust Leads / deputies during the visit.

- There are only certain external agencies which can make unannounced visits and have the power to access Trust property without permission from the Chief Executive. If in doubt, staff should contact the On-Call Director for guidance.

Where an unannounced visit is to take place out of hours the On-Call Director must be notified. Staff must call the Trust switchboard Tel: 01623 622515 and they will be put through to the On-Call Director.

- Staff must request formal identification to be produced by the external agents prior to allowing them access to Trust property. All external agents should carry a photographic identification card from the agency concerned.
- Following the visit, the Lead Director will be responsible for receiving, and responding to, any report and evaluating its recommendations.

The Executive Medical Director / Director of Nursing Quality & Governance will be informed of any return or subsequent visits / inspections by the Trust Leads and this information will be recorded on the electronic calendar and on the central resource

6.3 Preparation for the Visit

The Trust Lead or Deputy is responsible for:

- Agreeing the date of the external agency visit, inspection or accreditation (if appropriate).
- Ensuring they are aware of and have an understanding of the assessment requirements of the external body visiting, inspecting or accrediting the organisation.
- Preparing the evidence required in the format required by the external body visiting, inspecting or accrediting the organisation.
- Ensuring the assessor has a contact number and a designated place to meet on arrival in the organisation.
- Organising the requirements of the assessor for the external body visiting, inspecting or accrediting the organisation for example a venue, power source and telephone.
- Agreeing a timetable / schedule for the visit, inspection or accreditation with the representative of the external body.
- Liaising with the representative from the external body in regard to comfort / catering requirements.
- Ensuring access to any other staff the assessor from the external body may wish to meet during the visit, assessment or accreditation - produce a timetable if necessary.
- Ensuring the assessor will be able to access the areas required for the visit, inspection or accreditation.
- Ensuring that a venue is available for any feedback activity at the end of the external visit, inspection or accreditation.
- Ensuring any staff required for any feedback activity are aware of when and where they are required to attend for the feedback session, this should include the Director of Nursing Quality & Governance

6.4 Ensuring the evidence is valid

The Trust Lead or deputy should ensure the information provided for external visits, accreditations and inspections is valid and accurate by:

- Ensuring they have a clear understanding of exactly what information has been requested. When requesting information from other parts of the Trust (e.g. the Information Department or GSU) ensure that the request explicitly highlights that the information has been requested by an external body as part of a visit, accreditation or inspection and supply any guidance documentation provided by the external body.
- On receipt of the information, validate the information by following the steps contained within the "Information Validation SOP"

6.5 Procedure for Updating the Organisation

The Trust Lead or Deputy is responsible for:

- Updating the Accountable Committee or Group of the organisation's progress in preparing for the external visit, inspection or accreditation including highlighting any areas of potential non-compliance.
- Providing a self-assessment highlighting any areas of potential noncompliance to PSC approximately 3 months before the visit, inspection or accreditation. This self-assessment should also include any potential reputation issues which may result from the visit, inspection or accreditation.

6.6 Process for Managing the Visit

The Trust Lead or Deputy is responsible for:

- Meeting and greeting the representative from the external body visiting, inspecting or accrediting the organisation.
- Escorting the representative to the venue for the assessment.
- Confirming with the representative that the equipment and facilities previously organised are suitable for the purpose.
- Confirming the timetable in regard to comfort requirements / catering facilities etc as previously agreed.
- Escorting the representative around the organisation as required for the purpose of the visit, inspection or accreditation.
- Introducing the external agency representative to the relevant members of staff as previously identified.
- Where an external agency requests access to patient records e.g. the CQC as part of an inspection, staff must comply with the Health Records Management Policy and Information Governance Policy
- Where a patient record is shared with an external agency an entry to that effect must be made in the patient record.
- Confirming with the representative the arrangements for any feedback activity as previously agreed.
- Ensuring that any feedback activities as previously identified occur.
- Participating in any feedback activity as previously identified (including ensuring notes are taken).
- Confirming arrangements for receiving any further formal feedback information e.g. timescale for receipt of final report etc.

6.7 Receiving and disseminating feedback from the visit

The agency visiting, inspecting or accrediting the organisation will give feedback following the visit; this may initially be an informal summary of findings. This should be followed by the formal report.
The Trust Lead or deputy must provide a summary report of the initial findings arising from the specific external agency visit to the next meeting of:

- The Accountable Committee / group, highlighting any areas identified as being high risk or of media interest. The Accountable Committee / Group will review and escalate this summary report as appropriate.
- Executive Team Meeting (Via Director of Nursing Quality & Governance).

Where appropriate, on receipt of the final report following the external agency visit, inspection or accreditation the Trust Lead or deputy must ensure that all the information included in the report is accurate.

- Following an accuracy check of the final report, the Trust Lead or deputy must present the report and agreed remedial action plan (including responsibilities and timescales) to the next meeting of:
- The Accountable Committee / Group, highlighting any areas identified as being high risk or of media interest. The Accountable Committee / Group must review and agree the remedial action plan and escalate this report as appropriate.

Where possible the Director of Nursing Quality & Governance or nominated deputy should try to attend any closing meetings or feedback sessions.

6.8 Ensuring that the organisation-wide risk register is populated with risks identified from reviews

The Trust Lead or deputy must carry out / ensure that risk assessments are carried out for activities identified in the report's recommendations and, as appropriate, enter on the risk register as per the Trust's Risk Management Strategy.

6.9 Developing the Remedial Action Plan

Once the Trust Lead or deputy has checked the final report from the external agency is accurate they must:

- Develop an action plan to address any recommendations made. The action plan must include who is responsible for each action and the timescale in which the action will be completed. The final report and the action plan must be presented to the Accountable Committee which must approve the action plan and determine the frequency at which the Accountable Committee will monitor progress with the action plan.
- Log the final report and action plan on the central resource (These may also be logged onto local databases if required e.g. Q-PULSE (Pathology software system) with additional information required specific to that department)

6.10 Maintaining action plans to implement any recommendations made as a result of reviews

The Trust Lead or deputy must update action plans as required on the central resource. (These may also be logged onto local databases if required e.g. Q-PULSE with additional information required specific to that department). Action plans must be updated on at least a 6 monthly basis by Trust Leads or their deputies.

The Trust Lead or deputy must update the Accountable Committee on the progress against the action plan. The Accountable Committee must request a copy of the action plan and follow up progress against the action plan at least on a 6 monthly basis.

Any identified risks / issues arising from progress against the action plans must be escalated to risk committee by the Accountable Committee (i.e. any significant delays in the achievement of actions, or issues which mean the achievement of actions is unlikely).

6.11 Receiving assurances that actions/recommendations are being implemented

The Accountable Committee / Group will receive reports from the Trust Lead / deputy:

- Immediately following the visit, inspection or accreditation highlighting the informal / verbal feedback received on the day.
- Immediately following the receipt of the final report from the external agency including the action plan addressing all recommendations made in the final report. The Accountable Committee must agree the action plan.

The Accountable Committee / Group will decide the frequency of the update reports against the action plan it receives from the Trust Lead. This must be at least on a 6 monthly basis.
The Accountable Committee / Group must escalate any identified risks / issues arising from progress against the action plans to PSC (i.e. any significant delays in the achievement of actions, or issues which mean the achievement of actions is unlikely).
PSC will receive reports from the Trust Lead:

- Immediately following the visit, inspection or accreditation highlighting the informal / verbal feedback received on the day.
- Immediately following the receipt of the final report from the external agency including the agreed action plan addressing all recommendations made in the final report.

PSC will decide about which of the external agency visits, inspections or accreditations it requires further assurance regarding progress with the implementation of the recommendations. This enhanced assurance can be provided either by:

- PSC requesting further update reports from the Trust Lead.
- PSC commissioning the Executive Medical Director to validate the implementation of the recommendations with the accountable Service Unit / Accountable Committee.

If PSC commissions the Director of Nursing Quality & Governance (on behalf of the Executive Medical Director) Report to carry out a validation report:

- The Director of Nursing Quality & Governance will meet with the Governance Support Unit to design a validation approach ensuring provision of robust evidence for the [existing] NHSLA criteria standard 1 criteria 7.
- The Executive Medical Director will request assurance from the accountable SU / Accountable Committee regarding the implementation of the recommendations from the external agency visit, inspection or accreditation and validate this assurance.
- The Executive Medical Director will provide a validated report to CQ&GC.

PSC will receive the validated report from the Executive Medical Director and either:

- Sign off the report as providing sufficient assurance;
- Or escalate outstanding concerns regarding the compliance / implementation of recommendations to TMB.

The Quality Committee will receive reports from the Trust Lead:

- Immediately following the receipt of the final report from the external agency including the agreed action plan addressing all recommendations made in the final report.

The Quality Committee will decide about which of the external agency visits, inspections or accreditations it requires further assurance regarding progress with the implementation of the recommendations.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
All external accreditation and regulation bodies need a named Trust Lead	Director of Nursing Quality & Governance	Review of Trust Leads	Annual	Verbal report to Quality Assurance and Safety Cabinet by Director of Nursing Quality & Governance
Risks identified to accreditation or regulation are identified on the Trust risk register	Speciality Trust Lead	Review of Trust Risk Register	In line with Trust Risk Management Policy and scoring	Verbal report to Quality Assurance and Safety Cabinet by Director of Nursing Quality & Governance
Action plans in response to external regulation and accreditation	Speciality Trust Lead	Updated action plans	Quarterly	Trust Lead report to External Regulation and Accreditation Committee

8.0 TRAINING AND IMPLEMENTATION

Implementation of the policy is the responsibility of the Executive sponsor in liaison with the Director of Nursing Quality & Governance, who will develop an implementation plan which will include:

- A workshop being arranged by the Executive Medical Director / Director of Nursing Quality & Governance for all Trust Leads and deputies to ensure their understanding of the responsibilities outlined in this policy.
- Ensuring appropriate access/ or support to [central database] to all Trust Leads or their nominated deputies
- Training/ refresher training to identified Trust Leads and deputies. The training will include:
    - The roles and responsibilities of Trust Leads in line with this policy;
    - Use of central resource where appropriate

The Trust Risk Manager will be responsible for ensuring access to the Risk Register and providing associated training for Trust Leads/ Deputies as and when required.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix 01
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix 02

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- NHSLA Risk Management Standards

Related SFHFT Documents:

- N/A

11.0 KEYWORDS

Accreditation
Regulation
CQC
Quality Assurance

12.0 APPENDICES

Appendix One – Equality Impact Assessment
Appendix Two – Environmental Impact Assessment

APPENDIX 01 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: External Regulation and Accreditation			
New or existing service/policy/procedure: New			
Date of Assessment: 26/04/2021			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	No potential inequalities identified	None
Gender	None	No potential inequalities identified	None
Age	None	No potential inequalities identified	None
Religion	None	No potential inequalities identified	None
Disability	None	No potential inequalities identified	None
Sexuality	None	No potential inequalities identified	None
Pregnancy and Maternity	None	No potential inequalities identified	None
Gender Reassignment	None	No potential inequalities identified	None
Marriage and Civil Partnership	None	No potential inequalities identified	None
Socio-Economic Factors	None	No potential inequalities identified	None

(i.e. living in a poorer neighbourhood / social deprivation)			

What consultation with protected characteristic groups including patient groups have you carried out?

- None

What data or information did you use in support of this EqIA?

- None

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- No

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low level of impact

Name of Responsible Person undertaking this assessment: Candice Smith: Director of Nursing Quality & Governance

Signature:

Date:

APPENDIX 02 – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	