The organisation is a learning organisation and continually strives to maintain and improve upon high standards of safety and quality of care. The purpose of this policy is to provide information and guidance to Trust managers and staff on the management of external agency visits, inspections and accreditations. The anticipated benefit of implementing the management of external agency visits, inspections and accreditations policy is ensuring any recommendations made are considered and or implemented across the trust.

2 Policy scope

This policy applies to all staff working for the Newcastle upon Tyne Hospitals NHS Foundation Trust, or work on behalf of the Newcastle upon Tyne Hospitals NHS Foundation Trust. The process within this policy details how the Trust will maintain a central register of external agency visits, inspections and accreditations which records recommendations and requirements arising from those visits in order to be assured that they have been appropriately responded to.

3 Aim of policy

The aim of the policy is to set out the duties and responsibilities of key individuals and staff in relation to external agency visits, inspections and accreditations. It sets out the arrangements for preparation, recording recommendations and requirements arising from those visits.

4 Duties (Roles and Responsibilities)

4.1 Chief Executive

The Chief Executive has the ultimate responsibility for managing and responding to external agency visits, inspections and accreditations but will assign responsibility to the Medical Director.

4.2 Medical Director

The Medical Director is responsible to the Board of Directors for ensuring an effective system is in place for the management of external agency visits, inspections and accreditations.
4.3 **Director of Quality and Effectiveness**

The Director of Quality and Effectiveness is responsible for the implementation of this policy and for coordinating and reporting on any reviews carried out by external agencies together with ensuring that:

- A schedule of external agency visits, inspections and accreditations review dates is maintained
- Action plans to implement any recommendations made as result of reviews are maintained
- Ensure action plans are reviewed regularly and evaluated by the Corporate Governance Committee.

4.4 **Quality and Assurance Lead**

The Quality and Assurance Lead will be the nominated lead for recording and reporting on all external agency visits, inspections and accreditations. Duties include:

- Setting up and maintaining a central database to record external agency reviews
- Liaise with the nominated/appointed lead for each specific external agency visit, inspections or accreditation
- Receiving and maintaining a record of action plans developed to implement any recommendations made as a result of reviews
- Ensuring the register is populated with risks identified from the external agency visit, inspections and accreditations
- Producing and submitting progress reports six monthly to the Corporate Governance Committee
- Monitoring the effectiveness of this policy.
- Where appropriate liaise with service staff to ensure communication support; such as interpreting, is available to ensure that patients with limited English can be included in inspections
- Where appropriate liaise with specialist staff; such as the Learning Disability Liaison Nurse, to ensure disabled patients can be included in inspections

4.5 **Directorate Manager/Clinical Director**

The Directorate Manager/Clinical Director will be responsible for ensuring their staff are made aware of this policy and ensure that external agency visits, inspections and accreditations planned or occurring within their areas of responsibility are reported to CGARD. They will also be responsible for the dissemination and implementation of agreed actions and the management of identified risks within their areas of responsibility.

4.6 **Corporate Governance Committee**

The Corporate Governance Committee will have overall responsibility for ensuring that all recommendations identified as a result of external agency reviews are assessed and action plans implemented to address any shortfalls. The Corporate Governance Committee will receive progress updates from the Quality and Assurance Lead.
5 Definitions

Regulation 28 reports (Formerly Rule 43 reports) - after the verdict of an inquest, the coroner may write to any person or authority that has the power to take action to prevent future deaths. This is referred to as a Schedule 5, Section 7 Letter (see Coroners and Justice Act 2009 and the Coroners (Investigations) Regulations 2013).

6 Process

6.1 Process for Preparing for and responding to External Agency Visits

The process for preparing for and responding to the recommendations and requirements arising from external agency visits, inspections and accreditations:
- All external agency visits will be notified to CGARD who will register the visit on the Register of External Visits database
- The Director of Quality and Effectiveness will ensure that a lead manager is designated for each external visit, inspection or accreditation
- The lead manager will ensure that information; subsequent report and action plans are sent to CGARD who will populate the External Agency Register
- The department/directorate will facilitate the visit and provide the information required by officers of the external visit team
- The report from the external visit will be initially reviewed by the department/directorate clinical/management team for points of accuracy and for the reasonableness of the recommendations. Any areas of concern should be raised with the external visit team and the reasons noted.
- The Quality and Assurance Lead will ensure that the External Agency Register is updated with the date of the report, a summary of key findings and recommendations and the scheduled date for the Corporate Governance Committee review of the external agency report
- The Corporate Governance Committee will review the report together with key findings and recommendations and will agree any action plans arising from the report.
- Implementation of the actions will be monitored through the Corporate Governance Committee’s review process. It will also agree any principal risks identified from the report and where applicable added to the appropriate risk register.
- A review date for any action plan will be incorporated into the External Agency Register, for review at the Corporate Governance Committee.
### 6.2 External agency visit, inspection and accreditation report

The process for completing the six monthly report to Corporate Governance Committee is as follows:

- CGARD will send out the relevant abstracts from the External Agency Visits Register and action plan to the Directorate Manager / Lead Individuals for specific visits every quarter. This will involve circulation of either a blank template, if the directorate has not previously recorded any visits / assessments on the register, or if previous visits have been indentified, the appropriate section for that directorate will be circulated.

- The Governance Leads must review these and ensure that all the details are up to date. Where they are not they must up-date the details.

- Details should include:
  - any visits that have taken place in the period including recommendations and action plans (see Appendix 1)
  - update on previous recommendations and action plans. If any remain outstanding a reason for this should be given
  - any upcoming visits, accreditations or inspections that the directorate are aware of. These should be written in red to raise awareness that it is a future visit

- The updated register and action plan will then be returned to CGARD within the requested timeframe

- CGARD will update the register and the organisation wide action plan

- CGARD will collate the data and compile in to a six monthly report on behalf of the Director of Quality and Effectiveness.
6.3 Regulation 28 Letters (Formerly Rule 43 Reports)

In the event that a Schedule 5, Section 7 letter (formerly Rule 43 report) is sent to the Trust Chairman or Chief Executive by the Coroner, it will be passed in the first instance by the Directorate Manager concerned for an appropriate response and action plan to be drafted. The Trust Legal Advisor who will have represented the Trust at the Inquest will be aware from attendance at the Inquest that a Schedule 5, Section 7 letter is to be sent to the Trust and will inform the Legal and Committee Services Manager who will, in turn, inform CGARD.

The Trust Legal Advisor will draw up a draft response, on the basis of the information provided by the Directorate, for signature by either the Chairman or Chief Executive. Once complete and signed it will be returned to the Coroner. A response to the report will be required within the statutory 56 day time period and CGARD will monitor compliance to meet this deadline.

6.4 Action Plans

The organisation - wide action plan will be submitted to the Corporate Governance Committee as part of a six monthly report. The report will outline all progress made. Where deficiencies have been identified the Corporate Governance Committee will require a further local action plan to be developed and implemented to ensure completion. Appendix 1 has an example of an action plan that can be used by the Directorates to support them in the action planning process. A detailed explanation for any failure to comply with recommendations must be given to CGARD at the time the progress update is requested. The action plan will be reviewed six monthly by the Committee until each action is complete. Where areas of risk are identified from the recommendations it is the responsibility of the Lead Manager to escalate this risk to the Directorate Risk Register as per the Risk Register - Policy for Management and Use.

7 Training

There are no training requirements associated with this policy.

8 Equality and diversity

The Organisation is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.

9 Monitoring compliance with the policy

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process for reviewing external recommendations</td>
<td>Monitor the number of records entered onto the Register of External</td>
<td>CGARD</td>
<td>Corporate Governance Committee</td>
<td>Six monthly</td>
</tr>
<tr>
<td>Standard / process / issue</td>
<td>Monitoring and audit</td>
<td>Method</td>
<td>By</td>
<td>Committee</td>
</tr>
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<td>--------------------------------------------------------------------------------------------</td>
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<td>---------------------------------</td>
</tr>
<tr>
<td>specific to the organisation</td>
<td>Visits against the number presented to a relevant standing committee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process for reporting on external recommendations specific to the organisation</td>
<td>Monitor the number of external visit records entered onto the Register of External Visits</td>
<td></td>
<td>CGARD</td>
<td>Corporate Governance Committee</td>
</tr>
<tr>
<td>How action plans are developed as a result of external recommendations</td>
<td>Monitor the number of records with actions identified with the number of action plans uploaded to the Register of External Visits</td>
<td></td>
<td>CGARD</td>
<td>Corporate Governance Committee</td>
</tr>
<tr>
<td>How action plans are followed up</td>
<td>Monitor the number of action plans completed and presented at the Corporate Governance Committee</td>
<td></td>
<td>CGARD</td>
<td>Corporate Governance Committee</td>
</tr>
</tbody>
</table>

10 **Consultation and review**

This policy will be reviewed as a minimum on a three yearly basis. It may be reviewed earlier where guidance has changed and therefore the policy may require updating, or monitoring identifies deficiencies in the policy.

The policy has been sent to the Corporate Governance Committee for consultation prior to ratification.

11 **Implementation of policy (including raising awareness)**

Directorate Managers will be advised of the revised requirements via Directorate Managers meeting. Details of the reviewed policy will be included in the Policies and Guidelines newsletter.

12 **References**

- [Coroners and Justice Act 2009](#)
- [Coroners (Investigations) Regulations 2013](#)

13 **Associated documentation**

- [Risk Register - Policy for Management and Use.](#)
Action Plan for local use

**Action Plan**

<table>
<thead>
<tr>
<th>Project title</th>
<th>This should be the name of the External Agency Visit and the date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Action plan lead</th>
<th>Name:</th>
<th>Title:</th>
<th>Contact:</th>
</tr>
</thead>
</table>

Ensure that the recommendations detailed in the action plan mirror those recorded in the “Recommendations” section of the report. The “Actions required” should specifically state what needs to be done to achieve the recommendation. All updates to the action plan should be included in the “Comments” section.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Actions required (specify “None”, if none required)</th>
<th>Action by date</th>
<th>Person responsible (Name and grade)</th>
<th>Comments/action status (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Equality Analysis  Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 18/08/2014

2. **Name of policy / strategy / service:**
   - External Agency Visits, Inspections and Accreditations Management Policy

3. **Name and designation of Author:**
   - Steven Stoker, Clinical Effectiveness Manager

4. **Names & Designations of those involved in the impact analysis screening process:**
   - Corporate Governance Committee

5. **Is this a:**
   - Policy: X
   - Strategy: □
   - Service: □

   **Is this:**
   - New: □
   - Revised: X

   **Who is affected:**
   - Employees: X
   - Service Users: □
   - Wider Community: □

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*

   To ensure that there is a clear process for the organisation to be aware of all external assessments, inspections and accreditations happening within the organisation
   To ensure that there is a clear process for the review and follow up of reports and action plans from external assessments, inspections and accreditations and Rule 43 requests
7. Does this policy, strategy, or service have any equality implications? Yes □ No x

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

This policy is for the review of reports and has no immediate impact on patients, their family or carers. It will positively affect all groups as it is to ensure that all external reports etc. are implemented therefore improving standards of care.
It does affect certain staff as they will have to implement the policy, however it does not relate to any of the protected characteristics.

8. Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups related to this policy/service/strategy – please refer to the Equality fact files available via the link below (add link)</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>Interpreter service provided</td>
<td>This policy relates mainly to staff and the internal processes. However inspectors may wish to speak to patients. <strong>Action</strong> - include reference to Quality and Assurance Lead organising interpreters when required</td>
<td>Yes; provide interpreters so that inspectors can hear from a diverse range of people.</td>
</tr>
<tr>
<td><strong>Sex (male/female)</strong></td>
<td>No evidence of any difference for men and women</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td><strong>Religion and Belief</strong></td>
<td>Chaplaincy Team available for advise</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual orientation including lesbian, gay and bisexual people</strong></td>
<td>No evidence of any difference in relation to Lesbian Gay and Bisexual People</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>No evidence of any difference in relation to Young people. Actions or older people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</strong></td>
<td>BSL Interpreter service provided Learning Disability Liaison Nurse Post</td>
<td>Yes; provide interpreters so that inspectors can hear from a diverse range of people. Liaise with specific staff such as the Learning Disability Liaison Nurse to ensure that disabled people can be included.</td>
<td></td>
</tr>
<tr>
<td><strong>Gender Re-assignment</strong></td>
<td>No evidence of any difference in relation to Gender Re-assignment</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Marriage and Civil Partnership</strong></td>
<td>No evidence of any difference in relation to Marriage and Civil Partnership</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Maternity / Pregnancy</strong></td>
<td>No evidence of any difference in relation to maternity/pregnancy</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

9. Are there any gaps in the evidence outlined above. If ‘yes’ how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement  Yes  No X

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No

PART 2

Print name  S Stoker
(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)