

# The Newcastle upon Tyne Hospitals NHS Foundation Trust

## External Agency Visits, Inspections and Accreditations and Management Policy

Effective: October 2009

Review: October 2012

### 1. Introduction

The purpose of this policy is to outline the Trust approach to preparing for, and responding to, the requirements and recommendations of external agency assessments, inspections and accreditations. This process enables the Board to have assurance that all of these are effectively managed and the necessary actions implemented across the Trust.

### 2. Policy objectives

This policy has been developed to describe:

- the process of nominating an individual to prepare for, coordinate and report on any reviews carried out by external agencies
- how a schedule of assessment and accreditation review dates will be maintained
- how action plans will be implemented and monitored
- the duties and responsibilities of key individuals
- how identified risks associated with the external assessments are identified and recorded onto the risk register
- monitoring of compliance with the policy.

### 3. Policy Scope

This policy will apply to all external agency visits, inspections and accreditations in which the Trust participates.

### 4. Definitions

*External agency* – An organisation with an official advisory or regulatory role which has been mandated to regulate the corporate and professional activities of NHS Trusts.

*Accreditation* – Audit and review activities by internal and external agencies which deliver assurance that services are fit for purpose and are achieving the desired outcomes in accordance with internal and external strategies, policies and performance.

### 5. Roles and responsibilities

#### Trust Board

The Board functions as the main corporate decision making body and considers the key strategic and managerial issues connected with the Trust statutory and other functions. The

Board will therefore need to maintain an overview of the assessment and accreditation process.

### **Chief Executive**

The Chief Executive has the ultimate responsibility for managing and responding to external assessments, inspections and accreditations. Operationally however this responsibility is delegated to the Medical Director.

### **Medical Director**

The Medical Director is responsible for Governance arrangements within the Trust and has delegated responsibility from the Chief Executive for:

- Responding to and ensuring the external agency visits, inspections and accreditations are managed effectively
- communicating updated information about any external assessment or accreditation to the Executive Team and Trust Board
- ensuring that the Trust Board and delegated sub-committees with responsibility for quality, governance and risk receive and consider the reports from any assessment or accreditation events
- ensuring that completed outcomes or exceptions to progress against agreed action plans are reported to the Trust Board via the delegated sub committee
- reviewing identified and emergent risks which are added to the Trust's Risk register as a result of assessment/ accreditation process
- nominating an appropriate individual to coordinate the assessments performed by external agencies
- nominating an accountable committee to oversee the process and ensure that recommendations are acted upon throughout the Trust.

### **Director of Quality and Effectiveness**

Responsible for:

- communicating information regarding key external assessments Trustwide as appropriate and to all personnel likely to be involved with such assessments
- coordinating the Trust response to the external assessments by the NHS Litigation Authority (NHSLA), Clinical Negligence Scheme for Trusts (CNST) and Care Quality Commission in particular and communicating the findings to the Board via the Executive Directors
- ensuring that gaps in assurance are identified and entered onto the Trust Risk Register

- ensuring that the responsibilities of the Quality Standards Manager are discharged.

### **Quality Standards Manager**

Responsible for:

- coordinating and collating the evidence in support of key external assessments in particular NHSLA, CNST and Care Quality Commission
- maintaining the management system for collation of evidence to demonstrate compliance with the key external assessments
- undertaking a review of all other external assessments scheduled and the identification of Assessment Leads for each one
- facilitating progress reports by the Assessment Leads to the relevant Trust Committee against action plans arising from the external assessments and accreditations.

### **Nominated Assessment Leads**

Responsible for:

- informing the Quality Standards Manager of the assessment details for their area including deadlines, requirements, review dates and results
- sending final reports following an assessment or accreditation to the Quality Standards Manager
- maintaining knowledge of the process for their specified assessment and the current Trust compliance status
- identifying local risks which may undermine the success of the external assessments, entering this risk onto the Trust Risk Register as appropriate and communicating those risks to the Executive lead(s)
- contributing to the 6 monthly reports to the Corporate Governance Committee in relation to external assessments and accreditations as necessary
- providing support to the Trust as appropriate to ensure that the recommended actions are undertaken and implemented across the Trust.
- preparing reports and subsequent action plans following assessment and inspection and presenting these to the appropriate local committees.

## **6. Monitoring**

The Director of Quality and Effectiveness and the Quality Standards Manager will monitor the effectiveness of this policy by providing reports on a six-monthly basis to the Corporate Governance Committee detailing the results of any completed external assessments and any outstanding actions to be taken. A summary of external assessments will also be included in the Annual Risk Management report.

The Corporate Governance Committee will receive the reports and where deficiencies have been identified will require an action plan to be developed and implemented to correct these. The action plan will then be reviewed regularly by the Committee until all remedial actions are completed.

Author: Quality Standards Manager

**THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST**  
**IMPACT ASSESSMENT – SCREENING FORM A**

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

Policy Title:	External Agency Visits, Inspections, Accreditations and Management Policy	Policy Author:	Karen Lapworth
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		This policy applies equally to all irrespective of race, ethnicity, nationality, gender, culture, religion / belief, sexual orientation, age or disability.
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4(a).	Is the impact of the policy/guidance likely to be negative? (If "yes", please answer sections 4(b) to 4(d)).	No	
4(b).	If so can the impact be avoided?		
4(c).	What alternatives are there to achieving the policy/guidance without the impact?		
4(d)	Can we reduce the impact by taking different action?		

<b>Comments:</b>	<b>Action Plan due (or Not Applicable):</b>

Name and Designation of Person responsible for completion of this form: Karen Lapworth Quality Standards Manager Date 15th October 2009

Names & Designations of those involved in the impact assessment screening process: Corporate Governance Committee

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

*For advice on answering the above questions please contact Helen Lamont, Deputy Director Nursing & Patient Services, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) [steven.stoker@nuth.nhs.uk](mailto:steven.stoker@nuth.nhs.uk) together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.*