Public – To be published on the Trust external website

Title: External agency visits, inspections and accreditations

Ref: CORP-0041-v4.2

Status: Ratified
Document type: Procedure

Contents

1 Introduction

This procedure, covers the management of all external agency visits, inspections and accreditations within the Trust. It is designed to:

- As far as practicable, minimise disruption to services;
- Ensure that the Trust responds appropriately to findings and recommendations arising from external visits and inspections. Also to ensure that any risks and lessons learnt identified are addressed across the Trust.

This procedure is critical to the delivery of Our Journey to Change and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism. It helps us deliver our three strategic goals as follows:

- This procedure supports the trust to co- create a great experience for all patients, carers and families from its diverse population through ensuring outstanding and compassionate care all of the time by learning from inspection and accreditation feedback to make changes to service delivery.
- This procedure supports the trust to co-create a great experience for our colleagues by ensuring that staff are well led and managed and that their workplace is fit for purpose by using inspection and accreditation feedback to enhance knowledge, skills and practice.
- This procedure supports the trust to co-create a great experience for our partners by providing assurance of high quality, safe and effective care through working innovatively across organisational boundaries to improve services.

2 Purpose

The following principles underpin the procedure:

- Clinical care will not be compromised in any way by external visits and inspections. The privacy and dignity of service users, staff and inspectors will be maintained;
- The Trust and its staff will be supportive of external visits and inspections. Every effort will be made to accommodate reasonable adjustments required to support the protected characteristics of inspectors;
- The Trust will respond positively to findings and recommendations received from external agencies;
- Action taken in response to the findings of an external visit or inspection will be aligned to the Trust's internal control and assurance arrangements and be proportional to the identified risks;
- Accountability for actions to be taken will be clear.

3 Who this procedure applies to

This procedure affects all Trust staff involved in external agency visits, inspections and accreditation visits. Feedback from clinical and corporate staff has been considered in the development of this procedure.

The Procedure supports the Trust to ensure that the Trust values are maintained and are core to external agency, inspection and accreditation visits, so that people affected are treated with compassion and respect and that staff take responsibility for any practice issues.

4 Related documents

This procedure does not directly relate to any other Trust policies.

5 Procedure/ Process

The processes to be followed before, during (if required) and after external visits and inspections are set out in the following flowcharts attached to this procedure:

- Appendix 5 – Process Flowchart 1 – Preparing for Visits/ Inspections (Planned Visits only)
- Appendix 6 – Process Flowchart 2 - Unannounced Visits/Inspections
- Appendix 7 – Process Flowchart 3 – Post visit actions and assurance
- Appendix 8 – Process description for Care Quality Commission Inspection Visits
- Appendix 9 – Process descriptions - Post visit actions and assurance - all unplanned visits

6 Responsibilities

- This Procedure is designed to reflect the Trust's Management and Integrated Governance and Assurance arrangements.
- The roles and responsibilities of those required to support the management of and response to external visits and inspections are set out in Appendix 3.
- Lead Directors, Lead Committees and reporting arrangements are set out in Appendix 4.

7 Terms and definitions

Term	Definition
External agency	• A statutory or non-statutory body with a legitimate interest in the Trust and with whom the Trust is expected or required to co-operate (e.g. the Care Quality Commission).
Compliance	• Demonstration of evidence that practice and /or service delivery is consistent with the agreed standards.
Assurance	• Data or qualitative information that guarantees a specified outcome, standard or criteria.
Accreditation	• Independent assurance from a third party that the organisation has achieved a level of compliance with an agreed set of criteria/standards (e.g. the Royal College of Psychiatrists accreditation programmes).
Inspection	• Describes the role of statutory bodies with a specific remit to assess and report on the performance of the organisation (e.g., Fire Safety). This may be an onsite or virtual visit.

8 How this procedure will be implemented

This procedure will be published via the Trust intranet and external website.

This policy will be shared with all Trust employees via the all staff briefing and through Care Groups.

8.1 Training needs analysis

There are no immediate training needs resulting from this procedure. It is felt that all staff will have the knowledge, skills and understanding to deliver the requirements of the procedure. Any newly emerging training needs resulting from the issue of this procedure will be escalated to the Quality Governance Team and addressed.

9 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Compliance with the procedure's standards will be checked by the Trust's Internal Audit Service using a sampling technique.	The frequency of internal audit will be determined within the Trust's Annual Audit Plan (subject to the approval of the Audit and Risk Committee).	Internal audit findings will be reported to the Quality Assurance Committee.

10 References

TEWV Quality Strategy (Our Journey to Safer Care, Our Journey to Clinically Effective Care)

11 Appendices

12 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	15 February 2023
Next review date	15 February 2026
This document replaces	CORP-0041-v4.1
This document was approved by	Executive Quality Assurance and Improvement Group (EQAIG)
This document was approved	20 December 2022
This document was ratified by	Management Group
This document was ratified	15 February 2023
An equality analysis was completed on this policy on	10 December 2022
Document type	Public
FOI Clause (Private documents only)	N/A

Change record

Version	Date	Amendment details	Status
	6 Jan 2016	Review date extended to 1 July 2017	Withdrawn
	9 May 2018	Full review with minor changes to job titles and governance arrangements	Withdrawn
	12 April 2021	Review date extended to 09 Nov 2021	Withdrawn
4.1	Nov 2021	review date extended to 31 Dec 2021	Withdrawn

4.2	15 Feb 2022	Full review with minor amendments; changed from a protocol to a procedure, updated to current template and updated to reflect restructure (job titles and governance arrangements). Minor amendments and clarifications throughout.	Ratified

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Quality Governance, Nursing and Governance Directorate
Title	External Agency Visits, Inspections and Accreditations
Type	Procedure
Geographical area covered	Trust-wide
Aims and objectives	The aim of this procedure is to set out the Trust's approach to the management of external agency visits, inspections and accreditations, to ensure a consistent approach to sharing key findings and addressing any issues raised.
Start date of Equality Analysis Screening	01 September 2022
End date of Equality Analysis Screening	19 December 2022

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	The procedure benefits all Trust staff in maintaining high quality, safe and effective practices in line with national regulatory standards and evidence-based, best practice guidance. The procedure benefits service users, families and carers in receiving the best possible outcomes of care and high quality service delivery.
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO**

	• **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO**
Describe any negative impacts	Not applicable – no negative impacts identified.
Describe any positive impacts	This procedure enables compliance with key best practice standards which ensure that our services meet the equality and diversity needs of individual service users, families/ carers and staff.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	CQC Fundamental Standards and CQC Quality Statements
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes.
If you answered Yes above, describe the engagement and involvement that has taken place	Previous versions of this procedure have been subject to full consultation. This revised procedure has been subject to review and consultation via the Executive Quality Assurance and Improvement Group. Learning and feedback from service

	users, carers, staff and other stakeholders has been used to inform the development of this revised procedure.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	This procedure may be subject to further consultation as required and future versions will be informed by relevant learning and feedback from services, Groups and Committees.

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	No.
Describe any training needs for Trust staff	None identified.
Describe any training needs for patients	None identified.
Describe any training needs for contractors or other outside agencies	None identified.

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

	Title of document being reviewed:	Yes / No / Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	This document is a procedure.
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	N/A	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	No	There are no training requirements resulting from this procedure.

	Title of document being reviewed:	Yes / No / Not applicable	Comments
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	yes	(H&E 20 Dec 2022)
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
10.	**Publication**		
	Has the policy been reviewed for harm?	Yes	None identified.
	Does the document identify whether it is private or public?	Yes	Public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	

Appendix 3 – Roles and Responsibilities

1. Chief Executive

Role	Overall responsibility for the application, implementation and monitoring of the Procedure.
Responsibilities	• To ensure the procedure is operating effectively. • To receive reports arising from a visit/inspection on behalf of the Trust. • To ensure that the Board of Directors and Council of Governors is informed of any findings from external investigation which could impact on compliance with the Trust's Licence/ CQC Registration. • To appoint Lead Directors (if none identified)

2. Lead Director (see Appendix 3)

Role	• Overall planning for and management of visits. • Development and oversight of action plans in response to findings/ recommendations. • Provision of assurance to the Lead Committee on the implementation of actions.
Responsibilities	• To maintain a schedule of visits/inspections (where known). • To ensure plans to manage visits/inspections are put in place and implemented. • To develop (if required) action plans, liaising with other Directors as appropriate, in response to recommendations/findings from the visit/inspection or accreditation. • To either approve action plans (under delegated authority) or to submit them for approval to the Lead Committee. • To ensure that risks identified from visits are managed within the Trust's Integrated Risk and Assurance arrangements. • To monitor the implementation of action plans, reporting any exceptions to the Lead Committee. (*The Lead Director may delegate any of their responsibilities to staff within their Directorate including to relevant Departments)*

3. Executive Group (see Appendix 3)

Role	• To support the Lead Director to fulfil their roles and responsibilities
Responsibilities	• To assist the Lead Director to develop action plans, monitor implementation and provide assurance on progress.

4. Lead Committee (see Appendix 3)

Role	To be assured that: • Actions plans are robust, proportional and implemented. • Findings from visits are addressed, as appropriate, on a Trust wide basis.
Responsibilities	• To receive reports from external agencies. • To consider and, if required, approve action plans in response to the recommendations/findings from a visit/inspection. • To monitor progress on the delivery of the action plan (by exception). • To assure itself on the delivery of the action plan. • To assure itself that lessons learnt have been embedded across the Trust • To sign off completion of the action plan. • To be assured that any risks arising from external visits /inspections/ accreditations are being addressed within the Trust's Integrated Risk and Assurance arrangements

5. Quality Governance Department (see Appendix 3)

Role	• To provide support and provide information for planned visits • To provide support during visits/inspections. • To provide advice on regulatory compliance.
Responsibilities	• To keep an overview of visits/inspections with regard to compliance with their terms of reference • To provide guidance on regulatory matters. • To support the provision of evidence to external agencies.

6. Other Directors and all other staff

Role	• To support the Lead Director in managing the visit and implementing any actions arising.
Responsibilities	• To notify management of any unannounced external visits/ inspections. • To co-operate fully with external agencies, including undertaking action required by the Lead Director before, during and after the visit/ inspection. • To support the delivery of the action plan.

Appendix 4 – Lead Committees and Directors and Reporting Arrangements

Corporate

External Agency/Inspection	Lead Director	Lead Committee	Executive Group	Compliance Department	Reporting Arrangements
NHS England	Chief Executive	Board	Executive Quality Assurance and Improvement Group	Nursing and Governance/ Trust Secretary's Department	Bespoke Reports to the Board
CQC	Director of Nursing and Governance/Director of Quality Governance	Quality Assurance Committee	Executive Quality Assurance and Improvement Group	Quality Governance Team	CQC monthly compliance report to the QuAC Ad hoc compliance reports to QuAC
Mental Health Act	Director of Nursing and Governance/Director of Quality Governance	Mental Health Legislation Committee	Executive Directors Group	MH Legislation Administration Team	QuAC Quarterly MHL BoD reports
Overview and Scrutiny	Director of Nursing and Governance/Director of Quality Governance	Quality Assurance Committee	Executive Directors Group	Quality Governance Team	Bespoke reports
Committees Healthwatch	Director of Nursing and Governance/Director of Quality Governance	Quality Assurance Committee	Executive Directors Group	Patient Experience Team	Bespoke reports
ICO	Director of Finance and Information	Strategy and Resources Committee	ISGG	Information Governance Team	Bespoke reports to Strategy and Resources
Commissioners	Relevant Care Group Director/Director of Quality Governance	Strategy and Resources Committee	Executive Management Group	Management Group/ Care Groups	Bespoke reports
Deanery	Medical Director	Executive Directors Group	Medical Education Group	Medical Development Department	Bespoke reports
Universities (non-nursing)	Medical Director	Executive Directors Group	Medical Education Group	Medical Development Department	Bespoke reports
Royal Colleges (Medical)	Medical Director	Executive Directors Group	Medical Education Group	Medical Development Department	Bespoke reports
Royal College of Nursing	Director of Nursing and Governance	Executive Directors Group	N&G DMT/PNAG	Professional Nursing & Education Team	Bespoke reports
NMC	Director of Nursing and Governance	Executive Directors Group	N&G DMT/PNAG	Professional Nursing & Education Team	Bespoke reports
Universities (nursing)	Director of Nursing and Governance	Executive Directors Group	N&G DMT/PNAG	Professional Nursing & Education Team	Bespoke reports

External Agency/Inspection	Lead Director	Lead Committee	Executive Group	Compliance Department	Reporting Arrangements
Investors in People	Director People and Culture	People, Culture and Diversity Committee (PCDC)	People & Culture Group	HR Team	Reports to PCDC
NHS Protect (SMS)	Director of Finance and Information	Audit & Risk Committee	Finance team	Head of Accounting and Governance	Bespoke reports
HM Revenue and Customs	Director of Finance and Information	Audit & Risk Committee	Finance team	Head of Accounting and Governance	Bespoke reports

Environmental

External Agency/Inspection	Lead Director	Lead Committee	Executive Group	Compliance Department	Reporting Arrangements
PLACE	Director of EFM	Quality and Assurance Committee	EFM DMT	EFM Ops Team	Quarterly EFM reports to QuAC
HSE	Director of EFM	Quality and Assurance Committee	EFM DMT	EFM H&S Team	Quarterly EFM reports to QuAC
SMS	Director of EFM	Quality and Assurance Committee	EFM DMT	Health Safety and Security Working Group	Quarterly EFM reports to QuAC
DDA	Director of EFM	Quality and Assurance Committee	EFM DMT	E&D Team	Quarterly EFM reports to QuAC
Other Environmental	Director of EFM	Quality and Assurance Committee	EFM DMT	EFM	Quarterly EFM reports to QuAC

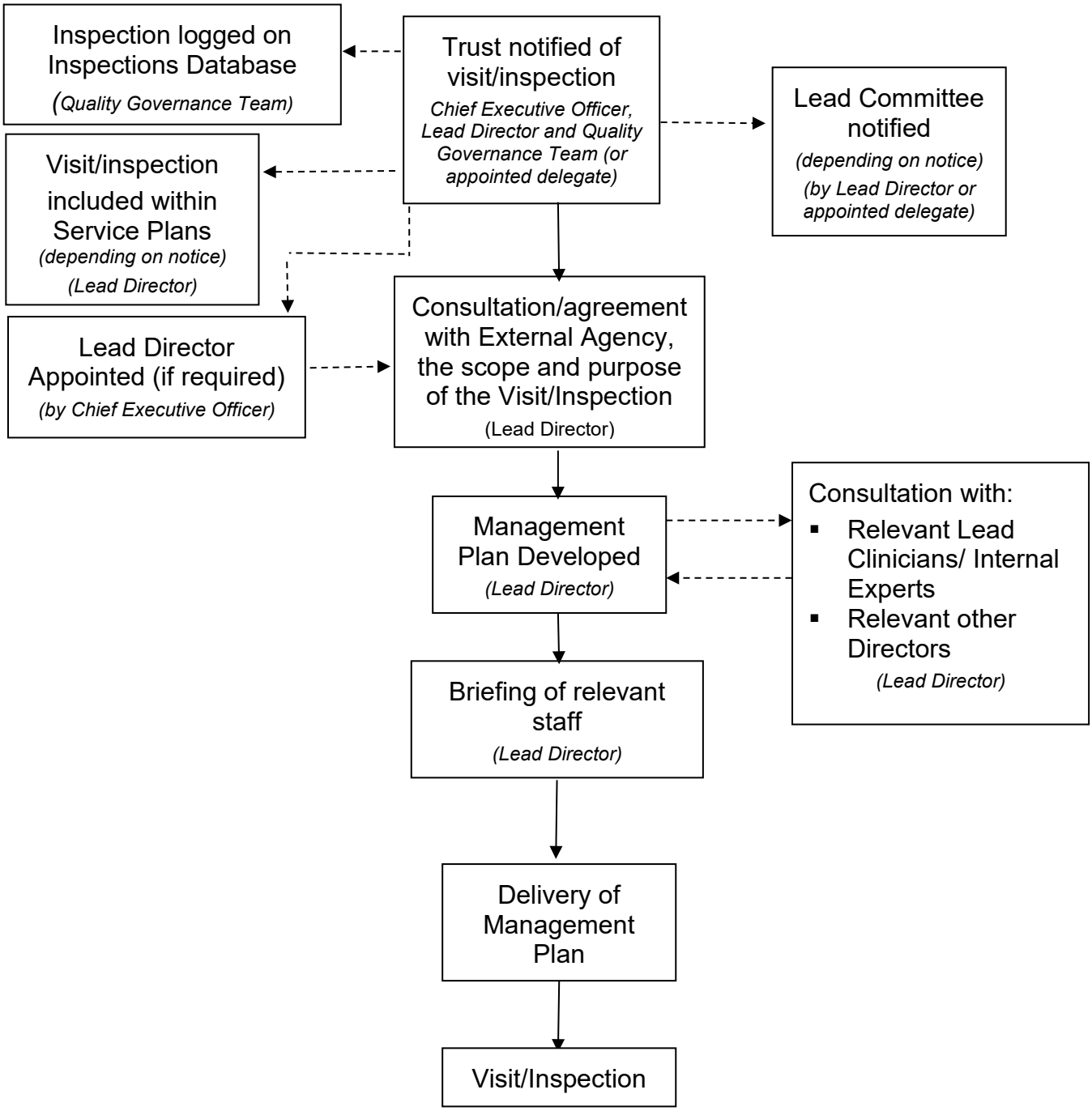
Operational

External Agency/Inspection	Lead Director	Lead Committee	Executive Group	Compliance Department	Reporting Arrangements
QuINIC RCPsych MSU ECTAS STAR/AIMS	Relevant Managing Director	Quality and Assurance Committee	Care Group Quality Assurance and Improvement Groups	Operational Teams	Bespoke reports

Other

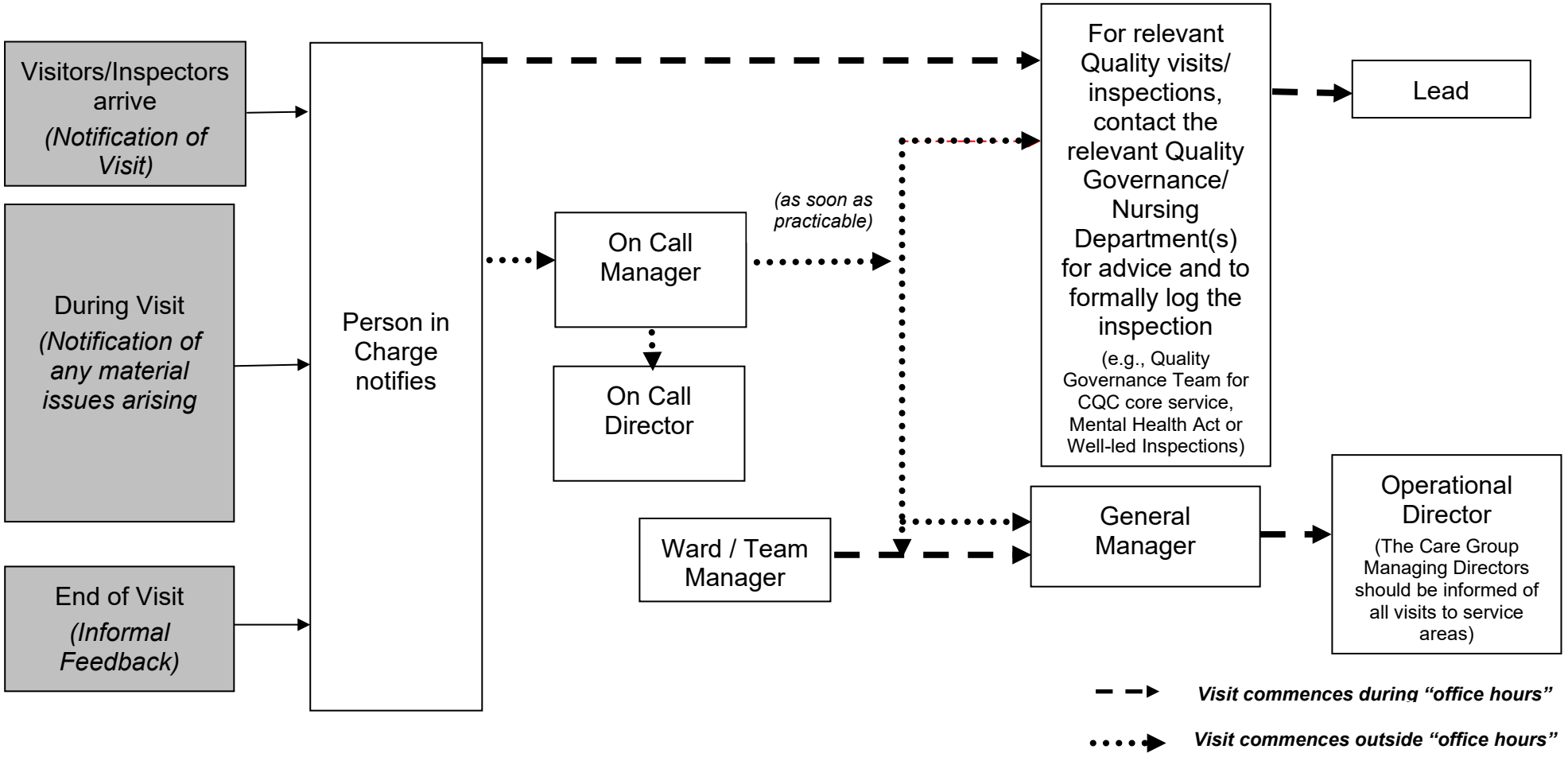
External Agency/Inspection	Lead Director	Lead Committee	Executive Group	Compliance Department	Reporting Arrangements
Other	Determined by Chief Executive	Nominated by CEO	Executive Directors Group	Operational Teams	Bespoke reports

Appendix 5 – Process Flowchart 1 – Preparing for Visits/ Inspections (Planned Visits only)

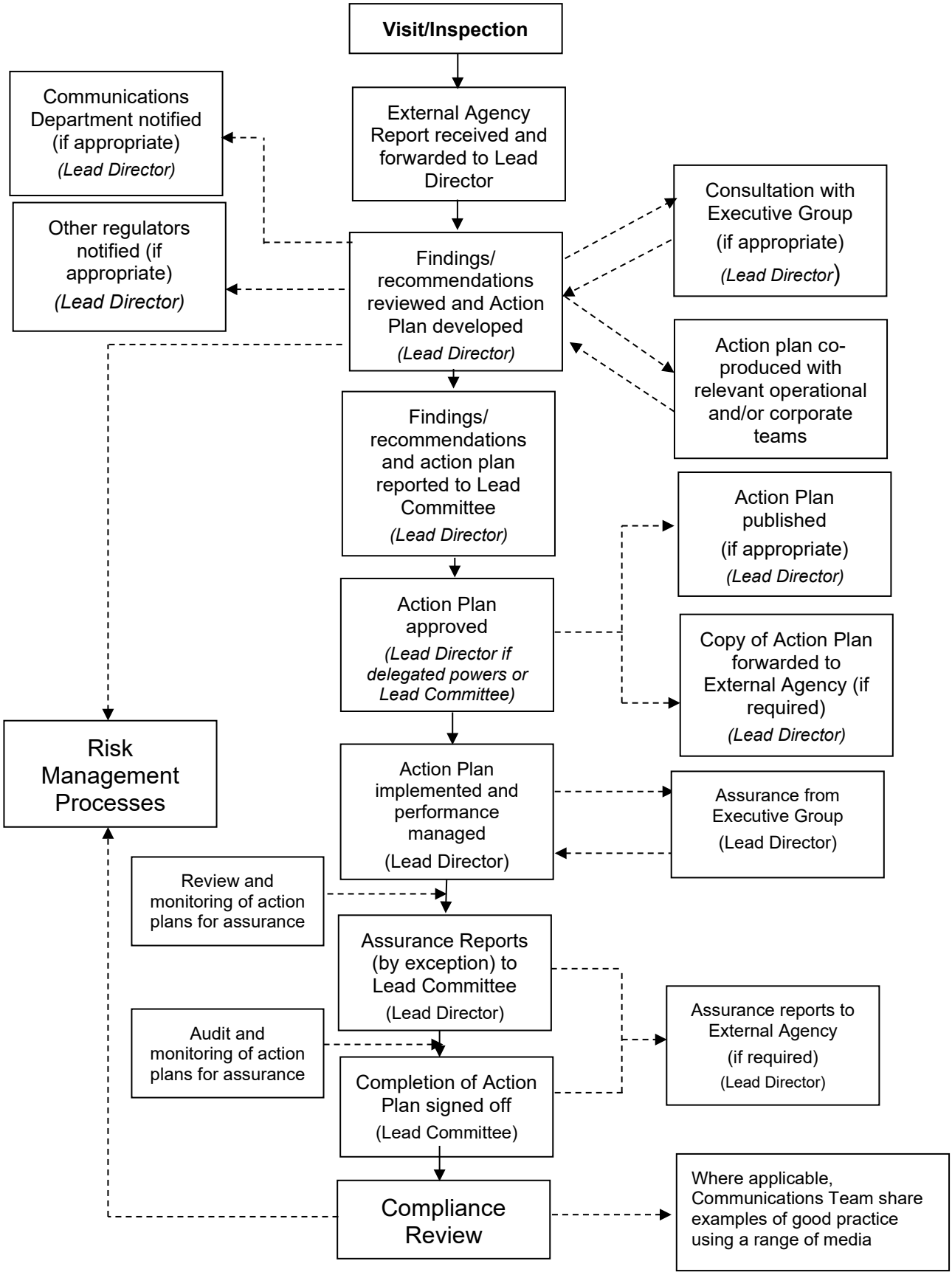


(See Appendix 8)

Appendix 6 – Process Flowchart 2 - Unannounced Visits/Inspections



Appendix 7 – Process Flowchart 3 – Post visit actions and assurance



Appendix 8 – Process description for Care Quality Commission Inspection Visits

Stage	Process step	Actions	Who	Timescale	Assurance
1	CQC draft compliance report received by Trust Nominated Individual– Director of Nursing and Governance (or designated Deputy)	• Read report • Identify any initial issues or inaccuracies • Disseminate the report by electronic mail to Care Group Managing Director, Deputy Medical Director and Group Director Nursing and Quality for Care Group inspected. • Disseminate copy to CEO and all other Executive Team members by electronic mail • Inform Chairman, Chair of Quality Assurance Committee, Trust Board Secretary and Quality Governance Team of report by electronic mail • Request relevant Care Group Managing Director identify any factual inaccuracies or challenges/ representations that need to be made to the CQC	Director of Nursing and Governance/Director of Quality Governance	Within 24 hours of report receipt	Electronic mail trail

Stage	Process step	Actions	Who	Timescale	Assurance
2	Findings reviewed following notification	• Evaluate findings against CQC Fundamental Standards/ Quality Statements compliance requirements • Assess risks to Trust from findings • Identify further actions (including escalation of any risk issues or increase in risk ratings)	Director of Nursing and Governance/Director of Quality Governance Quality Governance Team	Within 3 working days of report receipt	Risk identification Gap analysis of findings
3	Draft Action plan development	• Action planning group to be convened with support from the Quality Governance Team • Draft SMART actions using standard template to address the gaps/developments to meet the CQC compliance standards and requirements of best practice. Action plan to include the evidence that will be presented to assure completion. • Draft action plan submitted to the Executive Directors Group	Care Group Managing Director	Within 10 working days of receipt of draft report	Draft action plan including intended outcome and evidence identification that will demonstrate achievement and/or compliance

Stage	Process step	Actions	Who	Timescale	Assurance
4	Report findings presented	• Feedback the findings to the Executive Directors Group, explaining any compliance and/or quality deficits identified. • Agree any inaccuracies or representations to be made to the CQC	Director of Nursing and Governance/Director of Quality Governance	First EDG meeting after report is received	EDG minutes
5	Draft report returned	• Draft report sent back to CQC with factual accuracy amendment report completed	Quality Governance Team	Within 10 days of receipt of report	Electronic mail trail Factual Accuracy amendment report
6	CQC final report received from the CQC	• Final report disseminated to relevant Care Group Managing Director, Deputy Medical Director and Group Director of Nursing and Quality for the area –also Quality Governance Team, Executive Directors, Chairman, Chair of Quality Assurance Committee and Trust Board Secretary • Draft action plan checked against final report • Update report made to next available Quality Assurance Committee	Director of Nursing and Governance/Director of Quality Governance	Within 3 working days of final report receipt	Electronic mail trail

Stage	Process step	Actions	Who	Timescale	Assurance
7	Action plan sign off	• Check final action plan against final report • Amend if necessary • Present action plan to Executive Directors Group • Action plan approved by EDG and returned to CQC • Report and action plan made to the Quality Assurance Committee	Director of Nursing and Governance/Director of Quality Governance	No later than 10 working days after draft report is received	EDG minutes
8	Action plan implementation	• Action plan implemented by relevant operational and/or corporate services • Monitored by relevant Care Group Managing Director /EDG	Care Group Managing Director/ EDG	According to targets on action plan	Action plan Progress updates Evidence file
9	Action plan performance management	• Reporting system of assurance evidence set up with EDG • System of spot monitoring/audit of action plan implementation set up and implemented by Quality Governance Team • Assurance reports monitored by EDG • Maintain risk reviews throughout plan implementation • Update reports made to the Quality Assurance Committee	Director of Nursing and Governance/Director of Quality Governance	According to targets on action plan	Assurance reports Risk registers Spot checks Audit reports

Stage	Process step	Actions	Who	Timescale	Assurance
10	Action plan sign off	• Evidence of action plan implementation checked and validated by the Quality Governance Team • Completed plan presented to EDG • EDG sign off action plan • Notification of action plan completion communicated to CQC • Report made to next available Quality Assurance Committee	EDG	Within 10 working days of receipt of final report	Completed action plan Evidence from action plan validation
11	Compliance review	• Ongoing checks arranged of certain areas if required.	Director of Nursing and Governance/Director of Quality Governance	Ongoing from date of completion submission	Lead Committee report Lead Committee minutes Spot check and audit reports

Appendix 9 – Process descriptions - Post visit actions and assurance - all unplanned visits

Stage	Process step	Actions	Who	Assurance
1	External agency report received	• Read and disseminate the report • Identify any factual inaccuracies or challenges/representations to the Agency/ Inspector	Lead director	Lead Director report
2	Findings reviewed following notification	• Evaluate findings against compliance requirements or best practice • Assess risks to Trust from findings • Identify actions (including escalation of any risk issues or increase in risk ratings)	Lead Director Quality Governance Team	Risk identification Gap analysis of findings
3	Action plan development	• Draft SMART actions to address the gaps/developments to meet the compliance/requirements of best practice.	Lead Director (or identified delegate in services) following consultation with Executive Directors Group and Quality Governance Team. Lead director oversees and quality assures action plan.	Action plan including evidence identification
4	Report findings presented	• Feedback the findings to the lead committee, explaining any risks, compliance or quality deficits identified.	Lead Director and Lead Committee	Lead Committee minutes

Stage	Process step	Actions	Who	Assurance
5	Action plan sign off	• Action plan approved by Lead Committee and returned to Agency/ Lead Inspector if required.	Lead Director Lead Committee Compliance Department	Lead Committee minutes
6	Action plan implementation	• Action plan implemented by relevant operational and/or corporate services • Monitored by Care Group Managing Director or Corporate Director	Care Group Managing Director or Corporate Director	Implementation plan Local service meeting minutes
7	Action plan performance management	• Reporting system of assurance evidence set up with Lead Committee • System of spot checks/ monitoring of action plan implementation set up and implemented • Assurance reports monitored by Lead Committee • Feedback/ interim assurance reports sent to inspector of required. • Maintain risk reviews throughout plan implementation.	Lead Director	Assurance reports Risk registers Spot checks Audit reports
8	Action plan sign off	• Evidence of action implementation checked and validated • Presented to Lead Committee • Lead Committee sign off action plan • Notification of action plan completion communicated to inspector if required	Lead Director Lead Committee	Completed action plan Evidence from action plan validation

Stage	Process step	Actions	Who	Assurance
9	Compliance review	• Spot check/monitoring against action plan implementation completed • Report made to Lead Committee • Audit arranged if required.	Lead Director	Spot check and monitoring reports Lead Committee report Lead Committee minutes