University Hospitals of Leicester NHS
NHS Trust

External Agency Visits and Recommendations Policy

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Trust Lead:	Jennifer Kay Head of Quality Assurance
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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

January 2025 – Policy has been reviewed and transferred to the new policy template. New mailbox for reporting has been included. Governance processes and reporting committees have been updated to align to current structure, all hyperlinks have been checked and updated. Duplication and repetition have been removed.

KEY WORDS

External visits, visits, agency, peer reviews, accreditation

1 INTRODUCTION AND OVERVIEW

1.1 The purpose of this policy is to ensure there is a clear and consistent approach for the management of external agency visits, inspections, accreditations and reviews across the Trust. Throughout the Policy these are referred to as External Visits

1.2 The policy will minimise the burden on the organisation by reducing duplication and will allow potential gaps to be identified and addressed.

1.3 This policy outlines the process for the coordination and evaluation of all external agency visits to the Trust. This includes Peer Reviews, Inspections and Accreditations. The policy describes the reporting and action planning to achieve the implementation of recommendations following these reviews.

1.4 The Care Quality Commission and the NHS Litigation Authority expect Trusts to comply with all recommendations from external agencies and will expect evidence to show that there is a robust process for their management within the Trust. This reflects best practice and shows a consistent approach to the implementation, monitoring and review of recommendations and will assist in the achievement of the corporate objectives of a safe, high-quality service.

1.5 The Trust is required to ensure that there is a centrally held schedule of all external agency visits, inspections, accreditations, and peer reviews, which is kept updated and monitored within specific timescales. All services should report their external visits and outcomes centrally to the UHL external visits mailbox

1.6 This policy describes the formal review and reporting processes which includes specified timescales and the identification of Nominated Leads who will manage the implementation and review of recommendations, action planning and reporting.

1.7 The processes that this document describes are seen as part of the Trust's internal control systems and aims to provide assurance to the Executive Team who need, wherever possible, to make use of the work of the many external reviewers and to ensure the whole process is efficient.

2 POLICY SCOPE

2.1 This policy applies to all Trust staff and applies whenever an external agency inspects the Trust for the purposes of accreditation. There are a number of external agencies that review, inspect and accredit UHL. These reviews may be at Clinical Management Group (CMG) or Corporate level.

2.2 All external agencies that visit the Trust where a response is expected should come under the remit of this document. Where there is any doubt, advice should be sought from the Head of Quality Assurance

3 DEFINITIONS AND ABBREVIATIONS

External Agencies	External agencies and organisations which undertake assessments of the Trust systems and processes against a set of standards e.g. the Care Quality Commission and the Human Tissue Authority.
Peer Review	The objective evaluation of the performance of a professional or technical service by qualified experts in the same field.
Accreditation	Audit and review by internal and external bodies, which are required to deliver assurance to the Trust Board that the services being delivered by the Trust are fit for purpose and achieving the desired outcomes as laid down by Trust strategies and policies.
Inspection	A visit from an external body to ensure the Trust is meeting statutory requirements e.g. Fire Service, Health and Safety Executive, Environment Agency.
Internal Control	Internal control refers to the Trust's systems for reviewing its services, practices, risks and other aspects of performance to achieve organisational objectives. This includes review by auditors (internal and external).
Inquest Findings	HM Coroners have a remit to make reports to prevent future deaths. On receipt of a Regulation 28 letter, a written response must be submitted by the Trust within 56 days or an agreed extension period.

4 ROLES and RESPONSIBILITIES

4.1 Chief Executive

The Chief Executive has the ultimate responsibility for the process of managing and responding to these visits and enquiries effectively and efficiently and for the appropriate delegation of responsibilities.

4.2 Chief Nurse

The Chief Nurse shall be the Executive Director responsible for this policy and shall ensure that the Board is informed of all matters of importance in this area.

The Chief Nurse will delegate to the Head of Quality Assurance operational delivery of this policy.

4.3 Executive / Clinical Directors

4.3.1 An Executive/ Clinical Director will appoint a nominated individual for each visit and will be supported by a senior member of the Trust (Senior Responsible Officer).

They will have the key responsibility for advising the Head of Quality Assurance of all planned visits to the Trust as far in advance as possible. This can be done by contacting the external visits mailbox

4.3.2 They will be responsible for reporting unplanned visits as soon as possible to the Head of Quality Assurance

4.3.3 Following reviews, the Executive /Clinical Director (nominated individual) will feedback and address any issues of non-compliance directly with the Nominated Lead and will agree action plans to identify and address deficiencies.

4.3.4 When notified by the nominated lead that it is not possible for the Trust to meet all of the recommendations made in external agency visit reports and when actions cannot be closed due to deficiencies or issues of non compliance, they will agree with lead any remedial actions that can be put in place to provide partial compliance, or to mark the action/recommendation as undeliverable.

4.3.5 Ensure that the nominated lead updates the Trust risk register where any risks identified as being non compliant/undeliverable.

4.4 Head of Quality Assurance (or nominated deputy)

4.4.1 Will be responsible for the maintenance of a schedule on which relevant information relating to the visits will be held. This will include responses from Nominated Leads, action plans, timeframes and review dates.

4.4.2 Will liaise with the nominated indiividual/ lead for each specific external agency visit, inspection or accreditation.

4.4.3 Will raise a query with the Head of Information Governce on the need for Non Disclosure Agreements for those external visits ot covered by regulatory bodies

4.4.4 Will ensure that a Nominated Lead is agreed with the relevant Executive/CMG Director and that they receive appropriate notification and support to carry out the duties involved.

4.4.5 Ensure Nominated Leads provide regular updates on identified risks and progress of actions implemented following an external visit to their CMG boards and onto Patient Safety Committee as required.

4.4.6 Ensure Nominated Leads complete all actions within 12 months of the report being published, or where actions cannot be completed within the 12 month timeframe that these are escalated to the Nominated Executive/Clinical Director to agree a new timeframe for completion

4.4.7 Ensure dissemination of relevant information from reports to all areas to facilitate learning and improvements that result from these reviews.

4.4.8 Provide an annual update report on external visits to the Patient Safety Committee

4.5 Nominated Lead

4.5.1 On being appointed to the lead role by the Executive or Clinical Director they **will lead and facilitate the visit .**

4.5.2 Ensure the Head of Quality Assurance is aware of impending visits, via the external visits mailbox

4.5.3 Discuss with the Head of Quality Assurance if a non disclosure agreement is required for external visits not covered by regulatory bodies.

4.5.4 Act as primary point of contact with the external agency and maintain a relationship prior to and following the visit.

4.5.5 Ensure any operational requirements of the visit are met including collation of evidence of compliance with standards relevant to the visit.

4.5.6 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.

4.5.7 Provide a summary briefing of the initial findings of the specific external agency visit to Executive/ Clinical Director Lead and identified governance committee/group highlighting any areas identified as being high risk or of media interest.

4.5.8 Carry out risk assessments for activities identified in the report recommendations and, as appropriate, enter on the risk register in line with the UHL Risk Management Policy.

4.5.9 Develop a report and an action plan to address any recommendations made. This report is to be shared through the appropriate governance group/committee who will determine the frequency of monitoring of progress against the action plan.

4.5.10 Ensure action plans are reviewed, updated and evaluated. The frequency of review will be dependent upon the outcome of the visit and level of risk posed, however, actions should be completed within 12 months of a visit. Where actions cannot be addressed and completed within 12 months , the Lead will agree with the Executive/ Clinical Director a revised timeframe for completion. The frequency of monitoring the action plans will be shared with the Head of Quality Assurance and captured on the schedule of external visits.

4.5.11 Provide a regular summary of results and progress against action plans to the Head of Quality Assurance

4.5.12 Inform the Head of Quality Assurance when all actions associated with the visit and report are closed.

4.5.13 It is the responsibility of the Nominated Lead to maintain communication with External Agency Visit organisation, following the visit and publication of the report, to

update them on the Trust progress against recommendations and actions taken.

5 POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS.

5.1 There are 5 stages within the External Visits process, all of which require actions from those with key responsibilities/duties identified.

5.2 The 5 stage process ensures that

- A suitable individual is nominated to co ordionate and report on any visits undertaken by external agencies to the appropriate governance committee.
- A schedule of visits is maintained
- Action plans are developed with the service and Nominated Leads. Action plans must have agreed timescales, to facilitate the implementation of the recommendations.
- Actions are completed in 12 months
- Compliance with the implementation of the recommendations is reviewed, monitored and reported on by the service and/or Nominated Lead.
- Non compliance is escalated to the Executive/Clinical Director and to the relevant governance committee for scrutiny and recovery plans to be agreed OR agreement that recommendations cannot be met.
- Where agreed, , areas of non compliance will be recorded on the risk register by the service/Nominated lead
- A flow chart outlining the steps to follow for reporting and monitoring of external visits can be found in Appendix A

5.3 Stage 1- Notification of Visits

5.3.1 The Executive /Clinical Director are responsible for advising the Head of Quality Assurance of any upcoming visits via the external visits mailbox

5.3.2 The Head of Quality Assurance will maintain a schedule of planned external visits, with details of action plans, review dates and closed actions. Updates will be requested through the CMG Quality and Safety Boards.

5.4 Stage 2 – Appointing a Nominated Lead

5.4.1 The Executive/Clinical Director must appoint a Nominated Lead to facilitate the vist and coordinate the reporting of the outcomes of the visit and to work with the service on developing an action plan to address any recommendation made in the visit reports.

5.5 Stage 3 – Preparing for an External Visit

5.5.1 The Nominated Lead will be responsible for liaising with the relevant

personnel from the external body and ensuring that all relevant UHL staff are involved in the necessary preparation and for the visit itself.

5.5.2 The Nominated Lead needs to ascertain:

- The purpose of the visit and how it will be conducted.
- The format of the visit, who the inspector should report to and if necessary develop an agenda/timetable for the visit.
- Enquire who the Inspectors want to meet/interview during the vist and schedule these meetings.
- Find out which locations will be visited and any equipment/resources they will need on the day.
- If needed arrange a room for the inspectors to work from.

5.6 Stage 4 – Reporting findings and recommendations

5.6.1 On receipt of a report following an external visit, it should be checked for factual accuracy by the service/ Nomiated Lead, and this should be confirmed to the Executive/Clinical Director.

5.6.2 The CMG Board and the Patient Safety Committee must be informed of key findings and recommendation within the report.

5.6.3 The Executive/Clinical Director and designated oversight committee must ensure that areas of improvement and aspects of good practice have been identified, and where needed shared through the Trust using appropriate forums and established communication channels

5.6.4 The report, findings and recommendations must be shared with the Head of Quality Assurance who will update this information on the external visits schedule.

5.7 Stage 5 – Action plan development and approval

5.7.1 Action plans will be developed to meet the recommendations of the external visit report by the service/Nominated Lead and shared with the Head of Quality Assurance.

5.7.2 Actions should be completed within 12 months of the External Agency Visit, where this is not possible, they should be escalated to the Nominated Executive/Clinical Director to agree new completion timeframes

5.7.3 Action plan will be approved through the CMG Board/ Corporate Clinical Meeting.

5.7.4 Action plans must clearly state:

- The point requiring action and how it relates to the report (e.g. by reference or page number). Action points must be definitive and avoid use of terms such as ‘ongoing’ or ‘in’progress’ in the resolution of the action point.
- The post holder and name of the person responsible for the action
- Realistic target dates for completion of the action point.

- A Rag rating of current progress
- Clearly state in the progress note 'No Action' where none has occurred – where this results in changes to the target date the original date should be struckthrough, but remain on the action plan.
- Where actions are completed the action plan must state the date of completion and include information as to where and from whom, the evidence for completion can be obtained and what form the evidence takes.

5.7.5 The Head of Quality Assurance must be sent a copy of the action plan and will request regular updates, in line with the timescales of the action plan to ascertain its assurance status.

5.7.6 When all actions have been completed and signed off by the CMG Board/Corporate Clinical Meeting, the closed action plan must be sent to the Head of Quality Assurance via the external visit mailbox and the visit schedule will be updated and all actions marked as closed.

5.7.7 It is acknowledged that there will be occasions when the Trust cannot meet all of the recommendations made in an External Agency Visit report and actions cannot be closed due to deficiencies or issues of non compliance. The Nominated Lead must notify the Executive lead/Clinical Director, when this becomes apparent to agree any remedial actions that can be put in place to provide partial compliance, or to mark the action as undeliverable.

5.7.8 The Nominated Leads will include areas of non compliance in their report to the CMG/Corporate Clinical Meeting who will make the final decision on closing action plans with outstanding areas of non compliance and to agree if areas of non compliance are added to the risk register.

6 EDUCATION AND TRAINING REQUIREMENTS

None required

7 PROCESS FOR MONITORING COMPLIANCE

7.1 The 5 stage process wIll be monitored by the Head of Quality Assurance. Gaps in assurance will be reported through the CMG boards.

7.2 An annual report will be shared through the Patient Safety Committee

Monitoring table

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements Who or what committee will the completed report go to.
External Vists schedule	Head of Quality Assurance	Assessment and cross referencing against Visits taking place and reports received	Quarterly	Via the annual report to PSC
Action Plan	Head of Quality Assurance	Review of open and closed actions against agreed timeframes	Quarterly	Via CMG boards and annually to PSC

8 EQUALITY IMPACT ASSESSMENT

8. 1 The Trust recognises the diversity of the staff and local community it serves. Our aim therefore is to provide a safe environment free from discrimination, harassment and victimisation and treat all individuals fairly with dignity and respect and, as far as is reasonably possible, according to their needs.

8.2 As part of its development, an Equality Analysis on this policy have been undertaken and its impact on equality have been reviewed and no detriment was identified.

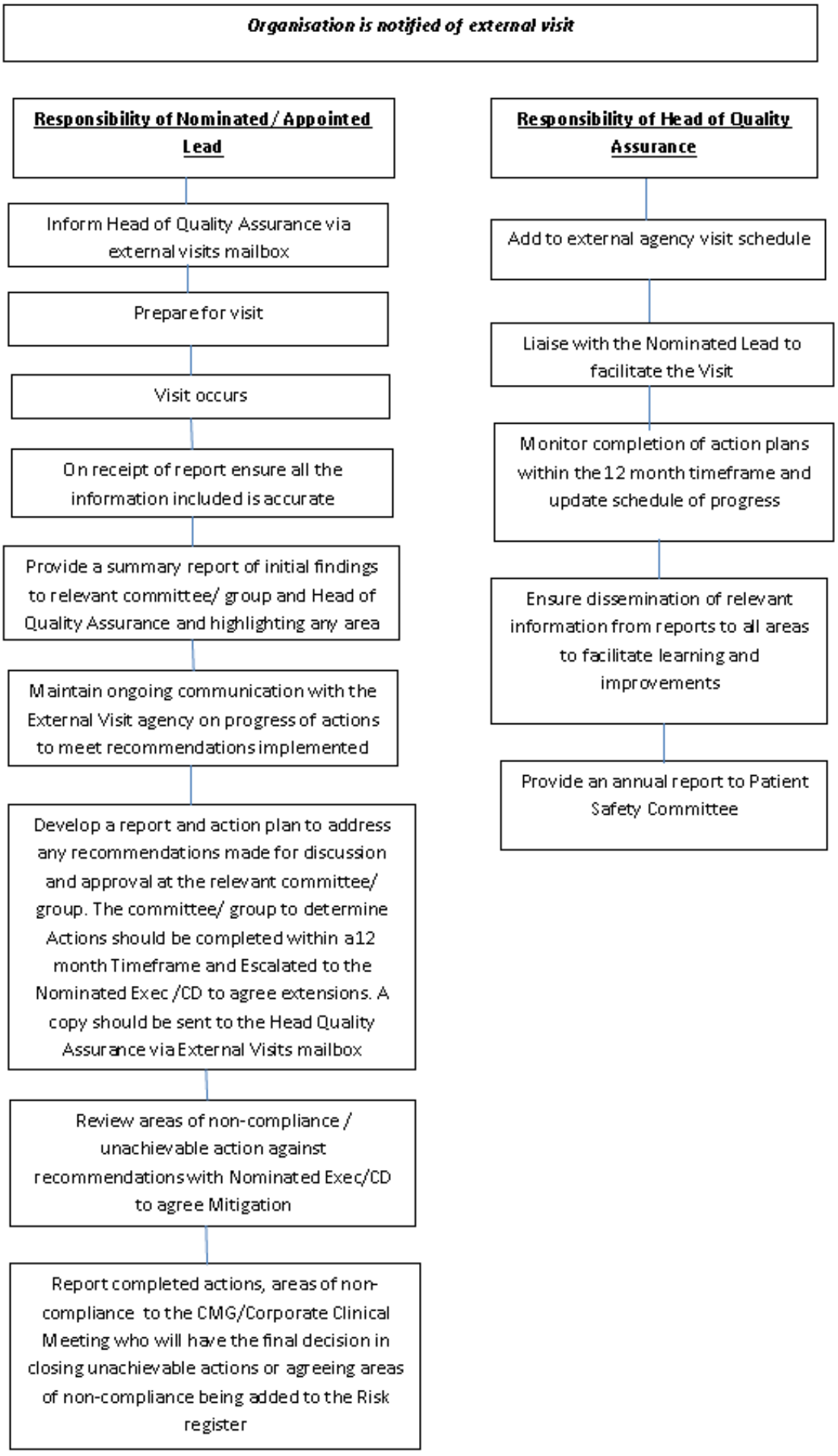
9.0 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This policy will reviewed every 5 years, unless there is a significant change in the process, that will necessitate and earlier review.

The Head of Quality Assurance will be responsible for reviewing this policy

The updated version of the Policy will then be uploaded and available through the Policies and Guidelines Library(PAGL) on UHL Connect and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trust's PAGL system

Appendix A


Organisation is notified of external visit
Responsibility of Nominated / Appointed Lead
Inform Head of Quality Assurance via external visits mailbox
Prepare for visit
Visit occurs
On receipt of report ensure all the information included is accurate
Provide a summary report of initial findings to relevant committee/ group and Head of Quality Assurance and highlighting any area
Maintain ongoing communication with the External Visit agency on progress of actions to meet recommendations implemented
Develop a report and action plan to address any recommendations made for discussion and approval at the relevant committee/ group. The committee/ group to determine Actions should be completed within a12 month Timeframe and Escalated to the Nominated Exec /CD to agree extensions. A copy should be sent to the Head Quality Assurance via External Visits mailbox
Review areas of non-compliance / unachievable action against recommendations with Nominated Exec/CD to agree Mitigation
Report completed actions, areas of non-compliance to the CMG/Corporate Clinical Meeting who will have the final decision in closing unachievable actions or agreeing areas of non-compliance being added to the Risk register
Responsibility of Head of Quality Assurance
Add to external agency visit schedule
Liaise with the Nominated Lead to facilitate the Visit
Monitor completion of action plans within the 12 month timeframe and update schedule of progress
Ensure dissemination of relevant information from reports to all areas to facilitate learning and improvements
Provide an annual report to Patient Safety Committee