University Hospitals of Morecambe Bay NHS Foundation Trust

Document Type: **Procedure**	**Unique Identifier:** CORP/PROC/030
Document Title: **Management of External Agency Visits, Inspections and Accreditations**	**Version Number:** 5
	Status: Ratified
Scope: This procedure applies to all staff working in University Hospitals of Morecambe Bay NHS Foundation Trust who are involved in responding to managing external agency visits, inspections and accreditations.	**Classification:** Organisational
Author / Title: Laura Robertson, Compliance and Assurance Officer	**Responsibility:** Governance Division Compliance and Assurance
Replaces: Version 4, Management of External Agency Visits, Inspections and Accreditations, GOV4	**Head of Department:** Barbara Becker, Head of Compliance and Assurance
Validated By: Mary Aubrey, Director of Governance	**Date:** 26/05/2017
Ratified By: Procedural Documents and Patient Information Leaflets Group	**Date:** 21/06/2017
Review dates may alter if any significant changes are made	**Review Date:** 01/04/2020

Which Principles of the NHS Constitution Apply? 3; 4; 5, 7	**Which Staff Pledges of the NHS Constitution Apply?** 5

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: Yes

Reference Check Completed …….Joanne Phizacklea……..Date……01/02/2017…….

To be completed by Library and Knowledge Services Staff

CONTENTS		
		Page

1. SUMMARY

This procedure has been developed to ensure that the Trust has a clearly defined process for managing and coordinating external agency visits, inspections, and accreditations and any resulting reports and action plans relating to these. These reviews are an essential element of the Governance and Risk Management agendas of the Trust. This procedure will help to minimise the burden on the Organisation by reducing overlap and allow potential gaps in assurance to be identified and addressed.

The Care Quality Commission (CQC) and the NHS Litigation Authority (NHSLA) in particular, require Trusts to demonstrate compliance with recommendations from external agencies and this will be achieved through the robust implementation of this policy.

The process will provide assurance to the Trust Board that structured mechanisms are in place ensuring action plans are being monitored and kept up-to-date within specified timescales. The following systematic management has been approved for implementation.

2. PURPOSE

This procedure sets out the processes which the Trust uses to provide assurance that external agency visits, inspections and accreditations are properly organised and communicated. It ensures that there is a systematic approach for responding to the recommendations and requirements of the visits, including the follow up, monitoring and reporting of action plans. In addition, it will ensure that a central register of visits is maintained.

Adherence to the procedure will provide a coordinated approach to external agency visits and encourage a culture of openness and learning.

The Compliance and Assurance Office will hold a database of all external agency visits, inspections and accreditations, which will be kept, updated and monitored so that the Board and / or relevant committees are aware of reports, progress with action plans and risks associated with their implementation.

In order to plan the Governance and Risk agenda for the Trust it is essential to determine the key external requirements that must be met by the Trust. The purpose of this document is to provide the framework and mechanisms to:-

- Identify the external agencies and reviews specific to the Trust
- Nominate the monitoring committee
- Nominate a lead manager/s
- Identify the requirements
- Identify gaps and assess levels of compliance
- Develop and implement action plans to address gaps
- Prepare for the review or inspection
- Facilitate the review or inspection
- Assess the outcome
- Communicate the outcome
- Receive the reports and recommendations
- Develop action plans where necessary

- Monitor and report progress against the action plans

3. SCOPE

This procedure applies to all staff working in University Hospitals of Morecambe Bay NHS Foundation Trust who are involved in responding to visits, with or without advance notice by external agencies, in the implementation of subsequent recommendations and in the assurance processes involved in the management of all external agency visits, inspections and accreditations.

This procedure applies to all visits from external organisations including the Signatories to the Concordat (see Appendix 1). These external visits could be for numerous reasons including:

- Regular inspection to assess the Trusts standards.
- Inspection to assess statutory compliance.
- Arranged visit to award accreditation to the Trust.
- Repeat visits to assess the Trusts progress following previous visits.
- Random visits to assess the Trusts standards.
- In response to incidents or accidents.
- In response to complaints by the public or staff.
- To undertake or in response to audits or surveys.
- At the request of the Trust as a monitoring or auditing tool.

4. PROCEDURE

4.1 Process for the Management of External Agency Visits, Inspections and Accreditations

A summary of the process to be followed in relation to the management of external agency visits, inspections and accreditations is outlined in the flowchart (Appendix 2) and in the duties outlined below.

4.2 Duties

The following management pathway will be followed to ensure all external agency visits, inspections and accreditation reviews are logged on the central database and action plans developed and actively monitored in order to implement any recommendations made as a result of reviews:

4.2.1 Trust Board/Monitoring Committees

- The Trust Board has overall responsibility for Governance, Risk Management and Internal Control. The accountability for ensuring that the Trust manages all external agency visits, inspections and accreditations is delegated through the committee and management structures.
- Responsible committees include Divisional Governance Assurance Groups; Executive Directors Group; Trust Board.
- The Board of Directors and / or the relevant monitoring committee will monitor progress to be assured that recommendations following external agency visits, inspections and accreditations are fully implemented and that these changes have had the intended effect of improving service delivery and reduce the level of

corporate risk to the Trust.

- The Board of Directors and / or the relevant monitoring committee will ensure the Compliance and Assurance team are informed of any external agency visits, inspections or accreditations and will report through the Divisional Governance Assurance Group on progress against recommendations and actions identified following the visit.

4.2.2 Nominated Divisional Lead Manager will:

- Work with the external agency to ensure that the visit is co-ordinated
- Inform the Director of Governance of any risks or other key issues associated with the inspection or guidance (e.g. possible non-compliance)
- If the report is received direct, ensure a copy is submitted, together with any proposed action plan to the Director of Governance to inform them of any problems arising out of the visit (e.g. actual non-compliance)
- Document any decision not to implement any external recommendations
- Forward copies of documentation to the Head of Compliance and Assurance / Compliance and Assurance Officer so that the required information can be entered onto the Database for Responding to External Recommendations Arising from External Agency Visits, Inspections and Accreditations (Appendix 3).
- Inform the Communications Manager of the visit / inspection in order that they can prepare for any media / public interest where relevant
- Note any recommendations from the external review and develop them into an action plan utilising the Trust template (Appendix 4) which includes as a minimum the following headings:
    - Recommendation
    - Action Required / Comments
    - Person Responsible
    - Time Scale
    - Progress
    - Date Completed
    - RAG Rated

  Additional information may be included as required.
- Identify which Assurance Committee the relevant progress reports and action plans are to be reported to and be responsible for providing progress reports including findings, outcomes or exceptions to progress against the action plan ensuring this is formally recorded in the minutes.
- Provide the Executive Director with a bi-monthly progress report against the action plan, together with any other relevant documentation, in order that the Executive Director can report to the Trust Board.
- Agree with the relevant Director which risks should be included in the organisational risk register and ensure that they are risk assessed and entered onto the appropriate risk register
- Ensure relevant information is included in the Board Assurance Framework
- Provide copies of all reports and action plans (electronically where possible) to the Head of Compliance and Assurance / Compliance and Assurance Officer so that a central database can be maintained
- Provide evidence of implementation of individual actions to the Head of Compliance and Assurance / Compliance and Assurance Officer
- Provide assurance and/or evidence to the relevant Assurance Committee in order for the action plan to be formally signed off on completion.

4.2.3 Head of Compliance and Assurance/Compliance and Assurance Officer will:

- Maintain the register as outlined above together with a schedule of review dates
- Ensure that progress reports against action plans are included on the relevant Assurance Committee agendas
- Ensure that the action plans are formally signed off by the Chair of the relevant Assurance Committee on completion
- Maintain a database of all review dates (both past and future) and unannounced visits (past) on the Compliance Information Register (Appendix 5).
- Maintain a database containing the detail resulting from the reviews and the action plans developed in response to any recommendations made. Once an action plan has been fully implemented and the Compliance and Assurance Officer / Head of Compliance and Assurance has been notified of this, the final version will be retained with relevant detail being recorded on the Responding to External Recommendations Arising from External Agency Visits, Inspections and Accreditations database (See Appendix 4).
- The database will include:
    - Visit / inspection / guidance details e.g. Name of External Agency, Date of Visit, Source
    - Lead Executive Director
    - Nominated Lead Manager
    - Hyperlink to the report
    - Hyperlink to the action plan
    - Details of the relevant Assurance Committee
    - Date(s) of action plan review and by whom
    - Date action plan signed off by the Chair of the relevant Assurance Committee as fully implemented.
    - Nature of Risk to the Trust and name of Risk register / folder that the risk assessment has been placed on.
    - Next assessment / review date.

4.3 Process for Unannounced visits

In the event of an unannounced visit the Director of Governance must be notified immediately who will inform the appropriate Lead Executive Director who in turn will nominate a Lead Manager to be responsible for conducting the visit/ inspection. The nominated Lead Manager must ensure that the Head of Compliance and Assurance / Compliance and Assurance Officer is aware of the visit / inspection and that the Communications Manager is made aware of the visit / inspection in order to prepare for any media / public interest where relevant. The nominated Lead Manager will be responsible for ensuring action plans are implemented and progress monitored through the process outlined above.

4.4 Process for ensuring that the Organisation Wide Risk Register is populated with risks identified from reviews

All moderate / high level risks should be placed on the relevant Risk Register in line with the Risk Management Strategy. This should be completed by the lead manager nominated for the external review.

4.5 External Investigation/Review of Care or/of a Service

The Trust may commission an external investigation/review of care or of a service to be carried out by an external organisation. This could also be in relation to a review, complaint, claim or incident which highlights concerns and which indicates the need for an external review. The aim of commissioning such reviews is to obtain an expert, independent view so that we can learn from any identified areas for improvement. Where appropriate an Executive Director will commission an external investigation/ review of care or of a service and will agree the Terms of Reference. The Executive Director who commissions the investigation will quality assure the final report.

The lead investigator will be identified by the Executive Chief Nurse or the Medical Director. The Director of Governance identifies the need for external agencies to be involved with the investigation in conjunction with the Executive Chief Nurse or the Medical Director.

Any member of staff who needs to be interviewed or re-interviewed as part of the investigation/review process will be undertaken in line with the Policy for Supporting Staff Following Traumatic or Stressful Incidents and the Policy for the Reporting and Management of Incidents Including Serious Incidents (SIRI) Requiring Investigation.

On completion of an external review, the Executive Director who commissioned the external review will report this to the Executive Directors Group and/or Trust Board and will communicate the findings to the relevant division for actions and lessons learned.

The process for external investigation/review of care or of a service is cross referenced in the complaints/ incidents/ claims policies.

5. ATTACHMENTS	
Number	**Title**
Appendix 1	Signatories to the Concordat
Appendix 2	Management of External Agency Visits, Inspections and Accreditations Flowchart
Appendix 3	Example of Database for responding to External Recommendations arising from External Agency Visits, Inspections and Accreditations
Appendix 4	Template for the development of an action plan responding to recommendations arising from External Agency Visits, Inspections and Accreditations
Appendix 5	Example of Compliance Information Register
Appendix 6	Process for Monitoring Compliance
Appendix 7	Equality & Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Corp/Strat/001	Risk Management Strategy http://uhmb/cs/tpdl/Documents/CORP-STRAT-001.docx
HR2	Supporting Staff following Traumatic or Stressful Incidents http://uhmb/cs/tpdl/Documents/HR2.pdf
Corp/Proc/022	Reporting and Investigation of Incidents including Serious Incidents http://uhmb/cs/tpdl/Documents/CORP-PROC-022.docx

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS References in full	
Number	**References**
1	NHS Litigation Authority Available at: NHSLA Risk Management Standards (accessed 01/02/2017)
2	Care Quality Commission (CQC) (accessed 01/02/2017)
3	Health & Safety Executive (HSE) (accessed 01/02/2017)
4	Monitor (2014) NHS foundation trusts: documents and guidance (accessed 01/02/2017)

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
External Body or Agency	An organisation, outside the management structure of the Trust, that has an official advisory or regulatory role concerning the professional or corporate activities of the Trust, or which has the statutory rights to visit, audit or inspect the Trust premises or processes, e.g. Care Quality Commission, NHS Litigation Authority, Health and Safety Executive
Accreditation	Provides independent assurance from a third party that the Trust has achieved an acceptable level of compliance against a defined set of criteria/standards The following list is for example only: - Clinical Pathology Accreditation (CPA) Pathology Laboratories, British Standards Institute Accreditation (BSI) Medical Engineering, Sterile Services
Inspection	An inspection is most generally, an organised examination or formal evaluation exercise. It involves the measurements, test, and gauges applied to certain characteristic in regards to an object or activity. The results are usually compared to specified requirements and standards for determining whether the item or activity is in line with these targets. Inspections are usually non-destructive.
Internal Audit	An independent, objective assurance activity that is designed to add value and improve an organisation's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluating and improving the effectiveness of risk management, control, and governance processes.

9. CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	**Job Title**	**Date Consulted**
Barbara Becker	Head of Compliance and Assurance	
Mary Aubrey	Director of Governance	

10. DISTRIBUTION PLAN	
Dissemination lead:	Laura Robertson
Previous document already being used?	Yes
If yes, in what format and where?	Available on the Intranet
Proposed action to retrieve out-of-date copies of the document:	Replace document on the Trust Intranet – Policy library
To be disseminated to:	Library Service Chairperson of Approving Committee Divisional General Managers Divisional Nurse or AHP Divisional Clinical Director Directors
Document Library	
Proposed actions to communicate the document contents to staff:	Please detail how staff will be informed of document contents and changes. Include in the UHMB Weekly News – New documents uploaded to the Document Library

11. TRAINING

Is training required to be given due to the introduction of this policy? No

Action by	**Action required**	**Implementation Date**

12. AMENDMENT HISTORY				
Revision No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
1.0	Nov 2007	All	Reformat to Trust template	Feb / Mar 09
2.0			Modified to reflect changes in management and committee structures	Jan 2012
3.0	Nov 2012	All	Reformat to trust template. Modified to reflect changes in management and committee structures. To strengthen the monitoring arrangements. Process flow chart included.	Aug 2015
4.0	July 2014	All	Change of title. Modified the reflect changes in managements of external agency visits, inspections and accreditations in order to strengthen the process.	July 2017
5.0	May 2017	Section 1, 2, 3, 4.2.1 and 4.2.2 Addition of Appendix 3	Paragraphs added Modified to reflect the most up to date processes.	April 2020

Appendix 1: Signatories to the Concordat

There are many external organisations that regulate, audit, inspect or review elements of health and social care in England. By inspection, we mean audits, reviews, assessments and the regulation of services. Key organisations have signed a voluntary agreement called the concordat (Reference 1), which aims to coordinate their activities such as audits, reviews, inspections and accreditations. By streamlining their activities, these signatories are supporting the improvement of health services for the public. Full signatories are those organisations that directly or indirectly (through other bodies), or whose constituent members (if an associate body):

- regulate, audit or review health and health care in England; and/or
- routinely place a burden on NHS or private organisations by requesting data or by undertaking inspection activity; and
- are willing to support the implementation programme in full, including the potential to attend on a regular basis, and at a senior level, the Health and Social Care Inspection Forum (quarterly), individual implementation group / team meetings (bi-monthly) and the potential to second staff to the Healthcare Commission or provide leadership for specific projects; and
- are prepared to be called to account by the NHS and the independent sector against the principles and objectives set out in the Concordat, and are required to complete the annual review template

The full signatories to the Concordat are:

- Audit Commission
- Commission for Social Care Inspection (CSCI)
- Conference of Postgraduate Medical Deans (COPMeD)
- General Medical Council (GMC)
- Health and Safety Executive (HSE)
- Care Quality Commission
- Human Fertilisation and Embryology Authority (HFEA)
- Mental Health Act Commission (MHAC)
- National Audit Office (NAO)
- NHS Counter Fraud and Security Management Service (NHS CFSMS)
- NHS Litigation Authority (NHSLA)
- Postgraduate Medical Education and Training Board (PMETB)
- Nursing Midwifery Council (NMC)
- Health Professions Council (HPC)
- Office for Standards in Education, Children's Services and Skills (OFSTED) via the Academy and any external National Vocational Qualification (NVQ) Assessors / Verifiers via local Training Providers

Appendix 2: Management of External Agency Visits, Inspections and Accreditations Flowchart

Director of Governance
Identifies Lead Executive Director who in turn will nominate a Divisional Lead Manager to be responsible for management of the visit.

Head of Compliance and Assurance / Compliance and Assurance Officer
Logs the details of the external agency visit, inspection or accreditation, identifying the Lead Executive Director / Nominated Divisional Lead Manager

Compliance and Assurance Team
In conjunction with the Nominated Divisional Lead Manager develops an Action Plan following feedback from the visit and populates the Trust action plan template on Ulysses

Compliance and Assurance Team

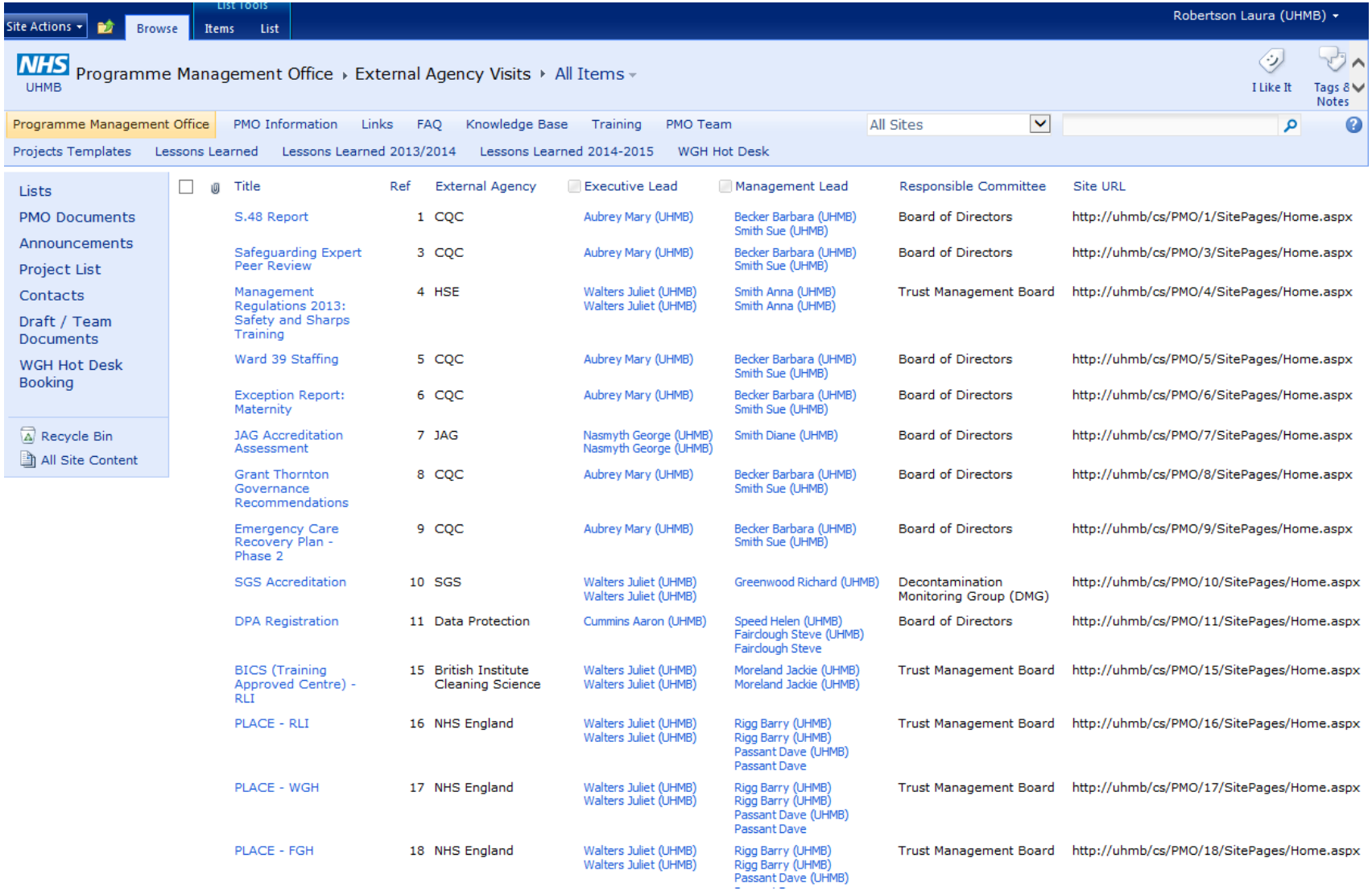
- Maintains a central up to date register of all external agency visits, inspections and accreditations
- Maintains a schedule of review dates for upcoming external agency visits, inspections and accreditations.

Lead Executive Director
Nominates a Divisional Lead Manager to be responsible for the visit

Nominated Divisional Lead Manager

- Co-ordinate the external agency visit, inspection, accreditation
- Inform the Communications Manager of any visits to prepare for any media / public interest where necessary.
- Forward copies of documentation to Head of Compliance and Assurance / Compliance and Assurance Officer for inclusion on a central database.
- Note any recommendations from the visit and in conjunction with the Compliance and Assurance team develop an action plan utilising the Trust template.
- Provide the Executive Director with a bi-monthly progress report against the action plan.
- Confirm monitoring arrangements and progress against recommendations to the Board and or relevant monitoring committee.
- Provide assurance to the relevant committee in order for the action plan to be formally signed off on completion.
- Ensure the Head of Compliance and Assurance / Compliance and Assurance Officer receives copies of all progress reports, supporting evidence and minutes for inclusion on the central database.

Appendix 3: Example of Database for responding to External Recommendations arising from External Agency Visits, Inspections and Accreditations



Title	Ref	External Agency	Executive Lead	Management Lead	Responsible Committee	Site URL
S.48 Report	1	CQC	Aubrey Mary (UHMB)	Becker Barbara (UHMB) Smith Sue (UHMB)	Board of Directors	http://uhmb/cs/PMO/1/SitePages/Home.aspx
Safeguarding Expert Peer Review	3	CQC	Aubrey Mary (UHMB)	Becker Barbara (UHMB) Smith Sue (UHMB)	Board of Directors	http://uhmb/cs/PMO/3/SitePages/Home.aspx
Management Regulations 2013: Safety and Sharps Training	4	HSE	Walters Juliet (UHMB) Walters Juliet (UHMB)	Smith Anna (UHMB) Smith Anna (UHMB)	Trust Management Board	http://uhmb/cs/PMO/4/SitePages/Home.aspx
Ward 39 Staffing	5	CQC	Aubrey Mary (UHMB)	Becker Barbara (UHMB) Smith Sue (UHMB)	Board of Directors	http://uhmb/cs/PMO/5/SitePages/Home.aspx
Exception Report: Maternity	6	CQC	Aubrey Mary (UHMB)	Becker Barbara (UHMB) Smith Sue (UHMB)	Board of Directors	http://uhmb/cs/PMO/6/SitePages/Home.aspx
JAG Accreditation Assessment	7	JAG	Nasmyth George (UHMB) Nasmyth George (UHMB)	Smith Diane (UHMB)	Board of Directors	http://uhmb/cs/PMO/7/SitePages/Home.aspx
Grant Thornton Governance Recommendations	8	CQC	Aubrey Mary (UHMB)	Becker Barbara (UHMB) Smith Sue (UHMB)	Board of Directors	http://uhmb/cs/PMO/8/SitePages/Home.aspx
Emergency Care Recovery Plan - Phase 2	9	CQC	Aubrey Mary (UHMB)	Becker Barbara (UHMB) Smith Sue (UHMB)	Board of Directors	http://uhmb/cs/PMO/9/SitePages/Home.aspx
SGS Accreditation	10	SGS	Walters Juliet (UHMB) Walters Juliet (UHMB)	Greenwood Richard (UHMB)	Decontamination Monitoring Group (DMG)	http://uhmb/cs/PMO/10/SitePages/Home.aspx
DPA Registration	11	Data Protection	Cummins Aaron (UHMB)	Speed Helen (UHMB) Fairclough Steve (UHMB) Fairclough Steve	Board of Directors	http://uhmb/cs/PMO/11/SitePages/Home.aspx
BICS (Training Approved Centre) - RLI	15	British Institute Cleaning Science	Walters Juliet (UHMB) Walters Juliet (UHMB)	Moreland Jackie (UHMB) Moreland Jackie (UHMB)	Trust Management Board	http://uhmb/cs/PMO/15/SitePages/Home.aspx
PLACE - RLI	16	NHS England	Walters Juliet (UHMB) Walters Juliet (UHMB)	Rigg Barry (UHMB) Rigg Barry (UHMB) Passant Dave (UHMB) Passant Dave	Trust Management Board	http://uhmb/cs/PMO/16/SitePages/Home.aspx
PLACE - WGH	17	NHS England	Walters Juliet (UHMB) Walters Juliet (UHMB)	Rigg Barry (UHMB) Rigg Barry (UHMB) Passant Dave (UHMB) Passant Dave	Trust Management Board	http://uhmb/cs/PMO/17/SitePages/Home.aspx
PLACE - FGH	18	NHS England	Walters Juliet (UHMB) Walters Juliet (UHMB)	Rigg Barry (UHMB) Rigg Barry (UHMB) Passant Dave (UHMB)	Trust Management Board	http://uhmb/cs/PMO/18/SitePages/Home.aspx

Appendix 4: Template for the development of an action plan responding to recommendations arising from External Agency Visits, Inspections and Accreditations

Name of Division / Directorate	**Governance**
Action Plan for the:	**Divisional Governance and Risk Management Assignment Report 2015 - 2016**
Date of Visit:	**January 2016**
Date Report Received:	**April 2016**
Date Action Plan Developed:	**April 2016**

No.	Recommendation	Action Required / Comments	Person Responsible	Resources Required	Timescale	Progress	Monitoring Arrangements	Date Completed	RAG
1	DGAGs should transparently share their results and engage in cross-division learning events	The Trust's Management Board and DGAGs should ensure that the Corporate Risk Register and Divisional Risk Registers are fully completed to enable all risks recorded on the registers to be thoroughly monitored in accordance with the Risk Management Strategy and their Terms of References.	Risk and Compliance Manager Risk Owners within the Divisions are responsible operationally		30/07/2016	The Risk and Compliance manager has made all the Control data fields mandatory, this includes; Control Type, Control Details, Gaps in Control, the Effectiveness of Control, Internal Assurance, External Assurance, Gaps in Assurance, the Adequacy of the Assurance, this will ensure that all new controls will be fully completed.	The Risk and Compliance manager in conjunction with the Divisional Governance Leads has put in place a programme of review for all the existing controls to ensure that the controls are reviewed and updated with the relevant information and any missing data is completed, and that any out of date or superfluous controls were removed.	30/07/2016	

Appendix 5: Example of Compliance Information Register

External Organisation & Information Requirement	Executive Lead	Lead Manager	Responsible Committee	Review Frequency	Date due
Care Quality Commission(CQC) - Annual review of registration	Director of Governance	Executive Directors Head of Compliance and Assurance	Board of Directors	As required	
Care Quality Commission (CQC) Hospital Inspection Announced Hospital Inspection Unannounced	Director of Governance	Executive Directors Head of Compliance and Assurance	Board of Directors	As required	
Monitor • Annual Report • Annual Quality Account • Annual Governance Statement • Annual Financial Account	Chief Executive Officer	Executive Directors	Audit committee	Annually	
			Clinical Governance and Quality Committee	Quarterly	
			Audit Committee	Quarterly	
			Finance and Performance Committee	Quarterly	
Public Health England Surveillance of Hospital Acquired Infection	Executive Chief Nurse	Director of Infection Prevention and Control	Infection Prevention and Control Committee	Monthly	
Deanery/ General Medical Council (GMC) visits	Medical Director	Associate Director Medical Education	Clinical Governance and Quality Committee	2 yearly	
Joint Advisory Group on GI Accreditation – (JAG)	Medical Director	Endoscopy Unit Managers – RLI, FGH, WGH	Clinical Governance and Quality Committee	Annually	
Department of Health Staff Survey	Director of Human Resources	HR Director	Trust Management Board	Yearly	
Department of Health Annual Certification of Fire Safety Management	Chief operating Officer	Divisional Estates Manager	Trust Management Board	Annually	
National Patient Survey- Inpatient	Executive Chief Nurse	Head of Patient Experience	Clinical Governance and Quality Committee	Annually	

External Organisation & Information Requirement	Executive Lead	Lead Manager	Responsible Committee	Review Frequency	Date due
National Patient Survey –(maternity A&E or Outpatients) this year Maternity	Executive Chief Nurse	Head of Patient Experience	Clinical Governance and Quality Committee	3 yearly Cycle	
National Friends and Family Test	Executive Chief Nurse	Head of Patient Experience	Clinical Governance and Quality Committee	Real time monthly report	
Department of Health Mixed Sex hospital accommodation	Executive Chief Nurse	Deputy Chief Nurses	Clinical Governance and Quality Committee	Routine Reporting	
Data Protection Registration – Information Commissioner	Director of Finance,	Director of Finance, Information & Supplies	Board of Directors	Annual	
Information Governance Toolkit Assessment	Director of Finance,	Director of Finance, Information & Supplies	Board of Directors	Annual	
Health Episode Statistics (HES) validation	Director of Finance,	Director of Finance, Information & Supplies	Finance and Performance Committee	Throughout year but annual refresh due in May	
Breast Screening Quality Assurance report	Medical Director	Breast Screening Program Director	Board of Directors	Annual	
Capita Payment By Results Data Assurance Framework Audit/s	Director of Finance,	Director of Finance, Information & Supplies	Audit Committee	Commissioned by PCT's	
Health And Safety Executive (HSE)	Chief Operating Officer	Health And Safety Manager	Trust Management Board	As required	
Trust Security Policy and Strategy	Chief Operating Officer	Health And Safety Manager	Trust Management Board	Annual	
Clinical Pathology Accreditation (CPA)	Chief Operating Officer	Head of Pathology	Divisional Management T	4 yearly	
Human Tissue Authority (HTA)	Chief Operating Officer	Head of Pathology	Divisional Management Team	Annual Compliance Submission	
Medicine and Healthcare Regulatory Agency (MHRA) Blood Transfusion	Chief Operating Officer	Chair of Blood Transfusion Committee	Blood Transfusion Committee	Annual Compliance Submission	

External Organisation & Information Requirement	Executive Lead	Lead Manager	Responsible Committee	Review Frequency	Date due
Rule 43 letters	Director of Governance	Associate Director of Governance and Quality	Clinical Governance and Quality Committee	As required	
Cancer peer reviews	Chief Operating Officer	Chief Operating Officer	Clinical Governance and Quality Committee	Annual	
Nursing and Midwifery Council - Practice Visits,	Executive Chief Nurse	Deputy Chief Nurses	Nursing and Midwifery Strategy Group	Awaiting informatio	
Monitor commissioned reports 4- Manchester review 5- PWC Governance arrangements	Company Secretary	Executive Nurse	Board of Directors	As required	
	Company Secretary	Associate Director of Quality Governance	Board of Directors	As required	
Patient –led assessment for the care environment (PLACE)	Chief Operating Officer	Head of Hotel Services	Trust Management Board/ Clinical Governance	Annually	
Doctor Foster Hospital Guide	Chief Operation Officer	Chief Operating Officer	Clinical Governance and Quality	Annually	
Safeguarding Section 11 Audits Lancashire	Executive Chief Nurse	Deputy Chief Nurse	Clinical Governance & Quality Committee	Annual	
Safeguarding Section 11 Audits Cumbria	Executive Chief Nurse	Deputy Chief Nurse	Clinical Governance & Quality Committee	Annual	
Procurement Audit - Grant Thornton UK LLP	Medical Director	Chief Pharmacist / Procurement Manager	Clinical Governance & Quality Committee	Annual	
Regional NHS Pharmaceutical Procurement and Distribution Services Audit	Medical Director	Chief Pharmacist / Procurement Manager	Clinical Governance & Quality Committee	Annual	
LIN Reports (Local Intelligence Network Reports) (Controlled Drug Incidents)	Medical Director	Trust Accountable Officer for Controlled Drugs	Clinical Quality and Governance/MMSC	Quarterly	

External Organisation & Information Requirement	Executive Lead	Lead Manager	Responsible Committee	Review Frequency	Date due
National Audits	Medical Director	Head of Clinical Audit	Clinical Quality and Governance/MMSC	Quarterly	
Networking Groups 4- Trauma 5- Critical Care 6- Neonatal Care 7- Cardiovascular 8- Stroke 9- Cancer	Medical Director	Ray McGlone - (Consultant in Emergency Medicine) Dave Highley – (Consultant in Anaesthetics) Owen Galt – (Consultant in Paediatrics) Andy Higham – (Consultant Physician) Sarah Cullen – (Clinical Service Manager in Unscheduled Care) David Fyfe – (Consultant Oncologist)	Clinical Quality and Governance/MMSC	Annual Peer Review	
Higher Education Institution Assurance team reviews the systems in place for trainees.	To be confirmed if required	To be confirmed if required	To be confirmed if required	Ad-Hoc Visits	

Appendix 6: Process for Monitoring Compliance

Requirement	Method	Frequency	Lead	Monitoring Group	Action plan lead	Committee/ group overseeing Action Plan
Process for reviewing external recommendations specific to the organisation	Audit	Annual	Head of Compliance and Assurance	Quality Committee	Head of Compliance and Assurance	Quality Committee
Process for reporting on external recommendations specific to the organisation	Audit	Annual	Head of Compliance and Assurance	Quality Committee	Head of Compliance and Assurance	Quality Committee
How action plans are developed as a result of external recommendation	Audit	Annual	Head of Compliance and Assurance	Quality Committee	Head of Compliance and Assurance	Quality Committee
How action plans are followed up	Audit	Annual	Head of Compliance and Assurance	Quality Committee	Head of Compliance and Assurance	Quality Committee

Appendix 7: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Compliance and Assurance			
Lead Assessor	Barbara Becker			
What is being assessed?	Management of External Agency Visits, Inspections and Accreditations			
Date of assessment	26th May 2017			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☒	Staff Side Colleagues	☒
	Service Users	☒	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☒	Other (Inc. external orgs)	☒
	Please give details:			

1) What is the impact on the following equality groups?

Positive:	Negative:	Neutral:
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	Impact (Positive / Negative / Neutral)	Comments ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	N/A

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.