NHS
Essex Partnership University
NHS Foundation Trust

PROCEDURAL GUIDANCE FOR THE MANAGEMENT OF EXTERNAL VISITS, INSPECTIONS AND ACCREDITATIONS (Including VIP Visits)

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PROCEDURE SUMMARY	
The purpose of this procedural guidance is to set out the trust policy and procedure for the management of external visits, inspections and accreditations per policy	
The Trust monitors the implementation of and compliance with this procedure in the following ways:	
These Guidelines are monitored by the Compliance Team through an External Visits database, which provides regular reports to the Quality Committee on any external visits undertaken in the Trust. The monitoring of actions is the responsibility of local reporting arrangements.	

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is the Chief Executive Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURAL GUIDANCE FOR THE MANAGEMENT OF EXTERNAL AGENCY VISITS, INSPECTIONS AND ACCREDITATIONS

Contents

1. INTRODUCTION....3
2. SCHEDULE OF REVIEW DATES....3
3. PREPARING FOR A VISIT (FOR CQC COMPLIANCE VISITS SEE SECTION 8) 4
4. VIP VISITS (Including MPs, councilors and celebrities) 4
5. INSPECTION VISITS....5
6. UNANNOUNCED VISITS AND INSPECTIONS....6
7. RECOMMENDATIONS 6
8. CQC INSPECTION 7
9. MHA VISITS 9
10. SURVEYS 9

SAMPLE ONLY

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURAL GUIDANCE FOR THE MANAGEMENT OF EXTERNAL VISITS, INSPECTIONS AND ACCREDITATIONS

Assurance Statement

The purpose of this procedural guidance is to set out the trust policy and procedure for the management of external visits, inspections and accreditations.

1. INTRODUCTION

1.1. This procedural guidance supports Corporate Policy CP43 "The Policy for the Management of External Visits, Inspections and Accreditations" by setting out the criteria for the management of all external visits, inspections and accreditations within the Trust. For the purpose of this procedural guidance the term 'visit' will used to represent external visits, inspections and accreditations.

1.2. This procedural guidance is designed to lay out the process for the correct reporting and implementing of external visits.

1.3. It is part of the Trust's internal control system and provide assurance to the Board, who need, wherever possible, to make use of the work of the many external reviewers and ensure the whole process is safe and efficient.

2. SCHEDULE OF REVIEW DATES

2.1. The Compliance Team will keep an assessment database, which will include a schedule of review for all external inspection visits known to the team and specific to the Trust along with copies of outcome reports with action plan progress reports; where appropriate.

2.2. The schedule will include information on:

- visit title
- area / location of where visit is taking place
- type of visit
- nominated Lead Manager
- nominated Committee (if applicable)
- frequency of visits (where applicable)
- date of last visit
- action plan identification
- date of next known visit

2.3. The schedule will be continually updated and all staff are responsible for informing the Compliance Team of any booked or unannounced external visits.

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3. PREPARING FOR A VISIT (FOR CQC COMPLIANCE VISITS SEE SECTION 8)

3.1. All inspection visits must be notified to the Compliance Team, the Service Management Team (SMT) or any other relevant committee / group as soon as they are known.

3.2. The person contacted by the external body will act as initial lead manager and must prepare a report to the SMT informing them of the visit outlining:

- Date, time and location of the visit.
- Any actions required in preparation
- Purpose of the visit
- Any implications for the Trust
- Any risks
- Who will be lead manager in coordinating the visit.

A copy of this report must be submitted to the Compliance Team.

3.3. The SMT will nominate an appropriate Trust Lead (where an existing lead has not previously been nominated) and Lead Committee (if appropriate) who will be responsible for coordinating and reporting on the visit.

3.4. The SMT will agree a timescale for progress reports to be submitted by the Lead Manager.

3.5. The Lead Manager will be responsible for preparing for the visits this may include:

- Preparing suitable venues
- Briefing staff
- Preparing required evidence in appropriate formats
- Providing the visitors with directions and parking/travel details
- Regular progress reports
- Ascertaining if the external visitors have any special needs, such as wheelchair access or dietary requirements where applicable.
- Ensuring access to electronic records (where required)

3.6. The lead manager must submit preparation progress reports to the SMT for monitoring on a regular basis. This monitoring can be delegated to an appropriate Committee/group by the SMT. Such reports must be copied to the Compliance Team.

4. VIP VISITS (Including MPs, councilors and celebrities)

4.1. All requested visits by VIPs (including Members of Parliament, councilors and celebrities) and by media representatives are to be handled and managed by the Communications Team. No visits by VIPs, journalists or media organisations are to be arranged without the approval and input of the Communications team. The communications team will liaise with the Trust's Executive Team and NHS England and Improvement regional communications team. A member of the communications team will need to be present for the visit who will advise on media handling on the day.

4.2. Particular care should be taken when managing requests to visit Trust premises during the pre-election period (Purdah), ensuring that national guidance is adhered to.

4.3. During the COVID-19 pandemic, additional measures will need to be taken in line with national guidance and infection, prevention and control measures including lateral flow tests prior to the media or celebrities being allowed to enter trust premises. Face masks and social distancing should be observed at all times.

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4.4. If the wards are struggling to host a visit based on patient safety and/or compromising clinical care, the external visitors should be asked to postpone the visit and/or offer an alternative ward in agreement with the Service Director/Manager as appropriate.

Please refer to appendix CPG43b VIP Visits Procedure for further details

5. INSPECTION VISITS

5.1. All visitors must produce photo ID, sign in and out of each area they visit and be escorted at all times whilst visiting Trust sites/clinical area

5.2. The Lead Manager must be in attendance during the visit at all times to ensure smooth co-ordination.

5.3. The services being inspected should make a welcome pack available for the inspection team on the day of the visit. This should include:

- The details of the ward / service being inspected, including details of the patient group.
- Details of facilities, including toilets, refreshment areas etc.
- Emergency procedures

5.4. Where electronic records are used, staff should facilitate the viewing of the patient record. If staff are unsure on giving external visitors access to patient records they should refer to the Information Governance and Security Policy (CP50) or Records Management Policy (CP9)

5.5. During an inspection visit, it is essential that clinical care is not compromised in any way. The Lead Manager should inform the manager of any clinical areas that will be visited at the earliest opportunity and ensure that visit times are booked appropriately. If the visit is found to be compromising patient care in any way, the Lead Manager must ask that the visit be suspended for a period of time or terminated with a full explanation given as to the reasons provided to any inspectors.

5.6. No area should have more than one visit taking place at any given time. Should such a circumstance arise a new time for the visit should be negotiated with the second visiting inspection team, where possible this should be on the same day.

5.7. Inspectors will use a range of methods to gather evidence about how well the Trust/service meets the needs of people who use it. This can include talking to people who use the services and observing their interaction with staff where appropriate. They can also look at the environment and facilities provided and check health records such as care plans, risk assessments, referrals, reviews and discharge summaries.

5.8. The Lead Manager should ensure any information / data requested during the visit is coordinated through the Compliance Team, where this is not available on the clinical site. The Compliance Team will then liaise with the relevant corporate function to obtain the data and submit to the Lead Manager. This will allow for the quality of control of the information provided and prevent duplication of multiple teams dealing with requests.

5.9. All staff must be co-operative and helpful to visitors/inspectors at all times. However, it is also important for staff to be honest and open where the behaviour of an inspector is not appropriate. If this happens staff should raise concerns with their manager and the Compliance Team immediately so appropriate action can be taken.

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5.10. The Lead Manager should arrange for a "breakout" room to be made available for staff to access during the visit. This should be used to debrief staff and gather any informal feedback.

5.11. The Director of the service and Compliance Team must be informed of any verbal feedback received at the time of the visit immediately.

5.12. The Trust welcomes and encourages staff to report any concerns about clinical practice and would ask staff to do this through the Trust Whistleblowing Policy CP53 or Adverse Incident Policy CP3 so they can be acted upon immediately. Visits would not normally be the appropriate place to initially raise a concern that has not been reported either through Whistle blowing or Incident processes.

5.13. It is important that if staff feel there are concerns about clinical practice during the course of an inspection, they should make the inspectors aware of the situation as well as following the above internal processes. It is important that staff are open and honest with any issues that arise during an inspection and provide assurance that internal processes are being followed to rectify as soon as possible.

6. UNANNOUNCED VISITS AND INSPECTIONS

6.1. In the event of an unplanned visit, the senior member of staff on duty acts as the Lead Manager and must inform their clinical lead / manager as soon as possible. The clinical lead must ensure they are available at the site of the visit should they be needed and must inform their director as soon as possible. The clinical lead should attend the area following the visit once it is over and ask staff on duty for initial feedback.

6.2. Out of hours, the on call manager must be informed as soon as possible. The on call manager must ensure they are available at the site of the visit and must inform the director on call as soon as possible. The on call manager should attend the area following the visit once it is over and ask staff on duty for initial feedback

6.3. An Action Card has been developed for display in all Clinical Areas and for inclusion in the on-call folder. Please see Appendix 1.

6.4. In the event of a CQC unannounced visit the senior staff member on duty must inform the operational director as soon as possible. Where possible The Director (or nominated individual) must attend the informal feedback at the end of the inspection to ensure any potential concerns are addressed as soon as possible. Further guidance can be found in Appendix 2.

7. RECOMMENDATIONS

7.1. Following all inspection visits, the Lead Manager is responsible for developing an action plan to ensure that all recommendations from the visit are followed up and acted upon. The minimum information required in an action plan should include recommendations, action required, trust lead, timescale and progress made. Any risks identified must be assessed and forwarded to the Compliance and Assurance Team for inclusion on the appropriate risk register immediately.

7.2. The Lead Manager will ensure that actions identified address the recommendations made and are achievable, are able to be embedded into practice and maintained on a long-term basis.

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7.3. The Lead Manager will present the initial action plan with the visit outcome report to the SMT within 1 month of the visit for ratification. Frequency of updates required by the SMT should also be agreed (minimum quarterly). A copy must also be sent to the Trust Compliance Team and the Lead Committee (where applicable).

7.4. In the event the external visit is unannounced and the Lead Manager is the senior member of staff on duty, the committee may find it necessary to identify a new Lead Manager post-visit to take forward the recommendations and progress updates for the committee.

7.5. The Lead Manager and Lead Committee (where appropriate) will monitor the action plan to ensure actions are undertaken within appropriate timescales and will send progress reports to the SMT and Compliance Team.

7.6. Once all actions have been completed and all recommendations met; the Lead Manager is responsible for reporting this to the Executive Team who will be required to sign off formally completion. The Compliance Team should also be advised so the schedule of assessments can be updated.

8. CQC INSPECTION

8.1. As part of the CQC inspection regime the CQC could undertake either unannounced focused and/or comprehensive inspections of providers of health and social care to ensure compliance with CQC registration requirements.

8.2. The purpose of a comprehensive inspection is to:

- Review Trusts (as a whole) against five key questions/domains (safe, effective, caring, responsive and well led) and publish a rating on each on a four point scale
- Assess the Core Services (as defined by the CQC)

8.3. Comprehensive inspections will be announced to the Trust Nominated Officer (Chief Executive Officer) in advance.

8.4. Upon receiving the notification this will be shared with the Compliance Team who will:

- Inform all relevant Trust Committees
- Ask Communications Team to initiate Trust wide communication regarding the comprehensive inspection and to inform relevant Trust partners/Stakeholders

8.5. The CQC will request a large amount of data / information prior to the inspection to allow them to focus their inspection. The Compliance Team will be responsible for coordinating with any services that hold the relevant data and collating all information for submission to the CQC. Any service who receives a data request must respond to this request within the timescale given, if this is not possible the service must inform the Compliance Team immediately.

8.6. The CQC will collate analysis of data / information provided in a ‘data pack’ for each service and send it to the Trust before inspection.

8.7. The CQC may carry out some pre-inspection case note tracking. This involves the pre-inspection review of selected (anonymised) patient case notes.

8.8. Site visits are a key part of inspection processes, giving the CQC an opportunity to talk to people using services, staff and other professionals to find out their experiences. They allow CQC to observe care being provided and to review people’s records to see how their needs are managed both within and between services.

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8.9. The CQC inspection team could consist of a large number of inspectors who will inspect all core services within the Trust. The Trust Head Office will be the central coordination point for the CQC for the duration of the inspection. The compliance team will ensure that relevant rooms are available for the CQC to use, taking into consideration the size of the inspection team.

8.10. The CQC may also undertake smaller more focused inspections, which will involve the review of one core service and two domains (one of which will always be Well-Led). This may mean a smaller inspection team will be used and the inspection will only focus on a few areas within the Trust.

8.11. All managers / senior staff on duty will be expected to facilitate CQC inspectors when they attend their area to inspect. This will include enabling staff member's time to be interviewed, enabling patients / relatives / carers to be interviewed, ensuring patient records are available and ensuring evidence of CQC compliance is accessible during the inspection. The manager / senior staff on duty are responsible for ensuring patient safety and care is not compromised during an inspection.

8.12. After the CQC has inspected a service, the manager / senior staff on duty are responsible for contacting the Compliance Team for de-briefing.

8.13. The CQC inspection team will use the key lines of enquiry (KLOEs) and collect evidence against these KLOEs. They will collect evidence using the following methods:

- Involving people who use services
- Listening Activities – gathering views and experience of the public prior to inspection.
- Inspection team will interview individual directors and staff at all levels
- Undertaking core focus groups (with a range of staff)

8.14. Other ways of gathering evidence will include:

- Observing care including using the SOFI 2 (Short Observational Framework for Inspection) tool. The CQC will always observe the care of people with dementia, frail older people using mental health services, people with a learning disability or autism and children and young people in hospital settings.
- Pathway tracking patients through care. CQC teams will choose to track the care of people using services who are particularly vulnerable. This will involve both reviewing records and speaking with staff involved in a person's care as well as the person themselves if they are willing to do so.
- Reviewing records.
- Reviewing policies and documents.

8.15. As part of the review of "well-led" the CQC will consider how the management of finances impacts on quality as part of a judgement on whether the quality of service is sustainable. At core service level this will include looking at the potential impact of cost improvement plans on safety and quality, and how well understood this is within the service.

8.16. During comprehensive inspections, Mental Health Act (MHA) experts will also undertake certain MHA monitoring in selected locations and review the way the provider discharges their duties under the MHA overall as part of the well-led domain.

8.17. The CQC will also carry out additional MHA monitoring visits, which will take place outside of comprehensive inspections (see section 9). Where concerns are identified, this may trigger further inspection or monitoring activity.

SAMPLE ONLY

8.18. Evidence from the inspections will be reviewed and further visits will be undertaken in order to explore emerging themes or concerns, or confirm findings of good practice. The CQC will return on an unannounced basis during the comprehensive inspection (see section 6).

8.19. CQC Inspection teams will base their judgements on all the available evidence, using their professional judgement. When making judgements, the CQC will consider the weight of each piece of relevant evidence.

8.20. The CQC inspection team leader will draft the inspection report, which will include all the ratings and this will be submitted to the Trust Chief Executive Officer. The Compliance Team will facilitate review of the draft inspection report to highlight any factual accuracy concerns. All concerns will be shared with the CQC.

8.21. CQC will publish the inspection reports and ratings (where appropriate) on their website. The Compliance Team will review all findings and work with directors to develop an action plan to respond to any CQC recommendations. The action plan will be submitted to the Trust Board of Directors before being shared with the CQC.

8.22. The Compliance Team will monitor implementation of actions and undertake evidence gathering and auditing of compliance as the actions are completed. When sufficient assurance of compliance is in place this will be shared with the Trust Board of Directors to confirm actions are closed before closure reports are submitted to the CQC.

9. MHA VISITS

9.1. Due to the frequency and unannounced nature of MHA Visits made by the CQC a different procedure should be followed:

9.1.1. In the event of a planned MHA visit by the CQC the Ward Manager / Lead must inform their Clinical Lead, MHA Administrator and Compliance Team of the booked date as soon as possible before the visit. In the event of an unplanned visit the Ward Manager / Lead must inform their Clinical Lead, MHA Administration and Compliance Team as soon as possible afterward and within 48 hours.

9.1.2. Following a visit the Ward Manager / Lead must send a copy of the visit feedback and action plan (provider response) to their MHA Administrators and the Compliance Team.

9.1.3. Action plan monitoring is as set as in section 8.

10. SURVEYS

10.1. National surveys should also be managed appropriately to ensure that any implications for the Trust are considered at every stage and that all actions are fully completed.

10.2. Preparation for the survey should be presented to the Executive Team.

10.3. Results of all national surveys must be reported to the Executive Team and copied to the Compliance Team. Reports must include:

- Outcome of the survey
- Comparison to national average
- Recommendations
- Action plan

10.4. Action plan monitoring is as set out in section 7.

END

SAMPLE ONLY