London Ambulance Service NHS
NHS Trust

Policy for the Management of External Agency Visits, Inspection and Accreditations

DOCUMENT PROFILE and CONTROL.

Purpose of the document: is to set out the process for responding to the recommendations and requirements arising from external agency visits, inspections and accreditations.

Sponsor Department: Governance and Compliance

Author/Reviewer: Assistant Director of Corporate Services. To be reviewed by September 2014.

Document Status: Final

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05/09/2012	3.2	Director of Corporate Services	Text update and formatting
24/07/2012	3.1	Assistant Director of Corporate Services	Updated monitoring table
21/05/10	2.1	Head of Governance	Reformatted. Added scope, responsibilities, action planning, processes, monitoring. Renamed, previously known as 'Process for Responding to External Recommendations Specific to the LAS'.
24/09/08	1.1	Head of Governance	Added monitoring
31/07/07	0.1	Head of Governance	First draft

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

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Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP035	Risk Reporting and Assessment Procedure	
TP005	Risk Management Policy	
LA167	Risk Assessment Form	
TP054	The Investigation and Learning from Incidents, PALS, Claims and Complaints Policy	
	Risk Management Standards for Ambulance Services, NHS Litigation Authority 2012-13	
	Audit Commission. Key Lines of Enquiry for Auditors: Local Evaluation Assessment. London: Audit Commission. (2008) Available at: www.audit-commission.gov.uk	
	Health & Safety Executive (A Strategy for Workplace health and safety in Great Britain to 2010 and beyond. London: Health and Safety Executive. (2004) Available at www.hse.gov.uk	
	Essential Standards of Quality and Safety Care Quality Commission: www.cqc.org.uk	
	Monitor The NHS Foundation Trust Code of Governance. London: Monitor. (2006) Available at www.monitor-nhsft.gov.uk	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

This policy has been developed to enable the London Ambulance Service NHS Trust (LAS) to respond to recommendations and requirements of External Agency Visits, Inspections and Accreditations. The process described in this document is part of the trust's internal control system and provides assurance to the Board that there is a robust system in place.

The LAS has three strategic goals;

a) To improve the quality of care we provide to patients.
b) Deliver care with a highly skilled and representative workforce
c) Deliver value for money

This process will be applied so that implementation of recommendations made following external agency visits, inspections and accreditations enhances patient care. This document should be used in conjunction with The Investigation and Learning from Incidents, PALS, Claims and Complaints Policy (TP054).

2. Scope

The policy relates to all external agency visits accreditations and inspections of the LAS and its services. It describes the process to be followed so that recommendations made as a result of external agency visits, inspections and accreditations are implemented within specified timescales and monitored appropriately. There is a formal reporting and reviewing process described in this document.

3. Objectives

- To explain to all staff the process to be followed so that all recommendations made by external agency visits, inspections and accreditation bodies are implemented within a specific timescale and are monitored following implementation as part of the formal reporting and reviewing process.

- To define the responsibilities, monitoring arrangements and reporting lines so that management of external agency visits, inspections and accreditations is consistent with LAS Strategic goals and the principles set out in The Investigation and Learning from Incidents, PALS, Claims and Complaints Policy (TP054).

4. Responsibilities

The Trust's Senior Management Group (SMG) provide assurance to the Board that continual improvement is being achieved within areas of their portfolio.

4.1 Trust Board

The Trust Board has ultimate responsibility for managing and implementing any recommendations made in reports made following external agency visits, inspections and accreditation reviews. Whilst the day to day work may be delegated to other committees or individuals as detailed below, details of all reports must be given to the Board.

4.2 Chief Executive

The Chief Executive's Office will be the gateway through which all such communication will be referred before it enters into the management system. This will happen either through the external body writing to him direct or through management leads forwarding a copy of any documentation they receive directly. Following receipt of notification of a visit, the Chief Executive will nominate the Director of Corporate Services to be responsible for managing the visit and will charge the SMG to oversee the process.

Following inspection, the Chief Executive will forward the report received to the Director of Corporate Services to manage the response on behalf of the Trust.

4.3 Committee with overarching responsibility for management of all external agency visits, inspections and accreditations

The Chief Executive, in discussion as considered appropriate with other Executive and Non Executive Directors of the Trust, will identify which committee will be responsible for monitoring the visit and the Trust's response to any subsequent report and recommendations. The identified Committee for some of the visits are shown in Appendix B. The identified committee will:

- Provide summary report of all visits etc and approve action plans to address the recommendations.

- Report through the governance structure to the Board.

- Ensure that communications at local management level are managed by local senior managers.

- Ensure, through the Director leads, that any lessons to be learned are identified and implemented across the Trust in agreement with the Director of Corporate Services.

4.4 Lead Director

The Director of Corporate Services (or the Chief Executive) will be responsible for:

- Identifying the Management Lead, to be responsible for leading the Trust's response to the visit report.

- Review and evaluate the report and oversee the development of an action plan to address the recommendations.

- Provide a response to the external agency.

- Ensure that details of the external report are provided to the Trust Board.

4.5 Nominated management lead

The Nominated management lead will be the Assistant Director of Corporate Services or a senior manager nominated by the Executive Director in whose Directorate the visit primarily falls. Their work will fall in to three categories:

4.5.1 Coordinating work prior to the visit

- Identify any staff/resources required to support the preparatory work.
- Manage the preparatory work to be undertaken prior to the visit.
- Support the process of the visit – liaison, briefings, programmes, evidence collation, and interim reports/briefings.

4.5.2 Managing the visit

- Manage the process of the visit.
- Ensure that all necessary papers are available for the inspector(s).
- Ensure that identified staff are available to talk to the inspector if required.

4.5.3 Developing the Trust's Action Plan and response following the visit

- Maintain a schedule of review dates for responding to the report as instructed by the reporting agency.
- Develop and maintain an action plan to implement any recommendations made as a result of reviews.
- Ensure the action plans are regularly reviewed and the progress being made is evaluated by the nominated committee/group. See Appendix B.
- Complete a Report Template following receipt of the report detailing the recommendations. See Appendix C.

4.6 Governance & Compliance Manager/Audit & Compliance Manager

- Ensure that any electronically held systems (i.e. Performance Accelerator, Datix) recording data relevant to external agency visits, inspections and accreditations is kept up to date.

- Ensure that all Trust risk registers (Board Assurance Framework, Corporate Risk Register, Local Risk Registers) are kept updated with any risks that may be identified from external agency visits, inspections and accreditations.

4.7 The Governance and Compliance Team are responsible for –

- Maintaining a schedule of review dates to be available for Board and relevant Committees.

- Receiving copies of notifications of all inspections.

- Establishing and maintaining a database on the Trust's IM&T electronic systems (e.g. trust intranet, shared directories) of papers relating to all visits, receiving updated reports and action plans.

5. Definitions

- ***External Agency*** – An authoritative body who have been given a role by the NHS Executive in regulating the corporate and professional activities of all NHS Trusts (a list of such bodies is included in Appendix A).

- ***Accreditation*** – Relates to audit and review activities of both internal and external bodies, which are required to produce Board Assurance that the services being delivered by the Trust are fit for purpose and achieving the desired outcomes as laid down by the Trust's strategy and policies.

- ***Inspection*** – A check or visit by an external agency to assess whether an organisation is meeting particular standards of care.

- ***Internal Control*** – A process within an organisation designated to provide reasonable assurance regarding the achievement of primary objectives.

6. Identification of External Organisations

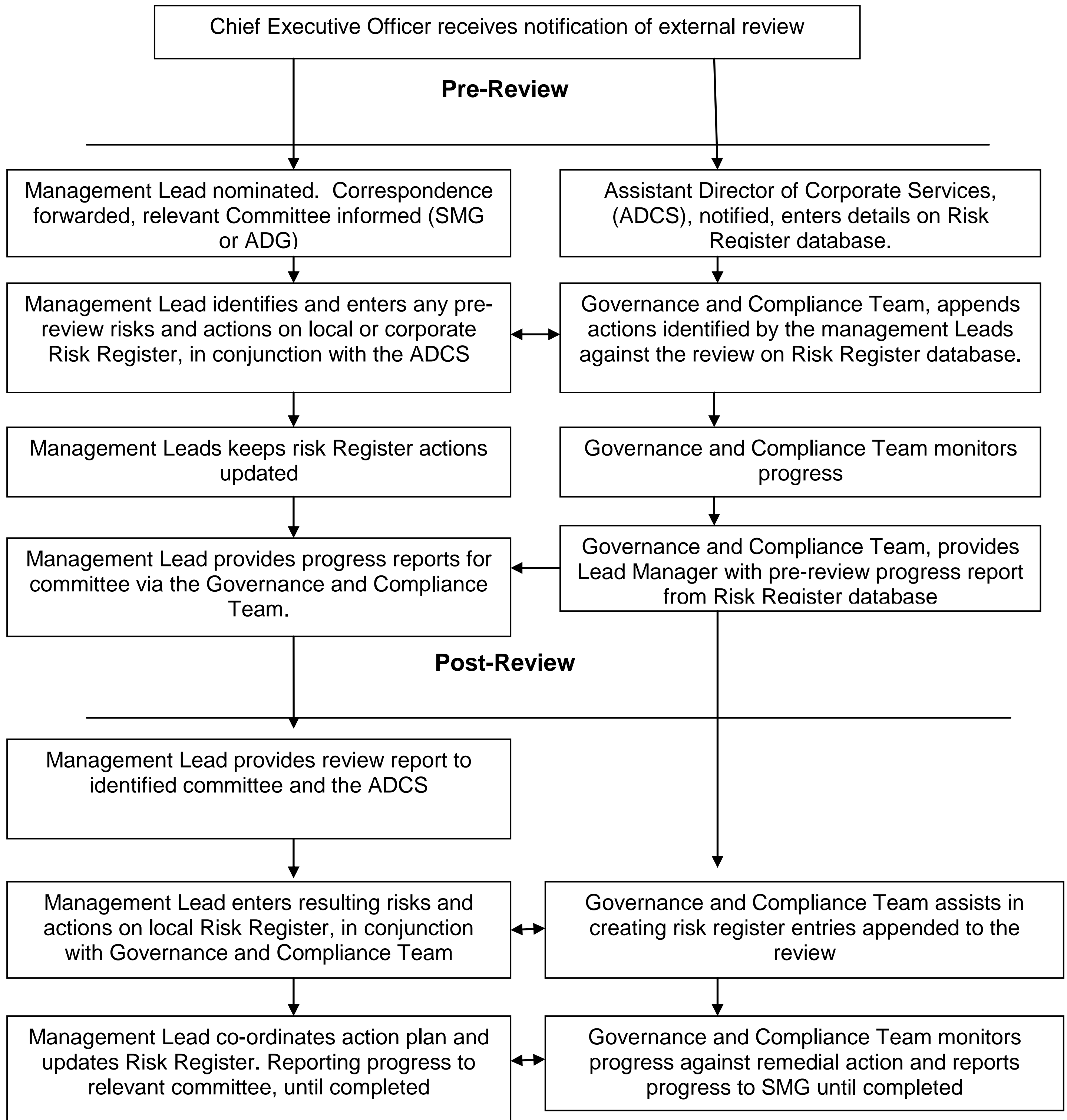
The LAS has identified all those external agencies undertaking a visit, inspection or accreditation in Appendix 1. This includes local inspections for specialist services as well as organisational inspections.

7. Scheduling Visits

The Director of Corporate Services will maintain and update a schedule of visits in the Trust calendar to ensure visits, inspections and accreditations do not overlap. In the event of an unannounced visit, the Director of Corporate Services will co-ordinate the Trust calendar with the Assistant Director of Corporate Services to make arrangements as outlined in section 4.5.

8. The Visit Process

To ensure that the LAS can provide assurance that continual improvement is being achieved the following process will be followed to ensure all external reviews are logged and resulting action plans actively managed:



9. Trust wide Visit Reports

Following receipt of the visit report, the nominated lead will use the template provided at Appendix D.

9.1.1 Provide informal feedback to the Director of Corporate Services and other Trust staff as appropriate.

9.1.2 Provide the Executive Lead, Director of Corporate Services and Governance and Compliance Team with the following information, so that the central register of visits can be updated with details of:

- Compliance with the recommendations of the visit
- Actions required
- Responsibility for all aspects of the action plan
- Date by which actions should be completed
- Arrangements for monitoring

9.1.3 Provide the Executive Lead, Director of Corporate Services and the Governance and Compliance Team with updates on progress against the action plan; quarterly or more frequently if required, for onward reporting to the SMG Committee and Board.

9.1.4 Immediately bringing to the attention of the Executive lead and the Director of Corporate Services, any barriers which may prevent implementation of any aspects of the action plan within the agreed timescales, for onward reporting to the SMG.

9.1.5 Ensure any identified risks are escalated to the Risk Compliance and Assurance Group for consideration of inclusion on the Trust-wide risk register.

9.1.6 Inform the Executive Lead, the Director of Corporate Services and the Governance and Compliance Team when all actions have been completed, so that the central register can be updated.

9.2 Specialty Specific Visit Reports

This includes all Directorates, specific departments and services.

Following receipt of the visit report, the nominated lead will

9.2.1 Provide informal feedback to the Executive Lead and the Director of Corporate Services.

9.2.2 Provide the ADCS, copying in the Executive Lead, Director of Corporate Services and Governance & Compliance Team with the following information, so that the central register can be updated.

- Compliance with the recommendations of the visit
- Actions required
- Responsibility for all aspects for the action plan
- Date by which actions should be completed
- Arrangements for monitoring

The nominated lead should do this using the template at Appendix D

9.2.3 Provide the above details to the SMG and any other parties.

9.2.4 Provide the Executive Lead and the Director of Corporate Services with updates on progress against the action plan; quarterly or more frequently if required, for onward reporting to the SMG Committee and Trust Board.

9.2.5 Bring to the attention of the Executive Lead and the Director of Corporate Services, and Area Governance Committee (for local issues), any barriers which may prevent implementation of any aspects of the action plan within the agreed timescales. This must be done immediately.

9.2.6 Ensure any identified risks are placed on the appropriate risk register: Area or Trust. If the risk needs to be put on the Trust Risk Register the nominated lead must escalate to the Director of Corporate Services for presentation to the Risk Compliance and Assurance Group for consideration of inclusion on the Trust-wide risk register.

9.2.7 Inform the Executive Lead and Director of Corporate Services, Area Governance Committee and the Governance and Compliance Team when all actions have been completed, so that the central register can be updated.

10. Monitoring and Evaluation

The Assistant Director of Corporate Services will review and evaluate the process following each visit to monitor compliance with this policy and identify any gaps or areas for improvement in following the process.

The evaluation will be fed back to the SMG and responsibilities for action will be agreed by them.

The process for each visit will be evaluated against the following criteria:

- Lead Director identified
- Stakeholders notified and consulted
- Responsibilities of committees and individuals fully met during process
- Action Plan produced
- Risk Register populated with risks from visit report
- Actions implemented within timescales set out in Action Plan
- Report from external agency acted upon and responded to within required timescale as required by agency
- Board reporting including evidence of action taken answering all points raised by external agency report that satisfied assurance requirements.

In addition the review/monitoring will include the minimum requirements within the NHSLA standards.

- Monitoring arrangements for compliance and effectiveness i.e. audit by committee and individual managers up to Board level.
- Responsibilities for conducting the monitoring/audit.
- The methodology to be used for monitoring/audit.
- The frequency of monitoring/audit until action plan is fully implemented
- The process for reviewing results and ensuring improvements result as intended from actions implemented.

10.1. Monitoring Compliance with, and the effectiveness of this policy

10.1.1 The nominated lead will review and evaluate the process following each visit to ensure the ongoing effectiveness of the policy.

10.1.2 The nominated lead will recommend any required changes to the process.

10.1.3 The report of the review by the nominated lead will be submitted to the Director of Corporate Services for agreement to any required changes to the process.

10.1.4 The Director of Corporate Services will provide a report to the Trust Board, including information from the report of the nominated lead and evidence of compliance with the following criteria:

- Nominated lead being identified and appointed
- Action plan being produced and actions being implemented and closed
- Actions being undertaken with the agreed timescales
- Risk Registers being populated with the risks identified as a result of the visit.

10.1.5 The Director of Corporate Services will ensure implementation of any required changes, including amendments to this policy.

10.1.6 SMG will receive the schedule of visits spreadsheet bi-annually to ensure that it is up to date and that all actions required as a result of visits have been, or are being, implemented within the required timescales.

10.2. Monitoring the outcome of visits

10.2.1 The SMG Committee will monitor the action plans developed as a result of Trust-wide visits.

10.2.2 The Director of Corporate Services will provide the Trust Board with bi-annual updates on the progress of the outcome of Trust-wide visits, or earlier should any issues arise that may have a negative impact on the Trust's business or reputation.

10.2.3 The Risk Compliance and Assurance Group will monitor the progress against any identified risk placed on the Trust-wide risk register.

<u>Area specific visits</u>

10.2.4 The Area Governance Committees will monitor the action plans developed as a result of Area specific visits.

10.2.5 The nominated lead will provide the Director of Corporate Services with quarterly updates on the progress of the outcome of speciality specific visits, or earlier should any issues arise that may have a negative impact on the Trust's business or reputation.

10.2.6 The Area Governance Committees will monitor the progress against any identified risk placed on the area risk registers.

IMPLEMENTATION PLAN	
Intended Audience	All LAS staff
Dissemination	Available to all staff on the Pulse
Communications	Revised Procedure to be announced in the RIB and a link provided to the document
Training	To be determined and recorded in the TNA and monitored by the Training Strategy Group. There are no specific training requirements, however advice, assistance and guidance will be provided by the Director or Assistant Director of Corporate Services with support from the Governance and Compliance Team available to staff involved in following the process described in this document.

Monitoring:

Aspect to be monitored	Frequency of monitoring AND Tool used	Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported	Committee/ group responsible for monitoring outcomes/ recommendations	How learning will take place
Process for reviewing and reporting on external recommendations specific to the organisation including how action plans are developed and followed up as a result of external recommendations (Sections 8 and 9)	Monthly	Governance & Compliance Associate Directors Group Senior Management Group Learning from Experience	Risk Compliance and Assurance Group	Published on the Pulse and cascaded through the organisation via Core Briefing & Bulletins

Appendix 1

External Agencies

- JRCALC
- Audit Commission
- Healthcare Ombudsman
- Conference for Postgraduate Medical Deans
- Counsel for Healthcare Regulatory Excellence
- Department of Health
- General Medical Council (GMC)
- Health and Safety Executive (HSE)
- Care Quality Commission
- National Audit Office
- NHS Counter Fraud and Security Management Services (CFSMS)
- NHS Health and Social Care Information Centre
- NHS Litigation Authority
- Postgraduate Medical Education and Training Board
- Monitor
- External audit consultancy
- Commissioners

Appendix 2

Identified Nominated Committees and Lead Directors

External Agency	Executive Committee	Nominated Lead Director
NHSLA	RCAG	Corporate Services
Audit Commission	Audit Committee	Finance
PEAT	SMG	Head of Estates
HSE	SMG	Human Resources and Organisational Development
CQC	SMG	Corporate Services

Appendix 3

Report template following External Agency visits

Recommendation (Detail each recommendation from the report)	Compliance Y/N/Partial	Action Required	Responsible Lead	Target Completion Date	Monitoring Arrangements	Date Completed

Appendix 4

Flowchart for managing the assurance following the receipt of a report