Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Management of Reviews, Visits, Inspections and Accreditations Policy

This procedural document supersedes: CORP/COMM 11 v.4 - Management of Reviews, Visits, Inspections and Accreditations Policy.

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Executive Sponsor(s):	Richard Parker – Chief Executive
Author/reviewer: (this version)	Fiona Dunn – Director Corporate Affairs
Date written/revised:	December 2022
Approved by:	Board of Directors
Date approved:	January 2023
Date issued:	March 2023
Next review date:	December 2025
Target audience:	Trust-wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the APD has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 5	30 December 2022	• Minor changes and updates to reflect Divisional structure and committee governance structures • Also now Includes visits/reviews undertaken virtually	Fiona Dunn
Version 4	29 January 2015	• Title change • Updates to reflect new Care Group structure, and changes to committee structure • Reporting of external assurance register added	Maria Dixon
Version 3	February 2013	• This policy has been re-written, please read in full. • New style format as per CORP/COMM 1.	Maria Dixon
Version 2	October 2009	• Title change • This policy has been re-written, please read in full	Maria Dixon

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1. INTRODUCTION

NHS organisations are required to participate in reviews by external agencies, some of which may be undertaken at short notice. Some review bodies such as the Health & Safety Executive and the Care Quality Commission (CQC) may also undertake unannounced visits.

This policy and process is for the effective coordination and evaluation of the work of such reviews. It will help to reduce overlap and allow potential gaps in assurance to be identified and addressed.

This is part of the organisation's internal control system and provides assurance to the board in order that it may benefit from the work undertaken by reviewers and ensure that the process is efficient and meaningful to the Trust.

2. SCOPE

The scope of this policy is limited to routine or risk-based visits, inspections, or reviews for assessment, accreditation or benchmarking purposes, or has the potential to impact upon the reputation of the Trust. Such reviews may be conducted internally or by an external agency, but the scope of this policy is restricted to those reviews which are either externally mandated or externally reported. For the purposes of this policy and procedure, the term "reviews" will be used to reflect all of these methods of enquiry. (Visits or reviews can also be virtual)

National Institute of Clinical Excellence Guidance (NICE) is outside the scope of this policy and is managed using the NICE Guidance Policy (CORP/COMM 10).

National Confidential Enquiries are outside the scope of this policy and are managed using the National Confidential Enquiry (NCE) Policy (CORP/COMM 20).

The scope of this policy does not include all external data collection exercises that take place within the Trust. The Trust's Information Team routinely participate in and manage data submissions which are overseen through the existing management arrangements. The scope also does not include routine internal assessments that are not reported or mandated externally, such as Tendable assessments.

In addition, some training programmes and initiatives within the organisation may seek accreditation from local universities with the accreditation process managed solely by the training provider. Such exercises do not fall within the scope of this policy, which primarily focuses on nationally led, external visits and inspections that have the potential to impact significantly on the Trust's performance assessments and reputation.

3. PURPOSE

There are a number of agencies that may undertake reviews to assess the Trust's performance or use the result of internal reviews to benchmark the Trust against its comparators. The principal purposes of this policy are as follows:

- To ensure that preparation for reviews includes a prospective gap analysis against standards or requirements in order to ensure that:
    - Review outcomes are as positive and compliant as possible, within available resources.
    - Wherever possible, there are no surprises from reviews and that financial planning can take place with maximum notice, enabling resources to be identified efficiently.
- To ensure that data and other information required for reviews is accurate, of the highest possible quality, has been validated prior to submission, and is shared with the relevant agencies in a timely manner.
- To ensure that there is a centrally held and internally audited record of all reviews together with their associated reports and action plans. These are to be maintained, updated and monitored in accordance with this policy.
- To ensure that recommendations and action plans arising from reviews are appropriately managed by the Clinical Governance Quality Committee, Performance, Overview & Support Meetings (POSM) or Trust Executive group (TEG) and escalated to the Board of Directors as required. This will be achieved through clear lines of accountability and responsibility in relation to each of the reviews as detailed in this section.

4. DUTIES AND ACCOUNTABILITIES

4.1 Chief Executive

As Accountable Officer, the Chief Executive is ultimately responsible for the process of managing and responding to reviews effectively and the delegation of these responsibilities.

Where no Accountable Director is named in this policy, the Chief Executive will be notified and is responsible for nominating an Accountable Director.

4.2 Executive Directors and Divisional Directors

All directors are responsible for supporting the Accountable Director and Operational Review Lead in conducting a gap analysis and risk assessments against any recommendations resulting from the review and implementing any resulting action plans.

All directors are responsible for ensuring that their Divisional risk register reflects any gaps identified in this gap analysis and are allocated an appropriate risk rating.

4.3 Accountable Director

The Accountable Director is the nominated lead, usually an Executive or Divisional Director. The Accountable Director will oversee preparation for reviews, nominate the Operational Review Lead and inform the Operational Review Lead, Trust Executive Group and Review Operational Working Group (where required) of their nomination.

The Accountable Director will inform the Director of Corporate Affairs of the forthcoming review. The Accountable Director will also inform the Director of Communications and Engagement and Head of Information if appropriate.

The Accountable Director will report progress, final results and implementation of recommendations to the Review Operational Working Group, Trust Executive Group, Chief Executive and Board of Directors as appropriate.

The Accountable Director will ensure that the Board Assurance Framework is updated to reflect assurance arising from reviews.

4.4 Board of Directors

This policy and procedure will ensure that the Board of Directors is assured regarding the management of reviews and of an appropriate organisational response to the outcome of the reviews where required. An 'External Assurance Register' will be maintained by the Trust Board Office.

4.5 Operational Review Lead

The Operational Review Lead will generally be a Divisional General Manager or a Divisional Director of Nursing, or a head of department or appropriate manager in a corporate directorate.

The Operational Review Lead will be nominated by the Accountable Director and is responsible to the Accountable Director for the effective management of the review until all actions resulting from the process are fully implemented.

The Operational Review Lead will:

(a) Inform the relevant staff and managers of the forthcoming review, detailing the scope of the review and agreed timescales;

(b) Decide whether to instigate a Review Operational Working Group to help with the whole planning of the visit which may include agreeing the logistics of onsite visits etc.

(c) Conduct a prospective gap analysis against standards or requirements in order to ensure that review outcomes are as positive and compliant as possible and that any necessary financial planning in relation to resourcing required actions can be undertaken in advance of the review;

(d) Complete the checklist at appendix 5 and return this to the Director Corporate Affairs confirming that the relevant preparation for the review has been undertaken;

(e) With the support of the Head of Information and/or other staff as appropriate, oversee the collation of relevant information for the review;

(f) Agree arrangements for validating data prior to submission with the Accountable Director;

(g) On receipt of the review report, ensure that all the information included in the report is accurate;

(h) Conduct a gap analysis and risk assessments against any recommendations made; develop an action plan if appropriate and agree this action plan with the Accountable Director. The action plan and risk assessment will, if appropriate, be reported to the Review Operational Working Group and Trust Executive Group;

(i) Review the report and actions plans regularly, in accordance with agreed timescales, and report the reviews to the Accountable Director, who will report to the Trust Executive Group if required.

4.6 Director Corporate Affairs

The Director Corporate Affairs (via Trust Board Office) will maintain an external assurance register, containing information relating to current, forthcoming and previous reviews. A summary form of this register, showing forthcoming and recent reviews, will be reported on a bi-monthly basis to the Trust Executive Group.

The Director Corporate Affairs will receive a copy of the post-review report for inclusion in the external assurance register.

4.7 Trust Executive Group (TEG)

A summary form of the external assurance register, showing forthcoming and recent reviews, will be reported on a bi-monthly basis to the Trust Executive Group. More detailed information regarding preparation for reviews will also be reported as appropriate.

Review reports will be reported to the Performance, Overview & Support Meetings, and the Trust Executive Group will approve the resulting action plan, if applicable. Action plans will be monitored through the Review Operational Working Group, unless otherwise determined by the Trust Executive Group.

4.8 Executive team

The executive team will determine whether post-review reports, action plans or any other information arising from a review should be escalated and reported in detail to the Board of Directors in addition to the arrangements outlined in paragraph 4.7 above.

4.9 All staff

All staff are responsible for notifying their Divisional Director or Executive Director if they receive information regarding a prospective review.

5. PROCESSES

The processes followed are as outlined in the process maps – see Appendix 1 and Appendix 2.

5.1 Notification of planned reviews

Notifications of reviews are received by the Trust in a variety of different ways. All notifications of this kind must be forwarded to the Accountable Director, who will proceed in accordance with the process on Appendix 1.

5.2 Notification of unannounced reviews

Notification of an unannounced review will occur when an external review body presents at a Trust site. In the case of the Care Quality Commission, it is likely that this will occur at the Chief Executive's Office. The member of staff who is first notified of the visit must contact the Chief Executive (in hours) or Director on Call (out of hours), who will proceed in accordance with the process on Appendix 2.

5.3 Failure to provide notification

Where notification of a review does not take place, and therefore appropriate preparatory actions have not been undertaken in accordance with this policy, the Accountable Director should report to Trust Executive Group on the circumstances. The Executive Team shall determine whether the matter is to be escalated to the Board of Directors.

5.4 Maintenance of the external assurance register

The Director of Corporate Affairs (via Trust Board Office) will maintain a register of all reviews, both past and future. The database will contain the reports resulting from the reviews.

The Trust Executive Group will review the External Assurance Register bi-monthly.

The Director Corporate Affairs will review the External Assurance Register annually to identify any items for inclusion in the annual report, quality account or other reporting mechanism as appropriate.

5.5 Development, maintenance and review of action plans

Following receipt of the report, the Operational Review Lead will:

(a) ensure that the report has been received by the Accountable Director and Director Corporate Affairs;

(b) review the report to ensure its accuracy;

(c) conduct a gap analysis and risk assessments against any recommendations resulting from the review;

(d) once the accuracy of the report has been confirmed, and where appropriate, develop a report and action plan in response to any recommendations. The report and action plan must detail the following:

- a summary of the main review findings
- recommendations made
- compliance with recommendations
- action required
- lead for each action
- timescales for the completion of actions
- review frequency for each action
- date actions completed

This report and action plan is to be agreed with the Accountable Director before being provided to the Director Corporate Affairs and formally submitted to the Trust Executive Group (TEG). The action plan will be approved by Trust Executive Group, provided the Trust Executive Group is satisfied that it is adequate.

The Operational Review Lead will oversee implementation of the agreed action plan on behalf of the Accountable Director. Monitoring of action plans will be through the Review Operational Working Group (if applicable) unless determined otherwise by the trust Executive Group.

Once an action plan has been fully implemented, the Operational Review Lead will notify the Director Corporate Affairs of this, for recording on the external assurance register and reporting to the Trust Executive Group.

Many reviews use bespoke action plan formats, and these should be used where they exist. Where there is no set action plan format, leads should use the standardised Trust action plan headings as indicated in section (d) above.

5.6 Post review reports

Post review reports will be provided to the Director Corporate Affairs for inclusion in the External Assurance Register. They will also be formally submitted to the Trust Executive Group, along with a report from the Accountable Director and an action plan if appropriate (see para 5.5).

The executive team will determine whether post review reports should be escalated and reported in detail to the Board of Directors in addition to the arrangements above.

5.7 Risk register and assurance framework

Following gap analysis and risk assessment of both forthcoming reviews and recommendations and action plans resulting from past reviews, the Operational Review Lead will escalate details of any risks assessed as ‘high’ or ‘extreme’ to their Divisional/

directorate risk register or to the corporate risk register (via Risk Management Board) as appropriate.

The Accountable Director will ensure that the Board Assurance Framework is updated to reflect assurance arising from reviews. Any risks added to the corporate risk register will be reviewed using the established mechanisms for doing so.

All directors are responsible for ensuring that their local risk registers reflect any outstanding gaps identified from this gap analysis and are allocated an appropriate risk rating.

6 TRAINING/SUPPORT

The training requirements of staff will be identified through a learning needs analysis (LNA). Role specific education will be co-ordinated/ delivered by the topic lead. Alternatively, training may be accessed via an approved e-learning platform where available.

7 MONITORING COMPLIANCE WITH T HE PROCEDURAL DOCUMENT

What is being monitored	Who will carry out the monitoring	How often	How reviewed/Where reported to
Monitoring of compliance with the policy	Divisional Director	Monthly	Monthly monitoring at SMT meetings
Monitoring of post-review action plans	Divisional Director	Monthly	Monthly monitoring at SMT meetings

8 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 6)

9 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

APPENDIX 1 - PROCESS MAP - PLANNED REVIEWS

REVIEWER (External or Internal) – (NB also includes virtual reviews)
Provides notification of forthcoming review.

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MEMBER OF TRUST STAFF
Notifies Accountable Director. In the absence of a named Accountable Director, the Chief Executive is notified and will nominate an Accountable Director.

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ACCOUNTABLE DIRECTOR
Notifies Operational Review Lead and Director Corporate Affairs (via Trust Board Office).
Notifies Head of Information / Director of Communications & Engagement if appropriate.

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DIRECTOR CORPORATE AFFAIRS
Adds review to external assurance register.
Ensures Trust Executive Group is notified of review.

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OPERATIONAL REVIEW LEAD

- Agrees key review contact within clinical / corporate service (where appropriate)
- Undertakes prospective gap analysis & develops action plan where appropriate
- Undertakes prospective risk assessment & escalates risk assessments where appropriate
- Makes arrangements for management of the review (possible Review Operational Working Group)
- Clarifies practical arrangements for on-site visits (where appropriate)
- Alerts & liaises with Divisional Directors / General Managers where appropriate
- Oversees collation of information, ensures information is quality assured prior to submission
- Ensures information is submitted within specified timescales

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REVIEWER
Provides post-review report

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OPERATIONAL REVIEW LEAD

- Shares report with:
  - Accountable Director and other key contacts in the relevant Division/directorate
  - Trust Executive Group, which will review the report and approve action plan if applicable
  - Director of Communications and Engagement
  - Director Corporate Affairs for inclusion in external assurance register
- Conducts gap analysis and risk assessment in response to recommendations
- Ensures action plan is developed in response to recommendations
- Reports progress against action plan in line with agreed review timescales to Review Operational Working Group (or other group as determined by Trust Executive group)
- Escalates risk assessments to Divisional risk register and corporate risk register as appropriate

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ACCOUNTABLE DIRECTOR
Reports back to reviewer regarding action taken.

APPENDIX 2 - PROCESS MAP - UNANNOUNCED REVIEWS

EXTERNAL REVIEW BODY
Presents at Trust site / Chief Executive's office unannounced

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STAFF INFORMED OF REVIEW
- Immediately notify Chief Executive (in hours) or Director on call (out of hours)
- CE or Director on call nominates and notifies Accountable Director and other Executive Directors as appropriate.

(if CQC, follow CQC Alert Action Cards found on the HIVE)

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ACCOUNTABLE DIRECTOR
Notifies Operational Review Lead, Director Corporate Affairs and any other appropriate members of staff If
(if CQC, follow CQC Alert Action Cards found on the HIVE)

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OPERATIONAL REVIEW LEAD
- Management of the visit / review
- Alerts Divisional Directors / General Managers where appropriate
- Ensures information is quality assured prior to submission
- Ensures information is submitted to external body within specified timescales
- Notifies Trust Executive Group at first opportunity

DIRECTOR CORPORATE AFFAIRS
Adds review to external assurance register

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EXTERNAL REVIEW BODY
Provides post-review report

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OPERATIONAL REVIEW LEAD
- Shares report with:
  - Accountable Director and other key contacts in the relevant Division/directorate
  - Trust Executive Group, which will review the report and approve action plan if applicable
  - Director of Communications and Engagement
    - Director Corporate Affairs for inclusion in external assurance register
- Conducts gap analysis and risk assessment in response to recommendations
- Ensures action plan is developed in response to recommendations
- Reports progress against action plan in line with agreed review timescales to Operational Working Group (or other group as determined by Trust Executive Group)
- Escalates risk assessments to Divisional risk register and corporate risk register as appropriate

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ACCOUNTABLE DIRECTOR
Reports back to external review body regarding action taken.

APPENDIX 3 – REVIEW OPERATIONAL WORKING GROUP AND TRUST EXECUTIVE GROUP REPORT TEMPLATE

Forthcoming reviews

Division/Directorate management teams are asked to:

- Notify the Director Corporate Affairs and relevant Executive Director of any forthcoming reviews that are not listed below.
- Notify the Director Corporate Affairs of any changes to the information shown below.
- Ensure the checklist (shown overleaf) for forthcoming reviews has been returned.

FORTHCOMING REVIEWS					
Review date	**Description**	**Operational Review Lead**	**Checklist returned** (date)	**Risk assessment**	**Outcome expected** (date)

Past reviews resulting in action plans

Division/Directorate management teams are asked to:

- Update the Director Corporate Affairs regarding completion on the action plans for the reviews shown below.
- Notify the Director Corporate Affairs of any changes to the information shown below.

PAST REVIEWS RESULTING IN ACTION PLANS					
Review date	**Description**	**Operational Review Lead**	**Action plan approved by TEG** (date)	**Risk assessment**	**Expected completion of action plan** (date)

APPENDIX 4 – SCHEDULE OF AGENCIES AND REVIEWS

This policy applies to all reviews which are mandated or reported externally, or which have PR implications for the Trust. The list below gives examples of the agencies and reviews to which this policy applies but is not exhaustive.

Agencies with statutory enforcement powers
Care Quality Commission (CQC)
Charities Commission
Environmental Agency
Environmental Health
Fire Service
Health & Safety Executive
Human Fertilisation and Embryology Authority
Human Tissue Authority
Information Commissioner office
Police
Regulators of health professionals, including: • GMC • Nursing and Midwifery Council • General Pharmaceutical Council • Health and Care Professions Council • and others
The Equality and Human Rights Commission

Other agencies or reviews (but not limited to those listed)
United Kingdom Accreditation Services (UKAS)
Commissioners
Confidential enquiries
Coroner
Health and Wellbeing Boards
Health Education England
Home Office – Controlled Drugs licence
Healthwatch England
IR(ME)R Regulations (Radiology)
JAG Accreditation (endoscopy)
Medicines & Healthcare products Regulatory Agency (MHRA)

MHRA Blood Bank Inspections (– Blood Safety and Quality Regulations 2005)
National Audit Office
National Cancer Action Team (peer reviews)
National Institute for Health and Care Research (NIHR)
NHS England
National Specialised Commissioning Group
NHS Blood and Transplant
NHS Counter Fraud and Security Management Service
NHS Resolution
OFSTED (safeguarding)
Overview and Scrutiny Committees of local authorities
Parliamentary and Health Service Ombudsman
Peer Reviews eg Trauma Peer Review
Patient Led Assessments of the Care Environment (PLACE)
National Staff Survey
UK Health Security Agency (UKHSA)
Universities and Local Training and Education Boards

APPENDIX 5 – PRE-REVIEW CHECKLIST

Review:	
Review body:	
Review date:	
Accountable Director:	
Operational Review Lead:	
Overall risk assessment:	

Action	Date Completed	Completed by
Director Corporate Affairs informed of review.		
Other relevant staff and managers informed.		
Identify aim of review, and desired outcome.		
Gap analysis - identify expected outcome and gaps.		
Action plan to address identified gaps developed and agreed by Accountable Director.		
Risk assess gaps and escalate risk assessments in line with policy if appropriate.		
Risk assess the overall review based on expected outcome, and escalate risk assessments in line with policy if appropriate.		
Agree arrangements for the collation of any information required, and for validating data prior to submission.		
Agree arrangements for practical management of the review.		

APPENDIX 6 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Management of Reviews, Visits, Inspections & Accreditations Policy	CEO	Fiona Dunn	Existing Policy	December 2022

1) Who is responsible for this policy? Name of Directorate Director Corporate Affairs (Chief Executive Directorate)

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? To improve preparation for and outcomes of reviews of the Trust (i.e. improve compliance and improve assurance regarding compliance)

3) Are there any associated objectives? Legislation, targets national expectation, standards No

4) What factors contribute or detract from achieving intended outcomes? – Compliance with the process maps in the policy.

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 6

Date for next review: December 2025

Checked by: CEO Date: December 2022