Trust Policy	Worcestershire Acute Hospitals NHS Trust

Policy for managing the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Department / Service:	Clinical Governance
Author/Owner:	Deputy Chief Nursing Officer (Quality)
Accountable Director:	Chief Nursing Officer
Approved by:	Clinical Governance Group
Date of approval:	4th October 2022
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All departments
Target staff categories	All staff

Policy Overview:
This policy outlines how the trust will meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The policy includes the requirement to maintain the trust's registration with the CQC, and to ensure compliance with the Standards of Quality and Safety.

Key amendments to this Document:

Date	Amendment	By:
24/6/13	New policy, developed June 2013	H Webb
May 2015	Major review in response to changes in the Health and Social Care Act, and changes to the CQC's approach to inspection.	H Webb
August 2017	Document extended as per email request from Heather Webb	H Webb
Nov 2017	Document extended whilst document under review	TLG
Dec 2017	Document extended for 3 months as per TLG recommendation	TLG
March 2018	Document extended for 3 months as approved by TLG	TLG
April 2018	Change of Owner for the document from Heather Webb to Jackie Edwards, Deputy chief nursing officer	
June 2018	Document extended for 3 months as approved by TLG	TLG
1st Oct	Document extended for 6 months whilst roles and	Jackie

2018	services have been agreed.	Edwards
Oct 2019	Document review	Siobhàn Gordon
Oct 2022	Document reviewed and updated; • Removal of the Quality Hub – updated with Healthcare Standards Lead • Update of job role title within Safeguarding • A sentence added around the Government's amendment to the Health and Care Bill 2021 in relation to the CQC and ICS • Committee names have been updated where required • Process for notifying the CQC of Deprivation of Liberties notifications updated • The process for notifying the CQC of incidents under the Mental Health Act has been updated to reflect the SLA in place with Herefordshire and Worcestershire Health and Care NHS Trust • Self-assessment and Quality Assurance processes list reviewed and updated • The management of Quality Assurance processes has been updated to Clinical Governance	Amy Gray

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1. Introduction

1.1 This policy outlines how the trust will meet the registration requirements of the Care Quality Commission (CQC).

1.2 The Care Quality Commission is the regulator of health and adult social care in England. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (hereafter referred to as "the Act") require providers of services that carry on 'regulated activities' to register with the Care Quality Commission. A full list of regulated activities is provided at appendix 1.

1.3 Failure to comply with the Act can result in the CQC taking enforcement action. The CQC has a wide range of powers, and carrying on a regulated activity without being registered can result in prosecution, with fines of up to £50,000.

1.4 Registration is location specific, and the trust must not carry out any regulated activities in any locations unless it is registered to do so. Any developments to services, including moving services from one location to another, may require an application to change our registration. Processes must exist to identify changes that may impact on our registration.

1.5 The trust is required to maintain a Statement of Purpose, which is submitted to the CQC on each occasion that it is amended.

1.6 In addition to outlining the requirements for providers to register with the CQC, the Act describes the Regulated Activities Regulations that people can expect services to meet.

1.7 The CQC continuously monitors compliance with the standards and the trust should have a system of self-assessment in place to identify any risk of non-compliance.

1.8 The CQC also requires the trust to notify the CQC of certain events.

2. Scope of this document

2.1 This policy does not set out the detailed requirements of the CQC in relation to registration, compliance with the standards or notification of events. These requirements are complex, and are outlined within various CQC guidance notes, which are updated frequently, and available on the CQC's website, at www.cqc.org.uk

2.2 Neither does this policy provide detailed procedures, which are separately documented.

2.3 Instead, this policy sets out the individual responsibilities for managing the requirements of the Act and the high level principles that will be adhered to.

2.4 It should be noted that the standards are applicable to all disciplines of staff, and are not simply 'nursing' standards.

3. Definitions

Regulated activity
Regulated activities are listed in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Organisations wishing to carry out any of these regulated activities, which are listed in Appendix 1 of this policy, must register with the CQC to do so. Organisations providing regulated activities must comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Location
1. A place to which people are admitted to for the purpose of receiving a regulated activity, or
2. A place in which people live as their main or sole place of residence or in which they are educated, and they receive care or treatment there, or
3. A walk-in centre, or
4. A primary medical, primary dental or out-of-hours service, or
5. The branch of an agency providing care, or
6. A regional headquarters from which a national or cross-regional independent ambulance service is managed, or
7. A stand alone purpose-built diagnostic or screening facility.

If none of these apply, then a location is also:
8. A place where regulated activities are managed from.

Essential Standards of Quality and Safety
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 outlines the standards of quality and safety that people who use the health and adult social care services have a right to expect.

Statement of Purpose
A statement of purpose is a document which includes a standard required set of information about a service, and must be provided to the CQC.

Statutory Notification
NHS Providers are required by law to notify the CQC about certain incidents, events and changes to their service. These are 'statutory notifications', outlined in the Care Quality Commission (Registration) Regulations 2009.

Nominated individual
A nominated individual is someone who has responsibility for supervising the management of one or more regulated activities.

Notice of Decision
A Notice of Decision is issued by the CQC and sets out the CQC's decision about applications to register or make changes to an existing registration.

Inspection
Inspections are carried out by the CQC, and may be unannounced. They will include a site-visit. CQC will rate providers as either 'outstanding', 'good', 'requires improvement', or 'inadequate'.

The Government's amendment to the Health and Care Bill in 2021 gives CQC a duty to review and assess integrated care systems, with a focus on "assessing leadership, integration of services and care pathways, as well as quality and safety".

Self-assessment
Self-assessment is the process by which we examine evidence to determine whether we are meeting a set of standards. The process requires that the risk of not meeting the standards is identified, and that all risks are addressed by the production of an action plan, which is monitored through to completion.

4. Responsibility and Duties

4.1 Chief Executive (CEO)

The Chief Executive is the accountable executive director for CQC registration and therefore responsible for implementation of this policy.

The CEO also acts as the 'Nominated Individual'. The CQC hold the nominated individual responsible for demonstrating that the organisation complies with the relevant regulations, and also for notifying the CQC of notifiable events and other circumstances that may impact on the trust's registration with the CQC.

Applications to amend the trust's registration with the CQC will be signed off by the Chief Executive, as the 'nominated individual'.

In the spirit of openness, the Chief Executive, or an officer delegated by them, should ensure that the CQC is informed of any significant and relevant facts that are outside the 'notifiable events' definitions in appendix 2, but which would inform the CQC's assessment of the trust's compliance with the essential standards.

4.2 Trust Board

The Trust Board seeks assurance on compliance with the requirements of the Act through its sub-committees.

It is a requirement of the CQC that all board members have sight of any applications to change the trust's registration prior to submission.

Healthcare Standards Lead The Healthcare Standards Lead is responsible for ensuring that there are adequate systems in place to manage the trust's registration with the CQC, including systems for notifying the CQC of any events notifiable to the CQC under the Care Quality Commission (Registration) Regulations 2014, regulations 12 & 15 (see appendix 2). The Healthcare Standards Lead will ensure that these systems are adhered to.

4.3 Executive Directors

Executive Directors must facilitate implementation of this policy. They must assure themselves that the requirements of this policy are adhered to.

Executive Directors should ensure that ad hoc requests from the CQC for information are managed in accordance with the requirements of this policy, and that the information provided to the CQC is accurate and complies with Information Governance Regulations and Caldicott Principles.

4.4 Divisional Managers

Divisional Managers are responsible for ensuring that any proposals to commence, change or cease services are referred to the Healthcare Standards Lead / Deputy Chief Nursing Officer for Quality so that any registration implications can be identified. This includes where services are moved from one hospital site to another.

Divisional Managers should also ensure that there are robust processes within the directorates to monitor compliance with the standards, including monitoring action plans.

Healthcare Standards Lead / Deputy Chief Nursing Officer for Quality

The Healthcare Standards Lead / Deputy Chief Nursing Officer for Quality will co-ordinate the process for managing the trust's registration with the CQC. They will notify the CQC of any events notifiable to the CQC under the Care Quality Commission (Registration) Regulations 2014, ensuring that the necessary approvals have been obtained. (See appendix 2).

The Healthcare Standards Lead will assess the impact of any proposals to commence, change or cease services, seeking the advice of the Care Quality Commission where necessary, and advising the Divisional Manager of any registration implications.

The Healthcare Standards Lead will ensure that there is a process that enables a judgement to be made of how safe, effective, caring, responsive and well-led the trust is, based on available information.

4.5 Healthcare Standards Lead

The Healthcare Standards Lead will coordinate ad hoc requests for information from the CQC, maintaining a log of information requested and information provided.

The Healthcare Standards Lead will support the development of tools to facilitate self-assessment. The Healthcare Standards Lead will facilitate the CQC inspection process.

4.6 Chief Nursing Officer

The Chief Nursing Officer is responsible for ensuring that a process is in place to self-assess the trust's compliance with the Standards of Quality and Safety.

Where the CQC has issued a judgement that the trust is non-compliant, the Chief Nursing Officer will be responsible for ensuring that an action plan is developed to return to a position of compliance.

The Chief Nursing Officer is responsible for notifying the named CQC Inspector, via the Healthcare Standards Lead once the trust has returned to a position of compliance, so that a re-inspection may take place.

4.7 Chairs of Trust Committees

Chairs of Trust Committees should consider the information provided to them in the context of the CQC's domains: safe, effective, caring, responsive and well-led. Chairs should ensure that where non-compliance, or the risk of non-compliance is identified, an action plan has been prepared, which the committee monitors through to completion. Chairs of committees are responsible for ensuring that this duty is included within the committee's terms of reference.

Committees report the extent of compliance to the Clinical Governance Group and are required to provide assurance that any actions to improve compliance are being progressed.

4.8 Chief Executive Team Management

The Chief Executive Team Management is responsible for ensuring that the registration implications of any service changes have been considered prior to approving these changes.

4.9 Quality Governance Committee

Quality Governance Committee receives CQC Update reports to an agreed reporting schedule. It seeks assurance that action plans have been developed for all areas where improvement is required, which are being monitored to completion.

4.10 Trust Management Executives

The Trust Management Executives will approve all registration applications, and amendments to the Statement of Purpose.

4.11 Patient Safety Team

The Patient Safety Team export data as required to the National Reporting and Learning System (NRLS) to ensure compliance with Care Quality Commission Registration regulations 16, 18(2)(a) & (b), 18(2)(e) and 18(2)(g). (See appendix 2)

4.12 Named Nurse, Safeguarding Adults

The Named Nurse, Safeguarding Adults will ensure that the appropriate Deprivation of Liberties notifications are made to the CQC for any outcomes received from the Local Authority Deprivation of Liberty Safeguards Team.

4.13 All Staff

All staff are responsible for the standard of care that patients receive, and this level of care must be consistent with that described in the CQC's Standards of Quality and Safety.

Staff have a responsibility to escalate to their line manager any instances where they feel they are unable to meet these standards.

5. Complying with the Requirements of the Act

5.1 Registration with the Care Quality Commission

- The Trust is registered to deliver a range of regulated activities across various locations. The regulations are complex. Consequently, it is essential that any plans to develop new services, change the services that the trust delivers, or move services from one location to another, are referred to the Healthcare Standards Lead by the Divisional Manager before the service commences. Decisions to cease services should also be referred to the Healthcare Standards Lead.

- The Healthcare Standards Lead will assess the impact of any proposals, seeking the advice of the Care Quality Commission where necessary, and advising the Divisional Manager of any registration implications.

5.1.3 Where a change to registration is required this will be coordinated by the Healthcare Standards Lead. The proposed change or addition to services or locations must not be implemented until the trust has received a Notice of Decision from the CQC, otherwise the trust will be operating illegally. This can take up to 10 weeks following submission of an application to the CQC.

5.1.4 Applications to amend the trust's registration with the CQC will be signed off by the Chief Executive, as the 'nominated individual'. Applications will then be approved by the Trust Management Executives and Board members will be made aware of the details of the application prior to submission, although Trust Board approval is not necessary.

5.1.5 Applications will be accompanied by an updated Statement of Purpose. (See paragraph 5.2.)

5.1.6 The Healthcare Standards Lead will advise the Divisional Manager when the Notice of Decision has been received.

5.1.7 The Chief Executive Team Management will ensure that the potential for registration implications has been considered as part of the process of approving Innovate proposals.

5.2 Statement of Purpose

- A Statement of Purpose will be maintained that complies with the CQC's guidance concerning what should be included in it.

- The Healthcare Standards Lead will make any necessary changes to the Statement of Purpose, as advised by the Divisional Managers and the Chief Executive Team Management. The updated Statement of Purpose will be approved by the Trust Management Executives.

- The Statement of Purpose will be submitted to the CQC by the Healthcare Standards Lead when it is updated, and any time the CQC requests it, following the CQC's submission instructions.

5.3 Notifications to the Care Quality Commission

- The trust is required by law to notify the CQC about certain incidents, events and changes to its service.

- The CQC has published detailed guidance about the events trusts must notify to them, together with the forms that must be used.

- The CQC's notification requirements, and the trust's arrangements for making these notifications, are outlined in **appendix 2.**

- In the spirit of openness, the Chief Executive, or an officer delegated by them, should ensure that the CQC is informed of any significant and relevant facts that are outside the 'notifiable events' definitions outlined within appendix 2, but which would inform the CQC's assessment of the trust's compliance with the essential standards.

  A written record should be made of the facts that have been shared in this manner.

5.4 Ad Hoc Requests for Information by the CQC

- All ad hoc requests for information by the CQC will be notified to the Healthcare Standards Lead as soon as they are received.

- Requests will be logged by the Healthcare Standards Lead and responsibility for gathering the information required will be allocated, along with the timescale for providing the information.

- Information must be validated and approved by an Executive Director before it is provided to the CQC.

- The Healthcare Standards Lead will coordinate the provision of the requested information to the CQC so that a central record can be maintained of the precise information provided.

- Provision of information to the CQC must comply with all Information Governance Regulations and Caldicott Principles. When providing information electronically all patient identifiable information must be redacted. Staff names

must also be redacted where the information being provided to CQC is sensitive, or not freely available.

Where the trust is unable to provide information that complies with all Information Governance Regulations and Caldicott Principles within the CQC's required timescales, CQC should be advised that additional time is required so that the trust does not breach IG regulations. The information will then be sent at the earliest possible opportunity.

5.5 Self-assessment process and Quality Assurance

A process of self-assessment and assurance against the Standards of Quality and Safety will be assessed via a variety of methods, such as:

- Internal and external Quality Assurance Visits
- Ward/Department Quality Checks
- Pharmacy Quality Checks
- Safety Huddles (which include triggers and escalation process) conducted at ward/ unit level
- Patient Public Forum Assurance Visits
- Path to Platinum Accreditation Programme Assurance Visits

Tools and processes to facilitate all self assessments and assurance visits will be developed, updated and shared via the Healthcare and Quality Standards Officer. Completed documentation will be shared with relevant wards/departments for learning and action plan development. To ensure compliance with GDPR requirements, all data will be secured within the Clinical Governance electronic management system for onward sharing with the CQC as required.

- The results of the self-assessments and Quality Assurance Visits, and progress against the action plans will be reviewed according to the trust's governance and performance framework.

- Responsibility for overview of the compliance with the standards of quality and safety is allocated to an appropriate committee. Each committee reports the extent of compliance to the Quality Governance Committee or the Trust Management Executives, as appropriate, and provides assurance that any actions to improve compliance are being progressed. The Board receives assurance through its sub-committees.

5.6 CQC Inspections and Reports

- CQC Inspections and resulting reports will be managed in accordance with the **Policy for the Management of External Agency Visits and Recommendations (WAHT-CG-020).**

- Where the CQC has issued a judgement that the trust is non-compliant, the Chief Nursing Officer will be responsible for ensuring that an action plan is developed to return to a position of compliance. This will be monitored in

accordance with the Policy for the Management of External Agency Visits and Recommendations (WAHT-CG-020).

- Once the Chief Nursing Officer is confident that the trust has returned to a position of compliance, the Healthcare Standards Lead will notify the named CQC Inspector that the trust has returned to a position of compliance.

6. Implementation

6.1 Plan for implementation

This policy will be implemented through;

- Raising awareness of the individuals with key responsibilities for implementing this policy, (outlined in section 4), and where necessary providing guidance on complying with the policy.
- Targeting any areas of non-compliance once identified through the monitoring arrangements at section 7.

6.2 Dissemination

The Policy will be placed on the Trust's Intranet.

The key staff identified in this policy will be informed of the policy and any changes to it directly by the Clinical Governance Department.

6.3 Training and awareness

Awareness of this policy will be raised through the dissemination process above.

Training has been provided to Divisional Quality Improvement leads for cascading throughout divisions.

7. Monitoring and compliance

Monitoring compliance with this policy will be undertaken as described in the following table;

Monitoring table;

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
5.1	Changes to services are notified to the Healthcare Standards Lead for consideration of any registration implications.	Annual check of services provided, through Statement of Purpose review.	Annual	Healthcare Standards Lead	Divisional Managers to be advised of any registration implications. Chief Executive Team Management advised of any failure to notify the Healthcare Standards Lead of service changes, once identified.	Ongoing
5.2	Compliance with the standards of quality and safety is assessed, and action plans are completed where improvements are required.	Committees with responsibility for quality and safety monitor compliance with the standards and review progress against the action plans.	In accordance with an agreed reporting schedule.	Committee Chairs	Quality Governance Committee	Four times a year
5.2	Quality Assurance Visits at ward/unit/department level are carried out, and action plans are completed where improvements are required.	Development of Quality Assurance Visits schedule.	In accordance with an agreed reporting	Chief Nursing Officer	Quality Governance Committee	Four times a year

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
			schedule.			
5.4	Notifications of changes to the organisation and its statement of purpose are made to the CQC.	Review of services, through review of Statement of Purpose.	Annual	Healthcare Standards Lead	Exception reporting to Trust Management Executives.	By exception
5.4	Notifications of reportable events, in accordance with regulations 18(2) (a) & (b), 18(2) (e) and 18(2) (g) are reported to NRLS via the Incident Reporting process.	The trust reviews benchmarking data that compares incident reporting rates with rates of similar trusts.	Twice a year	Patient Safety Committee	Patient Safety Group	Twice a year through the Patient Safety report
5.4	Notifications of Deprivation of Liberties application outcomes are made to the CQC by Matrons/ Ward Managers.	The Named Nurse, Safeguarding Adults will ensure that the appropriate Deprivation of Liberties notifications are made to the CQC for any outcomes received from the Local Authority Deprivation of Liberty Safeguards Team.	At least ten times a year.	Named Nurse, Safeguarding Adults	Exception reporting to the Quality Governance Committee, and annual assurance.	At least annual

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
5.4	Notifications of Deaths of people detained or liable to be detained under the Mental Health Act 1983 are made to the CQC.	Any reporting to the CQC is fed back into the Trust via the quarterly report received from the MHA Administration Manager. Healthcare Standards Lead will review notifiable incidents with the Patient Safety and Safeguarding Team.	Four times a year	Healthcare Standards Lead	Safeguarding Report to Trust Board	Quarterly and Annually
5.5	Where the CQC finds the trust to be non-compliant, an action plan is developed to return to a position of compliance.	Monitoring arrangements are described within the Policy for the Management of External Agency Visits and Recommendations (WAHT-CG-020).	-	-	-	-

8. Policy Review

This policy will be reviewed every 3 years, and approved by the Clinical Governance Group.

9. References

	Code:
CQC Website, frequently updated – cqc.org.uk	N/A
'The Scope of Registration' (CQC)	N/A
'Statutory Notifications' (CQC)	N/A
Acute Hospitals Provider Handbook (CQC)	N/A
Guidance for providers on meeting the regulations	N/A
Incident Reporting Policy	WAHT-CG-008
Deprivation of Liberty Safeguards Policy	WAHT-CG-422
Policy for the Management of External Agency Visits and Recommendations	WAHT-CG-020

10. Background

10.1 Consultation

Key individuals involved in the CQC Registration process have been consulted during the development of this policy, including;

- Executive Team
- Healthcare Standards Lead
- Divisional Managers
- Divisional Directors of Nursing/ Midwifery/ Departments/Therapies Manager
- Matrons
- Department Heads
- Patient Safety Team
- Safeguarding Team

Feedback received during the consultation process has informed the final version of the policy.

10.2 Approval process

This policy is approved by the Trust Management Executive.

10.3 Equality requirements

The content of this policy has no adverse impact on equality and diversity. A copy of the completed assessment is included as Supporting Document 1.

10.4 Financial risk assessment

This policy has no adverse financial impact. The financial assessment is included as Supporting Document 2.

Appendix 1

Full List of Activities Regulated by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Personal Care

Accommodation for people who require nursing or personal care

Accommodation for people who require treatment for substance misuse

Treatment of disease, disorder or injury

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Surgical Procedures

Diagnostic and screening procedures

Management of supply of blood and blood-derived products

Transport services, triage and medical advice provided remotely

Maternity and midwifery services

Termination of pregnancies

Services in slimming clinics

Nursing care

Family planning services

Appendix 2

Notifications that must be submitted directly to the CQC

Regulation	Notification	Responsibility for notification
12	Changes to the statement of purpose for an activity	Healthcare Standards Lead, in accordance with this policy
15	Other changes: • Plans for a new provider to carry on an activity • A new provider carries on an activity • A provider stops carrying on an activity • A provider changes their name • Change of a provider's main address • Change of nominated individual	Healthcare Standards Lead, in accordance with this policy
17	Deaths and unauthorised absences of people detained or liable to be detained under the Mental Health Act 1983	An SLA is in place with Herefordshire and Worcestershire Health and Care NHS Trust for Mental Health Act Administration
18(4)(b)	Applications to deprive a person of their liberty under the Mental Capacity Act 2005, and their outcomes	Matron/Unit/ Ward Manager in accordance with the Deprivation of Liberty Safeguards Policy (WAHT-CG-422)

Notifications to be submitted to the National Reporting and Learning System (NRLS)

Regulation	Notification	Responsibility for notification
16	Certain deaths of people using the service	Reported by Patient Safety Advisor via the NRLS, in accordance with the Incident Reporting Policy (WAHT-CG-008)
18(2)(e)	Allegations of abuse	
18(2)(g)	Events that stop or may stop the service from running safely and properly	
18(2)(a)&(b)	Serious injuries to people who use the activity	

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Amy Gray**

Details of individuals completing this assessment	**Name**	**Job title**	**E-mail contact**
	Amy Gray	Healthcare Standards Lead	Amy.hunt9@nhs.net
	Effie Gridley	Healthcare & Quality Standards Officer	Effie.gridley@nhs.net
Date assessment completed	01/10/2022		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Policy for managing the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014			
What is the aim, purpose and/or intended outcomes of this Activity?	The policy outlines how the Trust will meet the registration requirements of the Care Quality Commission (CQC).			
Who will be affected by the development &	❑✓ ❑✓	Service User Patient	❑✓ ❑✓	Staff Communities

implementation of this activity?	❑✓ ❑✓	Carers Visitors	❑ ❑	Other _____
Is this:	❑ ✓ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Health and Social Care Act 2008 – Legislation Gov UK The Scope of Registration published by the Care Quality Commission (CQC) CQC Strategy 2021 – "A new strategy for the changing world of health and social care" Worcestershire Acute Hospitals Trust – Quality and Patient Safety Plan 2022-2025			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Regular engagement with the CQC – Monthly meetings, quarterly engagement events			
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		✓		
Disability		✓		
Gender Reassignment		✓		
Marriage & Civil Partnerships		✓		
Pregnancy & Maternity		✓		
Race including Traveling Communities		✓		
Religion & Belief		✓		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sex		✓		
Sexual Orientation		✓		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	In line with policy review			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	18/11/2022
Comments:	
Signature of person the Leader Person for this activity	
Date signed	18/11/2022
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval