**Trust Policy**

Worcestershire Acute Hospitals NHS Trust

# Policy for the Management of External Body Visits and Recommendations

| | |
|---|---|
| **Department / Service:** | Healthcare Standards Team |
| **Originator:** | Healthcare Standards Lead |
| **Accountable Director:** | Chief Nursing Officer |
| **Approved by:** | Trust Management Executive |
| **Date of approval:** | 24th May 2023 |
| **Review date:**<br>**This is the most current document and should be used until a revised version is in place** | 18th May 2026 |
| **Target Organisation(s)** | Worcestershire Acute Hospitals NHS Trust |
| **Target Departments** | All |
| **Target staff categories** | Executive Directors<br>Corporate Lead Nurses & Divisional Management Teams of all Directorates and Departments receiving inspection visits |

| **Policy Overview:** |
|---|
| This policy outlines Worcestershire Acute Hospitals NHS Trust's processes for preparing for External Body visits, inspections and accreditations etc. and responding to the Trust specific recommendations and requirements that arise from them. |

## Key amendments to this document

| Date | Amendment | Approved by: |
|---|---|---|
| April 2023 | The department/ service owner has been updated from Clinical Governance & Risk Management to the Healthcare Standards (HCS) Team | TME – May 2023 |
| April 2023 | The frequent terms used within the policy have been updated to ensure consistency throughout i.e. 'External Body' instead of 'External Agency' | TME – May 2023 |
| April 2023 | Responsibilities and duties of the Healthcare Standards Lead added | TME – May 2023 |
| April 2023 | Inclusion of a process to ensure the HCS Team have oversight of External Body visits | TME – May 2023 |
| April 2023 | Development of a Master Log which will be held centrally by the HCS Team, returns to be submitted by the Divisional Director of Operations and Corporate Leads | TME – May 2023 |
| April 2023 | Flow processes reviewed and updated as appropriate | TME – May 2023 |
| June 2023 | Appendix 1 - Health Education West Midlands changed to NHS England – Midlands Team | Amy Gray |
| 5th March 2025 | Document extended for 6 months whilst under review | Rachel Beasley-Suffolk |

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## Appendices



## Supporting Documents

## 1. Introduction

There are a multitude of External Bodies that visit, review, inspect, assess or accredit NHS Trusts or make recommendations following inquests, inquiries or reviews etc.

The coordination and evaluation of these will bring benefits to the organisation by; minimising the operational burden by reducing overlap between visits, identifying potential gaps and providing a robust means of agreeing and implementing suitable actions in response. This will provide the Board and External Bodies with assurance that recommendations are responded to appropriately and the required standards are met.

This policy sets out the systematic processes to ensure that for each key visit the suitable preparation is made, resulting recommendations are implemented within a specified time scale, that they are monitored following their implementation, and there is a formal reporting and reviewing process through to Executive sign-off.

## 2. Scope of this document

The policy applies to all employees of the Worcestershire Acute Hospitals NHS Trust involved in the facilitation of any visits conducted by an External Body, both for clinical and non-clinical purposes.

This is inclusive of any special reviews commissioned by the Trust itself and undertaken by External Bodies or individuals.

This Policy lists External Bodies or sources of recommendations that are key and specific to the Trust, this list is not exhaustive and the principles of this policy should be applied to all External Bodies undertaking review activity within the Trust.

Excluded from the scope of this policy are:

- Reviews of individual staff by an External Body which would be addressed through Human Resources policies.

## 3. Definitions

**External Body** - an authoritative body that has been given a role by NHS England or other body in regulating the corporate and professional activities of all NHS Trusts. (e.g. Care Quality Commission (CQC), National Institute for Clinical Excellence (NICE), Health Education West Midlands, HM Coroner).

**Key External Body** – as above, but one that has been identified by the Trust for corporate attention and review, due to its significance, listed in Appendix 1.

**Accreditation -** relates to audit and review activities of both internal and External Bodies, which are required to deliver 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 formal review by a body with statutory powers to determine compliance with standards and report on the performance of the organisation.

**Peer Review** - a process of self-regulation by a profession or a process of evaluation involving qualified individuals within the relevant field. E.g. Cancer Peer Review.

**Visit** – a formal review to determine compliance with standards. For simplicity, this policy refers to 'visits' as a catch-all description of inspection, accreditation and assessment visits.

**Recommendation –** advice for improvement based on the findings of a visit / inspection / assessment / accreditation.

## 4. Responsibility and Duties

### 4.1 Chief Executive (CEO)

The Chief Executive is ultimately responsible for implementation of the processes described within this policy and is directly responsible for the oversight of Section 28 processes.

### 4.2 Healthcare Standards Lead

- To maintain the processes for the Trust to manage External Body visits and respond effectively to recommendations.
- To maintain a Master Log of forthcoming visits and visits that have taken place, the status of action plans and the name of the committee/group monitoring the outcome of the visit, as notified by the Divisions and Corporate Departments
- Report a Summary of the above to Quality Governance Committee (QGC) Quarterly
- Further responsibilities pertaining to the Trust's relationships with the CQC can be found in the Policy for managing the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (WHAT-CG-769).

### 4.3 Executive/Divisional Director of Operations

- An External Visit Lead is appointed for each External Body visit.
- Oversight of the External Visit Lead's plans for a successful visit
- Notification to the Healthcare Standards Team of the forthcoming visits.
- Submission of a Quarterly Return of forecasted or known forthcoming visits, and visits that have taken place (Appendix 5) within the specified timeframe, unless alternative notification methods have been agreed with divisions.
- The outcome of any visit is reported in accordance with the relevant committee schedule, together with an action plan and evidence for assurance.

### 4.4 External Visit Lead

This title refers to the individual(s) nominated as being responsible for preparing and co-ordinating an External Body visit;

- As soon as a visit becomes known (present or future), to inform the Healthcare Standards Team and the relevant Executive Lead, of the date and nature of the visit and anticipated date for receipt of a report.
- Preparations for the visit, as outlined in **Section 5.3**
- On receipt of the External Body's report, to provide a summary of the initial findings to the relevant committee and Executive Lead. Ensure strict confidentiality and embargo the report when leading the factual accuracy process.
- Coordinate the response to the report.
- Populate the Trust Risk Register with risks identified from the reviews with the relevant Datix source populated under 'External inspections' or as appropriate.

- Prepare a report and action plan to address any recommendations, the monitoring committee will determine the frequency for review
- Maintain action plans agreed to implement any recommendations as a result of the reviews and report to the relevant committee.

**4.5 Communications Team:**

- Media and internal communications of External Body visits and report findings will be coordinated by the Trust's Communications Team.

**4.6 Committees with overarching responsibilities**

**4.6.1 Trust Board**

The Board provides leadership and support for the implementation of this policy and the management of External visits. It gains assurance that this policy is implemented from the Quality Governance Committee.

**4.6.2 Quality Governance Committee (QGC)**

- Receives exception reports, through the Clinical Governance Group, where actions in response to External visits are not progressing to plan.
- Receives a quarterly report from the Healthcare Standards Team summarising reports received in the previous quarter and forthcoming visits, as notified by the Divisions and Corporate Departments.
- Provides assurance to the Board that External Visits are managed effectively.

**4.6.3 Clinical Governance Group (CGG)**

- Receives exception reports from the Divisions where actions in response to External visits are not progressing to plan.
- Monitors compliance with this policy and oversees the organisational learning from visits.

**4.6.4 Divisional Governance Framework**

- Receive summary report and action plan from the External Visit Lead.
- Provides any necessary support to ensure that action plans are progressed.
- Reports, by exception, to the Clinical Governance Group, all instances where actions in response to External visits are not progressing to plan, or where Trust wide action and support is needed.

**4.6.5 Responsible Committees (Appendix 1)**

- Reviewing summary reports and considering whether the identified action is adequate and appropriate to address the recommendations.
- Working in partnership with the relevant Divisional Governance or Management Team to monitor actions to completion and reviewing the evidence of assurance provided.

# 5 Processes Relating to External Body Activity and Recommendations

## 5.1 Identification of External Bodies

The External Bodies potentially visiting the Trust are numerous. A list of key visits has been derived to identify those that are of critical importance to the Trust's business as a provider of healthcare (Appendix 1). This list is not exhaustive and the principles of this policy should be applied to all External visits. This list will be reviewed and amended when this policy is reviewed and when new inspections / visits arise e.g. when the Chief Executive receives notification.

## 5.2 Scheduling External Visits

- All visits should follow the process as described in Appendix 2.
- The Healthcare Standards Team will maintain the Master Log of both national and local visits.
- The External Visit leads will make arrangements for each visit and notify the relevant Executive Lead and the Healthcare Standards Team, of the date so that it can be recorded in the Master Log. Any clashes will be identified within the Master Log and resolved with the External Visit Leads.
- The Trust is subject to unannounced visits and these are dealt with as a variation to this process, see **Section 5.7**.

## 5.3 Preparation for External visits

Each visit will have its own requirements but is likely to require these common factors that the External Visit Lead must include in their preparation:

- Preparation and provision of evidence to members of the External Body either before or during the visit.
- Preparation of relevant staff.
- Informing the responsible committee of the progress with preparations for the visit and escalate any issues that require resolution.
- Arranging logistics inclusive of: a suitable base room, catering, parking arrangements, availability of relevant staff including relevant Senior Staff/Directors, access to clinical/non-clinical areas.
- Welcoming members of the External Body.
- Checking the identification of members of the External Body and providing signing in process or safety briefing as necessary.
- Arranging logistics to facilitate a verbal feedback meeting to close the visit.

## 5.4 Receiving Verbal Feedback from External Visits

Feedback is usually provided verbally at the end of a visit and followed by a written report. External Visit Leads will prepare to receive verbal feedback as the External Body requires by:

- Determining which internal Staff members are required to be present at the verbal feedback session at the end of the visit to:
  - Receive the feedback.
  - Communicate the feedback to the relevant Executive Lead/ committee if they are not present.
  - Authorise any immediate actions to be taken in response to the verbal feedback.
  - Should immediate action be required to respond to an immediate risk, the responsible individuals are required to take the necessary action and/or conduct a risk assessment and document it on the Datix System.

## 5.5 Review and Response to Written Recommendations

### 5.5.1 Responding to External Bodies

If an initial letter is received from the External Body prior to the formal draft report the below processes should be replicated.

The recommendations and written report arising from an External Visit need to be considered by the External Visit Lead and any individuals/groups/committees with a responsibility for the service or function reviewed. Appendix 1 identifies the committees and individuals responsible for each of the identified key visits, all other visits should be managed using the same principles:

- Upon receipt of the draft report, adherence to strict confidentiality when internally distributing is essential.
- Completing factual accuracy checks against any guidance provided by the External Body prior to returning it and awaiting the final written report.
- Determine the response required to any recommendations.
- Prepare a summary report to include actions and timescales (Immediate, medium or long term).
- Enter significant risks arising from the visit on the Datix System's risk register with associated actions and continuously review and update them as appropriate.
- Provide the summary report to the responsible committee / Executive Lead for review of the findings and suitability of the actions at the first available opportunity.
- Agree actions, timescales and frequency of monitoring with the responsible committee that will formally receive and acknowledge the action plan at agreed intervals and monitor the actions through to completion.

### 5.5.2 Sustainable Change

The External Visit Lead and Responsible Committee will ensure that there is a process in place to ensure that completed actions have successfully addressed the recommendation and resulted in the necessary improvement, and that improvements have been sustained. This should be reflected by the Level of Assurance in the Quarterly Return to the Healthcare Standards Team (Appendix 5).

### 5.5.3 Opportunities for Shared Learning

External Visits provide an opportunity to share learning across the organisation. External Visit Leads should ensure that the results of External Visits are cascaded to all levels of staff and, where relevant, stakeholders.

Any action plans developed following External visits or other form of review should be shared widely, including to frontline staff via staff meetings and any other communication routes.

## 5.6 Communications

The internal and external communications for visits must adhere to strict confidentiality requirements with embargoes on distribution at various times through the process.

Staff receiving enquiries from the media about External reviews should refer the enquirer to the Communications Team to manage this process, liaising with the Executive Lead and External Visit Lead as appropriate.

### 5.7 Process Variations

#### 5.7.1 Unannounced visits

Some External Bodies use unannounced or limited notice visits to assess compliance with standards or the law. These include the Care Quality Commission, the Health & Safety Executive and commissioners of NHS Healthcare.

While limited specific preparation can be made for these visits, the response to recommendations will follow the same path as for recommendations received from other External Bodies.

The flow process for responding to unannounced visits, including where these occur out of hours, is provided in Appendix 3.

#### 5.7.2 Section 28 - Recommendations from a Prevention of Future Deaths Report

If a coroner feels that the evidence provided at an inquest gives rise to a concern that circumstances creating a risk of other deaths will occur or continue to exist, they may make a Section 28 report, this is sent to the organisation which has responsibility for the circumstances.

The Trust's Chief Executive will receive Section 28 letters and nominate an individual to Lead on the response to the recommendations. The response will be reviewed by the Chief Executive before it is released.

- A recipient of a Section 28 report must send a written response within 56 days.
- The response must give details of any action which has been or is proposed will be taken, or provide an explanation when no action is proposed.

#### 5.7.3 Claims Advisory Report and Risk Management Recommendations

NHS Resolution and their solicitors provide Advisory Reports and risk management recommendations identified from their case review and expert reports.

Within Worcestershire Acute Hospitals NHS Trust these are managed through the Head of Legal Services and the full process is described in the Claims Handling Policy & Procedure (WAHT-LS-01).

#### 5.7.4 Self-Commissioned Reviews

On occasions the Trust Board will commission its own reviews undertaken by External Bodies. The Chief Executive will make individual arrangements for each review and ensure that there is oversight by a Lead Executive. The principles contained within this policy will be adhered to.

# 6 Implementation

## 6.6 Plan for implementation

The principles of this policy have been previously embedded. However, the renewal of this policy will be highlighted to key staff and support for its implementation will be provided by the Healthcare Standards Team via the Quality Governance Committee where necessary.

## 6.7 Dissemination

The policy will be available to all staff via the Trust's Key Documents Page.

## 6.8 Training and awareness

Awareness of this policy will be raised through the dissemination process above. Limited training is necessary but assessment leads will be contacted and made aware of the policy's requirements as the visits are identified.

## 7 Monitoring and compliance

| 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: |
|---|---|---|---|---|---|---|
| | **WHAT?** | **HOW?** | **WHEN?** | **WHO?** | **WHERE?** | **WHEN?** |
| 5.2 | A Master Log is made of all External visits and is held by the Healthcare Standards Team. This Log is as accurate as the information provided via relevant parties. | Divisional Director of Operations to complete quarterly returns of scheduled visits and recent visits. | Quarterly | DDO/ PA to DDO. | QGC | Quarterly |
| 5.5 | Quarterly paper provided by the Healthcare Standards Team of:<br>• forthcoming visits<br>• recent visits<br>Summarised from Quarterly Returns provided by Appendix 5. | QGC to ensure compliance with schedule of expected papers and to seek assurance from monitoring committees when necessary. | Quarterly | QGC Chair | QGC | Quarterly |
| 5.5 | Risks raised from External visits and their recommendations are recorded on the Datix Risk Register in line with the Risk Management Policy. | Ongoing review of risk register, recorded actions and risk scores. | Ongoing | Responsible Committee, relevant DMT and External Visit Leads. | QGC | Quarterly |

## 8 Policy Review

This policy will be reviewed two years after its approval date, unless there are any major changes required before that date.

## 9 References

| References: | Code: |
|---|---|
| Claims Handling Policy & Procedure | WAHT-LS-01. |
| Risk Management Strategy | WAHT-CG-007 |
| Policy for managing the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 | WAHT-CG-769 |
| Health and Care Act 2022 (legislation.gov.uk)<br>102. Relevant bodies & Special Health Authorities | External |

## 10 Background

### 10.1 Equality requirements

The content of the policy has no adverse impact on equality and diversity.

### 10.2 Financial risk assessment

This policy has no adverse financial impact.

### 10.3 Consultation

Consultation should involve QGC as the committee responsible for oversight of all External visits and progress of actions against recommendations, furthermore the External Visit Leads outlined in Appendix 1.

**Contribution List**

This key document has been circulated to the following individuals for consultation;

| Designation |
|---|
| Executive Directors |
| Deputy Chief Medical Officers |
| Deputy Chief Nursing Officers |
| Divisional Medical Directors |
| Deputy Directors of Nursing |
| Divisional Directors of Nursing |
| Divisional Director of Nursing & Midwifery |
| Divisional Directors of Operations |
| Directorate Managers |
| Clinical Tutors |
| Health & Safety Manager |
| Director of Corporate Governance |
| Cancer Services Manager |
| Training & Development Manager |
| Patient Experience Lead Nurse |
| Communications Team |

This key document has been circulated to the chair(s) of the following committees / groups for comments;

| Committee |
|---|
| Clinical Governance Group |
| Quality Governance Committee |
| |
| |

**10.4 Approval Process**

This Policy will be approved by the Trust Management Executive.

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**10.5 Version Control**

This section should contain a list of key amendments made to this document each time it is reviewed.

| Date | Amendment | By: |
|---|---|---|
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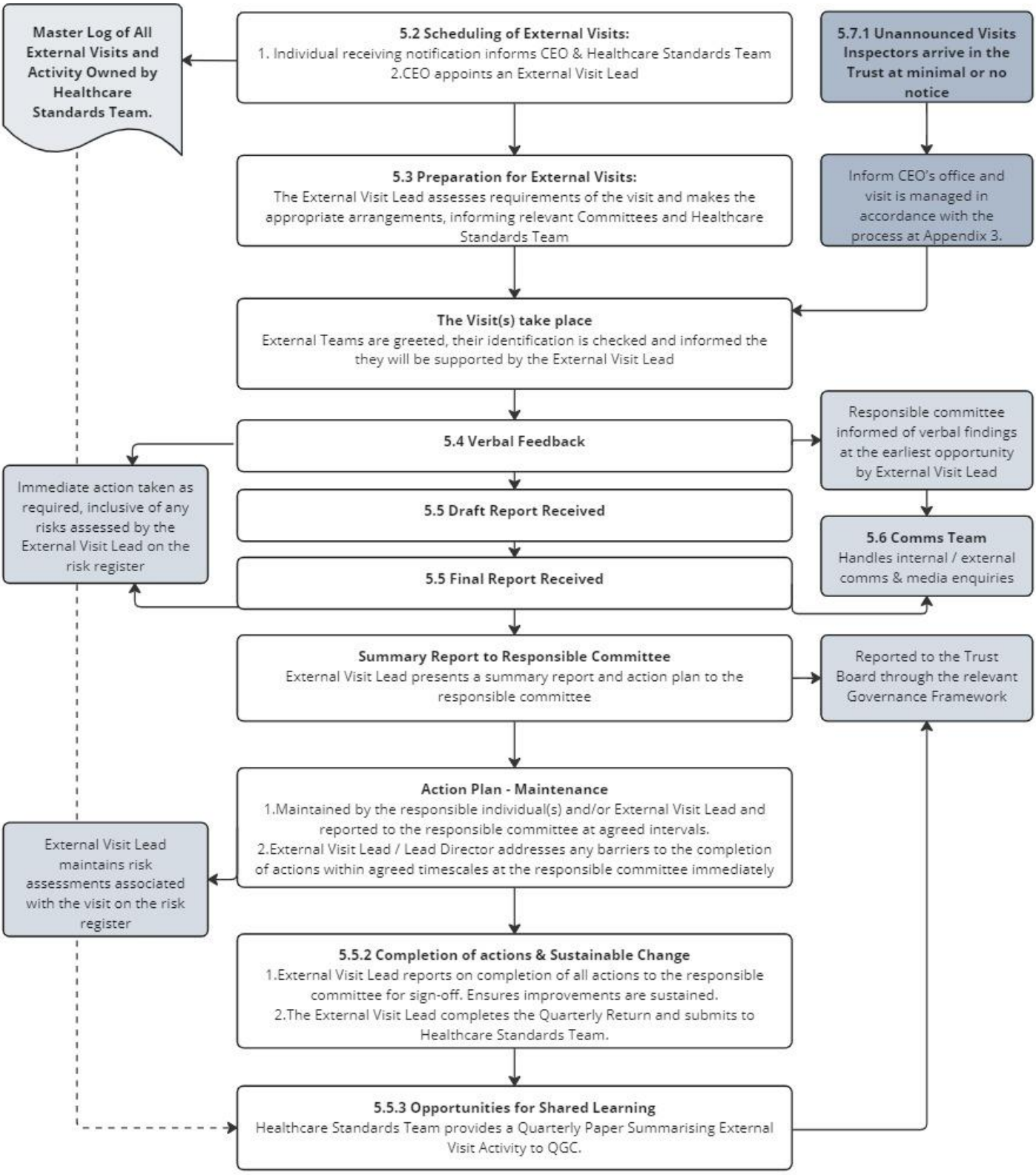
Appendix 1.

| External Body | External Visit Lead(s) | Responsible Committee |
|---|---|---|
| Reporting to Trust Board: | | |
| Care Quality Commission | Chief Nursing Officer | Clinical Governance Group |
| HM Coroner (Section 28) | Chief Executive | Learning from Deaths Group |
| National Clinical Assessment Service (NCAS) | Chief Medical Officer | Clinical Governance Group |
| General Medical Council (GMC) | Chief Medical Officer | Doctors & Associates Workforce Group |
| Reporting to Trust Management Executive (TME): | | |
| Health & Safety Executive | Health & Safety Manager | Health & Safety Committee |
| NHS England – Midlands Team | Clinical Tutors / | Trust-wide Learning & Development Group |
| Quality Assurance Agency for Higher Education | Training Manager | Workforce Assurance |
| UK Border Agency | Director of Workforce & Organisational Development | Workforce Assurance |
| NHS Protect (NHS CFSMS) | H&S Manager / Local Security Management Specialist | Health & Safety Committee |
| Fire Authority | Health & Safety Manager | Health & Safety Committee |
| Reporting to Clinical Governance Group (CGG): | | |
| NHS England | Chief Executive | Subject Dependant |
| West Midlands Quality Review Service | Determined by the subject of the review | Subject Dependant |
| MHRA (Blood) | Countywide Haematology and Blood Transfusion Quality Manager | Blood Transfusion Expert Forum |

| External Body | External Visit Lead(s) | Responsible Committee |
|---|---|---|
| Reporting to Clinical Governance Group (CGG) Continued: | | |
| Cancer Peer review visits | Cancer Peer Review Quality Manager | Cancer Board |
| Local Midwifery Supervisory Officer | Chief Nursing Officer / Head of Midwifery | Divisional Governance Framework |
| Joint Advisory Group (Endoscopy) | CD for Endoscopy | Divisional Governance Framework |
| West Midlands Trauma Network | MD for Patient Safety | Divisional Governance Framework |
| West Midlands Cancer Intelligence Unit – Cervical Screening | Hospital Based Programme Co-ordinator | Divisional Governance Framework |
| West Midlands Cancer Intelligence Unit – Bowel Screening | CD for Endoscopy | Divisional Governance Framework |
| Royal Colleges (various) | Specialty Education Leads / Clinical Tutors / Chief Medical Officer | Divisional Governance Framework |
| MHRA (Devices)<br><br>MHRA (Wholesaler's Dealers Licence) | Director of Asset Management<br><br>Clinical Director of Pharmacy | Medical Devices Group<br><br>Divisional Governance Framework |
| Regional QA Service – Farwell Audit | Clinical Director of Pharmacy | Medicines Safety Committee |
| Home Office (CD Licence) | Clinical Director of Pharmacy | Divisional Governance Framework |
| General Pharmaceutical Council – registered Pharmacy | Clinical Director of Pharmacy | Divisional Governance Framework |
| Clinical Pathology Accreditation (UK) Ltd | Countywide Haematology and Blood Transfusion Quality Manager | Pathology Quality and Accreditation Committee (PQAC) |
| Human Tissue Authority | HTA Designated Individual<br>Directorate Manager<br>Cellular Pathology Lead BMS | Pathology Quality and Accreditation Committee PQAC |
| Healthwatch Worcestershire | Chief Nursing Officer | Patient, Carer and Public Engagement Steering Group |
| PLACE inspections | Chief Nursing Officer | Patient Environment Operational Group |
| Commissioners (ICS, LAT) | Chief Nursing Officer | Subject Dependent |

## Appendix 2.


Master Log of All External Visits and Activity Owned by Healthcare Standards Team.
5.2 Scheduling of External Visits:
1. Individual receiving notification informs CEO & Healthcare Standards Team
2.CEO appoints an External Visit Lead
5.7.1 Unannounced Visits Inspectors arrive in the Trust at minimal or no notice
5.3 Preparation for External Visits:
The External Visit Lead assesses requirements of the visit and makes the appropriate arrangements, informing relevant Committees and Healthcare Standards Team
Inform CEO's office and visit is managed in accordance with the process at Appendix 3.
The Visit(s) take place
External Teams are greeted, their identification is checked and informed the they will be supported by the External Visit Lead
5.4 Verbal Feedback
Responsible committee informed of verbal findings at the earliest opportunity by External Visit Lead
Immediate action taken as required, inclusive of any risks assessed by the External Visit Lead on the risk register
5.5 Draft Report Received
5.6 Comms Team
Handles internal / external comms & media enquiries
5.5 Final Report Received
Summary Report to Responsible Committee
External Visit Lead presents a summary report and action plan to the responsible committee
Reported to the Trust Board through the relevant Governance Framework
Action Plan - Maintenance
1.Maintained by the responsible individual(s) and/or External Visit Lead and reported to the responsible committee at agreed intervals.
2.External Visit Lead / Lead Director addresses any barriers to the completion of actions within agreed timescales at the responsible committee immediately
External Visit Lead maintains risk assessments associated with the visit on the risk register
5.5.2 Completion of actions & Sustainable Change
1.External Visit Lead reports on completion of all actions to the responsible committee for sign-off. Ensures improvements are sustained.
2.The External Visit Lead completes the Quarterly Return and submits to Healthcare Standards Team.
5.5.3 Opportunities for Shared Learning
Healthcare Standards Team provides a Quarterly Paper Summarising External Visit Activity to QGC.

**Appendix 3.**

# Flow Process for Responding to an Unannounced Site Visit

1. It is the responsibility of the area affected by the visit to inform the Chief Executive's Office of any unannounced site visits by External Bodies IMMEDIATELY by telephoning extension 30883 (DDI 01905 733960).

2. All visitors should be asked to produce their ID, and if there is any doubt of the validity of this the offices of the visiting body should be contacted to verify their identity. (For CQC Inspectors, contact 03000 616161)

3. The CEO nominates a lead to manage the visit.

4. CEO's office informs all Executive Directors of the visit and the Healthcare Standards Team and nominates an External Visit Lead.

5. The External Visit Lead, or someone delegated by them, informs the following people of the visit;
Divisional Directors of Nursing
Divisional Medical Directors
Divisional Directors of Operations
Matrons
Directorate Managers
Clinical Directors

6. The External Visits Lead organises any escorts to accompany the visiting team, an office base and any other logistical requirements.

7. The External Visits Lead will ensure that the needs of visitors are met, including access to people and the provision of any information and documentation requested. They will delegate roles to a supporting team as necessary. Membership of the supporting team will be dependent on the scope of the visit.

8. The External Visit Lead, or someone delegated by them, will maintain a log of information requested and provided, during the visit and thereafter.

9. Adequate cover arrangements should be in place to cover periods where key individuals are absent or unavailable.

**Appendix 4.**

# Flow Process for Responding to an Out Of Hours Unannounced Site Visit

1. It is the responsibility of the area affected by the visit to inform the On-call Executive and On-call Manager of any unannounced site visits by External Bodies IMMEDIATELY when they arrive on site.

2. All visitors should be asked to produce their ID, and if there is any doubt of the validity of this the offices of the visiting body should be contacted to verify their identity. (For CQC Inspectors, contact 03000 616161).

3. The On-call Executive nominates an External Visits Lead to manage the visit (this lead may act in interim until the typical Lead is available). The lead will be dependent on the nature of the visit.

4. The On-call Manager informs relevant staff that a visit is taking place. Those to be informed will be dependent on the nature of the visit, but are likely to include;
a. Emergency Department Co-ordinator
b. All on-call consultants or the most senior doctors on site.
c. 401/ 0903 (depending on site affected) bleep holder
d. On-call Matron
e. PFI/ Facilities Manager

5. The individuals above cascade details of the visit to all relevant staff without delay.

6. The External Visits Lead will ensure that the needs of visitors are met, including access to people and the provision of any information and documentation requested. They will delegate roles to a supporting team as necessary. Membership of the supporting team will be dependent on the scope of the visit.

7. The External Visits Lead organises any escorts to accompany the visiting team, an office base, where required, and any other logistical requirements.

8. The External Visits Lead should ensure that a log of information requested and provided is maintained.

9. At the earliest opportunity following the visit the External Visits Lead informs the relevant parties and Healthcare Standards Team of the visit.

## Appendix 5.

Appendix 5_External Visits Log.xlsx

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.gray13@nhs.net |
| | Effie Gridley | Healthcare & Quality Standards Officer | Effie.gridley@nhs.net |
| **Date assessment completed** | 10/05/2023 | | |

**Section 2**

| | | | | | |
|---|---|---|---|---|---|
| Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.) | **Title:** Policy for the Management of External Body Visits & Recommendations | | | | |
| What is the aim, purpose and/or intended outcomes of this Activity? | This policy outlines how the Trust will manage external body visits and recommendations. | | | | |
| Who will be affected by the development & implementation of this activity? | ❑ ✓ | Service User | ❑ ✓ | Staff | |
| | ❑ ✓ | Patient | ❑ ✓ | Communities | |
| | ❑ ✓ | Carers | ❑ | Other _____ | |
| | ❑ ✓ | Visitors | ❑ | | |
| Is this: | ❑ ✓ Review of an existing activity<br>❑ 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. | |
| Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required) | |
| 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** | | ✓ | | |
| **Sex** | | ✓ | | |
| **Sexual Orientation** | | ✓ | | |

| Equality Group | Potential positive impact | Potential neutral impact | Potential negative impact | Please explain your reasons for any potential positive, neutral or negative impact identified |
|---|---|---|---|---|
| | | | | |
| **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** | 10/05/2023 |
| **Comments:** | |
| **Signature of person the Leader Person for this activity** |  |
| **Date signed** | 10/05/2023 |
| **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