External Accreditation, Regulation and Quality Assurance Management Policy

POLICY

Reference	GV/012		
Approving Body	Patient Safety Committee		
Date Approved	February 2026		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
			X
Issue Date	February 2026		
Version	V 3		
Summary of Changes from Previous Version	Full review		
Supersedes	V2		
Document Category	Governance		
Consultation Undertaken	N/A		
Date of Completion of Equality Impact Assessment	03/01/2026		
Date of Environmental Impact Assessment (if applicable)	03/01/2026		
Legal and/or Accreditation Implications	None		
Target Audience	All Trust Staff		
Review Date	January 2029		
Sponsor (Position)	Chief Medical Officer		
Author (Position & Name)	Director of Nursing Quality & Governance. Candice Smith		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	N/A		
Position of Person able to provide Further Guidance/Information	Director of Nursing Quality & Governance		

Associated Documents/ Information	Date Associated Documents/ Information was reviewed
Not Applicable	*Not Applicable*

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APPENDICIES

1.0 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-of

2.0 POLICY STATEMENT

The policy will ensure that there is a centrally held record of all external agency visits, inspections and accreditations together with their reports, and remedial action plans. This central record will be kept up to date and will be regularly monitored. Information relating to the preparation for, and outcome of, external agency visits, inspections and accreditations will be shared with the appropriate Trust committees in a timely manner thereby creating the appropriate level of "Executive line of sight".

3.0 DEFINITIONS/ ABBREVIATIONS

3.1. Definitions

Accreditation	The act of certifying that an institution maintains suitable standards
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), HM Coroner)
Inspection	A formal review by a body with statutory powers to determine compliance with standards and report on the performance of the organisation
Accreditation	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

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

3.2. Abbreviations

PSC	Patient Safety Committee
CQC	Care Quality Commission
DoH	Department of Health
TMB	Trust Management Board
NHS LA	NHS Litigation Authority
GSU	Governance Support Unit

4.0 ROLES AND RESPONSIBILITIES

4.1 Chief Executive (CEO)

The Chief Executive is ultimately responsible for the process of managing and responding to external agency visits, inspections and accreditations effectively and efficiently and is responsible for the oversight of Regulation 28 processes. This responsibility is delegated to the following committees and nominated individuals:

4.2 Executive Sponsor (Chief Medical Officer**)**
The Executive Sponsor is the owner of the process and will support the implementation of this policy at Corporate Level

4.3 Director of Nursing Quality & Governance

The Director of Nursing Quality & Governance is the appointed lead for the implementation of this policy supported by the Executive Sponsor. Responsibilities are:

- Providing information to the Chief Medical Officer on external agencies which may visit/inspect or accredit the Trust, ensuring:
    - nominated leads or deputies have been identified;
    - the accountable committees they report to have been identified
    - the database where the information is stored has been identified; access requirements to are identified as appropriate;
    - logging of evidence relating to the external agency visit, inspection or accreditation onto a central resource (e.g. final report and remedial action plan).
    - access requirements to the Trust's web enabled risk register are identified;
    - ensure the communications team is notified as soon as required

- Informing the Chief Medical Officer of all planned and unannounced visits notified to the Director of Nursing Quality & Governance as soon as notification is received
- Support Trust Leads with implementation of this policy

4.4 Trust Leads (or a named designated deputy)

This title refers to the individual(s) nominated as being responsible for preparing and coordinating an External visit:

- As soon as a visit becomes known, to inform the Director of Nursing Quality & Governance and the relevant Executive Lead, of the date and nature of the visit and anticipated date for receipt of a report.
- 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
- 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 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 patient Safety Committee.

4.7 Patient Safety Committee

- Receives exception reports form Divisional Clinical Governance forums, where actions in response to External visits are not progressing to plan.
- Provides assurance to the Quality Committee that External Visits are managed effectively.
- Monitors compliance with this policy and oversees the organisational learning from visits.

4.8 Divisional Governance meetings

- 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 PSC, all instances where actions in response to External visits are not progressing to plan, or where Trust wide action and support is needed.

5.0 DOCUMENT REQUIREMENTS

The following section will set out the process to manage the visit, inspection or accreditation giving guidance on the various stages.

5.1 Identification of External Organisations

The organisation will identify all those external agencies undertaking a visit, inspection or accreditation; this also includes local inspections for specialist services as well as organisational inspections. The details of all external agency visits, inspections and accreditations will be included on the central resource and recorded upon the electronic "External Agency Visits" calendar managed by the Director of Nursing Quality & Governance. The information on the central resource will be reviewed on a 6 monthly basis to ensure it is accurate.

5.2 Scheduling Visits

The Director of Nursing Quality & Governance will maintain and update a schedule of visits identified by Trust Leads or nominated deputies. This schedule will be stored on an electronic calendar managed by the Director of Nursing Quality & Governance and details recorded upon a central resource
The Corporate Services directorate will be informed of any unannounced visits by the Trust Leads / deputies during the visit.

- There are only certain external agencies which can make unannounced visits and have the power to access Trust property without permission from the Chief Executive. If in doubt, staff should contact the On-Call Director for guidance.

Where an unannounced visit is to take place out of hours the On-Call Director must be notified. Staff must call the Trust switchboard Tel: 01623 622515 and they will be put through to the On-Call Director.

- Staff must request formal identification to be produced by the external agents prior to allowing them access to Trust property. All external agents should carry a photographic identification card from the agency concerned.
- Following the visit, the Lead Director will be responsible for receiving, and responding to, any report and evaluating its recommendations.

The Chief Medical Officer/ Director of Nursing Quality & Governance will be informed of any return or subsequent visits / inspections by the Trust Leads and this information will be recorded on the electronic calendar and on the central resource

5.3 Preparation for the Visit

The Trust Lead or Deputy is responsible for:

- Agreeing the date of the external agency visit, inspection or accreditation (if appropriate).
- Ensuring they are aware of and have an understanding of the assessment requirements of the external body visiting, inspecting or accrediting the organisation.
- Preparing the evidence required in the format required by the external body visiting, inspecting or accrediting the organisation.
- Ensuring the assessor has a contact number and a designated place to meet on arrival in the organisation.

- Organising the requirements of the assessor for the external body visiting, inspecting or accrediting the organisation for example a venue, power source and telephone.
- Agreeing a timetable / schedule for the visit, inspection or accreditation with the representative of the external body.
- Liaising with the representative from the external body in regard to comfort / catering requirements.
- Ensuring access to any other staff the assessor from the external body may wish to meet during the visit, assessment or accreditation - produce a timetable if necessary.
- Ensuring the assessor will be able to access the areas required for the visit, inspection or accreditation.
- Ensuring that a venue is available for any feedback activity at the end of the external visit, inspection or accreditation.
- Ensuring any staff required for any feedback activity are aware of when and where they are required to attend for the feedback session, this should include the Director of Nursing Quality & Governance

5.4 Ensuring the evidence is valid

The Trust Lead or deputy should ensure the information provided for external visits, accreditations and inspections is valid and accurate by:

- Ensuring they have a clear understanding of exactly what information has been requested.
- When requesting information from other parts of the Trust (e.g. the Information Department or GSU) ensure that the request explicitly highlights that the information has been requested by an external body as part of a visit, accreditation or inspection and supply any guidance documentation provided by the external body.
- On receipt of the information, validate the information.

5.5 Process for Managing the Visit

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

5.6 Receiving verbal feedback from the visit

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: o 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.

5.7 Review and Response to Written Recommendations

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

- Upon receipt of the draft report, adherence to strict confidentiality when internally distributing is essential.
- Completing factual accuracy checks against any guidance 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 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.

5.8 Sustainable Change

The External Visit Lead and Responsible Committee (PSC) 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.

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**.**

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. 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.

Regulation 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 regulation 28 report, this is sent to the organisation which has responsibility for the circumstances. The Chief Executive will receive Regulation 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 Regulation 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.

Self-Commissioned Reviews
The Trust Board will, on occasion, 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

Implementation
The principles of this policy are embedded. The renewal of this policy will be highlighted to key staff and support for its implementation will be provided by the Governance Support Unit via the Divisional Clinical Governance forums.

Dissemination
The policy will be available to all staff on the intranet and awareness of this policy will be raised through the dissemination process above.

Training
Limited training is necessary, but assessment leads will be contacted and made aware of the policy's requirements as the visits are identified

6.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
All external accreditation and regulation bodies need a named Trust Lead	Director of Nursing Quality & Governance	Review of Trust Leads	Annual	Verbal report to PSC by Director of Nursing Quality & Governance
Risks identified to accreditation or regulation are identified on the Trust risk register	Speciality Trust Lead	Review of Trust Risk Register	In line with Trust Risk Management Policy and scoring	Verbal report to PSC by Director of Nursing Quality & Governance
Action plans in response to external regulation and accreditation	Speciality Trust Lead	Updated action plans	Quarterly	Trust Lead report to External Regulation and Accreditation Committee

7.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix 01
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix 02

8.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- NHSLA Risk Management Standards

Related SFHFT Documents:

- N/A

9.0 KEYWORDS

Accreditation
Regulation
CQC
Quality Assurance

10.0 APPENDICES

Appendix One – Equality Impact Assessment
Appendix Two – Environmental Impact Assessment

APPENDIX 01 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Equality Impact Assessment (EIA) form : EIA form stage 1:

NAME of EIA Assessor:	**Date of EIA completion:**
Department:	**Division:**
Name of service/policy/procedure being reviewed or created:	
Name of person responsible for service/policy/procedure:	
Brief summary of policy, procedure of service being assessed:	

Please state who this policy will affect: Patients or Service Users, Carers or families, Commissioned Services, Communities in placed based settings, Staff, Stakeholder organisations, Others (give details)
(Please delete as appropriate)

Protected characteristic	**Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)**	**Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening. Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.**
Race & Ethnicity	No	
Sex	No	
Age	No	
Religion & Belief	No	
Disability	No	
Sexuality	No	
Pregnancy & Maternity	No	
Gender reassignment	No	
Marriage & Civil Partnership	No	
Socio-Economic factors	No	

What consultation with protected characteristic groups including patient groups have you carried out? N/A

As far as you are aware are there any Human Rights issues to be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?
No

On the basis of the information/evidence/consideration so far, do you believe that the document will have a positive or negative adverse impact on equality? (delete as appropriate)

Positive			Negative			
High	**Medium**	**Low**	**Nil**	**Low**	**Medium**	**High**
If you identified positive impact, please outline the details here:						

EIA Form stage 2:

If you have answered 'yes' to any of the above in stage 1, please complete Stage 2 of the EIA

Protected Characteristic	Please explain, using examples of evidence and data, what the impact of the Policy, Procedure or Service/Clinical Guideline will be on the protected characteristic group.	Please outline any further actions to be taken to address and mitigate or remove any in barriers that have been identified.
Race and Ethnicity		
Gender		
Age		
Religion		
Disability		
Sexuality		
Pregnancy and Maternity		
Gender Reassignment		
Marriage and Civil Partnership		
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)		

Signature: *I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form*
Date:

APPENDIX 02 – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	