September 2015

Clinical Governance Framework

PublicHealth

TORBAY COUNCIL

Contents

Ratification Process

Quality Committee approval – 12 August 2015
Mayoral Decision to ratify –

For Review
This Clinical Governance Framework will be reviewed in 3 years, or less if legislative/organisational changes dictate.

1 Introduction

1.1 Background

Since 1 April 2013, Local Authorities have been responsible for improving the health of their local populations through the provision of a range of Public Health services. It is important for both individual service users and for communities that Local Authorities commission services and interventions which are cost-effective, high quality and safe for patients (Department of Health *a*, 2013).

1.2 Definition of Clinical Governance

The term, Clinical Governance, is a description of all the systems and processes needed to ensure that clinical and related services are able to deliver safe, high quality and cost-effective care; a *systematic method to raising standards of healthcare* (Collins, 2003). Scally and Donaldson (1998) expand this by defining Clinical Governance as, *the framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in healthcare will flourish".*

Lord Darzi (2008) defined quality as comprising:

- Patient Safety – avoiding harm from the care that is intended to help
- Effectiveness – aligning care with science and ensuring efficiency
- Patient Experience – services must be patient centred and equitable.

2 Why we need a Clinical Governance Framework

Torbay Council Public Health Team, as commissioners of clinical and related services, has a duty to assure itself that the services it commissions are safe, cost-effective and of high quality.

It is acknowledged that Public Health service providers can be organizationally complex and deliver clinical interventions and services where, by definition, there is an element of inherent risk. Risks can be grouped into categories, and the following represent common issues for Public Health services:

- Safeguarding risks – where clients of such services are vulnerable adults or young people
- Financial risks – through litigation and/or the provision of ineffective treatment
- Clinical risks – the prescription of controlled drugs requires a system of governance that is also a statutory requirement because of high levels of mortality and morbidity in the population served

- Reputational risk – particularly for public health services where partnership working and engagement of the public and service users is critical to successful service delivery.

The external and internal processes necessary to providing assurance to the commissioner that risk is being managed appropriately, and as planned, are described in this document.

The Local Authority – in its exercise of Public Health commissioning functions – is required by law to have regard to the NHS Constitution in its decisions and actions (Department of Health *b*, 2013). This requirement covers all services contracting with the Public Health Team, whether NHS Trusts or not.

Finally, in summary, the Public Health Team's clinical governance process is focussed on gaining assurance that the clinical governance systems of those providers it contracts with are robust and promote safety, cost-effectiveness and quality of service provision.

3 Managing Contractual Relationships and the Escalation Process

3.1 Commissioner Assurance

Contracts with public health providers each contain requirements that the providing organization has an effective clinical governance and quality assurance framework in place. They are also required to demonstrate that they adhere to clinical and service standards set by relevant professional organisations. These requirements are evidenced to the commissioner at point of procurement. Provider processes must provide reassurance that practice, incidents, risks and compliance are managed systematically, transparently and robustly.

In addition to their own internal systems, public health provider organisations are expected to disclose to the commissioner incidents, risks and compliance issues transparently, and on a prescribed frequency as laid out in contractual documentation. The provider organization is expected to report serious incidents within internal structures (as per local protocols) and is then expected to disclose the serious incident to the commissioner without delay. Less serious issues have less immediate timeframes.

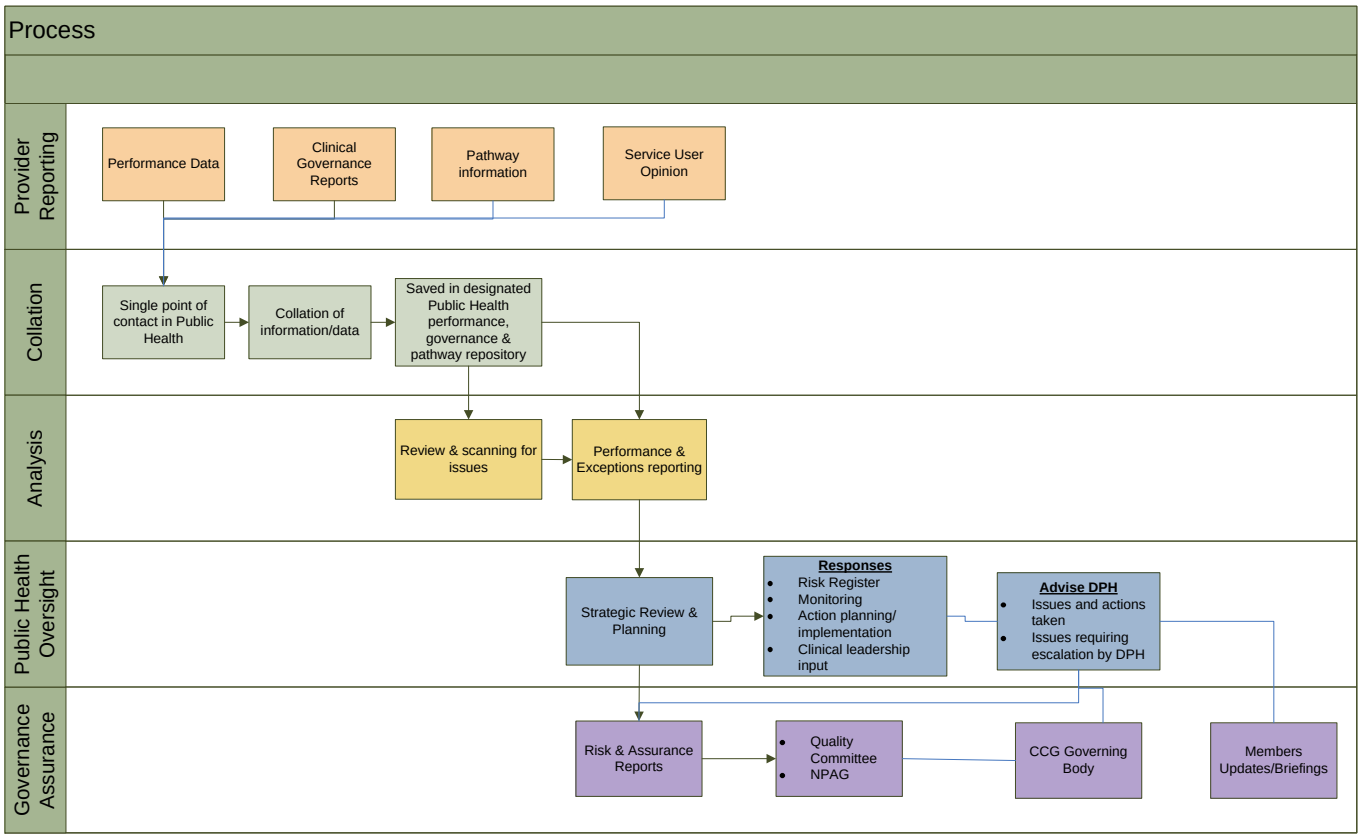
Robert Francis QC (2013) stated that 'there needs to be a relentless focus on the patient's interests and the obligation to keep patients safe and protected from sub-standard care'. He explains that this can be achieved, in part, by a culture of 'openness, transparency and candour in all the system's business'. The Public Health team will seek to monitor contracts in dialogue with providers using a collaborative and facilitative approach, where the findings of the Mid Staffordshire Inquiry are characteristic of the commissioner provider relationship.

3.2 Escalation

A framework for the escalation and resolution of issues that deviate from contractual and/or quality expectations is necessary, to ensure the commissioner is confident the provider is operating correctly. Clinical details and identifiable personal information is not within the commissioner's gift (rightly) however it is their responsibility to check provider processes are fit for purpose and are taking place.

Escalation will be proportionate to both the index incident/risk and the assurance that it is being appropriately managed by the provider organization.

- Non-clinical groups and managers (such as are common in the Local Authority) are convened to manage non-clinical risks.
- Clinical risks are escalated as appropriate, to Torbay and Southern Devon Clinical Commissioning Group ("CCG"), which provides their clinical governance mechanisms – in partnership with the public health team – right up to CCG Executive Level.



4 Public Health roles and responsibilities in the Escalation Process

4.1 Escalation Process

Activity	Responsibility
Data reporting	**Designated Responsibility: Ian Tyson**
Sending reports	Provider
Chairing of Public Health Provider Quarterly Review Meeting ("QRM")	Designated Responsibility: Lead Public Health Commissioner
Issue / incident reporting	Provider and Key Stakeholders
National datasets	Lead Public Health Commissioner with Public Health Epidemiology Team
Collation	**Designated Responsibility: Public Health Business Administrator**
Single Point of contact for Provider reports	Public Health Business Administrator
Collating data into designated Public Health Repository	Public Health Business Administrator
QRM reports and minutes	Designated Responsibility: Public Health Business Administrator
Issue or incident reports	Provider
Analysis	**Designated Responsibility:** • **Performance – Lead Public Health Commissioner** • **Governance – Public Health Treatment Effectiveness Manager**
Review of performance/issue identification and exception reporting	Lead Public Health Commissioner
Review of clinical governance/issue identification and exception reporting	Public Health Treatment Effectiveness Manager
Review of pathways	Public Health Principal/Public Health Consultant
Public Health Oversight	**Designated Responsibility: Head of Public Health Improvement**
Issues within tolerance and no escalation required	Lead Public Health Commissioner/Public Health Treatment Effectiveness Manager
Issues outside of tolerance and strategic input required	Head of Public Health Improvement/Public Health Consultant
Issues require the most senior input and/or action	Director of Public Health
Governance Assurance	**Designated Responsibility: Head of Public Health Improvement**
Reports provided to Quality Directorate / Committee	Public Health Treatment Effectiveness Manager
Reports provided to NPAG	Public Health Treatment Effectiveness Manager
Reports provided to Public Health Team/Senior Team	Public Health Treatment Effectiveness Manager / Lead Public Health Commissioner
Reports provided to Sexual Health Clinical Pathways Group	Lead Public Health Commissioner / Public Health Treatment Effectiveness Manager
Reports provided to Pharmaceutical Harm Reduction Panel	Public Health Treatment Effectiveness Manager
Reports provided to Treatment for Recovery Group	Public Health Treatment Effectiveness Manager

Activity	Responsibility
Update/Highlight reports for members	Head of Public Health Improvement
Update/Highlight reports for Health and Wellbeing Board	Head of Public Health Improvement

5 Overview of Analysis, Oversight and Response Process

The Public Health Team's structure allows for a clear division between performance and quality monitoring, whilst using the same structures to oversee both.

5.1 Quality Monitoring

The table at Appendix 2 represents the quality agenda (ie) the management and escalation of risks, incidents and compliance with national/professional standards. Quality, in its broadest sense, is overseen by the Treatment Effectiveness Manager, as a delegated responsibility from the Head of Public Health Improvement. [1] The Internal Public Health Governance will align with the contracting and performance monitoring architecture and processes.

See Appendix 2.

5.2 Performance Monitoring

The table at Appendix 3 represents the performance monitoring function, and the escalation process when significant deviations from expected contract outcomes / outputs are detected.

Whilst it is not anticipated that every underperformance or deviation from contract will be escalated beyond the Quarterly Contract Review Meeting ("QRM")[2], the process allows for an architecture in which the Public Health team can ensure provider organisations are delivering best possible outcomes: this translates as best value to the public.

See Appendix 3.

[1] Although distinct and separate, quality and performance monitoring may be undertaken in the same meetings.
[2] An initial approach will always be to work collaboratively with the provider organization to resolve performance difficulties in their contract delivery or service quality.

6 Scope

The final scope will be defined nationally.

Area of responsibility	Clinical Delivery	Direct delivery or commissioned
Comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)	• Torbay Sexual Medicines Service (SDHCFT) • The Eddystone Trust • School Nursing Service (T&SD)	Commissioned Commissioned Commissioned
National Child Measuring Programme	• School Nursing service (T&SD) • Independent Pharmacy contractors	Commissioned Commissioned
NHS Health Check assessments	• Independent GP contractors	Commissioned
Provide Public Health expertise to NHS Commissioners (Core Offer)	• Clinical commissioning advice to NHS England, Clinical Commissioning Group. • Screening Programmes • Tuberculosis interventions	Direct Delivery Direct Delivery Direct Delivery
Drug misuse services (treatment)	• Shrublands House (DPT) • Torbay Primary Care Drug Service (T&SD) • CheckPoint (Children's Society) • Independent Pharmacy contractors for Supervised Consumption & Needle Exchange	Commissioned Commissioned Commissioned Commissioned
Alcohol misuse services (treatment)	• Torbay Primary Care Alcohol Service (T&SD) • Shrublands House (DPT) • CheckPoint (Children's Society)	Commissioned Commissioned Commissioned
Tobacco control/smoking cessation services	• Independent GP contractors • Independent Pharmacy contractors • Healthy Lifestyles Team (T&SD)	Commissioned Commissioned Commissioned
Obesity and community nutrition initiatives	• Healthy Lifestyles Team (T&SD) • School Nursing Service	Commissioned Commissioned
Increasing levels of physical activity in the local population	• Healthy Lifestyles Team (T&SD)	Commissioned
Emotional health and wellbeing services	• Healthy Lifestyles Team (T&SD) • School Nursing Service (T&SD)	Commissioned Commissioned

Area of responsibility	Clinical Delivery	Direct delivery or commissioned
	• Health Visiting Service (T&SD)	Commissioned
Oral health services	• Healthy Lifestyles Team (T&SD)	Commissioned
Accidental injury prevention	• Health Visiting Team(T&SD) • School Nursing Service (T&SD)	Commissioned Commissioned
Population interventions to reduce and prevent birth defects	• Screening Programmes	Commissioned
Behavioural and lifestyle campaigns to prevent cancer and long-term conditions	• Screening Programmes • Lifestyles Team (T&SD)	Commissioned Commissioned
Local initiatives to reduce excess deaths as a result of seasonal mortality	• Lifestyles Team (T&SD)	Commissioned

7 Safety, Effectiveness and Quality Reporting by Commissioned Providers

7.1 Core Reporting Requirements 2015/16

	Indicator	Frequency
1	Compliance with CQC outcomes standards	Quarterly
2	Never Events – using NPSA national definitions	Monthly
	SIRIs or SEA's	
3a	Number of SIMs/STEIS reports	Monthly
3b	Number of SIRIs reported	Monthly
3c	Number of SIRIs outside policy timescales	Monthly
3d	Action plan updates for all closed SIRIs/SIMs	Quarterly
3e	Root causes and lessons learned for closed SIRIs/SIMs in the previous quarter	Quarterly
3f	Trend Analysis	Quarterly
	Safeguarding children and adults	
4a	Safeguarding children % compliance	Quarterly
4b	Safeguarding adults % compliance	
4c	Compliance with CQC outcomes standards	
	Complaints/ Patient Experience:	
	Submit a report that shows the following:	Monthly
5a	Concerns	
5b	Complaints	
5c	Compliments	

	Indicator	Frequency
5d	Comments	
5e	Patient Outcomes/Satisfaction of dealing with concerns and complaints	Bi-annual
5f	Evidence of learning from complaints including how services/provision changed as a result of investigation	
5g	Reported experience of patients and Service User involvement on how they are consulted with on key changes and proposals?	Quarterly
	Patient Experience Survey Results specifically:	
6a	Service user experiences	Quarterly
6b	Carer experiences	Quarterly
	NICE compliance	
7a	Report & evidence adherence to NICE Standards, Technology Appraisal and Guidelines	Quarterly
7b	Provision of NICE Guidance Exception Report	Bi-annual
	CAS/NPSA alerts	
8a	Provision of Exception Report detailing where CAS/NPSA Alerts have not been implemented or have not met the timeframes	Quarterly
8b	The number of CAS/NPSA alerts relevant to the service.	
8c	Detailed action plan addressing the lapsed status, (including action leads).	
8d	Risk rating in respect of lapsed status.	
	External Reports, Reviews or audits	
9a	The number of internal and external audit reports	Quarterly
9b	Findings and action plan implementation from audits	Quarterly
9c	What self-assessment against recommendations is occurring as a result of any National Review, or CQC Review of another establishment?	Quarterly
	Staff Wellbeing	
10a	Evidence of a workforce development plan	Annual
10b	Staff vacancy, long term sickness and absence report with remedial action plan where appropriate	Quarterly
10c	Number & proportion staff who receive supervision in accordance with organisational policy	Annual
10d	Number & proportion of staff who have attended all required essential training	Annual
	Infection Control	
11	Standard Hand Hygiene should be practiced. Compliance with the DH Hygiene Code 2006 and registration with the CQC. Report exceptions and include action plan	Monthly

7.2 Core Reporting Definitions 2015/16

Indicator	Descriptor
Compliance with CQC outcomes standards to include a report on any breaches or suspected breaches of compliance against any standard or regulation	Compliance the Care Quality Commission's national outcomes standards of quality and safety that are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Never Events – using the most up-to-date Department of Health national definitions	Incidents that the Department of Health has specified as unacceptable and preventable.
SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRI)	
Number of STEIS incidents recorded each month	The national NHS system for strategic oversight of Serious Untoward Incidents. Reporting the number of incidents that have been logged with the national incident system.
Number of STEIS incidents completed/removed each month	The number of logged incidents that are removed following completion of investigation and action planning or due to no longer being assessed as being necessary (indicate the reason for removal).
Number of SIRIs reported each month	A serious incident that can have a devastating and far reaching effect. These may involve service users, members of staff, visitors or the public. These incidents require investigation by the organisation and learning that comes out of this should inform service development. The number of these incidents each month is to be recorded, with any commissioning reporting in accordance with the service specification and contract.
Number of SIRIs not closed within policy timescales (with a Summary Report)	organisational policies for incident reporting and investigation include timescales for completion of any investigation. Exception reporting for the number of incidents SIMs/STEIS/SIRI not being completed within timescale are reported for each Quarter. A summary report for the reasons for delay
Root causes and lessons learned for closed SIRIs in the previous quarter	Report summarising root cause of serious incident and the lessons learnt.
Action plan updates for all closed SIRIs	Report summarising actions and their implementation that come out of learning from serious incidents
Trend Analysis (Summary report to be submitted)	Report summarising any themes of incidents in the year.
SAFEGUARDING	
Safeguarding children training completion (% of staff trained)	Linked to Ofsted Safeguarding Children - All staff (90% threshold to account for staff turnover) have up to date training appropriate to their role. An Adequate Grade three score would be expected to be no less than 85%.
Safeguarding adults training (% of staff trained)	All staff (90% threshold to account for staff turnover)have up to date training appropriate to their role and all staff are in receipt of regular supervision to support them in their role. An Adequate Grade three score would be expected to be no less than 80%.
COMPLAINTS AND PATIENT EXPERIENCE	
Submit a report that will allow Public Health to identify trends and provide assurance of service improvement in these areas. Show monthly totals against lines below: a) Concerns b) Complaints c) Compliments d) Comments	Numbers of concerns, complaints, compliments and comments received per month with summary report of good practice, issues, and themes.
Number of complaints escalated due to Service User dissatisfaction with response	Number of complaints where the complainee has been dissatisfied with the response received and further resolution is required.
Evidence of learning from complaints including how services/provision changed as a result of investigation	Summary report outlining issues, learning and implementation of developments arising from concerns, complaints or comments

EXPERIENCE OF SERVICE	
Service User experiences Carers & 'Concerned Significant Others' experiences	Summary report outlining service user involvement activities and learning from patient experience initiatives within the service to inform safety, quality and effectiveness of provision. Summary report outlining Carers & Concerned Significant Others' involvement in service user treatment.
NICE REPORTS	
Report adherence to NICE Standards, Technology Appraisal and Guidelines published in the last Quarter Provision of NICE Guidance Exception Report	Summary report providing assurance of service compliance to all relevant NICE standards published in the last Quarter. Report to include appendix of completed 'self-assessments' and any organisational ratification documentation where appropriate. Summary exception report for areas of non-compliance with NICE standards. To include appendix of action/implementation plans as evidence of assurance.
CAS/NPSA ALERTS	
The number of CAS/NPSA alerts published in the previous Quarter relevant to the service. Provision of Exception Report detailing where CAS/NPSA Alerts have not been implemented or have not met the timeframes in the last Quarter	The number of National NHS alerts to ensure patient safety that have relevance for the service and require remedial actions in the previous Quarter Summary exception report for areas of non-compliance with National Alerts. To include appendix of action plan addressing the lapsed status, (including action leads).
REPORTS, REVIEWS, AUDITS	
The number of internal and external audit reports completed in the last Quarter Submit a report that shows the findings and action plan implementation from audits What self-assessment against recommendations is occurring as a result of any National Review, or CQC Review of another establishment?	The number of audits that have taken place, with reports published in the last Quarter Summary report outlining the findings of the audits that have been published in the last Quarter, including appendix with action plans where remedial action is required. Summary report outlining the findings of self-assessments completed in the last Quarter, including appendix with action plans where remedial action is required.
STAFF WELLBEING	
Evidence of a workforce development plan Staff vacancy, long term sickness and absence report with remedial action plan where there is an impact on service delivery Percentage of staff who have received supervision in accordance with organisational/service policy Percentage of staff to attend mandatory/compulsory/essential/core training	Summary report of organisational and/or service work force development plans with implementation progress Summary report of vacancy, sickness and absence within the workforce where there is an impact on service delivery. To include appendix of action plans to mitigate impact. The percentage of staff who have received supervision to date in the year, in accordance with the frequency defined in the organisation or service supervision policy The percentage of staff who have undertaken the core or essential training that is mandatory within the organisation. (90% threshold to account for staff turnover)

8 Appendices

Core Quality reporting templates:

Governance core reporting template.xls:

Quality report summary template.do

Nanette Amos Tribble
Public Health Treatment Effectiveness Manager
September 2015

9 References

Department of Health, *a: Sexual Health: Clinical Governance*, October 2013

Department of Health, *b*: *Commissioning Sexual Health services and interventions,* March 2013

Francis QC Robert: *Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry*, February 2013

Scally G and Donaldson LJ, *Clinical governance and the drive for quality improvement in the New NHS in England,* 1998

10 Appendix 1

10.1 Local NICE Assessment, Assurance, Planning and Reporting Process

The National Institute for Health and Care Excellence, NICE, is an independent body which provides national guidance and advice to improve health and social care services. Published NICE guidance is a repository of the best available evidence to help organisations commission and deliver cost effective, modern, high quality, safe and evidenced services.

NICE guidance and advice is published at regular intervals to help organisations make continuous improvements to the services they commission or deliver. Organisations do this by:

- Comparing newly published NICE recommendations with existing service provision
- Auditing service provision
- Updating service specifications
- Informing contract monitoring conversations
- Using resources to best meet service user expectations
- Ensuring services are fit for purpose so as to fulfil independent audits from bodies like CQC or Ofsted.

Most documents NICE publishes are in the form of 'guidance', where commissioners and providers can jointly make informed decisions as to the appropriateness of adopting NICE recommendations; decisions that are based on local context and resources. However, the exception to this is Technology Appraisals where findings are mandated not just advised, and assurance must be provided through the Clinical Governance Framework that there has been implementation within 3 months.

NICE publishes guidance in relation to three main areas of service delivery:

- Clinical Guidance
- Social Care Guidance
- Public Health Guidance.

All three areas are relevant to Torbay, with the Public Health Team taking the lead on and co-ordinating the Public Health Guidance. The Public Health team may also need to contribute to Social Care and Clinical Guidance, but the expectation is that they will not ordinarily lead on this.

Many Public Health guidance documents take a system-wide approach to their recommendations. The Public Health Team is committed to multi-agency working and collaborative monitoring groups, so the best outcomes for service users in Torbay can be obtained.

The **NHS** in England has published its Five Year Forward View (2014) that emphasises the importance of ill health prevention and as a consequence, NICE has committed itself to a radical upgrade of its prevention and Public Health guidance. **NICE** (2015) says, 'ensuring people develop healthy habits from an early age can help prevent long-term disease and early death. We can help the NHS and local authorities to take action in their local area and educate younger people so that healthy choices become a life-long habit'.

Public Health providers and commissioners in Torbay can expect to see greater increasing input from NICE. Where NICE guidance and advice overlaps with Torbay Health and Wellbeing Board priorities, these will mean that changes, re-focusing and improvements in local services will be inevitable, and may form a major part of their work plan.

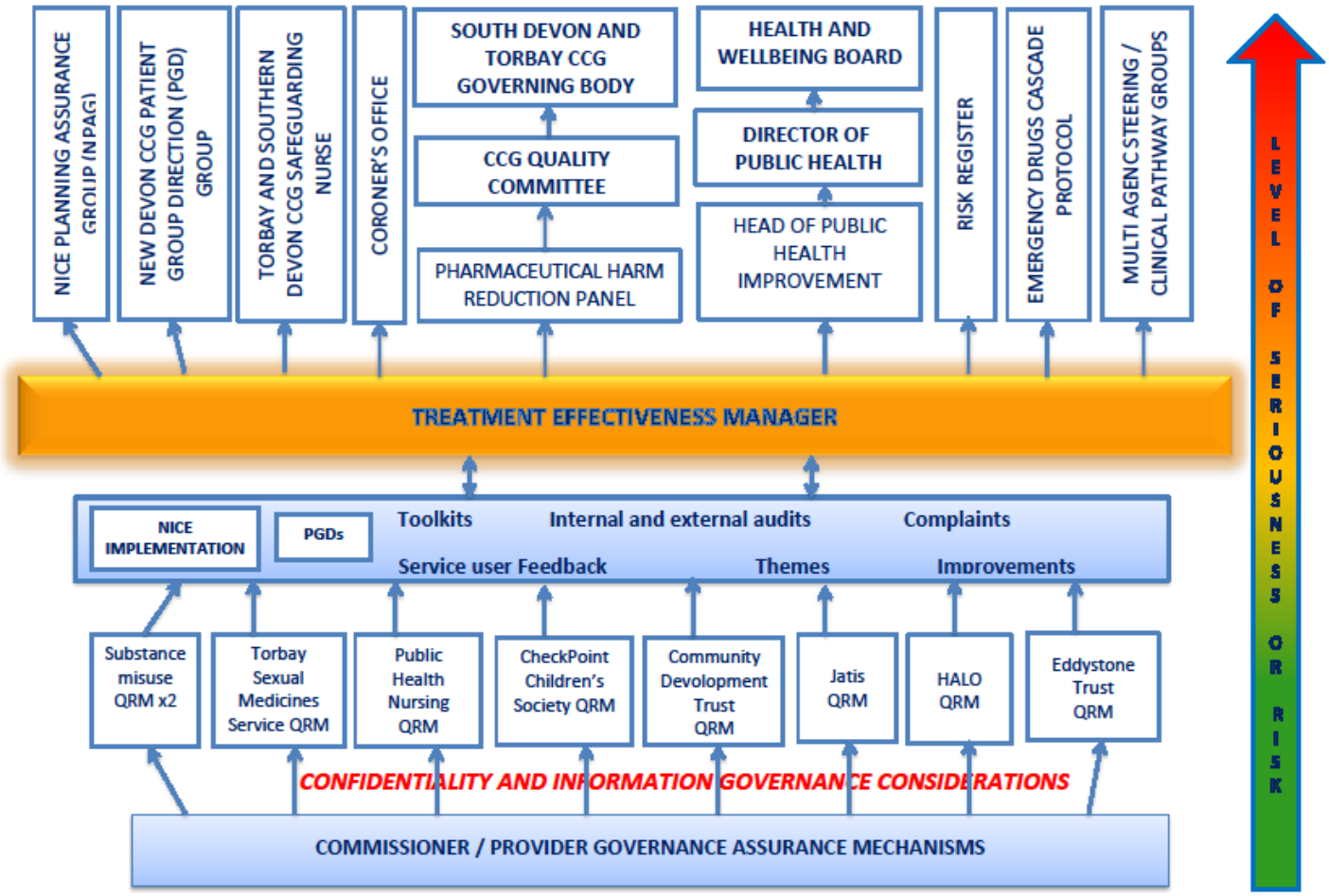
NICE assurance will be, via the Clinical Governance Framework, to NPAG and the CCG Quality Committee in their respective formats.

It is expected that each newly published NICE document will be reviewed in Public Health to consider whether there are implications for Public Health services. NICE also states that it aims to review each piece of NICE guidance every three years. However, the revisiting of NICE guidance and topic areas may also be triggered locally by the following situations:

- When there is a significant local service delivery change
- Where CQC, Ofsted, or other independent (internal or external) evaluation has been carried out, and it is deemed that there are areas for service improvement
- When a procurement exercise to appoint a new local provider is undertaken
- Where a referral pathway is not felt to be providing the outcomes that may have been expected
- Where there is a complaint about a local service that causes sufficient concern so as to warrant a revisit
- After three years, if there has been nothing new published by NICE in the meantime.

The Public Health Treatment Effectiveness Manager will take a lead on co-ordinating NICE guidance and service improvement action plans on behalf of the commissioning team. The interface with providers will be via interim Service Manager Meetings and those conversations ratified, as necessary, at the respective QRMs.

11 Appendix 2



12 Appendix 3