Clinical Governance requirements for Public Health in Local Authorities
Discussion Paper

1. Background

The Health and Social Care Act 2012 transferred substantial health improvement duties to local authorities from April 2013 onwards. Local authorities receive a ring-fenced public health grant intended to improve outcomes for the health and wellbeing of their local populations. Local Authorities will commission a number of services in order to fulfil their duties alongside directly providing some services to the local population in some instances, and to other commissioners, for example healthcare public health advice.

In commissioning services using funds from this grant, local authorities should also “ensure that appropriate clinical governance arrangements are put in place.”

“Clinical Governance (CG) is the framework through which NHS 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 clinical care will flourish”.

Local Authority Public Health (PH) Departments need to ensure that they have robust systems in place to fulfil their obligations. Arrangements may differ from area to area depending on local circumstances but it is important for Local Authorities to note the specific requirements for clinical services and make appropriate arrangements for these to be met.

2. Clinical Governance Requirements.

The following information provides a basis for discussion that sets out a draft list of Clinical Governance requirements that Local Authority Public Health Departments need to ensure are in place as commissioners of clinical services.

2.1. Governance arrangements for the Public Health Departments.

An organisation checklist is outlined by the Faculty of Public Health and includes:-

- Effective health programmes in place – this entails ensuring that programmes are informed by a robust evidence base and performance reviewed regularly.
- Explicit professional standards laid out for staff,
- Risk management programme in place – including emergency plans. Local Authorities will have internal risk management processes which PH departments will link in to.
- Critical incident reporting procedure in place,
- Complaints procedure set out,
• Performance appraisal system in place and recognised as the employing organisation's responsibility. This may need review and consideration as internal LA systems may not align with eg medical revalidation.
• CPD programme for all staff,
• Links forged with performance management,
• Regular departmental meetings to:
  o Review procedures,
  o Audit department’s work – this may involve audit of internal processes consideration should also be given to audits of commissioned work,
  o Develop annual work programmes/business plans,
  o Ensure adequate resources and infrastructure,
• Mechanisms in place to deal with poor performance,
• External appraisal (including peer review),
• Induction of new staff,
• Health and safety policy,

**Current situation** - Local Authorities will have policies in place for their organisations. Public Health Departments may need to look at the organisational policies and procedures against this list.

2.2 **Assurance around appropriate Clinical Governance arrangements for LA commissioned services**

• Departments need to assure themselves of the inclusion of robust systems in provider organisations for clinical governance. With new services this should be considered as part of the tender process. PH teams may also want to consider if they have sufficient assurance of existing contractors.
• Teams may want to consider commissioned services internal mechanisms for e.g. complaints (number and narrative), indicators, audits and outcomes, NICE implementation, staff training, feedback on incidents. PH commissioners will need to define how this is reported to them eg in regular contract/ quality meetings.
• Standards on reports from external systems – e.g. Care Quality Commission (CQC), Healthwatch. Again, commissioners will want to ensure mechanism for receiving such reports routinely.
• Clear standards for reporting to PH e.g. disclosure, timeliness of response, Serious Untoward Incident progress, learning and action plans, safeguarding standards, liaison requirements with regard to agencies such as the police, Public Health England, Health and Safety Executive (HSE), Coroner, Education Partners, Local Midwifery Supervising Authority or Medicines and Healthcare products Regulatory Agency (MHRA),
• Information governance standards and training,
• Staff training.
Current Situation - Many Local Authorities will have mechanisms in place through Pre Qualifying Questionnaires from providers and clauses in their contracts. There may be value in sharing how this assurance is being sought across Cheshire and Merseyside.

2.3 Public health input to NHS clinical governance systems as part of our mandated role to support the NHS.

This may include public health input to Post Infection Reviews, input into individual patient funding requests, quality committees etc. Consideration should be made via champs how this can be streamlined eg agree PH representation and relaying information at quality groups (eg quality surveillance group), HCAI groups etc.

3. Potential Gaps

The following information indicates those areas where clinical input is needed to support public health function

3.1. Medicines management support to Patient Group Directions (PGD) involving LA public health commissioned services. Examples include nicotine replacement therapy, emergency hormonal contraception. Much of the medicines management resource is within the commissioning support unit, with some resource in CCGs. The whole issue of PGD development is complex. Please see supplementary paper.

3.2. Serious Untoward Incidents (SUI)

Clinical and NHS support to Serious Untoward Incidents involving public health services to achieve learning broader than the Local Authority.

3.2.1. Serious Untoward Incident investigation is defined by the National Patient Safety Agency 4 as relating to NHS funded services. A national framework and protocols are in place that all NHS funded services are expected to adhere to.

3.2.2. The requirement on Local Authorities is to ensure that appropriate clinical governance arrangements are in place. If services are commissioned from NHS providers then these providers will already participate in the NHS SUI process and the expectation would be that they would do so for a SUI involving their public health services. However, local authorities will commission with non NHS providers where similar arrangements are not in place. The question arises as to what should be included in “appropriate clinical governance processes”.

3.2.3. Local authorities may have risk management and complaint procedures which they feel are adequate and don’t require an additional SUI process.

3.2.4. Local Authority Directors of Public Health may decide that there is value from the collective sharing of learning that the NHS system offers and wishes to replicate this for public health commissioned services. Options for managing this system include:
   a) Negotiation with local CCG to include public health SUIs in their process with the CCG providing the structure and process for review. This would mirror the process for post
infection review of MRSA in the cases where there is a dispute over ownership and the DPH leads the review process.

b) Public health to set up a separate process either independently or linked with the NHS England Area Team or Public Health England. This would take some further discussion and development.

3.3. Responsibilities relating to the assurance role of the Director of Public Health\(^5\) outlines that the DPH has responsibility for:

3.3.1. Exercising their local authority’s functions in planning for, and responding to, emergencies that present a risk to public health

3.3.2. Their local authority’s role in co-operating with the police, the probation service and the prison service to assess the risks posed by violent or sexual offenders

4. Next Steps

There may be different approaches to addressing these potential gaps and there is potential to explore these further. In some areas the LA is negotiating funded support from commissioning support unit whereas in other areas this support is forming part of the Memorandum of Understanding between the LA and CCG. There may be value in sharing current approaches and in some cases agreeing a common approach.

5. References

1. Definition – Clinical Governance

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