Final Internal Audit Report

Clinical Governance – Risk of a Bad Outcome from an Intervention

May 2017

Distribution:

Executive Director People (Final only)
Director Public Health
Consultant in Public Health
Head of Commissioning and Improvement (Corporate)

Assurance Level	Recommendations Made	
Substantial Assurance	Priority 1	0
	Priority 2	3
	Priority 3	0

Contents

Page

Executive Summary

Detailed Report

Appendices

Executive Summary

1. Introduction

1.1 The Department of Health (DoH) defines 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'. The DoH suggests the main elements of clinical governance are:

- Patient Safety;
- Clinical Effectiveness; and
- Patient/Public Experience.

1.2 The Public Health grant allocated to local authorities is intended to improve outcomes for the health and wellbeing of their local populations. A condition of the grant is that organisations must have appropriate clinical governance arrangements in place to cover services commissioned with grant funds. The Council must therefore ensure that services are commissioned from providers who have robust and effective clinical governance systems in place and who adhere to clinical and service standards set by relevant professional bodies.

1.3 A standard contract template is used by the Council which contains the following areas:

1. Risk management.
2. Safe guarding procedures.
3. Incident management.
4. Monitoring and reporting requirements.

1.4 Section 75 Partnership Board meetings are held between the Council and Croydon health Services, which include the review of clinical governance.

1.5 This audit is part of the agreed Annual Internal Audit Plan for 2016/17. The objectives, scope and approach are included in the Audit Terms of Reference at Appendix 1.

2. Key issues

Priority 2 Recommendations
A policy that covers the clinical governance within the Council is not in place. **(Rec. 1)**
No contract (or service level agreement) was in place with service providers engaged in the GP Enhanced service user support for drugs (shared care) programme for that funded element (although contracts for other funded elements were in place). **(Rec. 2)**
There is no overall review of clinical governance and clinical governance issues by the Council. **(Rec. 3)**

3. Actions and Key Findings/Rationale

Area 1 – Management, Organisational and Regulatory requirements				
Priority	**Recommendation 1**	**Detailed Finding/Rational**		
2	A Clinical Governance Policy should be formulated for the Council and be communicated to staff.	The Public Health grant allocated to local authorities includes a condition that appropriate clinical governance arrangements are in place. A key element to any such arrangements is a clinical governance policy, which sets out the governance framework and systems in place to monitor the quality and safety of the care the Council provides, to help the service improve and to reduce risks to the health, safety and welfare of service users and staff. Discussions confirmed that neither the Council nor the Public Health Division have a policy that covers the clinical governance within the Council. Where a Clinical Governance Policy is not in place, there is a risk that staff may not be aware of and comply with management's expectations regarding clinical governance.		
Management Response		**Agreed/Disagreed**	**Responsible Officer**	**Deadline**
We are currently putting a LBC and NHS team together to discuss and draft a local clinical governance policy.		Agreed	Consultant in Public Health	July 2017

Area 2 – Commissioned Services

Priority	Recommendation 2	Detailed Finding/Rationale
2	A full review of all commissioned Public Health services should be undertaken to ensure that appropriate contracts (or service level agreements) are in place.	A standard 'Contract for the provision of Public Health Services' has been drafted, which includes the minimum key elements expected of Service providers to achieve the desired clinical governance. Examination of the contract documentation for a sample of commissioned Public Health services confirmed that the standard 'Contract for the provision of Public Health Services' had been used in all instances, except for the service providers engaged in the GP Enhanced service user support for drugs (shared care) programme, where no contract (or service level agreement) was in place for that funded element (although contracts for other funded elements were in place). Where service providers are not bound by appropriate contracts (or service level agreements), there is a risk that these service providers are not aware of and do not feel obliged to adopt the Council's Clinical governance requirements.

Management Response	Agreed/Disagreed	Responsible Officer	Deadline
A number of parallel exercises to review PH contracts are currently being undertaken. A review with special emphasis on contracts for GP shared care is underway.	Agreed	Consultant in Public Health	July 2017

Area 5 – Monitoring and reporting

Priority	Recommendation 3	Detailed Finding/Rational
2	An overall review of clinical governance and clinical governance issues should be periodically conducted by the Council.	A key element of clinical governance is risk management, which is about minimising risks to patients by identifying what can and does go wrong during care, understanding the factors that influence this, learning lessons from any adverse events, ensuring action is taken to prevent recurrence and putting systems in place to reduce risks. Although each Public Health Service programme is individually monitored, including the clinical governance aspects of these, there is no overall review of clinical governance and clinical governance issues by the Council. It is acknowledged that there is a Partnership Board in place to provide strategic oversight of all S75 agreements for Public Health services between the Croydon NHS Trust and the Council; however, while this includes clinical audit and clinical governance, this is limited to those issues escalated to the Board. Where an overall review of clinical governance and clinical governance issues is not conducted by the Council, there is a risk that there is a lack of consistency and that opportunities for improvements may be missed.

Management Response	Agreed/Disagreed	Responsible Officer	Deadline
When discussing a local policy, the clinical governance group will also develop systems for the review of clinical governance issues and structures across Council commissioned services and how clinical governance fits into an overarching governance framework for LBC.	Agreed	Consultant in Public Health	July 2017

TERMS OF REFERENCE

Clinical Governance - Risk of a Bad Outcome from an Intervention

1. INTRODUCTION

1.1 The Department of Health (DoH) defines 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'. The DoH suggests the main elements of clinical governance are:

- Patient Safety;
- Clinical Effectiveness; and
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1.2 The Public Health grant allocated to local authorities is intended to improve outcomes for the health and wellbeing of their local populations. A condition of the grant is that organisations must have appropriate clinical governance arrangements in place to cover services commissioned with grant funds. The Council must therefore ensure that services are commissioned from providers who have robust and effective clinical governance systems in place and who adhere to clinical and service standards set by relevant professional bodies.

1.3 Guidance from the DoH suggests that contracts for commissioned services should contain clauses which allow the authority to monitor providers against these areas. In addition, guidance from The Faculty of Public Health states that clinical governance arrangements should include a risk management programme inclusive of emergency plans which link to the authority's internal risk management process and, a critical incident reporting procedure.

1.4 As part of the agreed 2016/17 Internal Audit Plan, an internal audit in respect of Clinical Governance: Risk of a Bad Outcome from an Intervention was identified to be undertaken.

2. OBJECTIVES AND METHOD

2.1 The overall audit objective is to provide an objective independent opinion on the adequacy and effectiveness of controls / processes.

2.2 The audit will for each controls / process being considered:

- Walkthrough the processes to consider the key controls;
- Conduct sample testing of the identified key controls, and
- Report on these accordingly.

3. SCOPE

3.1 This audit examined the Council's Clinical Governance, and will included the following areas:

Control Areas/Risks	Recommendations		
	Priority 1 (High)	Priority 2 (Medium)	Priority 3 (Low)
Management, Organisational and Regulatory requirements	0	1	0
Commissioned Services	0	1	0
Risk Management and Safeguarding Protocols	0	0	0
Incident Management; and	0	0	0
Monitoring and Reporting.	0	1	0
Total	**0**	**3**	**0**

Appendix 2

DEFINITIONS FOR AUDIT OPINIONS AND RECOMENDATIONS

In order to assist management in using our reports:

We categorise our audit assurance opinion according to our overall assessment of the risk management system, effectiveness of the controls in place and the level of compliance with these controls and the action being taken to remedy significant findings or weaknesses.

	Full Assurance	There is a sound system of control designed to achieve the system objectives and the controls are consistently applied.
	Substantial Assurance	While there is basically a sound system of control to achieve the system objectives, there are weaknesses in the design or level of non-compliance which may put this achievement at risk.
	Limited Assurance	There are significant weaknesses in key areas of system controls and/or non-compliance that puts achieving the system objectives at risk.
	No Assurance	Controls are non-existent or weak and/or there are high levels of non-compliance, leaving the system open to the high risk of error or abuse which could result in financial loss and/or reputational damage.

Priorities assigned to recommendations are based on the following criteria:

Priority 1 (High)	Fundamental control weaknesses that require the immediate attention of management to mitigate significant exposure to risk.
Priority 2 (Medium)	Control weakness that represent an exposure to risk and require timely action.
Priority 3 (Low)	Although control weaknesses are considered to be relatively minor and low risk, action to address still provides an opportunity for improvement. May also apply to areas considered to be of best practice.

Appendix 3

STATEMENT OF RESPONSIBILITY

We take responsibility to the London Borough of Croydon for this report which is prepared on the basis of the limitations set out below.

The responsibility for designing and maintaining a sound system of internal control and the prevention and detection of fraud and other irregularities rests with management, with internal audit providing a service to management to enable them to achieve this objective. Specifically, we assess the adequacy and effectiveness of the system of internal control arrangements implemented by management and perform sample testing on those controls in the period under review with a view to providing an opinion on the extent to which risks in this area are managed.

We plan our work in order to ensure that we have a reasonable expectation of detecting significant control weaknesses. However, our procedures alone should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify any circumstances of fraud or irregularity. Even sound systems of internal control can only provide reasonable and not absolute assurance and may not be proof against collusive fraud. The matters raised in this report are only those which came to our attention during the course of our work and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Recommendations for improvements should be assessed by you for their full impact before they are implemented. The performance of our work is not and should not be taken as a substitute for management's responsibilities for the application of sound management practices.