



Department
of Health

Sexual Health: Clinical Governance

Key principles to assist service commissioners and providers to operate clinical governance systems in sexual health services

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Prepared by

Department of Health and Public Health England

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Introduction

1. Since 1st 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 and interventions. 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.

Clinical Governance

2. “Clinical governance” is a catch-all term which is used to encompass all the systems and processes which are needed to ensure that providers of clinical and related services are able to deliver safe, high quality and cost-effective care. The Department of Health 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”.¹ It is a condition attached to the allocation of the public health grant that the local authorities must have appropriate clinical governance arrangements to cover services commissioned with grant funds². Annex A describes the main elements of clinical governance
3. The National Quality Board (NQB) was set up in 2009 following the NHS Next Stage Review. It brings together the national organisations across the health system responsible for quality including the Care Quality Commission, Monitor, the NHS Trust Development Authority, NICE, the General Medical Council, the Nursing and Midwifery Council, NHS England, Public Health England and the Department of Health.
4. In January 2013 the NQB published “Quality in the new health system – maintaining and improving quality from April 2013”. This document described the roles and responsibilities of a number of individuals and organisations for improving quality and addressing clinical governance issues from April 2013 onwards. It includes details of the local authority role in assuring quality and safety³.

Clinical governance and local authorities

5. As noted above, commissioning bodies like local authorities need to be sure that they are commissioning services from providers who have robust and effective clinical governance systems in place, (and that they commission services from providers who adhere to clinical and service standards set by relevant professional organisations)..
6. Local authorities can make sure that the contracts they have with providers of clinical services contain provisions which will enable them to check that providers have systems

¹ G. Scally & L.J. Donaldson, *Clinical governance and the drive for quality improvement in the new NHS in England*, 1998

² Ring-fenced Public Health Grant, LAC(DH)(2013)(1), 10th January 2013, paragraph 22

³ National Quality Board, *Quality in the new health system – maintaining and improving quality from April 2013*, January 2013

in place and that these systems are operating correctly. The Department of Health, working with local government and public health professionals, has developed a non-mandatory public health services contract for local authorities to use if they wish to. This contains clauses which will allow local authorities to commission and monitor providers against all the elements of clinical governance set out in Annex A.

7. The Department has also provided a standard service specification for integrated sexual health services, which can be used with the non-mandatory contract or other contracting mechanisms. This sets out a number of quality indicators and performance measures which can help local authorities to assure themselves that proper clinical governance procedures are in place⁴. The service specification itself includes further information on and links to other documents of relevance when considering clinical governance issues, including standards produced by British Association for Sexual Health and HIV and the Faculty of Sexual and Reproductive Health.
8. Given the importance of robust clinical governance arrangements, local authority commissioners may wish to include questions relating to capacity and structures to support clinical governance at the pre-qualification stage of a tendering process (and referring to the integrated service specification, mentioned at paragraph 7 above, may be helpful in framing questions about capacity and structures). This would allow commissioners to ensure that all those providers invited to tender will be able to deliver appropriate clinical governance and that the costs within the tenders reflect structures and capacity to support this. A local authority's Director of Public Health is Chief Adviser on Health to the local authority. They will play a key role in advising on the public health aspects of commissioning and contracting, bringing in specialised medical and pharmaceutical input into contracting and assurance processes, as well as giving or securing broader advice on clinical governance issues, for example, on the safe and effective use of medicines, including through the use of Patient Group Directions.
9. A number of local authorities, Clinical Commissioning Groups and NHS England (including Commissioning Support Units, which are part of NHS England) have entered into section 75 agreements⁵ allowing for the joint or collaborative commissioning of a number of services, including sexual health services. Such agreements can allow local authorities access to clinical expertise which resides in CCGs.
10. The NQB's document notes that Quality Surveillance Groups will be set up in all areas, which will bring together key players in the local health and public health economy to discuss issues of quality and how any identified quality failing could be addressed. Links made through representation on these Groups could help local authorities to address other areas of clinical governance.

⁴ The Public Health Contract and the integrated sexual health service specification can be found by linking this link <https://www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published>

⁵ Section 75 of the National Health Services Act 2006, which allows NHS bodies and local authorities to enter into arrangements for the joint and other provision of services. See Annex B.

11. Alternatively, more informal arrangements could be set up between the local authority and the CCG, with a potential role for the local Health and Wellbeing Board in facilitating these arrangements.
12. It has long been acknowledged that clinical input is an essential aspect of effective commissioning of clinical services.^{6,7} However, it is recognised that it is often not appropriate to involve local clinicians in tendering processes (on the purchaser side) as there may be perceived conflicts of interest. To enable commissioners to involve appropriate clinical expertise and avoid any potential conflicts of interest, the British Association for Sexual Health and HIV and the Faculty of Sexual and Reproductive Health intend to compile a list of their members who would be willing to offer local authorities expert clinical input into sexual health contracting processes. However, local authorities should note that they will most probably need to pay a charge for using these services, as the clinicians concerned will need to arrange cover for any time they spend on external contracting. Any local authority wishing to make use of this facility should contact:-

British Association for Sexual Health and HIV, Secretariat: admin@bashh.org
Faculty of Sexual and Reproductive Health, Administration Office: mail@fsrh.org
13. Some areas are undertaking provider events that include both incumbent (existing) providers and potential new providers. These events allow an open, transparent opportunity to develop models of care and generate solutions and new approaches to delivery.

Clinical governance and providers

14. Driving continuous improvement and tackling quality failure is a collective responsibility. The NQB's report⁸ sets out the responsibilities of each part of the system and states that 'the leadership within provider organisations is ultimately responsible for the quality of care being provided by that organisation.'
15. All providers should have a nominated lead for clinical governance and leads for level 1 and 2 services⁹ should establish robust links with local specialist genitourinary medicine and reproductive healthcare services. Sexual health networks can provide clinical leadership and support a framework for clinical governance across a range of organisations.

⁶ http://www.local.gov.uk/web/guest/past-event-presentations/-/journal_content/56/10171/3557929/ARTICLE-TEMPLATE

⁷ Effective Commissioning of Sexual Health and HIV Services: A Sexual Health and HIV Commissioning Toolkit for Primary Care Trusts and Local Authorities (2003)
http://www.swagnet.nhs.uk/Resources/Nat%20documents/commissioning_toolkit.pdf

⁸ National Quality Board, Quality in the new health system – maintaining and improving quality from April 2013, January 2013

⁹ Service levels 1, 2 and 3 are set out in the Department of Health's previous sexual health strategy : Department of Health (2001). *The National Strategy for Sexual Health and HIV*
(http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003133)

16. Providers of sexual and reproductive health are required to register with the Care Quality Commission (CQC) as providers of 'regulated activities'.¹⁰ CQC is the statutory regulator for health and adult social care in England and it is an offence not to register if a 'regulated activity' is being provided. A service provider can be an individual, a partnership or an organisation. Further information can be found on the CQC website¹¹ and a useful statement on CQC registration for providers of chlamydia screening and treatment can be found on the National Chlamydia Screening Programme website.¹² Community pharmacies are not required to register with the CQC, but are instead regulated by the General Pharmaceutical Council.
17. Providers and commissioners need to carefully consider how these requirements apply where services are provided in non-traditional, non-clinic settings such as services accessed through the internet or by text message, and other e-services or 'virtual clinics'. For example, diagnostic and screening procedures are regulated activities, however, some procedures are excluded, such as 'The sending of samples of body fluids to a place to be analysed, where the samples are not collected or taken by the provider. For example, when a person produces a urine sample and the provider sends it away to be tested.'¹³ Given this, it is possible that if a provider is simply providing the logistics associated with STI testing they may not be required to register with the CQC. However if they provide any element of regulated activities they must register. It is the providers' responsibility to review the CQC 'Scope of registration'¹⁴ document and ascertain whether or not the activities they undertake are within the scope of 'regulated activities'.
18. Both providers and commissioners will want to assure themselves that staff within provider bodies are appropriately qualified to provide clinical leadership for the services being offered whether they are sexual health or reproductive health services (for example, consultant level in level 3 services). Clinical leadership should be regarded as distinct from service leadership, although in some services, both roles may be provided by the same individual. Level 3 services can provide an important clinical leadership role across a local area for a network of services.

Clinical governance and sexual health

19. Professional bodies and local areas have highlighted a number of clinical governance issues which are of specific relevance to sexual health, and these are discussed below.

Patient Group Directions

20. A Patient Group Direction (PGD) is 'a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before

¹⁰ <http://www.cqc.org.uk/organisations-we-regulate/registering-first-time/regulated-activities>

¹¹ <http://www.cqc.org.uk/organisations-we-regulate>

¹² <http://www.chlamydia-screening.nhs.uk/ps/resources.asp>

¹³ http://www.cqc.org.uk/sites/default/files/media/documents/ra_8_diagnostic_and_screening_procedures.pdf

¹⁴

http://www.cqc.org.uk/sites/default/files/media/documents/20130717_100001_v5_0_scope_of_registration_guidance.pdf

presentation for treatment'¹⁵. A PGD allows a named, regulated health professional to supply and/or administer a named medicine to anyone who fulfils a pre-determined set of criteria described in the PGD, without the need for a specific prescription for a specific patient.

21. PGDs were used by NHS staff to supply or administer medicines in many of the public health services which are now the responsibility of local authorities. For sexual health services, they were principally used for some types of contraception, and for chlamydia treatment. They played and will continue to play a vital role in ensuring that these important services can be accessed quickly and easily by patients, and they can also help local authorities to ensure that services are offered cost-effectively by staff with the right mix of training, skills and experience. However, patient safety must not in any way be compromised by the use of PGDs.
22. The circumstances in which PGDs can be used, and the healthcare professionals who are allowed to administer medicines under a PGD, are set out in legislation¹⁶. The Medicines and Healthcare products Regulatory Agency (MHRA) also offers a guide to the legislation on their website¹⁷.
23. The legislation requires that PGDs must be signed by a doctor or dentist and a pharmacist, who have been involved in the development of the PGD and are responsible for ensuring that the clinical and pharmaceutical content is safe and accurate, and supported by the best available evidence. PGDs must also be authorised on behalf of the appropriate authorising body identified in the legislation., and this is typically the responsibility of the clinical governance or patient safety lead. Legislation also enables independent sector providers registered with the Care Quality Commission (including voluntary sector providers) to sign their own PGDs for specified regulated activities. If they are commissioned to provide sexual health services under an arrangement with an NHS body or a local authority the PGD must be authorised by the relevant commissioning organisation They must also comply with all the legal requirements of a PGD and – as is the case with all providers – they remain responsible for ensuring that health professionals are competent and authorised to work to the PGD and that appropriate governance systems and processes are in place.
24. In 2013, regulations were enabled to ensure that any PGD which had been developed by a PCT could continue to be used until it expired or was replaced, even though PCTs did not exist after 31st March 2013¹⁸. This will have allowed most existing PGDs to continue to be used when local authorities took over responsibility for commissioning the services they were used in, but they will need to be reviewed and updated as they expire,

¹⁵ Health Service Circular HSC 2000/026

¹⁶ The Human Medicines Regulations 2012 (regulations 229 – 234 and schedule 16)

¹⁷ <http://www.mhra.gov.uk/Howweregulate/Medicines/Availabilityprescribingandsupplyingofmedicines/ExemptionsfromMedicinesActrestrictions/PatientGroupDirectionsintheNHS/index.htm>

¹⁸ Paragraph 28 of Schedule 3 to the National Treatment Agency (Abolition) and Health and Social Care Act (Consequential, transitional and Savings Provisions) Order 2013

depending on how local authorities wish to structure the services they commission. These regulations also allow local authorities to authorise PGDs from 1st April 2013.

25. The National Institute for Health and Care Excellence (NICE) has recently issued new guidance providing good practice recommendations for individuals and organisations developing and using PGDs¹⁹, and it is recommended that commissioners and others familiarise themselves with this comprehensive guidance.
26. In addition, at section 3.8 The NICE guidance recommends that governance arrangements should include the process for reporting patient safety incidents relating to PGD use, such as medication errors, near misses and suspected adverse events. These arrangements should be included in existing local processes, but not replace national patient safety reporting systems, including the [yellow card scheme](#).
27. Further information and advice on PGDs, including a Frequently Asked Questions section is available at <http://www.medicinesresources.nhs.uk/en/Communities/NHS/PGDs/>. This website also includes information on PGD authorisation in the new organisational structures at <http://www.medicinesresources.nhs.uk/en/Communities/NHS/PGDs/News/PGD-authorisation-in-new-organisational-structures--DH-update-/>

Confidentiality

28. The general rule is that information which identifies patients should not be shared between authorities without the patient's consent, except in certain defined circumstances, for example if a criminal offence is involved. There is specific legislation which provides a greater level of protection for patients with regard to STI testing and treatment. Work is underway in the Department of Health and Health and Social Care Information Centre to publish a new statutory Code of Practice (CoP) on confidentiality. Providers of health and social care services will be legally obliged to follow the CoP. Separate guidance on confidentiality and disclosure of information on sexual health which will form part of the CoP will be developed. The current regulations and directions will then lapse.
29. Dame Fiona Caldicott's recently published review²⁰ of information governance sets out the law on and importance of good information governance. The Government has accepted all the recommendations of the review. The review includes information on the roles and responsibilities of health and social care organisations, including commissioning bodies, for information governance. Chapter seven covers using data for commissioning and contracting purposes, and notes that commissioning bodies should "[respect] ... patients' rights to consent, privacy and confidentiality, and access to information, as enshrined in data protection and freedom of information law and guidance." Local authorities should therefore ensure that the information they require providers to supply to them is in line with the law.

¹⁹ <http://www.nice.org.uk/mpc/goodpracticeguidance/GPG2.jsp>.

²⁰ Dame Fiona Caldicott, *Information : to share or not to share*, March 2013

30. Providers are also required to provide information on sexually transmitted infections and HIV to Public Health England. This information is used to monitor infections, manage outbreaks and helps public health professional to protect the health of individuals, their family and friends, and the population as a whole. More information about how this information is used and managed can be found at http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947352367.

Incident management

31. The non-mandatory public health services contract allows for commissioners to agree processes and procedures for reporting incidents, including serious untoward incidents (SUI). A set of definitions relating to incident and incident management is set out below. This definition was drawn up prior to Health and Social Care Act and as such refers to NHS- funded services. However, the definition is equally applicable to clinical services commissioned by bodies with new responsibilities, including local authorities.

Definitions ²¹

An Incident is an event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public.

An Incident Investigation is a process to determine the underlying reason for an incident and to identify actions to minimise the likelihood of the event recurring. A root cause analysis investigation should be undertaken.

A Serious Incident Requiring Investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- o Unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

- o Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes Incidents graded under the NPSA definition of severe harm).

- o A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure.

²¹ National Framework for Reporting & Learning from Serious Incidents Requiring Investigation; March 2010; National Patient Safety Agency

o Allegations of abuse.

o Adverse media coverage or public concern about the organisation or the wider NHS.

32. The Directors of Public Health need to assure themselves that there are appropriate incident management systems in place for the services they commission, from all providers, including escalation, notification and management of such incidents. Therefore, they must work closely with the provider organisation to ensure that this is the case.

33. Commissioners will want to ensure providers share reports on incidents and near misses, as well as reports on complaints and complements and other patient feedback. This should form part of the contract monitoring process. However, there is a role for reporting which goes beyond contract monitoring. Providers should share information about all incidents that occur in their services, regardless of whether these relate to the commissioners' specific population or not, as this allows broader lessons to be learned. Contracts should therefore ensure that they contain reporting mechanisms to allow the prompt reporting of all incidents.

34. Serious untoward incidents should be reported through the appropriate channels in a timely fashion (usually 2 working days). Some notifications must be sent to the CQC²² and the National Reporting and Learning System²³ (NRLS) enables patient incident reports to be submitted to a national database.

35. In all instances, the first priority for the provider organisation is to ensure the needs of individuals affected by the incident are attended to, including any urgent clinical care which may reduce the harmful impact.

36. All serious incidents should be investigated and many organisations will want to undertake investigations of other incidents to support learning. NRLS reports that organisations with a culture of high reporting are more likely to have developed a strong reporting and learning culture and experience from other industries indicates that as an organisation's reporting culture matures, staff become more likely to report incidents.

37. The scale of the investigation and the level of escalation should be proportionate to the seriousness of the incident and should include a root cause analysis (see <http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/>)

Clinical audits

²² <http://www.cqc.org.uk/organisations-we-regulate/registered-services/notifications>

²³ <http://www.nrls.npsa.nhs.uk/>

38. Clinical audit is a way to find out if health or social care is being provided in line with standards. Clinical audit lets care providers and patients know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve patient outcomes.²⁴
39. As stated in the NQB report²⁵, providers should be using data from a range of quality metrics including clinical audits with a view to improving the quality of the care they provide. Commissioners may wish to stipulate the minimum number of clinical audits undertaken each year by providers, and agree at the beginning of each year on the focus of the audits for that year. Many providers will have a calendar of planned audits which will cover a wide range of aspects of the service from medicines stock control to ensuring staff are maintaining their professional competencies.
40. The Department of Health standard service specification for integrated sexual health services also makes reference to the use of clinical audits to measure quality outcome indicators.²⁶

Education and training

41. Commissioners and providers will want to assure themselves that staff working in sexual and reproductive health service have the appropriate qualifications, expertise and experience. Details of the appropriate qualifications are detailed by the Faculty of Sexual and Reproductive Health²⁷ and the British Association of Sexual Health and HIV/Medfash²⁸.
42. It is also essential that staff maintain the appropriate competencies, for example with regard to FSRH Letters of Competence for intrauterine techniques and sub-dermal implants.
43. Commissioners will also wish to consider the training capacity required locally to support the training and development of both existing and new staff and services, and include these requirements within service specifications for key providers as appropriate.

Patient involvement / Patient needs

44. Patient and public involvement (PPI) comprises involving, consulting and listening to patients and the public, to make services responsive to patients' needs, improve clinical outcomes and patient experience, add value to services and support good governance.

²⁴ <http://www.hqip.org.uk/>

²⁵ National Quality Board, Quality in the new health system – maintaining and improving quality from April 2013, January 2013

²⁶ <https://www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published>

²⁷ http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf

²⁸ <http://www.medfash.org.uk/uploads/files/p17abk5ffh1d8f15amvq41dju1hnu5.pdf>

PPI presents particular challenges for sexual and reproductive health services due to stigma and confidentiality issues. The London Sexual Health Programme which existed prior to April 2013 developed a website to provide a practical and useful ‘toolkit’ that can help to implement PPI in sexual health services.²⁹

45. Sexual health commissioners and providers will want to engage with their local Healthwatch organisation³⁰ and take account of You’re Welcome standards³¹ when considering patient and public involvement.
46. The Faculty of Sexual and Reproductive Health³² and BASHH/Medfash³³ suggest a number of measures that can support user and public involvement:
- Annual patient surveys
 - Suggestions and comments boxes in clinics
 - Regular user satisfaction surveys
 - Mystery shopping
 - Patients’ compliments, comments and complaints procedure clearly displayed in clinic/practice (and commissioners may wish to include complaints and compliments as a standard item at each contract review)
 - Services responding appropriately to user feedback
 - Public consultation, including consultation with non-users, on service redesign /redevelopment

Primary care services

47. The Framework for Sexual Health Improvement in England³⁴ recognises that access to sexual health services has been improved through the expansion and integration of service delivery outside of specialist services, particularly in the community and general practice. The Framework also recognises that general practice is the largest provider of sexual health services – particularly the provision of contraception – and is the most frequently chosen first point of contact for those with sexual health concerns. (Although community pharmacies may be the first point of contact for people seeking emergency hormonal contraception).

48. The NQB report³⁵ reminds us that responsibility for quality applies equally to primary care and suggests that GPs should be regularly reviewing performance against quality indicators such as clinical audits, regularly reviewing complaints and demonstrating

²⁹ See www.londonsexualhealth.org/ppe-toolbox

³⁰ http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3700506/ARTICLE-TEMPLATE

³¹ <https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services>

³² Service Standards for Sexual and Reproductive Health (January 2013) Faculty of Sexual and Reproductive Healthcare

³³ Standards for management of sexually transmitted infections (2010) BASHH / Medfash

³⁴ Department of Health (2013) A Framework for Sexual Health Improvement in England

³⁵ National Quality Board, Quality in the new health system – maintaining and improving quality from April 2013, January 2013

variance within the practice team by regular data analysis. These are core roles for primary care providers, including both general practice and community pharmacies.

49. However, when commissioning smaller, independent providers such as GPs and pharmacies, commissioners need to assure themselves that there are appropriate structures, systems and capacity in place to support these providers to deliver high quality care. Commissioners may want to consider a variety of approaches to achieving this which might include combinations of the following arrangements:
- The commissioner, possibly in conjunction with colleagues from the local CCG or CSU, to undertake an annual audit of independent providers. This audit could include confirmation of whether staff are maintaining competencies, eg. undertaking sufficient number of LARC procedures; reports of incidents and actions taken to address them; number of early removals of LARC and reasons; uptake of HIV testing by patients presenting for STI testing and timely notification of results either positive or negative. This would allow for benchmarking between providers and enable the commissioner to discuss outlying providers to both share learning and improve practice across the piece.
 - The local level 2/3 specialist provider(s) could be commissioned to provide clinical leadership, including clinical governance and training, to independent providers. As independent providers are generalists, it may be appropriate for support and advice on specialist areas to be provided by clinicians with relevant expertise.
 - Commissioners may choose to use a lead provider model and commission one, or small number of, specialist providers who then sub-contract with other local providers, including primary care, to provide the services required across a local area. The lead provider could then be responsible for ensuring appropriate clinical leadership, including clinical governance, is in place for the subcontracted providers.

ANNEX A : CLINICAL GOVERNANCE

Main elements of clinical governance

Patient Safety

- Incident Management
- Risk Management
- Alerting System
- Waste Management
- Medicines Optimisation
- Safe Environment
- Safeguarding

Clinical Effectiveness

- Cost effectiveness
- Clinical Guidelines
- NICE guidance
- Evidence-based practice
- Care pathways
- Clinical Audits
- Policy Development
- Claims Management
- Information Governance
- Staff Management
- Education and Training
- Equality and Diversity

Patient/Public Experience

- Complaints Management
- Consent
- Nutrition and Hydration
- Patient/Public Information
- Patient/Public Involvement
- Patient/Public Needs

Care Quality Commission

Most of the sexual health services commissioned by local authorities will be undertaking activities which require them to register with the Care Quality Commission (CQC), who will monitor and inspect the service to ensure that they are complying with registration legislation and essential standards. Reports from the CQC and other healthcare regulators can provide a good guide to the strength of clinical governance systems within a provider. The latest reports and intelligence on registered providers can be found on the CQC's website:-

<http://www.cqc.org.uk/>

Guidance and other information about clinical governance

The professional bodies representing clinical staff working in sexual health have produced clinical governance guidance for their members.

Faculty of Sexual and Reproductive Healthcare

The professional body which covers staff working in contraception and reproductive healthcare is the Faculty of Sexual and Reproductive Healthcare, which is part of the Royal College of Obstetricians and Gynaecologists. Their guidance on clinical governance can be found at:-

<http://www.rcog.org.uk/what-we-do/clinical-governance>

British Association for Sexual Health and HIV

The British Association for Sexual Health and HIV (BASHH) represents clinicians working in genito-urinary medicine services. Information about Clinical Governance with suggested quality measures is available in the BASHH/MEDFASH National Standards for management of sexually transmitted infections.

<http://www.bashh.org/documents/MF%20BASSH%20standards%2018Jan%20for%20the%20websitesite.pdf>

Royal College of Nursing

Nurses play a key role in the provision of sexual health services. The Royal College of Nursing provide a web resource for their members containing information on clinical governance, which can be accessed by clicking the following link:-

http://www.rcn.org.uk/development/practice/clinical_governance

National Health Service Litigation Authority

The National Health Service Litigation Authority provides insurance for NHS organisations. The materials they produce are therefore focused on the NHS, but they do have some useful material on managing risk which can be accessed using the following link:-

<http://www.nhsla.com/Pages/Publications.aspx?library=safety%7cstandards>

Royal Pharmaceutical Society

Pharmacists have been providing sexual health services over many years, initially the provision of EHC and some are now providing chlamydia screening and treatment services, contraception services. The Royal Pharmaceutical Society is the professional body for pharmacists.

ANNEX B : COLLABORATION BETWEEN LOCAL AUTHORITIES AND THE NHS – RELEVANT LEGISLATION

Section 7A of the NHS Act 2006, as inserted by section 22 of the Health and Social Care Act 2012

“Exercise of Secretary of State’s public health functions

7A Exercise of Secretary of State’s public health functions

- (1) The Secretary of State may arrange for a body mentioned in subsection (2) to exercise any of the public health functions of the Secretary of State.
- (2) Those bodies are—
 - (a) the Board;
 - (b) a clinical commissioning group;
 - (c) a local authority (within the meaning of section 2B).
- (3) The power conferred by subsection (1) includes power to arrange for such a body to exercise any functions of the Secretary of State that are exercisable in connection with those functions (including the powers conferred by section 12).
- (4) Where the Secretary of State arranges (under subsection (1)) for the Board to exercise a function, the Board may arrange for a clinical commissioning group to exercise that function.
- (5) Any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by a body mentioned in subsection (2) of any function exercisable by it by virtue of this section are enforceable by or against that body (and no other person).
- (6) Powers under this section may be exercised on such terms as may be agreed, including terms as to payment.”

Section 75 of the NHS Act 2006

75 Arrangements between NHS bodies and local authorities

- (1) The Secretary of State may by regulations make provision for or in connection with enabling prescribed NHS bodies (on the one hand) and prescribed local authorities (on the other) to enter into prescribed arrangements in relation to the exercise of—
 - (a) prescribed functions of the NHS bodies, and
 - (b) prescribed health-related functions of the local authorities,if the arrangements are likely to lead to an improvement in the way in which those functions are exercised.
- (2) The arrangements which may be prescribed include arrangements—
 - (a) for or in connection with the establishment and maintenance of a fund—

- (i) which is made up of contributions by one or more NHS bodies and one or more local authorities, and
 - (ii) out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body or bodies and prescribed health-related functions of the authority or authorities,
 - (b) for or in connection with the exercise by an NHS body on behalf of a local authority of prescribed health-related functions of the authority in conjunction with the exercise by the NHS body of prescribed functions of the NHS body,
 - (c) for or in connection with the exercise by a local authority on behalf of an NHS body of prescribed functions of the NHS body in conjunction with the exercise by the local authority of prescribed health-related functions of the local authority,
 - (d) as to the provision of staff, goods or services in connection with any arrangements mentioned in paragraph (a), (b) or (c),
 - (e) as to the making of payments by a local authority to an NHS body in connection with any arrangements mentioned in paragraph (b),
 - (f) as to the making of payments by an NHS body to a local authority in connection with any arrangements mentioned in paragraph (c).
- (3) Regulations under this section may make provision—
- (a) as to the cases in which NHS bodies and local authorities may enter into prescribed arrangements,
 - (b) as to the conditions which must be satisfied in relation to prescribed arrangements (including conditions in relation to consultation),
 - (c) for or in connection with requiring the consent of the Secretary of State to the operation of prescribed arrangements (including provision in relation to applications for consent, the approval or refusal of such applications and the variation or withdrawal of approval),
 - (d) in relation to the duration of prescribed arrangements,
 - (e) for or in connection with the variation or termination of prescribed arrangements,
 - (f) as to the responsibility for, and the operation and management of, prescribed arrangements,
 - (g) as to the sharing of information between NHS bodies and local authorities.
- (4) The provision which may be made by virtue of subsection (3)(f) includes provision in relation to—
- (a) the formation and operation of joint committees of NHS bodies and local authorities,
 - (b) the exercise of functions which are the subject of prescribed arrangements (including provision in relation to the exercise of such functions by joint committees or employees of NHS bodies and local authorities),
 - (c) the drawing up and implementation of plans in respect of prescribed arrangements,
 - (d) the monitoring of prescribed arrangements,
 - (e) the provision of reports on, and information about, prescribed arrangements,

- (f) complaints and disputes about prescribed arrangements,
 - (g) accounts and audit in respect of prescribed arrangements.
- (5) Arrangements made by virtue of this section do not affect—
- (a) the liability of NHS bodies for the exercise of any of their functions,
 - (b) the liability of local authorities for the exercise of any of their functions, or
 - (c) any power or duty to recover charges in respect of services provided in the exercise of any local authority functions.
- (6) The Secretary of State may issue guidance to NHS bodies and local authorities in relation to consultation or applications for consent in respect of prescribed arrangements.
- (7) The reference in subsection (1) to an improvement in the way in which functions are exercised includes an improvement in the provision to any individuals of any services to which those functions relate.
- (8) In this section—
- “health-related functions”, in relation to a local authority, means functions of the authority which, in the opinion of the Secretary of State—
- (a) have an effect on the health of any individuals,
 - (b) have an effect on, or are affected by, any functions of NHS bodies, or
 - (c) are connected with any functions of NHS bodies,
- “NHS body” does not include a Special Health Authority.
- (9) Schedule 18 makes provision with respect to the transfer of staff in connection with arrangements made by virtue of this section.