Public Health England

Protecting and improving the nation's health

Quality governance guidance for local authority commissioners of alcohol and drug services

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Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Published July 2015
PHE publications gateway number: 2015214

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Purpose

This document is for local authority commissioners and, via commissioners, their strategic partners. It describes what quality governance is in relation to alcohol and drug treatment, why it is important, and provides an overview of the responsibilities of provider organisations, commissioners and national and regional bodies. It also sets out the assurance mechanisms which support quality governance and the delivery of safe and effective services, in line with the public health grant conditions (LAC(DH)(2013)3).[1]

Background

Local authorities are required to have effective quality governance arrangements in place for services that are commissioned using the public health grant. Safeguarding responsibilities, in relation to children and vulnerable adults, need to be recognised within these arrangements. Good quality governance processes and systems will enable local authorities to meet the care needs of their alcohol and drug using populations and by so doing also to achieve a wide range of positive impacts on their local communities.

Roles and responsibilities of key contributors to quality governance

Local authorities are responsible for ensuring that appropriate quality governance is in place for services they commission with the public health grant.
Local authority commissioners are responsible for meeting the drug and alcohol treatment and care needs of their populations through their commissioning of high quality services. However, it is the local authority elected members who are responsible for agreeing the final award of relevant contracts.
Elected members of local authorities are the decision and policy makers for future activities of the council, and have an overview and scrutiny role in relation to the day to day business of the local authority, including [care] quality governance. As statutory members of the local health and wellbeing boards, elected members, advised by their directors of public health (DsPH) have a key role to play in providing the strategic lead on quality governance.
Alcohol and drug **service providers** are ultimately accountable for the quality of care delivered in their services. They are responsible for ensuring that care is safe, that it is delivered in line with the evidence base by competent and supported staff, and that service users are fully involved in decisions about individual care and service delivery.

Service users should be fully involved in decisions about their care and treatment. Involvement in service design and delivery, and the development of local strategy by service users will increase service effectiveness and deliver more positive outcomes.
DsPH are defined by statute as the officer champion for health within the local authority[2], and the principal adviser on all health matters to elected members and officers. DsPH will wish to ensure that providers have appropriate quality governance arrangements in place that are equivalent to NHS standards.[3]

The national and regional strategic framework and new regulatory landscape

There is likely to be significant overlap in the treatment populations served by clinical commissioning group (**CCG)** and local authority commissioners, and **NHS England**, which has responsibility for the commissioning of prison-based alcohol and drug services. Local quality governance arrangements will be strengthened by effective engagement with the regional and national strategic framework for commissioning and regulation of alcohol and drug services.
Public Health England (PHE) supports local authorities to commission and deliver alcohol and drug services by providing evidence-based guidance and advice, and by collating and analysing alcohol and drug treatment performance data for local authorities.
Processes are in place to ensure that local commissioners are made aware of any significant deterioration in system performance and can provide support to help address. PHE will reflect any concerns it has about quality and safety issues in local treatment systems back to local authorities, and through other relevant channels, such as the **Care Quality Commission (CQC)** or **quality surveillance groups (QSGs)** as appropriate.

The CQC is the independent health and adult social care regulator, with a remit to monitor, inspect and regulate alcohol and drug services. **QSGs** exist to support collaboration and sharing of intelligence by all partner agencies across local health and care economies. They seek to provide the local health and care economy with a shared view of risks to quality as well as opportunities to coordinate actions to drive improvement. Local authorities will derive benefit from engaging with local QSGs

Assurance mechanisms which support quality governance

A local quality governance structure which has regular contract-monitoring meetings between providers and commissioners, where service user feedback is routinely gathered and acted on, where clinical leadership roles and accountability are clearly described, and which enables serious untoward incidents (SIs) to be routinely reported, investigated and learnt from, will support this assurance process to assist DsPH and ultimately the elected members in their functions.

There is a well-established **evidence base and authoritative clinical best practice guidance** on what constitutes effective care and treatment.
Service user feedback is a key element of effective quality governance. This will require effective **service user involvement** activity at both service and partnership level.

About this guidance

This guidance is for local authority commissioners of alcohol and drug services, and their partners. It provides a clear description of the framework for, and the assurance mechanisms that support, effective quality governance for drug and alcohol treatment services, in line with the public health grant conditions (LAC(DH)(2013)3) and PHE's clinical governance policy.[4] Following a background section, the document is divided into two parts:

1. The organisational landscape that defines and supports the system

2. The assurance mechanisms that are in place to ensure quality standards and continual improvement

Included within these sections are suggested implementation considerations which local authorities may wish to refer to when establishing local quality governance structures or reviewing existing structures. For a more detailed general description of the key elements for implementation of quality governance within drug treatment services, see 'Clinical governance in drug treatment: a good practice guide for providers and commissioners'.[5]

This guidance offers suggestions as to implementation activities which local authorities and providers may wish to undertake to review existing quality governance structures or establish new ones. Readers are referred to a range of supporting documents that support the effective implementation of quality governance

Background

Section 12 of the Health and Social Care Act 2012 introduced a new duty for all upper-tier and unitary local authorities in England to take appropriate steps to improve the health of the people who live in their areas. **From 1 April 2013, local authorities became responsible for improving the health of their local populations through the provision of a range of public health services and interventions, including alcohol and drug treatment services.**

The achievement of effective prevention, treatment and sustained recovery outcomes in those attending alcohol and drug treatment services requires joined-up working, often with a wide range of partners and sometimes over a prolonged period of time. A wide variety of strategic and commissioning partnerships, and organisational provider partnerships, now contribute to frontline delivery of alcohol and drug services. Good quality governance and quality assurance arrangements that ensure clarity of vision, leadership and strategy, and that are based on clear roles, responsibilities and agreed ways of working and reporting, have a crucial role to play in the new system.

Accountability for the safety and effectiveness of services requires the establishment of comprehensive quality governance structures. Quality governance (sometimes called clinical governance) is a term used to describe a structure and related processes to assure delivery of high quality, safe and effective services. It requires clear lines of accountability and communication between service providers, local commissioners and strategic partnerships and the local and national supporting framework. Quality governance components include lines of responsibility and accountability, quality improvement activities, policies that manage risk and procedures to identify and remedy poor performance. Some organisations and individuals are directly and statutorily accountable for elements of quality governance but all have a general responsibility to engage in activities that improve service user safety and service effectiveness.

What is quality governance?

This guidance uses the term ‘quality governance’, as feedback suggests this term is most widely used and understood by stakeholders in health and social care. The National Quality Board’s report ‘Quality in the new health system: Maintaining and improving quality from April 2013’ describes three dimensions to quality, which must all be present if a high quality service is to be provided. They are:

- clinical effectiveness
- safety
- service user experience

Why is quality governance important?

The public health grant conditions[6] make it clear that local authorities are responsible for ensuring that appropriate quality governance is in place for services they commission with the grant. The National Quality Board’s report (2013) states that:

“Responsibility for the quality of care being provided should be recognised by the governance within the local authority.”

Safeguarding children, young people and vulnerable adults is a statutory responsibility held by local authorities, which needs to be addressed adequately within the quality governance arrangements for alcohol and drug treatment provision. From April 2015, the Care Act (2015) puts adult safeguarding on a legal footing, and requires local authorities to work in partnership with the police and the NHS to take action if they suspect an adult with care and support needs is experiencing abuse or neglect. The proper storage, prescription and administration of controlled drugs are also priorities requiring specific attention within quality governance arrangements.

Commissioners have a fundamental responsibility for driving quality and ensuring the safety of patients and service users. Commissioners and providers also have a responsibility to foster a culture where staff and service users are supported to voice concerns about safety without fear. This is underlined in the reports which followed the systematic neglect and abuse of patients and vulnerable adults at Mid Staffordshire and Winterbourne View Hospitals,[78] and also in the NHS constitution. [9] The establishment of robust systems for ongoing monitoring of providers, and a willingness to use their intervention powers where there are signs of service failure are essential elements of effective quality governance.

The Francis report on Mid Staffordshire NHS Foundation Trust states:

“The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with”

And a key action from the Winterbourne View report states:

“We expect directors, management and leaders of organisations providing NHS or local authority-funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care”.

These reports echo the NHS constitution which states that individuals have a right “to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.”

It is important for individual service users, their carers, and communities that local authorities commission services and interventions which are cost-effective, high quality and safe. By providing a clear description of the relevant elements of the current systems of quality assurance and quality governance within which services are

commissioned, this document aims to align with and support the work of local authorities in developing their own quality governance arrangements that support local commissioning.

How can local authorities implement effective quality governance for alcohol and drug services?

To ensure that local services are high quality, commissioners will want to be assured, via their commissioning processes and relationships with providers, that care being delivered is effective and safe. An important way to test this is to consider the service user experience. This will require effective service user involvement activity at both service and partnership level. Commissioners are encouraged to invest in service user involvement as a core component of effective quality governance. It is also important to ensure that care and treatment delivered within services is in line with the evidence base and clinical best practice guidance, and is delivered by competent staff. Table 1 outlines the key components of a quality service:

Table 1

Effective	Safe	Service user experience
interventions delivered in line with evidence base (NICE) staff , peer mentors and volunteers competent to deliver and effectively supported service works in partnership with other key services to deliver recovery outcomes positive outcomes for service users	provider fosters a culture where service users and staff can voice concerns about safety without fear staff, volunteers and peer mentors are trained and supported to assess and manage risk, and escalate safeguarding issues when necessary service has a competent and engaged clinical lead and good lines of communication to other key services	service users have ownership of their own care plan and recovery journey service users are confident treatment meets their needs (and can challenge the 'offer' if not) service user feedback is used to develop the service to better meet needs

High quality service delivery should be underpinned by flexible and responsive local governance arrangements. Local authority commissioners will need to work closely with their counterparts in local CCGs and NHS England local area teams (LATs) to best serve the changing/emerging needs of local populations which are likely to include:

- safeguarding for children, young people and vulnerable adults
- complex/multiple needs, including domestic violence, co-existing substance misuse with mental health issues, criminal justice involvement and homelessness
- pathways for harmful/hazardous drinkers
- interventions for dependent and binge drinkers
- flexible responses to novel psychoactive substances (NPS)
- links to end of life pathways/palliative care

Effective quality governance structures for substance misuse services are likely to span a range of settings and require effective partnership working with:

- primary healthcare
- secondary/acute healthcare
- mental health services for common and more severe mental illness
- sexual health clinics
- social services
- prison healthcare

Additionally, there have been significant changes to the commissioning and delivery landscape for health, and providers and commissioners will want to be sure that their own quality governance structures are appropriately located within the local, regional and national quality governance frameworks that have emerged post April 2013. The next section describes the organisational landscape and shows how local authorties fit in to the national and regional strategic framework.

The organisational landscape

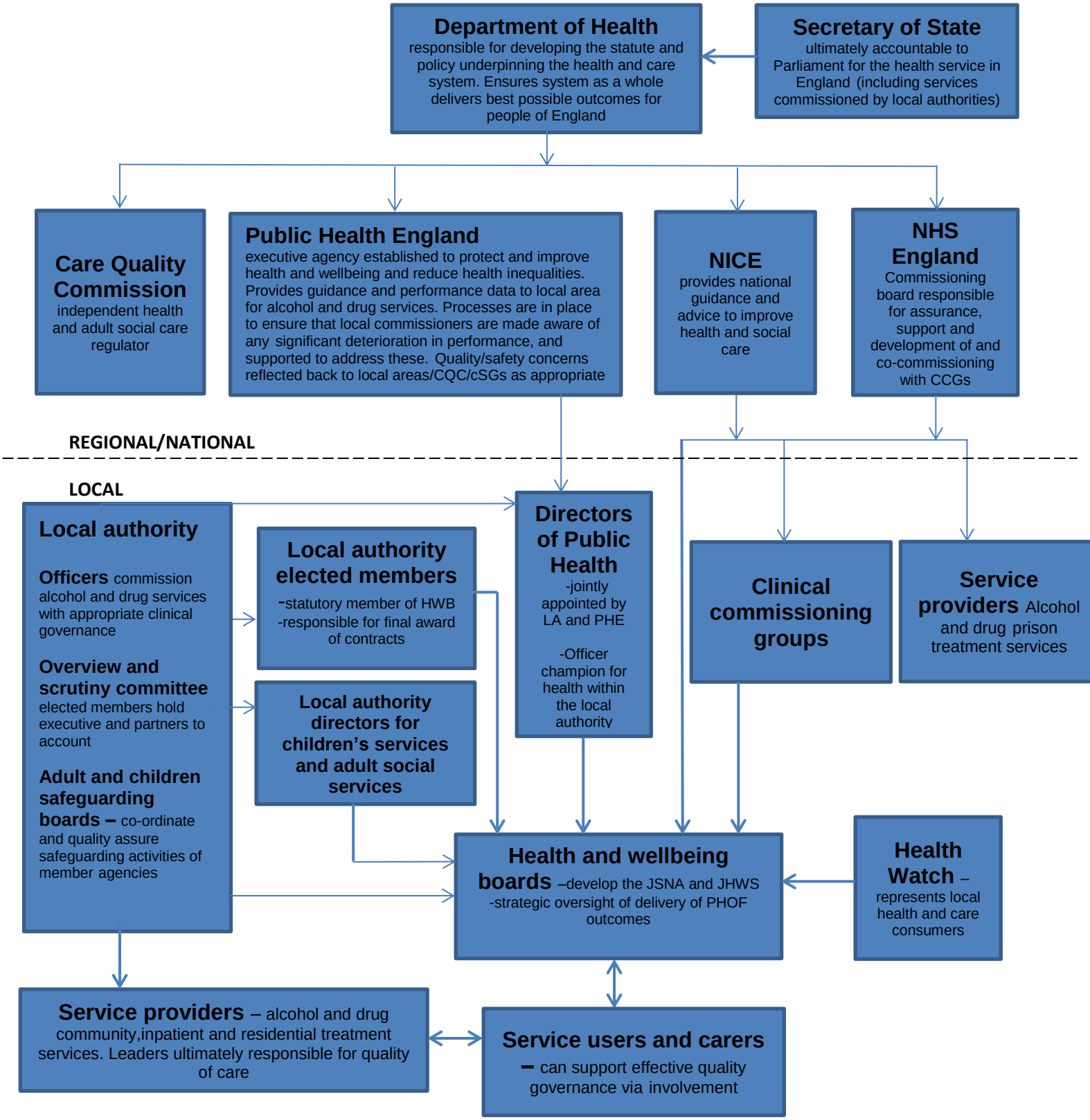
Quality governance operates in each organisational landscape with lines of responsibility and accountability. Organisations and individuals develop and maintain quality monitoring and improvement activities, policies that manage risk and procedures to identify and remedy poor performance. Some organisations and individuals are directly and statutorily accountable for elements of quality governance – but all have a general responsibility to assure and improve safety and effectiveness.

The key elements are ordered as follows:

1. National and regional strategic framework – see fig 1 below
2. Local commissioning framework – the key partners
3. Regulators and monitors of clinical safety and quality of commissioning

Included in section 2 are suggested implementation considerations for partners to undertake to support establishment of local quality governance structures which are effectively linked to and supported by the regional and national strategic quality governance framework.

Fig 1. The national and regional strategic framework



Local commissioning – the key partners

Although local commissioning of drug and alcohol services shares a number of common elements, there is significant scope for local flexibility in terms of strategy, commissioning and governance arrangements, and the degree to which commissioning and governance have been established between key partners including service users, service providers, CCGs and police and crime commissioners. Local areas will have been working to identify the governance arrangements that fit with their needs and resources.

Local authority commissioners

Local authority commissioners are responsible for meeting the needs of their populations through commissioning high quality services. They will wish to ensure that investment decisions are informed by "best evidence", and take into account relevant NICE guidance and quality standards, and in the case of drug treatment – the UK 'Orange Book' guidelines ('Drug misuse and dependence – UK guidelines on clinical management' (DH, 2007)). They can use their interactions with providers, including the agreement and monitoring of contracts, to drive continuous improvement and identify any actual or potential quality issues or failings. They will also wish to ensure that adequate systems are in place within the local authority for the reporting and oversight of provider-based risks. In particular commissioners, in conjunction with health partners, should take a leading role in reviewing serious incidents (SIs), including (but not limited to) alcohol and drug deaths. This is likely to involve convening and leading a panel to review local alcohol and drug related deaths.[10]

There is a distinction to be made between the corporate responsibility that local authorities as commissioning organisations have in relation to quality governance, and the strategic oversight responsibility of the health and wellbeing board (HWB). While the HWB may want to be assured about the safety and quality of services commissioned for the local population by all service commissioners (NHS as well as local authority), the strategic and high level oversight role of the HWB means it may not be the most appropriate body to provide oversight of SIs, near misses and other risks to quality for local authority commissioned services. Lines of accountability can be established via any appropriate local authority committee, the key is to ensure that the structures are clear and well understood by key partners – service users and providers, and local commissioners.

Concerns about whether providers are meeting the CQC 'essential standards of quality and safety'[11] should be raised through systems within the local authority, and with the CQC directly. Relevant information should be shared with the quality surveillance

groups (QSGs – see below) at local and regional levels. In particular, local authorities will need to ensure that non-NHS providers have equalivalent structures and procedures in place, as quality governance is likely to be better established in NHS providers.

Anyone who wishes to challenge the local authority's adherence to competition legislation has recourse to the courts. Where commissioning practice is not unlawful but poor, other levers such as Healthwatch, QSGs, CQC or PHE can be approached as appropriate.

Key quality governance considerations for local authority commissioners

- are there appropriate lines of accountability within the local authority's governance structure, linked to local safeguarding boards for children and adults?
- are reporting lines and accountabilities for reporting, reviewing and responding to SIs, near misses and other significant concerns about quality well understood and utilised by providers?
- do contracts make specific reference to quality governance responsibilities of providers? Does this include reference to staff competence, training capacity, service user involvement, clinical leadership and capacity to undertake regular clinical audit? Is contract monitoring regular and effective?
- are service users supported to be fully involved in their own care and treatment, and to contribute to strategy development, commissioning and service design? Is service user involvement reflected in contracts with providers as a key quality objective?
- have effective links to other local and regional governance structures been established, including (but not limited to):
    - CCG
    - NHS England's LATs
    - Local and regional QSGs?

Local authority elected members

Elected members have an important role in relation to quality governance of commissioned services. There are a number of ways in which elected members can influence effective quality governance:

- as statutory members of the local health and wellbeing boards, they will be able to engage with and influence local quality governance structures via local joint strategic needs assessment (JSNA) and joint health and wellbeing strategy (JHWS) processes

- as members of scrutiny and oversight committees for health they can hold the local authority executive and their partners to account in relation to commissioning and delivery of alcohol and drug services

- they are responsible for agreeing the final award of contracts (for many contracts this will be done by local authority officers acting under a scheme of delegation)

Key quality governance considerations for local elected members:

- are elected members informed about local quality governance arrangements and their role and responsibility in relation to these?
- do elected members routinely question/comment on quality governance arrangements as part of their oversight and scrutiny role?
- do quality governance considerations inform final award of contracts by elected members?

Service providers

Front-line workers are clearly important in, and individually accountable for their contribution to, the delivery of safe and effective services. However, the leaders of organisations who provide care are ultimately responsible for the quality of care being delivered by their organisation.

It is the responsibility of service providers to ensure that the staff they employ (including volunteers and peer mentors) are appropriately competent and registered. The professional regulatory bodies (such as the Health and Care Professions Council, the General Medical Council, the General Pharmaceutical Council and the Nursing and Midwifery Council) are responsible for setting the standards of behaviour, competence and education of regulated healthcare professionals. They also have responsibility for registering professionals who meet those standards, and taking action where the standards are not met. For other clinical and care staff, drug and alcohol national occupational standards (DANOS)[12] are widely used to set out the competences and qualifications required.

The safety and effectiveness of day-to-day practice should also be monitored and assured through line management and professional supervision, and through other well-established and well-described mechanisms of quality governance such as audit, quality assurance and risk management and reporting processes.

Service users, service providers and commissioners can support an effective user and carer contribution to quality governance by supporting and investing in local user and carer involvement and representation structures. Early response to user and carer

feedback is important, particularly when staff or service users are putting others at risk. as well as providing evidence of service improvements as a result of service user/carer involvement.

Key quality governance considerations for service providers

- are interventions delivered in line with clinical guidelines/NICE/evidence base?
- do all services have a named clinical lead? (this role should be regarded as distinct from service leadership, although both roles may be provided by the same individual)
- are all staff, volunteers and peer mentors appropriately supported by an effective supervision, appraisal and development framework, and are they working within the limits of their competency?
- is there a quality governance policy? Is it clear and accessible? Are accountabilities and reporting lines clearly understood by all staff, including volunteers and peer mentors?
- do services undertake regular clinical audits with a view to improving quality of care?

Service users

Service user feedback is a key element of effective quality governance. Services developed to meet the needs of users are safer, more effective and deliver positive treatment outcomes. Good service user involvement can support effective quality governance in a number of ways:

Involvement in care and treatment

It is essential that service users understand the treatment that they are able to access, have confidence that the treatment offered will meet their specific needs, and are able to ask questions, challenge the offer, and speak out with confidence when treatment and care falls short of the required standards.

Involvement in service design

Services will be more effective if they are developed and delivered with the direct involvement of the people who use them. Commissioners are encouraged to invest heavily in the service user voice, and reflect and support service user involvement in contracting, contract reviews and other monitoring activity with providers.

Involvement in strategic development and commissioning

This can take the form of service users contributing to the development, review and performance management of existing strategies and services, involvement in retendering of services, sitting on strategic boards such as DAAT and joint commissioning boards, or being on interview panels.

Key quality governance considerations for service users

- are service users fully involved in decisions about their own care and treatment? Do service users feel able to question/challenge what is on offer? If not, do they know where to get support?
- are service users involved in local commissioning strategy clear about their role and responsibilities, and how far they can have influence?
- are service users supported to engage fully with relevant commissioning and quality governance activities? This could include access to training/mentoring, and receiving payment for participation and/or reimbursement of expenses.

Directors of public health

DsPH are appointed jointly by the local authority and PHE (acting for the Secretary of State for Health). They are defined by statute as the officer champion for health within the local authority,[13] and the principal adviser on all health matters to elected members and officers. The DPH is required to take responsibility for the management of their authority's public health services, with professional responsibility and accountability for their effectiveness. When commissioning drug and alcohol services the DPH will wish to ensure that providers have appropriate quality governance arrangements in place that are equivalent to NHS standards.[14]

DsPH play a key role in advising on the commissioning and contracting of public health services. This is likely to involve bringing in specialised medical, nursing and pharmaceutical input into contracting and assurance processes, as well as giving or securing broader advice on quality governance issues. In practice, this means that DsPH will want to be assured that the safety and effectiveness of the services they have commissioned are being continually reviewed and appropriately improved. A local quality governance structure which has regular contract-monitoring meetings between providers and commissioners, where service user feedback is routinely gathered and acted on, where clinical leadership roles and accountability are clearly described, and which enables SIs to be routinely reported, investigated and learnt from, will support this assurance process.

Key quality governance considerations for DsPH:

- does the DPH receive appropriate reports on quality governance of commissioned services via the local authority governance structure? Does this include oversight of SIs/near misses?
- does the DPH receive appropriate outcome reports (can be by exception) to reassure that services are clinically effective?
- are there appropriate links to the local safeguarding children and adults boards?
- is the user voice appropriately represented in the local commissioning process? Does user feedback underpin strategy, commissioning and service design?

Health and wellbeing boards

As a statutory function under the Health and Social Care Act 2012,[15] top tier and unitary local authorities have set up health and wellbeing boards (HWB's), which are responsible for developing the JHWS in response to local needs identified via the JSNA). HWBs monitor progress on delivering the outcomes in the public health outcomes framework (PHOF) and check that the NHS and local authority commissioning plans are in line with the JSNA and JHWS, referring them back for reconsideration if not. As the achievement of outcomes will be contingent on the provision of high quality, safe and effective services, the HWB may wish to receive regular reports on the quality, safety and effectiveness of commissioned services, including oversight of any SIs or near misses (see below). This may be achieved by establishing reporting lines to the appropriate local authority committiee, or by using an already established subcommittee to monitor the safety and effectiveness of commissioned clinical services.

Key quality governance considerations for HWBs:

- does the HWB receive appropriate reports about the quality and safety of services? Does this include oversight of SIs/near misses?
- has the HWB established appropriate reporting lines to the local authority committee with quality governance responsibility?
- does the HWB receive appropriate outcome reports (can be by exception) to reassure that services are clinically effective?
- is the service user voice appropriately represented at HWB level? Is there a structure to ensure a range of user views are represented (including representatives of particularly vulnerable groups[1])?

[1] Vulnerable groups can be locally defined but are likely to include those in especially vulnerable circumstances or from specific population groups such as: pregnant women (and their unborn children); young people; lesbian, gay,

Other key partners

Clinical commissioning groups (CCGs)

CCGs are responsible for the large majority of primary and secondary health care commissioning, and there is likely to be significant overlap in the treatment populations served by both CCG and local authority commissioners. CCGs have established quality assurance structures, including quality/patient safety teams. CCGs and NHS England's commissioning support units are likely to undertake SI/safeguarding/quality monitoring of organisations that provide substance misuse services – particularly those provided by NHS trusts. At a practical level, CCGs are connected to the strategic executive information system (STEIS) for the reporting and closing of serious incidents. Local authorities should have alternative reporting procedures in place. It may make most sense to align these as much as possible to the CCG arrangements – ensuring that the links to the governance structure within the local authority are clear.

NHS England local area teams (LATs)

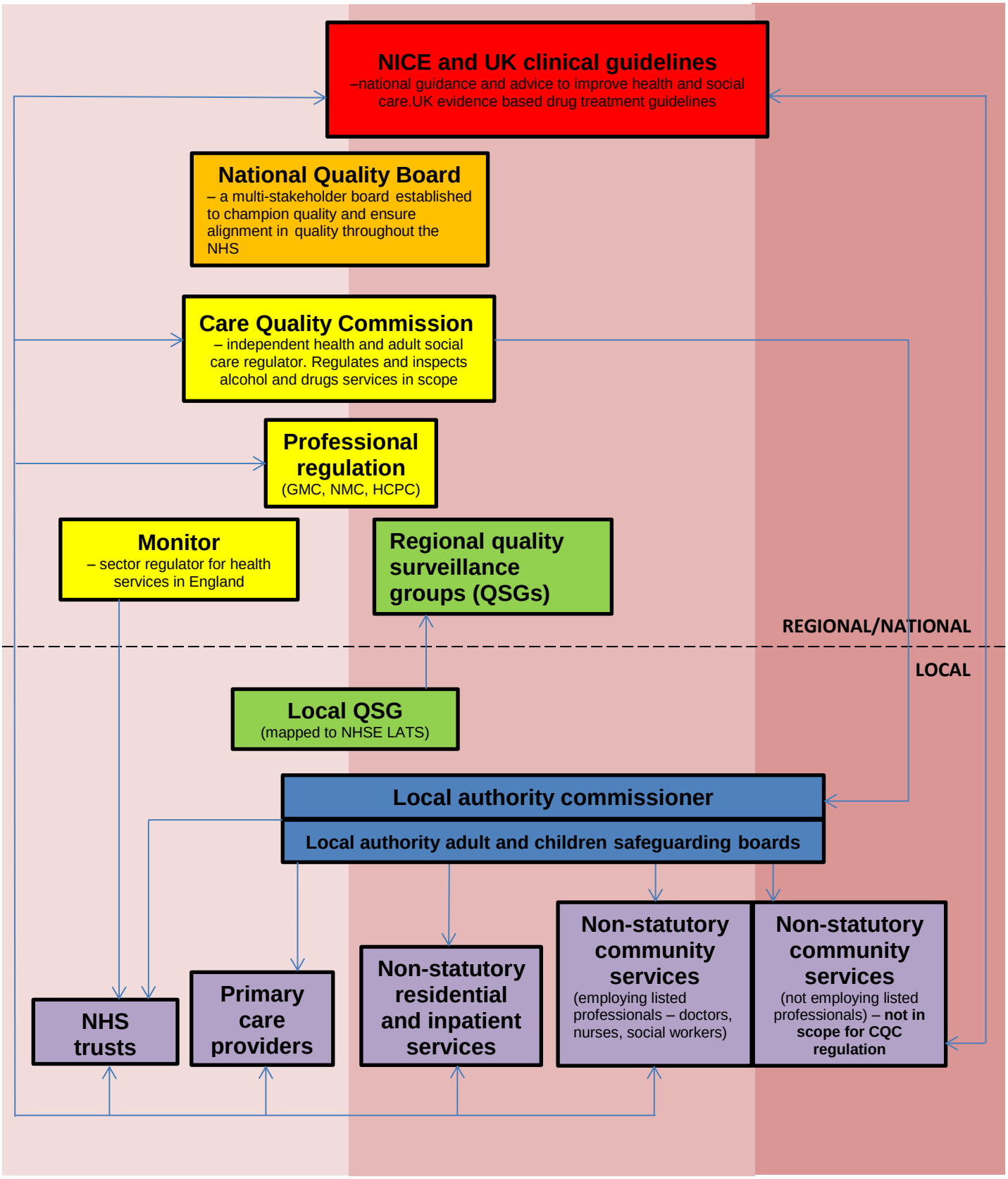
NHS England has overall responsibility for the commissioning of offender health services, including prison-based alcohol and drug services. While NHSE is a statutory member of the local authority HWB, it is likely that local authority commissioners will have established working links with the LATs at operational as well as strategic level. Iit will be important for the local authority and the LAT to share information about SIs and near misses,particularly given the higher risk of drug related death following prison release.

bisexual, and transgender people; people with complex needs, for example with concurrent mental health and drug/alcohol problems; homeless people; older people; victims of domestic abuse; offenders returning to the community; sex workers.

Regulators and monitors of clinical safety and of the quality of commissioning

Local authority commissioning of alcohol and drug services is located in a new regulatory landscape. For the majority of locally commissioned alcohol and drug services, the Care Quality Commission will continue to inspect and regulate services. Not all commissioned services will fall within scope for CQC regulation, and commissioners will want to be assured that local quality governance structures take this into account. All commissioned services should be delivering interventions in line with NICE and national clinical guidelines. From April 2013, a local and regional network of quality surveillance groups have been established, enabling partners to collaborate, share intelligence and identify and respond to emerging risks to quality across local health economies. The diagram at fig 2 depicts the new regulatory landscape, and the role of the organisations is described below.

Fig 2. The new regulatory landscape for local authority commissioned alcohol and drug services



Care Quality Commission

The Care Quality Commission (CQC) is the independent health and adult social care regulator for England, ensuring health and social care services provide people with safe, effective, compassionate and high-quality care. CQC monitor, inspect and regulate services to ensure that they meet fundamental standards of quality and safety. They also publish regular performance reports to help individuals select the care of their choice. The core activities of the CQC are:

- registration of health and social care providers to ensure they are meeting essential common quality standards
- monitoring and inspection of all health and adult social care
- use of enforcement powers, such as fines or public warnings or closure, if standards are not being met
- improving health and social care services by undertaking regular reviews of how well those who arrange and provide services locally are performing
- undertaking special reviews on particular care services, pathways of care or themes where there are particular concerns about quality
- reporting outcomes of CQC activity to provide service users with information about the quality of local health and adult social care services. Service providers are informed to see where improvements are needed, and can learn from each other as to the best ways to deliver care

It is likely that the majority of locally commissioned services fall within scope of CQC regulation (either by providing care in a residential setting or because care is delivered by listed professionals such as doctors, nurses or social workers). As such, the CQC have a key role to play within local quality governance structures, and regulated providers are required to report deaths of service users and other SIs to the CQC as well as via local structures.

It is important to note that not all locally commissioned services will fall within scope of CQC regulation (for example, community based services where care is not delivered by listed professionals). Local quality governance arrangements will need to take account of this to ensure that quality and safety are not jeopardised – with service providers and commissioners both having key roles to play. This might mean (where appropriate) making arrangements for independent audit, or ensuring arrangements for regular safety/quality audit are reflected in service specifications for services not regulated by CQC. Commissioners may also find it helpful to refer to CQC's standards,[16] which focus on asking five key questions of services – are they: safe, effective, caring, responsive and well-led?

National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence (NICE) carries out technology appraisals on the use of new and existing medicines and interventions in terms of the clinical evidence of their effectiveness and the economic evidence in terms of their value for money. As directed by the Secretary of State, the NHS is required to fund and resource medicines and treatments recommended by NICE's technology appraisals.[17] NICE guidance sets the standards for high quality healthcare which can be used by the NHS, local authorities, employers, voluntary groups and anyone else involved in delivering care or promoting wellbeing. Clinicians should also deliver care in line with 'Drug misuse and dependence: UK guidelines on clinical management'.[18]

Monitor

Monitor is the sector regulator for NHS provided healthcare in England and jointly licences providers of NHS funded care with the CQC, to ensure that essential services are accessible. Under this remit Monitor can vary terms of licence and take action where providers breach these terms. The organisation's main duty is to work to protect and promote the interests of service users, promoting the provision of effective healthcare services, with a view to improving quality. Monitor works closely with the CQC, particularly in relation to judgements on quality and safety, and is a member of local and regional quality surveillance groups.

National Quality Board

The National Quality Board[19] (NQB) was established in 2009 and brings together the national organisations across the health system responsible for quality. These include the Care Quality Commission, Monitor, the NHS Trust Development Authority, NICE, the General Medical Council, the Nursing and Midwifery Council, NHS England, PE and the Department of Health.

Local commissioners will wish to be aware of the NQB's role in relation to quality and safety when developing local quality governance structures. This role includes:

- providing strategic oversight and leadership for quality across the NHS system and in joining up health and social care
- aligning the national system around a single definition of success: creating shared goals for improving quality
- advising on priority areas for improving quality and the development of tools to support clinical teams to achieve improvements; and
- providing leadership and support to the service in driving forward improvements in quality

Quality Surveillance Groups (QSGs)

QSGs bring together all organisations with information and intelligence on the local health and care economies, providing a proactive forum for collaboration. QSGs operate at two levels: locally, on the footprint of NHS England's 27 area teams; and regionally, on the footprint of NHS England, the CQC, Monitor, PHE and the NHS Trust Development Authority's (TDA's) four regional teams. Their primary aim is to identify and act on risks to quality as early as possible by sharing information and intelligence between commissioners, regulators and those with a system oversight role. In their role as local leaders of public health, with a key role in commissioning public services, local authorities will wish to ensure that they are adequately represented on both their local and regional QSGs.

Healthwatch

Healthwatch England and the 152 local Healthwatch organisations have been set up to ensure that the concerns and comments from consumers and those who use services are taken into account by decision makers. Healthwatch England's strategic priorities include:

- addressing current concerns with health and social care services
- ensuring that future services are built to meet people's needs and are shaped by the people who will use them

each priority being addressed at the local level.
Local Healthwatch organisations have been issued with guidance which highlights the importance of their involvement with QSGs.[20]

Health Service Ombudsman

Where service users (or their carers or advocates) have concerns about the quality of service provision, complaints should be directed, in the first instance, at the service provider concerned and/or at the commissioning organisation. If the complaint remains unresolved, individuals can address their concerns to the Parliamentary and Health Service Ombudsman. The Ombudsman will resolve complaints for individuals and feed information to the sector and professional regulators where there are concerns about patient safety.

Quality governance assurance mechanisms

Systems and processes supporting quality governance should both “assure” and “improve”. They should operate at the level of individual professionals; provider organisations; local authority commissioners and health and wellbeing partnerships, regional and national monitoring and regulatory bodies, and in the systems supporting local and national decision-making. They include systems and processes that support both “doing the right thing” and “doing things right”.

Contracts and contract monitoring

Local authority commissioners need to be assured that they are commissioning services from providers who have robust and effective quality governance systems in place, and who adhere to clinical and service standards set by relevant professional organisations. The following are ways in which local authorities can ensure quality governance is effective through their contracting and contract monitoring with providers:

- include questions relating to capacity and structures to support quality governance at the pre-qualification stage of a tendering process.
- incorporate costs associated with the structures and capacity to deliver effective quality governance in tenders, including:
    - delivery of NICE/national clinical guideline compliant interventions by competent, trained and supported staff
    - effective service user involvement
    - requirement to promptly report, reflect on and share investigation reports on SIs and near misses (particularly important for services not in scope of CQC regulation)
- have regular contract monitoring meetings with providers which include:
    - review of SIs, near misses and risk registers
    - review of service user complaints and compliments
    - review of service outcomes
    - review of compliance with the evidence base, NICE and clinical guidelines
    - review of staffing levels, and staff maintenance of competencies to deliver interventions
    - monitoring compliance with the Human Rights Act and 2010 Equality Act
    - safeguarding procedures

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 agreements allowing for the joint or collaborative commissioning of a

number of services, including alcohol and drug services. Such agreements can allow local authorities access to clinical expertise which resides in CCGs. 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. The commissioner, possibly in conjunction with colleagues from the local CCG or commissioning support unit, may wish to undertake an annual audit of providers.[21]This audit could include confirmation of whether staff members are maintaining required competencies.

Patient group directions (PGDs)

PGDs allow 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. PGDs should be used only where they offer advantage for patient care without compromising safety, and where they are supported by clear quality governance structures.

Examples of PGDs relevant to drug and alcohol treatment include the administration or supply of:

- hepatitis B vaccination
- hepatitis A vaccination
- combined hepatitis A and B vaccination
- naloxone injection

NICE guidance provides practice guidelines for individuals and organisations developing and using PGDs, and it is recommended that LA commissioners familiarise themselves with these. The 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 alerting system (NPSAS) activity described in a following section below.

Further information about PGDs in the treatment of substance misusers can be found in “Non-medical prescribing, patient group directions and minor ailment schemes in the treatment of drug misusers” [22]

In 2013,[23] 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. This would enable the PGDs to continue to be used by local authority commissioners for the purposes they were intended, as long as the PGDs continue to be reviewed and are updated on expiry.

Quality surveillance groups assurance mechanisms

Local authorities will both add and derive value (from an assurance perspective), by being members of QSGs, sharing information and intelligence about local services. QSGs routinely consider whether the information/intelligence they share may be relevant to the roles and functions of safeguarding bodies, health and wellbeing boards and local authority overview and scrutiny committees.

QSGs are ideally placed in the system to take action to understand risk and ensure that aligned and coordinated action is taken to mitigate those risks. They do not have any statutory powers, but can take a range of actions as a result of the responsibilities of the statutory members of the group, and work to resolve issues at a local level where possible.

Controlled drugs accountable officers and local intelligence networks

NHS Trusts, NHS England local area teams and independent hospitals are required by regulation[24] to appoint controlled drugs accountable officers (CDAO's). CDAOs ensure that providers establish and operate appropriate arrangements for securing the safe management and use of controlled drugs such as methadone and buprenorphine; and review these as appropriate.[25] These arrangements are intended to work within and alongside existing assurance arrangements.

NHS England has appointed lead CDAO's to establish local intelligence networks. These networks bring together intelligence from CQC, the NHS and independent health, and other responsible bodies, regulators and agencies. Local authority commissioners may wish to be engaged in this process. The CQC publishes contact details for CDAOs on their website.[26]

National patient safety alerting system

The national patient safety alerting system (NPSAS) within NHS England provides another assurance mechanism for local authority commissioners. It was launched to strengthen the rapid dissemination of urgent patient safety alerts to healthcare providers via the central alerting system (CAS). There is a three-stage alerting system to put appropriate measures in place to prevent harm and encourage and share best practice in patient safety. Commissioners may wish to use the alerting system to identify emerging risks and examples of best practice within the drugs and alcohol treatment system. It may also be useful to align NPSAS with local authority alerting systems such as the multi-agency safeguarding hub (MASH).[27]

Safeguarding

Local authorities have the responsibility for ensuring the organisations they commission have systems in place that safeguard children and young people,[28] and vulnerable adults.[29] These requirements should be explicitly included within service contracts and monitored as part of the routine contract-monitoring processes. Any information regarding abuse or potential abuse should be shared with local authority safeguarding teams (and the police, where necessary). Safeguarding vulnerable people is everyone's responsibility. Organisations should embed safeguarding in their culture, and be places where staff members feel they can raise concerns and act as whistle-blowers without fear.

From April 2015 local authorities have new statutory responsibilities in relation to adult safeguarding. In practice, regardless of whether they are providing any services, councils must follow up any concerns about either actual or suspected adult abuse. All organisations who are involved in adult safeguarding will need to reflect the statutory guidance, good practice guidance and ancillary products that have been developed when devising their training and implementation plans for staff. Policies and procedures should be based on the processes laid out in the statutory guidance.

Safeguarding boards are a key mechanism by which local authorities can ensure effective governance of local safeguarding arrangements. Partner organisations should ensure that they are working together effectively and have an agreed policy on how they will cooperate with one another to safeguard and promote the welfare of children and vulnerable adults. The purpose of this partnership working should be to hold each other to account and to ensure safeguarding vulnerable adults and children remains high on the agenda across the local authority.

Serious incident reporting

Local authorities should ensure that their DsPH have oversight of all SI's in locally commissioned drug and alcohol services, either from NHS providers, or from commercial, voluntary and other public sector providers. If the provider is registered with the CQC they are required to report all SI's directly to the CQC. However, as outlined above, not all non-NHS providers will be required to register with CQC, and requirements to inform the commissioner of an SI, should be included in the contract. PHE has developed good practice guidance on handling adverse/serious incidents in local authority commissioned services which is included at appendix 1.

Staff competence

Staff competence is key to the quality and effectiveness of services. Evidence-based interventions will only be effective when delivered by appropriately competent and

supported staff. For those with professional qualifications, details of the appropriate competencies will be held with the their respective Royal Colleges (eg, Royal College of Psychiatrists, Royal College of General Practitioners, Royal College of Nursing, British Psychological Society). The local medical committee (LMC) and local pharmacy committee (LPC) are another useful source of reference/support for doctors and pharmacists delivering substance misuse services

For other clinical and care staff, DANOS can be found on the Skills for Health website, along with guidance on competencies and qualifications.[30] Commissioners will wish to ensure that service contracts include provision of training and development to both existing and new staff, as well as the provision of regular supervision .

It is important to reiterate that some services (those provided by non-statutory service providers and not employing doctors, nurses or social workers) will not be within the scope of CQC regulation, and staff within these services will not be required to maintain professional registration with the bodies mentioned above. It is especially important that service providers have a clear policy on staff support and development in these cases, and commissioners will want to see appropriate investment in staff development and competence as part of the overall contract.

Service user and carer involvement

Involvement of service users, their families, and their support networks can make services more responsive to their needs, improve outcomes and the service user experience, add value and support good quality governance.[31] When considering service user and public involvement, commissioners should engage with their local Healthwatch organisation, and take account of PHE's service user involvement guidance (in press) and the DH 'You're welcome' standards[32] which set out quality criteria for young people friendly health services.

There are a number of additional measures that can support SU and public involvement including:

- annual patient surveys
- suggestions and comments boxes in services
- regular user satisfaction surveys
- mystery shopping
- patients' compliments, comments and complaints procedure clearly displayed in services
- inclusion of 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.

- peer researchers/peer audits
- service user/carer representation at strategic provider and commissioner forums (eg, contract monitoring meetings, strategic partnership boards, etc)
- joint working with carer groups

Where can I get further information/support?

PHE centre teams can also offer guidance and support to local areas seeking to develop and implement local quality governance systems.

Please contact your PHE centre team in the first instance.

Supporting guidance

Quality governance/system oversight

National Treatment Agency. Clinical governance in drug treatment: a good practice guide for providers and commissioners. London: NTA; 2009.
www.nta.nhs.uk/uploads/clinicalgovernance0709.pdf

CQC essential standards for substance misuse services
www.cqc.org.uk/sites/default/files/20140919_cqc_a_fresh_start_substance_misuse_final_low_res.pdf

Quality surveillance group guidance
www.england.nhs.uk/wp-content/uploads/2014/03/quality-surv-grp-effective.pdf

Clinical guidelines

Department of Health (England) & devolved administrations. Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive; 2007. (update due 2016)
www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

National Institute for Health and Clinical Excellence. Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. London: NICE; 2007.
www.nice.org.uk/guidance/cg115

Staff competency

Public Health England. The role of addiction specialist doctors in recovery orientated treatment systems: a resource for commissioners, providers and clinicians. London: PHE; 2014.
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DANOS competencies
www.skillsforhealth.org.uk/standards

Appendix 1

Public Health England

HANDLING ADVERSE INCIDENTS/SERIOUS INCIDENTS (SIs) IN PUBLIC HEALTH SERVICES COMMISSIONED BY LOCAL AUTHORITIES
BEST PRACTICE GUIDANCE

INTRODUCTION

1. Following the reforms to public health, Local Authorities acquired responsibility for commissioning a range of specified service to improve and protect the public's health, such as drug and alcohol, and sexual health services. This paper provides best practice guidance on how SIs in services commissioned by local authorities should be handled. This guidance applies to these services only and not to other services that Local Authorities have already been commissioning.

2. Local authorities are required to have robust contracting mechanisms with all providers through rigorous legal contracts. This guidance does not seek to replace such mechanisms. Rather, it should be used by Local Authorities to ensure that their arrangements take into account the specific requirements of public health services that they have commissioned.

DEFINITIONS

3. The definitions in current use are given below. However, these are currently being reviewed by NHS England; should NHSE issue revised definitions, this section will require review.

4. An Adverse Incident is an unplanned or unexpected event, act or circumstance that arises from (or affects) a Local Authority commissioned public health service and which could have, or did result in harm, loss or damage to service users, the organisation, members of staff or property. It includes tangible events such as damage to equipment, and intangible such as damage to reputation.

5. A Serious Incident (SI) is:

- an adverse incident that arises from a Local Authority commissioned public health service and which results in serious injury, major or permanent harm or death (or the risk of) to a service user, member of staff, contractor or member of the public, or that has a significant impact on public health

- the action of a member of staff, in the course of the provision of relevant services, that is likely to cause significant public or professional concern

- an event that impacts on the delivery of Local Authority commissioned public health service causing urgent invocation of a business continuity plan, or which may reflect a serious breach of standards

- an identified trend of incidents which, when considered together, may constitute a SI

- any other incident which the Chief Executive considers to be a SI.

6. A Near Miss is an incident that did not result in actual harm, loss or damage to the organisation, individuals or property but which had the potential to cause such an effect. It may be appropriate for near misses to be treated in the same way as SIs.

SERVICES COMMISSIONED FROM THE NHS

7. NHS provider organisations have clear requirements in respect of SIs. They are required by the regulatory bodies to undertake a full investigation and root cause analysis, and to ensure that lessons are learnt. In addition, they are required to notify the relevant regulators – CQC via the National Reporting and Learning System and in the case of Foundation Trusts to Monitor.

8. NHS commissioners also have equally clear requirements made of them. They are required to seek assurance from the provider that the provider has relevant policies and procedures in place and implemented, and to ensure that monitoring arrangements are in place to oversee the implementation of any action points and plans arising from the incident.

9. Policies for SIs occurring in NHS services are developed by NHS England. Recognising that Local Authorities will already have arrangements for dealing with SIs, it is intended that these arrangements should, as far as possible, mirror those arrangements within the LA framework.

10. The SI process for the NHS in England has been developed over several years and is widely regarded as effective.

11. *It is therefore advised* that the same approach should be adopted for LA commissioned services. Provider organisations would undertake an investigation and RCA; as the commissioner, LAs would assure themselves that policies and procedures are in place and that action plans are implemented. *It is therefore recommended* that this requirement is clear in contracts.

12. The DPH has statutory responsibility for these services and must assure themselves that services are safe and of a high quality. In addition to the leadership role of embedding quality through clinical governance in such services, *it is therefore* advised that Local Authorities ensure that their DPH leadership includes the oversight of all SIs in commissioned services.

13. It must be recognised that a service provider may be providing the service for multiple local authority commissioners. *It is therefore advised* that where there are three or more LA commissioners, the DsPH should agree between them which DPH should undertake the lead professional role on behalf of all DsPH. This does not imply that the DPH will be working for Local Authorities other than their own, but rather seeks to recognise the value of having a single, professional lead.

SERVICES COMMISSIONED FROM NON NHS PROVIDERS

14. LA commissioned public health services will not necessarily be commissioned from NHS providers, but may be commissioned from a range of commercial, voluntary and other public sector providers. The proposed approach will depend to an extent on whether the organisation is registered with the CQC for the delivery of that service and should also take into account any DH clinical governance guidance, such as that issued for sexual health services.

15. If the provider is registered with the CQC they are required to report all SIs directly to the CQC. The CQC has the responsibility for ensuring that the incident does not call into question the providers registration for that service.

16. However, there is no requirement for a non NHS provider to inform the commissioner of an SI, unless already included in the contract. *It is therefore advised* that the requirement to report SIs to commissioners be written into the contracts held with non NHS providers in a similar manner to that required of NHS providers. Providers should furnish the LA commissioners with any report sent to the CQC at the same time as its submission to the CQC. As with NHS providers, *it is advised* that where there are three or more LA commissioners, the LAs and DsPH should agree between themselves which LA and DPH (who may be from the same LA of from different LAs) should undertake the assurance role on behalf of all LA commissioners.

17. If the provider is not registered with the CQC, there may be no requirement for the provider to undertake an investigation or RCA. *It is therefore advised* that the requirement to report SIs to commissioners be written into the contracts held with non NHS providers in a similar manner to that required of NHS providers. In addition, *it is advised* that commissioners assure themselves that the provider has the skills and resources to undertake a thorough investigation and RCA. If the commissioner(s) are not so assured, *it is advised* that the support of the Centre Director be sought to assist the provider with the investigation, either through helping identify individuals to provide expertise in support of the investigation of to identify possible training providers. Again, *it is advised* that where there are three or more LA commissioners, the LAs and DsPH should agree between themselves which LA and DPH (who may be from the same LA of from different LAs) should undertake the assurance role on behalf of all LA commissioners.

ROLE OF QUALITY SURVEILLANCE GROUPS

18. Quality surveillance groups have been established to ensure that all parts of the health and health care economy work together to improve service quality. As they become an established part of the quality assurance system, Local Authorites may wish to utilise their expertise and skills in supporting the implementation of action plans.

DISSEMINATION OF LEARNING AND IDENTIFICATION OF TRENDS

19. PHE is committed to reporting, investigating and learning from adverse incidents in order to minimise the chance of recurrence, and to ensure that where changes are required they become embedded in practice. *It is advised* that all SIs occurring in LA commissioned services should be notified to the Medical Director of PHE as Chair of the Quality Improvement and Assurance Board and joint National Executive lead for clinical governance. (S)he has two

responsibilities. First, to identify any trends of links between SIs occurring in different providers and secondly, to disseminate learning across PHE and the public health system

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August 2014

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