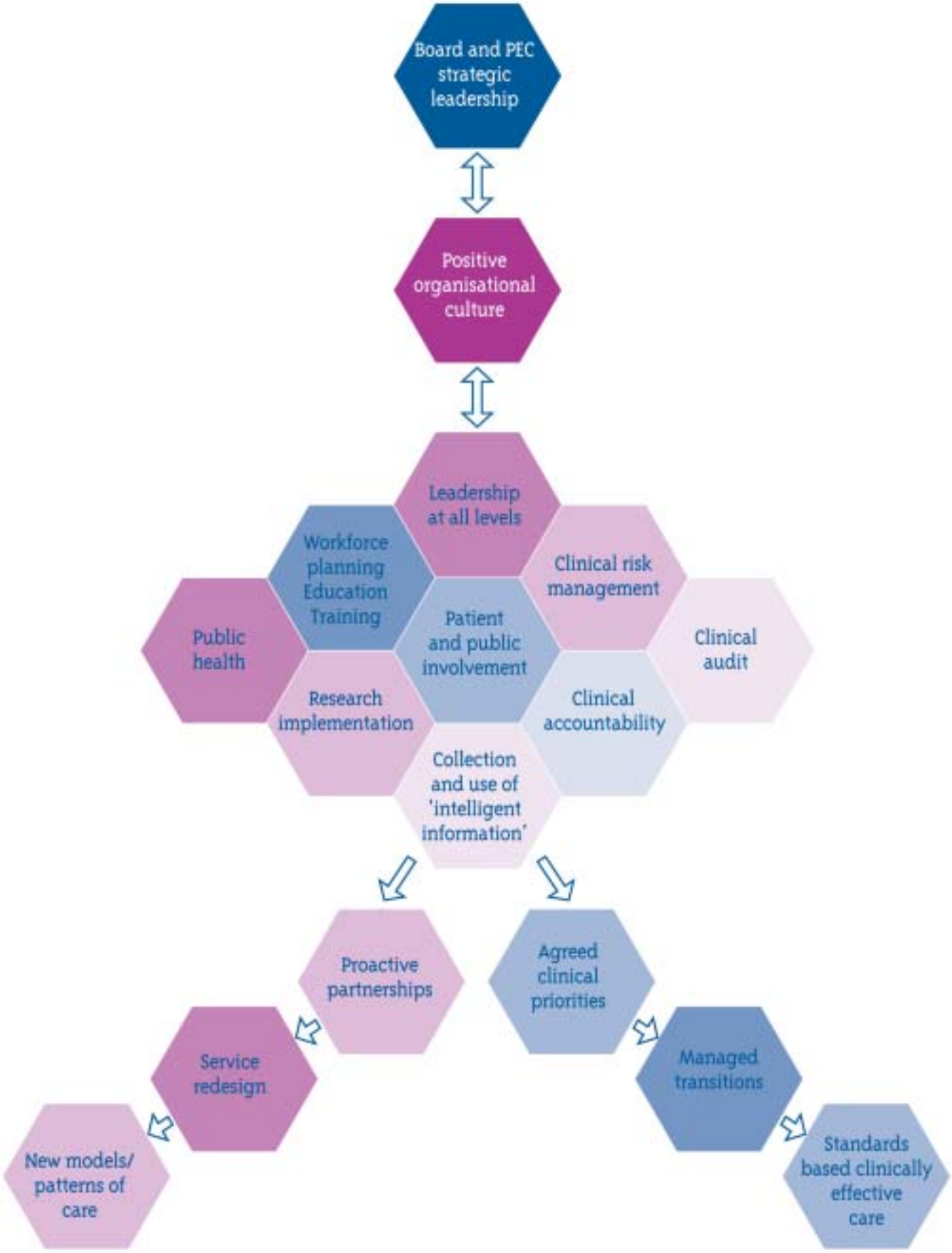
The Strategic Leadership of Clinical Governance in PCTs

A learning resource for the members of PCT Boards and PECs

NHS
Modernisation Agency
Clinical Governance Support Team

NHS
Modernisation Agency
National Primary and Care Trust Development Programme

CLINICAL GOVERNANCE



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SECTION ONE
INTRODUCTION

'Clinical governance is a process, not an event.'

Sir Liam Donaldson

Clinical governance is the primary means through which NHS bodies discharge their statutory duty of quality.

Quality is a fundamental and primary goal in health and social care provision. Quality protects individual patients and local communities. It protects the individual clinician, the inter-professional team and the reputation and good standing of the professions. It also protects the organisation and, in doing so, protects both the good name and the financial well-being of the entire NHS community. Quality services can reduce the levels of human suffering, professional stress and the deep drain on valuable resources arising from clinical negligence or systemic error.

The responsibilities of the PCT

Primary Care Trusts are at the forefront of achieving the Government's aims, set out in *The NHS Plan*, for a modern, flexible and patient-centred NHS. Members of the PCT Board and Professional Executive Committee have a wide range of responsibilities and targets to achieve and clinical governance is of central importance in the development of robust and reliable systems to ensure that the PCT fulfils its targets.

Chief Executives are accountable, on behalf of the Trust, for assuring the quality of NHS Trust services. Trust Boards are charged with establishing systems, structures and policies to ensure that the vision of a modernised NHS can be delivered safely, appropriately and in response to the needs of local people.

The principles of clinical governance apply to all those who provide or manage patient care services in the NHS. PCTs will need to demonstrate robust and transparent clinical governance mechanisms to their Strategic Health Authority (SHA), their local community (through their relationship with their Patient Forum and through the scrutiny provided by their Local Authority), to the Commission for Health Improvement (CHI) and to its successor body, the Commission for Health Audit and Inspection (CHAI).

Hitherto, the self-employed status of general practitioners, community dentists, pharmacists and optometrists has caused some uncertainty in terms of the boundary of

the PCT. Do these staff groups fall within or outside that boundary? Are they, by virtue of their existing and new contractual relationships with a PCT, integrated, semi-detached or separate?

While the new General Medical Services (GMS) will help to make this position clearer for those GPs who adopt it, whatever the legal, contractual and terminological niceties may imply, for the purposes of this consideration of clinical governance, all of these professional groups are deemed now to be part of one indivisible PCT 'community of practice'.

In other words, a fundamental distinction is drawn between the services that these professionals provide – which are here considered to be core PCT services – and those services that PCTs commission on behalf of their patient populations from other health care (or social care or other) organisations whether in the secondary or tertiary sectors.

This does not imply that the clinical governance duties and responsibilities of PCT Boards and Professional Executive Committees (PECs) extend only to 'directly provided services'. In discharging their commissioning functions, Boards and PECS and the organisations they lead need to:

- be alert to their overriding duty of quality
- embed within their commissioning arrangements and monitoring processes due regard to clinical governance and its component elements.

The pilot programme

Through a collaboration between the National Clinical Governance Support Team (NCGST) and NatPaCT (with the active support of the Department of Health, the Appointments Commission, Strategic Health Authorities and a group of critical friends from across the PCT community) a pilot programme on the Strategic Leadership of Clinical Governance was developed and run in the first eight months of 2003.

The pilot programme involved 63 PCTs, although one subsequently withdrew due to internal pressures and time demands. This sample represents more than 20% of all PCTs in England, and is broadly representative of the total PCT community in terms of life stage, size, functional complexity, geographical dispersal and the nature of the communities (urban, rural and mixed) that they serve.

The process required the individual members of the Boards and PECs of these PCTs to complete a structured analysis of the progress that they believed their PCTs had made in tackling the clinical governance agenda and in embedding quality across all aspects of the PCT's activities. Although participants were asked to identify their role within the Board and or PEC, their answers were anonymous.

The response rate of PCT Board and PEC members ranged from 57 to 100% (average 77%) with more than 1200 responses in total, including over:

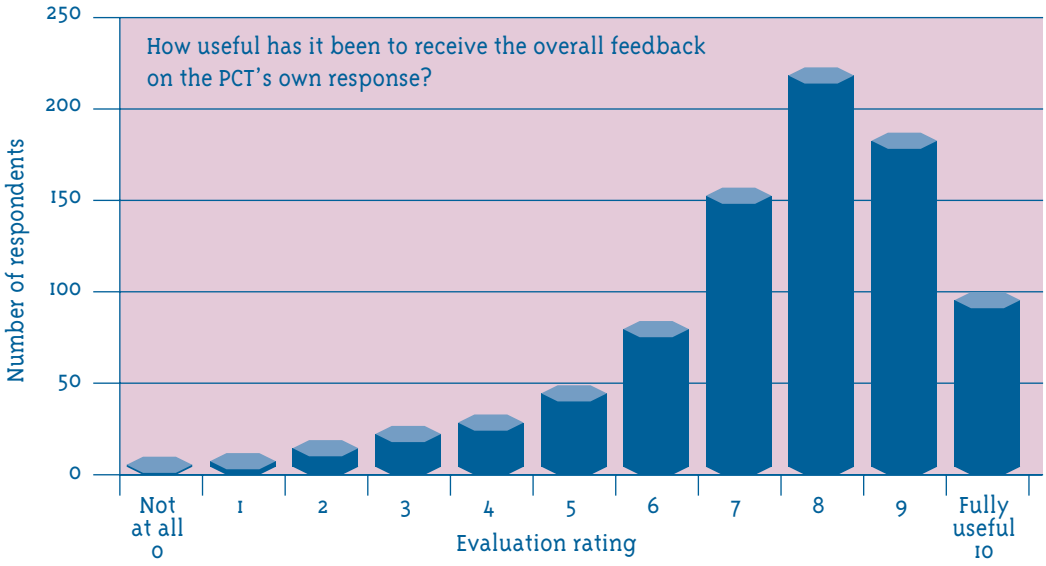
- 250 GPs
- 200 nurses and AHPs,
- 50 dentists, pharmacists and optometrists
- 180 members of the 'Three at the Top'
- 200 PCT Execs and managers
- 250 non-executives.

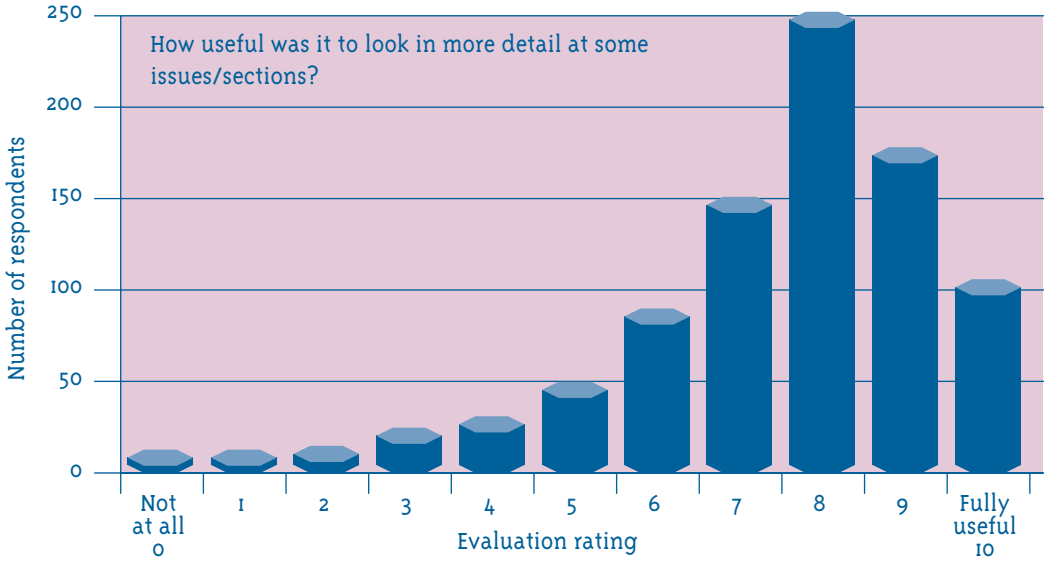
Their scores were then aggregated and the outcome of the analysis was fed back to the Board and PEC by a member of the NCGST Board Team at a half or full day workshop. The ensuing discussions and debates were a rich source of learning for all concerned, not least for the NCGST itself. The PCTs involved have subsequently been involved in determining their own developmental priorities and will be able to participate in a range of developmental workshops that respond to a number of needs that were clearly common to a significant proportion of PCTs (e.g. Preparing for CHI Review; Commissioning for Quality; Developing 'Intelligent Information').

The learning from the feedback workshops and subsequent dialogues with PCTs, together with the data from the questionnaires, is captured in the 'learning outcomes' that are now embedded within the process.

In order to ensure that the materials remain relevant to an ever-developing policy agenda and to emergent practice based wisdom, they have been reviewed and updated in November 2003. The feedback from participants has informed the redrafting and reduction of the number of questions posed, so that they map as closely as possible to the real needs of local communities and the emergent policy agenda.

The response of participants to their engagement with the pilot programme is summarised in the following graphs:





An aggregation of the overall outcomes of the programme for the participating PCTs is shown in the following graphs. Where progress for a particular section is shown, the sections referred to are those in the pilot programme.

Section two: Clinical Governance: an Overview

Section three: The Board and PEC Roles in Providing Strategic Leadership

Section four: Fostering Ownership of Clinical Governance

Section five: The Patient Experience

Section six: Patient and Public Involvement

Section seven: External Scrutiny of Clinical Governance

Section eight: Co-ordination and Alignment

Section nine: Data, Information and IM&T

Section ten: Clinical Risk Management

Section eleven: Clinical Accountability and Support

Section twelve: Clinical Audit

Section thirteen: Education and Training

Section fourteen: Research Governance and Research Implementation

Section fifteen: Clinical Effectiveness

Section sixteen: Staffing and Staff Management

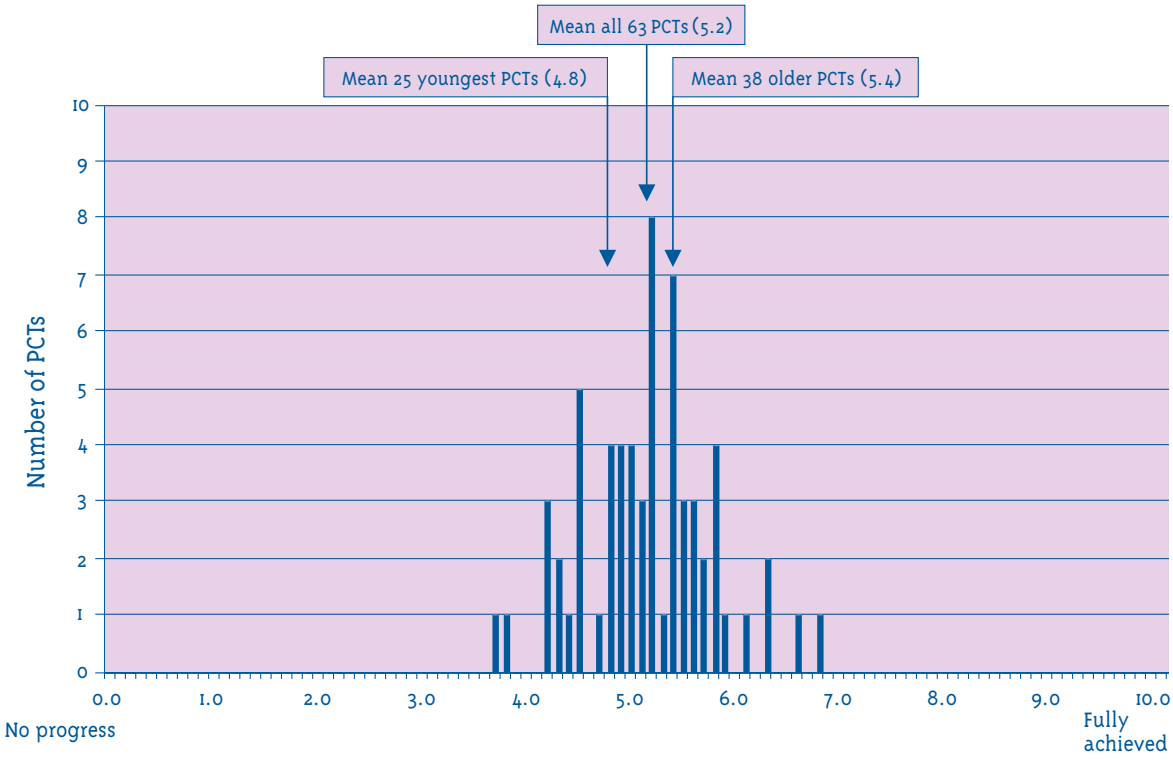
Section seventeen: Clinical Governance and the PCT's Public Health Function

Section eighteen: Clinical Governance and the Services Commissioned by the PCT

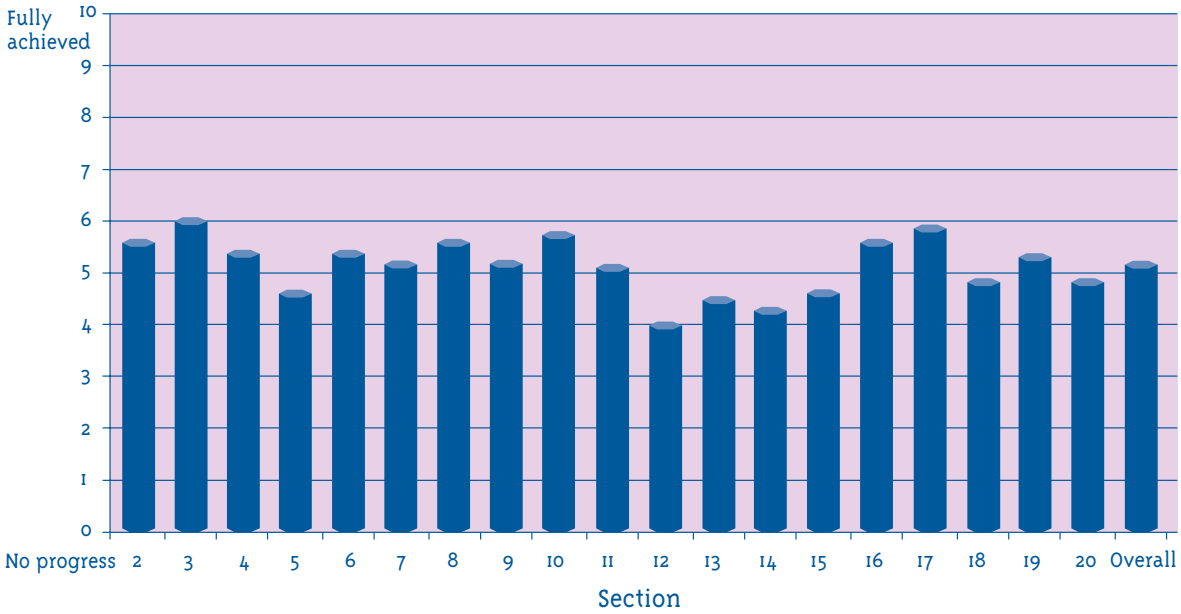
Section nineteen: Inter-organisational Elements of Clinical Governance

Section twenty: Additional PCT responsibilities

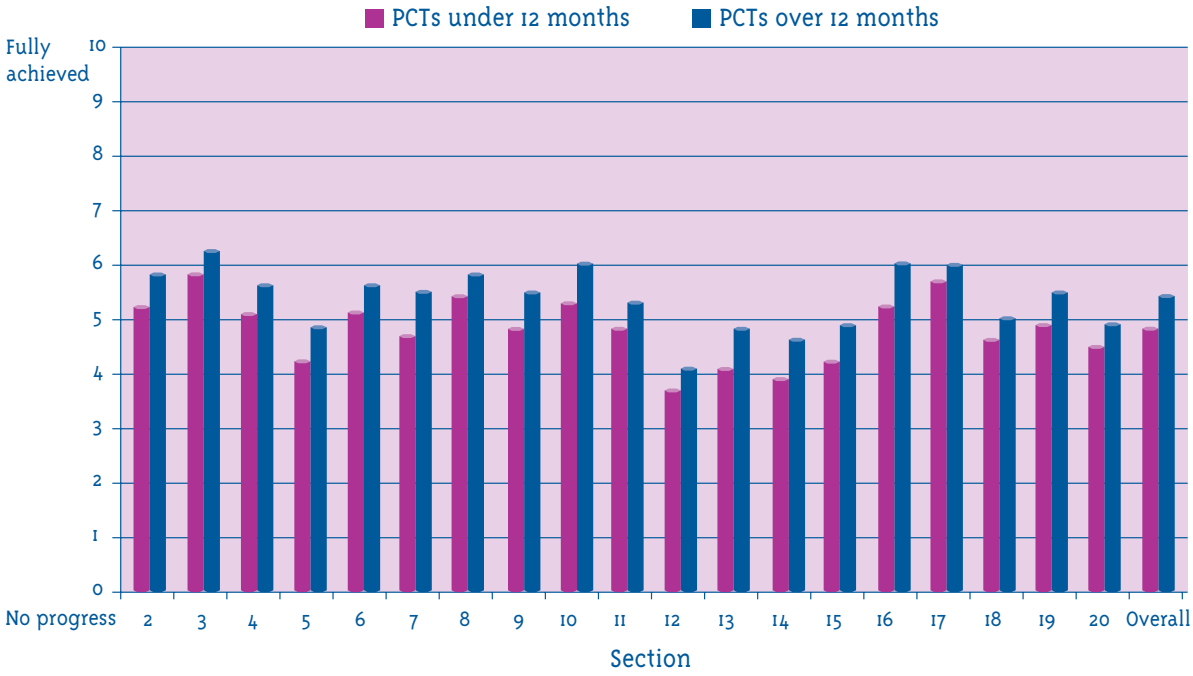
Overall stage of clinical governance progress reported by 63 PCTs: Board and PEC judgement of progress to date in embedding Clinical Governance



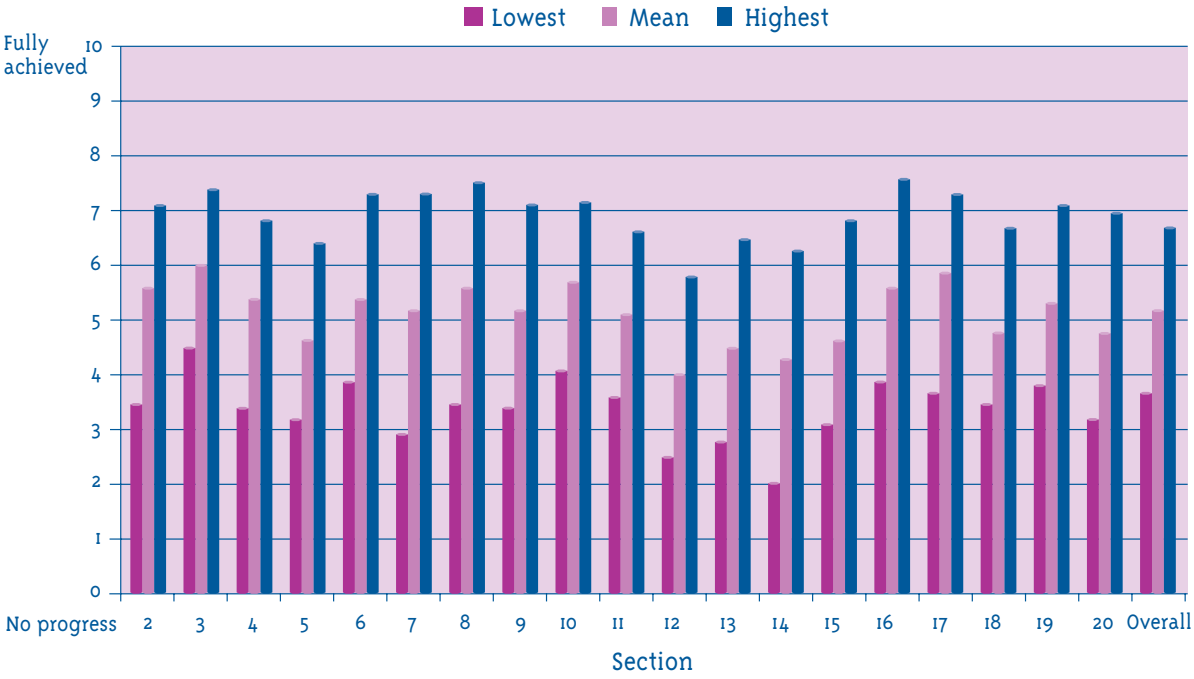
Developing Clinical Governance in PCTs: Self-diagnosis of progress by section across all participating PCTs



Section averages for PCTs over 12 months old vs PCTs under 12 months old



Mean, lowest and highest section averages amongst participating PCTs



The materials

These materials consider the demands and the opportunities presented by clinical governance from the unique and distinctive perspective of Primary Care Trusts (PCTs).

The changes outlined in *The NHS Plan* and *Shifting the Balance of Power* impose great challenges and responsibilities upon the PCT Board and PEC. The Modernisation Agency Clinical Governance Support Team (CGST) has produced this learning resource in response to requests from PCTs for support in delivering their main responsibilities in relation to clinical governance. It is also intended to support SHAs in their duty to develop clinical governance capacity within their respective health economies.

The materials draw on the expertise and experience of a number of colleagues working within the NHS, including people from:

- PCTs themselves
- the Department of Health
- the Commission for Health Improvement (CHI)
- patient groups
- patients themselves.

The materials consist of:

- an Executive Summary which briefly outlines the topics covered in the full clinical governance strategic leadership materials, followed by a series of questions asking you to judge where you as an individual think that the PCT is in its current stage of development
- the full clinical governance strategic leadership resource materials, which consist of 19 content sections, each of which expands the areas raised in the Executive Summary and includes opportunities for reflection and in-depth exploration of the topic; at the end of each section, there is a list of useful references and resources
- a response sheet, for your answers to the questions (enclosed at the end of the Executive Summary) including a 'don't know' option.

Your responses (and those of your colleagues within the PCT) will be analysed and fed back to the Board and PEC – see below.

Why these materials have been developed

The materials have been developed to help PEC and PCT Board members assess their understanding of, and preparedness for, implementing effective clinical governance, both individually and as a PCT Board. The materials form part of a programme aiming to identify Trusts that would benefit from support from the CGST and/or their own SHA. They capture what has been learned to date from working with 20% of all PCTs, and they make this learning available as a point of comparison for you and your PCT.

Board and PEC members can use the materials to:

- reflect on their understanding of their position in relation to key aspects of clinical governance, and
- identify areas where support would be helpful.

The materials should help members of Boards and PECs to:

- undertake an analysis of the PCT's current stage of development in relation to clinical governance
- identify priorities for action in relation to clinical governance and its component elements
- prepare for annual clinical governance reporting to the SHA and for CHI/CHAI reviews
- identify issues of importance in their strategic action plan
- provide a focus for discussion and debate within the Board and PEC.

How this pack can help you

This pack is intended to support PEC and PCT Board members in their obligations concerning the implementation of clinical governance. Clinical governance should be seen as a pervasive and supportive philosophy that underpins and informs the work of the Trust at every level and in every capacity.

These materials are intended to help you to become more aware of the point your PCT has reached in the 'ten year' journey of embedding robust clinical governance throughout the PCT community. They are intended to help to focus your mind – not to arouse anxiety or guilt.

Some of the issues covered will be very familiar to executives and PEC members and to more experienced non-executives, although the policy and the Guidance that gave rise to specific duties and responsibilities, some of the more recent developments in relation to the Commission for Health Audit and Inspection, and the new emphasis from the current Secretary of State may be unfamiliar (but predominantly welcome).

The Chair of one PCT, who acted a 'critical friend' by commenting upon early drafts of these materials, wrote eloquently about her initial response:

'While there is reference to clinical governance as a process rather than an end-state, a lot of the questions measure the degree of achievement of an assumed end-state. As a new organisation, I would expect to see a clear implementation plan for embedding clinical governance processes, procedures and culture into the organisation with some indication of phases and timing and achievements to date. I wasn't quite sure the questions captured that process. I was left feeling, quite often, a sense of panicky guilt that we couldn't honestly say we'd achieved quite a lot of the things the questions asked about. Yet in nine months, we couldn't reasonably have expected to achieve them: we could, however, have been expected to plan to achieve them and to be getting things into place to make their achievement possible.'

Lilian Power, Chair of Ipswich PCT

We have tried to capture the spirit of this comment in the redrafted version – and have chosen to use a ten-point rating scale in part to remind ourselves of the ten-year journey.

Inevitably, because of time pressures, many people will work predominantly from the Executive Summary. It is, however, important to note that most of those in the pilot who read the full learning resource materials felt that the duties and responsibilities were more extensive than they had assumed, and felt the need to adjust their score in the light of some unexpected insights and realisations. While the key learning points from each section are incorporated into the Executive Summary, the deeper exploration of these themes at the start of each section of the full materials may merit active consideration and reflection.

Not least because of the rate of change in the primary care environment, each section of the full resource materials has been written to stand alone. This will also enable you to read the sections in whatever order you think fit – or to concentrate on some sections in particular.

Each section:

- summarises the key issues in relation to the topics, including the learning from the pilot programme
- provides 'reflections' which prompt you to consider the PCT's position in relation to a specific issue
- contains quotations from, and pointers to, policy documents
- encourages you to identify priorities for action
- includes references and resources that will support further work in the area.

How to use the materials

We anticipate that everyone will read the Executive Summary and complete the diagnostic questions. Please note that failure to complete the questions will diminish the value of the feedback that the PCT will receive.

We also hope you will use the learning resource materials to enhance your engagement with the issues and point you in the direction of additional resources. However, we are well aware of the time pressures under which you operate and so you may prefer to use the resource learning as a reference as you go about the business of establishing procedures to embed clinical governance in the PCT.

The learning resource materials may also be useful to other colleagues who are engaged with the clinical governance agenda either as clinicians or managers. Please feel free to share the materials with them!

Work through the materials and answer the questions on the response sheet. Return your response sheet, by the agreed date, to your designated local PCT co-ordinator.

The feedback process

The Clinical Governance Support Team will analyse the returned data and prepare a synopsis for you of the key issues and themes that emerge.

NB No individual will be identified in this analysis.

Your PCT's designated co-ordinator for this process will organise a meeting of all members of the PCT Board and PEC. A member of the Clinical Governance Support Team will be there to discuss with you the key issues and themes that emerge from the aggregation of your PCT's data. This meeting will also enable you and you and your colleagues to reach a consensus view on:

- major issues that emerge
- key developmental priorities.

At a future point your developmental priorities will be shared with your Strategic Health Authority and, together, we will agree on and seek to meet any priority development needs.

Once we have completed the analysis of the data from other PCTs that are participating in the revised programme we will also provide you with an overview of the scores and the issues that emerge. This will enable you to compare your own PCT with the national picture.

We hope you will find these materials both stimulating and helpful and we would like to thank you for your help in taking part in this programme.