SECTION TWO
CLINICAL GOVERNANCE: AN OVERVIEW

This section considers:

- the use of secure and robust 'baseline measure' of the PCTs clinical governance capability and capacity
- the need for secure and robust evidence of clinical governance 'work in progress' and 'progress from work'
- how clinical governance permeates all aspects of the PCT's planning, strategies and actions
- the intra organisational challenge of clinical governance
- the inter organisational challenge of clinical governance.

Improving quality

Clinical governance provides NHS organisations and individual health care professionals with a framework within which to build a single coherent, local programme for quality improvement.

'It helps make sure that quality resumes its rightful place at the heart of the NHS.'

Department of Health, 1998

Clinical governance defines the values, the culture, the processes and the procedures that must be put in place in order to achieve sustained 'quality of care' both within and between the organisations that make up the NHS.

Clinical governance is a means to ensure the safety and quality of current provision. It is also about aspiration and about creating new patterns and forms of care for local communities. Everyone who provides strategic leadership to NHS organisations must understand and embrace the precepts of clinical governance.

'Clinical governance can be defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.'

Department of Health, 1998

Clinical governance must be a core concern of the Board and PEC of a PCT, as it is of those external bodies that performance manage or scrutinise and review its progress (the SHA and CHI/CHAI).

The CMO has emphasised that, by its nature, clinical governance is a process, not an event. Embedding clinical governance should be viewed as a ten-year journey. Each PCT needs to understand and record its own progress and performance both within this ten-year timescale and in relation to its own lifetime and inheritance.

' There is considerable variation in states of readiness for the development of clinical governance and it should be seen as a medium to long-term development objective.'

Department of Health, 2000

Key learning from the pilot programme

The members of the Boards and PECS who took part in the pilot programme believed that PCTs have, within a short time frame, made significant progress on this 'ten-year clinical governance journey'. However, all recognise that much remains to be done to embed clinical governance systematically in all aspects of the services that the PCT provides and commissions.

Some of the technical components of clinical governance are particularly challenging to PCTs, not least the need to generate the 'intelligent information' needed to underpin all of the decisions taken by a Board or PEC in relation to the quality of care and of the patient experience.

Without exception, all PCTs believed that they had made serious and sustained attempts to engage with the challenge posed by clinical governance.

To some extent they recognise that the nature and scale of the challenge faced by their own PCT in embedding quality in aspects of the organisation's activities stems from historical and functional factors beyond their control (these are considered in more detail in Section 7).

Equally, they recognise that how the Board and PEC lead the organisation and interact with local health economies is a major determinant of the progress that they can make, at the local level, in turning clinical governance from an aspiration into a reality that fundamentally shapes and improves the lives of their communities and the experiences of their patients.

Taking into account these factors, that PCTs are the youngest of NHS organisations (almost half of the pilot sample were less than a year old) and that they have in the last eighteen months assumed responsibility for 75% of the total NHS budget, it reflects significant credit upon them that they recorded 5.6 on the progress scale (range 3.4 to 7.1) on this section and 5.2 overall.

Predictably, given the pressures upon them, younger PCTs were likely to find Clinical Governance an even more challenging agenda than those that had had longer to begin to respond to its demands. The 25 PCTs that were under a year old when they completed

the questions scored an average on this section of 5.8 while those over a year old scored an average of 6.2.

It is important to note that on average the 25 newest PCTs scored lower across every single section than the rest of the sample. Life cycle is an important, but not overriding, determinant of progress. Several of the newest PCTs significantly outperformed their more mature peers even, in one case, where they were embedded within a deeply challenged health economy. Exemplary leadership and clarity of focus can overcome unpropitious context and legacy, but it is rare and so such examples are exceptions.

It is likely that the differences due to comparative life cycles will diminish with time, as progress is seldom purely temporally linear. Nevertheless, life cycle is currently an important factor to be borne in mind when assessing the performance and progress made by an organisation in embedding clinical governance.

It can be argued that the scores recorded are simply crude mathematical aggregations of the judgements of individual members of Board and PEC communities, but the nature and calibre of debates during the face-to-face feedback work with Boards and PECs revealed the integrity, validity and serious-minded application that the overwhelming majority had brought to judging their progress.

This is not to suggest that any simple correlation exists between an organisation's score and the calibre of its strategic leadership. It is instructive to consider the scores of the least and the most optimistic of the PCTs in the sample – one rating its progress at 3.4 and the other at 6.8.

One was a newly formed PCT with a difficult inheritance from its predecessor PCGs and the former community Trusts within which its community staff had been employed. It served one of the more deprived inner city communities in England and was embedded within a health economy beset by structural financial problems. The other was a mature (first wave) teaching PCT that had enjoyed a benevolent legacy from its constituent PCGs. It served a disparate rural population with pockets of affluence co-existing with rural deprivation and infra-structural decline, but was part of a health economy that had worked hard to achieve relative stability.

In both cases these organisations benefited from exemplary Board and PEC leadership and were able to draw upon the services of highly committed staff groups. The scores that they awarded themselves appeared, on the basis of discussion and debate, to be honest and perceptive reflections of the scale of the challenge that still lay ahead of both of them.

In one case, this challenge centred upon laying solid foundations upon which future clinical governance progress could be based. In the other, the challenge centred on building upon a solid foundation and taking the proverbially difficult steps from the high plateaus of good practice to the summit of sustained excellence.

It was clear from the pilot that the term PCT can itself be beguiling and misleading. It suggests that there is one species of organisational animal that is a 'Primary Care Trust'. This is not the case. The organisational profiles completed by the participating PCTs made it clear that the term PCT describes a 'zoo' that is home to many different species and subspecies. Recognition of characteristic difference should be a pre-requisite of intelligent judgement about performance and progress (this is explored more fully in Section 7).

However, despite profound differences of scale and functional complexity, the overwhelming majority of PCTs in the pilot subscribed wholeheartedly and unreservedly to the values of humanity, equity, justice, and respect that underpin clinical governance. In only a very small number did the leadership and management style of the organisation undermine and belie these principles.

It was also clear from the pilot that some of the component elements of clinical governance (not least the 'technical components' once called the 'pillars' of clinical governance) pose a particular challenge to PCTs.

It is also important to recognise that the very aspect upon which the new Commission for Health Audit and Inspection has, quite rightly, elected to focus – the quality of the patient experience – was the other area that PCTs found particularly challenging.

This did not reflect any rejection of the centrality of this measure, indeed PCTs welcomed it, but that, within existing performance regimes that emphasised financial or quantitative targets, sometimes to the exclusion of any quality consideration, most Boards and PECs had not yet decided to focus their attention upon these issues. When they did so during the feedback process it was with enthusiasm and relief.

Clinical Governance as a key facet of 'Integrated Governance'

It is obvious that within the boundary of any complex interconnected health care organisation it is impossible to make an arbitrary and absolute distinction between issues that relate to the quality of patient care, and those that relate to finance, environment, information management, etc.

Governing the NHS: a guide for NHS boards (DH, 2003) makes it clear that all aspects of the governance of an organisation have a reciprocal impact upon each other, and that the overall corporate duties of quality and care can only be effectively discharged if all of them are brought together in one coherent Board (or Board and PEC) strategy. This is integrated governance – a term that embraces all of the systems and processes by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services, and through which they relate to the wider community and partner organisations.

This approach to Board and PEC duties brings together the hitherto discrete domains of clinical, information, research, corporate and fiscal governance, and makes clear how they are all underpinned by the process of systematic and organisation-wide controls assurance.

Diagrammatically this can be expressed as follows:

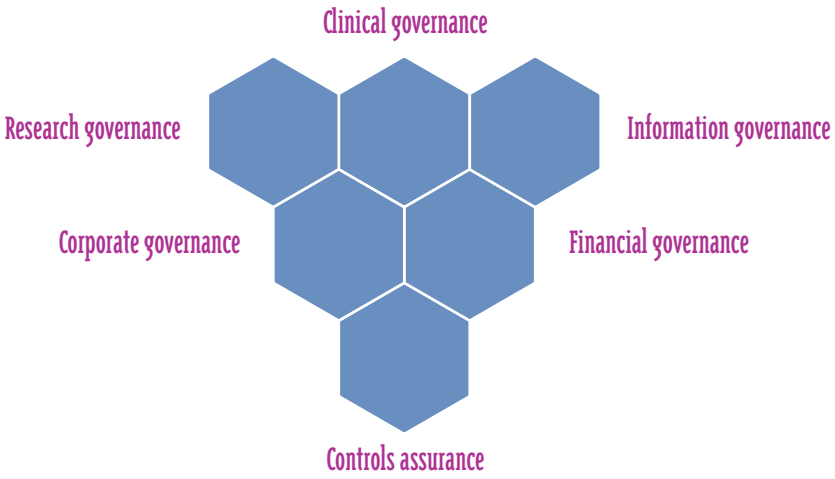

Figure 2.1 Current clinical governance elements

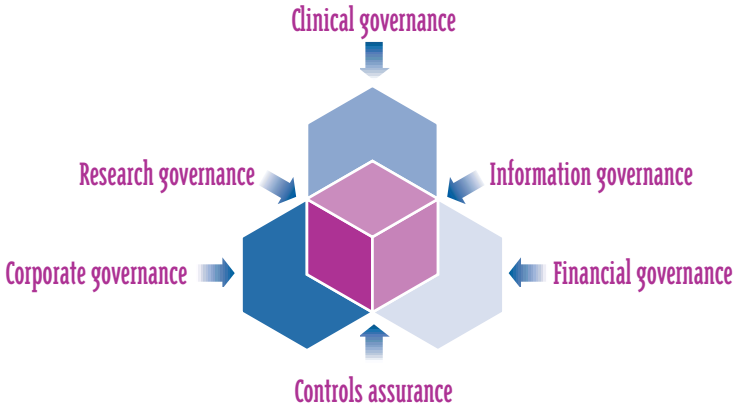

Figure 2.2 Integrated governance (1)

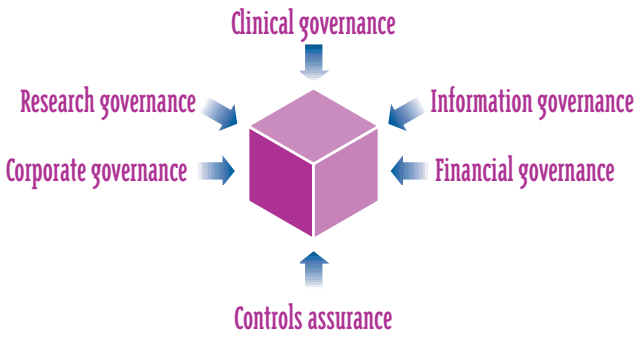

Figure 2.3 Integrated governance (2)

'One national holistic system of control and quality.'

NHS Governance Group: 2003

The crucial role of Audit Committee in providing assurance to the Board on all of these activities that must be captured within the Statement of Internal Control signed by the Chief Executive, will be considered in guidance shortly to be published by the DoH and the Appointments Commission.

The challenge of clinical governance

Clinical governance should permeate every single activity and action within the NHS and its constituent organisations. As an intra-organisational principle it brings coherence and alignment to the actions taken by an individual PCT or NHST within its own organisational boundary. As an inter-organisational principle it brings coherence and alignment to the actions of a local health economy and of the NHS itself, thus assuring that the total quality of the patient experience as well as the component episodes of care.

'Clinical governance is based upon a vision of health care in which the values of Boards, clinicians, managers and the workforce is aligned with the aspirations of patients and communities to generate and sustain a service that responds to the changing needs of its population. Successful clinical governance relies on proper arrangements for accountability, which are seen to be effective by the public, the wider health service ad individual practitioners.'

Department of Health, 1998

To enable this vision to become a reality, the Boards and PECs of PCTs must provide clear, confident and creative strategic leadership. This can be particularly challenging to recently-established PCTs, given the scale and the scope of their responsibilities and duties.

This is not only true for PCTs. The systematic implementation of clinical governance strategies and actions poses a significant challenge to all NHS Trusts. The Commission for Health Improvement was established to review progress and identify key issues that delay or obstruct progress. To date, its reviews across all sectors of health care (including PCTs) have identified four areas that present a significant challenge in the overwhelming majority of organisations reviewed:

'1 Overall organisations are reactive not proactive in relation to clinical governance and its component parts.

2 They do not formulate organisation-wide policies and strategies on clinical governance.

3 Even where such strategies exist, policies and strategy are not systematically implemented.

4 Learning is not systematically shared across and between organisations.'

Commission for Health Improvement

REFLECTION

How does the PCT measure up against these four areas of concern?

What evidence is there to support your view?

Notwithstanding the scale of the challenge, there is evidence that primary care has made a purposeful and promising beginning.

'Over the past three years, PCG/Ts have made great strides and have responded quickly to the challenges presented to them. Infrastructures have been established and initiatives have been implemented to improve health and tackle inequalities, often in partnership with other stakeholders and agencies.'

National Primary Care Resource and Development Centre, 2002

This view is strongly borne out by the findings from the Strategic Leadership of Clinical Governance Pilot Programme, whose findings are cited in each section of this document.

Establishing a secure 'baseline' measure

A baseline measure of organisational capability and capacity in relation to clinical governance was completed by PCGs/PCTs in April 2000 and submitted to the (then) Health Authorities. This was to be used as a benchmark against which progress could be measured.

In many cases, subsequent structural changes and mergers have meant that the base line established then is no longer meaningful or relevant as a foundation from which progress can be reliably measured by a new or significantly altered PCT.

Unfortunately, when organisations merged or took on significant additional responsibilities, it was not always clear to them that they needed to revisit the benchmarking process. This important first step has never been systematically taken in the majority of PCTs that took part in the pilot programmes. Some other PCTs have failed to make active use of the original benchmark to measure and evidence progress.

Boards and PECS are responsible for ensuring that a reliable and secure 'baseline' already exists, or for taking the actions necessary to establish one. This will enable the PCT to demonstrate, on the basis of a secure and explicit foundation, robust and valid evidence of clinical governance

- 'work in progress' – the prioritised strategies and action plans they are initiating to move them on from the baseline
- 'progress from work' – concrete examples of measurable changes and improvements that they are making as a result of these strategies and actions.

REFLECTION

What evidence exists of a secure 'baseline' measure for the PCT?

What evidence exists of 'work in progress' and of 'progress from work'?

Clinical governance as a unifying principle

Clinical governance must be viewed as central to the core business and actions of a PCT and to its relationship with other providers of care.

Clinical governance should permeate:

- the planning
- the strategies
- the systems
- the day-to-day interactions between every member of staff and the individual patients and communities that they serve.

Clinical governance is the business of every member of the PCT community. However, CHI reviews of PCTs found many cases where strategies in relation to clinical governance and its component elements had not been developed and cases where strategies that had been developed were not effectively project managed into embedded reality across the PCT community. These findings were echoed within the pilot programme for Boards and PECs, not least through the identification of a significant number of instances where Board or PEC members were unaware of strategies that had been developed or of significant work in progress to implement such strategies.

The ownership of such strategies by Boards and PECs is vital, but it alone cannot be sufficient to turn clinical governance from an aspiration into a reality. Clinical governance must become the business of every member of the PCT community – clinical, managerial, administrative or clerical (this is explored more fully in Section 4).

The duty of quality imposed by clinical governance extends to services that a PCT commissions and subcontracts (as a result of discharging its public health functions) as well as those it delivers. A PCT should share its understanding and expectations of quality with the organisations that provide commissioned or subcontracted care on its behalf so that clinical governance permeates the relationships between the PCT and other health and social care organisations and the care they provide (these are covered more fully in sections 17, 18 and 19).

'Primary Care Trusts will become the lead NHS organisation in assessing need, planning and securing all health services and … … they will actively engage local communities and lead the NHS contribution to joining work with local government and other partners.'

Department of Health, 2001

The twin foci of clinical governance – 'assurance' and 'transformation'

Clinical governance is a means to assure the safety and quality of current provision. It is also a key driver of the transformation in patterns and forms of care necessary to realise the vision set out in *The NHS Plan*.

'The NHS Plan sets out our ambitions to create a patient centred NHS. Our vision is to move away from an outdated system, towards a new model where the voice of the patient is heard through every level of the service, acting as a powerful lever for change and improvement. Our goal is to move away from a paternalistic model of decision making, towards a model of partnership, whereby citizens have a greater connection with their local services, and have a say in how they are designed, developed and delivered.'

Department of Health, 2001

Securing the quality of existing provision

A secure foundation for clinical governance must be laid by securing the safety and quality of existing provision.

'There is simply no issue more important in health care than ensuring the safety of our patients.'

Department of Health, 2002a

The Board and the PEC must:

- give sustained and persistent attention to the safety and the quality of all services provided by the PCT community
- take all reasonable steps to ensure the safety and the quality of the services that they commission on behalf of their patient population.

In order to do so, they must ensure that

- the technical components of clinical governance identified by CHI are focussed clearly and consistently upon current provision
- they are cognisant of the focus of scrutiny of the new Commission for Health Audit and Inspection and take all reasonable steps to prepare for its advent and to use it and the standards for care being developed by the Department of Health as supports to their own efforts at systematic quality assurance
- robust and reliable evidence of service quality and improvement is regularly scrutinised by the Board.

REFLECTION

What evidence is there to suggest that the Board and PEC understand how to scrutinise the concrete quality of existing provision?

Fostering innovation and transformation in patterns and models of care

Clinical governance guides and shapes the modernisation process. It is the vehicle by which the NHS can move from an historical base predominantly defined by the nature and shape of existing service provision to a future led by the needs of individual patients and individual communities. In this vision of the future, patient choice, participation and ownership inform all aspects of care. PCTs need to prepare to respond proactively to the range of challenges presented in making 'informed choice' a concrete reality, over time, for all of their patients.

PCTs have a pivotal role in commissioning and subcontracting as well as providing services to local communities. This position gives them a unique responsibility for ensuring that clinical governance is a transformational principle which focuses upon changing and improving the care provided by the whole system and not merely within its constituent parts. To meet the needs of an increasingly diverse society with health care expectations that have risen with improvements in the overall quality of life in the five decades since the creation of the NHS, the Secretary of State for Health has emphasised that reflecting the needs and aspirations of local communities implies:

'the absolute necessity of diversity.'

Reid, 2003

He has also argued powerfully that:

'Whitehall dictat does not deliver public service improvement. There are of course clear national responsibilities for improvement, but without their local development little long-term improvement will happen.'

Reid, 2003

His aspiration to 'localise the NHS' (Reid, 2003) has significant implications for PCTs and their transformational clinical governance responsibilities.

In the future, NHS organisations will be judged by their flexible responsiveness to changing and emerging need so that the entire service is

'... centred on the needs and concerns of the patient, encourages bottom up innovation within a national framework, and uses investment together with reform to deliver significant change and redesign. Underpinning all of these shifts must be a culture of mutual respect across all levels in the service.'

Department of Health, 2001

NatPaCT has produced 'The System Reform Friend For PCTs' to support PCTs in with this vital dimension of their responsibilities. It will help PCTs to:

- assess their position for delivering changes in the way health services are organised and delivered locally
- take forward their discussions with Strategic Health Authorities about implementing elements of the System Reform Programme.'

NatPaCT, 2003

The system reform changes cover:

- patient choice
- implementing payment by results through contracts for acute services
- contracting with primary care services and developing an enhanced range of primary care services
- the likely impact on PCTs from the development of NHS foundation trusts.

The value base of clinical governance

The values that inform and permeate clinical governance policies and implementation guidance are:

- humanity
- equity
- justice
- respect.

These principles should characterise the way a PCT responds to its patients, its communities and its own staff groups and to partner organisations. Like the process of caring itself, clinical governance needs to engage the emotions of all staff and harness their energies in the pursuit of excellence. Where positive values are not firmly embedded within an organisation, weaknesses and shortcomings in standards of care tend to go unrecognised.

'The Trust should review its corporate values and initiate a process of establishing an explicit statement of values that will underpin all of its policies and decisions and its relations with Trust users, carers, staff and other stakeholders.'

CHI Recommendations — North Lakeland NHS Trust

REFLECTION

What evidence is there to indicate that these values permeate the way in which the PCT conducts all aspects of its business?

Clinical governance and internal partnership

The Boards and PECs of a PCT must:

- debate and agree amongst themselves a common understanding of clinical governance
- demonstrate sustained commitment to it
- have a clear approach to its implementation and evaluation.

To secure the implementation of clinical governance across the PCT community, the Board and PEC must also develop strategies and oversee actions that ensure widespread understanding and ownership of clinical governance throughout the staff community for which they are responsible. This now includes subcontracted services such as dentistry, pharmacy and optometry.

A key element in the leadership task that confronts PCT Boards and PECs is to create a culture in which clinical governance is embedded: a culture that promotes partnership, responsibility and accountability at all levels and at all locations within the organisation.

As *A First Class Service* makes clear, clinical governance can not merely be the responsibility of clinicians — whether GPs, nurses or other professional groups. Every member of staff from receptionists to senior managers and non-executive directors has a concrete, unique and distinctive contribution to improving the quality of care and of service.

REFLECTION

To what extent do all staff within the PCT community understand their own contribution to clinical governance and have the opportunity to contribute their ideas? What evidence exists to support your view?

'The key to success is to release the energy, ideas and creativity of NHS staff. I believe that everyone who does a job knows how it might be done better.'

Peter Houghton CEO Norfolk, Suffolk and Cambridgeshire SHA

Boards and PECs will need to communicate and reinforce this message. Working with and through professional representative bodies and Trades Unions will help to ensure that a sense of ownership of, and commitment to, clinical governance reaches the grass roots of their organisations. Staff will only engage with this agenda if it is clear to them that the PCT is addressing, or helping them address, their own problems and priorities.

Transforming clinical governance into concrete reality for patients

Clinical governance is about both small and large-scale improvements in quality. This emphasis on concrete elements of the patient experience of care is particularly important since it can be difficult for professional and non-professional staff, for patients and for a Board or PEC to relate to or care about clinical governance as an abstract concept.

To make a difference to the quality of care that patients receive, clinical governance needs to be transformed at local level from a set of general propositions into concrete and tangible activities that engage staff, patients and communities in common tasks that seek to improve quality.

The co-ordination and alignment of clinical governance around key clinical priorities that are cast in the light of *Planning and Priorities Framework 2003-2006* and that derive from the Local Delivery Plan will enable the PCT community to focus on a manageable number of clinical conditions or topics that have been identified and agreed through dialogue and debate with:

- patients
- staff
- the local community
- the wider health economy.

'We must concentrate on the priorities recognising that we cannot do everything at once and make progress at the same pace in every area.'

Department of Health, 2002b

REFLECTION

What evidence is there to suggest that the PCT has a clear and widely understood set of clinical priorities?

How were these clinical priorities identified, agreed and shared?

In this way targeted investment of time and energy can produce significant and measurable improvements in the quality of existing provision at the same time as generating a vision of new and improved patterns or models of care. It is clear from the Strategic Leadership pilot programme that the most progress in generating evidenced improvements in the quality of care, and in generating new and more patient-centred locations, patterns and models of care, has been made by those PCTs that have, in partnership with their local health economies, focussed their efforts upon national and local clinical priority conditions and patient groups.

The work of the Primary Care Collaboratives provides further compelling evidence of the sustainable progress that can be achieved when systematic priority-setting, analysis, measurement and patient and staff engagement come together to generate clinical governance in action.

Key intra-organisational structural elements of clinical governance

In relation to current provision, as a minimum, the Board and PEC of a PCT need to ensure that they have put in place:

- clear arrangements for accountability and reporting, with ultimate Board level responsibility for arrangements to assure and improve quality;
- a coherent programme of quality improvement activity; and
- risk management processes, including mechanisms for detecting and dealing with poor professional performance.

Department of Health, 2000

Controls assurance embeds within a PCT's systems and processes the proactive management of clinical and other risks. It is an essential safeguard that provides a solid and essential foundation upon which new and improved forms of practice can be built.

'All NHS organisations must fulfill their Clinical Governance responsibilities, which are underpinned by the statutory duty of quality introduced in the Health Act 1999. Clinical Governance requires Boards to be assured that the organisation has in place systems and processes to support individual, team and corporate accountability for the delivery of patient-centred, safe, high quality care, within a reporting and learning culture. NHS Boards must fully take into account Clinical Governance when signing their Statement on Internal Control.'

(Corporate) Governance Framework for Primary Care Trusts and PCT Model Care Trusts – April 2003

REFLECTION

What evidence exists to suggest that these safeguards are in place across the organisation?

The intra-organisational 'technical components' of clinical governance

In addition to these assurance arrangements, clinical governance can only be systematically implemented within a PCT if a number of other 'technical components', in addition to risk management, are also systematically embedded throughout the organisation.

These include:

- proactive patient and community involvement
- systematic collection of clinical and other data and purposeful use of intelligent information derived from it
- clinical accountability
- clinical audit
- research governance
- proactive workforce planning and development
- education and training strategies
- evidence of clinical effectiveness.

Each of these technical components (which are covered in subsequent sections of this document) must be in place and must fulfil its clinical governance functions effectively and efficiently in its own right. A Board and PEC must also assure themselves that each of these components informs and supports each other – so that the whole is greater than the sum of its parts.

'It requires the creation of a culture as well as systems and methods of working which will ensure that opportunities for quality improvement are identified in all the organisation's services and that over time there is a major step up in the quality of care provided throughout the NHS.'

Department of Health, 2000

REFLECTION

What evidence exists to show that the technical components of clinical governance are all in place?

To what extent are they explicitly co-ordinated and aligned?

Clinical governance and external partnership

REFLECTION

What evidence is there to suggest that the PCT is actively engaged with other partners in the local health and social care economy?

What obstacles have been identified to effective partnership and collaboration?

Clinical governance should bring intra-organisational coherence by ensuring that, within the PCT community, productive linkages are made between the separate technical components of clinical governance. In addition, clinical governance should bring overarching coherence to the relationship between the PCT and its NHS and other partner organisations within the local health economy. This will help to ensure that all NHS energy and resource is targeted at improving the overall quality of care. Partnerships across the health and social care community include the private and voluntary sectors.

A PCT can make use of Health Act flexibilities to ensure ever-greater coherence and integration of its own services (and those of its partners) with those of local authorities and other providers of social care.

Paying simultaneous attention to assuring the safety and quality of current performance and to more radical forms of change is sometimes referred to as 'double running'. This approach requires an explicit balance to be struck by a Board and PEC if both these aspects of clinical governance are to receive the attention and scrutiny that they merit.

Priorities for action

Now that you have finished reading through this section, please identify three key priorities for action in relation to this section.

1

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3

CLINICAL GOVERNANCE

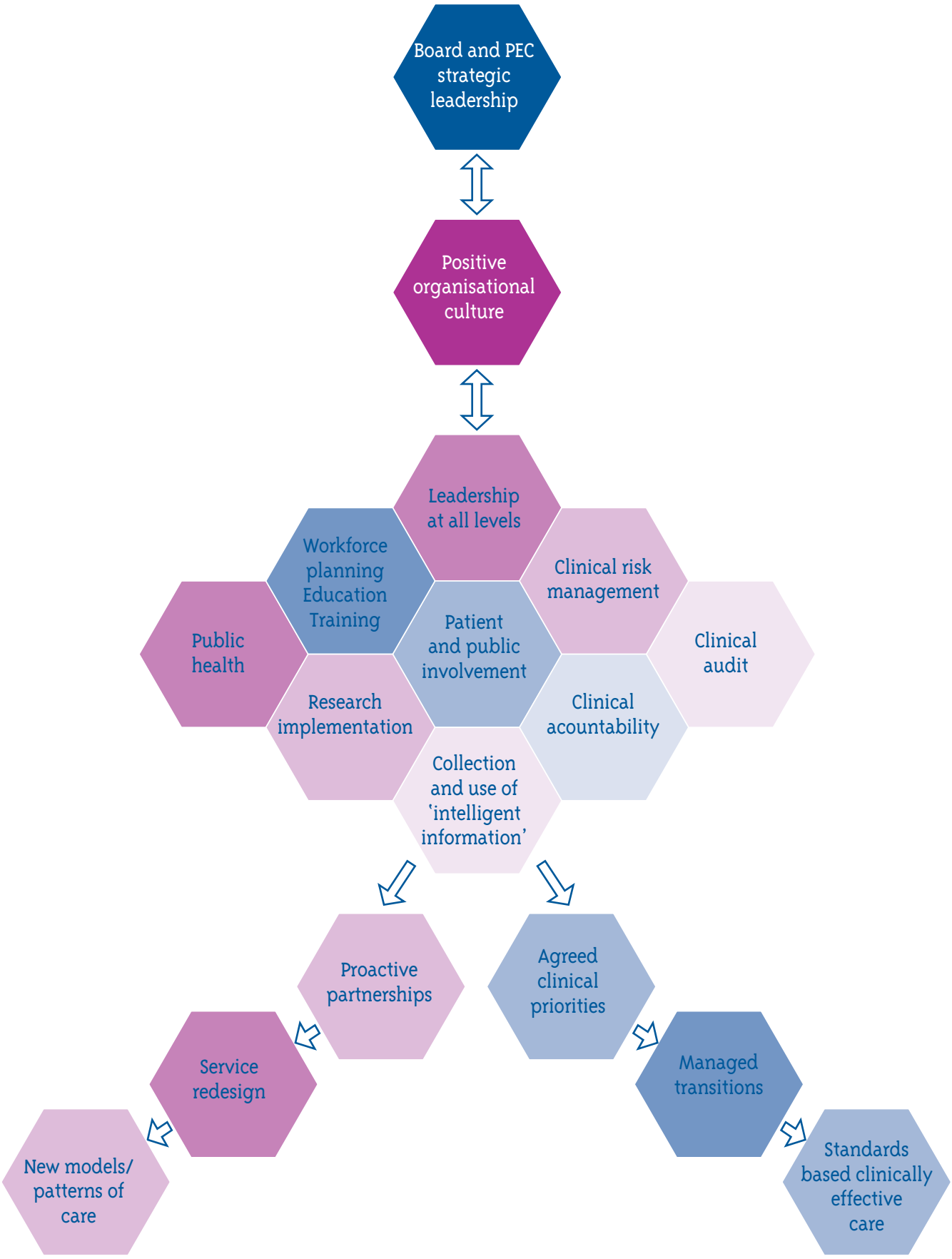

Figure 2.4 A model of clinical governance

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Reid, J. 2003. *Localising the National Health Service: gaining greater equity through localism and diverstity*, London: New Local Government Network

Resources

Clinical Governance Bulletin
www.rsm.ac.uk./pub/cgb.htm

Clinical Governance in the new NHS.
www.doh.gov.uk/clinicalgovernance

Commission for Health Improvement (CHI) aims to improve the quality of patient care in the NHS.
www.chi.nhs.uk

Department of Health – access to all Department of Health information is through their website:
www.doh.gov.uk

The Modernisation Agency is a valuable source of information. You can access the different strands of the Agency through the website at: www.modern.nhs.uk

National Audit Office: report on implementation of clinical governance.
www.nao.gov.uk/publications/nao_reports/02-03/02031055.pdf

National Clinical Governance Support Team (CGST) runs a series of programme to support the implementation of clinical governance 'on the ground'.
www.cgsupport.org

NHS Control Assurance – publications page at their website: www.info.doh.gov.uk/doh/rm5.nsf/AdminDocs/Publications?OpenDocument

The National Institute of Clinical Excellence (NICE) site contains details on the Institute, its ongoing work programmes, the methodology and processes it uses, the guidance it has issued to date, copies of all press releases and the minutes and papers from its Board meetings. www.nice.org.uk

The National Primary and Care Trust Development Programme – the NatPaCT team helps PCTs with organisational development.
www.natpact.nhs.uk

The National Primary Care Development Team (NPDT) helps to address access and service improvements for patients. www.npdt.org.uk

National Health Service Confederation: new paper: Planning with a purpose: local authorities and the NHS planning together to improve health and well being across the local strategic partnership.
www.nhsconfed.org/docs/planning_with_a_purpose.pdf

The Planning and Priorities Framework 2003-2006
www.doh.gov.uk/planning2003/2006/index.htm

Audit Commission – Corporate Governance in Health Organisations. The Audit Commission is developing a model of corporate governance as a tool to help regulators assess how well public bodies are working.
www.audit-commission.gov.uk/

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Department of Health 2003. *Keeping the NHS Local - a new direction of travel.*
www.doh.gov.uk/configuringhospitals/confighos.pdf

Redesigning health care Editorial in BMJ Vol 322 Saturday 26 May 2001
www.bmj.com

Rating the PCT's current stage of development

Please rate the PCT's current stage of development in relation to the following questions.

Remember to use the Response Sheet provided for your answers.

2.1 To what extent do the PCT Board and PEC understand their clinical governance duties and responsibilities in relation to the safety and quality of provision made directly by the PCT?

2.2 To what extent do the PCT Board and PEC understand their clinical governance duties and responsibilities in relation to the quality and safety of the services commissioned by the PCT?

2.3 To what extent do the PCT Board and PEC understand their clinical governance duties and responsibilities to transform local services working to create the seamless and flexible care set out in *The NHS Plan*?

2.4 To what extent is there a realistic clinical governance strategy for the PCT?

2.5 To what extent do the Board and PEC regularly review progress in implementing clinical governance?

2.6 To what extent do the Board and PEC understand the implications of 'integrated' governance?