SECTION SEVEN

EXTERNAL SCRUTINY OF CLINICAL GOVERNANCE

This section considers:

- the need to keep the *Clinical Governance Development Plan*, the *Out-Turn Statement* and the *Annual Clinical Governance Report* under active review
- the need to keep the CHI assessment framework, the emerging themes from their PCT reviews and the emergent strategy of the new Commission for Health Audit and Inspection under active review
- the need to keep the new forms of accountability to patients and the local community under active review.

External scrutiny and the duty of quality

In order to ensure that NHS organisations are discharging their 'duty of quality' appropriately, their performance is subject to external scrutiny and judgement.

External scrutiny and accountability operates at a number of levels. This is because of the complexity of the care task and because of the wide range of stakeholders with an interest in the quality of care that PCTs either provide or commission.

'All NHS trusts have responsibility for:

- ensuring that clinical governance principles, processes and systems are embedded through the trust board and within the organisation
- ensuring compliance with the statutory duty of quality and principles of clinical governance and patient safety for services commissioned from, hosted by, or jointly provided with, other providers
- ensuring that at a local level they have in place systems and processes to ensure the delivery of safe, high quality care
- ensuring that all clinicians are involved in regular clinical audit and review of clinical services
- assessing performance and identifying training needs for all staff
- developing an open culture within the organisation where incidents are reported and lessons are learned
- ensuring effective risk management processes and accounting for clinical governance responsibilities when signing their statement of internal control
- assuming and making clear the joint accountability for services which are provided on a multi-agency, multi-sector basis.'

Department of Health, 2002a

Transparency, probity and accountability are the key principles of corporate governance. They and the other aspects of integrated governance considered in Section 3 sit alongside clinical governance and underpin it through fiscal and broader operational assurance. External accountability is a key element of organisational clinical governance and is one of the elements that significantly influences the overall Performance Rating of PCTs and all other NHS Trusts.

Key learning from the pilot programme

Given the profound differences in function, scale and life stage between PCTs, star ratings, current CHI reviews and (most) SHAs, performance management criteria fail to reflect adequately the differential 'degrees of difficulty' in embedding CG that confronts individual PCTs. This failure may produce arbitrary outcomes that devalue the results and the utility of measurement.

So far as PCTs themselves are concerned, most were:

- focussed upon the achievement of national targets
- sensitive to local SHA performance measures (though SHAs themselves vary significantly in the approach that they take to overall and clinical governance performance measurement)
- reactive rather than pro-active in preparing for CHI review and the advent of the new CHAI.

Across all the PCTs in the pilot programme, the section on External Scrutiny was scored at 5.1 on the progress scale (range 2.9 to 7.2).

Predictably the more recently formed PCTs were likely to find this a significantly more challenging issue than those that had a longer time to become familiar with the complexities of the performance measurement system. The 25 PCTs that were under a year old when they completed the questions scored an average of 4.6 whilst the remainder scored an average of 5.6.

The 22 SHAs that we covered by the participating PCTs had a wide variety of approaches to performance measurement.

Some were actively involved in supporting PCTs and helping them in the formative stages of identifying and overcoming challenges; others were significantly more detached and summatively critical of performance outcomes.

Some SHAs placed significant emphasis upon clinical governance and quality of provided and commissioned services, while others were almost exclusively pre-occupied with financial and other quantitative measures, almost to the exclusion of measuring the quality of the patient experience or of clinical care.

Inevitably the focus of SHA scrutiny had a reverberative impact upon the agenda and the focus of PCT Boards in particular. Such a stance could generate a feeling in the PEC

and the wider clinical community in these PCTs that quality was not a corporate priority.

At the time when the questionnaire was completed, CHI had only recently begun its full reviews of PCTs. Perhaps for this reason, the majority of PCTs that had not been notified of their review date had taken few proactive steps towards owning and managing the CHI process.

It is, however, clear from the PCTs in the pilot that have undergone review (and from the other PCT reports published by CHI) that 'passionate ownership' of the clinical governance agenda – and thus of quality – by Boards and PECs is a major determinant of a positive outcome from the review process.

It is also clear that those PCTs that prepare pro-actively and systematically for CHI reviews derive the greatest overall benefit for their patients, their local communities and their own staff – since they approach the process not as a necessary evil but as a focus **for learning**, for sharing and for quality improvement.

It is important to note, however, that almost all PCTs (even those that have received favourable CHI reviews and whose performance is rated positively by their SHAs), believe that current performance measures fail adequately to reflect the very different nature and extent of the challenge that confronts a particular PCT in the light of its unique history, structure and context.

The pilot study identified a number of external or inherited factors that, in relation to any individual PCT create a unique degree (or tariff) of difficulty in embedding clinical governance, quality and service transformation. These factors are set out in the check list at the end of this section. These factors are often difficult for external bodies to appreciate or recognise. It is a useful exercise for a Board and PEC to calculate their unique degree of difficulty and to bring this explicitly to the attention of those who judge their performance. The checklist at the end of the section enables individuals or groups to do so.

There was a widespread belief that the results of performance measurement would be more robust and more useful if they could in this way be based upon 'intelligent information' about the overall context within which an organisation operates.

Thankfully, this fact appears to have been recognised by the Commission for Health Audit and Inspection (see below).

The structural arrangements for DoH/NHS accountability

The Secretary of State is politically accountable to Parliament for the actions of the Department of Health and through them for those of the NHS – including those of PCTs. The Department of Health provides the 'line of sight' from the Secretary of State, through SHAs, to the service on the ground. Figure 7.1 illustrates the line of accountability.

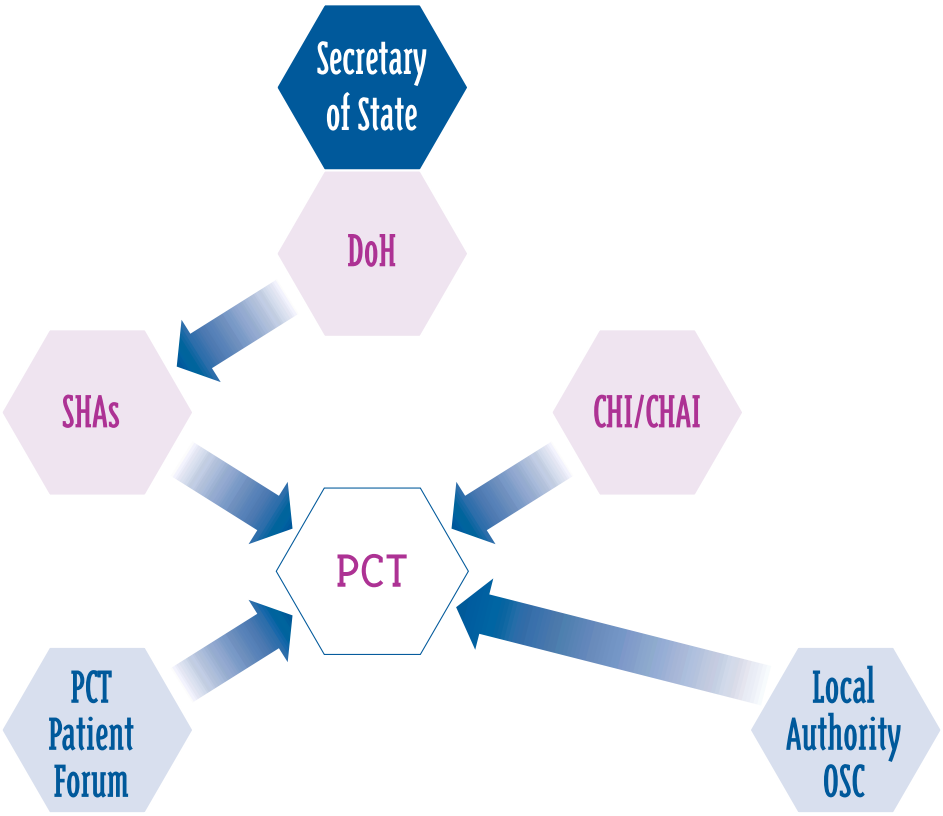

Figure 7.1 Structural arrangements for clinical governance accountability

Strategic Health Authorities

The Department of Health performance manages the 28 Strategic Health Authorities. With the abolition of the Directorates of Health and Social Care the role of SHAs has become an even more pivotal and vital one.

They are charged with:

- assuring the quality of provision within the health economies/systems which fall within their geographical remit
- performance managing the financial and clinical out-turns of their constituent NHSTs
- acting as agents to promote development, transformation and change.

' Strategic health authorities will have responsibility for:

- securing performance improvement in relation to the patient experiences and in relation to health care outcomes in the local health community
- ensuring that organisations work together to deliver service and health improvement within the community and identify pan-sector priorities for service improvement and local clinical audit.'

Department of Health, 2002b

SHAs have the regular performance management role in relation to all aspects of the behaviour of PCTs (and all other NHS organisations in their sphere of responsibility). SHAs

seek to regulate, guide and develop the separate and co-ordinated behaviour of all PCTs within their specific health economy.

'The three key functions of a Strategic Health Authority are:

- creating a coherent strategic framework;
- agreeing annual performance agreements and performance management;
- building capacity and supporting performance improvement'

Department of Health, 2002b

A specific part of the SHA's performance management role focuses upon the clinical governance policies, systems and processes which PCTs have in place to deliver (and commission) clinically governed care. In addition to this 'assurance role', SHAs also work with PCTs (and other providers) in a developmental capacity to foster innovation, to share and generalise best practice and to formulate new patterns of care.

REFLECTION

To what extent does the PCT's own SHA fulfil its performance development as well as its performance measurement role?

To what extent are all members of the Board and PEC clear about the performance management measures employed by the SHA?

PCTs' reporting mechanisms

All aspects of the care provided or commissioned by a PCT are subject to regular external scrutiny and monitoring.

'PCTs will be performance managed on the outcomes of the care that they provide (including preventive health improvement work and the commissioning of acute services)'

Department of Health, 2002b

The clinical governance baseline measure

PCTs are required to report regularly to SHAs and to the wider local community on their clinical governance arrangements and progress through a three phase process that should have as its common foundation a 'baseline measure of clinical governance capability and capacity'.

The original 'baseline measure of organisational capability and capacity' in relation to clinical governance had to be completed by PCGs/PCTs in April 2000 and submitted to the then Health Authorities. However, so great has been the structural and organisational change since that time, that few of the original baseline measures have direct relevance to current organisational reality. The commissioning function, the public health function, the services provided by community pharmacists, dentists, optometrists and many other additional duties assumed by the PCT were not captured.

Where no relevant or reliable document exists, therefore, PCTs would be well advised to return to the initial guidance, match this with the current CHI self-assessment template (see below) and undertake a systematic 'baseline measure' of competence and capacity in the current organisation.

This disciplined approach is likely to pay significant dividends in establishing a secure foundation on which future progress can be built and measured. In the absence of such a

REFLECTION

Is there a relevant baseline measure of the PCT's organisational capability and capacity in relation to clinical governance?

Is active use made of it in order to generate evidence of progress?

benchmark, it may be difficult for the Boards and PECs of PCTs to generate robust and 'intelligent information' about the progress that they make, year on year, in embedding clinical governance.

The (new) clinical governance reporting process

In 2002 the Department of Health issued guidance that makes clear the structure, format and composition of the clinical governance reporting arrangement that will apply to PCTs and all NHSTs in England.

Within a specified time frame all PCTs must prepare and submit to the SHA:

'...clinical governance development programmes which comprise:

- clinical governance development plans
- clinical governance out-turn summary.
- clinical governance annual reports.'

Department of Health, 2002a

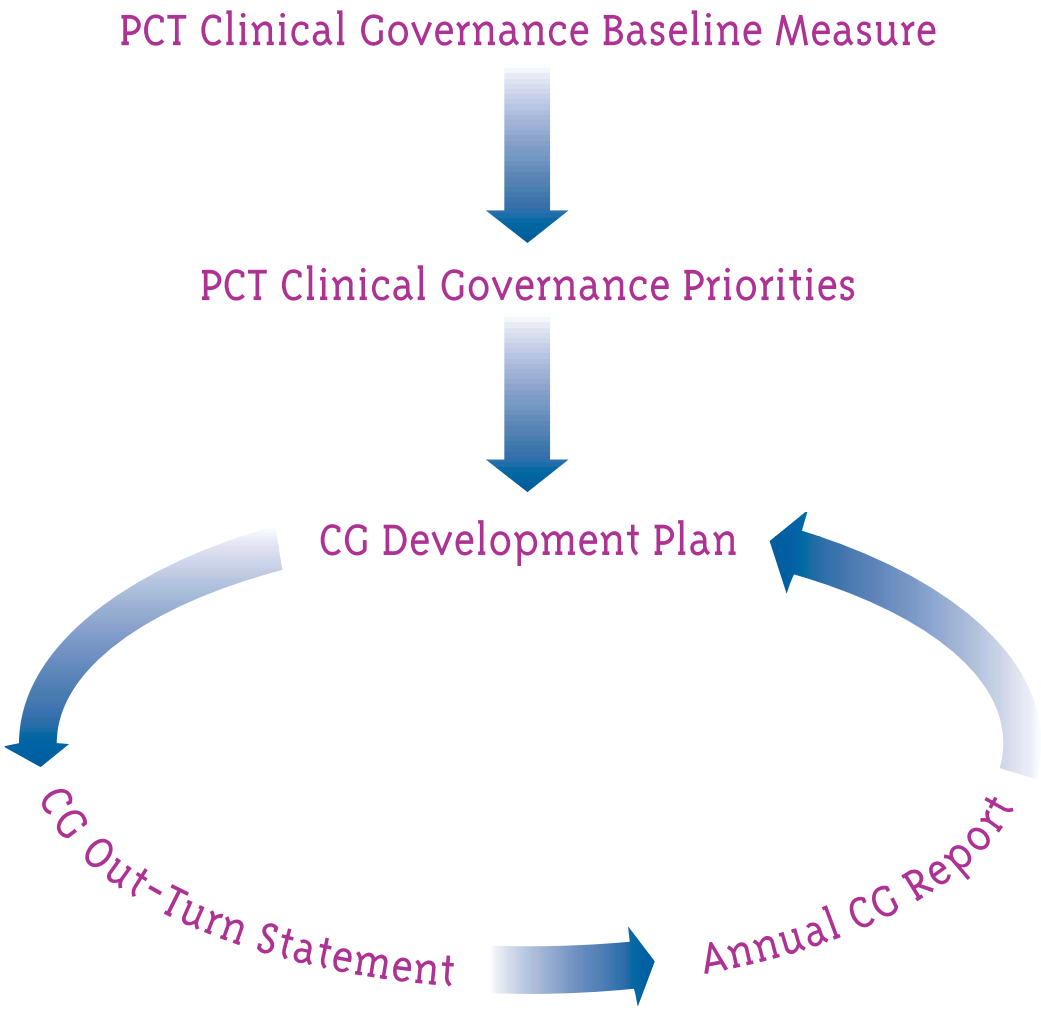

Figure 7.2 The Reporting Process

The guidance emphasises the comprehensive nature of the Clinical Governance Development Plan that is required from PCTs. It must:

'• cover all domains in the reporting framework and be based on a self-assessment of the strengths and weaknesses within the trust's framework for clinical governance

• clearly identify lead responsibility and target date for completion

• address learning from national inquiries e.g. Bristol and action to implement NPSA alerts

• be an active document used by the trust throughout the year. It should provide a mechanism for reflecting change and identifying progress across all aspects of clinical governance on a regular basis.'

Department of Health, 2002a

On the basis of the comprehensive development plan, the PCT must report on progress to the SHA through the Clinical Governance Out-Turn Statement. This must:

'• inform the SHA of completion and progress against the targets and actions identified in the development plan itself and progress to achieve longer term targets

• as a minimum address all action points identified in the clinical governance development plan at the beginning of the year and any actions and targets arising from external review which have been incorporated within the development plan during the year.'

Department of Health, 2002a

On the basis of the Development Plan and of the progress and actions reported in the Out-Turn Summary, the PCT must then prepare and distribute to its local community the Annual Clinical Governance Report.

'The Report must inform the public by providing concise details of systems and processes, illustrated by examples of how these systems and processes have resulted in change and quality improvement during the year.'

Department of Health, 2002a

The reporting framework

In completing all of these reports PCTs should take due account of the framework laid down in the guidance. This makes clear and explicit reference to all of the issues that must be covered – in whatever way is appropriate to the circumstances and context of a particular PCT.

The framework must cover:

'• leadership, strategy and planning including:
  – consultation and patient involvement
  – organisation and clinical leadership
  – planning of services
  – organisational performance review

  - health community partnerships.
- the patient's experience including:
  - the planning and organisation of care
  - the environment of care.
- use of information including:
  - information about the patient's experience
  - information about resources and processes
  - information about the outcomes of patient care.
- processes for quality improvement including:
  - risk management processes
  - clinical audit programmes
  - evidence based practice and clinical effectiveness programmes
  - learning from incident reporting
  - learning from complaints.
- staff focus including:
  - staffing and staff management
  - education, training and continuous personal development
  - multi-disciplinary team working.'

Department of Health, 2002a

REFLECTION

Do the Board and PEC keep all of these issues and the documents that report on them under active review?

Co-ordination and alignment of external reporting requirements

The Department of Health now recognises the information generation load that PCTs and other NHSTs are asked to carry in addition to their primary role of providing care. In order to minimise additional demands upon them, efforts are now underway to:

- align and unite the types and sources of information they are asked to produce
- rationalise the priorities that are laid down for them.

The new reporting requirements

'...start to harmonise the clinical governance reporting processes with data requirements for performance rating

Department of Health, 2002a

Importantly, the Department of Health now recognises that fewer targets should be set – and that those that are set by different bodies must:

- be aligned
- more accurately reflect the quality of the patient experience
- be responsive to local as well as national priorities.

Work underway in the Department of Health and between the Department and the new Commission for Health Audit and Inspection is likely to change and simplify from 2004/5 onwards the performance measures that generate PCT star ratings and produce a leaner and more robust performance framework.

The Commission for Health Improvement (CHI) and the new Commission for Health Audit and Inspection (CHAI)

In parallel with the regular monitoring and scrutiny of clinical governance undertaken by the SHA, every NHS organisation is subject to regular review of its clinical governance policies, actions and outcomes by the current Commission for Health Improvement. At the present time (the end of 2003) almost a third of all PCTs have been (or are currently) subject to CHI reviews. It seems likely that all will take part in the review process before the new 'Audit and Inspection' regime (see below) becomes fully operative.

The Commission for Health Improvement (CHI) was established to provide an authoritative and independent voice on the state of the NHS. CHI functions as the NHS inspectorate and seeks not only to make reliable and robust judgements on the standards of care that are being achieved but also to help the NHS and its constituent organisations improve the overall safety and quality of patient care.

Its main functions include:

'
- routine clinical governance reviews of NHS organisations
- investigations into serious service failures
- national studies on key themes like cancer and coronary heart disease
- reporting annually on the state of the NHS and providing leadership on best practice from inspection reports.'

CHI, 2002

So far as the specific clinical governance review function is concerned, CHI:

'
- aims to test whether clinical governance arrangements are effective
- identifies best practice and areas for improvement
- scrutinises systems and processes needed to monitor and improve services and whether they are working and making a difference to patient care.'

CHI, 2002

CHI's reviews of PCTs currently monitor and evaluate and give a score in relation to:

'Patient and public involvement

Risk management

Clinical audit

Clinical effectiveness programmes

Education, training and continuous professional and personal development

Staffing and staff management

Use of information'

CHI, 2002

The reviews also comment upon the PCT's strategic leadership capacity and performance and upon other key aspects of the PCT's functions, including the patient experience,

REFLECTION

Is there evidence that the Board and PEC actively review the CHI assessment framework?

How prepared is the PCT, in its current stage of development, for the rigours of a CHI inspection?

ownership of clinical governance across the staff community and the way in which the PCT discharges its commissioning functions. CHI has recently (October, 2003) published on their web-site a self-assessment framework that helps PCTs to undertake a gap analysis and prepare for review.

It is vitally important that Boards and PECs recognise the implications and gravity of the CHI review process.

Receiving an adverse CHI review because of serious clinical governance weakness is equivalent to receiving no stars on the balanced score card. It has significant implications for a Board and PEC, the PCT as a whole and the wider local community, since the public and media spotlights inevitably fall on PCTs whose performance appears to be the worst.

Those PCTs that have undergone review have, for the most part, derived considerable value from it – even where they themselves have been critical of specific elements within the CHI process and even where the CHI report has highlighted weaknesses or failings within the organisation. Inevitably the CHI Action Plan that must be completed on receipt of the report involes all members of the Board and PEC – and requires co-ordinated action across the PCT community.

It is prudent for all Boards and PECs to consider how well prepared they are to undergo a CHI review – whether or not they have been notified of an impending visit. Like the recently published self-assessment tool, the full assessment framework is openly available on the CHI website and can be used:

- as a point of reference for internal scrutiny
- as a template against which evidence of good practice can be systematically developed and recorded.
- as a focus for pro-actively involving all of the PCT community in quality improvement activities.

Nevertheless the pilot programme demonstrated that (until they received notification of their CHI review date) many PCT Boards and PECs had paid little or no explicit attention to the CHI criteria, process or emergent key messages. In the face of the other pressures upon them, they had neglected to take ownership of this vital process. As a result, they had missed the opportunity to delegate, in a timely fashion, responsibility and authority for management of the entire process to a named and appropriate group of staff who could report to them on a regular basis. Only when notification arrived, did these PCTs initiate action. They then had to work under the tightest of time deadlines – with all of the disruption to 'normal business' that inevitably ensues.

It is sometimes said that the CHI process lasts for 17 weeks. Wise organisations will recognise that those 17 weeks form only the end of a continuous process.

CHI themes should form:

- a minimum template which the PCT can use to understand and scrutinize clinical governance
- a framework for gathering evidence of active engagement with each of these issues and themes
- a framework for gathering evidence of the progress that has been made.

The development of a substantial and constantly updated portfolio evidence of clinical governance in action is the best form of preparation that any organisation can make for external scrutiny.

REFLECTION
Do the Board and PEC keep the CHI review process (and its outcomes – where relevant) under active review?

The lessons from CHI reviews to date

Initially, CHI focussed its attention on the acute NHS Trust sector. Up to December 2002, CHI teams had completed inspection visits and reports in relation to more than 125 acute NHS Trusts. More recently CHI began to look at other parts of the NHS and has undertaken reviews of mental health provision, of ambulance services and of almost a third of all PCTs.

REFLECTION
Is there clear responsibility for briefing the Clinical Governance Committee, the Board and PEC on CHI emerging themes?

It is important for Boards to require one or more members of the PCT community to keep the outcomes of these reviews under active scrutiny so that they can report back to the Clinical Governance Committee, to the Board and to the PEC, on an ongoing basis, about those issues and themes that pose problems to PCTs and those where exemplars exist of best practice. This will enable Boards and PECs and their clinical Governance Committee more effectively to scrutinise their own operations and learn important improvement lessons from the wider PCT community.

The Office for Information on Health Care Performance

Since April 2003, CHI's new 'Office for Information on Health Care Performance' has assumed a wide range of responsibilities and functions. The need for such a body was clearly identified by the BRI inquiry and Government accepted the recommendation.

The extensive remit of the Office will include:

- assessing performance
- national clinical audits
- national surveys of patients and staff.

Functions relating to performance assessment and national surveys have transferred from the Department of Health to the Office and those relating to national clinical audit will transfer from NICE and the Department of Health to the Office.

Detailed guidance on the nature and scope of the Office's duties, responsibilities and remit – and of their implications for PCTs and other NHSTs – are available on the CHI website. The Office itself and all of its functions will be subsumed from April 2004 in to the new Commission for Health Audit and Inspection (CHAI).

The new Commission for Health Audit and Inspection

As a further step in co-ordinating and aligning the various forms of scrutiny and inspection to which NHSTs are currently subject, a new body, the Commission for Health Audit and Inspection will formally be established subject to the passage of the Health and Social Care (Community Services) Bill currently before Parliament.

The new Commission is perhaps the single most important development since the advent of clinical governance itself.

Its duties, inter alia, as set out in the Bill will be

'• to inspect the management, provision and quality of NHS healthcare, taking into account national standards and priorities;

- to inspect arrangements for clinical governance in local NHS organisations;
- to register, inspect and regulate providers of healthcare in the independent sector in the light of national minimum standards;
- to identify where and how well public resources are used to provide healthcare;
- to investigate serious failures in the provision of healthcare'.

So that it can carry out these duties in a robust and transparent fashion the Department for Health is currently at work on a set of 'Standards' against which the new Commission can 'audit and inspect' the performance of NHSTs.

In carrying out this key function, the new Commission will be independent of both the NHS and Government. It will report annually to Parliament, not Ministers, on:

- the state of the NHS
- the performance of PCTs and other Trusts
- the use to which they have put the extra resources that have been made available, year on year to the NHS.

The Commission will:

- unite the hitherto discrete forms of scrutiny that assure integrated corporate as well as clinical governance
- assess the performance, quality of patient care and financial accountability of the NHS
- look in the most rounded way at all key areas of an organisation's clinical, fiscal and overall operational performance.

Subject to legislation, it will become the single inspectorate for NHS and private sector providers of health care (taking over the private healthcare inspection work currently carried out by the National Care Standards Commission). Its duties will encompass all of CHI's work alongside the healthcare element of the Audit Commission's inspectorial duties. Additionally, it will include the Mental Health Act Commission and have a key role in reviewing the second stage of NHS complaints procedure.

CHAI's Executive Chairman is Professor Sir Ian Kennedy, who chaired the Bristol Royal Infirmary Inquiry. He brings to the new post the same clarity, focus and rigour that characterised that process and its outcomes.

Building upon the foundations laid by CHI, he has recently published his 'Vision for the New CHAI'. This document sets out the direction of travel for the new organisation and has powerful messages for PCTs that wish take pro-active measures to 'future proof' themselves.

The Commission will develop over time

> 'an integrated approach to assessing the quality of care provided to patients wherever they are treated, and to assessing the capacity of the organisations delivering healthcare and public health to deliver services of high quality.'
>
> *CHI, 2003*

The approach differs from the current review regime in a number of important respects.

Kennedy points out that 'the process of inspection and audit' should not be confused with an 'inspection visit' – though a visit to an organisation may periodically form part of the overall process.

Inspection in this wider sense relates to ongoing scrutiny of evidence about the performance of an organisation – evidence that itself needs to be understood within the wider context of the health economy or economies within which an individual organisation is located. Judgement

> 'needs to take proper account of the various social and other factors which may affect what can be done, such as the relative level of disadvantage in a particular community, its demographic composition, and the ability of an organisation to attract and retain staff.'
>
> *CHI, 2003*

Much of this evidence therefore should be subject to self-inspection and self-audit by the organisation itself – so that its on-going actions are shaped and informed by 'intelligent information' about its own performance and its own local context.

The phrase 'intelligent information' lies at the heart of the vision for the new CHAI. By its nature an inspection process is based upon the scrutiny of evidence but Kennedy is aware of the gaps that currently exist in the health care evidence base.

> 'Although there is a considerable amount of data in the NHS, collected at the local and national levels, the data have not traditionally been used to provide systematic information on the quality of care that patients are receiving. Yet, the ability to improve care depends, critically, on having access to the necessary information. We will make information, "intelligent information", central to CHAI's activities.'
>
> *CHI, 2003*

Given their data and IT inheritance, this will pose a major challenge to PCTs (see Section 9).

Kennedy also appreciates that, hitherto, scrutiny of quality has failed to reflect the inter-connectedness of the care task.

'Any overall assessment of the quality of healthcare is complex. It reflects, for example, the standard of clinical services; the quality of the patients' care and experience; the coordination of services along the pathway travelled by the patient; waiting times; the existence and range of choice; the physical environment in which patients are treated; and the honesty and respect shown to patients and their families.'

CHI, 2003

This emphasis upon the 'patient journey', rather than just upon the 'episode of care', is a welcome one and echoes the concerns of patients themselves that care is not 'joined up'.

REFLECTION

Have the Board and PEC considered the implications of the approach to Inspection and Audit of the new Commission?

'Assessment should be addressed from the perspective of patients, based on an understanding of what they experience along the whole pathway of care along which they may travel.'

CHI, 2003

Overall the approach of the new CHAI marks a step change in the focus of scrutiny —and should help Boards and PECs to develop a clearer focus upon those things that will, in the future, be used to measure their performance and their success. It will be based upon:

'three central matters: the quality of care received by patients; the quality of patients' experiences, particularly along the pathway between organisations and services; and the quality of organisations and their capacity to produce improvements in services.'

CHI, 2003

Developing and demonstrating accountability to local communities

The Government and the health professions are accountable within the structural parameters of the national political process and the accountability structures of the DH and the NHS. In addition, they are keen to develop the transparency of organisational actions, decisions and processes and to make PCTs and other NHS bodies more directly accountable to the service users and local communities that they exist to serve.

'The increases in measurement, national standards, assessment and scrutiny within the NHS are key elements of steps towards creating a health service which is more open and questioning and, inevitably, accountable to its users.'

NHS Confederation, 2002

The new Secretary of State recognises that all that has been done has not always produced the intended consequences.

'A national system of accountability seeking to provide the public with a clear understanding of improvement has created something far from clear or accountable.'

Reid, 2003

He is keen, therefore, to explore innovative ways to reconnect local communities to their NHS providers so that they are pro-actively involved in all aspects of the planning, implementation and evaluation of services and of care. Boards and PECs must be aware that structural changes are already in train which will:

- significantly strengthen the local scrutiny to which PCTs and other health bodies are subject
- help to address what is sometimes referred to as the 'democratic deficit' in local health accountability processes.

These issues and the two exemplars that follow are covered more fully in Section 6, Patient and Public Involvement.

The PCT Patient Forum

The NHS Reform and Health Care Professions Act became law in June 2002. From December 2003, the new Commission for Patient and Public Involvement in Health will fund, set up and oversee Patients' Forums in each of England's PCTs and NHS trusts. The Patient Forum will act as an independent 'critical friend' to the organisation. The onus will be on forums to gather a real mix of views and actively involve 'ordinary' local people who are not usually consulted or involved in existing representative forums.

The Local Authority Oversight and Scrutiny Committee

In addition, form January 2003 the actions of PCTs and other NHS (and independent sector bodies) have been subject to oversight by the relevant Local Authority's Health and Social Services Oversight and Scrutiny Committee.

REFLECTION

To what extent is the PCT currently 'accountable' to the local community?

Priorities for action

Now that you have finished reading through this section, please identify three key priorities for action arising out of the external scrutiny of the PCT's clinical governance arrangements and performance.

1

2

3

Checklist: Tariff of difficulty

Identifying the unique 'tariff of difficulty' for your own PCT, rate the following on a 0 to 10 scale where 0 = Straightforward and 10 = Chaotically Complex.

Lifecycle (i.e. How long has the PCT been 'one community'?)	
Organisation's functional complexity (i.e. How great is the range of different services that it provides?)	
Organisation's size (i.e. How many staff, how many GP and other independent contractors and how many locations does it have to manage?)	
The Trust 'inheritance' from predecessor organisations (benevolent or malevolent)	
Fiscal constraints inherited by the PCT (in relation to its major acute providers as well as its own provider budget)	
Range and scope of patient populations (complexity, degree of deprivation, etc.)	
Scale of commissioning (and specialist commissioning) responsibilities	
Assured quality of care provided by existing acute providers (i.e. quality of information from the provider + independent assurance of quality from CHI, SHA or other sources)	
Assured quality of care provided by existing Mental Health providers (i.e. quality of information from the provider + independent assurance of quality from CHI, SHA or other sources)	
Overall state of local social care and voluntary sector provision (extent, quality and collaborative orientation of local 'partner' organisations)	
Please also add any additional Confounding Local Factors or problems beyond the control of the PCT and score each one of them:	
TOTAL SCORE =	

Tariff of Difficulty = TOTAL/(10 + Number of Local Factors Identified) =

References

CHI 2002. *Emerging Themes*, www.chi.nhs.uk

CHI, 2003. *Vision fo rthe New CHAI* www.chi.nhs.uk/eng/about/chai/CHAI_vision.pdf

Department of Health 2002a. *Clinical Governance Reporting Process* London: DH www.doh.gov.uk/clinicalgovernance/reportingprocess.htm

Department of Health 2002b. *Shifting the Balance of Power: The Next Steps*, London: DH

NHS Confederation 2002. *Nexus Background Managerial*, 4. www.nhsconfed.org/nexus

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

Resources

Commission for Health Improvement – CHI's aim is to improve the quality of patient care in the NHS. Essential information on the CHI assessment framework and on support tools can be found at their website.
www.chi.nhs.uk
CHI Self assessment tools
www.chi.nhs.uk/eng/assessment/index.shtml

Department of Health Clinical Governance Reporting Process – essential information can be found at:
www.doh.gov.uk/clinicalgovernance/reportingprocess.htm

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 Clinical Governance Support Team – the CGST runs a series of programmes to support the implementation of clinical governance 'on the ground'.
www.cgsupport.org

National Primary Care Research and Development Centre – is a Department of Health funded centre for health services research and development in primary care. The Centre is leading research on the development of PCTs and includes the National Tracker Survey of PCGs and PCTs (now complete); National Database of PCGs and PCTs; and a number of focused studies including clinical governance and topics covered by this programme
www.npcrdc.man.ac.uk
Publications line: 0161 275 0611

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.

7.1 To what extent do the Board and PEC understand the performance measures which will be used by the SHA to evaluate the PCT's clinical governance performance?

7.2 To what extent do the Board and PEC actively review the CHI assessment criteria?

7.3 To what extent do the Board and PEC keep under active review the *Vision for the new Commission for Health Audit and Inspection*?

7.4 To what extent do the board and PEC understand the role of the local authority Overview and Scrutiny Committee?