The Strategic Leadership of Clinical Governance in PCTs

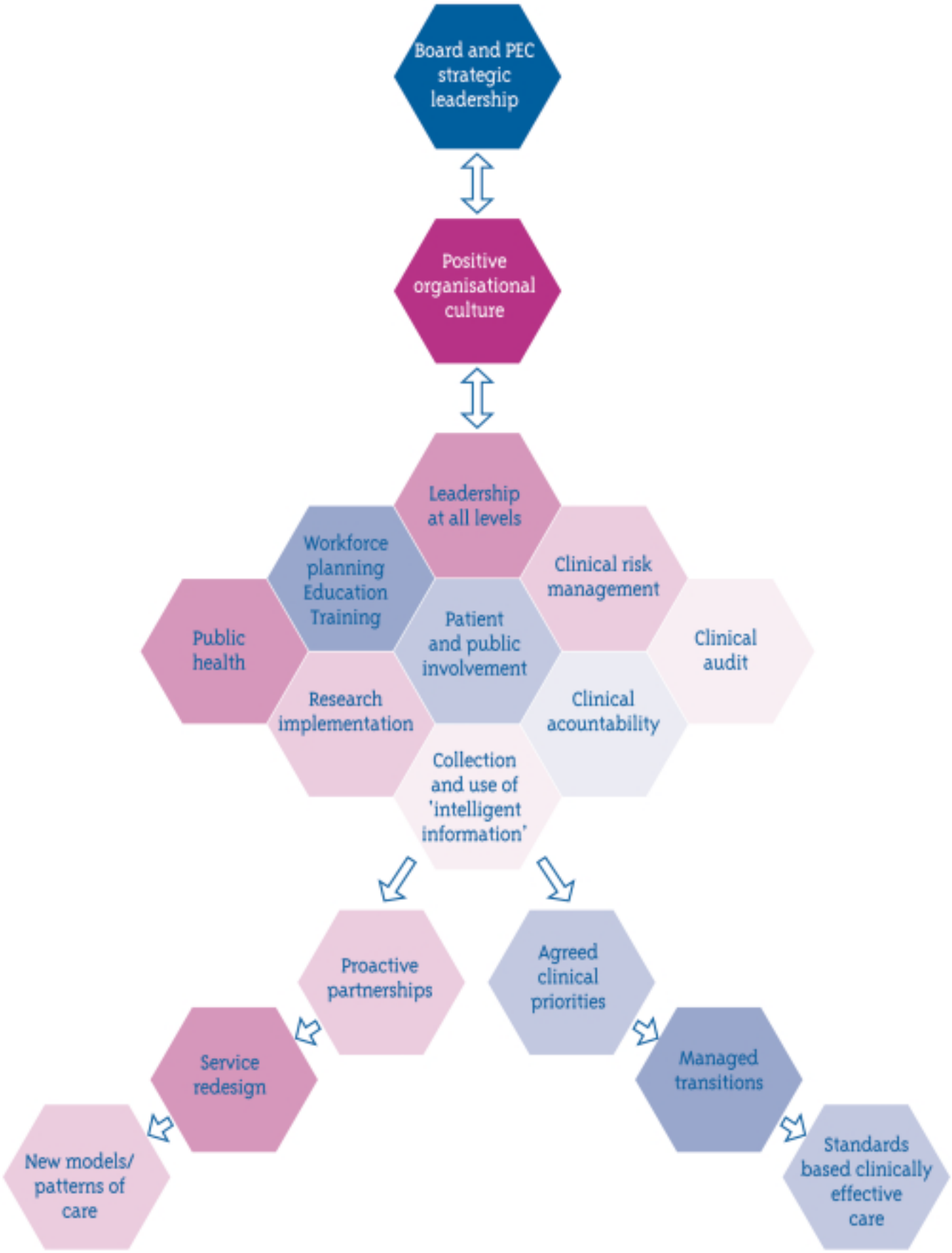
Executive summary

Second edition

NHS
Modernisation Agency
Clinical Governance Support Team

NHS
Modernisation Agency
National Primary and Care Trust
Development Programme

CLINICAL GOVERNANCE



CONTENTS

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, the Commission for Health Improvement (CHI/CHAI) and their newly created Patient Forums.

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?

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 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 programme 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.

In particular they now draw upon the experience of the 62 PCTs that took part in the first wave of the pilot programme. The learning from these PCTs is synopsised at the start of each of the sections in the Executive Summary and is explored fully in each of the the sections of the full resource materials.

The materials consist of:

- an Executive Summary which briefly outlines the topics covered in the resource materials, followed by a series of questions asking you to judge where you think 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 and in some cases checklists derived from dialogue with Boards and PECs that took part in the pilot programme
- a response sheet, for your answers to the questions, 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.

Board and PEC members can use the materials to:

- reflect on their understanding of their position in relation to key aspects of clinical governance
- 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, for CHI review (where this has not already taken place) and for the inspection and audit requirements of the new Commission for Health Audit and Inspection
- 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 discharging 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. 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.

Not least because of the rate of change in the primary care environment, each section 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
- corresponds to the section of the same number in the resource materials.

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 learning resource materials 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 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.

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.

SECTION TWO
CLINICAL GOVERNANCE: AN OVERVIEW

'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. *An Organisation with a Memory*. London: DH

A ten-year journey

Clinical governance is not an event. It is a ten-year journey to produce world-class, needs-led, seamless care for individual patients and for local communities.

In addition to establishing a corporate duty to assure the safety and the quality of existing services, clinical governance also establishes the underpinning principles that should drive the transformational agenda set out in *The NHS Plan*.

In order to maximise its impact, it needs to be understood within the overall context of the integrated governance of the PCT.

Translating vision into reality

Clinical governance cannot be 'bolted on' to the caring task; the values and the principles that it represents should be built into every aspect of it. It is the business of every individual in the health care community. Because of their pivotal role as commissioners and providers of care, PCTs have a unique responsibility for translating this vision of clinical governance into reality at the local level.

This can only occur if:

- systematic steps are taken to ensure that local communities, patients and carers play a full and active part in all aspects of the planning, delivery and evaluation of care
- understanding of, and commitment to, clinical governance is fostered across all of the professional and other staff groups that comprise a PCT community – and if this understanding and commitment is explicitly shared and owned by the Board and the PEC
- PCTs forge effective and creative partnerships within their local health (and social care) economies so that the patient journey is genuinely 'seamless'.

Key learning from the pilot programme

The members of the Boards and PECS who took part in the pilot programme believed that PCTs have made significant progress, within a short time frame, on the '10-year clinical governance journey'

All, however, recognise that much remains to be done to embed clinical governance systematically in all aspects of the services that the PCT provides and in all aspects of the services that they commission.

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

Overall PCTs recorded 5.5 on the progress scale (range 3.4 to 7.1) on this overview compared with 5.2 when their scores for the constituent elements of clinical governance were recombined and aggregated together.

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet 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 heir 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?

SECTION THREE

THE BOARD AND PEC ROLES IN PROVIDING STRATEGIC LEADERSHIP

'We must lead change as well as manage it. We need leadership in setting out the vision and working with and through people to achieve it.'

Nigel Crisp, Chief Executive Officer, NHS. 2002. *Managing for Excellence in the NHS.*

Duties of the PCT Board and PEC

Members of Boards and PECs of PCTs have a statutory duty to:

- assure the quality of the existing services that the PCT provides or commissions
- establish a clear direction of travel in relation to the transformational journey that is necessary to turn *The NHS Plan* into reality at local level.

Boards and PECs have a statutory duty to:

- work with, and on behalf of, their local communities
- provide clear and effective leadership to the staff community
- assure the quality of all that is done by the PCT or on its behalf.

Working harmoniously

Because of the unique separation of function between the Board and the PEC, within an over-arching corporate accountability, they must work harmoniously and effectively both singly and together – and due heed must be paid to the vital contribution of non-executive Board members.

The Board and PEC must consult regularly and must maintain an ongoing two-way flow of 'intelligent information' to ensure that they have:

- established a clear and realistic overall vision for the PCT in the light of financial as well as clinical considerations
- established achievable clinical governance priorities in relation both to quality assurance and to quality improvement
- put in place clear structures and processes for defining committee and individual responsibility and accountability for implementing and monitoring the actions necessary to turn strategic clinical governance priorities into concrete PCT-wide reality
- taken steps actively to foster a culture in which clinical excellence can flourish, and in which leadership is embedded in all locations, professional groups and teams
- kept progress under active scrutiny and review
- established effective partnerships with other key bodies in the local health and social care system.

Key learning from the pilot programme

Given the unique nature of their governance arrangements, the following are the key strategic leadership success factors for PCTs:

- the calibre of the 'three at the top' and the quality of their collaborative working
- the pro- active management of the Board/PEC interface, the investment of time in face to face discussions and debates and the on-going two way flow of intelligent information so that there is clarity and consensus about their respective roles and functions
- the extent to which the NED's role is understood and valued
- the clarity and transparency of clinical governance structures, roles and responsibilities
- the capacity and the calibre of a middle management tier that is able to operationalise existing strategies and to free senior executives to concentrate upon strategic development.

The section on the Board and PEC roles In Providing Strategic Leadership was the highest scoring of all of the sections with a score of 6 on the progress scale (range 4.5 to 7.3).

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying response sheet for you answers.

3.1	To what extent do the Board and PEC share and understanding of 'reasonable assurance'?
3.2	To what extent do the Board and PEC function effectively together?
3.3	To what extent is due weight given to the views of non-Executive Board members?
3.4	To what extent have the Board and PEC established clear clinical governance structures of operational delegation and accountability?
3.5	To what extent do the Board and PEC discharge their duty of care to the PCT community?
3.6	To what extent overall, does the PCT have effective leadership?

SECTION FOUR
FOSTERING OWNERSHIP OF CLINICAL GOVERNANCE

'Quality must be everybody's business.'

Department of Health. 2000. *An Organisation with a Memory*. London: DH

Clinical governance is everybody's responsibility

The term 'clinical governance' may seem to imply that it is the exclusive responsibility and preserve of clinical staff – but this is not the case. The actions of every member of staff within a PCT community make a significant and distinctive contribution to the overall quality of patient experience.

If this potential is to be realised, it is vital that all groups of staff are supported, respected and valued by the PCT. The Board and PEC have a vital role to play in fostering the development of a compassionate and just culture within the organisation.

Creating a common understanding of clinical governance

This culture must be based upon a clear and common understanding of what clinical governance is and implies. Even for many long-serving doctors and other healthcare professionals, the term clinical governance may be relatively unfamiliar – at least as it relates to their own actions and dealings with patients and the local community. This is likely to be even more true for administrative and support staff.

Not least because of the dispersed nature of the PCT staff community, common understanding cannot be assumed, but must be actively pursued by the PEC and the Board. Individuals and clinical teams must be supported and helped to embed clinical governance in their day-to-day practice.

If the local community itself – and individual patients – are to be full and active partners in their own care, it is important that the Board and PEC take steps to ensure that understanding of clinical governance is shared beyond the boundaries of the PCT itself, so that those who use the health service, as well as those that work within it (or with it) understand both the rights and the responsibilities that clinical governance implies.

Key learning from the pilot programme

When they completed the questionnaire in May/June 2003, – many PCTs still struggled to overcome the after shocks of merger, the complexity of their relationships with 'independent contractors' and the professionally and geographically dispersed nature of the staff community. Though some were taking systematic and persistent action to foster a sense of ownership of quality across all professional and other staff groups, a number had not developed robust strategies to address and resolve this key issue.

Across all the PCTs in the pilot programme the section on Fostering Ownership was scored at 5.3 on the progress scale (range 3.2 to 6.8).

A checklist developed during the pilot programme is given in the corresponding section of the full learning resource.

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

4.1 To what extent does the Board and PEC have an explicit strategy for embedding ownership of clinical governance across all sections of the PCT community?

4.2 To what extent do all members of the PCT community currently have a common understanding of clinical governance?

4.3 To what extent is there clear responsibility for leadership of clinical governance within all professional groups within the PCT?

4.4 To what extent does the current culture empower all staff to take initiatives aimed at quality improvement?

SECTION FIVE
THE PATIENT EXPERIENCE

'Users and their carers should have choice, voice and control over what happens to them at each step in their care.'

NHS. 2000. *The NHS Cancer Plan.* London: DH

The values underpinning clinical governance

The values of humanity, respect, justice, empowerment and partnership that underpin clinical governance should be reflected in every aspect of the patient experience. It is the quality of this experience that will lie at the heart of the concerns of the new Commission for Health Audit and Inspection.

So far as the services provided by the PCT itself are concerned, Boards and PECs must ensure that these values are given concrete expression so that all aspects of care are routinely timely, collaborative, effective, compassionate and empowering.

So far as the services that they commission are concerned, Boards and PECs must take all reasonable steps to ensure that these same principles characterise in-patient and other forms of provision.

Co-ordination and collaboration

Crucially, they must also seek to ensure that there is effective co-ordination and collaboration between the PCT and all of the different partners in the care process so that, from the perspective of the individual patient (and her/his informal carers), services are seamless and responsive to changing need.

The new Commission will place significant emphasis upon the quality of the total patient journey – not just upon the quality of the episode/s of care that occur within the boundary of any one health organisation.

At the same time Boards and PECs must give serious and sustained attention to the implications of the 'choice' agenda in order to ensure that they respond effectively to the challenge of making real and informed choice available to their patients.

Key learning from the pilot programme

In the face of the very real pressures that are attendant upon the creation of any new organisation – and in the light of the exponential increase in their overall duties and responsibilities – few PCT Boards and PECs in the sample had explicitly identified, measured and kept under active review the key determinants of the quality of the primary care patient experience.

All recognised the underlying importance of the issue – that it is indeed their core business. However, many felt that its importance was obscured rather than highlighted by many of the targets set for them – and that it received scant attention from some SHAs (though by no means all) when compared with financial concerns.

Finding robust and sensitive ways to track the quality of experience of the diverse primary care patient population demands imagination, creativity and persistent attention. Gathering robust 'intelligent information' about the patient experience and acting upon it must be a major priority for PCTs as they prepare for the new CHAI inspection regime.

Significantly across all the PCTs in the pilot programme the section on Patient Experience was the fourth lowest scoring at 4.6 on the progress scale (range 3.1 to 6.3). The highest recorded score was the third lowest for any section.

A checklist developed during the pilot programme is given in the corresponding section of the full learning resource.

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

You should also consider the checklist on the Patient Experience that is included at the end of this section in the Resource materials

5.1	To what extent has the Board and PEC identified key indicators of the quality of patient experience of PCT-delivered care?
5.2	To what extent is attention given within the commissioning process to the quality of the patient experience?
5.3	To what extent does the Board and PEC keep the overall co-ordination and 'seamlessness ' of patient care under active review?
5.4	To what extent are mechanisms in place to develop evidence about the overall quality of the patient experience?

SECTION SIX
PATIENT AND PUBLIC INVOLVEMENT

'*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. *Shifting the Balance of Power within the NHS: Securing Delivery*. London: DH

Partnerships with local communities and patient groups

Partnership is one of the key principles that underpins clinical governance. It is helpful to make a clear conceptual distinction between the strategies and actions that are needed to secure partnerships with local communities (and representative patient interest groups) and those that are needed to secure partnership with individual patients and their carers.

Proactive partnership with local communities and with patient groups is a distinctive feature at the macro-level of the identification of need, and of the planning, monitoring and evaluation of services.

More equal relationships with patients

At the micro-level of individual care, clinical governance implies a new and more equal relationship between professionals and patients and their informal care networks. In this relationship, patients are seen as active partners in (rather than passive recipients of) diagnosis, treatment and the evaluation of care.

Properly implemented, Section 11 implies far more than just mandatory forms and processes of consultation and dialogue. It demands a fundamental reappraisal by Boards, senior clinicians and all those who work in health, of the ways in which they understand their relationships with individual patients and with local communities.

Key learning from the pilot programme

PCTs in the pilot demonstrated a commitment to engage actively with patients and the wider community, but most had not yet developed the systems and processes to secure an effective local representative voice in all aspects of the planning, delivering and monitoring of their provided or commissioned services.

Across all the PCTs in the pilot programme the section on Patient and Public Involvement was scored at 5.3 on the progress scale (range 3.9 to 7.2).

A checklist developed during the pilot programme is given in the corresponding section of the full learning resource.

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

6.1 To what extent do the Board and PEC have a strategy for ensuring that the local communities become proactively involved in all aspects of the 'planning, delivery and evaluation of care'?

6.2 To what extent are the current arrangements to secure this level of community involvement effective?

6.3 To what extent do the Board and PEC have a strategy to ensure that patients and their carers develop 'choice, voice and control at every step in their treatment'? (NHS Cancer Plan)

6.4 To what extent are the current arrangements to secure this level of patient and carer involvement effective?

SECTION SEVEN
EXTERNAL SCRUTINY OF CLINICAL GOVERNANCE

'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. 2002. *Shifting the Balance of Power: The Next Steps.* London: DH

Accountability

Shifting the Balance of Power identified PCTs as the key bodies that will drive forward *The NHS Plan.* It placed upon them significant additional responsibilities and powers. To act as a check upon their discharge of these powers, it also established new forms and patterns of accountability both to Government and to local communities.

Just as Strategic Health Authorities are charged with bringing overall coherence to the regional health systems so, at the local level, PCTs are required to identify and co-ordinate the NHS response to need.

The Annual Clinical Governance Report

PCTs' overall fiscal and clinical performance is subject to the scrutiny and appraisal of the newly created Strategic Health Authorities. In relation to the discharge of their specific clinical governance duties and responsibilities, PCTs are required to report formally to SHAs through the Annual Clinical Governance Report on their progress in addressing the local priorities established in their Clinical Governance Development Plan.

Commission for Health Improvement (CHI)

Because SHAs also play a developmental role in supporting and guiding PCTs and the local health economy, PCTs are subject to periodic independent review by the Commission for Health Improvement (which focuses upon their clinical performance). A significant number of PCTs have already been subject to review – and valuable lessons can be learned by looking at the reviews that are published on their web site. If your PCT has not already been reviewed it is important to prepare systematically for the review process (and CHI provides helpful guidance on how to do this).

Commission for Health Audit and Inspection

With effect from April 2004, the new Commission for Health Audit and Inspection (CHAI) will assume responsibility for these and other key measurements of organisational performance. Their Chairman's 'Vision' has been published and sets important information for all NHSTs. The demands of the new inspection and audit regime should be kept under active review by PCT Boards and PECs.

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 SHA performance management criteria fail to reflect adequately the differential 'degree of difficulty' in embedding clinical governance that confronts individual PCTs and thus may produce arbitrary outcomes that devalue the results and the utility of measurement.

So far as PCTs themselves are concerned, most were:

- focused 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).

A checklist developed during the pilot programme is given in the corresponding section of the full learning resource.

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet 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 Oversight and Scrutiny Committee?

SECTION EIGHT
CO-ORDINATION AND ALIGNMENT

'Successfully implemented, clinical governance ensures that all the efforts of the organisation and those who work in it are focussed and co-ordinated to deliver high standards of care and service.'

Department of Health. 2001. *Building A Safer NHS for Patients.* London: DH

Inter connection and co-ordination

Clinical governance is a co-ordinating principle that should focus the energy and the activities of a health care community upon improvements in the quality of care – in the short term and at the micro-level, as well as in the long term and at the macro-level.

Many of the component elements of clinical governance have been established (to a greater or lesser extent) within health care organisations for a number of years. Often, however, initiatives such as Clinical Risk Management, Clinical Audit and Education and Training have existed in isolation. Important implications may have gone unrecognised and overall quality improvement has appeared to be less than the sum of the constituent parts.

Clinical governance emphasises that inter connections between the component elements are as important as the elements themselves.

Identifying clinical priorities

Not everything can be achieved at once. In organisations as complex, dispersed and diverse as PCTs, the principles of inter connection and co-ordination that clinical governance should foster could easily become no more than well-meaning but ineffective abstractions.

In the light of national priorities and in collaboration with their SHA and their partners in the local health economy, PCTs need to identify a manageable number of clinical priorities that will form the primary focus of their clinical governance implementation actions and energies – and those of their partner organisations.

Such an approach will bring coherence and concrete focus to the component elements of clinical governance and will provide a primary set of measurable targets against which quality improvement can be measured.

Key learning from the pilot programme

Although most PCTs believe that they understand the underlying principles of targeting, coordination and alignment that should underpin clinical governance, many had difficulty in pointing to concrete evidence that clinical governance initiatives had been purposefully targeted at local priority clinical conditions in order to generate improvements in the quality of the patient experience or of outcomes of care.

Most also found it difficult to generate robust evidence that the constituent elements of clinical governance had supported or informed each other – not least because many PCTs lacked professional and/or managerial expertise and/or capacity in relation to a number of the discrete 'technical components' of clinical governance – let alone their concrete integration and alignment.

Across all the PCTs in the pilot programme the section on Co-ordination and Alignment was scored at 5.5 on the progress scale (range 3.5 to 7.5).

A checklist developed during the pilot programme is given in the corresponding section of the full learning resource.

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

8.1 To what extent have the Board and PEC agreed key clinical priorities?

8.2 To what extent have these priorities been agreed across the local health economy?

8.3 To what extent are the component elements of clinical governance aligned with these clinical priorities?

8.4 To what extent is there concrete evidence of the improvements in the quality of care in relation to these priorities?

SECTION NINE
INTELLIGENT INFORMATION AND CLINICAL GOVERNANCE

'Healthcare is super-saturated with data. Few industries gather as much data as is gathered in health: the challenge is to turn it into information.'

Halligan, A. and Donaldson, L. 2001. 'Implementing Clinical Governance: Turning Vision into Reality (Education and Debate).' *British Medical Journal* vol. 322, no. 7298

The need for appropriate information

Boards need regular and timely access to what the new CHAI calls 'intelligent information' in order to discharge their governance duties safely and adequately.

PCTs, by the nature, the volume, the diversity and the complexity of the tasks that they perform, are awash with data, at least in relation to those services that they provide.

Transforming data into intelligent information

The key challenge is to manage the collection and aggregation of this data so that it can be systematically translated into robust, relevant and comprehensible information. Such information will enable the Board and PEC (and the individuals and committees that have been charged with specific responsibilities and duties) to:

- assure the safety and the quality of current provision
- make rational and appropriate judgements about developmental or transformational needs.

In collaboration with those organisations that provide acute and other forms of commissioned care on behalf of the PCT, the Board and PEC need to assure themselves that commissioning decisions have paid due regard to robust information and evidence of the quality of the care provided for their patient population.

Using new technology to improve the quality of information

Information management and new forms of technology have the potential to improve the quality of the information that reaches clinicians, managers and Boards whilst reducing the time currently spent on data collection and analysis. IM&T investment in health to date has not always delivered the promised improvement; the primary strategic responsibility for shaping a coherent strategy for common data collection and analysis across a health economy now rests with SHAs in the light of new national policy and guidance.

Whilst working alongside SHAs on this medium-term agenda, it is essential that PCTs do not view this as a justification for inaction in relation to their immediate information needs – and those of their patients and the communities they serve.

The best information must be extracted from current data that, because of its sensitive nature, must be handled in line with the highest standards of technical probity established by the Caldicott Committee.

Information must be used to:

- accurately identify need
- measure performance against key targets
- identify and then rectify problems
- measure progress
- plan for change.

Key learning from the pilot programme

Given the legacy of partial, uncoordinated and incompatible data systems that they have inherited, most PCTs are confronted by a significant challenge (and will require significant national and SHA leadership and support) if they are to generate and base their clinical and corporate actions upon the 'intelligent information' that will be sought by CHAI.

Equally importantly, given the unique and complex governance arrangements of PCTs, many need to develop 'smarter' ways of handling the information flow between the Board and the PEC (and within the boundary of each of these groups) in order to ensure the coherence, the alignment and the effective overall strategic leadership of the PCT.

Across all the PCTs in the pilot programme the section on Data, Information and IM&T was in the middle of the range of overall section scores scoring 5.1 on the progress scale (range 3.3 to 7.1).

Note: When the original pilot questions and materials were developed this section was called Data, Information and IM&T.

A checklist developed during the pilot programme is given in the corresponding section of the full learning resource.

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

9.1	To what extent do the Board and PEC have a strategy to develop 'intelligent information' systems?
9.2	To what extent is the information available to the Board and PEC sufficiently robust for them to discharge their public health functions in relation to the current and future needs of their communities?
9.3	To what extent is the information available to the Board and PEC sufficiently robust to assure the safety and quality of current provision made by the PCT?
9.4	To what extent is the information available to the Board and PEC sufficiently robust to assure the safety and quality of the services commissioned by the PCT?
9.5	To what extent is the PCT currently meeting the Caldicott Standards?
9.6	To what extent have strategies to generate 'intelligent information' been agreed across the local health economy?

SECTION TEN
RISK MANAGEMENT

'Strong leadership is needed in primary care to promote patient safety. It is unreasonable to expect front-line workers to take patient safety seriously until leaders do.'

Clinical Governance Bulletin, December 2001, vol. 2, no. 5

Managing risk

Risk is inherent in most forms of complex human and organisational interaction. Health care provision, by its nature, is concerned with the identification of, and engagement with, risk – both to individual patients, to communities and to the organisation itself. Risk cannot be eliminated, but it must be managed.

Controls assurance

In discharging their overall integrated governance responsibilities, Boards and PECS are required to ensure that they have in place systems of controls assurance that identify and minimise all of the risks to which an organisation, its users and its staff are exposed.

So far as clinical risks are concerned, Boards and PECS must take every reasonable step to ensure that:

- risks have been proactively identified and minimised
- all staff and service users have played a full and active part in this process.

They must pay particular attention to the needs and the risks confronting vulnerable or marginalised groups.

Learning from experience

Boards and PECS must ensure that their own organisational culture is one that promotes the identification of emergent clinical errors, serious untoward incidents and 'near misses' so that the PCT itself (and, through the new National Patient Safety Agency reporting mechanisms, the wider NHS community) learns from, and takes action to improve, systems, processes and procedures.

So far as commissioned services are concerned, they must, in collaboration with service providers, take all reasonable steps to assure themselves that these providers have in place their own robust risk management systems and safeguards. Where the PCT has concerns about the safety of commissioned services, the Board and PEC must take action upon them.

They must also take all reasonable steps to ensure that risks that occur at points of transition between care provided by the PCT and by other providers have been identified, and that they are effectively managed.

Key learning from the pilot programme

All PCTs rightly accord significant priority to to the mangement of risks but many are still reactive rather than pro-active in the identification, management and minimisation of clinical risks – not least in relation to dentistry, and optometry.

PCTs would welcome national action to raise the profile of risk in primary care and to foster greater understanding of the characteristic ways that evidence of safety can be generated and that clinical risk can be minimised, not least through engagement of patients and carers as active partners in the process.

Across all the PCTs in the pilot programme, the section on Clinical Risk Management was the third highest scoring at 5.7 on the progress scale (range 4 to 7.1).

A checklist developed during the pilot programme is given in the corresponding section of the full learning resource.

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

10.1 To what extent is there a strategy proactively to identify and minimize clinical risks to patients?

10.2 To what extent is particular attention paid to the risks confronting vulnerable or marginalized people?

10.3 To what extent is there a strategy proactively to identify and minimize risks to staff?

10.4 To what extent are patients and their carers actively involved in the identification and management of clinical risks?

10.5 To what extent are patient complaints systematically analysed to identify and eliminate risks?

10.6 To what extent does the PCT culture promote the identification of and learning from serious untoward incidents or near misses?

SECTION ELEVEN
CLINICAL ACCOUNTABILITY AND SUPPORT

'There must be clear and understood systems of responsibility and accountability: a culture of blame is no substitute for such systems.'

Bristol Royal Infirmary Inquiry. 2001. *Final Report*

Assuring quality and safety

Although professional self-regulation is a necessary support to the development of clinically governed care, it is not of itself sufficient to provide the degree of corporate assurance of quality and safety that is demanded by clinical governance. PCTs (and other NHSTs) must take active steps to support and strengthen mechanisms of professional self-regulation, and connect them appropriately to their organisational duty of quality and accountability.

Boards and PECs of PCTs are corporately accountable for:

- the standards of the clinical services provided by the PCT community
- taking all reasonable steps to assure the safety and quality of the services that they commission.

Boards and PECs need to make explicit the systems and processes that a PCT has in place to:

- monitor the quality of clinical practice
- provide professional and emotional support to staff whose work brings with it inescapable exposure to decision stress and to human suffering.

This requires PCTs to attend to issues of clinical and professional leadership and support as well as merely to performance-monitoring measures.

Supporting ALL professionals in the PCT community

Historically, the work of general practitioners has not been subjected to direct organisational scrutiny and accountability. The new GMS contract will help to address specifically the issue of quality and quality assurance. Similar assurance must be developed in relation to the work of all clinical staff employed directly by GP practices (including practice nurses) and other professional staff whose services are contracted with PCTs — not least those dentists, pharmacists and optometrists who have only recently joined the PCT community.

PCT-employed community-based nurses, health visitors and professions allied to medicine also need proactive support, leadership and transparent systems of clinical accountability. 'Clinical supervision' was first advocated for all nurses almost a decade ago, but its implementation has been haphazard and its relationship to organisational accountability unclear and unsatisfactory. Arrangements for monitoring and supporting health visitors have been equally patchy.

Monitoring performance

Even where good supervision practice had emerged, much of it has been difficult to sustain in the face of rapid changes in organisational boundaries and in employment status.

Boards and PECs of PCTs must satisfy themselves that they are putting systems and processes in place that:

i) monitor the standards of clinical care provided on their behalf, and
ii) support their staff to deliver safe and high quality care.

They must have in place clear, timely and transparent processes that identify (and differentiate between) safe, sub-optimal and unsafe performance. They must ensure that appropriate steps are taken to deal with each and every instance of unsafe practice that is identified.

Boards and PECs must also assure themselves that all reasonable steps have been taken to ensure that staff of organisations providing services to their patients are accountable for their practice and that their practice is appropriately monitored and supported. In doing so they can give a lead to the entire health care community.

Boards and PECs need to keep under active review compliance with DH accountability requirements arising from the Bristol Royal Infirmary, Victoria Climbié and (as yet unpublished) Shipman Inquiries.

Key learning from the pilot programme

Most PCTs recognised that few formal accountability and support structures or processes are currently in place in relation to independent contractors and that, at best, the situation is variable so far as community nurses, health visitors and AHPs are concerned.

Very few, however, had concrete strategies or action plans to address this fundamental deficit, although many recognised that the new GMS contract provides a major opportunity to define 'quality led' accountability and support needs and to implement processes whose underlying principles could then be adapted for all other professional groups.

Across all the PCTs in the pilot programme the section on Clinical Accountability and Support was scored at 5 on the progress scale (range 3.6 to 6.5).

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

11.1 To what extent has PCT's put in place clinical accountability and support arrangements for GPs in the constituent practices?

11.2 To what extent has the PCT put in place clinical accountability and support arrangements in relation to community nurses, health visitors and other health professionals?

11.3 To what extent has the PCT put in place clinical accountability and support arrangements in relation to community dentists, pharmacists and optometrists?

11.4 To what extent does the PCT have a strategy for maximizing 'quality gains' through the new GMS contract arrangements?

SECTION TWELVE
CLINICAL AUDIT

'The process of clinical audit...should be at the core of a system of local monitoring of performance.'

Department of Health. 2001. *Learning from Bristol* (Recommendation 143). London: DH

Evidence of quality, standards and improvements

Clinical audit is a key component of clinical governance since (properly conducted) it provides vital local evidence of:

- the quality of practice
- compliance with agreed national or local standards or protocols
- the need for improvement and change – in the behaviour of systems as well as of teams and individuals.

Identifying priorities and developing inclusive systems

Because properly conducted clinical audit cycles demand the investment of time and energy and because there is so much that could potentially be subjected to the scrutiny of audit, it is essential that PCTs focus upon national audit priorities and those that derive from their own clinical governance priorities.

It is also essential to develop systems to ensure that audit processes:

- are informed by new national guidance
- are genuinely inclusive and multi-professional
- are shaped and informed by the views and perspectives of patients themselves
- lead to appropriate remedial or improvement action
- feed into the setting of education and development priorities
- generate 'intelligent information' of clinical effectiveness.

Mapping the patient journey

Wherever possible, audit should map and measure the complex reality of the patient journey – not focus merely upon isolated episodes or instances of care – or only upon those elements of care that are delivered by the PCT itself. This is likely to demand active collaboration with health (and other) organisations that provide care to the PCT's patient population.

Completing the audit cycle

Crucially, Boards and PECs must satisfy themselves not only that audit does take place, but that action then follows to address all the issues, shortcomings and opportunities for improvement that may be revealed. In other words, they must ensure that systems and processes are in place to ensure that the audit cycle is carried through to completion.

Similarly, Boards and PECs must take all reasonable steps in their commissioning arrangements to ensure that:

- similar good practice is followed by those organisations that provide services to their patients
- they build key audit activities into their commissioning requirements
- they, or their delegated sub-committees or nominated individuals, see the results of audits undertaken by their commissioned providers (where appropriate) and the actions that follow from them.

Key learning from the pilot programme

For PCTs, clinical audit is currently the most challenging of the 'technical components' of clinical governance.

The new national framework on clinical audit will provide an opportunity to offer implementation guidance and support to help all PCTs to focus their audit activities upon clinical priority topics; to secure multi disciplinary engagement with clinical audit and; to use audit as a lever for co-ordinated improvement in the quality of the overall patient journey via collaborative audit across organisational and system boundaries.

Across all the PCTs in the pilot programme the section on Clinical Audit proved to be the most challenging scoring only 4.0 on the progress scale (range 2.5 to 5.8).

A checklist developed during the pilot programme is given in the corresponding section of the full learning resource.

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

12.1 To what extent does the PCT have an explicit clinical audit strategy derived from local and national clinical priorities?

12.2 To what extent are all professional staff groups involved in multi-professional audit activity?

12.3 To what extent does any PCT-led activity audit the complete patient journey?

12.4 To what extent is there evidence of change as a result of clinical audit outcomes?

SECTION THIRTEEN
EDUCATION AND TRAINING

'Education, training and continuing personal and professional development does not reflect clinical governance priorities or draw on other clinical governance components such as audit, complaints and patient surveys, or staff surveys in some organisation … education and training, which causes relatively little concern in the most common type of organisation, the acute trust, causes most concern to CHI in all other types of organisation.'

CHI. 2002. *Emerging Themes* (December)

Investing in staff – the most valuable resource

Staff are the most costly and the most precious resource within primary care. In a rapidly changing clinical and technological environment, it has increasingly been recognised by all professional bodies that the foundation laid by basic professional education, however firm, needs to be reinforced and strengthened by regular and systematic updating throughout a professional career.

Workforce Development Confederations and the University for the NHS

The NHS has always invested heavily in education and training. Much of this resource has historically targeted doctors and nurses employed within the acute sector. Almost all of it has been targeted at the learning of individuals rather than at the behaviour of teams or systems of care. Very little of it has been formally evaluated to determine its impact upon improved standards and outcomes of patient care.

Workforce Development Confederations (WDCs), that are now located within SHAs, have been established to help NHS Trusts co-ordinate investment in training and target it at national and local workforce and service development priorities. In this endeavour they will be helped by the University for the NHS, which has been established in order to promote best practice and to facilitate the development of new models and styles of professional learning.

Promoting a culture of learning

Boards and PECs of PCTs must map the competences and the development needs of all their staff groups and develop a flexible workforce that is fit for a constantly evolving purpose. They need to ensure that the organisation develops systematic methods of identifying the training needs that derive from their agreed clinical governance priorities. They will also want to identify those that are uncovered through other elements of clinical governance such as audit, clinical risk management or clinical effectiveness activities.

Boards and PECs need to develop an organisational culture that fosters and promotes learning – in and through practice itself as well as from formal training 'events' – and one that is sensitive and responsive to the training needs identified through DH requirements as a result of emergent enquiries such as Climbié, Shipman, etc.

Developing a workforce that is 'fit for purpose'

The Board and PEC need to keep under active review the investment that the PCT makes in training and development, and the extent to which formal and informal training activities actually target and impact positively upon the patient experience and outcomes of care – and upon staff satisfaction and retention. Wherever possible (and appropriate), the Board and PEC should ensure that patients and local communities:

- have an active voice in shaping the training agenda
- participate both as trainers and as co-learners.

In terms of their commissioning activities, they need to take all reasonable steps to satisfy themselves that the workforces of organisations that deliver care to their patients are appropriately trained and fit for purpose.

Key learning from the pilot programme

Very few PCTs within the pilot sample had developed a comprehensive education and training strategy that proceeded explicitly from their current clinical and corporate priorities.

In most cases education and training activities derive from historical precedent and are often unsupported by robust evidence of impact upon standards of care or the quality of the patient experience.

Given both the above-the-line cost of NHS training spend with Universities and other training providers and the opportunity cost of the down time that staff spend in off-the-job training, conferences, etc., it is essential that the NHS is able to demonstrate robust evidence that this investment represents 'best value' for local communities and for patients

PCTs need to work together with WDCs, the University for the NHS and the Modernisation Agency systematically to address and resolve these long-standing issues and to develop national guidance that will enable all PCTs to make more rational and informed decisions about their investment in effective education and training.

Across all of the PCTs in the pilot programme, the section on Education and Training was the third lowest scoring at 4.5 on the progress scale (range 2.8 to 6.5).

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

13.1 To what extent is there a comprehensive education and training strategy derived from an anlysis of the 'fitness for purpose' of the PCT 's workforce?

13.2 To what extent does the education and training strategy consider the needs of all clinical staff?

13.3 To what extent does the education and training strategy consider the needs of managerial and administrative staff?

13.4 To what extent is there robust evidence of improvement in patient experience or outcomes as a result of education and training investment?

SECTION FOURTEEN

RESEARCH GOVERNANCE AND RESEARCH IMPLEMENTATION

'Proper governance of research is therefore essential to ensure that the public can have confidence in, and benefit from, quality research in health and social care. The public has a right to expect high scientific, ethical and financial standards, transparent decision-making processes, clear allocation of responsibilities and robust monitoring arrangements.'

Department of Health, 2001

Ensuring high standards

Like all NHS Trusts, PCTs are now required to have in place a comprehensive research governance strategy and policies to ensure that all members of staff engaged in any form of research that involves patients of the PCT comply with the highest standards of clinical research and of patient information and safety.

Fostering, monitoring and implementing research

In addition to keeping this framework under active review, Boards and PECS need to ensure that the culture of the PCT is research-aware and, wherever appropriate, research-active. Strategies and actions need to be initiated that foster and monitor the implementation of current research findings in clinical practice – across all professional groups within the PCT community. Particular and explicit attention needs to be paid to the implementation of NSF-led research findings and NICE Guidance.

So far as their commissioning responsibilities are concerned, the Board and PEC need to take all reasonable steps to ensure that organisations providing care to their patients:

- have in place appropriate research governance policies
- actively promote and monitor the uptake of research in practice.

Key learning from the pilot programme

Research Governance had not, at the time of the pilot programme, received the systematic attention from many PCTs that it demands.

Equally, although all PCTs recognise the importance of ensuring that practice is based upon the best available research, even those that have systems in place to maximise access to clinical research have few mechanisms to effectively monitor its systematic impact upon and implementation in practice.

The majority of the PCTs in the pilot programme found the issue of Research Governance and Research Implementation challenging, scoring 4.3 on the progress scale (range 2 to 6.2) – and after Clinical Audit the most problematic of the 'technical components' of clinical governance.

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

14.1 To what extent do the Board and PEC understand their Research Governance duties and responsibilities?

14.2 To what extent are systems and protocols in place that ensure that these duties and responsibilities are implemented in practice?

14.3 To what extent is there a strategy to monitor the implementation of research into practice across the PCT community?

14.4 To what extent do the Board and PEC monitor the implementation of NICE guidance?

SECTION FIFTEEN
CLINICAL EFFECTIVENESS

'Improving care of patients with coronary heart disease (CHD) is based around clinical evidence on the effectiveness of medication and best practice in delivering care.'

National Primary Care Development Team. 2002. *The National Primary Care Collaborative: The First Two Years.* Manchester: NPCDT

What is clinically effective care?

Clinical effectiveness is an essential component of clinically governed care and is, to some extent, a product of clinical governance in action.

In clinically effective care:

- patients are active partners in the care process
- that process is characterised by humanity and by compassion
- clinical risks are identified, managed and minimised
- the outcomes of research and of training are routinely implemented
- there are routinely high levels of concordance with treatment
- efficacy is justly and transparently balanced against cost.

Clinical effectiveness should be a key topic for investigation through clinical audit – and the clinical effectiveness agenda is most likely to achieve clarity and impact when it is focussed upon the PCT's explicitly agreed clinical priority topics. Exemplary evidence of this is provided by the success achieved by the Primary Care Collaboratives in addressing secondary prevention in relation to coronary heart disease.

Clinical effectiveness is also a significant contributor to the most prudent and just use of financial and other forms of scarce resource. Such judgements need to take into account the total costs that are likely to fall upon the public purse – rather than merely considering those costs that have an impact within the boundary of the PCT's own budget.

Managing knowledge and promoting a culture of learning

Due to the diverse and geographically dispersed nature of primary care, active systems of professional knowledge management must be developed. Such systems enable 'intelligent information' to underpin clinical decision making.

Boards and PECs have a clear duty to foster a culture where:

- clinical effectiveness challenges clinical habits
- lessons are learned and shared both within the boundary of the PCT and across the care network.

Boards and PECs have commissioning responsibilities for the care that other organisations deliver to their patients. They must ensure that care is clinically effective as well as cost-effective.

Key learning from the pilot programme

Whilst recognising unequivocally its crucial importance, most PCTs struggle to identify concrete evidence of the clinical effectiveness of the care that they provide or of the care that they commission.

The tracking of the efficacy and outcomes of treatment in primary care and across the patient journey is notoriously more difficult than the task of measuring the efficacy of a single episode of acute care. To derive 'intelligent information' about effectiveness, whether at the level of the PCT or of a constituent practice, from a plethora of data and over a meaningful time period represents a major challenge to the health care community, and to those who seek to measure its performance.

Overall, PCTs would welcome national guidance on the promotion and measurement of clinical effectiveness.

Significantly, across all the PCTs in the pilot programme, the section on Clinical Effectiveness was the fourth lowest scoring at 4.6 on the progress scale (range 3.0 to 6.8).

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

15.1 To what extent is there a strategy to develop evidence about the clinical effectiveness of PCT-delivered care?

15.2 To what extent is the effectiveness of clinical care routinely monitored and compared to national standards?

15.3 To what extent does the PCT have explicit processes for balancing the cost of treatment against its evidenced efficacy?

15.4 To what extent is attention paid to issues of concordance with treatment as well as to appropriate diagnosis and prescription?

SECTION SIXTEEN
STAFFING AND STAFF MANAGEMENT

'Modern health services require modern employment practices that:

- accept a joint responsibility with staff to develop a range of working arrangements that balance the needs of patients and services
- value and support staff according to the contribution they make to patient care and meeting the needs of the service
- provide personal and professional development and training opportunities that are accessible and open to all staff irrespective of their working patterns
- have a range of policies and practices that enable staff to manage a healthy balance between work and their commitments outside work.'

National Audit Office. 2002. *Improving Working Lives*

Powers, responsibilities and a diverse workforce

As a result of *Shifting the Balance of Power*, PCTs have acquired a broad swathe of powers and responsibilities. Many PCTs are the result of mergers of previously separate (and recently formed) PCGs, which are themselves the products of the unions of historically separate and unique GP practices.

In many cases, the PCT's professional workforce has grown dramatically through the absorption of community-based nurses, health visitors and other professional staff – as well as through the recent extension of the PCT community to embrace dentists, pharmacists and optometrists.

Auditing demand and capacity within the workforce

The inherited management (and administrative) infrastructure has not always been sufficient to cope effectively with the expansion of PCT duties and responsibilities and with the resultant and coincident demands of:

- complex financial management
- new HR and public health functions
- an enhanced range of service provision
- commissioning responsibilities

If the Boards and PECs of PCTs are to discharge their clinical and broader integrated governance responsibilities adequately and safely, they need the support of an effective and sufficient management and administrative infrastructure which, like the clinical workforce, needs to be fit for purpose.

In the light of the overall organisational vision and of their identified clinical and other priorities, PCT Boards and PECs need to have undertaken a fundamental audit of the scale, nature and skill mix of their overall workforce to determine to what extent it is currently 'fit for purpose'. This will enable them to target recruitment, education and training, and organisational development efforts at identified quantitative or qualitative deficits – whether in their clinical, administrative or management staff groups. Ideally this process should be done in collaboration with:

- internal partners such as trades unions and local professional bodies
- external partners such as the SHA and the WDC.

Improving Working Lives

Alongside attention to skill mix, Boards and PECs also need to give explicit attention to fostering within the staff group a sense of belonging and of common identity.

As a further facet of building a sustainable learning-focussed, facilitative and positive culture, they will also need to be proactive and imaginative in their response to the Improving Working Lives initiative – and apply this to their own executive team as well as to the wider staff community.

Building flexible capacity

Finally, in the light of the fundamental changes and development in provision that will be necessary to deliver the needs-led, patient-centred care demanded by *The NHS Plan*, PCT Boards and PECs need to pay sustained attention to the development of flexible and adaptive capacity – within the workforce as a whole and in relation to their own strategic leadership performance.

Key learning from the pilot programme

Although most PCTs express general satisfaction with the capability of their staff groups – and have paid significant and serious attention to Improving Working Lives initiatives (for all but their own senior managers) – few of them have undertaken a systematic analysis to map their inherited staff groups' capacity and competence against their current, and future, core clinical and business priorities.

Many, therefore, lack a comprehensive and robust staff recruitment, retention and development strategy.

All, however, recognise both the opportunity and the challenge presented by the nGMS

Across all the PCTs in the pilot programme the section on Staffing and Staff Management was the third highest scoring at 5.5 on the progress scale (range 3.9 to 7.5).

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

16.1 To what extent has the PCT undertaken a detailed analysis of the skill mix of all staff groups to assess their 'fitness for purpose '?

16.2 To what extent does the skill mix match the PCT's overall responsibilities?

16.3 To what extent is the management and administrative infrastructure sufficiently robust to ensure that strategies can be translated into reality?

16.4 To what extent do the Board and PEC keep their own development needs under active review?

SECTION SEVENTEEN

CLINICAL GOVERNANCE AND THE PCT'S PUBLIC HEALTH FUNCTION

'Better population health is the sum of better health of individuals, but needs more than individuals' action to achieve it.'

Donaldson, L. 2001. *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function*, London: DH

Determinants of health and the responsibilities of the PCT

It is widely recognised that there are four key determinants of the overall 'health' of any given population. These are:

- Population Life Circumstances (including economic, environmental and 'quality of life' factors)
- Population Lifestyles (including diet, patterns of exercise, habitual dependence, etc.)
- Population Genetic Endowment
- The availability and quality of NHS (and other health and social care) provision.

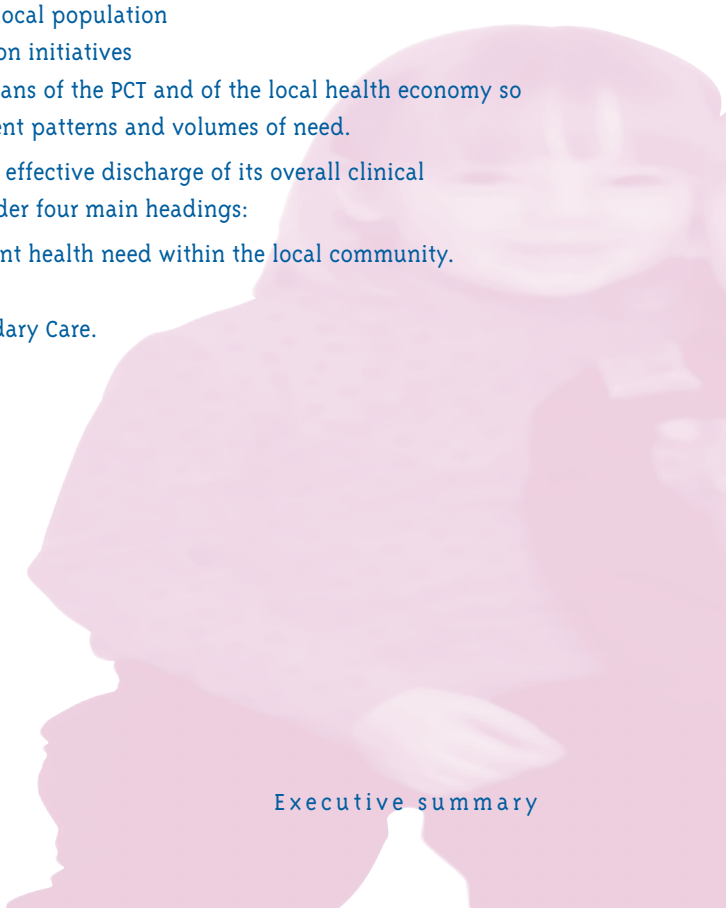
In addition, the complex interplay of life circumstances and lifestyles combine to produce a fifth key variable: namely, damagingly high and sustained levels of stress.

Since the abolition of Regional Health Authorities, PCTs have assumed a wide range of responsibilities in relation to Public Health and have a pivotal role to play in:

- identifying the evidence-based health needs of their local population
- co-ordinating health promotion and disease prevention initiatives
- helping to shape the commissioning strategies and plans of the PCT and of the local health economy so that they correspond optimally to current and emergent patterns and volumes of need.

These Public Health responsibilities are central to a PCT's effective discharge of its overall clinical governance duties and they characteristically cluster under four main headings:

1 Defining the nature and extent of current and emergent health need within the local community.
2 Promoting Local Health Improvement.
3 Developing Local Primary Care/Commissioning Secondary Care.
4 Developing Local Public Health Capacity.



Carrying out public health functions

If they are to carry out these wide-ranging and demanding functions effectively it is essential that:

- Boards and PECs understand and give a lead to the PCT community concerning the centrality and importance of the public health task, and recognise the impact of inequality upon sections of their patient population and the local community
- there is clear, confident and authoritative leadership of the public health agenda
- ownership and understanding of, and commitment to, public health is shared across all of the professional, managerial and support staff of the PCT
- the workforce are equipped with the requisite competences (the values, the knowledge and the skills) that are needed to enable them to discharge their public health functions.

PCTs will be supported in the discharge of their Public Health functions by the Regional Directors of Public Health (RDPH) and by the Health Protection Agency (HPA) and performance managed by the SHA.

Key learning from the pilot programme

Many PCTs have made commendable progress in establishing effective leadership of the public health agenda.

In some PCTs, serious attention is now being paid to overall determinants of health as well as to the management of illness and disease. In those that have made the most progress, public health perspectives are beginning strongly to influence and (potentially) to shape:

- the scale
- the nature, and
- the location

of the services that PCTs provide as well as those that they commission.

Only in this way will transformation be led by the evidenced needs of local communities.

Despite the fact that PCTs have only recently assumed responsibility for public health, across all the PCTs in the pilot programme the section on public health was the second highest, scoring at 5.8 on the progress scale (range 3.8 to 7.2).

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

17.1 To what extent do the Board and PEC have a clear and shared understanding of the PCT 's public health duties and responsibilities?

17.2 To what extent is there clear, effective and authoritative leadership within the PCT of the public health agenda?

17.3 To what extent is the nature and location of care provided by the PCT shaped and informed by public health-led understandings of local need?

17.4 To what extent is the commissioning process informed and shaped by public health-led understandings of local need?

SECTION EIGHTEEN

CLINICAL GOVERNANCE AND THE SERVICES COMMISSIONED BY THE PCT

'The fundamental mission of PCTs should be to redesign care so that it is more appropriate and cost-effective. It is imperative to their continued existence that they should succeed in doing so and therefore imperative that they should rapidly create the commissioning relationships that will allow this to happen.'

Department of Health. 2003. *NHS Alliance National Survey: 'What is the State of Commissioning in Primary Care Trusts?'* London: DH

The responsibilities of commissioning

The statutory duty of quality and the demands of clinical governance placed upon the Boards and PECs of PCTs extends to the services they commission on behalf of their patient population from outside the PCT community – as well as to those provided by the PCT.

For PCTs, commissioning represents a significant set of responsibilities and functions. This is particularly true for those PCTs that also take on lead specialist commissioning responsibilities on behalf of others in their local health economies (and sometimes beyond) – and for those that will be contracting with newly-formed Foundation Trusts.

Monitoring the quality of commissioned services

PCTs must:

- ensure that the local community has an active voice in setting the commissioning agenda
- ensure that their clinical staff groups have an active voice in shaping (and monitoring) this agenda
- ensure that the contracts with acute and other commissioned providers of care make explicit reference to clinical quality and the component elements of clinical governance
- explicitly address issues of patient transition and the management of the interface between commissioned services and their own
- take all reasonable steps to monitor the actual quality and safety of the services that their patients receive
- take effective action where significant shortcomings are uncovered.

They may seek ways of measuring independently the views of a proportion of members of their patient population who have direct experience of commissioned services, to act as a point of triangulation against the quality data provided by providers of care themselves.

Commissioning for transformation – making patient-centred, needs-led, flexible care a reality

While attending to immediate and short-term concerns about safety and quality, PCTs are also charged with developing strategies to transform local patterns and forms of provision. The vision set out in *The NHS Plan* of needs-led and flexible, patient-centred care will only become a reality at local level if the Boards and PECs of PCTs pay sustained attention to this longer term agenda..

The relationship between the PCT and its provider network therefore needs to be understood as more than an arms-length contracting one. As the commissioners of services, PCTs have to be conscious of the leverage that they can exercise, both for change and for improvement, and they must be prepared to invest in prioritised and targeted medium-term quality improvements in the provider network in order to secure sustainable and high quality provision within their local health economy. Imaginatively constructed, Long Term Service Agreements can give concrete expression to these aspirations.

It is also vital that all PCTs (not only those that have 'first wave' Foundation Trusts within their local health economy) are attentive to the additional demands of contracting with emergent Foundation Trusts.

Key learning from the pilot programme

A significant number of PCTs had failed, hitherto, to recognise that their clinical governance duties and responsibilities extend to those services that they commission, as well as services they provide.

In these cases, as in many others, commissioning continues to be driven primarily by concerns with cost and volume to the exclusion of quality, 'best value', and longer-term service improvement considerations.

Many PCTs do not believe that, notwithstanding their potential commissioning leverage, they are able to exercise significant influence within local health economies that continue to be driven by the financial and other demands of acute care providers.

In addition, many PCTs lack the breadth and depth of expertise in commissioning for quality that would enable them to make the best use of the leverage that they do have. All would welcome support and guidance in developing their ability to commission for quality

For all the PCTs in the pilot programme, the section on Commissioning was predictably challenging scoring only 4.75 on the progress scale (range 3.5 to 6.8).

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

18.1 To what extent do the Board and PEC take 'all reasonable care' to assure the quality of the services commissioned by the PCT?

18.2 To what extent do the Board and PEC understand the relationship between their clinical governance duties and responsibilities and those of the organizations from which they commission care?

18.3 To what extent are the PEC and the clinical governance committee actively engaged with the commissioning process?

18.4 To what extent are local communities actively engaged with the commissioning process?

18.5 To what extent does the commissioning process promote the delivery of seamless care?

18.6 To what extent does the PCT's commissioning strategy promote transformation to the models and patterns of care necessary to achieve *The NHS Plan*.

SECTION NINETEEN

INTER-ORGANISATIONAL ELEMENTS OF CLINICAL GOVERNANCE

'We must plan together across NHS organisations and with local authorities to pool our resources and plan services together wherever possible; look at new options for delivering services... challenge ourselves and each other to be creative and bold, just doing more of the same won't deliver.'

Crisp, N. (NHS CEO). 2002. *NHS and Social Care Bulletin* No. 24

'Improving the patient experience as a whole is clearly a much bigger challenge than managing the institutions or departments that provide the care'.

Department of Health. 2002. *Managing for Excellence in the NHS.* London: DH

Realising the vision of seamless care

Clinical governance is about more than assuring the quality of individual caring transactions, or episodes of care. It is the primary means of turning into reality the vision of flexible, needs-led and seamless care and of securing the quality of the overall patient journey – one of the three key foci for the audit and inspection processes of the new CHAI.

By its nature, high quality and seamless care demands collaboration and integration between the different organisations that make up a local health (and social care) economy. Clinical governance and the duty of quality provide the value base, the principles and the technical components that should shape and inform the way that all of these organisations work collaboratively together in the overall interests of patients and of local communities. However, for clinical governance to be truly effective, new forms of partnership-based governance need to be developed that bring clarity of leadership, responsibility and accountability to patterns of care (such as the NSFs and the Cancer Care Networks) that are not constrained by organisational boundaries.

Integrating and co-ordinating patient care

Weaknesses in any system of care are most likely to be experienced, from the patient perspective, at points of transition. These typically occur:

- across the interfaces within a health care organisation
- at the boundaries between one health care organisation and another
- at the frontiers that currently divide health from social care and voluntary sector provision.

Minimising risks at these points of transition and smoothing the flow of care so that the patient experiences an integrated and co-ordinated whole is a critical issue that needs to be managed through networks and partnerships of care.

Managing transitions

Because of their dual provider and commissioner roles, PCTs have particular responsibility and opportunities for monitoring and managing the impact of transitions in the current treatment journeys made by their patients. New and more seamless forms of care need to emerge through the development of integrated information management systems and the generation of collaborative integrated care pathways or protocols.

Responding to need

PCTs are uniquely placed to work with and through their local communities to develop innovative patterns and forms of care (within the local health and social care economy) that are more accessible and responsive to need than are many historically derived and inherently fragmented existing forms of provision.

Key learning from the pilot programme

All PCTs in the pilot demonstrated a consensual willingness common to Boards and PECs to work collaboratively with local partners.

Most PCTs recognised that co-ordination and alignment of the services within a health (and social care) economy is a fundamental building block in the overall quality of the patient experience.

However, in view of the many competing short-term financial and target-driven pressures upon them, many were still to explore and exploit the longer-term opportunities proceeding from the Health Act flexibilities and from their commissioning responsibilities and leverage.

The section on Inter-organisational Clinical Governance was scored in the middle of the section averages at 5.2 on the progress scale (range 3.8 to 7.0).

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

19.1 To what extent does the PCT have a strategy for developing its partnerships with all local stakeholders?

19.2 To what extent has the Board and PEC critically appraised the appropriateness and sustainability of inherited patterns of provision within the local health and social care economy?

19.3 To what extent does the PCT actively and imaginatively promote the creation of Integrated Care Pathways?

19.4 How effective are partnership arrangements with the local social care and voluntary sector communities?

SECTION TWENTY
ADDITIONAL PCT RESPONSIBILITIES

'PCTs will have responsibility for the management, development and integration of all primary care services (medical, dental, pharmaceutical and optical).'

Department of Health. 2001. *Shifting the Balance of Power within the NHS: Securing delivery.* DH: London

Integrating new responsibilities

PCTs have recently assumed additional responsibilities in relation to community dentistry, pharmacy and optometry. These pose, in the short term, significant additional clinical governance challenges to the Boards and PECs. In the fullness of time, all of these responsibilities need to become an integral part of the mainstream core responsibilities and functions of PCTs.

No matter how well developed existing clinical governance strategies, structures and action plans are, they will need to be fundamentally reconsidered in order to ensure that they adequately address – at the level of concrete patient reality – these new forms and types of responsibility.

Analysing clinical governance strategies

Boards and PECs need to consider the overall appropriateness and adequacy of clinical governance strategies. They also need to assure themselves that the component elements of clinical governance (clinical risk management, clinical audit, etc.) have been critically appraised to ensure that they routinely embrace and address the needs of patients served by, and of the professional staff working in, dental, pharmaceutical and optometry services.

In order to undertake this analysis adequately – and to plan timely and appropriate actions in the light of its outcomes, Boards and PECs need to ensure that they have within their ranks appropriate expertise and professional representation.

Key learning from the pilot programme

The assumption of responsibility for prison-based health provision has been met with pro-active imagination in some cases, though in others it is a cause of considerable and persisting concern.

Most PCTs also struggled to make concerted headway in incorporating pharmacists (and especially), dentists and optometrists into their professional community.

There were, however, a number of notable exceptions where dentists and pharmacists in particular now function as fully integrated members of the PCT professional communities. Examples of this degree of integration of optometrists were, at the time of the pilot activity, harder to identify.

Not least because of the high volume and invasive nature of general dental practice, with all of the attendant risks of communicable infection, most PCTs expressed particular conerns about the management of risks associated with these activities.

While recognising that community pharmacy might pose at least equal risks, most PCTs felt that their existing or newly-formed links were more securely based. However, a number expressed concern about the difficulties associated with verifying the professional credentials of locum pharmacists.

All PCTs would welcome the active support of the respective professional lead bodies in developing strategies to secure engagement and effective collaborative working, though some were still resistant to extending to these groups the opportunity for representation on the PEC and/or CG committees.

Across all of the PCTs in the pilot programme, the section on Additional Responsibilites scored 4.8 on the progress scale (range 3.1 to 7.0).

Note: In the original version this section also included issues in relation to 'Emergency Planning' but these have been, for the most part, mainstreamed by PCTs and are not now considered.

PCT Boards and PECs need to consider the questions below and take appropriate action. Please use the accompanying Response Sheet for your answers.

20.1 To what extent does the PCT have a strategy for integrating dentists, pharmacists and optometrists into the PCT community?

20.2 To what extent is there a strategy to explain to the local community the fact that the PCT now has responsibility for the quality of these services?

20.3 To what extent is there clear and effective professional leadership for all of these groups?

20.4 How adequately are these groups represented within the existing PEC and Board structures?

Acknowledgements

These materials are the result of the efforts of many people

Written by: Paul Stanton, National Clinical Governance Support Team

Edited and project managed by: Pilgrim Projects Limited, Cambridge and Jill Rogers Associates, Cambridge

Designed and laid out by: Design Study, Mundford, Norfolk

Printed by: Print in Touch Limited, Bury St Edmunds

Marion Hay has organised the piloting process and has kept things running smoothly.

The Steering Group consists of: Philip Leech, Ron Cullen, Paul Stanton, Peter Stewart, Eddie Kinsella, Clare Gerada, Jim Kennedy, Jill Rogers and Pip Hardy.

We would like to thank the following 'critical friends' for reading and commenting on early drafts of the materials:

Professor Aidan Halligan

Alastair Henderson, The NHS Confederation

Alex Tobin, National Clinical Governance Support Team

Amanda Hedley, National Clinical Governance Support Team

Baroness Cumberlege

Carol Limber, GPwSI

Catherine Dewsbury, Royal Pharmaceutical Society

Clare Gerada, National Clinical Governance Support Team

Claire Jones, National Pharmaceutical Association

Dawn Hillier, Faculty of Health, Anglia Polytechnic University

Eddie Kinsella, NatPaCT

Emilie Roberts, CHI

Geraint Davies, NW London Strategic Health Authority

Ian Basnett, North East London Strategic Health Authority

Jan Mainz, European Society for Quality in Health Care

Jane Austin, NHS Workforce Confederation

Jim Kennedy, CHI

Judith Smith, Health Services Management Centre, University of Birmingham

Judy Oliver

Lilian Power, Ipswich PCT

Martin Shelly, GP, Clinical Governance Support Team

Martin Whittle, Lincolnshire South West Teaching PCT

Mary Burrows, Northampton PCT

Michael Soljac, NW London Strategic Health Authority

Nigel McFetridge, Hampshire and Isle of Wight Strategic Health Authority

Norman Pinder, Norfolk, Suffolk and Cambridgeshire Strategic Health Authority

Owen Lloyd, Bedfordshire and Hertfordshire Strategic Health Authority

Philip Leech, Department of Health

Ron de Witt, CEO, and the Board of Northwest London Strategic Health Authority

Professor Mike Salmon, Essex Rivers Healthcare Trust

Sarah Squire, Clinical Governance Support Team

Sheena Parker, Department of Health

Sheila Salmon, Health Business Centre, Anglia Polytechnic University

Sophia Christie, Eastern Birmingham PCT

Stephen Ryan, Association of Optometrists

Terri Hobbs, National Clinical Governance Support Team

Tim Wilson, Department of Health

Tricia Hart, Southwest Peninsula Health Authority

Val Jones, Eastern Birmingham PCT

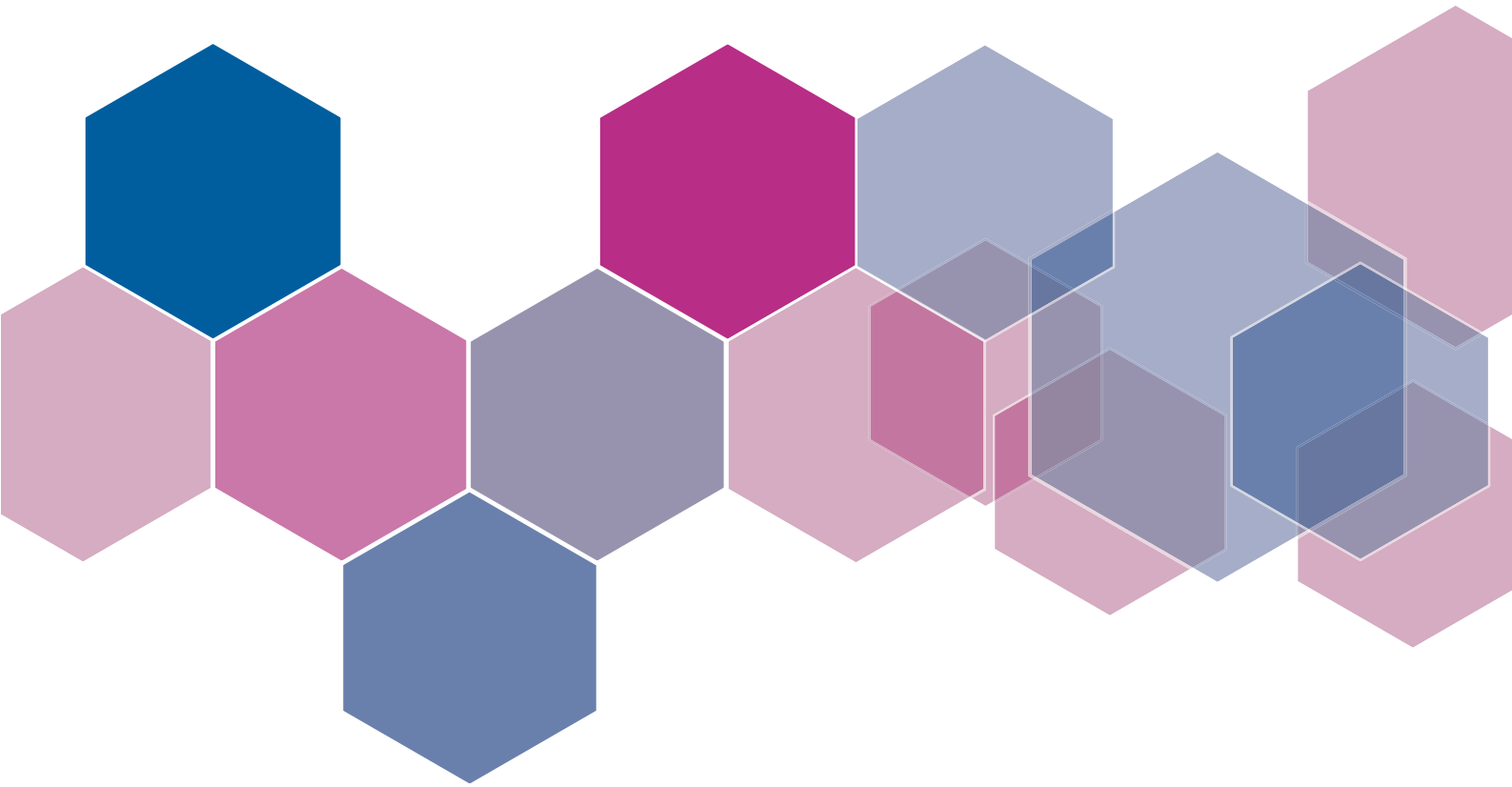
Particular thanks are also due to members of the Boards and PECs of West Wiltshire and Eastern Birmingham PCTs who piloted sample questions and Response Sheets.

Finally, we are grateful to the 62 PCTs who took part in the pilot programme.

All materials have been produced for the NHS Modernisation Agency by Pilgrim Projects Limited and Jill Rogers Associates.

PILGRIM PROJECTS

JILL ROGERS ASSOCIATES JRA



The Strategic Leadership of Clinical Governance in PCTs