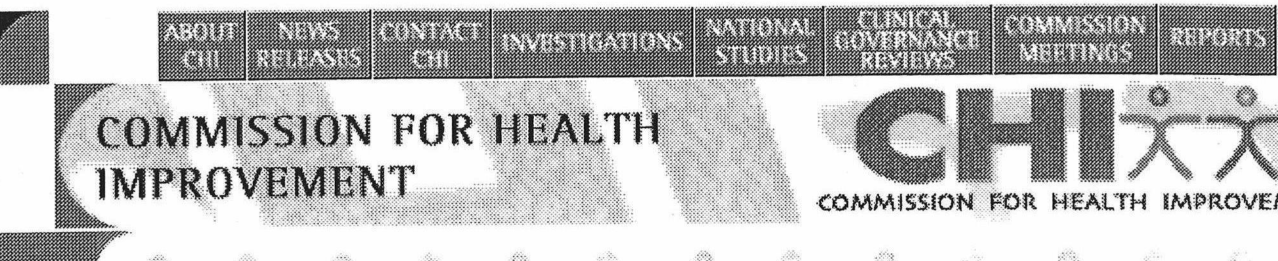

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Pre Review:

The Commission for Health Improvement's aim is to improve the quality of patient care in the NHS. For CHI the patient's experience of the NHS is at the heart of its work.

CHI will raise standards by:

- assessing every NHS organisation and making its findings public
- investigating when there is serious failure
- checking that the NHS is following national guidelines
- advising the NHS on best practice

CHI will be independent, rigorous and fair in its work, highlighting best practice in the NHS and encouraging others to adopt it, while not flinching from saying clearly where urgent improvement is required.

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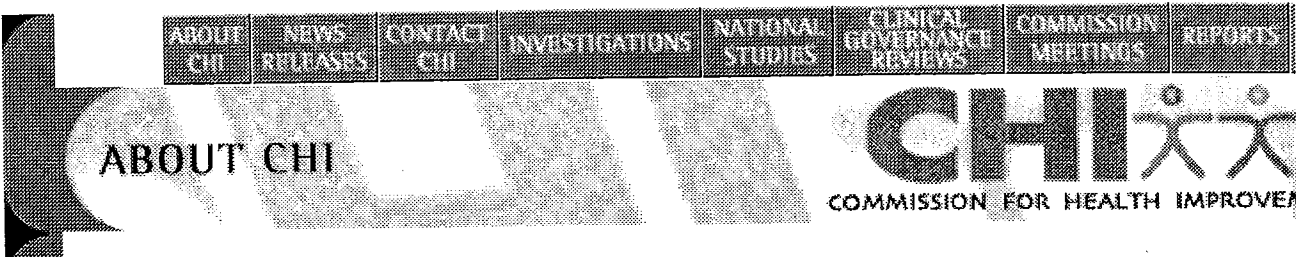

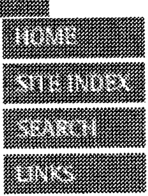

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Service problems in the NHS: how CHI and others work together

The First Step Roadshows

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CHI Annual Work Programme 2001-2002 PDF **192kb**

Order a hard copy of the Annual Work Programme

Frequently asked questions

Whistle blowing policy for CHI staff

- Introduction
- CHI's principles
- What is clinical governance
- The Challenge
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Introduction

The Commission for Health Improvement (CHI) was set up by the government to improve the quality of patient care in the NHS across England and Wales.

For many years it has been apparent that the standard of care offered by the NHS in England and Wales has varied greatly, for example, between hospitals, between departments in the same hospital and between general practices. CHI is one of the Government's reforms to address unacceptable variation.

In October 1999, the Prime Minister described the foundation of CHI as "the boldest step yet" in the Government's programme to modernise the NHS. CHI started operating on 1 April 2000 and has a programme underway which aims to ensure that every NHS patient receives the same high level of care. The patient's experience is at the heart of CHI's work.

CHI will assure, monitor and improve the qualit of patient care by undertaking clinical governance reviews. CHI will visit every NHS trust and health authority, which includes primary care groups, local health groups and general practices, in England and Wales on a rolling programme every four years. CHI's findings will be based on evidence and not opinion.

CHI also investigates serious service failures in the NHS when requested by the Secretary of State for Health in England and the National Assembly for Wales and will carefully consider

other requests.

Over time, CHI will develop considerable knowledge, understanding and expertise to hel NHS staff and organisations improve their services.

The legislative basis for CHI is the 1999 Health Act and its associated regulations.

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CHI's Principles

Six principles have been adopted that underpin all work that will be conducted by CHI:

- The patient's experience is at the heart o CHI's work
- CHI will be independent, rigorous and fai
- CHI's approach is developmental and will support the NHS to continuously improve
- CHI's work will be based on the best available evidence and focus on improvement
- CHI will be open and accessible
- CHI will apply the same standards of continuous improvement to itself that it expects of others

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Top

What is clinical governance

CHI defines clinical governance as the system o steps and procedures adopted by the NHS to ensure that patients receive the highest possib quality of care. It includes:

- a patient centred approach
- an accountability for quality
- ensuring high standards and safety
- improvement in patient services and care

For further information see:
Clinical governance reviews section of this site

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The Challenge

The task set for CHI is extremely demanding. I has to meet the high expectations of the public and politicians. And it has be to accepted as credible and fair within the NHS. CHI has to

balance its review activities with its response to requests for investigations - the "elective" and "emergency" elements of its work. It will need to forge good working relationships across the NHS and with the public and other organisations.

CHI will help the NHS to have robust clinical governance arrangements in place locally by providing advice and help.

Top

Studies CHI monitors the progress that the NHS is making towards meeting recommendations laid down by the National Service Frameworks and the National Institute of Clinical Excellence (NICE) guidance. The first study is a review of cancer services which will be published in summer 2001.

For further information see:
National Studies section of this site

Top

Investigations CHI responds to requests from individuals and organisations which are seriously concerned about the quality of services within an NHS organisation.

For further information see:
Investigations section of this site

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Leadership CHI will lead, review and assist NHS healthcare improvement and act as an adviser on best practice and problem solving. By reviewing clinical governance in every identified NHS organisation in England and Wales over the nex four years, CHI will be able to disseminate goo practice through the NHS.

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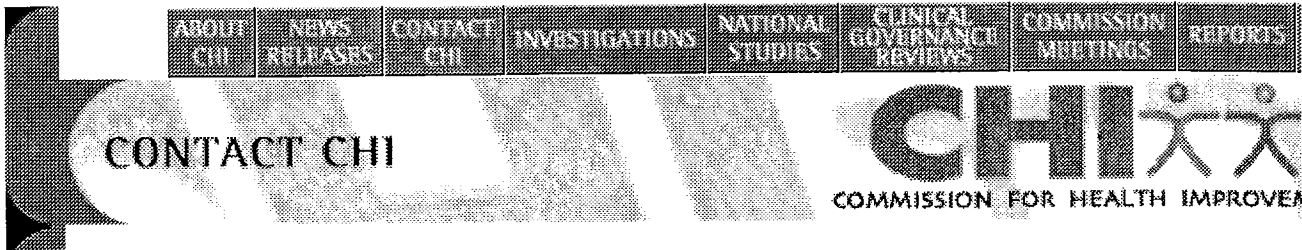

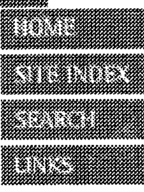

Contact CHI

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020 7448 9200

Text phone (Minicom):
020 7448 9292

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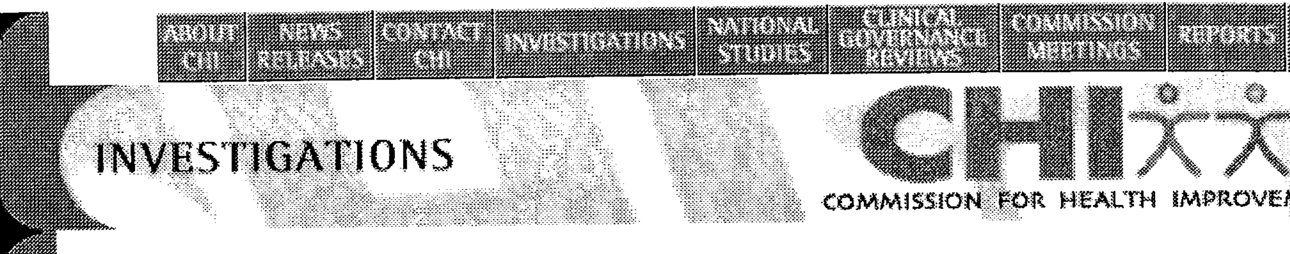

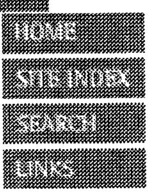

Investigation reports

Current investigations

Service problems in the NHS: how CHI and others work together

CHI Policy on assessing requests for investigations and fast track clinical governance reviews PDF 32kb

- What is an investigation
- Aim of an investigation
- Requesting an investigation
- Relationships with other investigative bodies
- Disciplinary functions
- Investigation teams

Introduction

The Commission for Health Improvement (CHI) was set up by the government to improve the quality of patient care in the NHS across England and Wales. CHI started operating on 1st April 2000 and has a programme underway which aims to reduce unacceptable variations i care and ensure that every NHS patient receive a high level of care. The patient's experience is at the heart of CHI's work.

One of CHI's four statutory functions is to conduct investigations into serious service failures in the NHS. These failures may be a breakdown of processes and standards, a pattern of incidents of widespread public concern or other issues that remain unresolved through other reviews or investigations.

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What is an investigation?

An investigation is an in-depth examination int the underlying causes of a service failure.

Investigations:

- involve patients, staff and stakeholders
- provide opportunities for staff to talk to the CHI team
- have teams which are multi-professional and include lay members

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Aim of an investigation

A CHI investigation aims to improve patient and to make recommendations to restore publi confidence in the NHS.

CHI will establish the cause of failures in the NHS by looking at individual as well as organisational practices. In an investigation, CHI will draw attention to areas that are failing and make recommendations to ensure that improvement is achieved. The investigators organisation's regional office in England or the National Assembly for Wales will ensure the recommendations are implemented.

CHI will publish a report on the investigation findings and recommendations, which will be made public and available on CHI's website.

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Requesting an investigation

CHI investigates serious service failures in the NHS when requested by the Secretary of State for Health in England and the National Assembl for Wales and will carefully consider other requests. CHI can also decide to investigate where it thinks it has sufficient information for to do so.

CHI does not investigate individual complaints. The appropriate professional regulatory bodies, individual organisation's complaints procedure, Community Health Councils and the Health Service Ombudsman exist to deal with such cases.

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Relationships with other investigative bodies

Investigations and inquires are often conducted by other organisations within the health sector including the NHS Executive, the NHS Directorate in Wales and the General Medical Council. These procedures will continue to operate when there is a failure in health care.

CHI cannot address every instance of individua and organisational failure. In most cases, local investigative processes including those involvin the NHS Executive, Regional Offices or the National Assembly for Wales will be completed before CHI is asked to conduct an investigation

In time, CHI will set standards on how to undertake high quality investigations and

inquiries.

Top

Disciplinary functions CHI was not granted disciplinary functions in th Health Act of 1999. CHI does not have the powers to remove or replace any member of NHS staff, management teams or board members.

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Investigation teams The Medical Director and the Director of Nursin of CHI are responsible for investigations. They provide leadership, advice and guidance to the investigation team.

The Investigation Manager is a full-time CHI employee experienced in investigation work. The manager supports their team throughout the investigation.

The investigation team members' skills and experience are matched to each investigation. lay person will always be included on the team.

Apart from the investigation manager and lay person, investigation team members will usuall work in the NHS.

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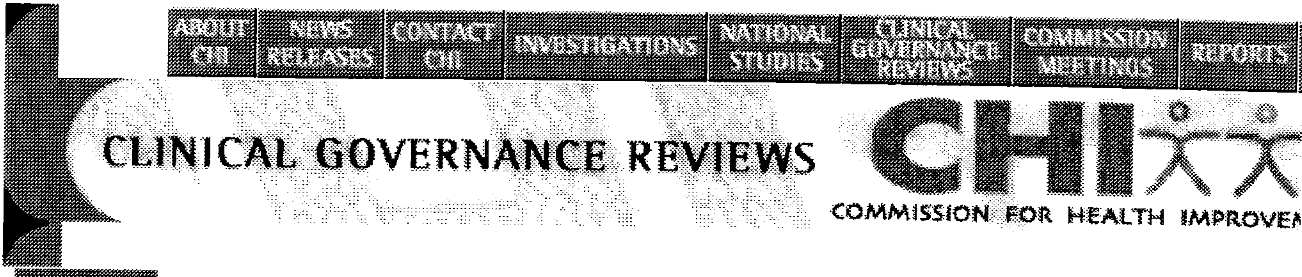


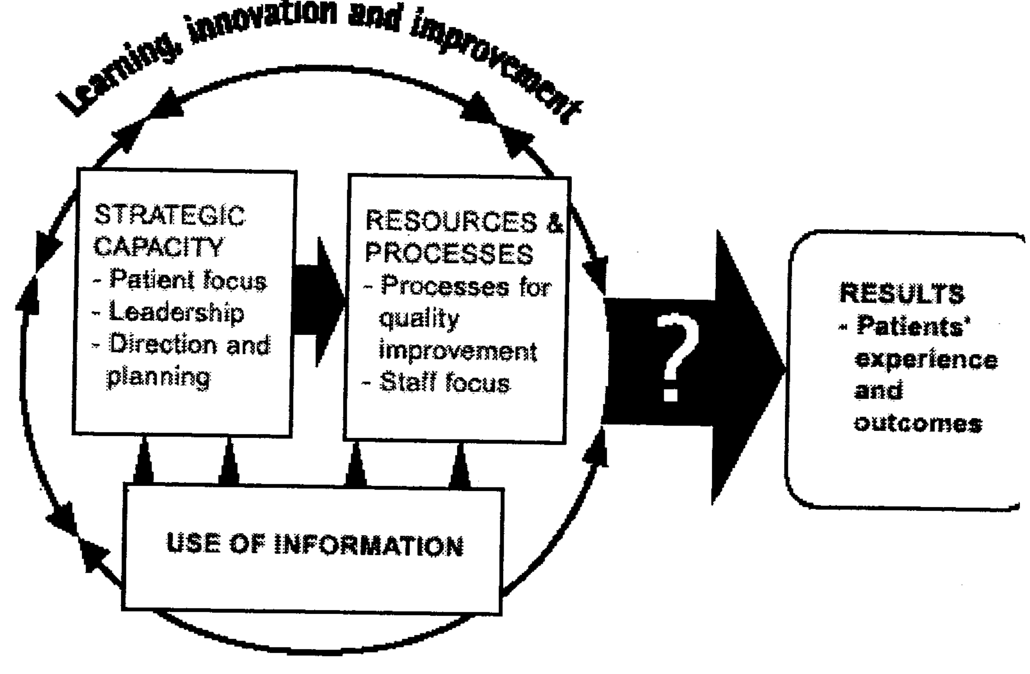
Assessing clinical governance

Download this document 168kb (this version updated 20.09.01)

CHI is introducing a systematic framework for assessing clinical governance in trusts so that judgements made in reports of reviews are reliable, fair and consistent. The assessment framework is being developed with the NHS Clinic Governance Support Team in England and the Clinical Effectiveness Support Unit (CESU) in Wale (CESU closed at the end of March 2001). This will ensure that consistent messages are given to trusts about clinical governance.

CHI's model for clinical governance (Figure 1) illustrates its belief that effective clinical governance depends upon a culture of continuous learning, innovation and development and will improve patients' experience of care and treatmen in hospital. Over time, CHI will use the information it accumulates from reviews to help determine which aspects of clinical governance are the most important for improving patients' experience and outcomes.

Figure 1: CHI's model for clinical governance



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Work is in progress to identify the dimensions of the patients' experience and outcomes under the 'RESULTS' part of the model so that CHI can assess the information it collects about what it is like to be a patient and interpret information abou clinical processes and care outcomes.

CHI evaluates clinical governance by exploring three key, interlinked areas identified in the mode

- strategic capacity: how far does the trust's leadership set a clear overall direction that focuses on patients? How well is it integrate throughout the trust?
- resources and processes: how robust are its processes for achieving quality improvemen such as consultation and patient involvemen and clinical audit? How effective are the trust's arrangements for staff management and development?
- use of information: what information is available on patients' experience, outcomes processes and resources, and how does the trust use it strategically and at the level of patient care?

Each of these areas comprises a number of components that CHI examines in every trust. CH has so far identified seven components of 'RESOURCES AND PROCESSES' and 'USE OF INFORMATION' (Figure 2). Work is being carried out to identify the components of 'STRATEGIC CAPACITY'.

Figure 2: Components of clinical governance resources and processes and use of information

	Component
Resources and processes	
(i) processes for quality improvement	Consultation and patient involvement
	Clinical audit
	Clinical risk management
	Research and effectiveness
(ii) staff focus	Staffing and staff management
	Education, training and continuing personal and professional development
Use of information	Use of information to support clinical governance and health care delivery

CHI's review teams assess how well clinical

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governance is working throughout the trust by making enquiries about each of these seven components at corporate and directorate levels an in clinical teams. This involves collecting information systematically about review issues tha have been defined for each component. CHI will introduce similar methods to assess information collected about components of 'STRATEGIC CAPACITY' in future rounds of reviews.

On the basis of the evidence collected, CHI's reviewers assess each component of clinical governance against a four-point scale:

I. little or no progress at strategic and plannin levels or at operational level

II. worthwhile progress and development at strategic and planning levels or at operational level, but not at both

III. good strategic grasp and substantial implementation. Alignment of activity and development across the strategic and planning levels and operational level of the trust

IV. excellence – co-ordinated activity and development across the organisation and with partner organisations in the local health economy that is demonstrably leading to improvement. Clarity about the next stage o clinical governance development

There is wide variation within trusts in progress made developing the component parts of clinical governance. At this stage of development, CHI believes it is most useful to trusts to assess each component separately to help them prioritise their development of clinical governance. It will not make judgements to produce an overall rating for a trust.

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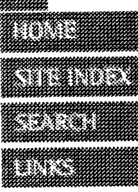

CLINICAL GOVERNANCE REVIEWS

Review issues

- Consultation and patient involvement
- Clinical audit
- Clinical risk management
- Research and effectiveness
- Staffing and staff management
- Education, training and continuing personal and professional development
- Use of information to support clinical governance and health care delivery

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Consultation and patient involvement

1. Commitment to communication with patients/user and understanding of their needs and priorities, and the structures and accountabilities to lead this

2. Mechanisms to involve patients, or their representative organisations, in the planning and monitoring of services:

   - public participation groups
   - lay/citizen representation on trust board and clinical governance committees
   - public consultation exercises
   - use of validated instruments to find out patients' views

3. Co-ordination of the strategy and programmes for consultation and patient involvement and integration with the wider quality improvement programme

4. Training in patient (customer) care, communicatio skills, confidentiality issues

5. Training for staff in complaints handling

6. Processes to involve patients in the planning and delivery of their care, including consent to treatment and agreement not to resuscitate

7. Availability of information for patients and carers about treatments, services and facilities

8. Processes for patients and carers to voice concerns, issues and compliments about services

9. Processes for dealing with informal and formal complaints from patients and carers and action taken to prevent their recurrence

10. Arrangements to find out about, and meet, patients' needs:

    - cultural
    - spiritual
    - disability
    - dietary

11. Arrangements to ensure patients' rights to privacy dignity and confidentiality about themselves and their treatment

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Top

Clinical audit

1. Commitment to the management and direction of the clinical audit programme, and the structures and accountabilities to lead this

2. Reporting of audit results and the impact of clinica audit on changes to practice

3. The extent to which clinical audit work goes acros organisational boundaries – for example, involves primary care and social services

4. Co-ordination of the strategy and programmes for clinical audit, priorities for clinical audit, and integration with the wider quality improvement programme

5. Involvement of patients or carers in clinical audit

6. The involvement of staff and the extent to which there is a team-based approach to clinical audit project identification, design, implementation and evaluation

7. Availability and uptake of training and developmen in audit skills

8. Support and resources for clinical audit and systems for audit approaches and methods

9. Learning from clinical audit including:

    - the extent to which clinical audit results in sustained change and improvements to

service plans and to patient care
- the extent to which clinical audit activity leads into and develops research questions

10. Participation in confidential enquires and national audits (according to NICE priorities and guidance)

Top

Clinical risk management

1. Commitment to the management and direction of the clinical risk management programme, and the structures and accountabilities to lead this

2. Promotion of an open, blame-free culture for reporting incidents and near misses

3. Communication of requirements of staff to report risks and incidents (including induction training), and the measures they must take to prevent and control risks – for example, infections and pressur sores

4. Involvement of partner organisations in clinical ris management for patients whose care is provided by a number of organisations

5. Co-ordination of the strategy and programmes for clinical risk management and systems for collectin and bringing together all information about risks

6. Systems for assessing clinical risks

7. Systems for reporting clinical incidents and near misses

8. Strategies and support for preventing and managing identified clinical risks – for example, use of trigger events, protocols for dealing with specific incidents

9. Learning from knowledge about clinical risks:

    - systems to identify trends in incidents and t take action on them
    - consideration of clinical risks in service decisions
    - dissemination of information about risks and incidents

10. Notification of specific serious clinical incidents to the regional office/National Assembly for Wales

11. Performance – for example, the number of incidents reported, occurrence of infections,

occurrence of pressure sores (performance indicators to be determined)

12. Attainment of external risk management standard – for example, Clinical Negligence Scheme for Trusts (CNST)

Top

Research and effectiveness

1. Commitment to the management and direction of the research and effectiveness programme, and the structures and accountabilities to lead this

2. The importance placed on implementing and monitoring evidence-based practice

3. The extent to which research work goes across organisational boundaries – for example, the involvement of primary care, social services and educational organisations

4. Co-ordination of the strategy and programmes for research, priorities for research and effectiveness work and integration with the wider quality improvement programme

5. Involvement of patients and carers in research project identification, design, implementation and evaluation

6. Involvement of staff and the extent to which there is a team-based approach to research project identification, design, implementation and evaluation

7. Access and support for staff in the development o skills in research and evidence-based practice – fo example, critical appraisal skills training

8. Access to research results and evidence of effectiv practice by clinicians

9. Learning from research:

   - mechanisms to make operational effective practices – for example, evidence-based guidelines for disease management
   - the extent to which research results in sustained change and improvements to service plans and to patient care
   - identification of performance indicators from research results
   - dissemination of the findings of research

10. Compliance with NICE guidelines, National Service Frameworks (NSFs) and other agreed national guidelines

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Staffing and staff management

1. Commitment to the management and direction of the staffing and staff management issues and the structures and accountabilities to lead this

2. Communication to staff of their own responsibilitie and accountabilities and reporting arrangements

3. Monitoring and reporting of key performance indicators – for example, staff sickness rates and action taken to tackle problems

4. Joint approach to those aspects of care delivery where there is close partnership working with othe organisations – for example, discharge arrangements

5. Human resources strategy which links with clinica governance and delivers national priorities – for example, Working Together and Improving Working Lives targets

6. Processes for workforce planning, linked to service planning, that incorporate current and future skill requirements and turnover

7. Human resources processes, including recruitmen and the promotion of equality of opportunity and good race relations

8. Systems and support for:

   - induction
   - appraisal & personal development planning
   - clinical supervision
   - dealing with cases of poor performance

9. Arrangements to ensure deployment of appropriat staffing and skills:

   - minimum 'safe' numbers and mix
   - schemes of delegation and supervision – for example, operating at night
   - protocols for staff working in extended roles – for example, nurse prescribing

10. Team working within teams – for example, multidisciplinary team working, handover arrangements, ward rounds, case conferences

11. Team working between teams – for example, handover on transfer of patients, access to specialist advice, arranging discharge of patients

12. Employee support services – for example, occupational health services, support against bullying and harassment

13. Learning from staff – for example, through staff attitude surveys, staff appraisal and feedback processes, exit interviews

14. Risk assessments and management strategies to tackle accidents and violence to staff, and issues o workplace health, safety and ergonomics

15. Compliance with directives on working time

16. System to ensure that clinical staff registration an qualifications are checked on appointment and at time of revalidation

17. Staff well being and satisfaction (performance indicators to be determined)

18. Performance – for example, staff sickness rates, staff turnover (performance indicators to be determined)

19. Attainment of external human resource standards – for example, Investors in People

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Education, training and continuing personal and professional development

1. Commitment to education, training and continuing professional development (CPD) and the structure and accountabilities to lead this

2. Involvement of partner organisations in education training and CPD:

    - partnerships with educational establishment
    - joint training with staff from other health an social care organisations where there is partnership working

3. Co-ordination of the strategy and programmes for education, training and CPD linking in with broad training and development plans

4. Opportunities for, and participation by, staff and multidisciplinary teams in work-based training

5. Opportunities and support for, and participation b staff in CPD programmes

6. Opportunities and support for obtaining professional, or further, qualifications

7. Support for staff undergoing formal education

8. Systems to ensure that mandatory training requirements are met – for example, cardio-pulmonary resuscitation (CPR), moving and handling

9. System to ensure that results of external assessments of training and education programmes are considered and acted upon

10. Performance – for example, percentage of staff trained in CPR (performance indicators to be determined)

11. Attainment of external standards/accreditation – for example, Investors in People, Royal Colleges etc

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Use of information to support clinical governance and health care delivery

1. Responsibility and accountability for the development and use of information about the patients' experience

2. Scope of available information about the patients' experience

3. Priority given to information management and technology (IM&T) in strategic plans for clinical governance and to the needs of clinical governanc in strategic plans for IM&T

4. Involvement of partner organisations in the development, collection and use of information about the experience of patients whose care is provided by a number of organisations

5. Communication of information about individual patients between GPs and hospital staff

6. Access to information – for example, through the information technology infrastructure, health care records

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7. Communication of information about individual patients within teams and between teams

8. Use of information to inform service strategies and plans, to support performance review and improvement and to inform clinical governance activities

9. Access for staff to training and support in access t and use of information

10. Systems for assuring data quality

11. Compliance with information requirements of the NHS – for example, national patient surveys, patient charter, hospital episode statistics (HES), common information core, NSFs

12. Compliance with requirements to keep patient information confidential

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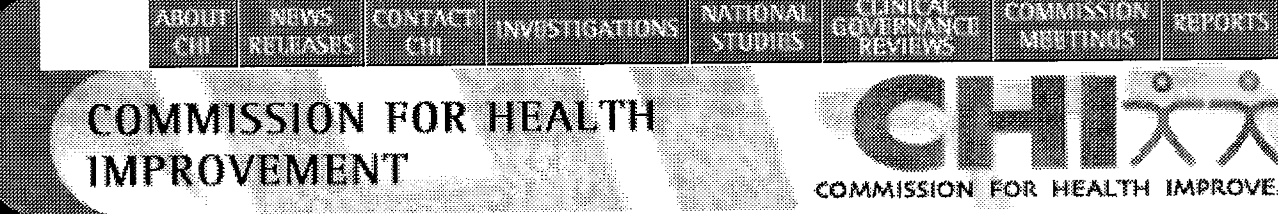

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CHI investigation at Gosport War Memorial Hospital

Terms of reference

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Press releases:
22.10.01: Investigation at Gosport War Memorial Hospital
02.11.01: Local comment sought

In September 2001, the Commission for Health Improvement decided to undertake an investigation at Gosport War Memorial Hospital to look at the management, provision and quality of healthcare provided to older people. Full details of the investigation can be found in the terms of reference,

The investigation will look at whether, since 1998, there had been a failure of trust systems to ensur good quality care for patients. The investigation will focus on in patient services for older people, in particular rehabilitation and continuing care.

Investigation Manager: Julie Miller
email: julie.miller@chi.nhs.uk

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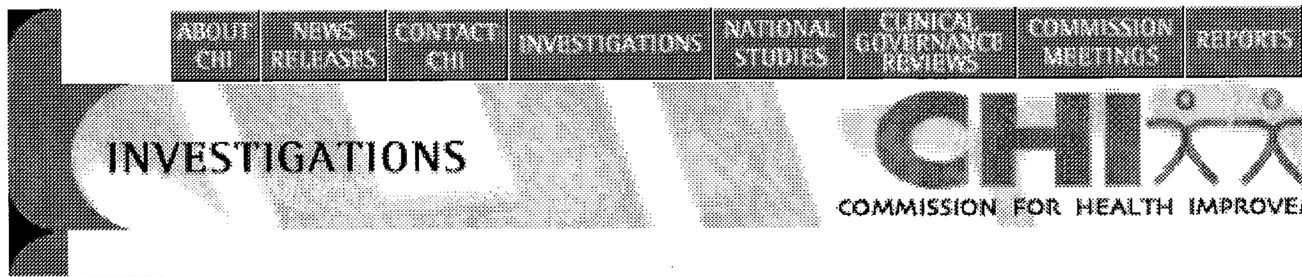

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CHI investigation at Gosport War Memorial Hospital

Terms of reference

1 Concerns have been raised with CHI about the quality of patient care for older people at the Gosport War Memorial Hospital. These concerns include the following:

i. Arrangements for the administration of drug
ii. Transfer arrangements for patients between the Gosport War Memorial Hospital and othe local hospitals
iii. Responsibility for patient care
iv. The culture in which care is provided

2 As a result, in September 2001 CHI decided to undertake an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust is responsible a the Gosport War Memorial Hospital.

3 The investigation will look at whether, since 1998, there had been a failure of trust systems to ensur good quality patient care. The investigation will focus on the following elements within services for older people (inpatient, continuing and rehabilitative care) at Gosport War Memorial Hospital.

i. Staffing and accountability arrangements, including out of hours.
ii. The guidelines and practices in place at the trust to ensure good quality care and effective performance management.
iii. Arrangements for the prescription, administration, review and recording of drugs.
iv. Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations.
v. Arrangements to support patients and their relatives and carers towards the end of the patients life
vi. Supervision and training arrangements in place to enable staff to provide effective care.

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4 In addition, CHI will examine how lessons to improve care have been learnt across the trust from patient complaints.

5 The investigation will also look at the adequacy of the trusts clinical governance arrangements to support inpatient continuing and rehabilitative car for older people.

Note: Gosport War Memorial Hospital is managed by Portsmouth Healthcare NHS Trust and will become part of a Primary Care Trust (PCT) in April 2002.

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