FAREHAM AND GOSPORT PRIMARY CARE TRUST

COMMISSION FOR HEALTH IMPROVEMENT

1.6 Please describe briefly the clinical and non-clinical services commissioned by the PCT.

Clinical

The following clinical services are commissioned by the PCT:

- Acute hospital services (including specialist services) from NHS Trusts and private providers. The Trusts main acute providers are Portsmouth Hospitals NHS Trust and Southampton University Hospitals NHS Trust
- Non-acute specialist services from a range of providers
- Mental health services from West Hampshire NHS Trust
- Community services, such as District Nursing and rehabilitation from neighbouring Primary Care Trusts (i.e Southampton City and Mid Hampshire PCTs).

In addition, the dissolution of Portsmouth Healthcare NHS Trust and the formation of Portsmouth City, East Hampshire and Fareham and Gosport Primary Care Trusts led to the development of PCT 'hosting' arrangements for some district community services. Fareham and Gosport PCT therefore commissions the following services from East Hampshire and Portsmouth City PCTs:

East Hampshire PCT	Portsmouth City PCT
Elderly Medicine	Community paediatrics
EMI	Psychology and counselling
Community Dental	Speech and Language therapy
	Substance mis-use services
	Family Planning
	Sexual health
	Acute physiotherapy
	Smoking cessation

The PCT has three-year service level agreements with the majority of providers from which it commissions clinical services for Fareham and Gosport residents. These agreements are reviewed annually by the lead PCT. Specialist services are commissioned on behalf of the PCT by the Central South Coast Specialist Services Confederation.

2.9 Please describe briefly the PCT's managed systems and processes for commissioning clinical healthcare services.

Accountabilities and Structures:

The commissioning of clinical healthcare services for the registered population of Fareham and Gosport is undertaken by the Directorate of Strategic Development. The Directorate is managed by the Director of Strategic Development who is responsible for ensuring the delivery of the commissioning agenda. The Director is supported by the Head of Commissioning and Planning.

Rachael

The Primary Care Trust has developed a comprehensive planning structure for ensuring the commissioning of high quality, easily accessible clinical healthcare services. Local and District Implementation Teams (LITs / DITs) have been established to oversee the delivery of the National Service Frameworks for CHD, Diabetes, Children, Mental Health, Cancer and Older People. In addition, in conjunction with the PCTs main acute provider, Portsmouth Hospitals NHS Trust (PHT), specialty taskforces ensure the delivery of the national waiting times targets and explore whether, through modernisation, more efficient and effective services can be provided.

The contracting of acute services with the PCT's main providers (PHT and SUHT) is undertaken via regular Service Level Agreement review meetings. The District-wide Commissioning Group provides a forum for local PCTs to discuss commissioning issues and where necessary, to agree a consistent approach.

The delivery of the commissioning agenda is monitored by the PCT's Performance Management Committee and Professional Executive Committee. Both Committee's report to the PCT Board.

Planning and Priority Setting:

The PCT's commissioning priorities are contained within it's Business Plan and Local Delivery Plan. The development of the 2003/04 Business Plan has occurred through the Trust's normal business and planning structures and as a result, it incorporates national Local Delivery Plan targets and local service priorities and plans developed and prioritised through existing planning mechanisms, such as the LITs and DITs. These groups consist of representatives from a range of statutory and voluntary organisations, as well as lay members, which ensures that the service priorities and key objectives for delivery are owned by the Trust and its key stakeholders.

As part of the wider business planning process, PCT service managers also identify service priorities for delivery within the next financial year. The Business Plan and LDP priorities are agreed and approved by the PCT Professional Executive Committee and PCT Board.

Communication:

The PCT's Business Plan sets out the PCT's priorities for delivery over the next twelve months. Following approval by PEC and ratification by the Board, the PCT's Business Plan is circulated to PCT Managers for dissemination to staff and to the PCT's stakeholders. The Business Plan forms the basis for the development of department plans, personal objectives and for agreeing personal development plans.

Monitoring:

The Director of Strategic Planning and Performance has responsibility for ensuring that the PCT has robust performance management systems. The commissioning of clinical healthcare services against agreed priorities for delivery are monitored via the PCT's Performance Management Committee. Quarterly performance monitoring reports are presented to the Committee, which operates as a sub-committee of the PCT Board.

The PCT has identified lead managers who are responsible for ensuring the delivery of the LDP priorities through local planning structures. The lead managers provide the information required by the Performance Management Committee to monitor the Trust's performance.

The PCT also monitors the delivery of the service level agreements with its main acute providers, SUHT and PHT, through regular SLA review meetings.

Evaluation:

The PCT monitors performance against its clinical priorities for delivery within the financial year through the Performance Management Committee. The Committee ensures that where necessary, action is taken to address poor performance.

The quarterly performance reports demonstrate progress against the delivery of the priorities (which include CHI indicators and LDP targets). The PCT's performance informs the PCT's star rating.

Reporting:

Quarterly performance monitoring reports are produced for the PCT Performance Management Committee. The PCT Performance Management Committee is a sub-committee of and reports directly to the PCT Board.

2.11 Please describe briefly one example each of how the PCT involves the community health services clinical staff and GPs in the commissioning and purchasing of:

a) general hospital care

Objectives and staff and services involved:

The District Cancer Implementation Team (DIT) is a multi-disciplinary group with clinical and managerial representatives from primary care, community services and the PCT's main acute provider, Portsmouth Hospitals NHS Trust. The main aims of the DIT is to ensure the local delivery of the Cancer Plan and to ensure the provision of high quality, accessible cancer services. The group identifies and jointly agrees national and local priorities for investment in cancer services, which are considered by PCT's as an integral part of the LDP process. The PCT has a lead cancer clinician who is a General Practitioner and involves community staff in the commissioning of cancer services (i.e in the development of care pathways and reconfiguration of service delivery).

What activities did the initiative deliver:

The DIT jointly agreed the following as the highest priorities for investment within 2003/04:

- 2 view mammography
- reduction in radiotherapy waiting times and the delivery of the national maximum cancer waiting times
- Specialist palliative care to enable people with a terminal illness to die at home instead of within an acute hospital or hospice

What Clinical Governance improvements occurred:

- Provision of two-view mammography. Evidence has shown implementation of 2 view mammography increases detection rates.
- Reduction in radiotherapy waiting times from 12 weeks in September 2002 to 4.6 weeks in October 2003. This ensures patients receive faster access to treatment, improving prognosis.
- Consistent delivery of the maximum two week from urgent GP referrals to first outpatient appointment through collaborative work between primary and secondary care.
- Development of a palliative care pathway and investment in palliative care services to enable increased numbers of terminal patients to die at home. The impact of the recent investment will be carefully monitored and evaluated.

b) mental health services (Paul Turner to complete)

c) primary care services (Margaret Smith to complete)

d) support services (Alan Pickering to complete)

2.13 Please describe briefly either one or two examples of PCT initiatives to improve the quality of services purchased from a general secondary/tertiary care provider in the last 12 months (e.g main general hospital provider or a tertiary provider or a private sector hospital or a diagnostic and treatment centre.

Objectives:

The Chronic Pain Taskforce was established to explore more efficient and effective ways of service delivery through modernisation. The Chronic Pain Taskforce is led on behalf of the District by Fareham and Gosport Primary Care Trust.

Referrals to the Chronic Pain service had increased beyond available clinic capacity, resulting in lengthening waiting times for first outpatient appointments. As patients are referred by GPs but also by Orthopaedics, Rheumatology and Oncology, this was also resulting in increased demand on these services, which were having to provide on-going management whilst patients were on the waiting list to be assessed by the Chronic Pain Service. Research showed that patients could benefit from specialist physiotherapy treatment and that many of the patients referred to the service had chronic back pain but had not received recent specialist physiotherapy treatment. The provision of specialist physiotherapy treatment as an integral part of the Pain Management Programme could potentially reduce the need for all patients to be seen by a chronic pain consultant.

The objectives of the initiative were to:

- Reconfigure the chronic pain service to ensure all referrals were triaged by a physiotherapy specialist. The physiotherapist would ensure that where appropriate, patients receive specialist physiotherapy treatment.
- Address capacity issues and reduce waiting times

Staff and services involved:

The Chronic Pain Taskforce has clinical and managerial representatives from PCTs, physiotherapy and the acute chronic pain service.

What activities did the initiative deliver:

The initiative will be evaluated following an 18 month pilot. The expected outcomes are:

- Reduction in the number of patients who need to see a consultant
- Reduction in the overall waiting times for GP referrals
- Improved patient outcome after treatment interventions, with reduced need for further procedures and earlier discharge from clinic
- Improved treatment pathways for patients with back pain, with more effective access to specialist pain management
- Improved multi-disciplinary working

What Clinical Governance improvements occurred:

The patient pathway has improved by ensuring patients are now able to see the most appropriate health professional. It is also expected that patient outcomes will improve, with reduced need for further procedures and earlier discharge from clinic.

2.14 Please describe briefly either one or two examples of PCT initiatives to improve the quality of services purchased by mental health secondary / tertiary care providers in the last 12 months.

Paul Turner to complete

2.15 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of commissioning clinical and non-clinical services

Clinical Services:

Objectives:

The further development of local intermediate care services for older people to:

- Prevent, where appropriate, acute hospital admissions and to facilitate early discharge
- Reduce acute emergency admissions
- Reduce delayed transfers of care
- Provide additional rehabilitation, closer to home

Staff and Services Involved:

Joint planning with partnership agencies through the Older Persons Strategic Planning Forum, consisting of managerial and clinical representatives from the PCT (Commissioning and service managers), EMI services, Elderly Medicine and Hampshire Social Services. The development of a strategy for the further expansion of local intermediate care services and the joint agreement of commissioning priorities for 2003/04 in line with local and national priorities. Strategy informed by stakeholder workshop to identify priorities for service development.

What activities did the initiative deliver:

Local intermediate care services have enabled local people to receive comprehensive rehabilitation and/or support services either within their own homes or a local intermediate care bed without the need for an acute hospital admission. The further development of intermediate care services was agreed as a local priority for the PCT within 2003/04.

This led to the formation of the Older Person's Strategic Planning Forum and the development of a Strategy for the future development of local intermediate care services. The Strategy identified the further development of local intermediate care services with a single point of access, underpinned by a single assessment process, agreed care pathways and integrated health and social care records.

Commissioning priorities for 2003/04 included:

- development of a single point of access to local intermediate care services
- the further development of EMI services as an integral part of the Community Enabling Service
- the development of an integrated falls service
- health promotion initiatives i.e Runcorn pilot in primary care

What Clinical Governance improvements occurred:

The further development of intermediate care services will:

- enable patients to receive individualised rehabilitation / care packages either within their own homes or community intermediate care beds
- reduce delayed transfers of care
- reduce acute emergency admissions

The initiatives implemented within 2003/04 will be carefully monitored and evaluated and will help to inform commissioning priorities for 2004-06.

2.16 Please identify the PCT's priority areas for developing commissioning in the next 12 months

The PCT's priorities for developing commissioning over the next 12 months are:

- The implementation of national guidance: NSFs, NICE, Patient Choice, Payment by Results, nGMS, Improving Working Lives, Foundation Trusts, new Consultant's contracts.

- Delivery of key LDP priorities and CHI indicators i.e access targets, reduction in emergency admissions, development of mental health crisis resolution and early intervention services, smoking cessation.

- Delivery of local priorities within the PCT's business plan: Improved access to dental services; expansion of the local intermediate care service; review of local service provision across Fareham and Gosport (linked to the PFI reconfiguration); the development of learning disability services; Healthfit. The continued provision of high quality, easily accessible services for local residents, (through the shift of services from secondary to primary care).

- Continued delivery of the PCT's Service Improvement Plan: To ensure three star status by 2005/06.

6.6 Please describe briefly any examples in the last 12 months where the PCT has withdrawn a treatment that has shown to be ineffective.

The PCT has not withdrawn complete access to any treatment over the last 12 months. The PCT does have a list of treatments that it does not routinely purchase. This list has been developed based on evidence of clinical reviews regarding the clinical effectiveness of procedures or treatments. The PCT has an established process through which GPs can request that a patient's case is reviewed to take into account individual circumstances. This is undertaken through the PCT's OATs/Treatments not Normally Purchased Panel, whose membership includes the PCT Directors of Public Health, NED, G.P, Head of Commissioning and Service Planning Managers.

1-1 Just!
Hope this helps!
Jc

The PCT's strategic priorities are contained in the Trust's 5-year Strategy document *Working Together for our Future Health*, which was published in the summer of 2003 after extensive involvement of and consultation with local partners.

This document outlines 8 key strategic priorities, summarised as

- Quicker and convenient access and choice
- Improving everyone's Health
- Being a valued employer
- Being approachable and accountable
- Involving patients and carers
- Integrating services
- Managing Resources well
- Having clear governance arrangements

Over the next three years the PCT intends to deliver on these agendas using the additional resources contained in the LDP, coupled with the opportunities in the new primary care contracts, our status as a LIFT site and our whole system improvement programme *Fit for the Future* to radically change the way in which is care is provided for local people. Our focus will be to ensure that social, primary, community and intermediate care services are developed to support independence and reduce the number of emergency and elective admissions to hospital.

All our work will be underpinned by our values, ensuring that safe and sustainable services are available for local people when they need them.

Pls let bk

Dear Ian
This is major grovel. I ran out of time! Please will you complete 1.1 and give to Justina. Guidance is attached. Will bring reward!
Thanks Auger

1.0 Strategic intent

1.1 What are the PCT's main strategic priorities:

During the current year?

The main strategic priorities for the current year are contained within the Business Plan 2003/04. These priorities have been derived from national targets and particular local areas of need.

During the next three years?

The strategic plan for the next 3 years will build on the Business Plan 2003/04 and are reflected in the refreshed Local Delivery Plan. This is informed by the strategies and plans emerging from National Service Framework Local Implementation Teams.

1.2 What are the PCT's main priorities for developing clinical governance during the next three years?

The PCT has developed its Clinical Governance Development Plan around the aspects of clinical governance as defined by the Commission for Health Improvement. The Clinical Governance Strategy and framework set the direction and accountability arrangements.

1.3 Please describe briefly the financial resources in your PCT for the current year (£):

HCHS:

Other:

Provider turnover:

1.4 Please provide a brief profile of the primary and community care services provided directly by the PCT. *Please feel free to attach a separate document.*

(Working Together for Our Future Health)

IH/AP/DW/KR/NK/FC/JP

1.5 Please provide a brief profile of the clinical and non clinical services hosted by the PCT on behalf of other PCTs. *Please feel free to attach a separate document.*

DW – learning Disabilities
FC – Complaints 2nd Stage
JP – Training & Education

1.6 Please describe briefly the clinical and non clinical services commissioned by the PCT.

IH – Clinical Rachael.
AP-Non-clinical

1.7 Please identify the committee and staff responsibilities for ensuring the PCT complies with its duties under the Race Relations (Amendment) Act. Has the PCT published a race equality scheme? [If so, when was it published and how was it disseminated to staff?]

An Equality and Diversity Group has been established to monitor and implement the Trust's obligations under the Race Relations Act. The activity of this group is then monitored by the Personnel Panel.

2.0 PCT Wide Issues

Clinical Governance

2.1 Please identify the designated lead(s) for clinical governance in your PCT.

Name:
Dr Andrew Paterson
Nicky Heyworth
Caroline Harrington
Team Development Facilitator
Fiona Cameron
Justina Jeffs
Ann Turner

Professional background:

What training have they received to prepare for their clinical governance role?

How much time is allocated for clinical governance activities in their job plan?

There is a strong Quality Team within the PCT from varied backgrounds who support the Lead for Clinical Governance.

2.2 Please describe briefly how does the PCT communicates corporate priorities for clinical governance across the PCT (eg newsletters, cascade briefing etc).

Briefing – An all staff monthly briefing is used to communicate key issues determined by the Operational Management Team which is then cascaded via regular monthly staff meetings.

Newsreach – Monthly newsletter including information from staff, for staff and delivered to all PCT sites.

Your Health – Quarterly information provided to the population of Fareham & Gosport regarding PCT issues. Delivered by Royal Mail to all households within the PCT catchement area.

Hazard Notices
H&S Newsletter
Clin Gov. Development Plan

2.3 Please describe briefly the PCT's managed systems and processes for developing clinical governance across its community health services (eg district nurses, therapists etc) and provider arms. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

(see Clinical Governance Annual Report)

2.4 Please describe briefly the PCT's managed systems and processes for developing clinical governance among independent contractors, for example GPs, dentists, etc. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

(see Clinical Governance Annual Report)

2.5 Please describe briefly either one or two examples of PCT initiatives to improve the quality of services provided by community health service staff (eg district nurses, therapists etc) and provider arms in the last 12 months.

Swallowing
Nursing & Allied Health Profession Strategy

2.6 Please describe briefly either one or two examples of PCT initiatives for improving the quality of services provided by independent contractors (eg GPs, dentists etc) in the last 12 months.

PRIMIS
CHAD for pharmacy
Baseline assessment for Dental/Optometry

Strengths and weaknesses

2.7 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of developing clinical governance.

Appraisal
Essence of Care

2.8 Please identify the PCT's priority areas for developing clinical governance in the next 12 months.

Risk Management in Primary Care/Independent Contractors
Clinical Audit/Effectiveness

Commissioning and purchasing

Name and designation of person responsible for completing this section

Name:

Designation:

Name and position of the designated lead(s) for commissioning

Name:

Position:

Is this a PCT lead or board level lead?

2.9 Please describe briefly the PCT's managed systems and processes for commissioning clinical healthcare services. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

IH Rachael.

District Commissioning Group
NSF informing the commissioning process
LDP
Partnership Board & LIGS
NITs/DITs
Acute Specialty taskforces
SLAs & monitoring processes
Quarterly service reviews
PCT Performance Management Committee
DCGC

2.10 Please describe briefly the PCT's managed systems and processes for commissioning non clinical services. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

IH/FC/AP/KR/NK

IT
Estates AP

2.11 Please describe briefly one example each of how the PCT involves its community health service clinical staff and GPs in the commissioning and purchasing of:

Rachael.

a) general hospital care:

PCT clinician & general medical contractor representation at acute specialty taskforces ie general surgery, CHD, Diabetes.

b) mental health services:

F&G Mental Health Local Implementation Team.
Lead GP for commissioning, mental health & CHD

c) primary care services (where commissioned from another organisation):

GP Groups ie development of GPs with a specialist interest.

d) support services (Estates, HR, IT, Finance, etc if appropriate):

? Training & Education group
Employee partnership forum

2.12 Please describe briefly either one or two examples of how local health needs are reflected in the Local Delivery Plan for the current financial year.

KR/NK Rachael.

2.13 Please describe briefly either one or two examples of PCT initiatives to improve the quality of services purchased from a general secondary/tertiary care provider in the last 12 months (eg main general hospital provider or a tertiary provider or a private sector hospital or a diagnostic and treatment centre).

Acute Specialty taskforces: Multi professional groups with acute and PCT representatives.
Remit = ongoing monitoring of PLTs to ensure delivery of maximum waiting times targets and service re-design and modernisation.
Agreed audit programmes
PCT CG managers invited to quarterly commissioning meetings Rachael.
DCGC
Re-launch of DEC
CES
Orthopaedic Pilot
Eyes (contracting out)

2.14 Please describe briefly either one or two examples of PCT initiatives to improve the quality of services purchased by mental health secondary/tertiary care provider in the last 12 months.

Adoption of the performance improvement framework by the F&G Mental Health LIT.

Action plan developed by LIT covering all NSF targets. Implementation of targets via sub-groups. Delivery monitored via LIT.
Development of Mental Health Commissioning Group.
Liaison via NIHME via Mental Health Network to develop an annual work programme to address wider strategic planning issues ie service redesign, workforce planning, transition between services etc.
Mental Health Practitioners
Mental Health LIT – Policy for use of Adult Mental Health beds by Learning Disabilities clients.
Cross boundaries to voluntary sector – PCT donates to Mental Health voluntary sector.

Strengths and weaknesses

2.15 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of commissioning clinical and non clinical services.

(Expand on 2.13 answer)

2.16 Please identify the PCT's priority areas for developing commissioning in the next 12 months.

IH LIT input to PCT. Patient Choice + Systems reform.

Health improvement/public health

Name and designation of person responsible for completing this section

Name:

Designation:

Name and position of the designated lead for health improvement/public health

Name:

Position:

Is this a PCT lead or board level lead?

2.17 Please describe briefly either one or two examples of PCT initiatives to assess or develop public health skills within the local community, eg health visitors, etc?

Health promotion team training programme
Public Health Development Project (Hants-wide)

2.18 Please describe briefly your managed systems and processes for dealing with the following. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

a) communicable diseases in the population:

KR/NK

b) infection control within community health services:

FC

c) immunisation and vaccination:

KR/NK

Health Protection Unit – Memorandum of understanding developed.
District Flu Immunisation Group co-ordinates annual Flu immunisation campaign. Lead PCT manager identified. Flu immunisation publicity campaign. Ongoing monitoring of uptake rates.
District immunisation and vaccination group

KR/NK

d) health screening programmes, eg cancer, etc:

IH

Currently reviewing links with Health Protection Agency. Specific projects planned for cervical and breast screening for LD clients.
Scoping paper on screening programmes to provide status report on main screening programmes. Pan-PCT arrangements in place for commissioning and public health input.

e) emergency incident planning (including environmental hazards):

FC

Joint PCT Emergency Planning & Major Incident Response Policy (East Hampshire, Fareham & Gosport and Portsmouth City PCTs)
Action Cards for each Service & role setting out responsibilities and steps to follow in the event of a Major Incident
F&G PCT Risk Management Committee oversees Emergency Planning arrangements within the PCT Joint Health Emergency Planning Group (multi-agency group, including Social Services, Portsmouth Hospitals, Hampshire County Council
Regular communications exercises, and participation in local and national exercises.
Pan-PCT Annual Training programme in place Board Report on the PCTs preparedness to respond to a Major Incident

Safety alert broadcast system pilot site/PEAT/COSHH/Risk Assessment
Health & Safety
Decontamination Group across PCTs

f) health needs assessment and link to commissioning

KR/NK/IH

2.19 Please describe briefly either one or two examples of how the PCT has used information on patient or population health needs to improve the quality of services provided by community health services and, or independent contractors.

KR/NK

Smoking cessation
LIFT
Five a day
HAP awareness training (V.P.)
Wonder if it is worth asking for examples from staff re changes in practice
Radiotherapy (additional investment to reduce waiting times)
CHD services (additional investment in rapid access chest pain clinic and revascularisation services)
Mini PDS to provide emergency dental access for patients not registered with a dentist

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2.20 Has the PCT undertaken any recent work to assess health needs of black and ethnic minority communities or disadvantaged groups (refugees, asylum seekers, travellers, addicts etc). Please describe and note the relevant changes to services that resulted.

KR/NK

Needs assessment for Haslar Removal Centre resulted in HIMP change in service/focus and provision (primary care, mental health)

Strengths and weaknesses

2.21 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of health improvement initiatives.

KR/NK

Sure Start
Five a Day
Community Safety Plans (with Las etc)

2.22 Please identify the PCT's priority areas for developing health improvement initiatives in the next 12 months.

KR/NK
LD Screening Pilot

Prescribing and medicines management

Name and designation of person responsible for completing this section

Name:

Designation:

Name and position of the designated lead for prescribing and medicines management

Name:

Position:

Is this a PCT lead or board level lead?

2.23 Please describe briefly the PCT's systems and processes for prescribing and medicines management by community health service staff, independent contractors and any specialist provider arms of the PCT. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

KR/NK
PACT data (GP level, Practice Level, PCT Level)
NICE guidance and audit tools
Incentive schemes
Pharmaceutical advisors have programme of practice visits
Use of Practice Support Pharmacists (PSPs) in practices pan PCT toolkit for (PSPs) for quarterly performance monitoring graphs of major areas.
PGDs and PGS audits
Attendance by PCT Pharmaceutical Adviser at PCT and Pan-PCT
Nurse Prescribing Meetings.
Programme of workshops
Formulary

2.24 Please describe briefly either one or two examples of how the PCT has used prescribing and medicines management information to improve patient care across the PCT.

KR/NK

Strengths and weaknesses

2.25 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of prescribing and medicines management.

KR/NK
Medication Reviews
4 new guidelines (as per CHI Action Plan)
Antibiotic prescribing guidelines
PHT & PCT Formulary
Medication reviews by PSPs
APC Business Cases

2.26 Please identify the PCT's priority areas for developing prescribing and medicines management in the next 12 months.

KR/NK
Development of medicines management strategy
Further development of ongoing training of nurse prescribers
NICE

3.0 Patient and public involvement

Name and designation of person responsible for completing this section

Name:

Designation:

Name and position of the designated lead for consultation and patient/service user involvement?

Name:

Position:

Is this a PCT lead or board level lead?

3.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to promote and support patient and/or carer involvement.

3.2 Please describe briefly the PCT's managed systems and processes for involving patients, users, carers and the public in the provision of community health services in accordance with Section 11 of the Health and Social Care Act 2001. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

FC/KR/NK
(see Clinical Governance Annual Report)
? PPI Strategy

3.3 Please describe briefly the PCT's managed systems and processes for involving patients, users, carers and the public in the provision of general practitioner services in accordance with Section 11 of the Health and Social Care Act 2001. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

~~JH~~/KR/NK/FC
National Patient Survey
2nd Stage Complaints

3.4 Please describe briefly either one or two examples of how the PCT has involved patients, carers, users and the public to improve the quality of services provided by community health services and, or independent contractors.

KR/NK
Improved information at GWMH
CHC Survey action plan
National patient Survey action plan
PALS – elements from CHI action plan
Bereavement Leaflet
Activity Nurses - GWMH

4.0 Clinical audit

Name and designation of person responsible for completing this section

Name:

Designation:

Name and position of the designated lead for clinical audit

Name:

Position:

Is this a PCT lead or board level lead?

4.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to promote and support clinical audit.

4.2 Please describe briefly the PCT's managed systems and processes for clinical audits by community health services, for example district nurses, health visitors, therapists, etc. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

4.3 Please describe briefly the PCT's managed systems and processes for clinical audits by specialist provider services of the PCT, for example specialist services that are provider arms of the PCT such as community paediatrics, mental health, child and adolescent psychiatry etc). [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

4.4 Please describe briefly the PCT's managed systems and processes for supporting clinical audits by independent contractors, for example GPs, dentists, etc. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

4.5 Please describe briefly either one or two examples of how the PCT has involved NHS and partner organisations in clinical audits across the PCT (eg other NHS trusts and, or Social Services etc).

4.6 Please describe briefly either one or two examples of PCT multidisciplinary clinical audits in the last 12 months that jointly involved at least two of the following three areas: community health service staff and independent contractors and specialist provider services.

4.7 What national or regional multi centre audits does the PCT participate in?

Strengths and weaknesses

4.8 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of clinical audit. Please also give details of arrangements in place to transfer these examples of good practice across the PCT.

4.9 Please identify PCT's priority areas for improving clinical audit in the next 12 months.

5.0 Risk Management

Name and designation of person responsible for completing this section

Name:

Designation:

Name and position of the designated lead for risk management

Name:

Position:

Is this a PCT lead or board level lead?

Name and position of the designated lead for clinical risk management

Name:

Position:

Is this a PCT lead or board level lead?

5.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to promote and support clinical risk management.

5.2 Please describe briefly the PCT's managed systems and processes for clinical risk management. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

5.3 Please describe briefly the most important clinical risk assessment undertaken by the PCT in the last 12 months. Please also describe briefly the managed changes in the PCT that directly resulted from undertaking the clinical risk assessments.

5.4 Please describe briefly the clinical incident report systems used by the PCT's community health services, for example district nurses, health visitors, therapists, etc. [In particular the system of reporting serious untoward incidents (SUIs).]

5.5 Please describe briefly the clinical incident report systems used by the PCT's specialist provider services, for example community paediatrics, mental health etc. [In particular the system of reporting serious untoward incidents (SUIs).]

d) older people: **FC**

NSF
Transitional protocols (CHAMS to AMH and AMH to EMI)
Discharge guidelines. EMI guidelines for dementia
Older persons NSF District implementation team
CES policy has multi agency focus

e) learning difficulties and vulnerable adults **DW**

5.9 Please describe briefly either one or two examples of how the PCT promotes and supports an open and just culture as a basis for encouraging staff to report clinical errors.

RCN & UNISON representation on Health & Safety Committee
Multi-agency Critical Incident Review (Bomb Scare, GWMH 4/10/02)
Whistleblowing policy
Employee partnership forum

5.10 Does the PCT have any improvement notices, prohibition or enforcement orders from the health and safety executive either pending or current? If yes, please give details.

Improvement notice (pending) regarding moving & handling training at induction, on wards, and documentation to evidence training on specific equipment.

5.11 Have you had any case reviews conducted in accordance with chapter 8 (enquiries into child abuse) that have reported in the last three years? If yes, what changes have you made as a result.

KR

5.12 Are there any services, including those provided on one of your hospital sites but managed by another organisation where health professionals also work for your

PCT or closely with your PCT staff, where quality of care has caused concern or been subject to investigation (in the last three years)? Please give details.

FC

Strengths and weaknesses

5.13 Please describe briefly one or two examples of what the PCT considers to be best practice in respect of clinical risk management. Please also describe briefly what arrangements are in place to transfer these examples of good practice across the PCT.

Coshh Assessment
Annual Risk Assessments

5.14 Please identify PCT's priority areas for developing clinical risk management in the next 12 months.

FC

6.0 Clinical effectiveness programmes

Name and designation of person responsible for completing this section

Name:

Designation:

Name and position of the designated lead for clinical effectiveness

Name:

Position:

Is this a PCT lead or board level lead?

6.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to promote and support clinical effectiveness.

6.2 Please describe briefly the PCT's managed processes and systems for developing and supporting initiatives on clinical effectiveness across the PCT. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

KR/NK

Individual service meetings (clinical network meeting which are unidisciplinary and the strategic nursing network).
Medicines management & guidelines group
NICE implementation group
Clinical Governance Committee
Policies Group
LITs
Dissemination of drugs and interventions guidance produced
PEC ie agreement of treatments not normally purchased guidelines
LD Nurse lead group

6.3 Please describe briefly either one or two examples of initiatives on clinical effectiveness in the current financial year.

KR/NK

Current scoping activity taking place
DRIVE
Infection control guidelines in primary/secondary care

6.4 Has the PCT developed or adopted:

a) evidence based co management protocols (eg screening diabetic retinopathy)?

KR/NK

Adopted from NSF
DRIVE
CHD

b) a local formulary?

KR/NK
Yes – developed

c) disease management guidelines or integrated Care Pathways across primary and secondary care

KR/NK

6.5 please describe briefly the PCT's managed systems and processes for implementing, monitoring and reviewing the adoption of NICE guidelines, NSFs, and other national guidance (eg Victoria Clumbie, Bristol etc). [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

KR/NK
Establishment of NICE Action Group
LITs and LDP
Peer review of Clinical Policies – possible extension to guidelines
Clinical audits

6.6 Please describe briefly any examples in the last 12 months year where the PCT has withdrawn a treatment that has been shown to be ineffective?

Rachael.

IH/KR/NK
Commissioning decisions (policy doc. On not usually purchased etc)
Treatments not normally purchased – updated within 2002/03 to include varicose veins/botox/ excess sweating and blushing based on public health clinical effectiveness reviews

---

6.7 What support does the PCT provide for training on evidence based practice and critical appraisal skills?

JP/KR/NK
Links with R&D Unit
Links with ARDSU

Strengths and weaknesses

6.8 Please describe briefly one or two examples of what the PCT considers to be best practice in respect of clinical effectiveness initiatives in your PCT.

KR/NK
Setting up of Medicines Managements and guidelines group
Individual service EBP groups
Guideline dissemination
PGDs
Development of audit tools

6.9 Please identify PCT's priority areas for developing clinical effectiveness in the next 12 months.

KR/NK
Establishing links between Clinical Effectiveness and all other aspects of Clinical Governance
Formation of Journal Club
Closer links with ARDSU to strengthen academic focus
Robust mechanism for NICE dissemination/interpretation/implementation

7.0 Staffing and staff management

Name and designation of person responsible for completing this section

Name:

Designation:

Name and position of the designated lead for staffing and staff management

Name:

Position:

Is this a PCT lead or board level lead?

7.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to staffing and staff management.

Workforce trajectories were recently produced as part of the Fareham and Gosport Local Delivery Plan. The PCT has a Recruitment group which focuses on workforce planning and identifying recruitment gaps. Workforce projections are produced monthly by the Personnel Dept for Community Hospitals.

7.6 Please describe briefly the PCT managed systems and processes for staff appraisals, including how appraisals are linked to the PCT's clinical governance objectives. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The PCT has a recently updated Appraisal and Development Policy.

7.7 Please describe briefly the PCT managed systems and processes for supporting personal development plans (PDPs), annual appraisal and revalidation for GPs, including how appraisals are linked to the PCT's clinical governance objectives. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

a) The PCT has a Performance management policy which applies to all staff, but which needs updating as a priority.

b) We have Service Level Agreements with our external service providers which are monitored on a regular basis.

7.8 Please describe briefly the PCT's arrangements for dealing with poor performance among community health service staff (eg district nurses, therapists etc). In particular what arrangements has the PCT for remedial education, support and monitoring for poorly performing professionals.

7.9 Please describe briefly the PCT's arrangements for dealing with poor performance among independent contractors (eg GPs, dentists etc). In particular what arrangements has the PCT for remedial education, support and monitoring for poorly performing professionals.

Poorly performing doctors policy/guidance

7.14 Please describe briefly how the PCT communicates and monitors compliance by staff and independent contractors with its human resources policies, including equal opportunities, race relations and human rights.

A list of Personnel policies is given to new staff at the induction, and a Personnel manager briefly explains the list and what is available in the staff handbook. A number of policies, including whistleblowing and appraisal and development have recently been relaunched. Pamphlets giving an overview of these relaunched policies will be issued to all staff.

Strengths and weaknesses

7.15 Please describe briefly one or two examples of what the PCT considers to be best practice in respect of staffing and staff management. Please also describe briefly what arrangements are in place to spread these examples of good practice across the PCT.

The PCT IWL portfolio evidence is currently being collated and contains a number of best practice examples. A copy of the portfolio can be provided at a later date. An action plan will be put together following our IWL assessment.

7.16 Please identify the PCT's priority areas for developing staffing and staff management in the next 12 months.

Sickness monitoring and management has been identified by the PCT as an area for improvement. A review of our current recruitment practice is taking place, as part of a review of our recruitment and selection policy.
The PCT intends to develop a policy for the management of poor performance as a priority. Workforce planning and analysis information needs to be developed and monitored as part of a detailed workforce plan.

8.0 Education, training and continuing personal and professional development

Name and designation of person responsible for completing this section

Name:

Designation:

Name and position of the designated lead for education, training and continuing personal and professional development

Name:

Position:

Is this a PCT lead or board level lead?

8.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to training, education and continuing professional development.

8.2 What other resources does the PCT make available for professional development and continuing education and training (eg libraries, learning materials etc)?

Access to Southampton University programme in house education programme both LD specific and in partnership with other services.
Learn Direct Centre based at SJH
Shared Training Services quarterly programme
Target programme to be developed for primary care

8.3 Please describe briefly the PCT's managed systems and processes for supporting education, training and continuing professional development among community health service staff for example district nurses, therapists, etc. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The PCT has recently reviewed the Appraisal and Development Policy. A PCT Training and Education group has also been set up. The PCT has an annual partnership agreement with the WDC.

8.4 Please describe briefly the PCT's managed systems and processes for supporting education, training and continuing professional development among independent contractors eg GPs, dentists, etc. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

Joint training post across PCTs for practice staff.
Practice nurse Induction training portfolio and appraisal work – Training Booklet for all GP staff.
Appraisal process in progress and evaluation of process running
Dental Adviser – local training services. Local LDP/PCT group for strategic direction working
Dental Advisor link with Deanery.

Dental Nurse training very advanced in conjunction with workforce Development Confederation.
Local training of Pharmacy Advisers in General Practice

8.5 Please describe briefly arrangements for working with NHS, non NHS, and academic partner organisations to support education and training initiatives.

Fareham and Gosport PCT works closely with the Workforce Development Confederation, Portsmouth University, and Southampton University in particular for post qualification training. The PCT works with local colleges with regards to foundation degrees and NVQs.
Portsmouth Hospitals NHS Trust provides IT training for Fareham and Gosport PCT.

8.6 Please describe briefly how the PCT monitors and reports on staff attendance at internal and external training courses.

Reports are produced by the training and development service detailing attendance and non-attendance at internal courses. A list of non-attendees is also sent to relevant managers. A record of mandatory training is kept on the Personnel computerised records system. Learning Disabilities have a very detailed updating and monitoring procedure for mandatory training.

8.7 Please describe briefly what action the PCT takes if a member of staff persistently fails to attend arranged training sessions.

Managers are informed by training and development if a member of staff fails to attend a training session. Repeated non-attendance may be dealt with under the Performance Management procedure.

8.8 Please describe briefly how the PCT ensures cover for frontline staff to enable them to attend professional training and education events.

Via individual appraisals and ongoing supervision.
Specific – Essence of Care re-launch/GNP
Ad hoc – Clinical Governance part of most meeting agenda's.
Support – CG manager works with individuals and teams. Practice development facilitator in post.

Cover for training is managed within service areas.
This may involve using overtime, bank or agency staff.
There is some allowance for training in establishments.

8.9 Please describe briefly any training initiatives in managing equality and diversity within the PCT, including that received by the PCT board.

A Diversity awareness training course is currently provided by the Training and Development Service. The Equality and Diversity focus group are currently planning a series of further training sessions.

8.10 Does the PCT have access to NHS library services? If so at which NHS trust, and what is its latest HeLicon accreditation rating?

8.11 Did the NHS library Helicon accreditation find that the libraries resources in terms of budget, staffing and IT access to be adequate?

8.12 Which PCT staff groups have access to library services?

8.13 Did the Helicon accreditation find that library users had access to electronic resources, document delivery services, reference and enquiry services, and stock lending, reservation and renewal?

Strengths and weaknesses

8.14 Please describe briefly one or two examples of what the PCT considers to be best practice in respect of education, training and CPD. Please also describe briefly what arrangements are in place to transfer these examples of good practice across the PCT.

A Lifelong Learning Advisor has recently been appointed to the PCT. An Information Technology Access Centre was recently opened at GWMH.

Nurse in community hospitals undertook the gerontological nursing programme.
Clinical supervision structures are developing in most service areas.

8.15 Please identify the PCT's priority areas for developing education, training and CPD in the next 12 months.

Monitoring and recording of mandatory training
Production of an annual training plan
Evaluation of individual training courses
Linking training and development to the LDP/business plan.
Resourcing.

9.0 Use of information

CHRIS TITE

Name and designation of person responsible for completing this section

Name:

Designation:

Name and position of the designated lead for clinical information management

Name:

Position:

Is this a PCT lead or board level lead?

9.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to information technology (IT).

a) IT:

b) Information analysis:

9.2 Please describe briefly the PCT's managed systems and processes for information communication and technology (ICT). [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

9.3 Please describe briefly one or two examples of how the PCT is developing the use of clinical information in order to improve services in community health services (eg district nurses, therapists etc).

9.4 Please describe briefly one or two examples of how the PCT is developing the use of clinical information in order to improve specialist clinical services provided by the PCT (eg community paediatrics, mental health etc).

9.5 Please describe briefly one or two examples of how the PCT is developing the use of clinical information in order to improve services among independent contractors (eg GPs, dentists etc).

9.6 Please describe briefly either one or two examples of how the PCT involves different types of clinical staff in improving the quality and use of clinical information in order to improve services.

9.7 Please describe briefly either one or two examples of how the quality of patient care has improved as a direct result of PRIMIS facilitators or other IT / information initiatives working with general practices in the PCT.

9.8 Please describe briefly the PCT's managed systems and processes for ensuring that employed staff are aware of and comply with Caldicott. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

9.9 Please describe briefly the PCT's managed systems and processes for ensuring that independent contractors are aware of and comply with Caldicott. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

9.10 Please describe briefly the PCT's arrangements for sharing patient information with social services (eg around joint provision of health and social care etc).

9.11 Please describe briefly either one or two examples of the electronic transfer of patient information between the PCT and secondary care providers (eg acute general hospitals, mental health providers etc).

9.12 Please describe briefly the PCT's arrangements for ensuring patient consent. In particular describe the arrangements for minors and patients who have guardians (learning difficulties, mental health problems etc)

Strengths and weaknesses

9.13 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of its use of clinical information. Please also describe briefly what arrangements are in place to spread these examples of good practice across the PCT.

9.14 Please identify the PCT's priority areas for developing clinical information in the next 12 months.

10.0 Overall strengths and weaknesses

Name and designation of person responsible for completing this section

Name:

Designation:

10.1 What do you think are the strengths and weaknesses of your PCT, overall, in respect of clinical governance?

a) strengths:

FC

b) weaknesses:

FC

Any other comments you wish to add...

Thank you for taking the time to complete this questionnaire.
Please return to cgr.trust@chi.nhs.uk

- END -

GUIDANCE NOTES FOR PRIMARY CARE TRUSTS (PCTS) ON COMPLETING CHI'S TRUST QUESTIONNAIRES

Guidance on answering questions in the 'trust questionnaire PCT':

What do we mean by 'describe the PCT's managed systems and processes for...'?
This type of question appears frequently in several questionnaires. You should (as a minimum) answer this type of question for each of the different areas of clinical governance by using the following format:

a) **Accountabilities and structure:**
Who is accountable for the managed system and/or process? Which directorate is responsible for organising or delivering the process and/or activities? Which PCT committee is accountable for scrutinising the managed system and/or process?

b) **Planning and priority setting:**
Who plans the activities? Who determines priorities? How are priorities set?

c) **Communication:**
Who is responsible for communicating the priorities and plans? How are these communicated within the PCT?

d) **Monitoring:**
Who is responsible for monitoring processes and/or activities? What is the PCT mechanism for monitoring relevant activities?

e) **Evaluation:**
Who is responsible for evaluating outcomes? What is the PCT mechanism for evaluating outcomes? (e.g. how does the PCT know what was achieved? What clinical governance improvements occur due to the system?)

f) **Reporting:**
What is the mechanism for reporting activities and outcomes up through the accountability structure to the board and across the PCT?

How to answer questions that begin: 'Please describe briefly either one or two examples of.....'
This type of question appears in several sections. You should (as a minimum) structure your answer to this type of question using the following format:

1) What was (were) the objective(s) of the initiative?

2) Which staff and services were involved?

3) What activities did the initiative deliver (outputs)?

4) What clinical governance improvements occurred (outcomes)?

(Please do not provide the same example in the questionnaire.)

Wherever possible please describe current arrangements and examples:

Your answers should always describe your current managed systems and processes and examples of initiatives that have been completed or are underway. Please do not provide, instead, a description of what your PCT intends to do in the future unless a question specifically asks for this.

In addition PCTs providing inpatient and day case services will need to complete the 'Trust questionnaire – PCT community hosp precoded.doc' questionnaire:

Guidance on completing 'Trust questionnaire PCT-community hosp precoded.doc'.
Some PCTs have different clinical governance arrangements in place for staff working in community hospitals. 'Trust questionnaire PCT-community hosp precoded.doc' is intended to identify clinical governance arrangements for community hospitals that contain inpatient and, or day case beds that are operated and managed by your PCT.

You will need to complete a version of this questionnaire for each community hospital operated by the PCT. Do not complete this questionnaire if your PCT operates a community hospital that is solely a base for staff working in the community or as a venue for outpatient clinics.

If completing more than one community hospital questionnaire please amend the file name of each questionnaire to indicate which site it refers to.

When you tell us about the work that you are doing:
When you answer the trust questionnaires you should make sure that you tell us about work that is being done at the moment and work that has been done in the past, as well as work that is planned for the future.

If you have any questions please contact the phase one team for guidance.

Fareham & Gosport Primary Care Trust (PCT)

PCT clinical governance arrangements

The following tool is designed to collate your views on your primary care trust's (PCT's) arrangements for clinical governance. It is intended to complement the data set and information required by the Commission for Health Improvement (CHI) in readiness for the review process.

This questionnaire is divided into the different areas of clinical governance. **Each section should be completed by the PCT lead for that area.**

Please read the guidance shown below on answering questions in the questionnaire.

This questionnaire is provided as an electronic file as well as in hard copy. Please complete and return the questionnaire **electronically**. It contains hidden codes to help CHI to process the answers: for this reason, please only enter text between the question and the question dividing line.

Once you have completed the questionnaire either:

Email to: cgr.trust@chi.nhs.uk

Or post to:

Phase 1 team
Commission for Health Improvement
Finsbury Tower
103-105 Bunhill Row
London EC1Y 8TG

The deadline for returning this document is **20 February 2004**

Name and designation of person collating this questionnaire

Name:

Designation:

Chief executive

Signature:

Date:

CHI guidance on answering questions in this questionnaire

How to answer questions that begin: *'please describe briefly the PCT's managed systems and processes for...'.*

You should (as a minimum) answer this type of question using the following format:

(a) **accountabilities and structure:**
Who is accountable for the managed system and, or process? Which directorate(s) are responsible for organising, or delivering the processes and, or activities? Which of the PCT committee is accountable for scrutinising the managed system and, or process?

(b) **planning and priority setting:**
Who plans the activities? Who determines priorities? How are priorities set?

(c) **communication:**
Who is responsible for communicating the priorities and plans? How are these communicated within the PCT?

(d) **monitoring:**
Who is responsible for monitoring processes and, or activities? How are processes and, or activities monitored?

(e) **evaluation:**
Who is responsible for evaluating outcomes? What is the PCT mechanism for evaluating outcomes? [eg what clinical governance improvements occur due to the system?]

(f) **reporting:**
What is the mechanism for reporting activities and outcomes up through the accountability structure to the board and across the PCT?

How to answer questions that begin: *'Please describe briefly either one or two examples of...".*

This type of question also appears frequently in several sections. You should (as a minimum) structure your answer to this type of question using the following format:

1 what was the objective(s) of the initiative?

2 which staff and services were involved?

3 what activities did the initiative deliver (outputs)?

4 what clinical governance improvements occurred (outcomes)?

[NBnb Please do not provide the same example in different sections in the questionnaire.]

Wherever possible please describe current arrangements and examples:

Your answers should always describe your current managed systems and processes and examples of initiatives that have been completed or are well underway. Please do not provide instead, a description of what your PCT intends to do in the future, unless a question specifically asks for this.

CH i

Fareham and Gosport NHS
Primary Care Groups

MEMORANDUM

To: SEE DISTRIBUTION LIST **From:** Fiona Cameron

Date: 29th October 2003 **c.c.**

TITLE/SUBJECT: Strategic Leadership of Clinical Governance Board & PEC Pilot Programme

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You may be aware that a number of PCTs within Hampshire & Isle of Wight Health Authority have previously participated in this self-assessment programme for the members of PCT Boards and PEC.

The strategic Health Authority is keen for all PCTs to have completed the self-assessment and the process will be advantageous in terms of our preparation for our CHI Clinical Governance Review early in 2004.

I have spoken with a number of PCTs who have undertaken the work, and they have also spoken very highly of it.

I am attaching a copy of the Executive Summary, which is essential reading for all members of the Board and PEC and contains the questions that are used in the self-assessment.

The time commitment from each of you will be roughly 2 hours in the first instance and there is a requirement that 75% of the Board and PEC engage in the process for the PCT to derive maximum benefit. Once the self-assessment has been undertaken, the analysed data will be fed back to both the Board and PEC. Initial time scales for this are the diagnostic process during December with feedback in February 2004.

I will keep you posted as I have more information, I am attending the feedback session from other PCTs on 24th November, so will hopefully have other information at that stage.

In the meantime, if you have any questions or concerns please do not hesitate to contact me.

Fiona

Code A

DISTRIBUTION LIST:

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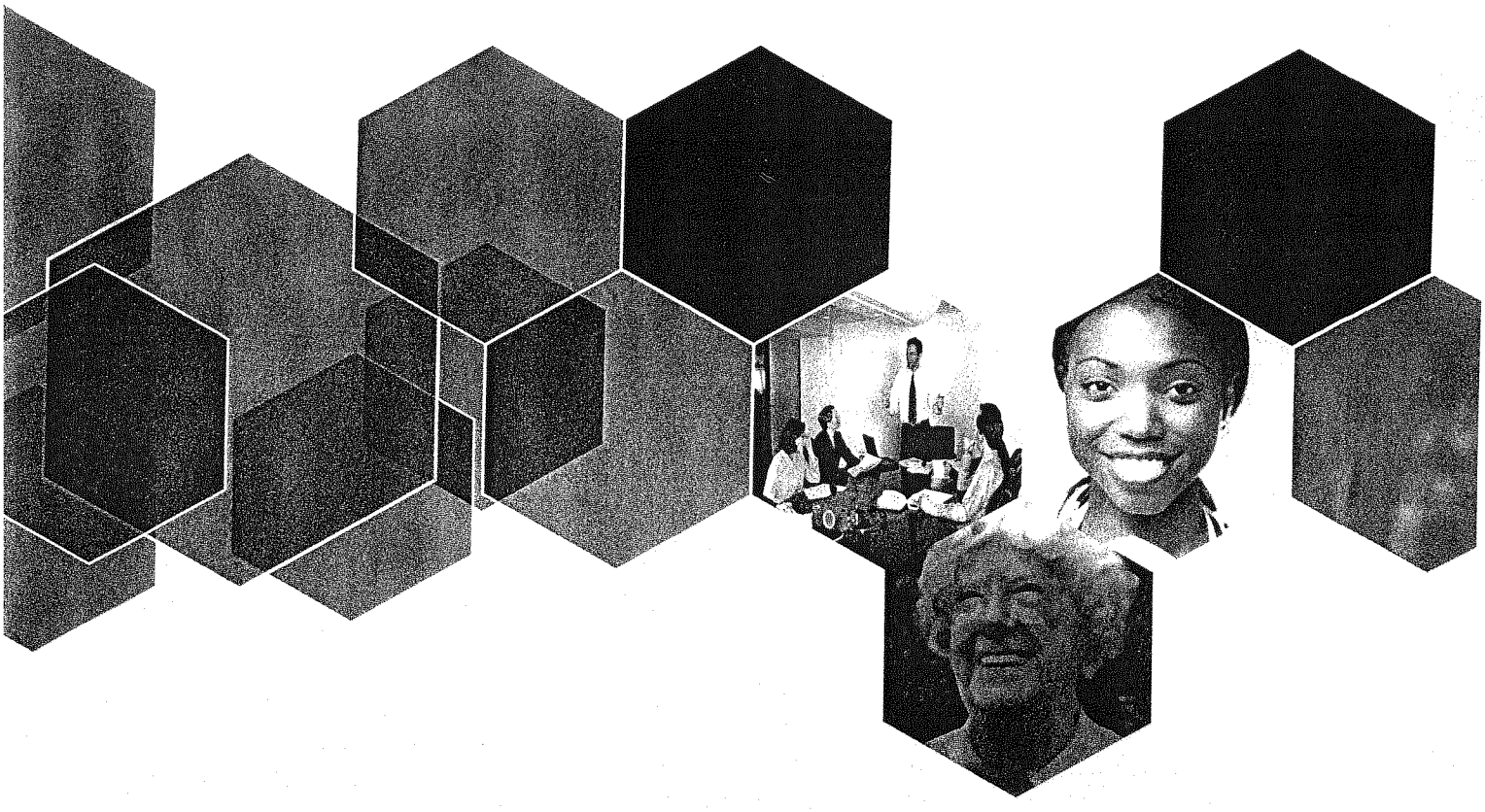
The Strategic Leadership of Clinical Governance
Pilot programme for the members of PCT Boards and PECs

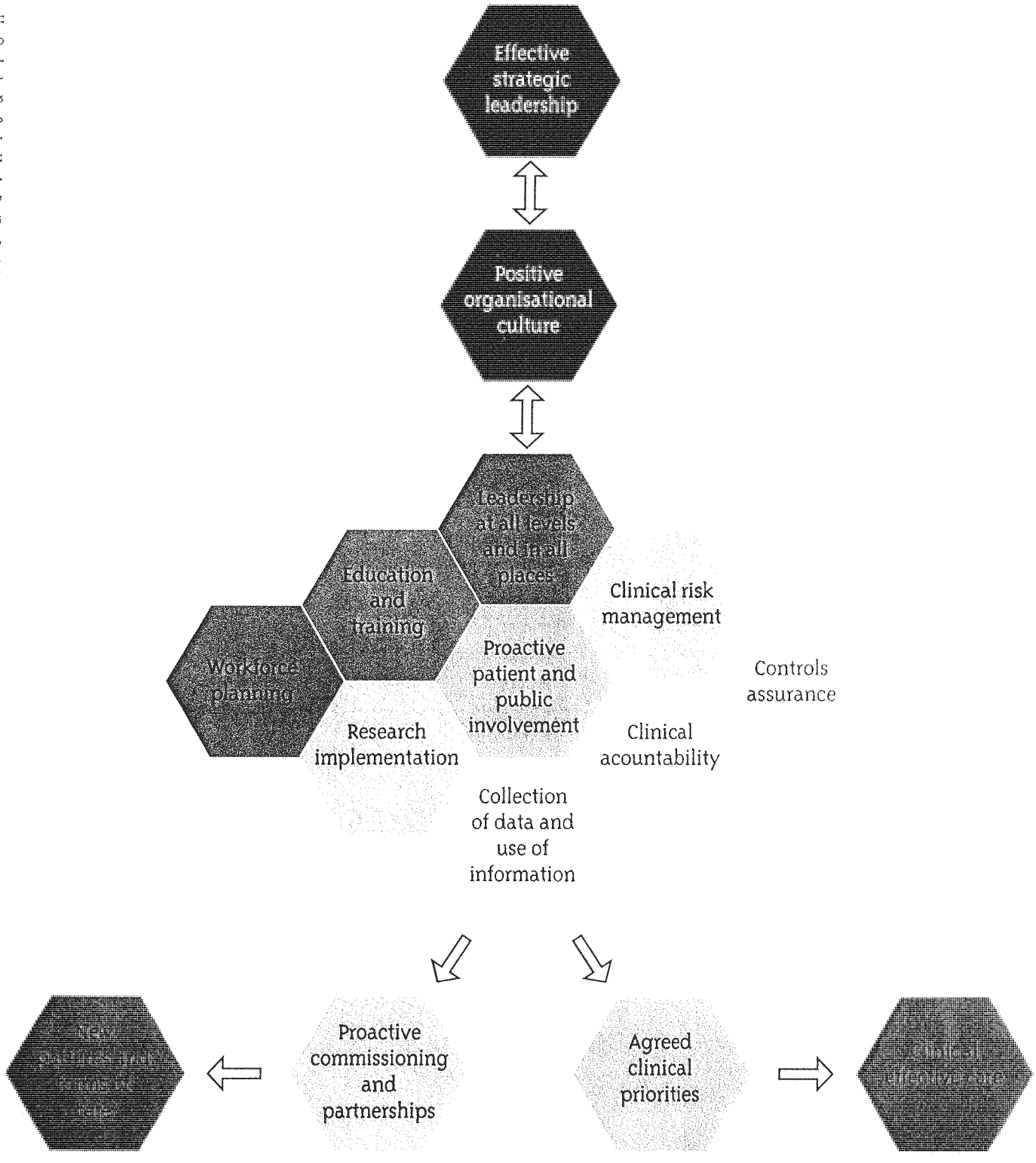
Executive summary



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 both the Strategic Health Authority and the Commission for Health Improvement (CHI/CHAI).

The self-employed status of general practitioners, community dentists, pharmacists and optometrists can cause 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 pack in response to requests from PCTs for support in delivering their main responsibilities in relation to clinical governance. They are also intended to support StHAs in their duty to develop clinical governance capacity within their respective health economies.

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

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

The materials consist of:

- an Executive Summary with a brief outline of each of the 19 topics covered in the full support 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 support materials which consist of 19 content sections, each of which expands the areas raised in the Executive Summary and includes opportunities for reflection and in-depth exploration of the topic. At the end of each section, there is a list of useful references and resources.
- a response sheet, for your answers to the questions (enclosed at the end of the Executive Summary)
- a pilot questionnaire asking about your experience of using these materials.

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 StHA.

Board and PEC members can use the materials to:

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

The materials should help members of Boards and PECs to:

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

This pilot version of the materials is also intended to help us refine and improve the materials which will subsequently be sent out to all PCTs.

How this pack can help you

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

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

How to use the materials

We anticipate that everyone will find the Executive Summary essential reading and will 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 full support 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 full support materials as a reference as you go about the business of establishing procedures to embed clinical governance in the PCT.

The full support 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!

You will have about three weeks to work through the materials and answer the questions on the response sheet. Return your response sheet, by the stipulated date, to the 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 (CGST) 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:

- an accurate overall score for each topic area
- developmental priorities.

This consensus score and your developmental priorities will be shared with the Strategic Health Authority and, together, we will agree on and seek to meet any priority development needs.

Once we have completed the analysis of the data from all of the 60+ PCTs that are participating in the pilot, 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 pilot.

Note: we have made every effort to ensure that the content and references contained in these pilot materials are accurate and up to date at the time of going to press (at the beginning of March, 2003). If you are aware of recent developments, or more correct or fuller references, please let us know via the materials evaluation form.

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.*

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'.

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 have a shared understanding of their clinical governance duties and responsibilities in relation to the quality of existing provision made directly by the PCT?

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

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

2.4 To what extent are the PCT Board and PEC discharging their statutory Section 11 responsibilities to ensure that patients and the local community are actively involved in all aspects of the PCT's work?

2.5 To what extent are the PCT Board and PEC taking active steps to ensure common understanding and commitment to clinical governance across all of the professional and other staff groups within the PCT community?

2.6 To what extent is there a comprehensive and robust clinical governance 'baseline measure' against which progress can be measured and evidenced?

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 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.

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

3.1 To what extent has a realistic vision for the PCT been established through consultation?

3.2 To what extent do the Board and PEC maintain a balance between their corporate and clinical governance responsibilities?

3.3 Overall, how effectively do the Board and PEC function together?

3.4 To what extent is due weight given to the views of non-Executive Board members?

3.5 To what extent have realistic local strategic clinical governance priorities been established by the Board and PEC in the light of *The NHS Plan* and of local need?

3.6 How well are these priorities understood across the local health and social care community?

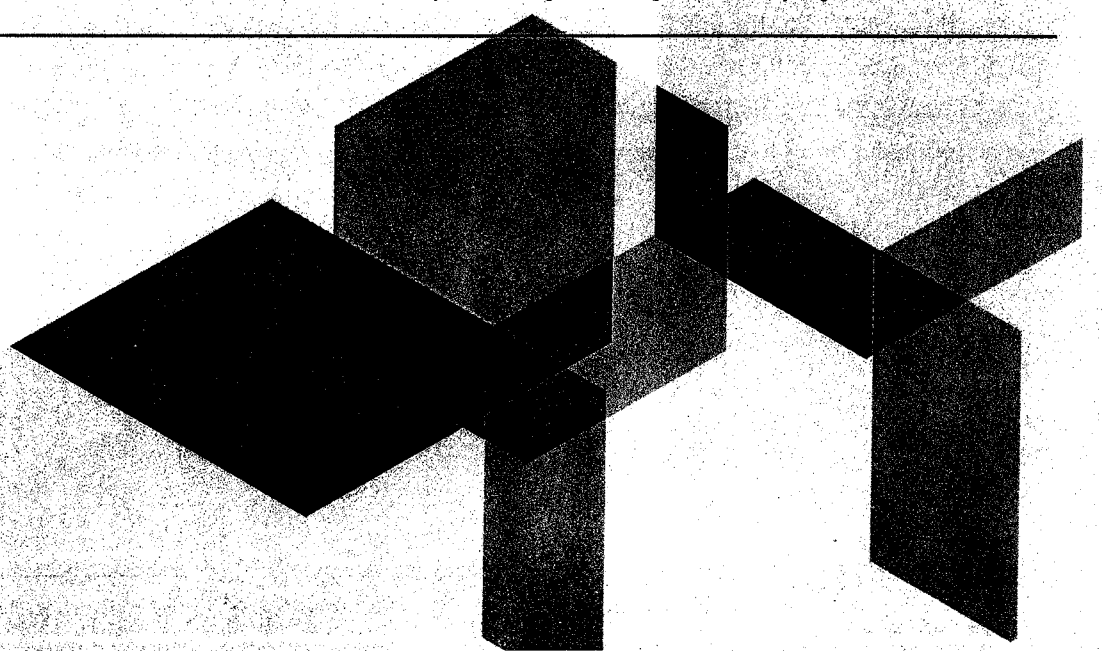
3.7 To what extent have the Board and PEC established clear clinical governance structures of operational delegation and accountability?

3.8 To what extent has a culture been developed throughout the PCT in which clinical excellence can flourish?

3.9 Overall, to what extent does the PCT have effective leadership?

3.10 To what extent has clinical leadership been embedded in all locations, professional groups and teams?

3.11 How active are the Board and PEC in critically reviewing clinical governance progress?



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.

Common understanding cannot be assumed, but must be fostered 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.

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 How widespread is a common understanding of clinical governance across the PCT community?

4.2 Does the Board and PEC have an explicit strategy for embedding ownership of clinical governance across all sections of the PCT community?

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 do the Board and PEC give attention to their 'duty of care' to the whole staff community?

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

4.6 How well has the PCT shared its understanding of clinical governance with patients and the local community?

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.

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.

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

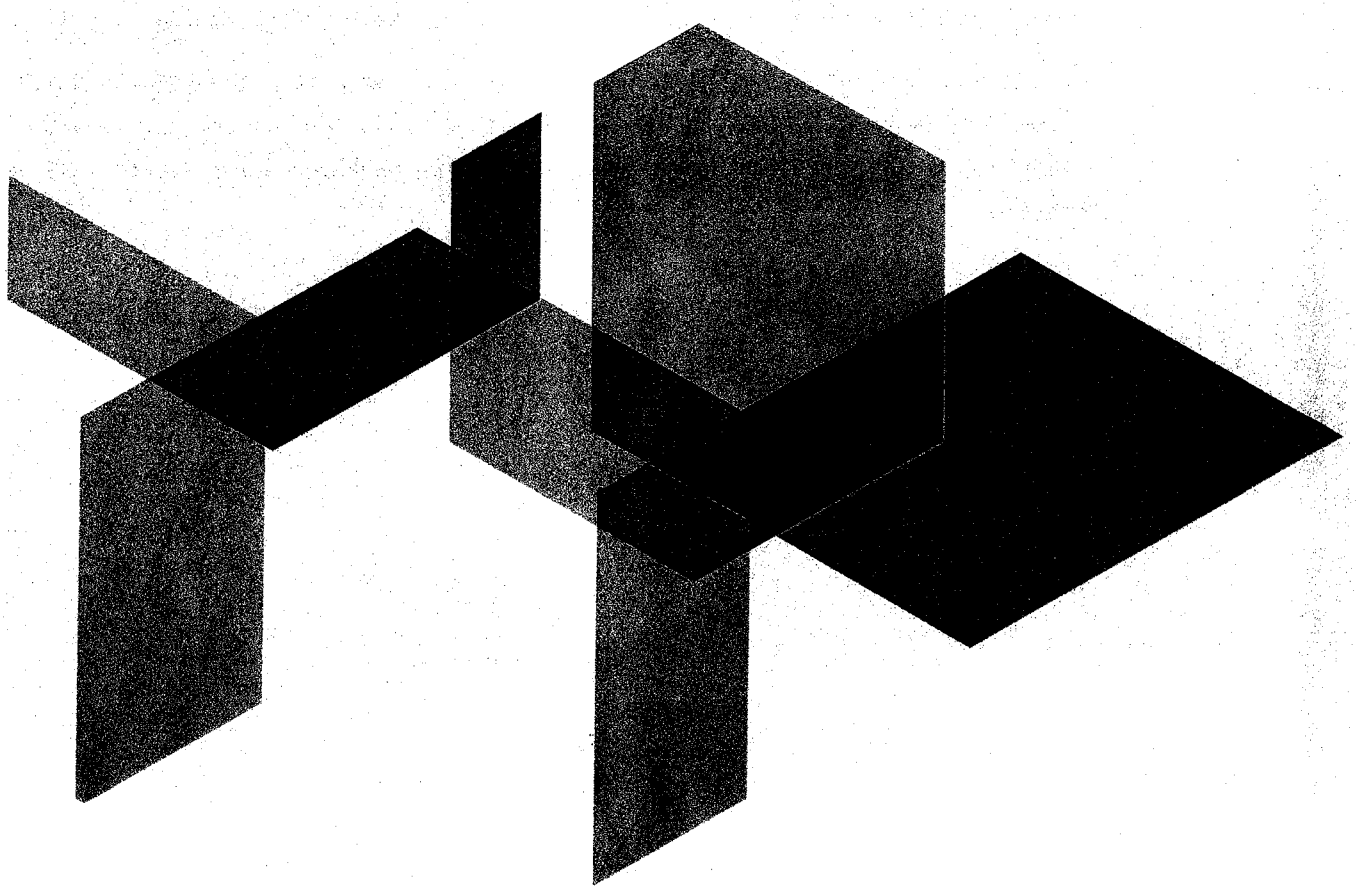
5.1 To what extent has the Board and PEC identified key indicators of the quality of patient experience of PCT-delivered care?

5.2 To what extent is evidence routinely presented to the Board and PEC of the quality of the patient experience of PCT services?

5.3 To what extent has the Board and PEC kept access to 'timely' care under active review?

5.4 To what extent is attention given within the commissioning process to the quality of the patient experience?

5.5 To what extent does the Board and PEC keep the overall co-ordination and 'seamlessness' of patient care under active review?



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. 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.

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 welcome the promotion of an active voice for patients and the public?

6.2 How effective are the PCT's arrangements for securing patient and public involvement in planning, delivering and monitoring performance?

6.3 How well prepared is the PCT to respond to the challenges of new structures for patient and public involvement?

6.4 To what extent do the Board and PEC routinely review feedback from users of the PCTs services?

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 StHAs 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 StHAs 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). Building upon pilot work in 2002, CHI will begin the systematic scrutiny of PCTs in 2003.

This scrutiny will form one part of the overall organisation-wide inspection that will ultimately be carried out by the newly created Commission for Health Audit and Inspection (CHAI).

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 to evaluate the PCT's clinical governance performance?

7.2 To what extent do the Board and PEC receive evidence of progress, or obstacles to progress, in making the clinical governance strategy a reality?

7.3 To what extent do the Board and PEC actively review the Clinical Governance Development Plan and the Annual Clinical Governance Report?

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

7.5 To what extent do the Board and PEC actively review the CHI emerging themes?

7.6 To what extent do the Board and PEC actively review the development of new forms of accountability to patients and the local community?

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 StHA 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.

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 identified key and concrete clinical priorities?

8.2 How well co-ordinated and aligned are the component elements of clinical governance with these clinical priorities?

8.3 To what extent has it been possible to generate a consensus within the local health community about a number of key clinical priorities?

SECTION NINE
DATA, INFORMATION AND IM&T

'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 appropriate 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 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 StHAs.

Whilst working alongside them 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.

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 receive timely information for careful consideration before decisions are reached?

9.2 How adequate is the information available to the Board and PEC to discharge their public health functions so that they can identify and respond to the current and future priority health needs of the local community?

9.3 To what extent is the information available to the Board and PEC sufficiently robust for them to assure the safely and quality of current provision made by the PCT?

9.4 To what extent has the PCT critically appraised the adequacy of current data systems and outputs?

9.5 How adequate is the information available to the Board and PEC to assure the safety and quality of the services commissioned by the PCT?

9.6 To what extent is the PCT currently meeting the Caldicott Standards?

9.7 To what extent has the PCT developed a clear and realistic IM&T development strategy?

9.8 To what extent has the PCT developed a financial strategy for IT investment to meet its information needs?

9.9 How well developed are strategies to improve data collection and analysis across the whole local health economy?

SECTION TEN
CLINICAL 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 and to communities. Risk cannot be eliminated, but it must be managed.

Controls assurance

In discharging their overall 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.

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 How well embedded are controls assurance processes in all aspects of the PCT's activities?

10.2 To what extent do members of the PCT Board and PEC share an understanding of 'reasonable assurance'?

10.3 To what extent are systems in place proactively to identify clinical risks to patients and staff?

10.4 To what extent are these clinical risks actively managed?

10.5 To what extent is attention paid to the risks confronting vulnerable or marginalised people?

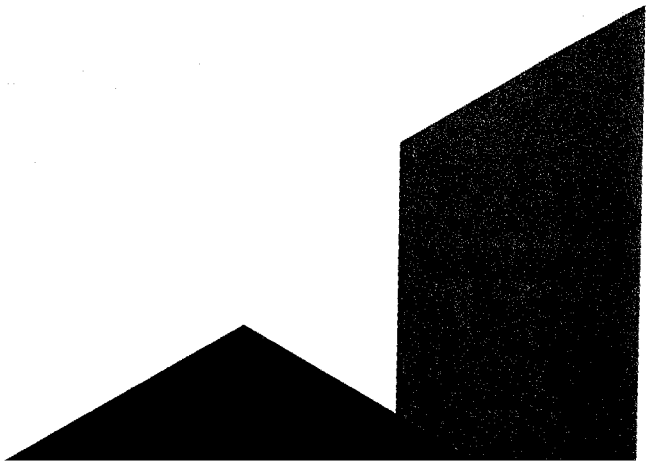
10.6 Does the commissioning process take all reasonable steps to ensure patients' safety and the quality of care?

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

10.8 To what extent are patient complaints systematically analysed to help identify and eliminate potential or actual risk?

10.9 To what extent does the staff culture promote the identification of serious untoward incidents or near misses?

10.10 To what extent does the PCT learn from complaints, serious untoward incidents or near misses and other forms of proactive risk identification?



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.

Supporting ALL professionals in the PCT community

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

Historically, the work of general practitioners has not been subjected to direct organisational scrutiny and accountability. However, the new GP contract will 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 monitor the standards of clinical care provided on their behalf, and 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.

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 How well developed are the PCT's clinical accountability and support arrangements in relation to GPs in the constituent practices?

11.2 How well developed are the PCT's clinical accountability and support arrangements in relation to community dentists, pharmacists and optometrists who have recently joined the PCT community?

11.3 How well developed are the PCT's clinical accountability and support arrangements in relation to community nurses, health visitors and other health professionals?

11.4 What steps has the PCT taken to support and strengthen professional self regulation?

11.5 How well developed are the PCT's arrangements for assuring the adequacy of clinical accountability and support arrangements in those organisations from which they commission clinical services?

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.

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.

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 How involved are patients or patient groups in defining clinical audit priorities?

12.4 How much do patients or patient groups participate in clinical audit activity?

12.5 To what extent are other components of clinical governance aligned with the clinical audit programme?

12.6 To what extent does any PCT activity audit the complete patient journey?

12.7 How much evidence is there of changes made as a result of clinical audit?

12.8 To what extent are prioritised clinical audit requirements built into commissioning contracts?

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

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) have been established to help NHS Trusts co-ordinate investment in training and target it at national and local workforce and service development priorities. The relationship between a PCT and the WDC is a critical one.

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.

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 the PCT's clinical governance priorities?

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 are outcomes from other clinical governance activities (e.g. audit, CRM) analysed and used to identify training and development needs?

13.5 How supportive is the PCT's relationship with the local Workforce Development Confederation?

13.6 How effective is that relationship in securing targeted training investment to support the PCT's clinical priorities?

13.7 How actively are patients and the public involved in the design and delivery of education and training activities?

13.8 To what extent is the impact of training on patient outcomes and satisfaction actively monitored by the Board/PEC?

SECTION FOURTEEN
RESEARCH GOVERNANCE AND RESEARCH IMPLEMENTATION

'A recently announced ministerial review will increase the focus upon the research and the learning capacity and agenda in primary care....within the new NHS structure, PCTs should be supported to deliver on learning and research, while providing improved local patient care.'

CEO Bulletin 145 Dec 2002

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.

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 How well developed is the research governance framework across all staff groups within the PCT community?

14.2 Does the PCT have an explicit strategy and action plan for monitoring the uptake of research in practice across all professional groups?

14.3 To what extent does the Board and PEC consider research governance and implementation issues within the broader context of the overall clinical governance agenda?

14.4 To what extent does the Board and PEC receive reports about the monitoring and implementation of NICE guidance?

14.5 To what extent does the Board and PEC receive reports about progress on the implementation of NSFs?

14.6 To what extent is the appraisal of provider organisations' research governance and implementation built into the commissioning process?

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 the practical and concrete application of the fruits of other elements of clinical governance.

In clinically effective care:

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

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. This is one of the input foci of IM&T systems, whose output is robust clinical data.

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.

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 have systems been developed in the PCT to ensure that all aspects of clinical governance support the provision of clinically effective care?

15.2 How robust are the methods for monitoring and gathering evidence of the effectiveness of clinical care?

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

15.4 To what extent are clinical effectiveness initiatives targeted at clearly defined and agreed clinical priority topics or conditions?

15.5 To what does the PCT have transparent processes for balancing the cost of treatment against its evidenced efficacy?

15.6 To what extent does the PCT have a Knowledge Management Strategy to support delivery of clinically effective care?

15.7 To what extent do the Board and PEC consider clinical effectiveness as well as cost-effectiveness as part of the commissioning process?

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
- commissioning responsibilities
- emergency planning responsibilities.

If the Boards and PECs of PCTs are to discharge their clinical and broader 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 may need to undertake 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 StHA 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.

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.

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 in the PCT meet the needs of its clinical governance responsibilities?

16.3 To what extent can the management and administrative infrastructure support the PCT's responsibilities, including providing quality care and supporting the commissioning process?

16.4 How well developed is the PCT's strategy in relation to 'Improving Working Lives'?

16.5 To what extent has the Board and PEC fostered a sense of identity and belonging across the PCT staff community?

16.6 To what extent has the Board and PEC developed a strategy to help all staff groups work more flexibly?

16.7 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 StHA.

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 PCT's commissioning process influenced and shaped by public-health-led understandings of community need?

17.4 To what extent has the PCT developed a clear and prioritised health promotion strategy?

17.5 To what extent have the public health training and development needs of the PCTs workforce been actively considered?

17.6 To what extent is the PCT working actively with organisations in the local community to improve the overall life circumstances of the population?

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 and new 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).

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.

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 does the Board and PEC pay attention to the quality of services commissioned by the PCT on behalf of its patients?

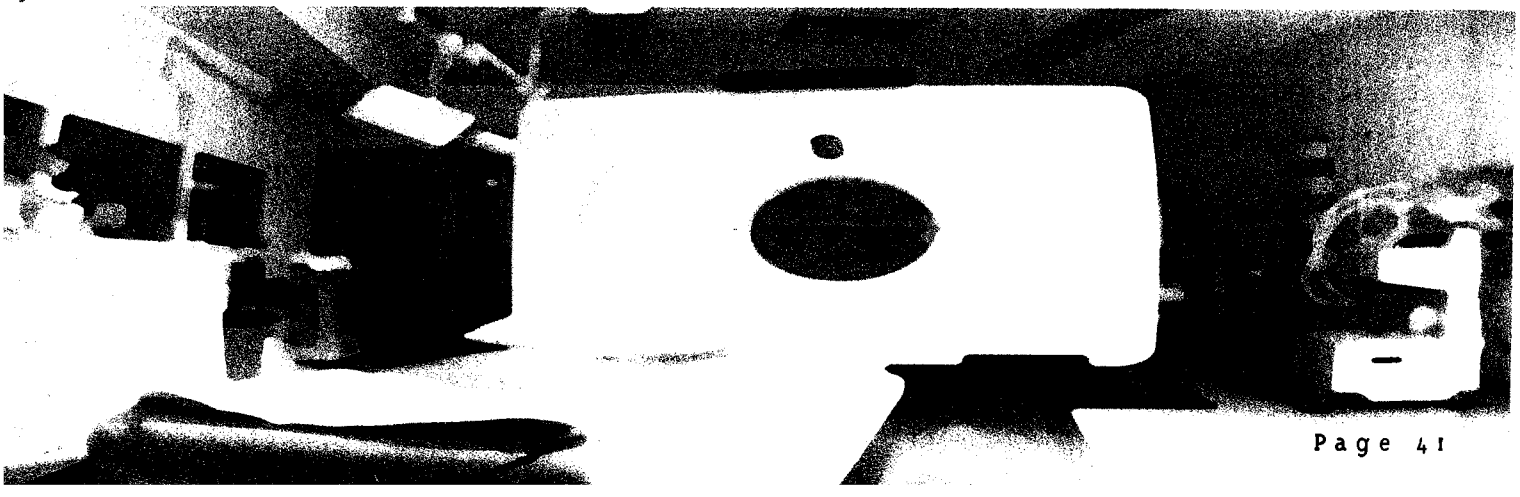
18.2 To what extent does the PEC and the Clinical Governance Committee scrutinise agreements reached with acute and other providers of care?

18.3 To what extent are the PCT's clinical staff actively engaged in shaping and monitoring the commissioning agenda?

18.4 To what extent does the local community have an active voice in setting the commissioning agenda?

18.5 To what extent does the PCT collaborate with its provider network to reduce clinical risk and improve the quality of service?

18.6 To what extent does the PCT collaborate with provider organisations to develop new forms or patterns of care?



SECTION NINETEEN

INTER-ORGANISATIONAL COMPONENTS 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 & 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 episodes of care. It is the primary means of turning the vision of flexible, needs-led and seamless care into reality.

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.

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

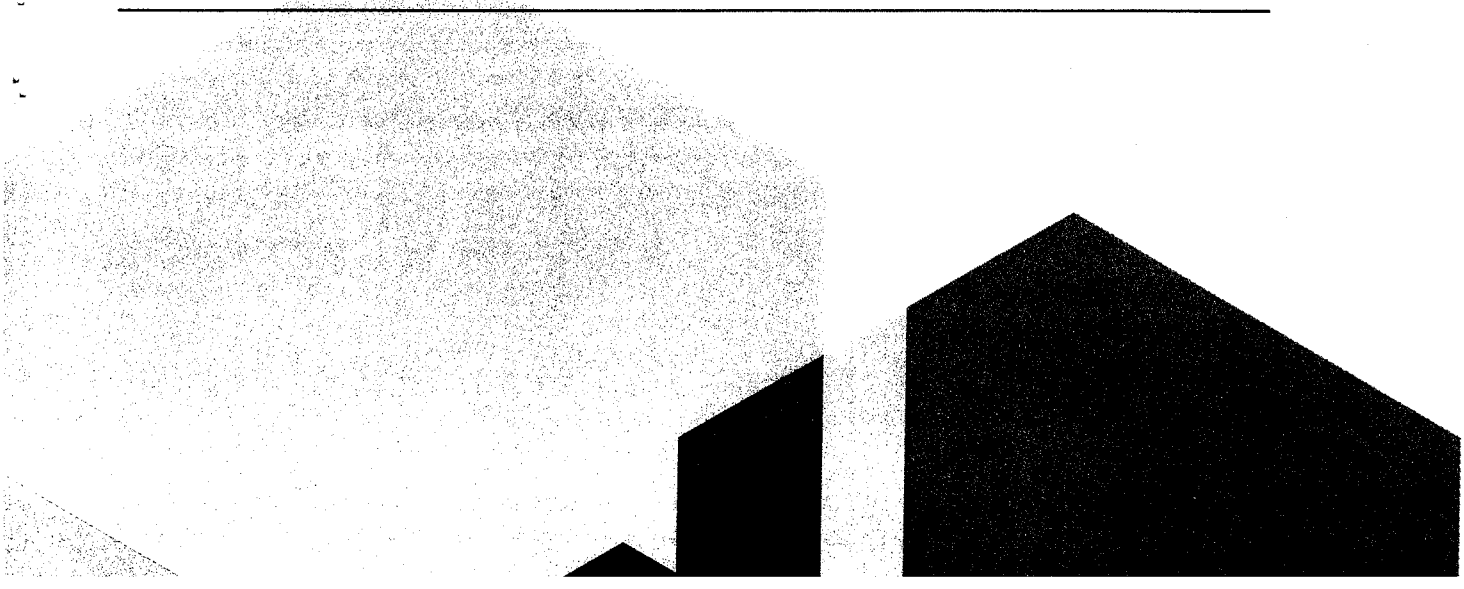
19.1 To what extent does the Board and PEC actively manage and monitor the quality of patients' transitions between PCT services and those of other health or social care providers?

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 To what extent has the PCT worked with partner organisation to develop clear and effective forms of collaborative clinical governance for, for example, cancer networks?

19.5 To what extent has progress been made within the local health economy in identifying 'transformational priorities' to support achievement of *The NHS Plan*?



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, and the new Emergency Planning. 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, these services – or affected by their Emergency Planning functions.

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.

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 do the PCT's clinical governance strategy and procedures discharge the duty of quality in relation to dentistry, pharmacy and optometry?

20.2 To what extent is the current expertise available within the Board and PEC sufficient to assure planning, scrutiny and support of these services?

20.3 To what extent has the PCT taken account of the need to work in partnership with the local community in undertaking its 'emergency planning responsibilities'?

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:

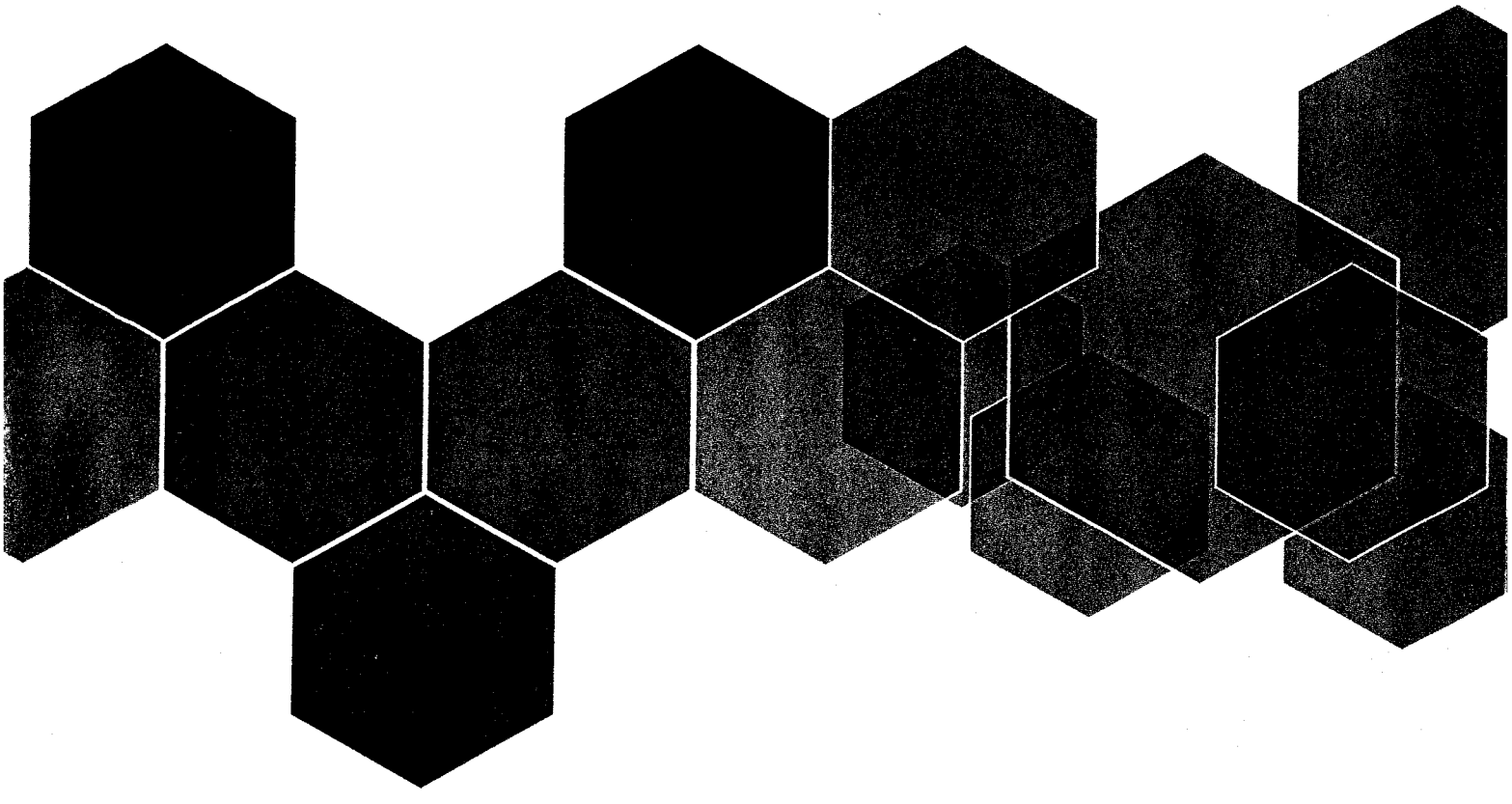
Professor Aidan Halligan
Alastair Henderson, The NHS Confederation
Alex Tobin, National Clinical Governance Support Team
Amanda Hedley, National Clinical Governance Support Team
Baroness Cumberlege
Carol Limber, GPwSI
Catherine Dewsbury, Royal Pharmaceutical Society
Clare Gerada, National Clinical Governance 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
Owen Lloyd, Bedfordshire and Hertfordshire Strategic Health Authority
Philip Leech, Department of Health
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, 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 East Birmingham PCTs who piloted sample questions and Response Sheets.

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

Pilot programme for the members of PCT Boards and PECs