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Progress in Implementing Clinical Governance in Primary Care: Lessons for the New Primary Care Trusts

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IMPROVING QUALITY AND SAFETY

Progress in Implementing Clinical Governance in Primary Care: Lessons for the New Primary Care Trusts

CONTENTS

SUMMARY

1 The Health Acts of 1999 and 2003 set out a statutory 'duty of quality' for all providers of NHS services. At the local NHS level, this duty of quality is discharged largely through implementing clinical governance **(Figure 1)**. Since the first Primary Care Trusts (PCTs) came into being in 2001, they have had the dual role of providing primary care services and commissioning services on behalf of their local health economy with accountability for PCT performance vested in the PCT Chief Executive **(Figure 2 on page 6)**. Clinical governance, implemented effectively, can provide PCT Chief Executives with assurance that healthcare, whether provided directly or commissioned from other providers, is both safe and of good quality.

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

Source: A First Class Service – Quality in the new NHS, Department of Health, 1998

1 Why implementing clinical governance is important for quality in the NHS

"The scope of the new quality programme which is emerging in the NHS is bold and broad-based. Underpinning this has been the concept of clinical governance – a unifying concept for quality which provides organisations with a systematic means for ensuring that they comply with their statutory duty. It aims to effect a change of culture in NHS organisations to one where:

openness and participation are encouraged, where education and research are properly valued, where people learn from failures and blame is the exception rather than the rule, and where good practice and new approaches are freely shared and willingly received."

Sir Liam Donaldson, Chief Medical Officer[1]

"In my view, if properly developed and well resourced, clinical governance could provide the most effective means of achieving two important aims. First, it could enable PCTs to detect poorly performing or dysfunctional GPs on their lists. It could also help practices to discover any problems or weaknesses among their own number. Second, it could have the beneficial effect of helping doctors who are performing satisfactorily to do even better."

Dame Janet Smith, fifth Shipman report[2]

The NHS has one of the strongest and most transparent systems for quality in the world: clear national standards, strong local clinical governance arrangements (to assure and improve quality locally), robust inspections and rigorous patient safety arrangements. … We will continue to give a high priority to clinical governance and patient safety. The programme of patient safety launched by the Chief Medical Officer's report *An organisation with a memory* is becoming integral to local services.

Department of Health[3]

"Clinical governance is deeply embedded in some services but is largely lacking in others … few Chief Executive Officers match the depth of their fear of missing budgetary and productivity targets with the strength of their passion to improve quality and safety of services for their consumers."

Sir Liam Donaldson, Chief Medical Officer[4]

"For many, clinical governance is seen as the organisational conscience, and, at its most idealistic, the 'beating heart' of care. … It encapsulates an organisation's statutory responsibility for the delivery of safe, high quality patient care and it is the vehicle through which … accountable performance is made explicit and visible."

Professor Aidan Halligan, former Director of Clinical Governance for the NHS[5]

NOTES

1 *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005-06–2007-08*, Department of Health, 2004.

2 *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, Shipman Inquiry, 2004.

3 *Our health, our care, our say: a new direction for community services.* Department of Health, January 2006.

4 *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*, A report by the Chief Medical Officer, Department of Health, July 2006.

5 *Clinical governance: assuring the sacred duty of trust to patients*, Professor Aidan Halligan, 2005.

2   Roles responsibilities and accountabilities for quality and safety of primary care services

The Department of Health sets overall policy for quality and safety across the National Health Service through

- Policy statements and initiatives
- Chief Medical Officer reports annually on quality and safety in the NHS

DH Department of Health

Additional support is provided to the NHS through, for example, the **NHS Clinical Governance Support Team** and the **Institute of Innovation and Improvement**

Strategic Health Authorities monitor and review implementation of clinical governance by PCTs and provide support for example through clinical leads' forums; oversee PCTs' clinical governance performance.

NHS

Professional Executive Committees assist trust Boards in the management of the trust, in particular providing clinical leadership and advice on quality and clinical governance

Primary Care Trusts have a statutory 'duty of quality' with accountability for quality through the Chief Executive for all the services that a PCT provides and commissions. Clinical governance is the framework for ensuring delivery of this statutory duty of care. In 2005-06, PCTs spent £68 billion, of which £23 billion[1] was on commissioning primary care and providing healthcare.[1]

NHS

Accountabilities

- PCTs are directly accountable for all the services the trust provides and commissions

Various arm's length public bodies have a role in inspecting PCTs' performance in relation to quality and safety including the **Healthcare Commission** and its performance assessments against the Standards for Better Health

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£5 billion[1]

£18 billion

Direct provision of healthcare services by directly employing a range of primary care professionals

Accountabilities

- PCTs have direct control over day to day management of quality and safety

Commissioning of primary care services from independent contractors and other providers

Accountabilities

- PCTs do not have direct control over day to day management of quality and safety

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Patients and the Public use primary care services – 800,000 people each day; with nine out of ten NHS patients diagnosed and treated entirely within primary care.

Source: National Audit Office and Department of Health

NOTE

1   These figures include all care provided directly by Primary Care Trusts, which include some secondary care (such as community health services).

2   The concept of clinical governance was introduced in 1998 as the centrepiece of the Government's ten year programme to improve continuously the overall standard of clinical care; reduce variations in outcomes of, and access to, services; and ensure that local decisions are based on the most up to date evidence of what is known to be effective.[1, 2, 3] The key principles of clinical governance are: a coherent approach to quality improvement, clear lines of accountability for clinical quality systems and effective processes for identifying and managing risk and addressing poor performance. It involves putting in place the information, methods and systems to ensure good quality so that problems are identified early, analysed and action taken to avoid further repetition.[4]

3   There are a number of models of clinical governance, comprising distinct quality programmes known variously as pillars, elements or components.[5] For the purposes of this review we assessed PCTs' progress in implementing nine key components of clinical governance that the Department of Health (the Department) and our expert panel agreed provided a robust clinical governance framework for the provision of primary care services, consistent with the components of clinical governance identified by the Chief Medical Officer[6] (**Figure 3** and Appendix 1).

3   The key components of clinical governance in primary care
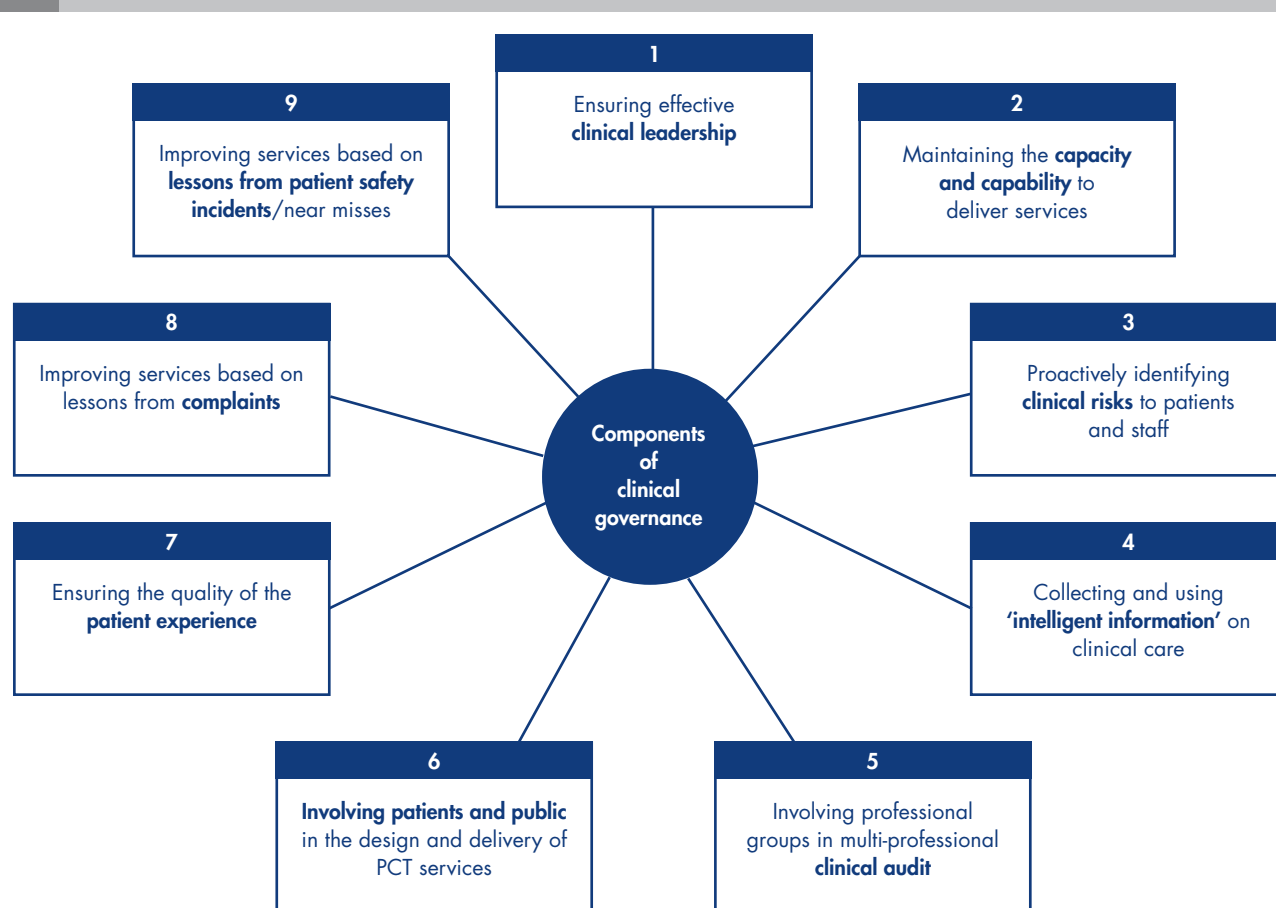
Source: National Audit Office/Health Services Management Centre University of Birmingham

4   In 2003, we published our report *Achieving Improvements through Clinical Governance: A Progress Report on Implementation by NHS Trusts*.[4] This report was the first national evaluation of the impact and importance of clinical governance in acute, mental health and ambulance trusts; however, because many PCTs had only been established for 12 months or so, we excluded them from this review but gave a commitment to examine clinical governance in PCTs at a later date.

5   In July 2005, the Department announced that, as part of the NHS Reform agenda the number of Strategic Health Authorities would be reduced from 28 to 10 with effect from 1 July 2006 and that PCTs would be reconfigured and reduced to around 150 from 1 October 2006.[7, 19] The Department considered that primary care had reached an important cross-road and that there was a need for profound organisational change to enable them to respond effectively to their responsibilities for implementing key national initiatives such as Choice, Payment by Results and Practice Based Commissioning and for managing contracts with General Practitioners, dentists and pharmacists.

6   The NHS Reform agenda involves a radical shift in emphasis, from top-down targets and performance management, to bottom-up leadership and innovation. It also involves giving patients more choice as well as a real voice.[8] We identified a unique window of opportunity to examine progress in implementing clinical governance in the 303 PCTs prior to the reconfiguration. Our aim was to provide a comprehensive assessment of progress, what had been done well, what had been done less well, the lessons learned and the risks that will need to be managed if quality and safety is to be fully embedded in the new Primary Care Trusts.

7   The main fieldwork for our study took place between October 2005 and January 2006. Our methodology (Appendix 1) included a census of PCT Chief Executives and clinical governance leads together with surveys of members of the PCT Professional Executive Committee (PECs) and PCT Boards and a survey of different staff groups in selected PCTs. We also commissioned surveys of front-line staff (GPs, practice nurses and pharmacists) and a sample of patient and carer groups and held focus groups and workshops with patient support groups. Our consultants, from the University of Birmingham Health Services Management Centre (HSMC), provided a detailed analysis of the PCT census and survey findings, including an assessment of differential levels of progress in which PCTs are allocated to one of five bands of overall performance (Bands A to E).[9] Detailed reports on each of these strands of research are available on our website www.nao.org.uk.

8   At the same time as we were planning our review of clinical governance, the Healthcare Commission was undertaking its first review of PCTs' compliance with the new Standards for Better Health.[10] We therefore collected as much information as possible from secondary sources and consulted with the Healthcare Commission to ensure that our survey questions were relevant and compatible with their review of the Standards for Better Health.[11]

9   In our 2003 study of the acute sector (paragraph 4), we found that because clinical governance was an integral part of the way in which trusts deliver services that it did not lend itself to being costed separately and few trusts could provide any cost estimates. Our preliminary work in developing the survey questions for the primary care study revealed that PCTs were unable to provide any estimate of the cost of clinical governance structures and processes or the management time taken up in implementing them. However, as clinical governance is key to PCTs meeting their statutory 'duty of quality', if properly developed and well resourced its implementation should deliver benefits that will outweigh the costs, a sentiment echoed by Dame Janet Smith in her fifth Shipman report.

Main findings

On progress in establishing structures and implementing clinical governance

10   **Almost all PCTs have structures and processes in place for implementing clinical governance at PCT level, with named individuals responsible for progress.** Ninety per cent or more of PCTs responding to our survey reported that they had the requisite structures and processes in place across the key components of clinical governance. Whilst almost all PCTs had a named lead member of staff for each component, the structures and processes were not always supported by written strategies about how to implement or sustain implementation of clinical governance. PCTs rated the effectiveness of these structures and processes as moderate to good in helping them to manage risks and improve the patient experience (paragraphs 1.19 to 1.22).

11   Implementation of clinical governance is weaker where PCTs have to work with others to deliver services with PCTs needing to build quality, more explicitly, into commissioning decisions. Where PCTs had to work with other PCTs or other agencies they were least likely to have implementation plans for components of clinical governance in place. Strategic Health Authorities expressed concerns about readiness for commissioning in their areas, for example whether appropriate clinical governance indicators would be used in commissioning arrangements. The recent publication of the *Intelligent Commissioning Board: Understanding the information needs of Strategic Health Authorities and PCT Boards*[12] provides a navigation aid for the new Boards aimed at ensuring quality is more consistently delivered through commissioning and provision of healthcare (paragraphs 1.23 to 1.29).

12   PCTs ranked in the lowest performance band for clinical governance were consistently least effective across all clinical governance activities whereas PCTs ranked in the highest performing band were strong across the board. The characteristics of PCTs rated band A as opposed to band E were that they: displayed effective clinical leadership, maintained the capacity and capability to deliver services, improved services based on lessons from complaints and patient safety incidents and gave a high priority to learning from the patient experience. In addition, PCTs in the highest band were found generally to perform better when compared to a range of other performance indicators, such as staff survey results, number of complaints received, Healthcare Commission ratings, and GP vacancy levels (paragraphs 2.3 to 2.8).

13   The Professional Executive Committee (PEC) is important for achieving clinical engagement in the PCT clinical governance agenda, yet PEC members are more sceptical about progress than Chief Executives and PCT Board members, and report lower perceived achievement with its implementation. Effective clinical leadership is essential in embedding clinical governance across the PCT; however we found that Professional Executive Committee members reported lower perceived achievement with clinical governance compared to Chief Executives and Board members. The NHS Alliance in its work has reinforced the need for a clear PEC remit and close working between the PEC and the PCT Board if they are to serve collectively the needs of local communities.[13] The Department of Health has recently signalled its intention to review Professional Executive Committees, with a consultation announced in November 2006 and new arrangements planned to come into effect from April 2007[14, 15] (paragraphs 2.9 and 2.10).

14   Clinical governance links between PCTs and independent contractors are undeveloped. We found that whilst independent contractors such as GPs and pharmacists have processes and structures for clinical governance in place, these are not as extensive as at PCT level, tending to concentrate on the more clinical aspects such as complaints, incident reporting, performance evaluation and appraisals. Contractors felt that they receive only limited support from the PCT in helping them embed clinical governance. On incident reporting, a lack of participation in national reporting systems (three quarters of respondents to our GP survey did not routinely report adverse incidents to the National Patient Safety Agency) means that opportunities for learning and development of solutions are being lost across much of primary care. Our survey of GPs found that where GPs were involved in complaints reported to their PCT, just half of GP respondents were routinely informed of the outcome of complaints by the PCT (paragraphs 2.11 to 2.26).

15   Primary Care Trusts have worked hard to get structures and processes in place for clinical governance, but there are barriers to progress going forward. PCT Chief Executives considered the main risks to sustaining progress in clinical governance to be: training in evidence-based practice, benchmarking of commissioning, joint working and leadership development. Front-line staff reported a variety of day to day pressures that made the pursuit of clinical governance and quality goals more difficult. Specific barriers were lack of time, financing and staff. To help ensure that clinical governance becomes more firmly embedded in primary care culture and practice, the NHS Clinical Governance Support Team is working on a range of tools and resources aimed at managers and practitioners in primary care to help them to gain a better understanding of clinical governance and to share experiences and best practice (paragraphs 2.28 to 2.32).

16   The implementation of clinical governance has delivered clear benefits for quality of patient care and has helped some PCTs to deliver efficiency improvements. Eighty two per cent of PCTs responding to our census considered that the implementation of clinical governance had delivered clear benefits for the quality of patient care, with none saying that there had been no impact. Twenty per cent of PCTs considered that clinical governance had delivered efficiency savings for example, reduction in incidents, near misses and consequently litigation. Efficiency savings were also reported from streamlining of prescribing processes and improved referral and appointment systems. Fifteen per cent of GPs identified clinical governance as helping them to deliver efficiency benefits (paragraphs 2.33 to 2.36).

On improving patient and public involvement and the patient experience

17 PCTs have structures and processes for patient and public involvement in place, but patient and public involvement is one of the least well developed components of clinical governance. The Department's NHS Reform agenda has confirmed public involvement as one of the most important components of clinical governance[16] yet, as we found in 2003, this is one of the least well developed. Whilst 98 per cent of PCTs have structures and processes in place to involve patients and the public in the design of services, we found that lack of involvement of service users in service development is one of the higher risks to progress in implementing clinical governance. In giving a commitment to allow patient choice and to give patients a real voice in the design of services under the NHS Reform agenda, patients' expectations have been raised and as yet PCTs are unable to meet these expectations. The Department's July 2006 Commissioning Framework and its October 2006 report *A Stronger Local Voice* set out proposals for strengthening patient and public engagement via Local Involvement Networks as well as the strengthening of duties to consult and to involve the public. These proposals are a key initiative to try and redress the above imbalance (paragraphs 3.7 to 3.9).

18 PCTs' level of engagement and collaboration with voluntary organisations that support patients has generally been low. The 14 voluntary groups that we surveyed agreed unanimously that PCTs needed to engage more effectively with them, although those groups that supported patients with a condition which had a national target, such as diabetes, reported a more positive experience. Voluntary groups also considered that collaboration was rarely instigated by the PCT, although we found examples of PCTs collaborating with voluntary groups as they recognise that the services and specialist information voluntary groups offer can complement NHS services[17] (paragraphs 3.10 to 3.14).

19 Patients say that the quality of the patient experience is determined primarily by quality of interpersonal care they receive, with less emphasis on technical aspects of care. To patients, the quality of care experienced is determined primarily by the sensitivity with which healthcare is delivered, with less emphasis on the technical aspects of care or competence. Patients put empathy, understanding and respect as the key to them receiving good quality of care. The most frequent complaints were that clinicians were often insensitive or lacked appropriate knowledge about the condition they were dealing with and therefore tended to dispense treatment rather than care. There were also concerns about timekeeping and the emphasis given to targets. Patients were often confused about how to make a formal complaint, especially when they were dealing with more than one organisation or healthcare provider at the same time (paragraphs 3.15 to 3.18 and 3.26).

20 Patients consider that they have only one journey and are conscious that services are not always joined up to meet their needs. The patient journey or patient pathway can cross different NHS departments and organisational structures and involve a number of different communication and administrative processes, with different primary care healthcare professionals. Smoothing the patient journey requires an improvement in the quality, appropriateness and flow of information between healthcare professionals and for clinicians to have up to date evidence-based practice information (paragraphs 3.21 to 3.25).

21 Patients and carers reported feeling excluded from aspects of the patient's care and that better information would help improve health outcomes. Patients expressed a need to be more informed about the treatment they receive, the options available to them and the qualities of any consultants that they are referred to. Carers believed that they could be more effective if they were informed about treatment and included in decision-making. Carers also felt that they could save NHS staff resources if only they were provided with appropriate training to deal with the condition of the patient they were looking after (paragraph 3.19 and paragraphs 3.29 to 3.31).

Overall conclusions

22   The organisational structures and processes for clinical governance have largely been put in place at PCT level. But progress in implementing the different components of clinical governance varies both within and between PCTs. Whilst quality and safety are now more overtly monitored and managed with more explicit accountability of clinicians and managers for clinical performance, as identified in the Chief Medical Officer's report, more needs to be done to strengthen the systems which provide assurance about the performance of General Practitioners and which protect the safety of patients.

23   The key features of those PCTs that can demonstrate consistent improvements in quality include effective clinical leadership, maintaining the capacity to deliver services, ensuring the quality of the patient experience and improving services based on lessons from complaints and patient safety incidents. The behaviours that were evident in the higher performing PCTs were: availability and accessibility of information to support evidence-based medicine; all staff appraised against an agreed work and development programme; service users involved in service development; clear action plans developed in response to clinical risks; and underperformance by clinical staff addressed by clear management procedures.

24   We identified that the areas of greatest need for attention to ensure quality and safety in future primary care organisations were: leadership development; sustaining partnerships and joint working between health and social care; developing practice based commissioning; and the benchmarking of commissioning. Indeed, the aspects of poorest coverage and lowest perceived effectiveness are those aspects concerned with commissioning for quality. If the Department's central goal of improving quality of patient care and the value for money from public money spent on health services is to be realised, these needs will need to be explicitly addressed. Continued investment of time and resources in clinical governance across primary care services with Board level commitment to evaluating progress will remain a crucial factor in ensuring an effective and safe transition to the new NHS.

Recommendations

25   Improving the quality and safety of healthcare provision has been an explicit component of Department of Health policy for the last eight years. Primary Care Trusts (PCTs) are currently some four years into this journey and the restructuring of Primary Care Trusts provides an important opportunity to take stock of progress and to identify the key issues that the new PCTs will need to focus on. The recommendations below provide a clear steer to enable the new PCTs to create a professional and organisational culture that accepts and promotes accountability and the pursuit of high quality safe care as the behavioural norm.

26   In addition to this report we have produced individual feedback reports for each new PCT to enable them to benchmark their component PCTs' performance prior to the restructuring to help pinpoint the key risks and priorities for improvement.

27   We have also drawn a number of lessons from this study to inform questions that Chief Executives and Boards of the newly established PCTs should ask themselves in order to assess their progress with clinical governance. These lessons and questions are considered in a separate guide which is published alongside this report.

28   For the implementation of clinical governance to deliver sustained and tangible benefits to patients, we identify the following three issues which the Department, Strategic Health Authorities and PCTs need to focus on, and which are themes running through our recommendations:

- Ensuring that quality remains at the heart of the health agenda in the face of the current round of restructuring and reorganisation of the architecture of provision and commissioning;

- Maintaining and building effective relationships with those from whom primary care services are commissioned, in particular independent contractors. As PCTs take on more of a commissioning role they will need to make quality a cornerstone of the commissioning agenda; and

- Joining up services within and across PCTs to improve the patient experience, thereby increasing the likelihood of seamless care for patients, and improving the scope for delivering efficiencies.

29 In going forward we make the following recommendations:

For the Department of Health:

a In developing its guidance for PCT commissioning, the Department should ensure that quality is an explicit requirement and that there are clear measures in place by which Strategic Health Authorities and regulatory bodies can monitor that PCTs are including quality in their commissioning activities.

For Strategic Health Authorities:

b Strategic Health Authorities should put in place effective oversight of accountability arrangements – as suggested by the Department's proposed *practice-based commissioning governance and accountability framework*[18] – so that clear lines of accountability for clinical governance are in place throughout the system including handling of potential conflicts of interest.

For the new Primary Care Trusts:

c Ensuring that safe and good quality care is delivered requires effective working relationships between Strategic Health Authorities, Primary Care Trusts, and their independent contractors delivering primary care services. Primary Care Trusts, supported by their Strategic Health Authorities, should develop a strategy for engaging independent contractors in the clinical governance agenda.

d Professional Executive Committees are still an important component of establishing a continuing commitment to quality in the new PCTs. However, their skills and leadership need strengthening. As a first step to achieving this, PCTs should select members of Professional Executive Committees using the same recruitment principles as for Board members and ensure that people with leadership, strategic planning and organisational skills are recruited.

e For the implementation of clinical governance to deliver tangible improvements, PCTs should put development programmes in place which emphasise the development of leadership skills for all PCT staff and for staff responsible for managing the commissioning and provision of services. Priorities are for developing skills in the following areas:

■ Benchmarking skills, so that benchmarking of commissioning can be undertaken against other PCTs and of provision against other agencies;

■ How to work jointly with other local agencies so that clinical governance culture and practice is integrated across different care boundaries;

■ How to involve service users in service development; and

■ Training of staff in evidence-based practice and in clinical audit, particularly in developing multidisciplinary audits agreed between PCTs and providers.

f PCTs should actively seek the views of patients in their areas and demonstrate how they have built patients' views into the design and delivery of services. PCTs are well positioned to analyse performance across different providers and should identify where and how improvements to the patient journey and the patient experience have been made and amplify the lessons learned to other providers.

g PCTs should engage with voluntary groups supporting carers and patients to identify where they can achieve efficiency gains and more consistent support to patients and their carers from closer joint working. This might include, for example, joint provision of information to providers about support available to patients and consulting voluntary organisations at least twice a year to develop closer understanding of the patient experience.

h PCTs should require all providers to have an active incident reporting system in place that includes both patient safety incidents as well as other untoward events. PCTs should be in a position to demonstrate to SHAs that they have (i) undertaken regular audits to ensure that incidents and untoward events are being captured; (ii) through benchmarking, addressed underreporting, whether by types of staff or by types of incidents; (iii) working with the National Patient Safety Agency, analysed the root causes or contributory factors to serious or recurring incidents and drawn out themes across services so that solutions and/or risk reduction strategies can be developed to address incidents.

i Complaints should be viewed as an important source of customer feedback which enables managers to see the organisation from a fresh perspective and to develop innovative and patient centred improvements. PCTs need to work with their Patient Advice and Liaison Service and their Local Overview and Scrutiny Committee to develop and put in place an effective complaint handling process. They should also identify ways of ensuring that the process is clearly communicated to all patients and carers, including adopting methods to communicate with ethnic minority groups or others who may be unable to frame their complaint or present it effectively because of language or literacy issues.

PART ONE

The systems and processes of clinical governance are largely in place

1.1 Most Primary Care Trusts (PCTs) were established between 2001 and 2002. In 2003 we published our report *Achieving Improvements in Clinical Governance: A Progress Report on Implementation by NHS Trusts*. Given that PCTs were still in their infancy we focussed our 2003 report on the secondary and tertiary sectors. However, we gave an explicit commitment to examine the primary care sector at a later date.[4]

1.2 Similarly, whilst many of our other published reports on the NHS since 2002 have covered aspects of quality and safety (see www.nao.org.uk), they have also been focussed on the secondary and tertiary sectors with an understanding that we would cover these issues in primary care at a later date.

1.3 In July 2005 the Department announced, in *Commissioning a patient-led NHS,* a radical reconfiguration of PCTs with the aim of aligning them more clearly with local authority social services boundaries and changing them from providers of services towards being patient-led and commissioning-led organisations. Alongside this, the Government proposed the alignment of Strategic Health Authorities (SHAs) with those of Government Office boundaries, with a new role for SHAs in support of PCT commissioning and contract management. Following consultation the number of SHAs was reduced from 28 to 10 from 1 July 2006[19] and the number of PCTs was reduced from 303 to 152 with effect from 1 October 2006.[20]

1.4 This review therefore, provides a unique opportunity to examine the progress achieved in implementing clinical governance in primary care, over the last four or so years, and the extent to which quality and safety have been embedded in service provision so that the lessons learned will not be lost in the reorganisation but can be learned and applied in the new NHS. This Part of the report examines what clinical governance means for primary care, why it is important, the progress in developing the systems and processes that comprise clinical governance and the effectiveness of the support provided to PCTs.

Clinical governance is central to the Department of Health's approach to delivery of healthcare that is safe and of good quality

1.5 Following a series of clinical and organisational failures in the late 1990s[21], the Government identified a need for the NHS to introduce a much more systematic approach to improving quality. Clinical governance is central to the Department of Health's approach to improving clinical service quality[22], and to ensuring that patient care in the NHS is safe and of good quality. *A First Class Service: Quality in the new NHS* set out the Department's approach to national standards set through National Service Frameworks and the responsibility for local delivery and monitoring of healthcare quality through a new system of clinical governance.[23] The Health Acts of 1999 and 2003 set out a statutory "duty of quality" for services commissioned and provided by all NHS trusts for which trust Chief Executives are accountable on behalf of trust Boards. Clinical governance is the framework for ensuring delivery of this statutory duty of care.

Clinical governance

"The framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish"

Source: A First Class Service – Quality in the new NHS, Department of Health , 1998, from Clinical governance and the drive for quality improvement in the new NHS in England, Scally & Donaldson, BMJ 1998; 317:61-65

1.6   The Government has established various organisations which have a role in supporting the implementation of clinical governance throughout the NHS. These are set out in Appendix 2. The origins and development of clinical governance in the NHS is detailed in Appendix 3.

1.7   Just as the Bristol Inquiry provided an impetus for the development of clinical governance in the late 1990s, the reports of the Shipman Inquiry[24], published between 2002 and 2005, have highlighted the need for linkage between doctors' performance and good clinical governance systems. The Shipman reports condemn weaknesses and dysfunctions in past systems to protect patients from harm and cast serious doubt on the adequacy of the GMC's proposals for the five year revalidation of a doctor's licence to practice. In July 2006, the Chief Medical Officer, Sir Liam Donaldson, published a consultation report *Good Doctors, Safer Patients* which presents new proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients.[6] The report re-emphasises the underpinning philosophy of clinical governance:

- patient-centredness;
- shared, well evidenced standards;
- individual and organisational accountability;
- systematic learning from untoward incidents;
- mechanisms for continuous quality improvement;
- strong local leadership; and
- organisational, professional and occupational cultures that value excellence.

1.8   The Chief Medical Officer's report highlights the fact that whilst there is a clear, comprehensive and appropriate framework within the NHS to enable quality assurance, for quality improvement and patient safety to be embedded in all day to day activities, a more comprehensive approach to implementation is needed because the framework still falls short of its full potential. For example clinical governance is a strong feature of some services but largely lacking in others, and more work is still needed to bring about the underlying cultural change needed to achieve the full potential of the framework. Without this cultural change, significant clinical failures could continue to occur even if the governance structures were in place. Furthermore, the CMO's report also considered that few Chief Executives of health organisations match the depth of their fear of missing budgetary and productivity targets with the strength of their passion to improve quality and safety. In the best healthcare organisations in the world, the 'business plan' and the 'quality plan' are one and the same.[6]

1.9   The CMO's report references our 2003 progress report on achieving improvements in clinical governance in the secondary and tertiary sectors, and draws attention to our conclusion that clinical governance was delivering some clear and demonstrable benefits: quality issues had become more mainstream; there is greater explicit accountability for clinical performance and a change in professional culture towards more open and collaborative working. But it also notes that we described overall implementation as patchy and that the structural response to the government agenda had not been fully matched by a behavioural and cultural shift in approach to the issues of quality and safety.

1.10   The CMO's report covers many of the issues which we have identified in this report on clinical governance in primary care and, where relevant, we cross reference our findings to the CMO's report. Overall we believe that our findings support the recommendations in the CMO's report and provide definitive evidence of the actual progress across the primary care sector.

Primary Care Trusts were established to develop and secure delivery of effective NHS services for local health economies

1.11   The Health Act 1999 paved the way for the establishment of Primary Care Trusts (PCTs). PCTs were established in three waves, with initially just 17 PCTs, rising to 303 PCTs by April 2002 (although by the time of this study a number of PCTs were working collaboratively with a view to future mergers). The 303 PCTs varied considerably in the geographical and socio-economic nature of the areas that they served, with the size of population covered ranging from 64,000 to 367,000 (prior to the October 2006 reorganisation).[25]

1.12   PCTs have strategic and operational responsibilities for a broad spectrum of healthcare including seven statutory functions **(Figure 4)**. PCTs are governed by a Board comprising executive and non-executive directors, with a Professional Executive Committee (PEC) assisting the Board in the management of the PCT and providing the mechanism for advice on clinical matters **(Figure 5)**.
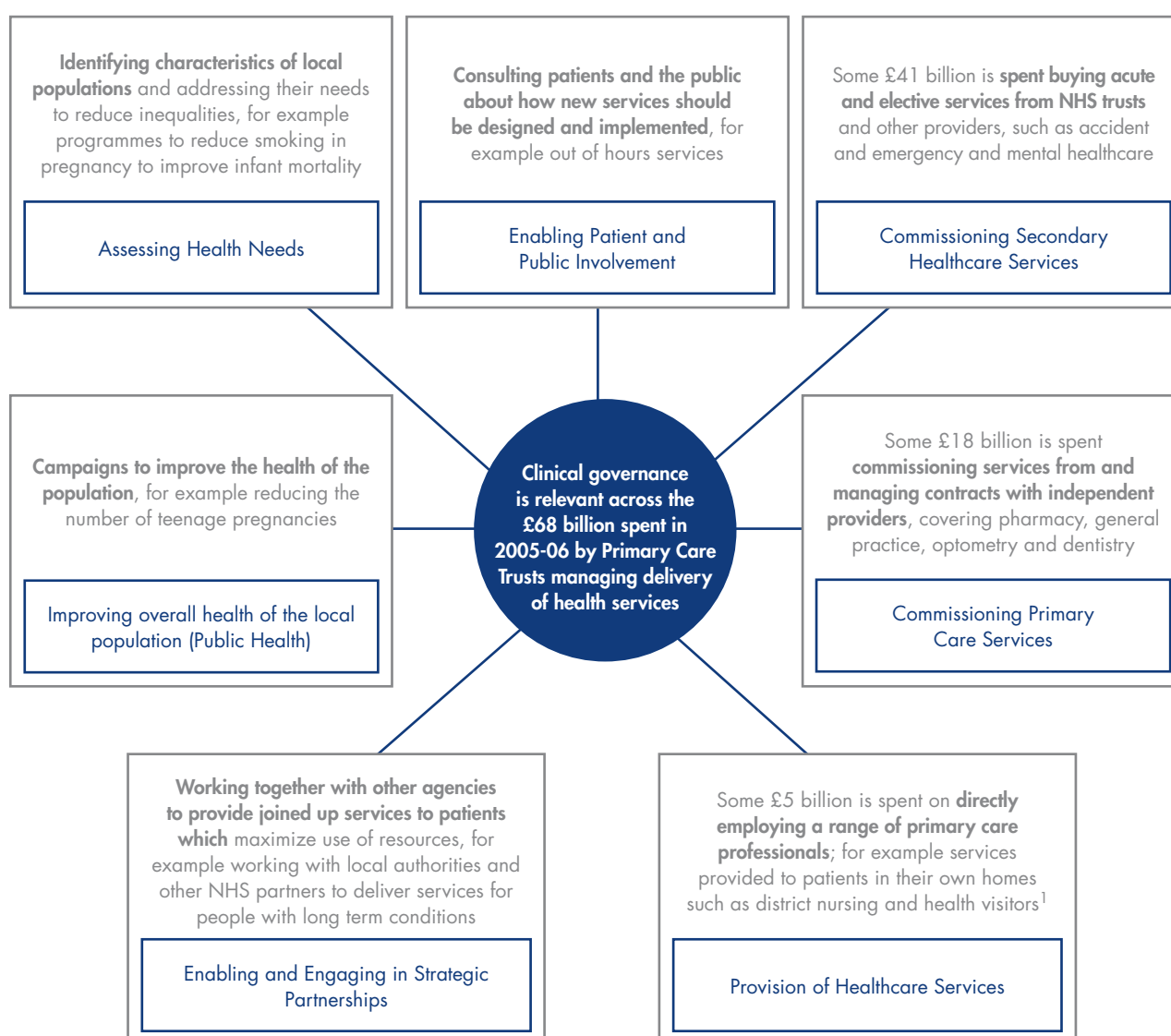
Primary Care Trusts commission three quarters of primary healthcare from independent contractors, including paying GPs for delivering a number of outcome targets

1.13 In addition to providing primary care services, for example community hospitals, PCTs have a duty to secure delivery of primary care services from independent contractors, including General Practitioners, dentists, optometrists and pharmacists. Of the £23 billion spent on primary care services in 2005-06[26], over three quarters

(78 per cent) is directed at commissioning of services from independent contractors and other providers. A number of different types of standard contracts are available to PCTs to obtain these services but, whatever route is chosen, PCTs have a statutory duty of care for all services they commission and provide. This presents a particular challenge for PCTs since although they commission services from them they do not have a line management relationship for those providing services (with the exception of some GPs and dentists who work directly for PCTs).

4   The responsibilities of Primary Care Trusts

Identifying characteristics of local populations and addressing their needs to reduce inequalities, for example programmes to reduce smoking in pregnancy to improve infant mortality

Assessing Health Needs

Consulting patients and the public about how new services should be designed and implemented, for example out of hours services

Enabling Patient and Public Involvement

Some £41 billion is **spent buying acute and elective services from NHS trusts** and other providers, such as accident and emergency and mental healthcare

Commissioning Secondary Healthcare Services

Campaigns to improve the health of the population, for example reducing the number of teenage pregnancies

Improving overall health of the local population (Public Health)

Clinical governance is relevant across the £68 billion spent in 2005-06 by Primary Care Trusts managing delivery of health services

Some £18 billion is spent **commissioning services from and managing contracts with independent providers,** covering pharmacy, general practice, optometry and dentistry

Commissioning Primary Care Services

Working together with other agencies to provide joined up services to patients which maximize use of resources, for example working with local authorities and other NHS partners to deliver services for people with long term conditions

Enabling and Engaging in Strategic Partnerships

Some £5 billion is spent on **directly employing a range of primary care professionals**; for example services provided to patients in their own homes such as district nursing and health visitors[1]

Provision of Healthcare Services

Source: National Audit Office and Department of Health

NOTE

1   These figures include all care provided directly by Primary Care Trusts, which include some secondary care (such as community health services).

Fundamental changes are being made to the provision of NHS primary care services but quality and safety remain paramount

1.14 The NHS is involved in some of the most profound organisational changes that have taken place since its inception in 1948: changes which will have a significant impact both on PCTs' day to day operations and on their longer term strategies.

5	The management of Primary Care Trusts – 'three at the top'

In all organisations the clarity and quality of the relationship between a Chair and Chief Executive is crucial to effective functioning. The ability to work closely together with an understanding based on trust and clear appreciation of each other's role and responsibilities is vital. The structure of PCT governance arrangements, however, gives rise to a unique tri-partite relationship at the top of the organisation – between the Chair, Chief Executive and Professional Executive Committee (PEC) Chair. In a sense PCTs have three leaders, each one appealing to different constituent parts of the organisation.[1]

The relationship between the Board and the PEC is one of the most vital determinants of overall progress in relation to clinical governance and quality. The PCT Board, which comprises executive and non-executive directors, is responsible for setting the strategy and monitoring the performance of the trust. The Chair of the PEC is a member of the PCT Board. The membership of the PEC can vary from PCT to PCT but will usually comprise a majority of primary and community care professionals. Its remit is extensive in assisting the Board in the management of the trust, but a key responsibility is to advise on quality and clinical governance and to provide clinical leadership. The PEC members are elected by their peers, but there have been calls for a more formal appointment system to ensure effective clinical leadership.[2]

In September 2006 the Department of Health announced that as part of the NHS Reform and Reorganisation agenda PECs will be retained. However, the Department will be consulting stakeholders on their form and function from December 2006.

Source: National Audit Office

NOTES

1 The Strategic Leadership of Clinical Governance in PCTs, Modernisation Agency 2004

2 The Intelligent Commissioning Board July 2006. Understanding the information needs of SHA and PCT boards.

1.15 In July 2005, the Department published *Commissioning a patient-led NHS*, signalling a move from the NHS as a 'provider-driven' to a 'commissioning-driven' service, by enabling every GP to hold a practice-based commissioning (PBC) budget. Under the arrangements, GPs take responsibility for commissioning services, with practices holding an 'indicative budget' from the PCT which enables them to 'buy' services for patients from a range of providers, supported by PCTs who will manage the contracts for their local health economy. The policy allows practices to make decisions on commissioning and to use any savings made for the benefit of patient care. All PCTs must put in place arrangements for universal coverage of practice-based commissioning by December 2006.[27]

1.16 In December 2005 the Department's *Health reform in England: Update and next steps*, explained how the NHS reforms are intended to relate to each other and set out a programme for further development. **Figure 6** outlines the framework for the reforms. These include demand side reforms such as more choice of provider for patients; transactional reforms such as Payment by Results, to provide incentives for the development of alternative primary and community services where these are more clinically effective and cost effective than hospitalisation; and supply side reforms such as introducing more primary care providers and the development of a wider range of primary and community services.[8] The paper recognises that "PCTs and practices will be taking on new roles that are both complex and important". All new PCTs will be assessed for their 'fitness for purpose', using a tool that enables benchmarking against best commissioning practice.

1.17 Our review of the implementation of clinical governance was undertaken in the context of these changes. Against this background it is essential that PCTs do not lose sight of quality and safety, and that in the new enhanced commissioning role they have explicit requirements for securing quality and safety from providers.
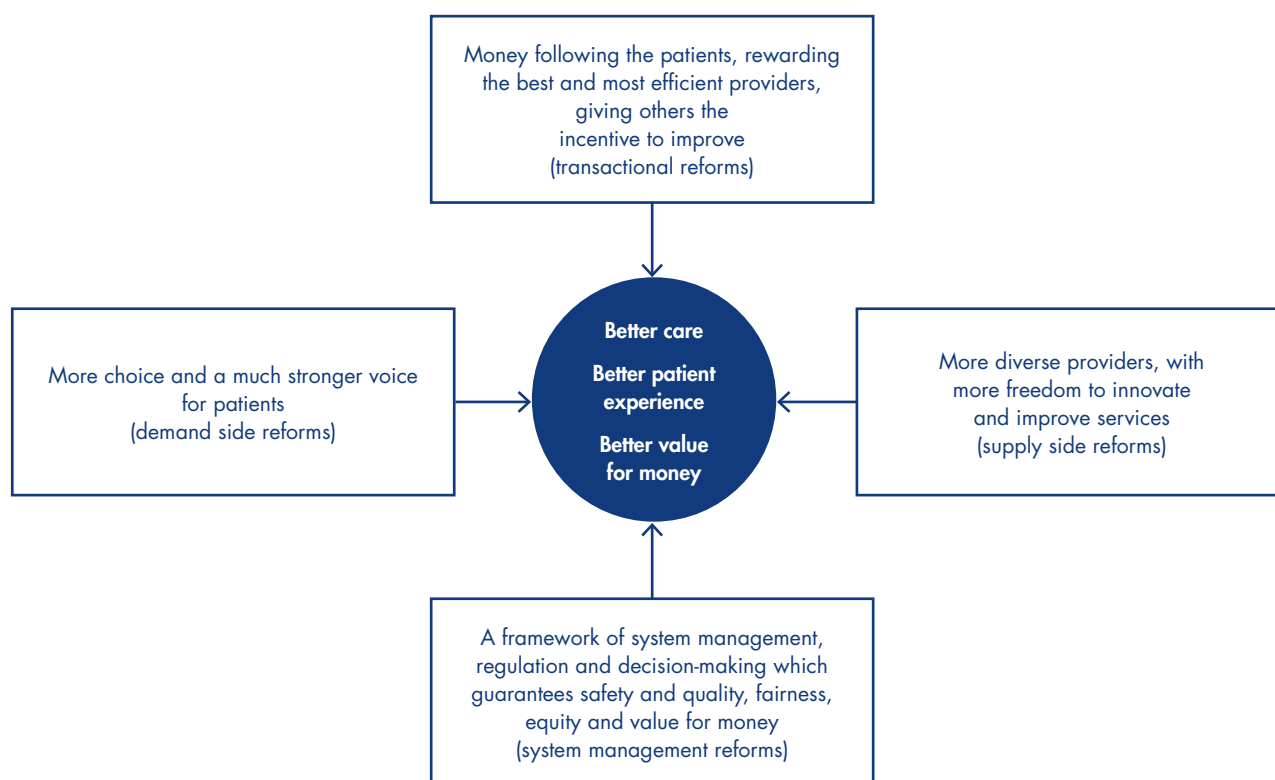
Standards for Better Health and their relevance to our review of clinical governance

1.18 In July 2004, the Department of Health published *Standards fo Better Health*.[28, 29] Until 2004-05, PCTs were assessed according to a 'star rating' system, but from 2005-06 the Healthcare Commission has replaced the star ratings approach with a system requiring PCTs to self assess themselves against the Standards for Better Health. In designing our PCT survey questions on clinical governance, our consultants, the Health Services Management Centre (HSMC) of the University of Birmingham, aligned their data collection as far as possible to the Standards for Better Health to enable PCTs to use the same information to complete our survey as they used in their self assessments. In total, HSMC identified some 26 different elements that underpin the nine key components of clinical governance. Taken together, this report and the more detailed evaluation report by HSMC (www.nao.org.uk), and individual trust feedback reports generated from the detailed survey results, should complement the Healthcare Commission's assessments and should enable PCTs to have a clear view of their own performance and how best to prioritise improvements.

Primary Care Trusts have structures, processes and named individuals in place for the key components of clinical governance

1.19 Whilst structures and processes do not of themselves guarantee that clinical governance is being implemented or that clinical governance activity is taking place, they provide the foundation and cornerstones which need to be in place if clinical governance is to be effective. We found that the overwhelming majority of PCTs who responded to our census indicated that they had structures and processes in place across the main components of clinical governance – over 90 per cent for each of the nine components, with named lead members of staff. Components were generally supported by written strategies although this was less the case for some components (maintaining capability and capacity to deliver services (77 per cent), ensuring the quality of the patient experience (75 per cent), ensuring effective clinical leadership (68 per cent), and collecting and using 'intelligent information' on clinical care (52 per cent)).

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6 Framework for health reforms

Money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve (transactional reforms)

More choice and a much stronger voice for patients (demand side reforms)

Better care

Better patient experience

Better value for money

More diverse providers, with more freedom to innovate and improve services (supply side reforms)

A framework of system management, regulation and decision-making which guarantees safety and quality, fairness, equity and value for money (system management reforms)

Source: Health reform in England: Update and next steps, Department of Health, 2005

Primary Care Trusts consider that the structures and processes are generally effective in helping them to manage risk and improve the patient experience

1.20 While existence of formal governance processes and accountabilities for areas of practice are important, they are only valuable to the extent that they are implemented. The NHS Clinical Governance Support Team concluded that clinical governance had been initially understood as both a structural and cultural initiative, but that in some places there was a misconception that implementing particular committee structures, roles, responsibilities and lines of reporting was sufficient to ensure safely governed, high quality care.[6]

1.21 We asked PCTs to assess on a scale of one (completely ineffective) to seven (fully effective) the overall effectiveness of the nine key components of clinical governance in helping them to manage service risks and improve the patient experience. Overall, PCTs considered that the effectiveness of clinical governance structures are moderate to good at helping them to manage risks and improve the patient experience across all nine components of clinical governance, with slightly better perceived average effectiveness in improving services

based on lessons from patient safety incidents and near miss reporting than for collecting and using intelligent information on clinical care **(Figure 7)**.

1.22 Results from our sample of front line staff in PCTs reflected these ratings: respondents felt that less progress has been made in the planning and integration of quality improvement programmes with more progress indicated in risk management and avoidance of a 'blame culture'. Respondents reported that a variety of day to day pressures made the pursuit of clinical governance and quality goals of lower priority. On the other hand they also reported a genuine attempt to establish a learning culture and share good practice in their PCTs.

Explicit structures are strongest at the level of existing Primary Care Trusts rather than above or below this level

1.23 To identify the extent to which clinical governance has been embedded below PCT level we asked PCTs to identify all of the levels at which structures were available for addressing the elements of clinical governance covered by the survey (whether sub-PCT level, at PCT level or across multiple PCTs). **Figure 8** shows the results.

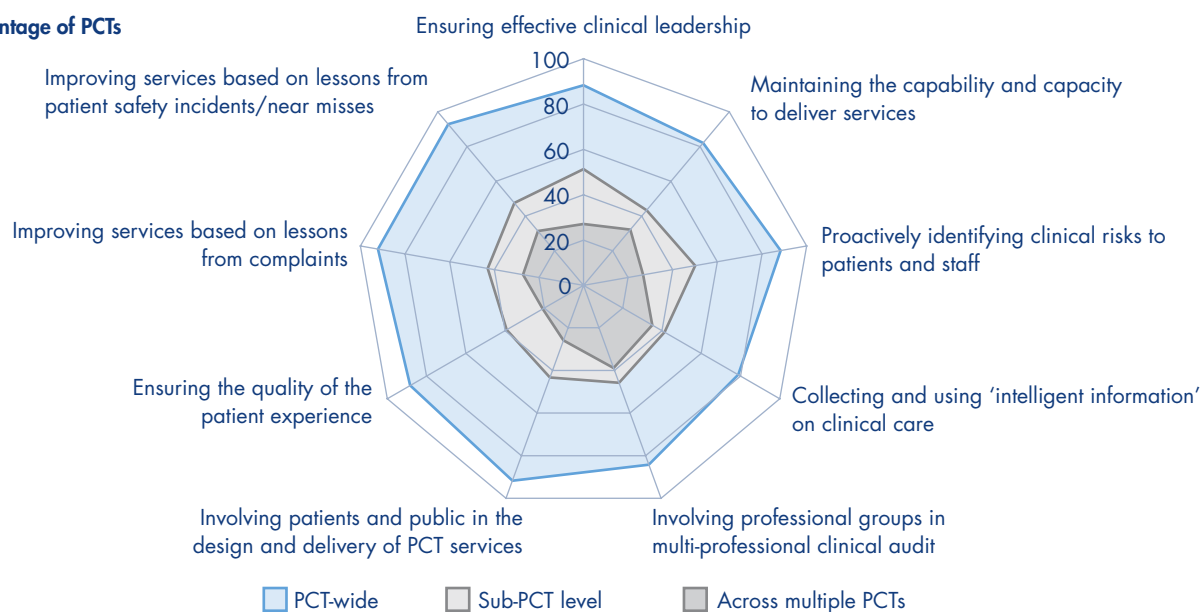| **7**	Overall effectiveness of available clinical governance structures and processes

PCTs assessed themselves on a scale of 1 (completely ineffective) to 7 (fully effective). The mean average score was between 4 and 6 for all components of clinical governance, for both managing risks and improving the patient experience.

	Managing service risks		Improving patient experience	
	Mean	SD	Mean	SD
Proactively identifying clinical risks to patients and staff	5.66	0.79	5.31	0.95
Improving services based on lessons from patient safety incidents/near misses	5.62	0.91	5.34	0.98
Improving services based on lessons from complaints	5.57	0.92	5.48	0.94
Ensuring effective clinical leadership	5.15	0.94	4.87	1.01
Maintaining the capability and capacity to deliver services	5.10	1.05	4.78	1.10
Ensuring the quality of the patient experience	4.89	1.13	5.08	1.08
Involving professional groups in multi-professional clinical audit	4.86	1.13	4.67	1.17
Involving patients and public in the design and delivery of PCT services	4.72	1.15	5.16	1.13
Collecting and using 'intelligent information' on clinical care	4.56	1.20	4.39	1.26

Source: Census of PCTs, Health Services Management Centre, University of Birmingham

8 Levels at which clinical governance structures are available

Percentage of PCTs

- Ensuring effective clinical leadership
- Improving services based on lessons from patient safety incidents/near misses
- Maintaining the capability and capacity to deliver services
- Improving services based on lessons from complaints
- Proactively identifying clinical risks to patients and staff
- Ensuring the quality of the patient experience
- Collecting and using 'intelligent information' on clinical care
- Involving patients and public in the design and delivery of PCT services
- Involving professional groups in multi-professional clinical audit

Legend: PCT-wide · Sub-PCT level · Across multiple PCTs

Source: National Audit Office/HSMC census of PCTs, Autumn 2005

1.24 Respondents identified the PCT as the organisational unit most commonly containing explicit structures for each of the clinical governance components identified (between 79 per cent and 93 per cent). Structures were available at sub-PCT level in 40 per cent to 51 per cent of PCTs depending on the component, and across multiple PCTs in just 21 per cent to 39 per cent of cases. This finding has implications as the number of PCTs is reduced and PCTs will be combining to form new PCTs. As the number of PCTs reduces, these cross-PCT structures will mean that, although there was no prior Department of Health requirement for such structures to be in place, PCTs who have participated in them will be well placed to establish clinical governance structures in the new PCTs. **Figure 9** presents an example from Gloucestershire where structures in clinical audit are well established across existing PCTs.

9 Case example: Gloucestershire Primary and Community Care Audit Group

The Gloucestershire Primary and Community Care Audit Group (PCCAG) provides a clinical audit service to primary healthcare teams and community healthcare providers in the three PCTs in Gloucestershire. Cheltenham & Tewkesbury PCT is the lead PCT for clinical audit, and acts on behalf of Cotswold & Vale PCT and West Gloucestershire PCT. The data quality team for the local GP IT systems is also incorporated within the PCCAG, recognising the importance of data quality to clinical audit and the wider clinical governance agenda.

The PCCAG reports into the three PCTs' clinical governance committees and is accountable to an oversight committee. Membership of the committee is multidisciplinary and is coordinated by the three PCTs to ensure even and appropriate distribution between PCTs. It also includes a PCT non-executive director.

The PCCAG supports audit projects within PCTs and across the county, and provides training in audit skills, clinical coding and the use of clinical (IT) systems.

Results of the county wide audits are published on the PCCAG website (www.glospccag.nhs.uk), which speeds up dissemination and puts information in the public domain. The PCCAG also ran a multidisciplinary Stroke Study Day in November 2005 for health and social care staff, following an audit of stroke prevention and a survey of carers.

Source: National Audit Office examination; Gloucestershire Primary and Community Care Audit Group

Primary Care Trusts have received useful support from the Department and Strategic Health Authorities

1.25 The Department has provided support and guidance to PCTs throughout the last five years, mainly through its NHS Modernisation Agency and the NHS Clinical Governance Support Team (NCGST). Initially the focus was on committee structures, roles, responsibilities and lines of reporting. Latterly the focus has been on helping to create professional and organisational cultures in PCTs whereby accountability for safe high quality performance is seen as a behavioural norm. Most PCTs have found this support helpful with around 40 per cent stating that it has been very useful.[9] The NCGST continues to work with PCTs and has developed a Primary Care Development Programme for managers in primary care. This online training programme has received favourable feedback from managers who have undertaken the training, and the NCGST hopes that the programme will be accredited at foundation degree level.

1.26 All fifteen SHAs we interviewed had a named individual responsible for leading on clinical governance. Their job title, Directorate, level of responsibility in the organisation and medical training all varied. The most common type of support provided was to host a forum or network for the clinical governance leads of the trusts within the SHA 'patch'. In addition to PCTs these generally involved acute, mental health and ambulance trusts, and enabled the trusts to share good practice and other information, typically on a quarterly basis. One SHA describes their clinical leads' group as 'invaluable', and states that it will be transferred into the new SHA structure. Some SHAs hosted clinical audit and risk forums. Other types of support included regular meetings, workshops and newsletters.

1.27 SHAs identified a number of challenges that PCTs had faced in putting structures and processes in place including a lack of clarity as to what needed to be done and managers with inadequate authority and who were spread too thinly. There were also concerns about a lack of engagement by non-executive PCT Board members who were much less likely to challenge compared to acute non-executive Board members.

1.28 Four fifths of PCTs acknowledged that their SHA had provided support to help them implement clinical governance although only 40 per cent considered the support was very useful. Most SHAs also monitored performance in implementing clinical governance which three quarters of respondent PCTs found at least moderately useful. Sixteen per cent of responding PCTs did not consider the performance monitoring useful.

1.29 Evidence of effective support was associated with developing professional working relationships between the two organisations: "It is about influence and trust"[30]; and "The SHA has thrived on supporting and building relationships with PCTs – this has paid off"[30]. At the time of our interviews with SHAs in November and December 2005, all SHAs expressed concerns about readiness for commissioning in their areas. For instance, they thought it would be particularly important for PCTs to adopt the right structures and indicators to ensure quality was built into commissioning arrangements. In July 2006, new guidance for PCTs, *The Intelligent Commissioning Board*, emphasised the need to strengthen further the relationships between the new SHAs and PCTs if PCTs are to be effective in their commissioning role.[12]

PART TWO

There are variations in progress in implementing clinical governance

2.1 Part One of this report examined the extent to which PCTs have adopted structures and processes to allow effective clinical governance to take place. However, structures and processes can only be effective if they and the systems which underpin them are implemented. This Part of the report examines the progress made in implementing clinical governance across primary care, the contribution that the main components of clinical governance have made towards improvements in quality and safety, and draws on information provided by both PCTs and practitioners. This Part also identifies the characteristics that are found in the highest and lowest performing PCTs.

2.2 The first section of this Part of the report covers the findings from our surveys of PCT Chief Executives, Board members and Professional Executive Committee members. These findings were used to determine key characteristics, behaviours and practices prevalent in the best performing PCTs. The later sections of this Part examine the findings from our surveys of practitioners and examines their engagement with clinical governance processes and practices, as well as their relationships with their PCTs.

The strongest Primary Care Trusts are consistently stronger at implementing clinical governance across the board and vice versa

2.3 In order to assess the differential levels of progress in implementing clinical governance, our consultants, the Health Services Management Centre (HSMC), analysed the response to 26 questions in the PCT Chief Executive questionnaire (see methodology Appendix 1 and separate report by HSMC at www.nao.org.uk).

2.4 These questions, covering the key areas of clinical governance, were then analysed into average percentage coverage and a progress index and grouped into five bands, A to E, each covering one fifth of the PCTs. We

were then able to undertake statistical analyses to identify the characteristics of the PCTs in the different bands, and the relationships between our census of Chief Executives and surveys of Professional Executive Committee and Board members of PCTs. For some elements of clinical governance there were no statistically significant differences between PCTs, whilst in most areas there were significant differences between the top and bottom bandings. Variations in performance between the top and bottom bandings were generally quite modest in absolute terms, and even PCTs in the lowest performance banding reported that they had made substantial progress in implementing clinical governance structures and processes.

2.5 We found that PCTs in band A (the strongest) were consistently the most effective in progressing activities and had the highest coverage across their PCTs for clinical governance issues. Conversely, PCTs in band E (the weakest) were consistently least effective in progressing almost all activities, and had lower coverage across their PCTs for most aspects of clinical governance. The characteristics of PCTs rated band A, as opposed to band E were that they:

- **displayed effective clinical leadership**, for example by ensuring that clinical risk management processes are well defined and fully communicated in commissioning arrangements;

- **maintained the capacity and capability to deliver services**, for example by certifying that all staff comply with their Continuing Professional Development requirements;

- **ensured the quality of the patient experience**, for example by implementing processes to ensure that feedback and recommendations from patient satisfaction surveys are applied;

- **improved services based on lessons from complaints**, for example by introducing a new telephone booking system following complaints about difficulties accessing primary care services; and

■ **improved services based on lessons from patient safety incidents**, such as holding facilitated Significant Event Analysis[31] meetings to learn promptly from incidents.

2.6 We also found that external challenge and support played an important role in encouraging active and effective implementation of clinical governance. For example, the following factors had a statistically significant association with the higher banded PCTs – suggesting a positive impact on further clinical governance:

■ experience of a review by the Commission for Health Improvement (reviews which took place between 2002 and the establishment of the Healthcare Commission in 2004 – **see Figure 10**). Eighty four PCTs in our survey (35 per cent of the total) reported having received a CHI review in the last three years;

■ receiving useful support from the Strategic Health Authority; also, but to a lesser extent,

■ participation in NHS Clinical Governance Support Team activity.

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10 Commission for Health Improvement clinical governance reviews

Between 2002 and 2004 the Commission for Health Improvement undertook 102 reviews of clinical governance in PCTs. It published its analysis of the first 48 clinical governance reviews in March 2004. Although the findings of the remaining reviews have been published and are available on the Healthcare Commission website[1], no comprehensive analysis was undertaken drawing the findings of all 102 reviews together.

For this report, the NAO has looked at the positive and negative comments that CHI made in the reviews, about implementation of the components of clinical governance in PCTs. The key factors affecting successful implementation of clinical governance from the CHI reports were:

■ board commitment and involvement with implementing clinical governance;

■ links between the different components of clinical governance;

■ clear accountabilities and responsibilities;

■ a cohesive, strategic and coordinated approach to each component; and

■ systems in place for learning from results and sharing best practice.

Source: What CHI has found in primary care trusts, Commission for Health Improvement, March 2004, and NAO analysis of subsequent CHI examinations

NOTE

1 www.healthcarecommission.org.uk/yourlocalhealthservices/nhsa-zbyorganisationname.cfm

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2.7 We also examined the results of the banding for any geographical patterns at SHA level and Government Office Region level. We found considerable variation in performance between Strategic Health Authorities, with weaker SHAs from our analysis generally concentrated in South East and Central England, whereas the better performing SHAs were more evenly spread throughout the country, with clusters in South West, West, and North. We identified a similar pattern at Government Office Region level, with lowest scores in Central and Eastern England, and good performance concentrated in the North East and South West (Appendix 4).

There is a relationship between Primary Care Trusts' overall clinical governance ratings when compared to a range of other performance indicators

2.8 We compared the clinical governance performance bands to other performance indicators at PCT level. These were financial performance, Healthcare Commission star ratings, complaints received, staff survey results, and GP vacancy levels. We found that PCTs in bands A and B tended to perform better across the board than those in the lower bands, receiving fewer complaints, achieving higher staff survey scores, and generally having sounder financial performance. We also found that the weakest performing PCTs in terms of clinical governance were generally weaker across the board when compared with a range of indicators (Appendix 4).

Professional Executive Committee and Board members report that stronger performing Primary Care Trusts undertake more clinical governance activity, and vice versa

2.9 A separate questionnaire, aimed at members of the PCT Board and the PCT Professional Executive Committee (PEC), was used to examine how far PEC members endorsed the extent of engagement of their PCTs in 20 clinical governance activities. The responses indicate that PEC members were generally less positive about progress on clinical governance than other respondents. Of these, GPs (making up 29 per cent of PEC respondents) consistently gave lower scores than all other PEC members. However, PEC and Board members broadly confirmed the views of relative performance of the highest and lowest rated PCTs. PEC members identified the behaviours evident in band A PCTs, that were not evident in band E PCTs, as:

- information to support evidence-based medicine is available and easily accessible;

- all staff are appraised against an agreed work and development programme;

- underperformance by clinical staff is addressed by clear management procedures;

- clear action plans are developed in response to clinical risks; and

- service users are involved in service development.

2.10 The NHS Alliance's 2004 report *Making a Difference – engaging clinicians* in PCTs found that PEC members often lack leadership and strategic skills and that PECs need a clear remit and close working between the PEC and the PCT Board if they are to serve collectively the needs of local communities.[13] The July 2006 paper *The Intelligent Commissioning Board*[12] recognised that clinical leadership and input to commissioning is a key requirement for driving through the redesign of services in PCTs, and suggested that the composition and membership of PECs should be given early and urgent consideration by newly formed PCTs to improve their effectiveness. In September 2006 the Department of Health announced its intention to retain Professional Executive Committees but that their form and function would be reviewed following a consultation exercise, which was launched in November 2006, with new arrangements planned to come into effect from April 2007.[14, 15]

Clinical governance links between Primary Care Trusts and independent contractors are undeveloped

2.11 Our structured interviews with SHAs found that a major challenge in working with PCTs to implement clinical governance was the independence of primary care contractors. Engaging contractors in the clinical governance agenda, both formally and through developing positive working relationships, was seen as key. One SHA referred to the "pivotal role of the practice manager" in this regard.

2.12 Our surveys of General Practitioners, community pharmacists and pharmacists working in PCTs, practice nurses and other primary care nurses, found that independent contractors had processes and structures in place for clinical governance, but often these are not as extensive as at PCT level, tending to concentrate on the more clinical aspects such as complaints, incident reporting, performance evaluation and appraisals. Whilst they felt that clinical governance provided assurance about their own performance they were much less likely to benchmark their performance with other practices or share their evaluations

with their PCT. Overall, contractors felt that they received limited support from PCTs to help them embed clinical governance in their practices.

2.13 The Department has introduced mechanisms aimed at improving the quality of services to patients delivered by GPs. In April 2004, the Department introduced a new reward and incentive programme, called the Quality and Outcomes Framework (QOF) as part of the GP contract. Under the QOF, practices score points for achievement against a range of 146 evidence-based indicators and are paid according to the points achieved.[32] The primary purpose of these data is, however, that they are collected for payment purposes (linking remuneration to evidence of the quality of service), and since in 2006, each practice on average achieved 96 per cent of the points available – or 1,011 out of a possible 1,050[33], we found that their further analysis did not yield useful comparative data for assessing progress in implementing clinical governance.

Complaints processes are in place but the outcome of complaints is not always communicated back to contractors by the Primary Care Trust

2.14 Almost all the respondents in our GP survey had a complaints process in place and investigated complaints to help identify quality and safety issues. Our surveys of nurses and pharmacists indicated similar confidence about having complaints processes in place and how they were investigated and learned from internally to improve services (at practice level or pharmacy level).[34, 35]

2.15 Where GPs were involved in complaints that were reported to their PCT, however, just over half of GP respondents (53 per cent) were routinely informed of the outcome of such complaints by the PCT, one quarter were not and the remainder did not know.[34]

Incident reporting systems are in place, and where patient safety incidents are reported through these systems, lessons are learned and changes to clinical practice often result

2.16 Almost all GP respondents (94 per cent) had a patient safety incident reporting system in place, a proportion also reflected by the nurses and pharmacy surveys. Around two thirds of GPs and nurses in our surveys had reported an incident,[34] and one third of GPs had reported an incident to their PCT.[34] However, only four per cent of GP respondents routinely reported adverse incidents to the National Patient Safety Agency (NPSA), with more than three quarters saying they did not. Incidents which are reported to PCTs are automatically reported to the NPSA, although practitioners

may alternatively choose to report incidents directly to the NPSA. The Healthcare Commission report on the State of Healthcare 2006 concluded that safety in primary care has received less attention than safety in acute trusts and that the systems for reporting are generally less well developed and not as widely used.[36]

2.17 Our surveys indicated that it is commonplace for changes to take place as a result of learning from mistakes identified by these processes **(Figure 11)**.[34] For example, 80 per cent of the GPs responding to our survey had changed clinical practice as a result of reporting incidents. Local reporting requirements form part of the Quality and Outcomes Framework contract for GPs, and GPs use a technique known as Significant Event Audit to learn from incidents. However a lack of participation in national reporting systems means that opportunities for learning and development of solutions are being lost across much of primary care. For example, of 94,983 incidents from community care settings reported to the National Patient Safety Agency, only 3,793 – four per cent – were reported as occurring in general practice.[37] The National Patient Safety Agency is currently examining ways in which learning from Significant Event Audits can be shared more widely.

Clinical audit programmes are largely in place but multidisciplinary audits agreed with the Primary Care Trusts are not well established

2.18 The Chief Medical Officer found in his report that clinical audit has played a prominent part in discussions about quality and standards of medical practice, and considerable, ring-fenced sums were invested to facilitate its introduction in the NHS, with funding in particular for primary care in the early 1990s. By the mid 1990s, ring-fenced funding had ceased and the amount of money spent on clinical audit activity is now difficult to ascertain.[6]

2.19 We found that 84 per cent of GP respondents had a clinical audit programme in place, a proportion also reflected by nurse respondents. Sixty per cent of these had participated in clinical audit activity to benchmark performance. Just half, however, reported that their audit programme included only one multidisciplinary audit agreed with the PCT.[34] In contrast we found that 95 per cent of PCTs had structures and processes in place to involve professional groups in multidisciplinary audit, and 87 per cent said they had a written strategy in place.[9]

11	Examples of learning from application of incident reporting processes

"All the pharmacies I work in have changed practice following review of critical incidents, for example moving items on a shelf that are too similar in appearance, applying shelf edge reminder stickers near high risk items, reviewing protocols and retraining to ensure addresses are checked when giving out medication".

"I use the near miss reporting forms to help train my dispensers. Anything found dispensed or labelled incorrectly before it reaches the patient involves a near miss form being completed by the individual. We do this…to identify the mistake, why it may have happened, and what we can do to prevent it reoccurring. This has made dispensers more careful and attentive to their work, led to less dispensing errors, and improved customer satisfaction".

Burnley, Pendle and Rossendale PCT has initiated a Good Areas of Practice for Sharing (GARPS) scheme. Community pharmacists who make errors or near misses report these anonymously to the PCT. The PCT collates and presents these on a leaflet or poster distributed to all pharmacists in the PCT, explaining the risks arising from the incident, asking "could any of these happen in your pharmacy?", and providing advice to prevent the incident happening.

Five per cent of GP respondents made changes to their approach for reviews or audits of Critical Incidents and Significant Event Auditing, and four per cent noted changes in internal reporting or auditing.

"We have changed the type of instrument for taking blood samples to reduce the potential for needlestick injuries to staff from contaminated needles".

Source: National Audit Office survey of pharmacists, Autumn 2005; Medix survey of GPs, December 2005

2.20 For pharmacy, clinical audit was covered by guidelines prior to the introduction of the new contract, and is one area of the contract which is being implemented slowly. Less than half (45 per cent) of pharmacists we surveyed had a clinical audit programme in place. Of these, just one third said the programme included one multidisciplinary audit agreed with the PCT. Many pharmacists reported that they felt ignorant about the requirements of clinical audit and were awaiting guidance from their PCT. Pharmacists often feel isolated because of the nature of their role, and some see multidisciplinary audit as a key enabler to improving practice.[35] The NHS Clinical Governance Support Team has developed, with the Royal Pharmaceutical Society Great Britain, an online training module on clinical audit for community pharmacists as part of its overall clinical governance training for the NHS. This training resource has so far been used by around 400 community pharmacists and feedback has been positive.

GPs and practice nurses generally have arrangements in place for Continuing Professional Development and receive annual appraisals

2.21 Our survey of GPs found that just over one third of GP respondents (35 per cent) received appropriate induction training on joining their practice. The more recently GPs had qualified, the more likely they were to have received appropriate induction training. The majority of GPs (90 per cent) had had their requirements for Continuing Professional Development (CPD) identified, and most of these (79 per cent) felt that there were arrangements in place to meet their requirements, whilst 18 per cent felt there were no arrangements in place (results for nurse respondents were similar).[34]

2.22 Almost all GP respondents (96 per cent) received an annual (NHS) peer appraisal, but three per cent did not. Eighty five per cent of the nurse respondents received a performance appraisal on at least an annual basis. Three quarters of nurse respondents considered arrangements were in place to meet their CPD requirements, although half considered they had not received specific clinical governance training.[34]

2.23 In recent years, the Department has emphasised the importance of doctors and dentists keeping their skills and knowledge up to date and maintaining their competence. Its approach recognises the importance of seeking to tackle performance issues through training or other remedial action rather than solely through disciplinary action.[38]

Assessment of doctors' performance and the procedures in primary care organisations to deal with poor clinical practice need to be strengthened

2.24 The Bristol and Shipman inquiries have highlighted the importance of identifying and remedying poor performance. Our 2003 report, *The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England*,[39] drew attention to the need for significant improvements in the way poor performance is managed. However, the power of PCTs to investigate and deal with concerns about a General Practitioner's performance or conduct are different to those in hospitals, mainly due to the independent contractor status.

2.25 The CMO's 2006 report *Good doctors, safer patients* highlights the actions that are available to PCTs. It found that although PCTs now have much stronger powers to deal with

poorly performing GPs, these have only been in place for a short time, and many PCTs feel unable to take local action themselves, relying instead on the General Medical Council to deal with concerns about poor performance.[6] The report notes that whilst local clinical governance systems have contributed to better identification of poor performance, the fact that PCTs do not have direct line management authority over individual contractors means that PCTs may be unable or unwilling to take remedial action to address concerns about a GP's conduct or performance.[6] The report identifies the need for effective systems of communication between professional, regulatory and educational organisations to ensure that such doctors can be picked up – and the importance of the concept of "one NHS" in relation to poor clinical performance between employers.[6] We consider that other clinical staff would benefit from similar systems.

2.26 In 2003 in our report on suspensions[39], and again in our report on patient safety in 2005[40], we identified the progress made by the National Clinical Assessment Service in helping to reduce the number and length of formal doctor suspensions. Likewise, they have an important role to play in relation to suspensions and managing poor performance in primary care. General Practitioners, who constitute 29 per cent of all doctors[41], accounted for around 40 per cent of the cases referred to the National Clinical Assessment Service in the last nine months of 2005.[42]

2.27 Much of the above is about identifying poor clinical performance. But patients and the public want assessment of doctors to go beyond technical skills and address communication skills, involvement of patients in treatment decisions and to be treated with privacy and dignity. As we show in Part Three, primary care still has some way to go in this respect.

Knowledge management and training in evidence-based practice are identified as relatively high risks to progress in implementing clinical governance

2.28 Effective clinical governance requires PCTs and independent contractors to generate, identify and use relevant information. It involves PCTs bringing together information generated by the different components of clinical governance to enable evidence-based decision-making. PCTs rated the lack of training in evidence-based practice as a relatively high risk to progress in improving quality and safety, followed by benchmarking of commissioning and provision of services against other PCTs, and working jointly with health and social care agencies on clinical governance issues.

2.29 For GPs knowledge about research findings, evidence of best practice and information on effective prescribing practices are essential. Practitioners have a professional responsibility to ensure that their knowledge base is up to date. The NHS can and does supply some of this knowledge, but practitioners will continue to derive knowledge from, for example, professional bodies and journals. The National Programme for IT (NHS Connecting for Health), established in October 2002, is a ten year Programme which aims to create an information infrastructure for the NHS that will increase the efficiency of clinicians and other NHS staff to help facilitate the delivery of good quality, safe care.[43]

There are practical barriers to the implementation of effective clinical governance

2.30 GPs and pharmacists identify similar barriers to implementing clinical governance, although almost a third of GP respondents either could not think of any barriers or did not believe that barriers existed for implementing clinical governance in their practice. The most important barriers reported were lack of time and lack of financing.[34] The help required to develop clinical governance in their practice followed a similar pattern **(Figure 12)**[34]. For primary care nurses, lack of time was considered the main barrier (by 56 per cent), and lack of interest and lack of staff were also considered important (by 20 per cent).[34]

2.31 For GPs, these findings are consistent with the messages from the Commission for Health Improvement reviews of clinical governance in PCTs, about what independent contractors want from PCTs **(Figure 13)**. For GPs the consistent themes are protected time and funding, whilst for other contractors the themes are basic guidance and practical advice on implementing clinical governance (perhaps as it is a relatively new discipline for them).

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12 Barriers to implementing, and areas where further help is needed to implement, clinical governance

Percentage of respondents

■ Main barriers to implementing clinical governance
■ Help required in developing clinical governance
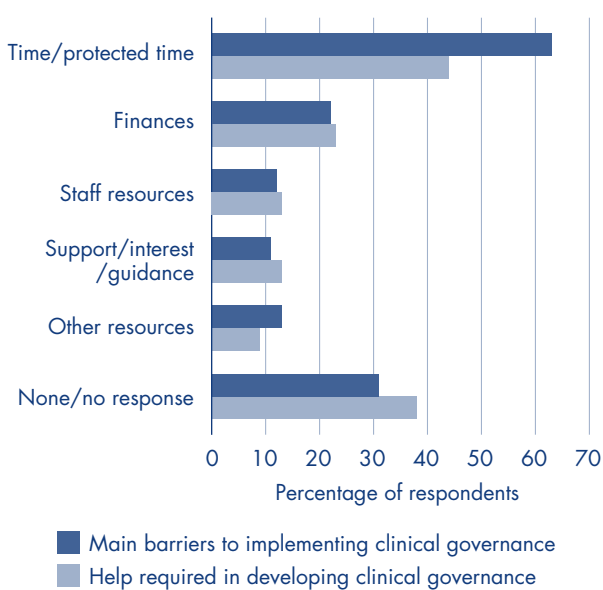
Source: National Audit Office/Medix survey of GPs, December 2005

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13 The Commission for Health Improvement's assessment of the top three things primary care professionals want from their PCT[1]

General practices

1 protected time and locum cover, particularly for training

2 funding for more clinical staff, GP appraisal, clinical governance time

3 improved communication, for example regular meetings relevant to primary care at flexible times to share ideas and facilitate communication between practices

Optometry practices

1 definition of clinical governance, help and practical advice on how to implement it in optometry

2 improved communication and contact between PCT and practice and between hospital, GP and optometrist

3 training or workshops

Dental practices

1 practical advice, information and support to keep practices updated, in particular on clinical governance and PCTs' expectations of practices

2 funding, particularly for IT, training, staff

3 training or workshops

Pharmacies

1 advice, guidelines, for example templates for audit and information on local issues

2 funding for training, health promotion activities, reward for good practice

3 improved communication to bring pharmacies together and share learning

Source: What CHI has found in primary care trusts, Commission for Health Improvement, March 2004

NOTE

1 Responses to CHI's practice surveys sent to general practice teams, dentists, optometrists and pharmacists as part of the clinical governance review.

2.32 To help ensure that clinical governance becomes more firmly embedded in primary care culture and practice, the NHS Clinical Governance Support Team is working on a range of resources aimed at managers and practitioners in primary care. These tools include a set of competencies and a training programme for PCT leaders whose role is to ensure the delivery of clinical governance, and tools – including an online forum – for practitioners to help them to gain a better understanding of clinical governance and to share experiences and best practice.

The implementation of clinical governance has delivered clear benefits for quality of patient care

2.33 Eighty two per cent of our respondent PCTs considered that the implementation of clinical governance had delivered clear benefits for the quality of patient care, with none saying that there had been no impact.

Figure 14 shows some examples of how changes in the PCT structure or processes driven by clinical governance have impacted on the quality of patient care.

14	Examples of the impact of clinical governance on the quality of patient care

Category	Situation	PCT Action	Outcome
Leadership for clinical audit	There was no clear structure for clinical audit across the PCT.	"Appointed a clinical governance manager with a clear remit for audit and effectiveness. Developed a clinical audit action plan, and rolling programme of audit."	Programme informs future work and management actions within clinical teams. Infection control audit within practices has improved the patient environment.
Improved staff training	The PCT wanted to promote and enable a culture where staff felt able to report incidents without fear of retribution, and to learn from incidents.	"Trained one risk champion per service to be able to work at a local level to raise awareness about risk management. Set up a support and information cascade and feedback network throughout the PCT."	Staff are much more risk aware. Incident reporting has increased. Staff members receive feedback and feel more supported.
Proactively identifying clinical risk	The PCT was not satisfied with the handling of referrals for Obstructive Pulmonary Disease patients.	"A new, nurse-led community service was developed where GPs can refer all Obstructive Pulmonary Disease (COPD) patients. Patients call the service directly if they feel unwell, and are guaranteed a response in two hours."	Some GPs were resistant to the service and their admission rates remain high, whereas admissions for other GPs are falling because the service works across the primary/ secondary interface. Patients are happy with the new service.
Improved public engagement	Services for people with learning disabilities were underdeveloped.	"Service user council formed. Service users trained and supported to engage in the process."	A strategy to develop services has been created and introduced.
Learning from incidents	The PCT did not know whether the management of complaints and incidents in General Practice was effective.	"A quarterly reporting process was put into place with an opportunity to report in detail for more serious incidents on an anonymous basis. These are included in a newsletter, which aims to share learning from incidents."	Incidents are included on a PCT database. Complaints handling is more sophisticated.
Better complaints management	There was a sudden upsurge in complaints about access to Phlebotomy services.	"A Project Group was set up to address the issues and concerns raised. Agreement was reached for the service to be reinstated with improved access."	A new Phlebotomy service has been introduced in community clinics to secure better and more equal access to the service. Patient complaints have stopped.

Source: National Audit Office analysis of responses to HSMC census of PCTs, Autumn 2005

2.34 One in eight respondents to our GP survey (12 per cent) were able to provide examples of good practice to illustrate how clinical governance has made a difference to their work.[34]

Clinical governance has helped to deliver efficiency improvements

2.35 Twenty per cent of PCTs considered that clinical governance had delivered efficiency savings across five broad areas **(Figure 15)**, and a further 66 per cent said that clinical governance may have delivered efficiency savings but they had not been fully assessed.

2.36 Although just two per cent of the respondents to our GP survey had undertaken a formal cost-benefit analysis of the implementation of clinical governance, 79 per cent had not. Nineteen per cent of respondents were unsure whether their practice had carried out a cost-benefit analysis or not. Fifteen per cent felt clinical governance had helped them to deliver efficiency benefits.[34]

15	Examples of how clinical governance has helped deliver efficiency savings	
Area	**Example reported**	**Per cent of PCTs reporting**
Prescriptions/procurement management	■ Streamlining prescribing so that it is more cost effective	12.9
	■ Better management of equipment/prosthetics procurement	1.3
Risk management	■ Reduction in litigation	3.3
	■ Reduction in infection rates	2.5
	■ Reduction of incidents/near misses	2.1
	■ More systematic use of resources	3.3
Links with secondary care	■ Reduction in unnecessary hospital attendance	4.6
	■ Improved referral and appointment systems	2.5
Service redesign	■ Development of patient pathways	3.3
	■ Application of lessons from clinical audit/best practice	3.8
	■ Redesign of delivery such as podiatry services	4.6
	■ Efficiencies generated by application of evidence-based practice	1.3
Resource issues	■ Better utilisation of staff through training	4.6
	■ More effective use of information	0.4

Source: National Audit Office/Health Service Management Centre census of PCTs, Autumn 2005

PART THREE

Patient and public involvement and the quality of the patient experience need strengthening

3.1 A key objective of the NHS Reform agenda is to improve the patient experience by, among other things, strengthening the involvement of patients and the general public in shaping the future provision of services. Patient and public involvement and the quality of the patient experience are two important components of clinical governance.

3.2 Effective clinical governance in primary care can help to ensure the quality of outcomes experienced by patients. The quality of patients' experience depends largely upon:[44]

- fast access to reliable health advice;

- effective treatment delivered by trusted professionals;

- participation in decisions and respect for preferences;

- clear, comprehensible information from practitioners and support for self care;

- attention to physical and environmental needs;

- emotional support, empathy and respect;

- involvement of, and support for, family and carers (for example from voluntary organisations);

- continuity of care, smooth transitions between healthcare providers and 'seamless' delivery of service from the different organisations they come into contact with as they receive care; and

- whether it is straightforward to complain if they are dissatisfied with the service they receive.

3.3 This Part of the report assesses the extent to which PCTs are addressing patient and public involvement, and progress being made in improving the quality of the patient experience. Our assessment draws on our census of PCTs, findings from the work we commissioned from Pilgrim Projects (which probed the experiences of voluntary organisations and specific groups of patients to provide insight into their experience of primary care services), and on the Healthcare Commission's annual patient surveys (Appendix 1).

The quality of the patient experience is not solely linked to the quality of clinical care, but effective clinical governance arrangements should ensure a better patient experience

3.4 Patients want primary care professionals who are good communicators and who have sound, up to date clinical knowledge and skills. They also want professionals who are interested, sympathetic, involve them in decisions about their care, give sufficient time and attention and provide advice on health promotion and self care. Implementing the systems and processes of clinical governance will help meet this requirement. Indeed most patients responding to patient surveys are positive about their experiences of primary care **(Figure 16 overleaf)**.

Patient and public involvement has a direct impact on the quality of the patient experience

3.5 As far as clinical governance is concerned, patient and public involvement has two dimensions: at the community level it relates to involving the public in strategic planning and decision-making; on an individual level it is about enabling patients to make informed choices about the service or treatment they receive.

3.6 'Patient experience' refers to patients' perceptions of the care and treatment they receive, for example the prompt provision of good, safe care in a clean and welcoming environment. Improving patient involvement will create a more positive patient experience and **Figure 17 overleaf** summarises how patient involvement (input) and patient experience (outcome) are linked.

16 Key findings from the 2005 primary care patient survey

Positive experiences

92 per cent said they were treated with dignity and respect by the doctor

82 per cent said the doctor listened carefully to them

74 per cent said they definitely had enough time with the doctor to discuss their problem

76 per cent said they had complete confidence and trust in their doctor

85 per cent had complete confidence and trust in other primary care staff

Negative experiences

41 per cent would have liked more say in decisions about medicines

39 per cent of those prescribed new drugs wanted more information about side effects

70 per cent of patients referred to a specialist were not given copies of referral letters

57 per cent of patients who had phoned the practice had had difficulty contacting the practice

*Source: Healthcare Commission, Primary Care Trust survey of patients, 2005*

Primary Care Trusts' levels of engagement with service users have been low

3.7   Under clinical governance, engagement with the patient is based on partnership, with the aim of shifting the balance of power away from a patient-passive relationship towards patient empowerment and establishing a more equal relationship between the NHS and patients where patients become "more active partners in their care"[45]. Engagement can take place on different levels from one to one engagement with individual patients to larger scale patient forums or committees.

Structures and processes for patient and public involvement are in place in Primary Care Trusts, but lack of patient and public involvement is identified as one of the higher risks to progress in implementing clinical governance

3.8   Our evidence indicates that patient and public involvement is relatively less well developed than many other aspects of clinical governance. Our census of PCTs found that almost all have structures and processes in place for involving patients and the public in the design and delivery of services (98 per cent) and have a strategy for doing so (95 per cent). However, PCTs rated lack of involvement of service users in service development as one of the higher risks to progress in improving quality and safety compared to other aspects of clinical governance.

17 Model of dynamics between patient involvement and experience
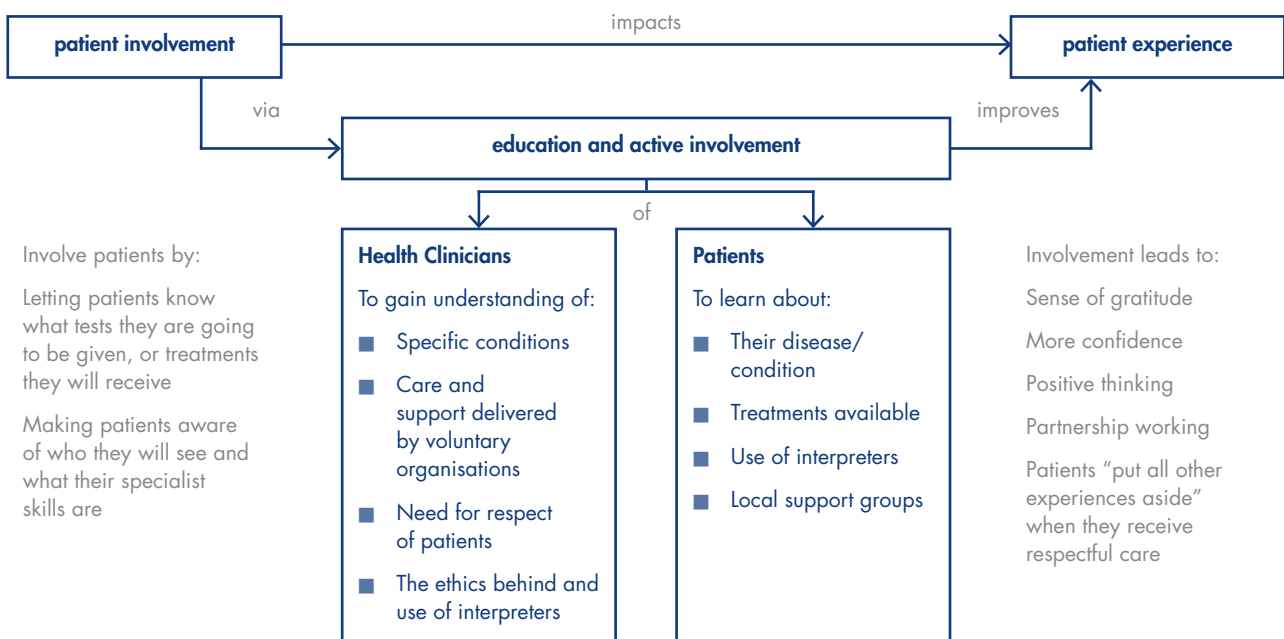
Source: National Audit Office, derived from Pilgrim Projects research

3.9 Our survey of GPs found that patient panels were used as a method of engagement with patients by just under a third of GP respondents, whilst 60 per cent said they did not have a patient panel in place, and 9 per cent did not know.[34]

Primary Care Trusts' levels of engagement with voluntary organisations supporting patients are low

3.10 By the nature of the service they provide, voluntary support groups have close contact with patients, both individually and collectively. Our survey of 14 voluntary support groups reported the following views to the National Audit Office:

- All groups felt that there was scope for PCTs to engage more effectively with their client groups, though responses varied depending on how rare the health conditions are.

- Some PCTs have consulted patients about their views on current services, demonstrating that action is being taken to improve patient engagement.

- In terms of improvement since the introduction of clinical governance in 1998, three saw no improvement in PCT engagement with client groups, four felt there had been minimal improvement, with another four stating moderate levels of improvement. Only one felt there had been considerable improvement.

- The use of surveys and public and education events were among the most common examples of improvements that they have seen PCTs use to engage with patients.

- The group with a national target on a condition (Diabetes UK), reported a more positive experience of working with PCTs than those in other voluntary groups for which no national targets are in place.

- Only three organisations reported that they been involved in a clinical audit conducted through a PCT. Three organisations also reported that they had been involved in clinical risk assessment.

- All agreed that communication and cooperation with PCTs are vital to improve healthcare for patients, but although engagement is present, it is not consistent or coordinated, as some organisations have had more contact with PCTs than others.

18	Examples of improvements reported by voluntary organisations in the way PCTs have engaged with patients

- Mailing patients to inform them of public consultation meetings through the use of registers (for example Rugby PCT and Cannock PCT).

- Involvement and presence of PCT senior management at presentations and events.

- Structured education surveys carried out.

Source: Pilgrim Projects survey of voluntary organisations, Autumn 2005

3.11 Our findings also suggest the level of engagement across different voluntary organisations is uneven, as well as across different PCTs. Engagement depends on the nature of the voluntary service and the number of people affected. Thus asthma and diabetes organisations experience a greater level of engagement than those for cystic fibrosis or endometriosis. We found that the extent to which the introduction of clinical governance had led to improvements in the way PCTs engage with responding voluntary organisations was mixed. One voluntary organisation reported a considerable improvement, three reported no improvement whatsoever and the remainder fell between these responses.

Some Primary Care Trusts seek to collaborate with voluntary groups as they recognise that the services and specialist information they offer can complement NHS services

3.12 The Government has encouraged collaboration between the NHS and the voluntary sector. In 2004 the then Health Secretary launched a new agreement between the Department of Health and the voluntary sector. The National Strategic Partnership came into place in November 2004 to "add to the diversity of provision", and primary care contracting enables PCTs to commission services from a wide range of providers. The Alternative Providers of Medical Services (APMS) contract in particular enables partnership and collaboration between PCTs and non-NHS bodies such as the voluntary sector or commercial providers.

3.13 Our survey of voluntary sector organisations found evidence of collaboration between the voluntary sector and PCTs. For example, Diabetes UK (London branch) jointly publishes patient education pamphlets with Newham PCT that are used by patients in the area. Diabetes UK (North West region) is involved in planning processes with PCTs, as well as developing patient information packs and being invited to strategy days. Seven PCTs have supported the Society for Mucopolysaccharide (MPS) Diseases regional specialist clinics, enabling experts to work alongside local paediatricians and adult physicians, resulting in patients and their families having a more local access to expert medical help. Some PCTs work alongside voluntary organisations for example to set up support groups for patients and carers; to distribute their published material to patients in waiting areas and receptions; and to hold joint workshops at PCT Education Days.

3.14 Other respondents, however, have had very little collaboration with their local PCTs. Very often the contact is initiated by the voluntary organisations rather than the PCTs. The level of collaboration depends in part upon the level of interest shown and action taken by PCTs. Some voluntary organisations had sent letters of introduction to PCTs, to which some PCTs requested further information, whilst others invited the voluntary organisations to join the appropriate committees, and some PCTs did not respond at all. **(Figure 19)**

19	Engagement between PCTs and voluntary organisations

"We can help raise awareness among people with asthma and health professionals but for better access to happen asthma needs to be given a higher priority in the majority of PCTs, not just an enthusiastic minority".

"In general, the communications are one way! However, once a relationship has been established, some PCTs are open and welcoming".

"We have approached PCTs from time to time to address a particular problem, but to my knowledge, a PCT has never approached us or our client group".

"It is possible for PCTs to engage more effectively with the Cystic Fibrosis Trust, but as each of them may only have 20 or so patients with Cystic Fibrosis, we do not get high enough up their agenda or onto their radar screen. 300 PCTs are too many bodies for a patient organisation representing 7,500 patients to deal with."

Source: Pilgrim Projects survey of voluntary organisations, Autumn 2005

Patients say that the quality of the patient experience is determined primarily by quality of interpersonal care they receive, with less emphasis on technical aspects of care

3.15 To patients, the quality of care experienced is determined primarily by the 'humaneness' and sensitivity with which healthcare is delivered, with less emphasis on clinical quality or competence.[46] Receiving empathy, understanding and respect are key to improving the patient experience **(Figure 20)**.

3.16 This has been recognised in the NHS for some time, and the NHS Modernisation Agency in 2004 considered that a PCT's activities with its patients, communities, staff and partners should be characterised by the values of humanity, justice and respect, and that clinical governance policies and implementation should embody these values in a way that engages all staff in the pursuit of excellence.[5]

20	A good patient experience depends upon quality of service

Patient quotes

"Quality in healthcare means that you should be seen by the right person, at the right time (on time), be fully informed as to your health situation and all the available options of treatment, be treated with sensitivity and respect and to be looked on as a human being not 'an interesting case'."

"I've rarely been in an NHS environment where I have felt 'cared for'. I don't think you receive care, I think you receive treatment; it's very different."

"Treat the patient and the illness, not just the illness."

"Although most of our experiences are good, it's the bad ones that stick in our minds, because we have an emotional response to them. It is our feelings that govern our attitude to our patient experiences."

"I just see them as people who monitor me in a puzzled or expectant way. There is very little emotional 'care' from anyone."

Source: Pilgrim Projects research commissioned by the National Audit Office

3.17 Patient surveys have found that the proportion of primary care patients saying that doctors always treat them with respect and dignity has remained consistently high at around 92 per cent.[47] In the work we commissioned from Pilgrim Projects, we found that insensitivity and ignorance among clinicians, and specifically the lack of respect with which patients are treated, was the most frequent complaint made. Lack of good time keeping, or the failure on the part of the PCT to deliver a service, were also specifically mentioned.[17]

3.18 We found that some patients and carers felt that the achievement of targets (for example on achieving financial balance or on access to services) sometimes happened at the expense of meeting patients' expectations of quality, and that targets and financial constraints are more important to the NHS than the quality of patient care.[17] Many of the targets set, however, by the Department of Health in recent years have been directly addressed at improving the quality of care – for example the take up of evidence-based interventions in primary care such as reducing death rates from heart disease.[48]

Patients may feel excluded from aspects of their own care

3.19 Patient responses from our focus groups highlighted a desire to be informed about any tests they are to be given, the treatments they are to receive, the options available to them, who they are going to see and what specialist skills clinicians and their teams have. Having the power and confidence that comes from a full awareness of their condition enables patients to make informed choices about their care, and limits feelings of loss of control over their own situation and exclusion from aspects of their own care **(Figure 21)**. Guidance recognises the importance of giving choice and power to individuals (patients or carers), and the role it plays in relieving stress, fear, and vulnerability. Our findings reflected this demand for more equity and say in treatment from the perspective of the individual patient **(Figure 22)**. In 2005, 69 per cent of primary care patients said they were definitely involved as much as they wanted to be in decisions about their care.[47] Other studies however, have found that British patients feel less likely to be involved in treatment decisions by their doctor, such as prescribing decisions or diagnoses, than in other countries.[49]

21   Patients may feel excluded from aspects of their care

"Eventually I found the Blood Pressure Association on the web, because I desperately needed some support, some information, but I didn't know it existed. Nobody told me."

"I had high blood pressure but I read information in the doctor's surgery in a leaflet, because the doctor didn't tell me much or give me much information. I went to the library and read some books about it, then my blood pressure went down because I stopped taking salt in my diet."

"I didn't know that we could get chiropody at home. There needs to be a list of dentists, chiropodists, opticians, who might do home visits or at least who can care for people with dementia – there's a lack of information – they don't tell you what's available."

Source: Pilgrim Projects research commissioned by the National Audit Office

22   Individual patients expect more say in their treatment

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

Department of Health, NHS Cancer Plan

"The individual knows their own body, they know their own tolerance of pain, their own tolerance of discomfort, they know what side effects they're prepared to put up with, what side effects they're not prepared to put up with and it's really for them, I think, to call the shots in negotiating a course of treatment. But we as patients can't do that, unless there's a full disclosure of the information and unless we as patients are prepared to shoulder the responsibility of learning what we need to know to make the decision."

Expert patient

Source: Clinical Governance Matters Pip Hardy and Ross Scrivener, UK Health Education Partnership in 2004

3.20 Our focus groups also highlighted the importance of keeping carers, as well as patients, involved or at least informed of aspects of patients' care.[50] We found that carers often felt overlooked within healthcare, excluded from the decision-making process and uninformed about the patient's treatment or their rights as a carer. Great appreciation is felt by carers when doctors or nurses recognise the importance of their role and their welfare patient **(Figure 23)**.

Patients have only one journey and are conscious that services are not always joined up to meet their needs

3.21 The patient journey refers to the processes a patient passes through from the first contact with the health service (for example contacting NHS Direct or visiting a GP) right through to the end of his or her care (including where relevant treatment in secondary or tertiary care). This 'journey' forms the patient's experience of the healthcare system. Common features of most patient journeys are communication processes, administration processes and visits to different NHS departments or organisations. A patient's journey can be eased by ensuring these processes are reasonably joined up and that they complement, rather than duplicate, one another, and that the standard and quality of care is continuous and of a consistently high standard through the different stages.

3.22 As they are usually the first port of call for patients, primary care professionals are seen as the 'gateway' to the rest of the NHS. Even if patients are then referred on to secondary care or other providers, primary care

professionals play a crucial role in determining that patients receive the right type of care at the time it is required. The patient journey through a joined up system therefore forms part of clinical governance because it is linked with quality assurance, efficiency and appropriateness of care as well as the patient experience.

3.23 Our research with patients and support groups found that not all patients experience a smooth journey **(Figure 24)**. We found that patients often experience a variety of negative emotions that result directly from the difficulties they encounter during their journey through the healthcare system. In particular, patients speak of feeling 'marginalised' if their condition is complex, is rare or less well known within primary care, for example cystic fibrosis or endometriosis, or if they have a disability (such as blindness, deafness, illiteracy, or learning difficulties).

3.24 Effective flows of information between primary care and other care providers, in particular between generalists and specialists, are therefore key to improving the patient journey, and the flow of information needs to be two way. Transferring information about the patient's symptoms and history to specialists is important, but so is the transfer of information back to the GPs about how to spot symptoms and how to ensure patients reach the appropriate specialists when needed.

3.25 In the Healthcare Commission's survey of PCT patients, of those people who had been referred by their GP to a specialist, 30 per cent reported that the specialist had only some of the necessary information about them, and a further nine per cent reported they had none of the information.

23	Carers also play an important role in healthcare

"The GP told me I was not the patient; therefore he could not deal with me! Yet my husband is not able to talk for himself. Is this a lack of care? Most patients visit their GPs for medication for their complaint. I think the GPs should be responsible for handing them a short booklet of information on what care is available and who provides it. Most patients and carers do not know where to go for help and advice."

"[the doctor] says that if you don't look after yourself, then we'll have two patients! She looks out for us."

"My doctor is really good – he commented that he would keep an eye on me."

Source: Pilgrim Projects research commissioned by the National Audit Office

24	Patients' experience of NHS services is often not joined up

"Of course you can't expect the GP to know everything – they are generalists. They can try to refer you to different people, and while the patient is getting frustrated, the GP is just trying to go through the different possibilities. They do the best they can."

"You don't see the same person every time, but see different people every time."

"You need a GP that will back you up and refer you."

"Specialists are, by their nature, specialist. This often means they don't see the bigger picture and aren't comfortable with the way their treatment impacts on other illnesses or the rest of your life generally."

Source: Pilgrim Projects research commissioned by the National Audit Office

Patients are often confused about how to complain

3.26 Part of improving PCT engagement with patients and carers involves effective complaints procedures so that information can be fed back and incorporated into future service design. Listening to user group complaints also forms a very important element of 'engagement' and 'involvement' in its own right. We found, however, that patients were often confused about how to place a formal complaint – especially when they were dealing with more than one organisation or healthcare provider at the same time (nevertheless 35,431 written complaints were received by GP practices in 2004-05[51]). Carers in particular feel undecided over their rights to complain and, if so, what processes are available for them to do so.[17]

3.27 The Department is developing proposals for a new complaints procedure which is accessible, easy to understand and consistent, irrespective of the health service context (whether primary or secondary care).

Education and information for clinicians, carers and patients improves patients' experience of healthcare

3.28 We found that education and information for clinicians is seen by patient groups as central to successful treatment and delivery of better quality patient care, particularly for those with less well understood ailments and for carers. Our focus groups found that lack of knowledge, both at junior and senior level, is seen as the root of many of the problems with the quality of patient experience.

3.29 We also found that access to information enables patients to participate more fully in the process of care. Patients told us that they are ready to become involved with detailed information on their condition in order to understand better their options, and to help clinicians manage their care; patients are more likely to be distressed and frustrated with their own care if they lack information about their illness.

3.30 Results from the Healthcare Commission's survey of PCT patients[52] show that 75 per cent of patients received an explanation from their GP that they could understand. Of respondents who were prescribed new medication, 80 per cent said they were given enough information about the purpose of their medication, and 86 per cent received enough information about how to use their medication: with four per cent saying they received no information at all.

3.31 Patients see education as a two level process: the provision of factual guides (literature or seminars) about the specific ailment and its treatment, and personal one to one information about treatment which is being offered or applied. Our focus groups considered that whilst self education through patient and carer groups or from internet research can be valuable, it is seen as a substitute for information that could be provided by the health service but is not. Voluntary organisations we consulted consider that they should provide education for NHS staff as well as for their members, patients and carers, in order to promote more effective partnership working to improve the quality of care.

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25 Patient groups' comments about making complaints

"Patients don't know who to complain to. This doctor doesn't refer you to other people, he just gets irritated."

"They don't really want complaints; they just have to show that they've asked you."

"I think what they need to do is just listen to people – it's not ignorance, it's just a matter of time and sympathy. I think the only way to change anything is to complain. If you don't complain nothing happens."

Source: Pilgrim Projects research commissioned by the National Audit Office

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26 Patients consider having adequate information affects the quality of care they receive

"Doctors need communication training so they can give people bad news – or any news."

"We need information we can understand on paper, plus we need someone to speak to us. It's important to know what affects you the most so we can guard against it. You need to go to the barbers and churches so everybody knows what's going on and people can be protected early."

"I went along with some notes and questions (because I also have dyslexia, so I write everything down) but the nurse was horrified! I think she was frightened that she might not know the answer!"

"The primary care sector is very naive to the needs and wants of a person with cystic fibrosis, this inhibits their quality of care. Improvement would be for them to have a basic understanding of what is normal procedure for a person with cystic fibrosis."

Source: Pilgrim Projects research commissioned by the National Audit Office

APPENDIX ONE

Methodology

The evidence used in this report was collected between October 2005 and January 2006. There were five main aspects to our fieldwork:

- **A postal census of PCTs**, carried out on behalf of the NAO by a team at the University of Birmingham's Health Services Management Centre (HSMC) led by Professor Peter Spurgeon. The three questionnaires were developed in consultation with the Health and Social Care Information Centre (HSCIC) Review of Central Returns (ROCR) Committee, who considered them to be useful and reasonable, in terms of the burden on PCTs (Gateway reference number 5480). Questionnaires were piloted with PCTs before despatch, and questions were designed to be relevant and useful in the context of the Annual Health Check. The census frame was validated by contacting each Strategic Health Authority and seeking confirmation of contact details of a lead person for clinical governance to whom the survey should be directed. The approach to PCTs had three elements:

  - **Questionnaire A.** *A census of PCT Chief Executives*, completed by them with assistance from their appointed clinical governance leads. This was a new instrument prepared in partnership between the NAO and HSMC. Out of a total of 303 PCTs, 240 responses to the questionnaire were received (a 79 per cent response). We considered this response rate was reasonable given the changes and reorganisations afoot in primary care during the period of the census. We also compared the non-respondents and their star rating and found no bias to lower or higher starred trusts. From the responses HSMC prepared an assessment of progress that discriminates between PCTs, based on the responses to 26 key clinical governance activities and then using methods of Average Index Banding and Progress Index Banding (to accommodate for non-normal distribution of scores in some PCTs). In this

study we primarily use the results from Progress Index Banding, which indicates high (band A) or low (band E) progress in implementing clinical governance (we also analysed these banded results against other PCT performance indicators – see Appendix 4).

- **Questionnaire B.** *A survey of the views of members of the Professional Executive Committee and the PCT Board.* Each PCT was posted ten copies of a short questionnaire for completion by members of their Professional Executive Committee and Board members. This consisted of a modified version of HSMC's Organisational Progress in Clinical Governance (OPCG) instrument, which assesses respondents' perceptions of achievement on a series of organisational competencies related to clinical governance. The OPCG requires respondents to score their organisation's achievement against items which are aggregated under five domains: improving quality; managing risk; improving staff performance; corporate accountability; and leadership and collaboration. We examined how far PEC and Board members endorsed that their PCTs were engaged in 20 clinical governance activities. In total, 3,237 responses were received, 1,120 (one third) from the members of PECs. PEC members were generally more pessimistic about progress across 20 elements of clinical governance than other respondents. Of these, GPs (making up 29 per cent of PEC respondents) consistently gave lower scores than all other PEC members.

- **Questionnaire C.** *Assessing the 'lived experience' of clinical governance by front-line staff.* A random sample of 12 PCTs within the total PCT population were asked to identify a liaison person within their provider unit arm (Learning Disability, Mental Health or

Community Units) and then these individuals were then asked to distribute the Questionnaire C forms to 30 front-line staff on a random basis. Questionnaire C is a modified version of HSMC's Clinical Governance Climate Questionnaire (CGCQ) which measures the 'lived experience' of clinical governance on six sub-scales: quality improvement; proactive risk management; the absence of unjust blame and punishment; working with colleagues; training and development opportunities; and organisational learning. A total of 170 questionnaires were received in response to the survey, from 11 of the 12 participating PCTs.

The questionnaires and the outputs prepared summarising the results from these surveys are accessible at www.nao.org.uk.

- **Consultation of those in the NHS working in primary care**, in order to determine lessons learned in the implementation of clinical governance and identify what more needs to be done.

  Details of these exercises are available at www.nao.org.uk. This had four elements:

  An online survey of General Practitioners and Practice Nurses. On behalf of the NAO, Medix UK undertook in December 2005 a survey of 503 GPs and 54 practice nurses. All members of Medix who are GPs and primary care nurses in England were invited to participate. The surveys covered three areas:

  - quality and safety of care to patients;

  - quality and safety of practices; and

  - experiences and comments of respondents about implementing clinical governance.

  An online questionnaire for completion by pharmacists. In consultation with the Royal Pharmaceutical Society of Great Britain (RPSGB), the NAO designed an online web-based questionnaire accessible from the NAO website. The questionnaire was promoted to pharmacists at the British Pharmaceutical Conference, advertised in the Pharmaceutical Journal, and circulated through the Royal Pharmaceutical Society's local networks. 169 responses to the questionnaire were received by mid December 2005 when the questionnaire was closed down and responses analysed.

  A workshop with nurses working in primary care. At the Nursing in Practice conference held in London in September 2005, the NAO hosted a workshop attended by 60 nurses fulfilling different roles in primary care. 200 nurses attending the conference also completed a questionnaire covering their experience of clinical governance. The responses were analysed for triangulation with other sources of evidence.

  A workshop of clinical governance leads from PCTs. At the NHS Alliance conference in November 2005 the NAO hosted a workshop where clinical governance leads from ten PCTs contributed their experiences of clinical governance.

- **Semi-structured telephone interviews with 15 Strategic Health Authorities (SHAs)** to identify the support provided by SHAs to PCTs to implement clinical governance, what challenges they had faced in working with PCTs to implement clinical governance, and the extent to which they are monitoring PCTs' clinical governance performance. The interviews were conducted in November and December 2005 with 15 clinical governance leads from a total 28 SHAs.

- **Consulting patients and carers.** We commissioned Pilgrim Projects, a small consultancy experienced at capturing the views of patients and carer organisations, to help answer the question: "are PCTs achieving improvements in the patient experience and quality of care delivered to patients?". To address this, Pilgrim Projects carried out:

  - *A survey of patient and carer organisations*. The survey approached 15 voluntary organisations representing different patient and carer groups, selected because of their focus on primary care and likely contact with PCTs and primary care services; 14 responses were received covering ten organisations. Chief Executives of each organisation were sent a questionnaire (some CEOs disseminated the questionnaire to regional managers). The organisations covered in the report provide support for patients with the following conditions:

    - Alzheimer's disease and dementia;

    - asthma;

    - cystic fibrosis;

    - diabetes;

    - endometriosis;

    - high blood pressure;

    - leg ulcers;

    - mucopolysaccharide diseases; and

    - osteoporosis.

- *A review of research carried out by voluntary organisations.* Five organisations provided research reports and articles covering the quality of care received by members; Pilgrim Projects also drew on previous research carried out with patients and carers, including organisations specifically set up to help carers.

- *Collection of patients' and carers' experiences of healthcare by* engaging with seven patient and carer groups and facilitating focus group events during local meetings of patient and carer groups in different parts of England.

A report covering the Pilgrim Projects work is published on the NAO website at www.nao.org.uk.

- **Review of secondary data available from the Department of Health and the Healthcare Commission.** The Healthcare Commission has asked patients about their experiences of primary care services each year since 2003; 116,939 people responded to the 2005 survey of patients (a response rate of 47 per cent; see www.healthcarecommission.org.uk); data generated on primary care complaints, and financial information collected by the Department of Health and analysed by the NAO in its reports on NHS financial management.

We also examined PCTs against the star rating system in place to 2004-05, and against the self assessments against the Standards for Better Health introduced from 2005-06. The standards, which apply to all NHS trusts, including PCTs, have two principal objectives:

- to provide a common set of requirements to ensure that the provision of health services is safe and of an acceptable quality; and

- to provide a framework for continuous improvement in the overall quality of care people receive.

Twenty four core standards "describe a level of service which is acceptable and which must be universal".[29] The core standards form the basis of the Healthcare Commission's regulatory framework and are the principal way of regulating PCTs. Various standards incorporate some of the components of clinical governance, with a specific Governance standard, C7, for example, which states: "Healthcare organisations should apply the principles of sound clinical and corporate governance". We compared the results of our analysis of clinical governance performance (Part Two) against some elements of the standards. However, of the self assessment data currently available relating to performance against the standards, over 92 per cent of PCTs declared that they fully complied with those standards we compared against. It was therefore not possible to obtain any meaningful results from such an analysis. The Healthcare Commission's first assessments of PCTs' performance against the standards were published in October 2006.

We also convened an **Expert Panel** which advised us on emerging findings and issues arising as our fieldwork progressed. The members of the Expert Panel were: Dr David Colin-Thomé, National Clinical Director for Primary Care, Department of Health; Professor Aidan Halligan, former Director of Clinical Governance for the NHS; Dr Jane Moore, Division Head, Healthcare Quality, Department of Health; Professor Ellie Scrivens, Director of Healthcare Standards Unit, Keele University; Professor Ruth Chambers, Director of Postgraduate General Practice Education/Associate Head of Primary Care Education at the Workforce Deanery, NHS West Midlands and Professor of Primary Care, Staffordshire University; Professor Tim van Zwanenberg, Medical Adviser to County Durham and Tees Valley SHA; David Pruce, Director of Practice and Quality Improvement, Royal Pharmaceutical Society; Debbie Glenn, Joint Chief Executive of Blackwater Valley and Hart PCT and North Hampshire PCT; Ruth FitzJohn, Chair of Cheltenham and Tewkesbury PCT; Dr Vikram Tanna, Royal College of GPs.

APPENDIX TWO

The main national bodies with a role in supporting the implementation of clinical governance in the NHS

NHS Clinical Governance Support Team	Established in 1999, the NHS Clinical Governance Support Team (NCGST) was set up to work with the NHS in implementing clinical governance. In the past it has offered practical support both through development programmes and by working directly with "challenged trusts" as well as acting as a centre of expertise on clinical governance matters. The NCGST's role is to provide information guidance and to assist organisations in understanding and successfully implementing clinical governance and is currently exploring innovative ways of delivering this support through online and blended learning (for example the primary care management development programme) and through wider use of web facilities such as online discussion forums.
National Patient Safety Agency	The National Patient Safety Agency (NPSA) is a Special Health Authority that was set up in 2001 to implement a mandatory reporting system to collect and learn from patient safety incidents and coordinate activities and learning to support those involved in healthcare. Since April 2005 the NPSA has also been responsible for supporting local organisations in addressing the performance of doctors and dentists through its responsibility for the National Clinical Assessment Service (formerly the National Clinical Assessment Authority).
Commission for Health Improvement	The Commission for Health Improvement (CHI) was established in November 1999 to support and oversee the quality of clinical governance and of clinical services provided by the NHS. One of its key functions was to undertake reviews of the clinical governance arrangements in every NHS trust and PCT in England and Wales. It began its programme of review visits in April 2000, although it did not start reviewing PCTs until October 2002.
Healthcare Commission	In April 2004 the Healthcare Commission was established as the new inspectorate body for health and social care in England, covering the NHS and the private and voluntary sectors. The Healthcare Commission has assumed the responsibilities previously incumbent on CHI but it has ceased the programme of clinical governance reviews. CHI and the Healthcare Commission reviewed a total of 102 PCTs.

Source: National Audit Office examination

IMPROVING QUALITY AND SAFETY
PROGRESS IN IMPLEMENTING CLINICAL GOVERNANCE IN PRIMARY CARE: LESSONS FOR THE NEW PRIMARY CARE TRUSTS

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APPENDIX THREE

The origins and development of clinical governance in the NHS

1948	In the first 40 years of the NHS, quality improvement initiatives had mixed success; efforts to improve the quality of patient care remained fragmented and disparate.
1980s	Managers, policy-makers and clinicians tried to apply industry-based approaches of Total Quality Management (TQM) and Continuous Quality Improvement (CQI).
Early 1990s	Medical and clinical audit introduced, but criticised as being dominated by medical professions; benefits not readily apparent to the wider health service or to patients.
End of 1990s	Public confidence was undermined and serious doubts raised about the quality of NHS care available to patients. Clinical and organisational failures, such as children's heart surgery at the Bristol Royal Infirmary; and the removal retention and disposal of human organs and tissues following post mortem examination by the Royal Liverpool Children's NHS Trust, meant that the quality and safety of patient care across all NHS organisations needed to be systematically and urgently addressed.
1997	The NHS policy paper, *The New NHS Modern, Dependable* was published.
1998	The consultation document, *A First Class Service: Quality in the New NHS* published. It laid down that the principles of clinical governance should apply to all who provide or manage patient care in the NHS, and set out accountability of Chief Executives, on behalf of trust Boards, for assuring the quality of NHS trust services.
1998	A programme of National Service Frameworks (NSFs) launched.
1999	NHS Executive Health Service Circular, *Clinical Governance: Quality in the new NHS* published.
1999	*Health Act* made 'quality' a legal duty and introduced corporate accountability for clinical and organisational performance across the NHS. NHS trust Chief Executives became ultimately responsible for assuring the quality of healthcare services provided by their organisations.
February 2000	The Government announced that, in the light of the case of Harold Shipman, who murdered 15 of his patients while he was a General Practitioner, an independent inquiry would establish what changes to current systems should be made in order to safeguard patients in the future. The inquiry was chaired by Dame Janet Smith DBE, and its six reports were published between July 2002 and January 2005.
2000 and 2002	The NHS Plan (2000) and Delivering the NHS Plan (2002) further emphasised the need to implement structures and mechanisms reinforcing the NHS quality strategy.
2000	First NHS trust clinical governance reviews by the Commission for Health Improvement (CHI).
2001	Annual star ratings on the performance of NHS organisations (acute hospital services) first published.
July 2002	First report of *The Shipman Inquiry* published.
April 2003	The General Medical Council issued guidance on periodic revalidation of doctors, requiring from January 2005 all doctors to provide a certificate, to be signed off by the trust Chief Executive, to demonstrate their fitness to practise, including that they are compliant with local clinical governance requirements.
September 2003	Publication of the National Audit Office report, *Achieving Improvements through Clinical Governance – A Progress Report on Implementation by NHS Trusts.*

| 2003 | The Health and Social Care (Community Health and Standards) Act 2003 sets out the Standards for Better Health, organised within seven 'domains' of: |

- safety;
- clinical and cost effectiveness;
- governance;
- patient focus;
- accessible and responsive care;
- care environment and amenities; and
- public health.

| 2003 | *The Victoria Climbié Inquiry Report* published, citing "gross failure" in the organisation and management of the key public services involved. Lessons identified about poor communication and a lack of good leadership and multidisciplinary teamwork. |

| 2004 | The Commission for Healthcare Audit and Inspection (Healthcare Commission) replaced CHI on April 1. Additional functions include the private and voluntary healthcare functions of the National Care Standards Commission (NCSC) and elements of the Audit Commission's work, relating to value for money in healthcare. The Commission has a statutory duty to assess the performance of healthcare organisations, award annual star (performance) ratings for the NHS and coordinate reviews of healthcare by others. |

| 2004 | *Standards for Better Health* puts quality, underpinned by clinical governance, at the forefront of the NHS agenda, and for private and voluntary providers of NHS care. All NHS organisations are required to take the SfBH into account when developing, providing and commissioning healthcare. Healthcare Commission assessments use the standards as a key component. |

| 2004 | *The NHS improvement plan: Putting people at the heart of public services* sets out NHS priorities for 2004 to 2008 and Government's direction in seeking to create an NHS which would be patient-led; affecting the way individuals and organisations behave. It set out the key commitments that the NHS would be expected to deliver, including maximum waiting times, patient choice, management of long term conditions and goals on public health. |

| November 2004 | The Department of Health announces integrated governance to provide the umbrella for all NHS governance approaches, combining the principles of corporate/financial accountability with clinical/management accountability. Integrated governance is not intended to replace clinical governance, but to emphasise its interdependence and linkage, bringing all forms of governance together in a coordinated whole. |

| January 2005 | *The Shipman Inquiry*, into the criminal conduct of GP Harold Shipman, completed its final and sixth report. The fifth report has particular relevance for clinical governance: *Safeguarding Patients: Lessons from the Past Proposals for the Future* considers the handling of complaints against GPs, the raising of concerns about GPs, GMC procedures and its proposal for revalidation of doctors. The reports highlighted the need for linkage between doctors' performance and good clinical governance systems. |

| March 2005 | Publication of *Creating a Patient-led NHS: Delivering the NHS Improvement Plan* indicated widespread changes to the form and function of PCTs, and outlined a range of initiatives, including: |

- patient choice of services and treatments;
- payment by results (PbR);
- new partnerships with the private sector; and
- a new system of independent assessment by the Healthcare Commission.

| October 2005 | PCTs return draft declarations to the Healthcare Commission stating how far they think they are meeting the Government's core Standards for Better Health. |

| January 2006 | *Our health, our care, our say: a new direction for community services*, published. It builds on earlier reforms in health and social care, reiterating the Government's main goals to put people more in control of their care and to have a greater emphasis on prevention of illness. It also confirms that clinical governance remains at the heart of the Government's drive to improve quality in the NHS. |

| April 2006 | PCTs return their final declaration of progress against the Government's core Standards for Better Health. |

| October 2006 | Publication of the first performance ratings for trusts. |

Source: National Audit Office

APPENDIX FOUR

Clinical governance bandings compared to other performance indicators

We performed chi–square tests between PCT clinical governance bandings and a number of other performance indicators, namely:

- Healthcare Commission star ratings (2005);

- the number of written complaints received (2004-05);

- staff survey results (2005), focussing on four 'key scores' relevant to clinical governance;

- GP vacancies per 100,000 patients (2006); and

- financial performance (in terms of spend against budget, 2004-05 and 2005-06).

Initially, we tested for relationships between clinical governance banding and each indicator individually, and found the following results:

- there is a relationship between Healthcare Commission star ratings and clinical governance bandings but it is not significant at the five per cent level (significance level 0.061);

- while there appears to be a relationship between the number of complaints received and clinical governance bandings, particularly within bands B through to E, the relationship is not statistically significant;

- there is no statistically significant relationship between staff survey results and clinical governance bandings;

- there is no statistically significant relationship between clinical governance bandings and GP vacancies; and

- there is no statistically significant relationship between clinical governance bandings and financial performance. However, there are more A banded PCTs with good financial status than poor, and PCTs with poor financial status tend to fall within the lower bands. Of the 15 poorest PCTs in terms of clinical governance, in 2004-05 and 2005-06, two thirds

were running a deficit, whilst of the 15 top performing PCTs, just one fifth were running a deficit for these two years.

We also performed a cluster analysis, whereby PCTs with similar characteristics were grouped together into six clusters, on the basis of nine categories (clinical governance banding, Healthcare Commission star rating, complaints, four staff survey key scores, GP vacancies, and financial performance). This highlighted the following interesting points:

- the two clusters ranked highest in terms of clinical governance banding (consisting predominantly of PCTs within bands A and B) had the lowest number of complaints, and the best staff survey results;

- the cluster ranked lowest in terms of clinical governance banding (consisting predominantly of PCTs within band E) had the highest number of complaints, and the worst staff survey results;

- the highest ranking cluster for clinical governance was ranked second for both Healthcare Commission star rating and GP vacancies. The lowest ranking cluster for clinical governance was ranked fifth for both of these categories; and

- there appeared to be little correlation between clinical governance banding and financial performance. However, the highest ranking cluster for financial performance was ranked second in terms of clinical governance, and the lowest ranking cluster for clinical governance was ranked fifth in terms of financial performance.

Cluster ranking for each variable in the cluster analysis (clinical governance bandings and other indicators)

	Clinical governance band	Complaints	Staff survey results key scores				HCC star rating	GP vacancies	Financial band
			KS20	KS22	KS23	KS26			
Cluster 1	1	1	3	1	1	1	2	2	4
Cluster 2	2	2	1	2	3	2	4	6	1
Cluster 3	3	4	5	5	5	6	6	4	6
Cluster 4	4	3	2	3	4	3	1	1	3
Cluster 5	5	5	4	4	2	4	3	3	2
Cluster 6	6	6	6	6	6	5	5	5	5

Notes:

The number of PCTs in each cluster varies between 29 and 43.

All PCTs in Cluster 1 are in clinical governance band A or B.

83 per cent of PCTs in Cluster 2 are in band A or B. The remainder are in band C.

76 per cent of PCTs in Cluster 3 are in band C. The remainder are in band B.

80 per cent of PCTs in Cluster 6 are in band E. The remainder are in band D.

Staff survey results key scores:

KS20 – Quality of job design (clear job content, feedback and staff involvement).

KS22 – Extent of positive feeling within organisation (communication, staff involvement, innovation and patient care).

KS23 – Fairness and effectiveness of procedures for reporting errors, near misses and incidents.

KS26 – Staff job satisfaction.

HCC Star rating – Healthcare Commission star ratings 2005.

We compared PCT bandings with performance against some of the Standards for Better Health most relevant to clinical governance. However, since the only data relating to this was self assessment based, and over 92 per cent of PCTs declared themselves compliant against each of the standards, the analysis did not yield meaningful results.

In conclusion, although there was little significant correlation identified between clinical governance banding and individual performance indicators, cluster analysis has indicated a tendency for PCTs which are in the higher bands to perform better across a number of indicators than those in the lower bands.

Geographical analysis

In order to assess whether there are any geographical patterns in terms of PCT clinical governance banding, we analysed the results at SHA and Government Office Region level. Each PCT was assigned a score between 1 (band E) and 5 (band A), and the average score for each SHA and Region was calculated. We found a large variation in performance between SHAs, with scores ranging from 1.33 to 4.14. The SHAs with lower scores were generally concentrated in South East and Central England, whereas the better performing SHAs were more evenly spread throughout the country, with clusters in South West, West, and North all having a score of 3.00 or greater. A similar pattern was identified at Government Office Region level, with lowest scores in Central and Eastern England, and good performance concentrated in the North East and South West.

We also compared the clinical governance banding with Area Classification data obtained from the Office for National Statistics. This analysis was limited by an uneven distribution of PCTs across the seven area classifications, (for example there were 96 PCTs classified as 'Prospering UK', but only four classified as 'London Cosmopolitan'). We conclude from the data available there does not appear to be any relationship between the area classification and clinical governance performance.

ENDNOTES

1   The new NHS Modern. Dependable: Department of Health Cm3807, 1997.

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3   The NHS Plan: a plan for investment, a plan for reform. Department of Health
Cm 4818-1, 2000.

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5   The Strategic Leadership of Clinical Governance in PCTs. NHS Modernisation Agency 2004
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Development Agency).

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performance of doctors and to protect the safety of patients. A report by the Chief Medical Officer.
Department of Health. July 2006.

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9   Improving Quality and Safety: Progress in implementing clinical governance in Primary
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Management Centre, University of Birmingham 2006 (www.nao.org.uk).

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assetRoot/04/13/89/37/04138937.pdf).

15   Government launches discussion on Professional Executive Committees 2006/0363 Department of Health. 23 November 2006.

16   A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services, Department of Health (July 2006) sets out plans to strengthen public involvement via Local Involvement Networks and strengthening of duties to consult and to involve the public.

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18   Health Reform in England – update and commissioning framework (Appendix D). Department of Health 2006.

19   Health secretary announces new architecture of the local NHS. 2006/0142. Department of Health. 12 April 2006.

20   New NHS organisations to strengthen patient services. 2006/0182. Department of Health. 16 May 2006.

21   For example: The inquiry into the management of care of children receiving complex heart surgery at the Bristol Royal Infirmary. Bristol Royal Infirmary Inquiry. July 2001; The investigation into the removal, retention and disposal of human organs and tissues following post mortem examination at Alder Hey Hospital. Royal Liverpool Children's Inquiry January 2001. Final reports of both inquiries were published in 2001.

22   The new NHS: Modern. Dependable. Department of Health Cm 3807, 1997.

23   A First Class Service – Quality in the new NHS. Department of Health 1998.

24   Harold Shipman was convicted of the murder of 15 of his patients while he was a general practitioner, and sentenced to life imprisonment. Police have also investigated allegations that he may have murdered many more patients while he was a GP. In February 2000, the Secretary of State for Health announced that an independent inquiry would take place to establish what changes to current systems should be made in order to safeguard patients in the future. The inquiry was chaired by Dame Janet Smith DBE, and its six reports were published between July 2002 and January 2005.

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26   Department of Health.

27   Chief Executive's Report to the NHS. Department of Health, June 2006.

28   A First Class Service – Quality in the new NHS. Department of Health 1998. In 1998, the Department of Health first introduced the concept of clear national standards to set out the quality standards that patients should expect to receive from the NHS, and which all parts of the NHS would be expected to meet.

29   National Standards, Local Action. Department of Health 2004.

30   National Audit Office interviews with Strategic Health Authority clinical governance leads.

31   Significant event analysis (SEA) is a relatively new method of clinical audit that is now widely promoted in primary healthcare. It differs from conventional criterion based audit primarily because it requires practitioners to apply a qualitative rather than a quantitative approach to monitoring and improving patient care. SEA has also been recommended as a method for enhancing patient safety and risk management and in facilitating adverse incident reporting.

32   The QOF is a voluntary process that awards surgeries points for specific aspects of clinical care, how well the practice is organised, the patient experience and the extra services offered – such as child health and maternity services. The more points the practice achieves, and the more services they provide, the more money they earn, although the final sum paid to practices is also adjusted to take account of their workload and the relative health of patients in their area.

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36   Sate of Healthcare. Healthcare Commission. 30 October 2006.

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44   Based on What do patients and the public want from primary care? Angela Coulter, British Medical Journal, 19 November 2005.

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46   What do patients and the public want from primary care? Angela Coulter, British Medical Journal, 19 November 2005, reporting on Wensing et al. A systematic review of the literature on patient priorities for general practice care. 1998.

47   Trends in patients' experiences of the NHS. Picker Institute. 2005.

48   For example, the Autumn Performance Report 2004 (Department of Health, 2004), reporting progress on targets in the Spending Review 2002.

49   Engaging patients in their healthcare. How is the UK doing relative to other countries? Picker Institute. April 2006.

50   A carer is someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability. Carers come from all walks of life, all cultures and can be of any age. Many carers do not consider themselves to be a carer, they are just looking after their mother, son, or best friend, just getting on with it and doing what anyone else would in the same situation (The Princess Royal Trust for Carers, www.carers.org). There are approximately 5.7 million carers in Great Britain who, together with voluntary organisations, make a contribution to the health service valued at over £57 billion each year. Source: Without Us…? Calculating the value of carers' support and Ten Facts about Caring, Carers UK, 2002.

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