

FINAL REPORT

**Achieving improvements  
through clinical governance**

**A survey of Trust managers' views for the  
National Audit Office**

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## **Executive summary**

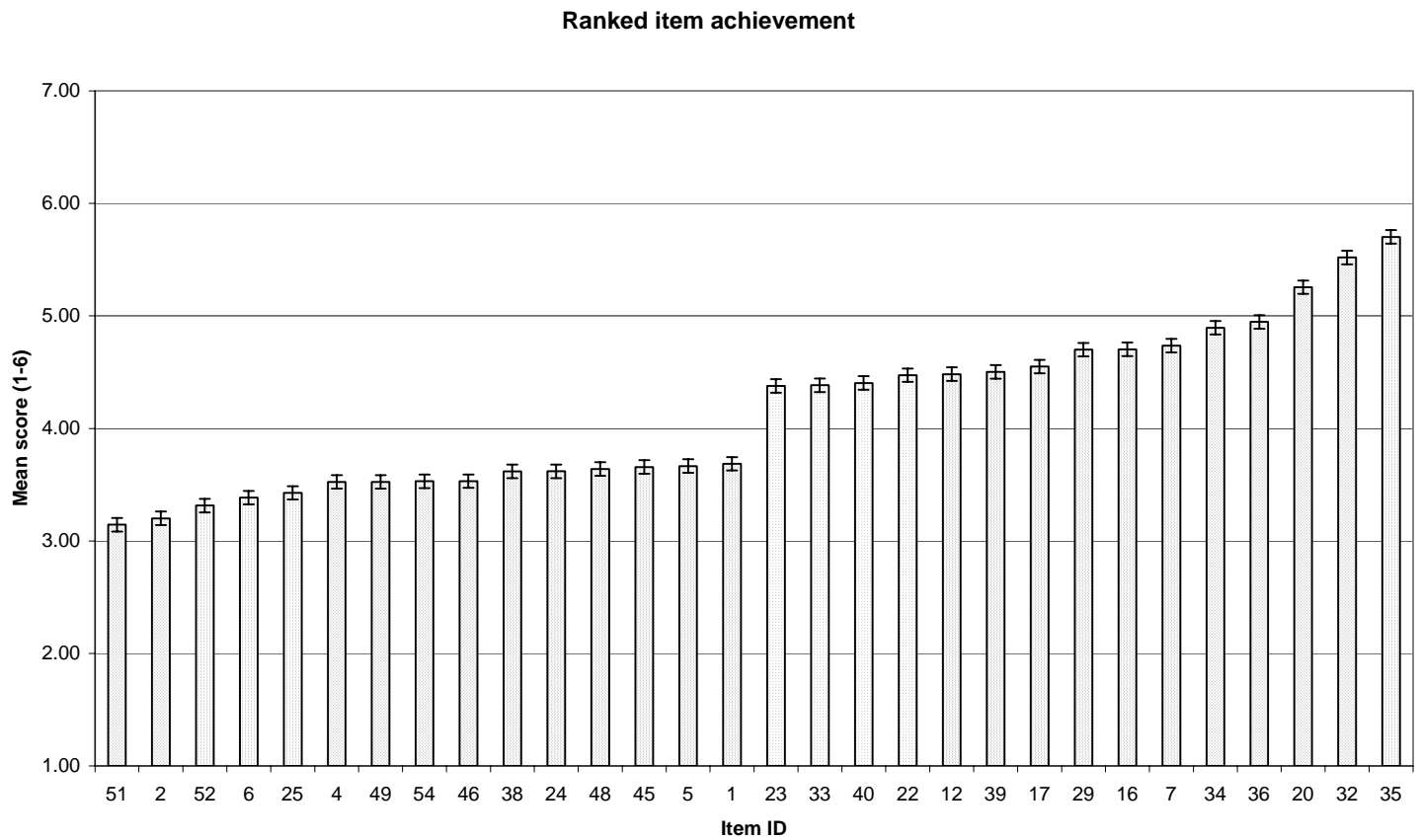
The Organisational Progress in Clinical Governance (OPCG) schedule explores perceptions of achievement in 54 competencies, encompassing quality improvement; risk management; performance improvement; corporate accountability; and leadership & collaboration.

1. Trusts show greatest achievement against items relating to committee structures and the collation and examination of complaints / risk / adverse events data. They show rather less achievement against joint working across the local health economy; evidence-based practice; user involvement; and promoting clinical teams. Thus, the controls assurance aspect of clinical governance is more developed than quality improvement.
2. Respondents found it difficult to prioritise the importance of the items. However, items concerning corporate accountability and action on risk management were considered slightly more important than others.
3. While trusts are largely achieving the corporate accountability agenda, there is rather more room for improvement in the long-term developmental agenda of clinical governance, most notably leadership & collaboration and quality improvement.
4. In terms of concrete achievements, trusts are largely achieving the structural changes required by clinical governance such as committee structures, appraisal systems and collation of complaints. However, they are achieving less against associated processes such as reviewing and discussing adverse incident data, and less still against outcomes, such as

improving service quality following review of adverse incident data. Trusts will require ongoing support and development to move beyond the structural agenda.

5. There is some variation in achievement between trusts. Trusts with the lowest global scores tend to do poorly on quality improvement, performance improvement and leadership & collaboration domains.
6. There were some statistically significant yet small differences in achievement between acute, ambulance and MH/LD trusts. Acute trusts achieve the lowest quality improvement scores, yet out perform ambulance trusts in corporate accountability. Performance improvement was slightly lower in ambulance trusts than in others. There is scope for collaborative work in these areas across sectors.
7. CHI visits have only a small impact on corporate accountability and performance improvement domains. There was no difference on other, more developmental, domains. While this suggests a limited effect, the caveat is that the existence of CHI may itself be sufficient to encourage trusts to engage with the clinical governance agenda, activity heightening during the visit process. There is no real 'non intervention' group, as all trusts are operating in the NHS and could receive a CHI visit at relatively short notice.

(a) On which competencies are trusts achieving most / least?



The graph shows means for competency items with the 15 lowest / highest achievement scores.

Low scoring items included joint work across local health communities (51 & 52);

benchmarking for quality improvement (2); use of research evidence (6 & 4); using clinical

indicators (25 & 24); user involvement (49) and promoting clinical teams (45 - 46). Conversely,

high scoring items included committee structures (35 & 32); collation of complaints /

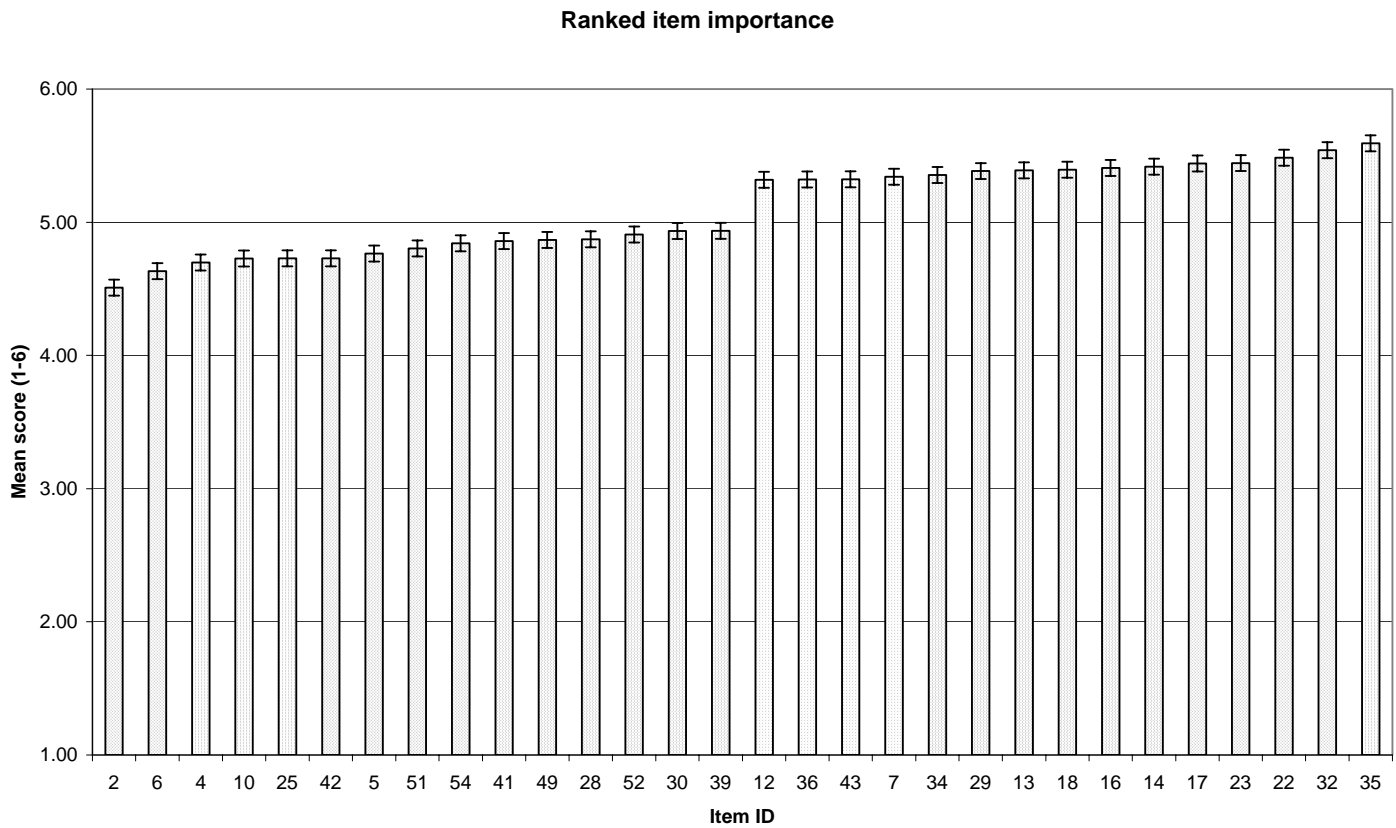
information (20 & 36); raising clinical issues (7); discussing risk and adverse event data (16) and

priority planning (39 & 40). This shows that trusts have achieved more against items concerning

structural change for corporate accountability than they have against quality improvement or

collaborative outcomes.

(b) Which competencies are perceived as most / least important?

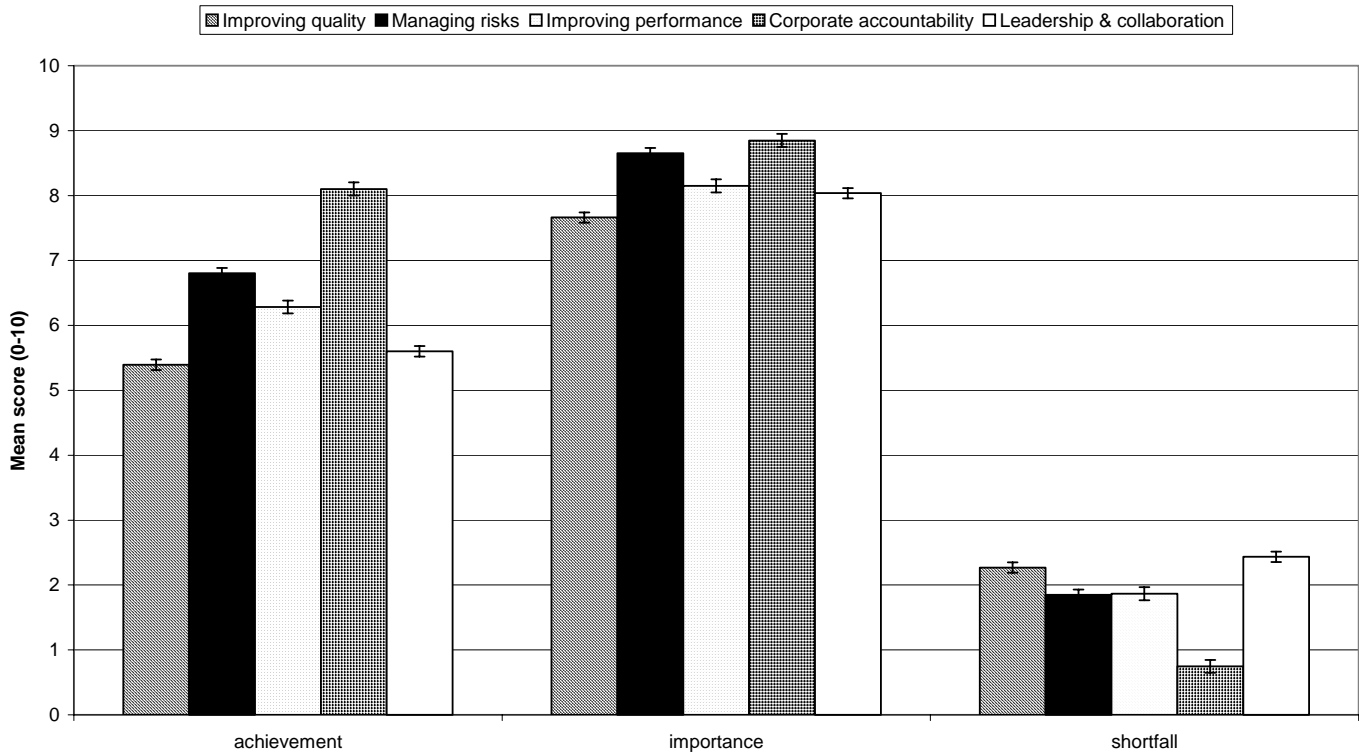


The graph shows means for competency items with the 15 lowest / highest importance scores.

People found it difficult to prioritise the items and there was little variation. Items regarded most important included formal committee structure (35 & 32); 'no blame' culture (22); raising concerns and action planning / improving quality around risks and adverse events (23 & 17 & 14 & 13 & 16 & 18). Least important items included benchmarking (2); use of research and clinical indicators (6 & 4 & 25 & 5); and joint working with partner agencies and shared protocols (51 & 52 & 41). In short, respondents considered corporate accountability structures and planning & action on adverse events / risks as most important and regarded items concerning collaboration and evidence-based practice as less important.

(c) On which domains are trusts achieving most / least?

**Perceived achievement, importance and shortfall across all domains**



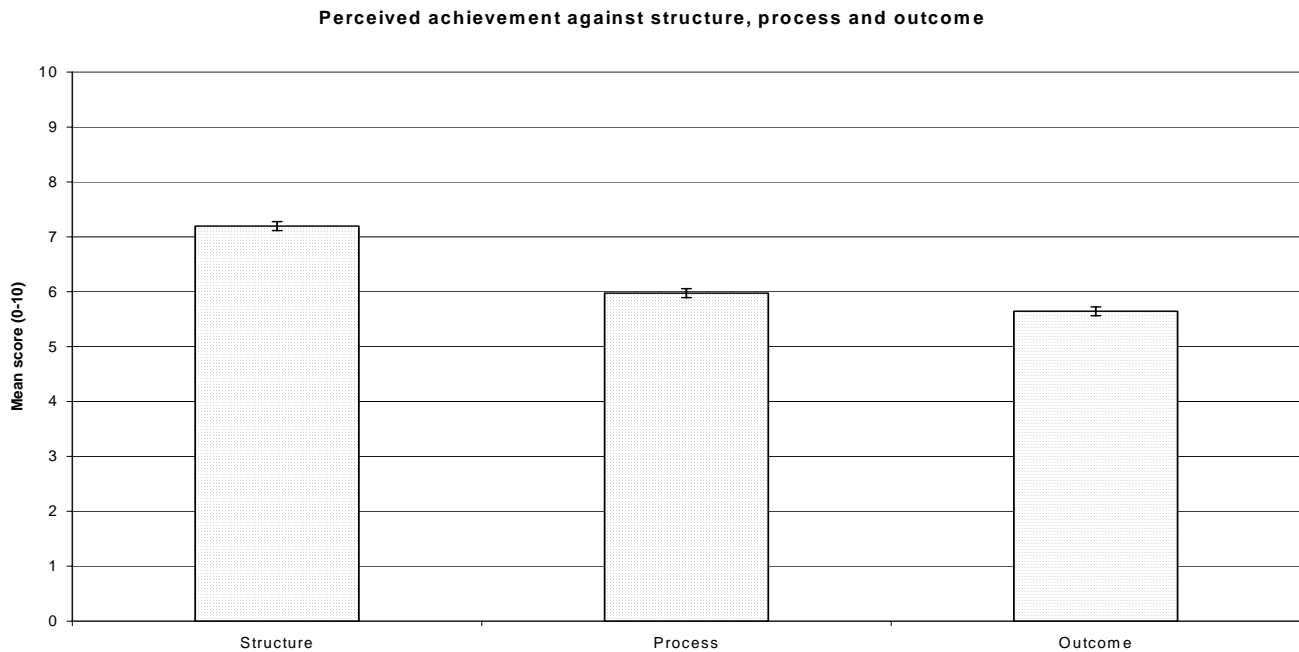
**Achievement scales (0-10)**

	Count	Minimum	Maximum	Mean	Standard Error of Mean	Std Deviation
Improving quality	1177	.36	9.45	5.40	.04	1.44
Managing risks	1177	.31	10.00	6.81	.04	1.51
Improving performance	1177	.00	10.00	6.29	.05	1.88
Corporate accountability	1177	1.60	10.00	8.10	.05	1.56
Leadership & collaboration	1177	.32	9.68	5.61	.04	1.52

Mean scores for items were aggregated into five domains, scored between 0-10. The domains showing highest achievement across the sample were corporate accountability and risk management, respectively scoring 8.10 and 6.81 out of a possible 10. There was evidence of less achievement in quality improvement and leadership & collaboration, with mean scores of 5.40 and 5.61 respectively. This suggests considerable room for improvement in the long-term clinical governance agenda, reflected in shortfalls between importance and achievement.



(d) What progress are trusts making against structures, processes and outcomes?

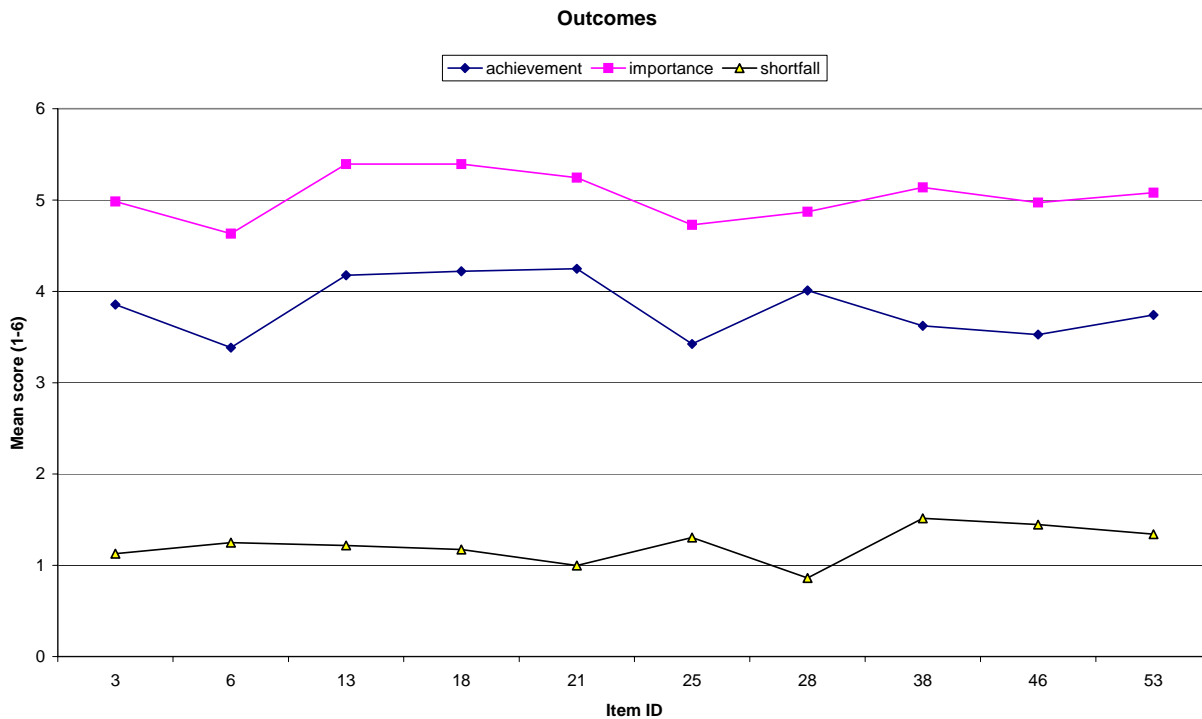


**Structure, process and outcome achievement (0-10)**

	Count	Minimum	Maximum	Mean	SE of mean	Std Deviation
Structure	1177	1.45	10.00	7.20	.04	1.36
Process	1177	.44	9.81	5.98	.04	1.37
Outcome	1177	.20	9.60	5.65	.04	1.44

Item scores were further aggregated under the heading 'structure', 'process' or 'outcome' and standardised between 0-10 to aid comparison (items in each domain detailed pp.46-48). Trusts are making most progress against items relating to structural change (e.g. 35), and rather less against process (e.g. 48) and outcome (e.g. 53). This is consistent with the perceived importance of the structural corporate accountability agenda identified above. However, there is rather less achievement against the outcomes associated with clinical governance, such as changing practice to avoid risks (and in line with the best practice of others). There is a danger that trusts are concentrating on the structural veneer, achieving far less against the long-term agenda.

(e) What concrete achievements are there against outcomes?

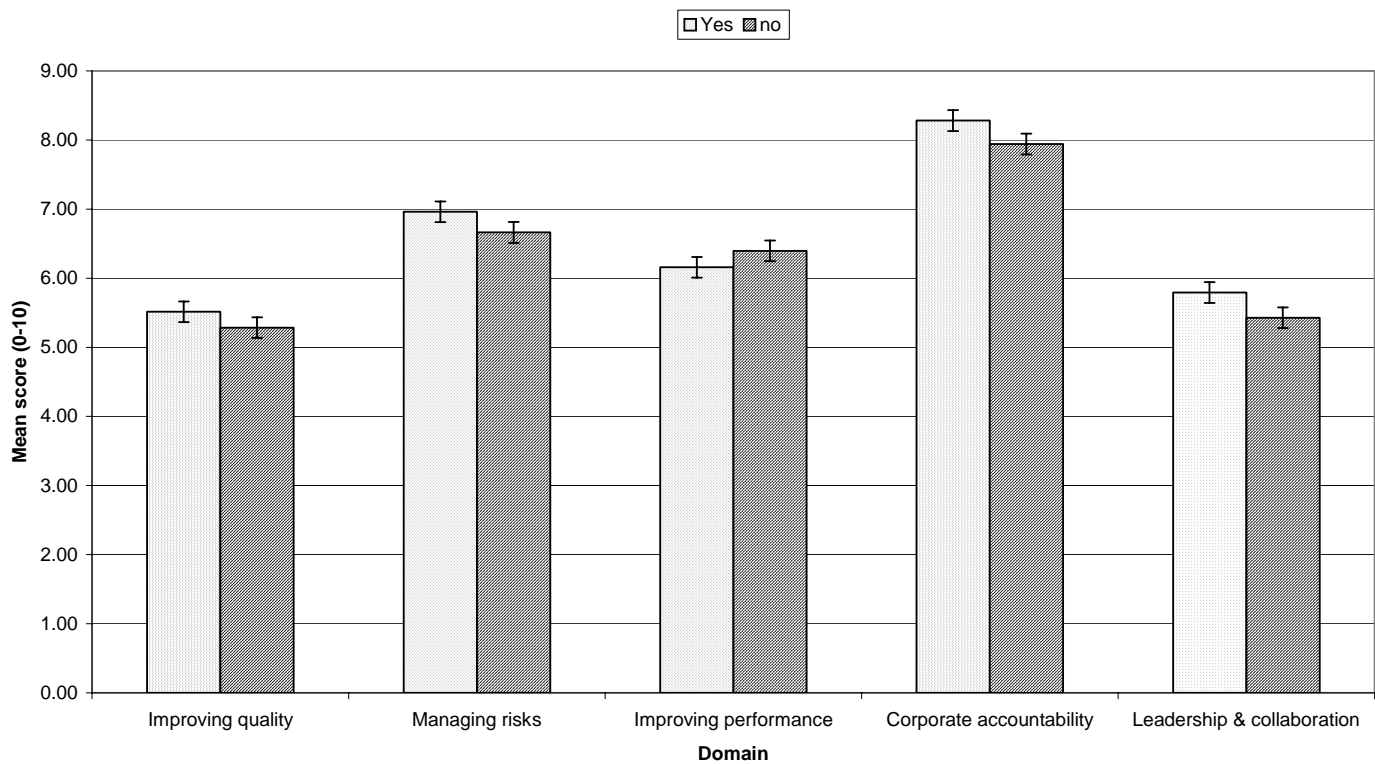


Outcomes		Means		
		Achievement	Importance	Shortfall
3	Where appropriate, staff modify their care processes to reflect the best practice of others	3.86	4.99	1.13
6	Research information is used consistently to inform our approach to quality improvement	3.38	4.63	1.25
13	Following identification of a problem from risk data, clinical quality is improved	4.18	5.39	1.21
18	Following identification of a problem from adverse events data, clinical quality is improved	4.22	5.39	1.17
21	Following identification of a problem from complaints data, clinical quality is improved	4.25	5.25	1.00
25	Clinical indicators are used to reflect on, review and integrate services	3.43	4.73	1.30
28	New skills gained through development activity are used in clinical settings	4.02	4.87	0.85
38	Decisions about service developments or cutbacks are made on clear criteria	3.62	5.14	1.52
46	Clinical teams respond to changes in their environment by reorganising work processes	3.53	4.97	1.44
53	Staff are able to develop new and innovative services.	3.75	5.08	1.34

The ten items relating to concrete outcomes concern changing care processes, use of research in quality improvement activity, use of risk / adverse events and complaints data to improve quality, and using new skills. Results show only moderate achievement against these items.

(f) Do perceptions of achievement vary by board membership status?

**Achievement scores by board membership**

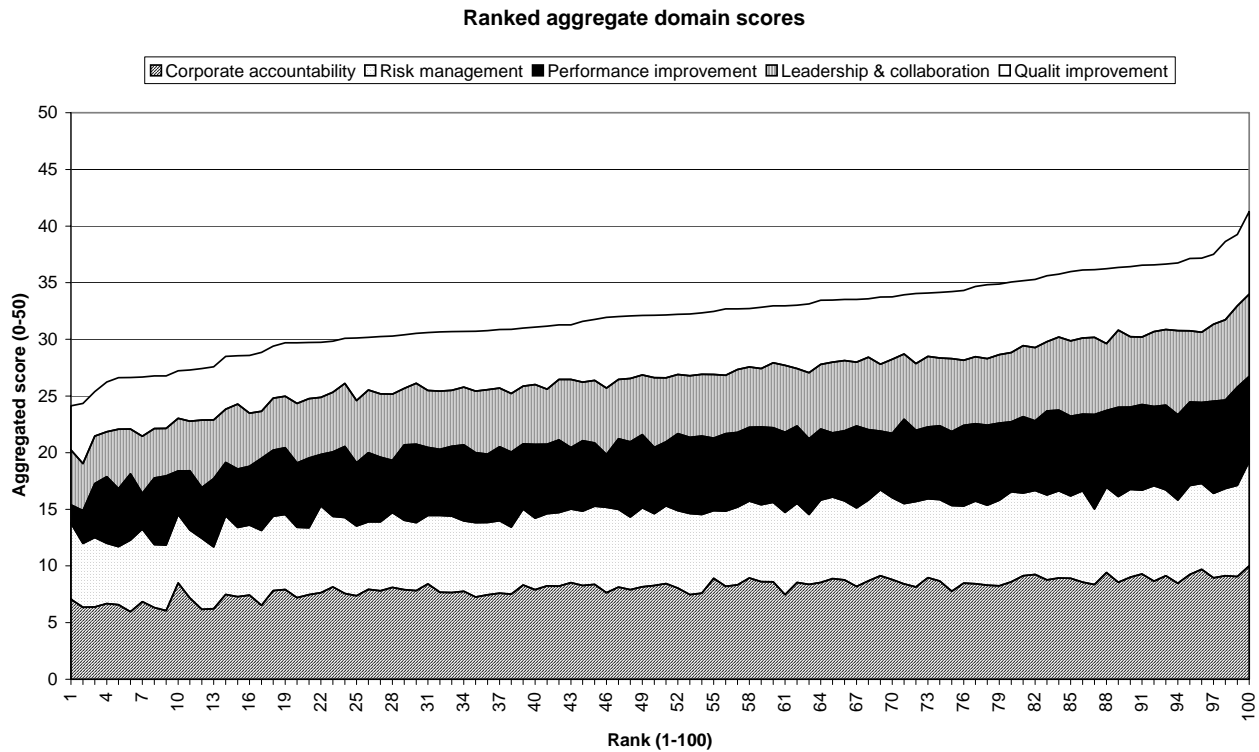


**Achievement (0-10) by board status**

	boardmember?			
	Yes		No	
	Mean	Standard Error of Mean	Mean	Standard Error of Mean
Improving quality	5.52	.06	5.29	.06
Managing risks	6.97	.06	6.67	.07
Improving performance	6.16	.07	6.41	.08
Corporate accountability	8.28	.06	7.94	.07
Leadership & collaboration	5.80	.06	5.44	.06

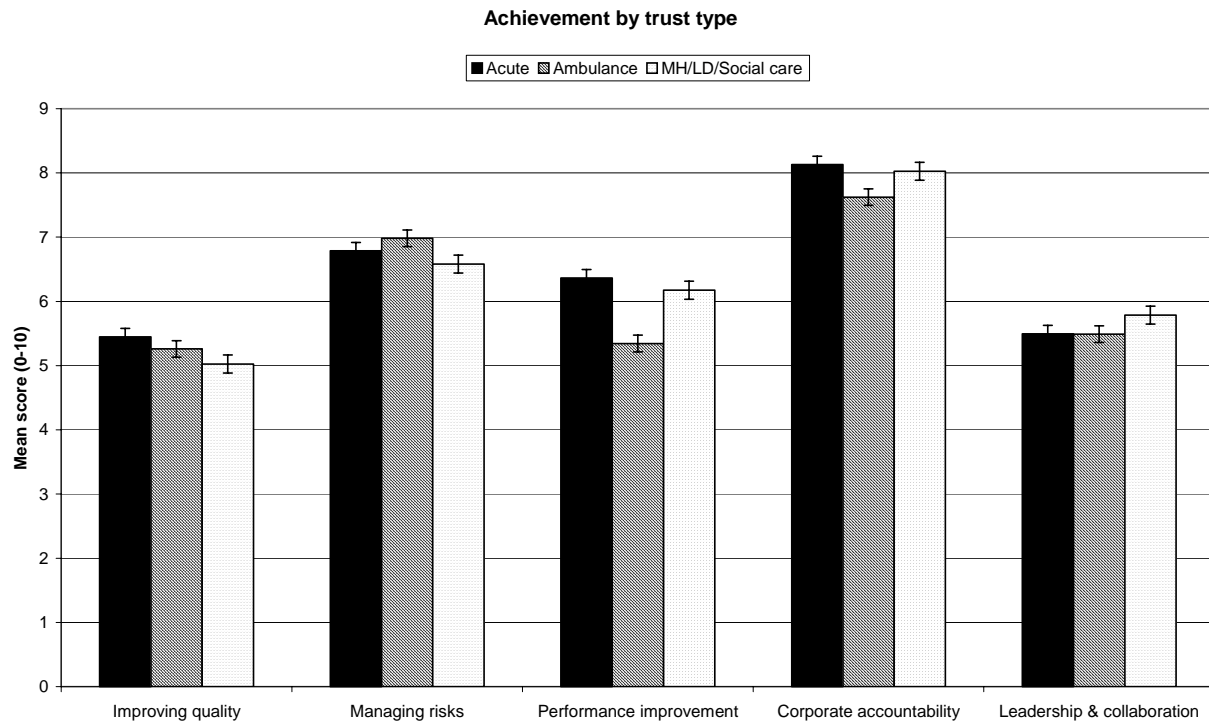
There were statistically significant yet minor differences between board members and non-board members, with the latter scoring achievement slightly lower than the former across all domains other than improving performance. It is encouraging that the differences are so slight, as it confirms that the opinions of board members are comparable to their non-board colleagues.

(g) How much variation of achievement is there between trusts?



As scores varied more *between* trusts than *within* them across all five domains, domain scores were aggregated by trust (0-10), summed to produce a single summary score (0-50); and ranked from lowest to highest (graph above). Global scores showed middling achievement across the sample, suggesting considerable room for improvement. Trusts with the lowest global scores tended to score particularly poorly on quality improvement, leadership & collaboration and performance improvement. Across the sample, corporate accountability scored quite highly; quality improvement and leadership & collaboration showed rather more room for improvement.

(h) Do perceptions of achievement vary by trust type?

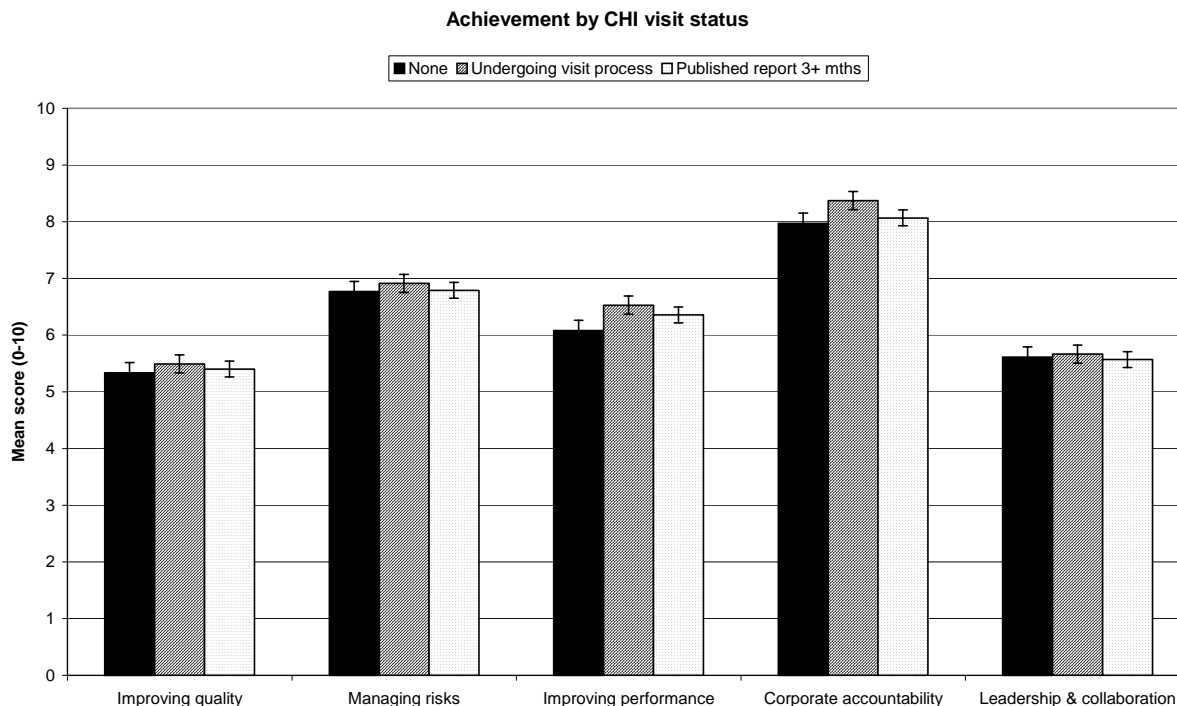


**Achievement (0-10) by trust type**

	Trust type					
	acute		ambulance		MH/LD/Social care	
	Mean	Standard Error of Mean	Mean	Standard Error of Mean	Mean	Standard Error of Mean
Improving quality	5.48	.05	5.38	.17	5.12	.09
Managing risks	6.83	.05	7.10	.15	6.64	.09
Improving performance	6.44	.06	5.25	.27	6.22	.12
Corporate accountability	8.17	.05	7.70	.19	8.02	.10
Leadership & collaboration	5.54	.05	5.60	.16	5.84	.09

There were no differences between acute, ambulance and MH/LD trusts in terms of managing risks or leadership & collaboration. While differences in other domains were small, they show that performance improvement in ambulance trusts is lower than others; corporate accountability is lower in ambulance than acute trusts; and that acute trusts are achieving less than others in quality improvement.

(i) What impact do CHI visits have on progress?



**Impact of CHI visit on achievement scales (0-10)**

	Trust had a CHI visit?					
	None		Undergoing visit process		Published report 3+ mths	
	Mean	SE of mean	Mean	SE of mean	Mean	SE of mean
Improving quality	5.34	.07	5.49	.08	5.40	.07
Managing risks	6.77		6.91	.08	6.79	.08
Improving performance	6.08	.10	6.53	.11	6.36	.08
Corporate accountability	7.97	.08	8.37	.09	8.07	.07
Leadership & collaboration	5.61	.07	5.67	.09	5.57	.08

CHI visits had no significant effect on improving quality, managing risks and leadership collaboration scores: this suggests that the development agenda is not influenced by CHI visits. However, scores for corporate accountability were slightly higher in trusts undergoing the visit process than for others, suggesting a temporary heightening of activity. Trusts undergoing a CHI review reported higher scores for improving performance than those yet to be reviewed.

## **Appendix 1: Methodology**

The study assessed progress in clinical governance across acute, ambulance and mental health / learning disability trusts in England. Primary care organisations were excluded, given large-scale reorganisation within this sector occasioned by the move from Primary Care Groups (PCGs) to Primary Care Trusts (PCTs) during April 2002.

### *Participants and procedures*

The study was conducted between May and July 2002. The NAO supplied a list of acute, ambulance and mental health / learning disability trusts in England, from which a stratified sample of 100 trusts was drawn to reflect the number of each type of organisation.

Consequently, 68 acute, 11 ambulance and 21 mental health / learning disability trusts were selected. Following site identification, up to 10 board members and 10 directorate level managers / clinical leads were sampled randomly from each site based on entries in Binley's database, resulting in a total sample of 1916. Participants received three mailings of a six-page questionnaire containing indicators of progress in clinical governance, against which they scored item importance and current achievement on a scale between 1 ('low') and 6 ('high'). In total, 1177 (61.4%) responded.

### *Study measures*

The study used the Organisational Progress in Clinical Governance (OPCG) schedule, previously developed at the University of Birmingham Health Services Management Centre, to assess achievement against 54 competencies in five domains (appendix 2).

**Appendix 2: The OPCG schedule**



**THE UNIVERSITY  
OF BIRMINGHAM**

**Organisational Progress in Clinical Governance  
(OPCG)**

**A variance measure of organisational progress  
in clinical governance**

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## **Organisational Progress in Clinical Governance (OPCG)**

<b>A) Improving quality</b>	Item(s)
1. Benchmarking practice	2-3
2. Using research evidence	4-6
3. Discussing clinical issues	8
4. Auditing clinical practice	9-11
5. Using performance indicators	24-25
<b>B) Managing risks</b>	
6. Using risk management systems	12-15
7. Using adverse events systems	16-19
8. Using complaints systems	20-21
9. Learning from complaints, adverse events and near misses	22
10. Raising issues in confidence	7, 23
<b>B) Improving performance</b>	
11. Professional development for staff	26-28
12. Appraising staff	29-31
<b>C) Corporate accountability</b>	
13. Accountability for clinical quality	32, 34
14. Organising clinical governance committee structures	35-37
<b>D) Leadership and collaboration</b>	
15. Linking development activity to the clinical governance agenda	33, 38-39
16. Using National Service Frameworks (NSFs) & guidelines	40-43
17. Leadership and team building	44-47
18. Involving service users in service development	48-50
19. Collaborating with local health and social care partners	51-52
20. Developing organisational learning	1, 53-54

**The aim of this questionnaire is to obtain your views about progress in clinical governance in your organisation.**

The OPCG schedule is designed to canvass opinion on progress in clinical governance across a number of domains, including quality improvement processes, corporate accountability and collaboration with partner agencies. We seek your views on the relative importance of the elements of clinical governance, as well as your assessment of your Trust's success in integrating those elements into its working practices.

**Some additional points**

1. Funded by the NAO, the study is part of a linked series of research activities into clinical governance. Findings will be reported to the Public Accounts Committee.
2. We give an assurance that individuals responding to this questionnaire will not be identifiable in any reports of the findings. Your responses will be held in complete confidence by the research team at the Health Services Management Centre, University of Birmingham.
3. The statements contained in the questionnaire do not necessarily represent the views of HSMC.
4. **There are no right or wrong answers. We are simply interested in your views.**

Thank you for giving us some of your valuable time.

## Initial questions

CODE

We need to know whether your organisation has undergone a visit from the Commission for Health Improvement (CHI), and whether you are a member of the trust board

### 1. Has your trust been subject to a CHI review?

- Yes <sub>1</sub>  
No <sub>2</sub>

### 2. Are you a member of the trust board?

- Yes <sub>1</sub>  
No <sub>2</sub>

## The OPCG items

The remainder of the schedule asks for your opinion of your organisation's achievement against a series of statements reflecting good practice in clinical governance. For each statement, we would like you to indicate the current level of **achievement** of the organisation. We would also like you to indicate the level of **importance** you attach each statement. For example, the first statement is 'teams work across boundaries to address quality issues'. If you think that that this is not currently happening in your organisation, and that it is moderately important for clinical governance that it does happen, you would circle '1' under 'Achievement', and '3' under 'Importance'.

## Organisational Progress in Clinical Governance (OPCG)

	Achievement						Importance					
	Low				High		Low				High	
1 Teams work across boundaries to address quality issues	1	2	3	4	5	6	1	2	3	4	5	6
2 Staff identify best practice through benchmarking against other providers	1	2	3	4	5	6	1	2	3	4	5	6
3 Where appropriate, staff modify their care processes to reflect the best practice of others	1	2	3	4	5	6	1	2	3	4	5	6
4 Research evidence is regularly reviewed and discussed	1	2	3	4	5	6	1	2	3	4	5	6
5 Training in evidence-based practice and critical appraisal is available to staff	1	2	3	4	5	6	1	2	3	4	5	6
6 Research information is used consistently to inform our approach to quality improvement	1	2	3	4	5	6	1	2	3	4	5	6
7 Clinical issues are raised for discussion	1	2	3	4	5	6	1	2	3	4	5	6
8 Discussions on clinical issues are not dominated by any single profession	1	2	3	4	5	6	1	2	3	4	5	6
9 Staff participate in clinical audit activity	1	2	3	4	5	6	1	2	3	4	5	6
10 Training in clinical audit is available to staff	1	2	3	4	5	6	1	2	3	4	5	6
11 Topics for audit are selected according to their potential impact on care quality	1	2	3	4	5	6	1	2	3	4	5	6
12 Risk management data is regularly reviewed and discussed	1	2	3	4	5	6	1	2	3	4	5	6
13 Following identification of a problem from risk data, clinical quality is improved	1	2	3	4	5	6	1	2	3	4	5	6
14 Clear action plans are developed in response to identified clinical risks	1	2	3	4	5	6	1	2	3	4	5	6
15 Staff are trained to use the risk management system	1	2	3	4	5	6	1	2	3	4	5	6
16 Adverse incident data is regularly reviewed and discussed	1	2	3	4	5	6	1	2	3	4	5	6
17 Clear action plans are developed in response to adverse incidents	1	2	3	4	5	6	1	2	3	4	5	6
18 Following identification of a problem from adverse events data, clinical quality is improved	1	2	3	4	5	6	1	2	3	4	5	6

	Achievement						Importance					
	Low			High			Low			High		
19 Staff are trained to use adverse event systems	1	2	3	4	5	6	1	2	3	4	5	6
20 Complaints are collated	1	2	3	4	5	6	1	2	3	4	5	6
21 Following identification of a problem from complaints data, clinical quality is improved	1	2	3	4	5	6	1	2	3	4	5	6
22 There is a 'no-blame' culture around reporting adverse events and near misses	1	2	3	4	5	6	1	2	3	4	5	6
23 Staff can raise clinical concerns about their colleagues in confidence	1	2	3	4	5	6	1	2	3	4	5	6
24 There is good access to agreed clinical performance indicators	1	2	3	4	5	6	1	2	3	4	5	6
25 Clinical indicators are used to reflect on, review and integrate services	1	2	3	4	5	6	1	2	3	4	5	6
26 Staff have development plans which identify training and development opportunities	1	2	3	4	5	6	1	2	3	4	5	6
27 Training identified in staff development plans matches individual needs to organisational needs	1	2	3	4	5	6	1	2	3	4	5	6
28 New skills gained through development activity are used in clinical settings	1	2	3	4	5	6	1	2	3	4	5	6
29 There is an annual staff appraisal process for most staff	1	2	3	4	5	6	1	2	3	4	5	6
30 An agreed work and development programme is used as the basis of staff appraisal	1	2	3	4	5	6	1	2	3	4	5	6
31 Staff appraisal is used as an opportunity to reflect on progress and plan future development	1	2	3	4	5	6	1	2	3	4	5	6
32 There is an executive director with responsibility for developing the clinical governance agenda	1	2	3	4	5	6	1	2	3	4	5	6
33 Service delivery plans include quality improvement activity	1	2	3	4	5	6	1	2	3	4	5	6
34 Clinical areas have a nominated clinical governance lead	1	2	3	4	5	6	1	2	3	4	5	6
35 There is a formal clinical governance committee, reporting to the board	1	2	3	4	5	6	1	2	3	4	5	6
36 There are local arrangements to collate information for the clinical governance committee	1	2	3	4	5	6	1	2	3	4	5	6
37 Organisation-wide clinical governance systems are underpinned by systems in clinical areas	1	2	3	4	5	6	1	2	3	4	5	6

	Achievement						Importance					
	Low			High			Low			High		
38	1	2	3	4	5	6	1	2	3	4	5	6
39	1	2	3	4	5	6	1	2	3	4	5	6
40	1	2	3	4	5	6	1	2	3	4	5	6
41	1	2	3	4	5	6	1	2	3	4	5	6
42	1	2	3	4	5	6	1	2	3	4	5	6
43	1	2	3	4	5	6	1	2	3	4	5	6
44	1	2	3	4	5	6	1	2	3	4	5	6
45	1	2	3	4	5	6	1	2	3	4	5	6
46	1	2	3	4	5	6	1	2	3	4	5	6
47	1	2	3	4	5	6	1	2	3	4	5	6
48	1	2	3	4	5	6	1	2	3	4	5	6
49	1	2	3	4	5	6	1	2	3	4	5	6
50	1	2	3	4	5	6	1	2	3	4	5	6
51	1	2	3	4	5	6	1	2	3	4	5	6
52	1	2	3	4	5	6	1	2	3	4	5	6
53	1	2	3	4	5	6	1	2	3	4	5	6
54	1	2	3	4	5	6	1	2	3	4	5	6

**Thank you for completing this questionnaire**

We would be most grateful if you would return it to us here at HSMC in the envelope provided using the pre-paid slip **within two weeks of receipt of this form**. The return address, which is printed on the pre-paid slip enclosed, is repeated here:

Ms. Wendy Spurr  
Health Services Management Centre  
University of Birmingham  
Park House  
40 Edgbaston Park Road  
Birmingham B15 2RT

If you would like further information on the study, then please do not hesitate to contact me by e-mail, telephone or letter:

Mr. T. Freeman  
Lecturer  
Tel: (0121) 414 7050  
e-mail: t.freeman@bham.ac.uk  
Address: as above

Once again, many thanks for your time and co-operation; it is very much appreciated.

### **Appendix 3: Detailed reporting**

#### **Quality improvement**

Eleven OPCG items concern aspects of quality improvement activity including benchmarking practice, using research evidence, auditing practice and using clinical indicators.

#### *Importance*

There was some limited variation in the importance attributed to these items. Items on benchmarking, using research evidence and training in critical appraisal & audit were seen as relatively less important than participating in audit activity.

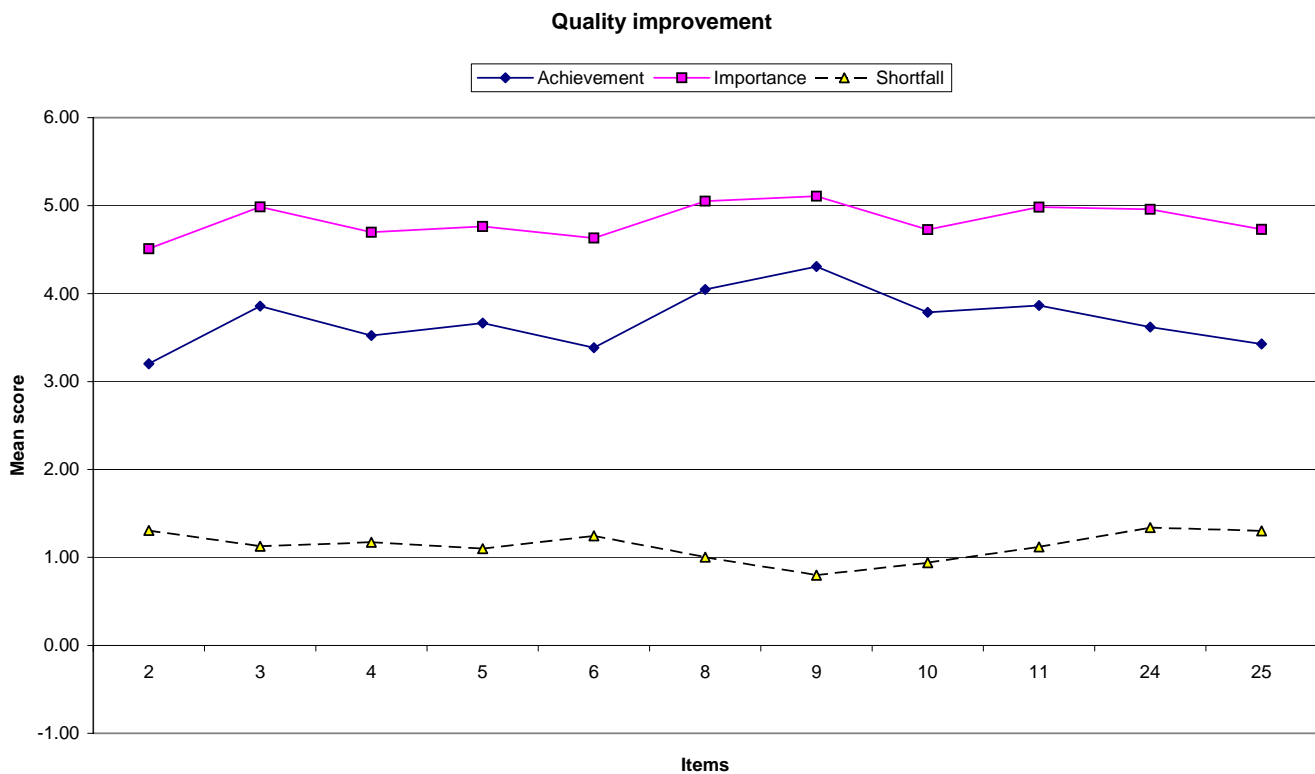
#### *Achievement*

Moderate achievement scores (3-4) were attained for most items, indicating considerable room for improvement across the domain. This was particularly so for item 2 on benchmarking and items 4-6 on use of research evidence. While involvement in clinical audit was high, respondents indicated moderate achievement against selection of audit topics based on quality improvement considerations.

#### *Shortfall*

Principal shortfalls included using research to inform quality improvement and selection of audit topics based on quality improvement needs.





Quality improvement items	Means		
	Achievement	Importance	Shortfall
2 Staff identify best practice through benchmarking against other providers	3.20	4.51	1.31
3 Where appropriate, staff modify their care processes to reflect the best practice of others	3.86	4.99	1.13
4 Research evidence is regularly reviewed and discussed	3.52	4.70	1.17
5 Training in evidence-based practice and critical appraisal is available to staff	3.67	4.76	1.10
6 Research information is used consistently to inform our approach to quality improvement	3.38	4.63	1.25
8 Discussions on clinical issues are not dominated by any single profession	4.05	5.05	1.00
9 Staff participate in clinical audit activity	4.31	5.11	0.80
10 Training in clinical audit is available to staff	3.79	4.73	0.94
11 Topics for audit are selected according to their potential impact on care quality	3.86	4.98	1.12
24 There is good access to agreed clinical performance indicators	3.62	4.96	1.34
25 Clinical indicators are used to reflect on, review and integrate services	3.43	4.73	1.30

Data tables: achievement

**Frequency tables for quality improvement items**

	1.00	2.00	3.00	4.00	5.00	6.00
	Count	Count	Count	Count	Count	Count
A2	36	276	423	316	109	17
A3	7	68	319	505	247	31
A4	37	230	310	330	219	51
A5	60	190	261	328	249	89
A6	45	215	375	352	164	26
A8	31	104	219	368	335	120
A9	11	67	190	356	387	166
A10	59	151	266	327	254	120
A11	23	120	286	386	288	74
A24	43	160	318	396	201	59
A25	47	189	364	395	155	27

**Frequency tables for quality improvement items (%ages)**

	1.00	2.00	3.00	4.00	5.00	6.00
	%	%	%	%	%	%
A2	3.1%	23.4%	35.9%	26.8%	9.3%	1.4%
A3	.6%	5.8%	27.1%	42.9%	21.0%	2.6%
A4	3.1%	19.5%	26.3%	28.0%	18.6%	4.3%
A5	5.1%	16.1%	22.2%	27.9%	21.2%	7.6%
A6	3.8%	18.3%	31.9%	29.9%	13.9%	2.2%
A8	2.6%	8.8%	18.6%	31.3%	28.5%	10.2%
A9	.9%	5.7%	16.1%	30.2%	32.9%	14.1%
A10	5.0%	12.8%	22.6%	27.8%	21.6%	10.2%
A11	2.0%	10.2%	24.3%	32.8%	24.5%	6.3%
A24	3.7%	13.6%	27.0%	33.6%	17.1%	5.0%
A25	4.0%	16.1%	30.9%	33.6%	13.2%	2.3%

## **Risk management**

Thirteen OPCG items concern aspects of risk management, including the review and discussion of data on risk and clinical incidents / near misses; planning and service development in the light of identified trends; and a blame-free reporting culture.

### *Importance*

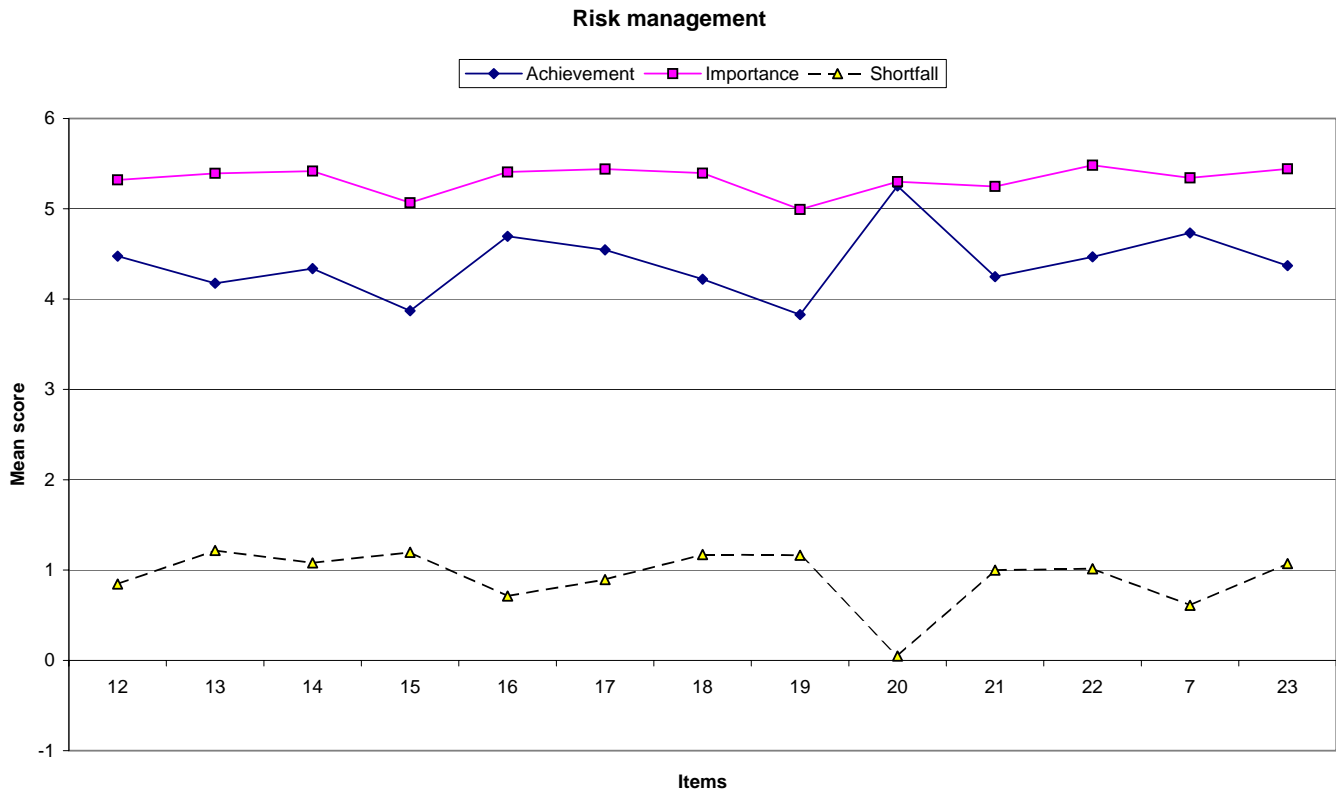
There was little variation in perceived importance; all items gained a mean score of more than five indicating high importance.

### *Achievement*

Moderate scores (3-4) were achieved for training in use of risk management and adverse event systems, pointing to the need to ensure that staff are aware of reporting systems and are able to use them appropriately. While organisations scored highly on collation of complaints and reviewing and discussing data on adverse events and risk management, they scored less well on improving quality once problems are identified from data (items 13,18 and 21).

### *Shortfall*

Areas with greatest perceived shortfall between importance and achievement concern training in adverse event and risk management systems, and moving from identification of problems in adverse event / risk data to action to improve quality.



Risk management items	Means		
	Achievement	Importance	Shortfall
12 Risk management data is regularly reviewed and discussed	4.48	5.32	0.84
13 If problems are identified from risk data, quality is improved	4.18	5.39	1.21
14 Clear action plans are developed in response to identified clinical risks	4.34	5.42	1.08
15 Staff are trained to use the risk management system	3.87	5.07	1.20
16 Adverse incident data is regularly reviewed and discussed	4.70	5.41	0.70
17 Clear action plans are developed in response to adverse incidents	4.55	5.44	0.89
18 If problems are identified from adverse events data, quality is improved	4.22	5.39	1.17
19 Staff are trained to use adverse event systems	3.84	5.00	1.16
20 Complaints are collated	5.25	5.30	0.05
21 If problems are identified from complaints data, quality is improved	4.25	5.25	1.00
22 There is a 'no-blame' culture for reporting adverse events / near misses	4.47	5.48	1.01
7 Clinical issues are raised for discussion	4.73	5.34	0.61
23 Staff can raise clinical concerns about their colleagues in confidence	4.38	5.44	1.07

Data tables: achievement

**Frequency tables for risk management items**

	1.00	2.00	3.00	4.00	5.00	6.00
	Count	Count	Count	Count	Count	Count
A12	18	62	152	285	422	238
A13	12	66	206	415	375	103
A14	9	55	188	376	375	174
A15	52	122	257	355	278	113
A16	11	42	117	263	427	317
A17	12	52	118	332	421	242
A18	7	57	197	423	393	100
A19	34	135	276	377	254	101
A20	5	14	38	140	402	578
A21	9	44	208	423	366	127
A22	24	59	136	317	399	242
A7	3	24	99	276	529	246
A23	20	48	166	382	356	205

**Frequency tables for risk management items (%ages)**

	1.00	2.00	3.00	4.00	5.00	6.00
	%	%	%	%	%	%
A12	1.5%	5.3%	12.9%	24.2%	35.9%	20.2%
A13	1.0%	5.6%	17.5%	35.3%	31.9%	8.8%
A14	.8%	4.7%	16.0%	31.9%	31.9%	14.8%
A15	4.4%	10.4%	21.8%	30.2%	23.6%	9.6%
A16	.9%	3.6%	9.9%	22.3%	36.3%	26.9%
A17	1.0%	4.4%	10.0%	28.2%	35.8%	20.6%
A18	.6%	4.8%	16.7%	35.9%	33.4%	8.5%
A19	2.9%	11.5%	23.4%	32.0%	21.6%	8.6%
A20	.4%	1.2%	3.2%	11.9%	34.2%	49.1%
A21	.8%	3.7%	17.7%	35.9%	31.1%	10.8%
A22	2.0%	5.0%	11.6%	26.9%	33.9%	20.6%
A7	.3%	2.0%	8.4%	23.4%	44.9%	20.9%
A23	1.7%	4.1%	14.1%	32.5%	30.2%	17.4%

## **Performance improvement**

Six items concern performance improvement, including professional development and appraisal.

### *Importance*

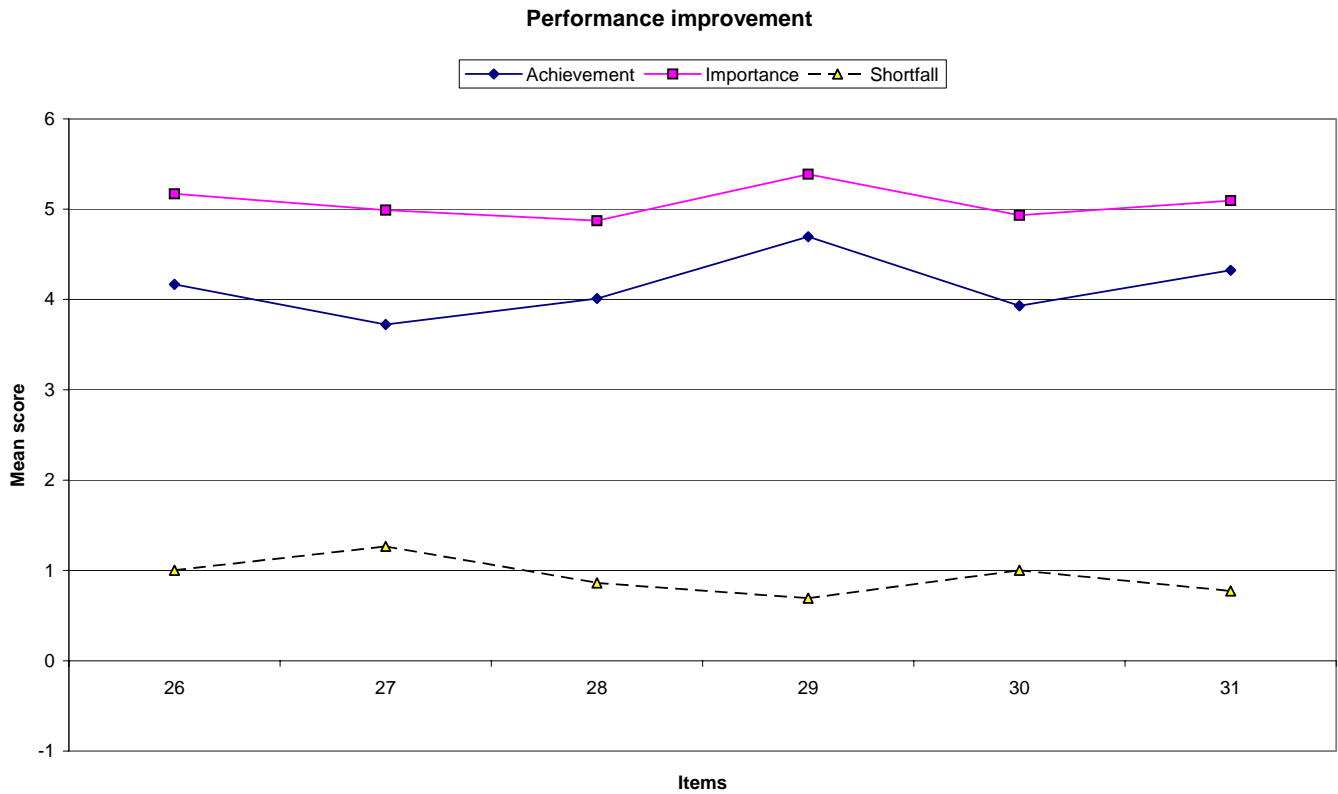
Respondents considered most items important with a mean of approximately five. Items concerning annual appraisal were slightly more important than the use of new skills gained through staff development.

### *Achievement*

Only moderate achievement scores (3-4) were attained for the matching of individual and organisational needs through staff development. The existence of staff appraisal systems and their use to identify development was scored higher, between 4-5.

### *Shortfall*

The largest perceived shortfalls concerned staff development plans identifying training opportunities; and matching individual and organisational needs in staff development.



Performance improvement items	Means		
	Achievement	Importance	Shortfall
26 Staff development plans identify training and development opportunities	4.18	5.17	1.00
27 Staff development training matches individual and organisational needs	3.73	4.99	1.26
28 New skills gained through development activity are used in clinical settings	4.02	4.87	0.85
29 There is an annual staff appraisal process for most staff	4.70	5.38	0.68
30 Agreed work and development programmes form the basis of staff appraisal	3.93	4.93	1.00
31 Staff appraisal is used to reflect on progress and plan future development	4.33	5.10	0.77

Data tables: achievement

**Frequency tables for performance improvement items**

	1.00	2.00	3.00	4.00	5.00	6.00
	Count	Count	Count	Count	Count	Count
A26	19	74	212	393	334	145
A27	32	136	323	391	219	76
A28	13	66	248	480	299	71
A29	33	42	113	224	410	355
A30	43	112	229	400	281	112
A31	33	52	179	330	401	182

**Frequency tables for performance improvement items (%ages)**

	1.00	2.00	3.00	4.00	5.00	6.00
	%	%	%	%	%	%
A26	1.6%	6.3%	18.0%	33.4%	28.4%	12.3%
A27	2.7%	11.6%	27.4%	33.2%	18.6%	6.5%
A28	1.1%	5.6%	21.1%	40.8%	25.4%	6.0%
A29	2.8%	3.6%	9.6%	19.0%	34.8%	30.2%
A30	3.7%	9.5%	19.5%	34.0%	23.9%	9.5%
A31	2.8%	4.4%	15.2%	28.0%	34.1%	15.5%



## **Corporate accountability**

Five items concern corporate accountability, including systems and structures for clinical governance.

### *Importance*

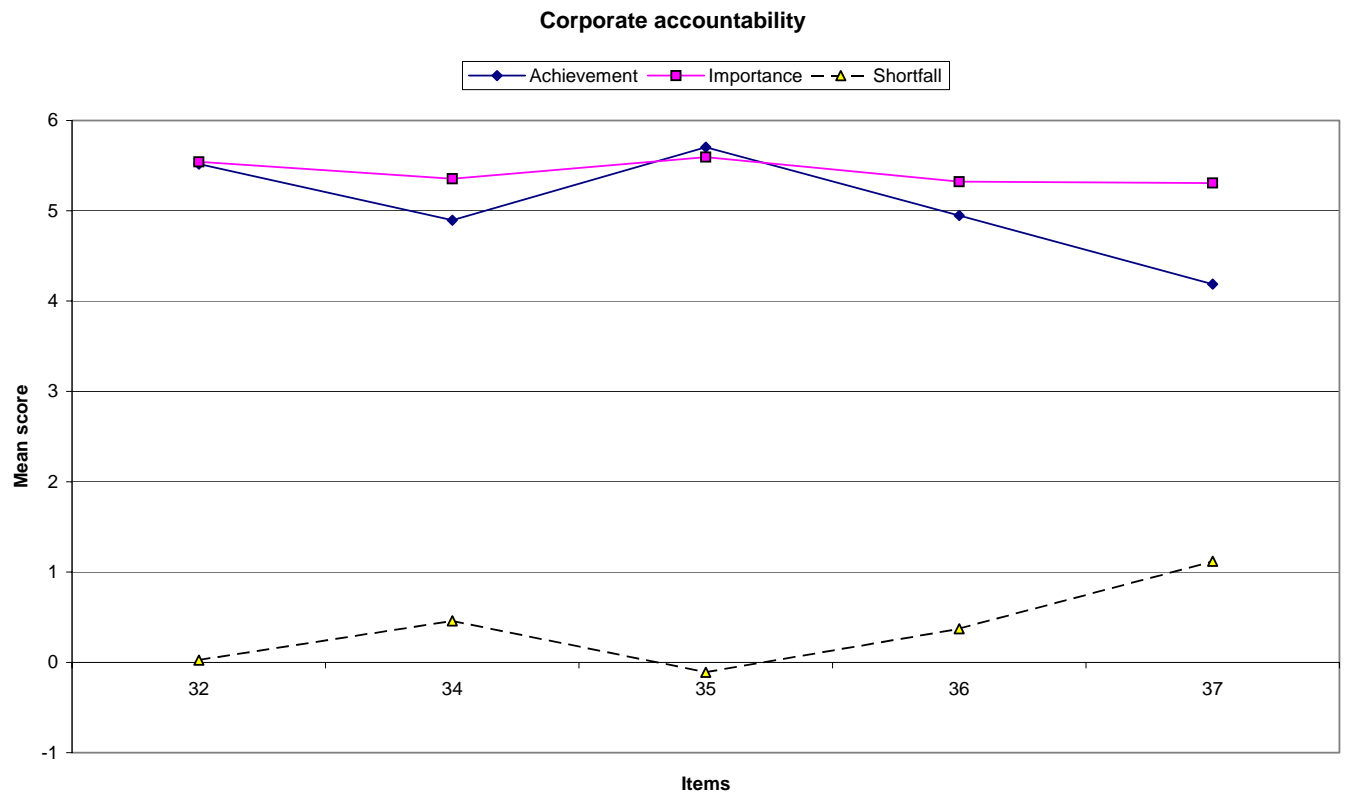
Items concerning systems and structures were considered to be highly important, with mean scores above five.

### *Achievement*

Understandably, the early targets of the existence of an executive committee and an executive director with lead responsibility scored more than five. However, respondents rated achievement in the underpinning of organisation-wide clinical governance with systems in clinical areas less well, with a mean value of 4.19.

### *Shortfall*

The areas showing highest shortfall were the underpinning of clinical governance with systems in clinical areas, and a nominated clinical lead in clinical areas.



Corporate accountability items	Means		
	Achievement	Importance	Shortfall
32 There is an executive director with responsibility for clinical governance	5.52	5.54	0.02
34 Clinical areas have a nominated clinical governance lead	4.89	5.35	0.46
35 There is a formal clinical governance committee, reporting to the board	5.70	5.59	-0.11
36 There are local arrangements to collate information for the CG committee	4.95	5.32	0.37
37 Organisation-wide CG is underpinned by systems in clinical areas	4.19	5.31	1.11

Data tables: achievement

**Frequency tables for corporate accountability items**

	1.00	2.00	3.00	4.00	5.00	6.00
	Count	Count	Count	Count	Count	Count
A32	14	14	23	68	235	823
A34	34	52	91	170	310	520
A35	2	7	21	38	173	936
A36	9	38	85	210	367	468
A37	26	74	210	381	309	177

**Frequency tables for corporate accountability items (%ages)**

	1.00	2.00	3.00	4.00	5.00	6.00
	%	%	%	%	%	%
A32	1.2%	1.2%	2.0%	5.8%	20.0%	69.9%
A34	2.9%	4.4%	7.7%	14.4%	26.3%	44.2%
A35	.2%	.6%	1.8%	3.2%	14.7%	79.5%
A36	.8%	3.2%	7.2%	17.8%	31.2%	39.8%
A37	2.2%	6.3%	17.8%	32.4%	26.3%	15.0%

## **Leadership and collaboration**

The nineteen items relating to leadership and collaboration concern leadership, building clinical teams, involving service users, collaboration with local health and social care partners and organisational learning.

### *Importance*

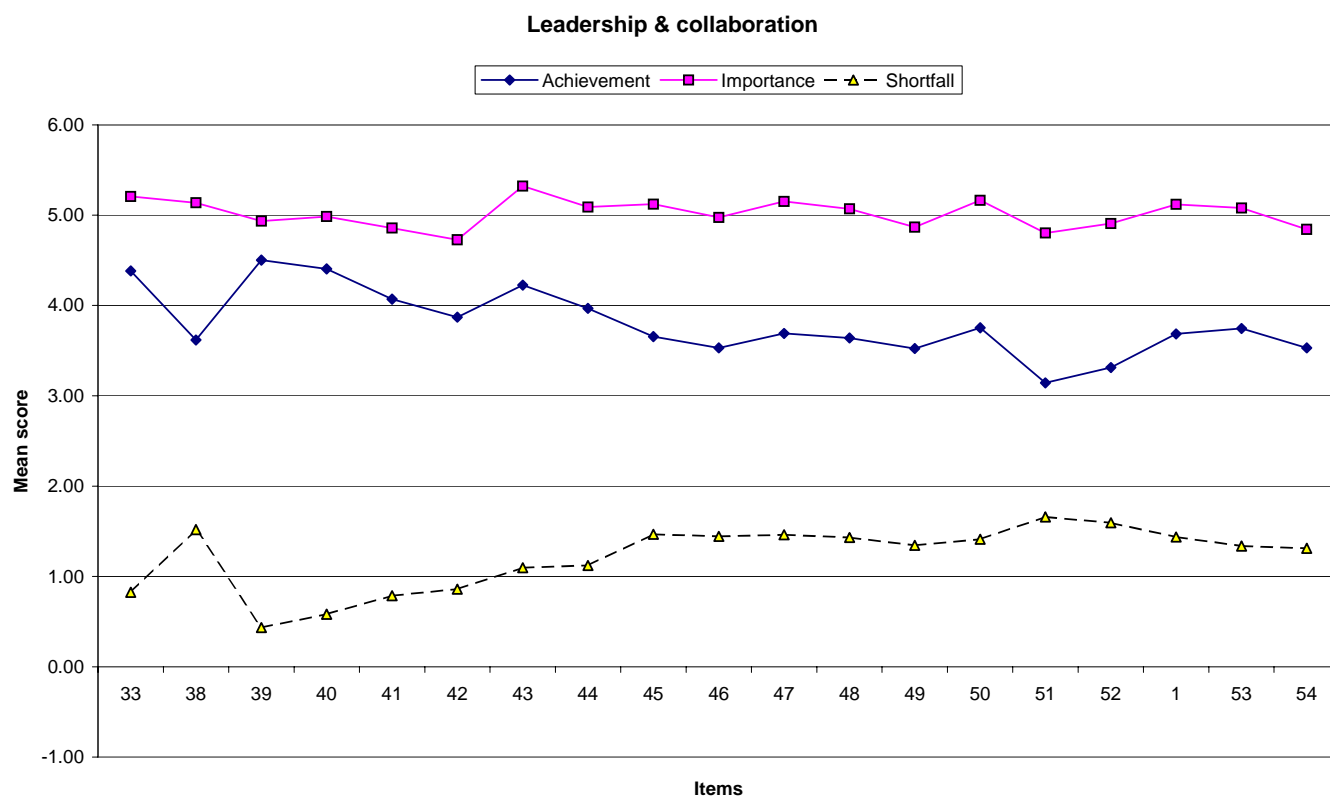
Again, there was limited variation between items, with most scoring over five. Items 51 and 52 concerning local health and social care collaboration were rated slightly lower than others, as was item 42 on sharing clinical protocols across agencies.

### *Achievement*

These items were generally less well scored than the others, showing only moderate achievement. Items 51 and 52, concerning joint clinical governance arrangements and partnerships with health and social care agencies, scored particularly low. Items concerning building clinical teams and user involvement achieved a mean score of around 3.5, indicating modest achievement.

### *Shortfall*

Given modest levels of achievement, there was considerable shortfall across many items. Particularly notable are those items relating to collaboration with local partners, user involvement and clinical teams.



Leadership & collaboration items	Means		
	Achievement	Importance	Shortfall
33 Service delivery plans include quality improvement activity	4.38	5.21	0.82
38 Decisions about service developments / cutbacks are made on clear criteria	3.62	5.14	1.52
39 Local & national priorities are used to prioritise service development	4.50	4.94	0.43
40 NSFs are integrated with business planning / quality improvement activity	4.40	4.99	0.58
41 External guidelines are critically appraised before local adoption	4.07	4.86	0.79
42 Clinical protocols are shared with staff who work outside this organisation	3.87	4.73	0.86
43 The organisation shares a common vision for clinical governance	4.23	5.32	1.10
44 Leadership skills are identified and developed through training programmes	3.97	5.09	1.12
45 Clinical teams receive performance feedback	3.66	5.12	1.47
46 Clinical teams respond to changes by reorganising work processes	3.53	4.97	1.44
47 Staff have clear and shared objectives	3.69	5.15	1.46
48 There are clear processes for involving service users in service development	3.64	5.07	1.43
49 There are clear criteria for establishing user involvement groups	3.52	4.87	1.34
50 Service improvement activity focuses on the patient experience of care	3.75	5.17	1.41
51 Local health & social care agencies work jointly on clinical governance	3.14	4.80	1.66
52 Partnerships with health & social care agencies have clear, shared purposes	3.31	4.91	1.59
1 Teams work across boundaries to address quality issues	3.69	5.12	1.44
53 Staff are able to develop new and innovative models of service	3.75	5.08	1.34
54 Staff evaluate the best ways of training and learning from experience	3.53	4.84	1.31

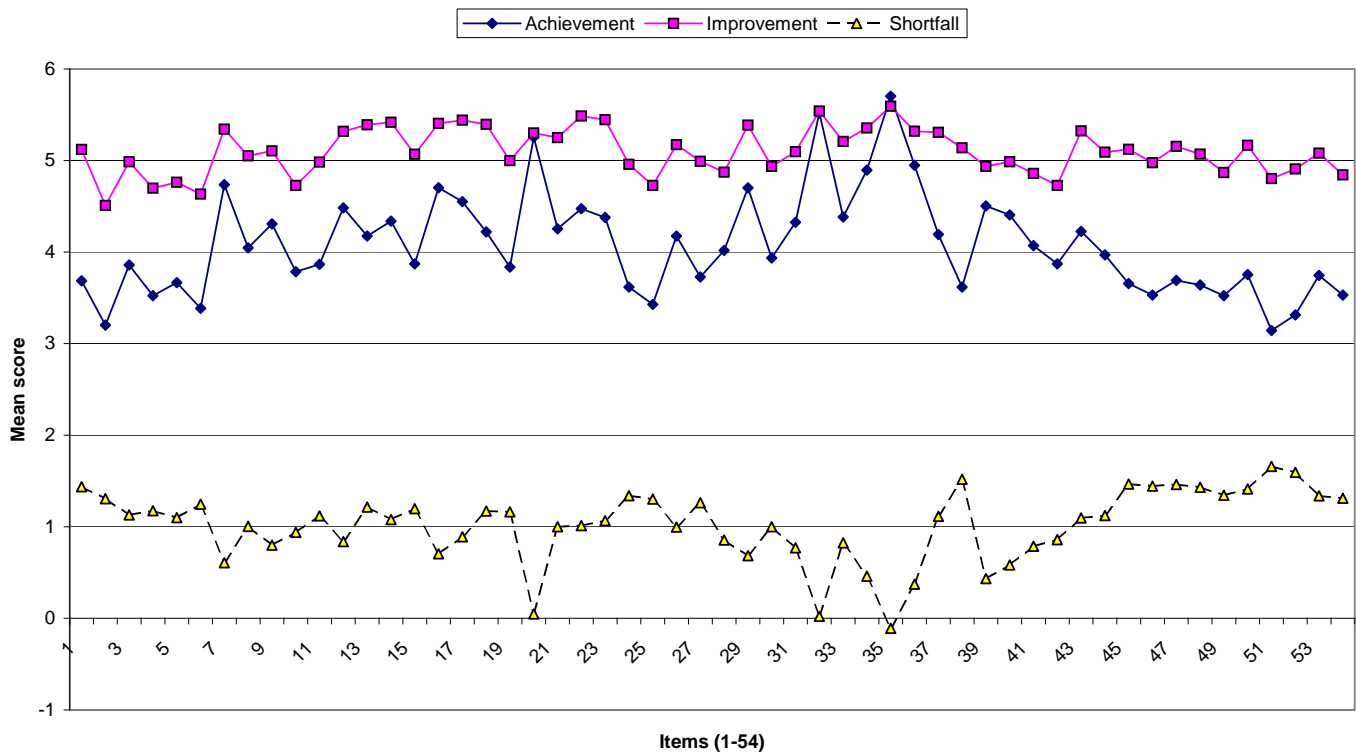
**Frequency tables for leadership & collaboration items**

	1.00	2.00	3.00	4.00	5.00	6.00
	Count	Count	Count	Count	Count	Count
A33	13	63	158	362	387	194
A38	51	177	284	385	218	62
A39	13	48	130	328	460	198
A40	13	50	176	335	415	188
A41	19	86	233	397	339	103
A42	26	139	282	348	279	103
A43	36	83	176	345	357	180
A44	55	128	217	335	283	159
A45	47	153	323	361	220	73
A46	38	155	368	410	172	34
A47	35	120	319	444	217	42
A48	46	194	280	356	220	81
A49	62	210	312	310	208	75
A50	28	145	284	422	227	71
A51	110	282	345	265	118	57
A52	92	234	336	302	153	60
A1	11	124	341	488	174	39
A53	25	116	318	438	235	45
A54	24	162	384	410	167	30

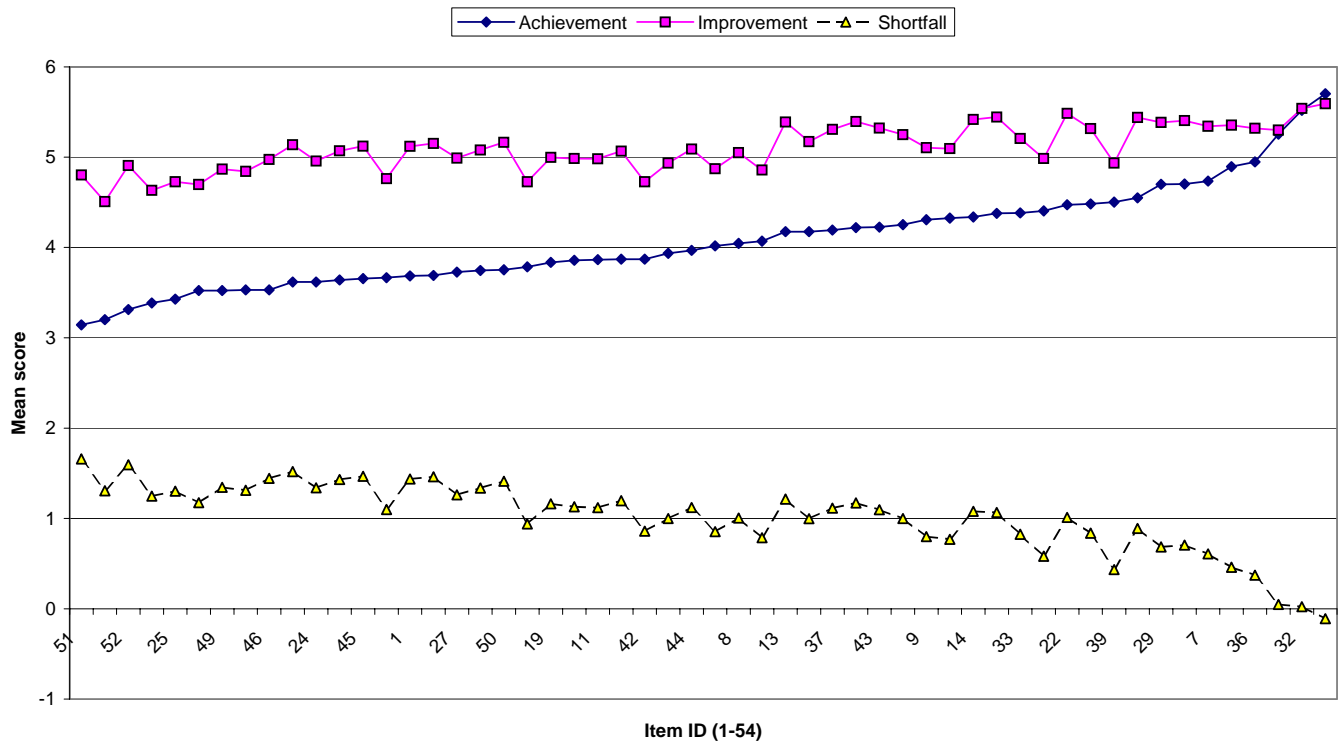
**Frequency tables for leadership & collaboration items (%ages)**

	1.00	2.00	3.00	4.00	5.00	6.00
	%	%	%	%	%	%
A33	1.1%	5.4%	13.4%	30.8%	32.9%	16.5%
A38	4.3%		24.1%	32.7%	18.5%	5.3%
A39	1.1%	4.1%	11.0%	27.9%	39.1%	16.8%
A40	1.1%	4.2%	15.0%	28.5%	35.3%	16.0%
A41	1.6%	7.3%	19.8%	33.7%	28.8%	8.8%
A42	2.2%	11.8%	24.0%	29.6%	23.7%	8.8%
A43	3.1%	7.1%	15.0%	29.3%	30.3%	15.3%
A44	4.7%	10.9%	18.4%	28.5%	24.0%	13.5%
A45	4.0%	13.0%	27.4%	30.7%	18.7%	6.2%
A46	3.2%	13.2%	31.3%	34.8%	14.6%	2.9%
A47	3.0%	10.2%	27.1%	37.7%	18.4%	3.6%
A48	3.9%	16.5%	23.8%	30.2%	18.7%	6.9%
A49	5.3%	17.8%	26.5%	26.3%	17.7%	6.4%
A50	2.4%	12.3%	24.1%	35.9%	19.3%	6.0%
A51	9.3%	24.0%	29.3%	22.5%	10.0%	4.8%
A52	7.8%	19.9%	28.5%	25.7%	13.0%	5.1%
A1	.9%	10.5%	29.0%	41.5%	14.8%	3.3%
A53	2.1%	9.9%	27.0%	37.2%	20.0%	3.8%
A54	2.0%	13.8%	32.6%	34.8%	14.2%	2.5%

Perceived achievement, importance and shortfall (items)



Perceived achievement, importance and shortfall (ranked by achievement)



The above graphs show data on achievement, importance and shortfall across all items in order to facilitate comparisons. Areas in which trusts are performing well include raising clinical issues (7); participating in audit (9); reviewing and discussing risk/ adverse event/ complaints data (12,16,20); appraising staff annually (29); a notified executive lead (32); and formal committee structures (35). Areas where there is room for improvement include working across boundaries (1); benchmarking (2); using research QI (6); improving quality after identifying problems from risk / adverse events data (13 & 18); training in reporting systems (15 & 19); access to and use of clinical indicators (24 & 25); and evidence-based service development (38). All of the leadership / collaboration items show considerable room for improvement.



Data table: Item achievement

	Count	Minimum	Maximum	Mean	SE of Mean	Std Deviation
A1	1177	1.00	6.00	3.69	.03	.99
A2	1177	1.00	6.00	3.20	.03	1.04
A3	1177	1.00	6.00	3.86	.03	.92
A4	1177	1.00	6.00	3.52	.04	1.21
A5	1177	1.00	6.00	3.67	.04	1.32
A6	1177	1.00	6.00	3.38	.03	1.12
A7	1177	1.00	6.00	4.73	.03	.97
A8	1177	1.00	6.00	4.05	.04	1.21
A9	1177	1.00	6.00	4.31	.03	1.13
A10	1177	1.00	6.00	3.79	.04	1.33
A11	1177	1.00	6.00	3.86	.03	1.14
A12	1177	1.00	6.00	4.48	.03	1.19
A13	1177	1.00	6.00	4.18	.03	1.06
A14	1177	1.00	6.00	4.34	.03	1.10
A15	1177	1.00	6.00	3.87	.04	1.28
A16	1177	1.00	6.00	4.70	.03	1.13
A17	1177	1.00	6.00	4.55	.03	1.12
A18	1177	1.00	6.00	4.22	.03	1.02
A19	1177	1.00	6.00	3.84	.04	1.22
A20	1177	1.00	6.00	5.25	.03	.92
A21	1177	1.00	6.00	4.25	.03	1.04
A22	1177	1.00	6.00	4.47	.03	1.20
A23	1177	1.00	6.00	4.38	.03	1.15
A24	1177	1.00	6.00	3.62	.03	1.17
A25	1177	1.00	6.00	3.43	.03	1.10
A26	1177	1.00	6.00	4.18	.03	1.15
A27	1177	1.00	6.00	3.73	.03	1.16
A28	1177	1.00	6.00	4.02	.03	1.02
A29	1177	1.00	6.00	4.70	.04	1.25
A30	1177	1.00	6.00	3.93	.04	1.23
A31	1177	1.00	6.00	4.33	.03	1.20
A32	1177	1.00	6.00	5.52	.03	.93
A33	1177	1.00	6.00	4.38	.03	1.14
A34	1177	1.00	6.00	4.89	.04	1.32
A35	1177	1.00	6.00	5.70	.02	.70
A36	1177	1.00	6.00	4.95	.03	1.13
A37	1177	1.00	6.00	4.19	.04	1.21
A38	1177	1.00	6.00	3.62	.04	1.22
A39	1177	1.00	6.00	4.50	.03	1.09
A40	1177	1.00	6.00	4.40	.03	1.12
A41	1177	1.00	6.00	4.07	.03	1.13
A42	1177	1.00	6.00	3.87	.04	1.22
A43	1177	1.00	6.00	4.23	.04	1.25
A44	1177	1.00	6.00	3.97	.04	1.35
A45	1177	1.00	6.00	3.66	.04	1.21
A46	1177	1.00	6.00	3.53	.03	1.08
A47	1177	1.00	6.00	3.69	.03	1.09
A48	1177	1.00	6.00	3.64	.04	1.26
A49	1177	1.00	6.00	3.52	.04	1.29
A51	1177	1.00	6.00	3.14	.04	1.29
A52	1177	1.00	6.00	3.31	.04	1.28
A53	1177	1.00	6.00	3.75	.03	1.07
A54	1177	1.00	6.00	3.53	.03	1.04

Data table: Item importance

	Count	Minimum	Maximum	Mean	SE of Mean	Std Deviation
I1	1177	2.00	6.00	5.12	.02	.81
I2	1177	1.00	6.00	4.51	.03	.93
I3	1177	1.00	6.00	4.99	.02	.80
I4	1177	2.00	6.00	4.70	.03	.94
I5	1177	1.00	6.00	4.76	.03	.94
I6	1177	1.00	6.00	4.63	.03	.95
I7	1177	3.00	6.00	5.34	.02	.74
I8	1177	1.00	6.00	5.05	.03	.94
I9	1177	1.00	6.00	5.11	.02	.80
I10	1177	1.00	6.00	4.73	.03	.95
I11	1177	1.00	6.00	4.98	.02	.86
I12	1177	1.00	6.00	5.32	.02	.77
I13	1177	1.00	6.00	5.39	.02	.75
I14	1177	1.00	6.00	5.42	.02	.70
I15	1177	1.00	6.00	5.07	.03	.89
I16	1177	1.00	6.00	5.41	.02	.75
I17	1177	1.00	6.00	5.44	.02	.73
I18	1177	1.00	6.00	5.39	.02	.73
I19	1177	1.00	6.00	5.00	.03	.89
I20	1177	1.00	6.00	5.30	.02	.79
I21	1177	1.00	6.00	5.25	.02	.79
I22	1177	1.00	6.00	5.48	.02	.74
I23	1177	1.00	6.00	5.44	.02	.73
I24	1177	1.00	6.00	4.96	.02	.85
I25	1177	1.00	6.00	4.73	.03	.94
I26	1177	1.00	6.00	5.17	.02	.83
I27	1177	1.00	6.00	4.99	.03	.87
I28	1177	1.00	6.00	4.87	.03	.87
I29	1177	1.00	6.00	5.38	.02	.81
I30	1177	1.00	6.00	4.93	.03	.94
I31	1177	1.00	6.00	5.10	.03	.88
I32	1177	1.00	6.00	5.54	.02	.79
I33	1177	1.00	6.00	5.21	.02	.82
I34	1177	1.00	6.00	5.35	.02	.84
I35	1177	1.00	6.00	5.59	.02	.74
I36	1177	1.00	6.00	5.32	.02	.83
I37	1177	1.00	6.00	5.31	.02	.80
I38	1177	2.00	6.00	5.14	.02	.80
I39	1177	1.00	6.00	4.94	.03	.98
I40	1177	1.00	6.00	4.99	.03	.91
I41	1177	1.00	6.00	4.86	.03	.89
I42	1177	1.00	6.00	4.73	.03	1.00
I43	1177	1.00	6.00	5.32	.02	.83
I44	1177	1.00	6.00	5.09	.03	.91
I45	1177	1.00	6.00	5.12	.02	.83
I46	1177	1.00	6.00	4.97	.03	.88
I47	1177	1.00	6.00	5.15	.02	.83
I48	1177	1.00	6.00	5.07	.03	.91
I49	1177	1.00	6.00	4.87	.03	1.01
I50	1177	1.00	6.00	5.17	.03	.89
I51	1177	1.00	6.00	4.80	.03	1.02
I52	1177	1.00	6.00	4.91	.03	.98
I53	1177	1.00	6.00	5.08	.02	.85
I54	1177	1.00	6.00	4.84	.03	.91

### **Aggregated data for the five domains**

The graph and tables overleaf show aggregated item scores in each of the five domains of the OPCG. As there are different numbers of items in each scale, scores were standardised to between zero (low) and 10 (high) for each scale. Respondents considered each of the five domains important to the clinical governance agenda, although quality improvement was seen as the least important, with a mean of 7.66.

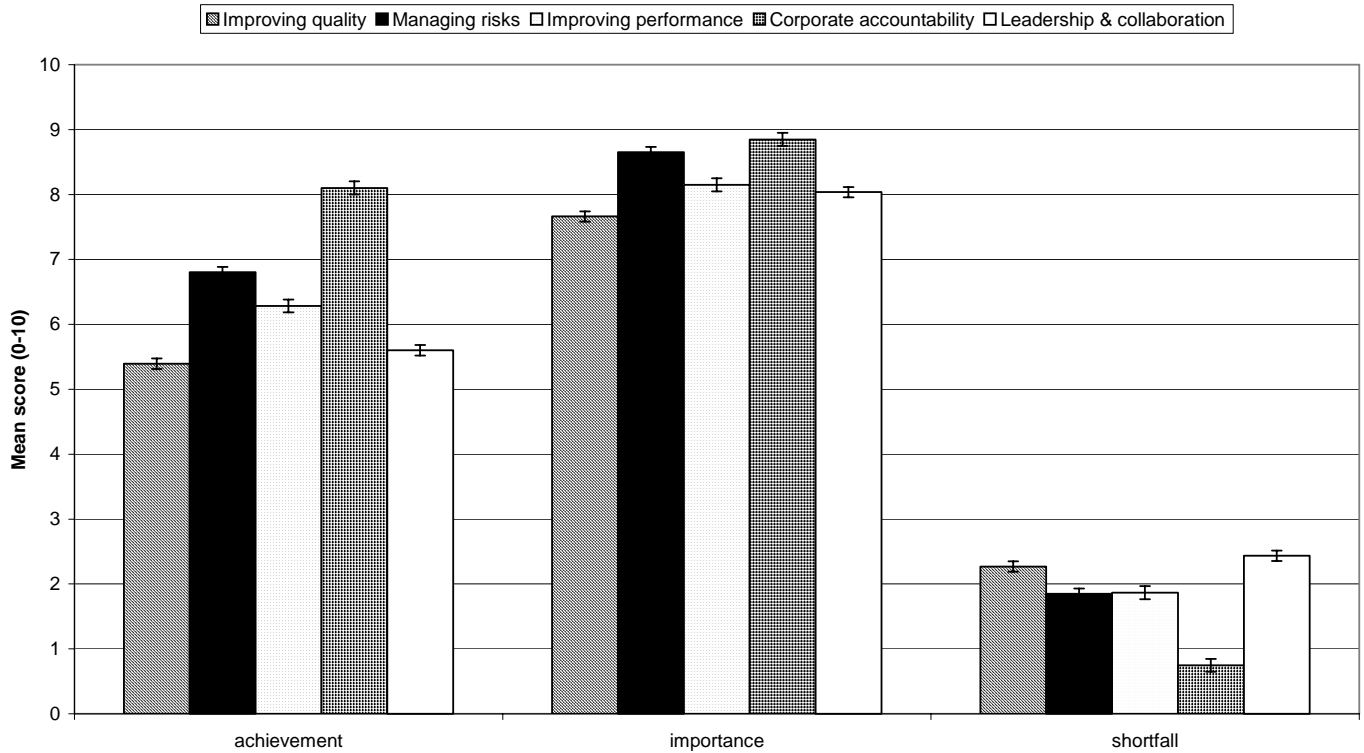
#### *Achievement*

Mean achievement scores for domains ranged from 8.10 to 5.40, indicating room for improvement across all. The domains where respondents believed greatest achievement had been made were corporate accountability (mean = 8.10) and managing risks (mean = 6.81). This is encouraging, as it shows that the priorities of corporate accountability and risk management are being addressed. However, improving quality and leadership & collaboration were scored less highly, with means of 5.40 and 5.61 respectively. This suggests considerable room for improvement in the long-term clinical governance agenda of quality improvement and development.

#### *Shortfall*

Corporate accountability shows lowest mean shortfall of .74, evidence of good achievement in this important domain. Risk management and performance improvements have a mean shortfall of 1.84 and 1.86 respectively, showing the need for continued work. The largest shortfalls were in the areas of quality improvement and leadership & collaboration, with mean shortfalls of 2.26 and 2.43 respectively.

**Perceived achievement, importance and shortfall across all domains**



**Achievement scales (0-10)**

	Count	Minimum	Maximum	Mean	Standard Error of Mean	Std Deviation
Improving quality	1177	.36	9.45	5.40	.04	1.44
Managing risks	1177	.31	10.00	6.81	.04	1.51
Improving performance	1177	.00	10.00	6.29	.05	1.38
Corporate accountability	1177	1.60	10.00	8.10	.05	1.56
Leadership & collaboration	1177	.32	9.68	5.61	.04	1.52

**Importance scales (0-10)**

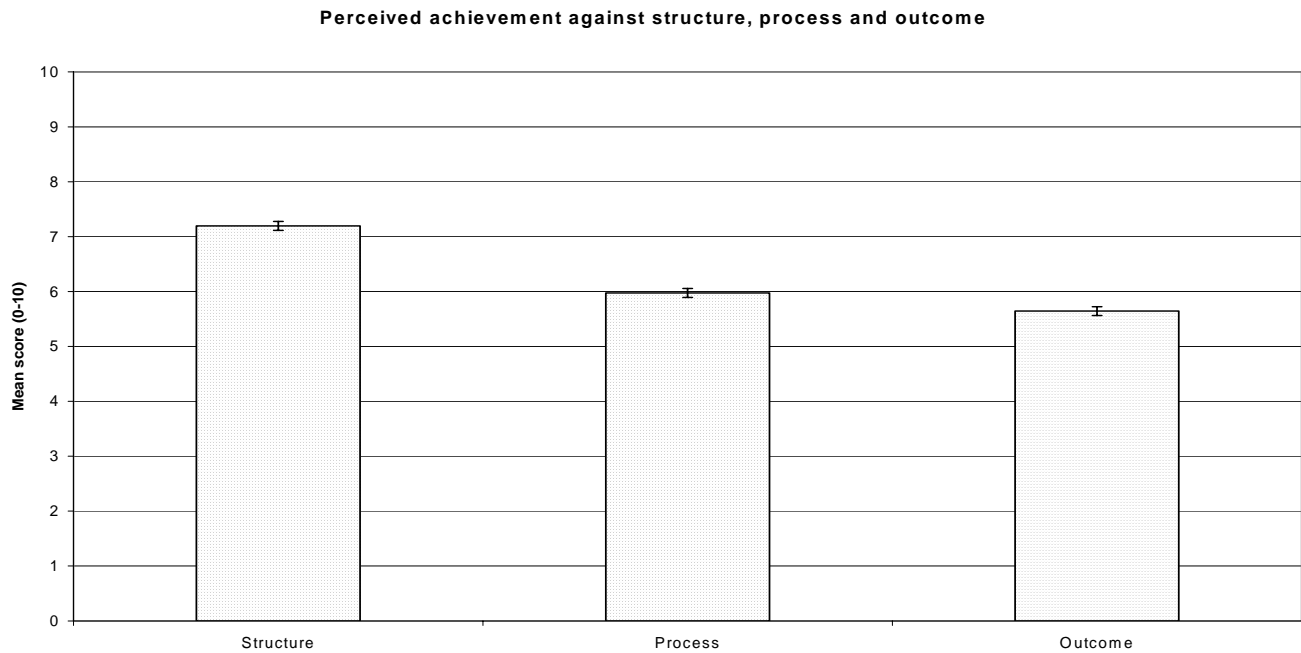
	Count	Minimum	Maximum	Mean	Standard Error of Mean	Std Deviation
Improving quality	1177	1.82	10.00	7.66	.04	1.21
Managing risks	1177	.77	10.00	8.65	.03	1.13
Performance improvement	1177	1.33	10.00	8.15	.04	1.41
Corporate accountability	1177	.40	10.00	8.85	.04	1.30
Leadership & collaboration	1177	.63	10.00	8.04	.04	1.26

**Shortfall (0-10)**

	Count	Minimum	Maximum	Mean	Standard Error of Mean	Std Deviation
Improving quality	1177	-4.55	8.00	2.26	.04	1.48
Managing risks	1177	-2.77	7.08	1.84	.04	1.38
Performance improvement	1177	-3.67	9.00	1.86	.05	1.77
Corporate accountability	1177	-6.80	8.40	.74	.04	1.42
Leadership & collaboration	1177	-1.47	8.32	2.43	.04	1.48

## Structure, process and outcome

Achievement scores were further aggregated under headings 'structure', 'process' or 'outcome', standardised between 0-10. Perhaps unsurprisingly, items relating to structural change (e.g. item 35) were scored more highly than those relating to processes (e.g. item 48), which in turn scored higher than those relating to outcome (e.g. item 53). While good progress has been made against the structural agenda, there is some considerable way to go in order to realise the long-term outcomes claimed for clinical governance.



**Structure, process and outcome achievement (0-10)**

	Count	Minimum	Maximum	Mean	SE of mean	Std Deviation
Structure	1177	1.45	10.00	7.20	.04	1.36
Process	1177	.44	9.81	5.98	.04	1.37
Outcome	1177	.20	9.60	5.65	.04	1.44

## 'Structure' items

- 5 Training in evidence-based practice and critical appraisal is available to staff
- 9 Staff participate in clinical audit activity
- 10 Training in clinical audit is available to staff
- 20 Complaints are collated
- 24 There is good access to agreed clinical performance indicators
- 29 There is an annual staff appraisal process for most staff
- 32 There is an executive director with responsibility for developing the clinical governance agenda
- 34 Clinical areas have a nominated clinical governance lead
- 35 There is a formal clinical governance committee, reporting to the board
- 36 There are local arrangements to collate information for the clinical governance committee
- 37 Organisation-wide clinical governance systems are underpinned by systems in clinical areas

## 'Process' items

- 1 Teams work across boundaries to address quality issues
- 2 Staff identify best practice through benchmarking against other providers
- 4 Research evidence is regularly reviewed and discussed
- 7 Clinical issues are raised for discussion
- 8 Discussions on clinical issues are not dominated by any single profession
- 11 Topics for audit are selected according to their potential impact on care quality
- 12 Risk management data is regularly reviewed and discussed
- 14 Clear action plans are developed in response to identified clinical risks
- 15 Staff are trained to use the risk management system
- 16 Adverse incident data is regularly reviewed and discussed
- 17 Clear action plans are developed in response to adverse incidents
- 19 Staff are trained to use adverse event systems
- 22 There is a 'no-blame' culture around reporting adverse events and near misses
- 23 Staff can raise clinical concerns about their colleagues in confidence
- 26 Staff have development plans which identify training and development opportunities
- 27 Training identified in staff development plans matches individual needs to organisational needs
- 30 An agreed work and development programme is used as the basis of staff appraisal
- 31 Staff appraisal is used as an opportunity to reflect on progress and plan future development
- 33 Service delivery plans include quality improvement activity
- 39 Local and national priorities from NSFs and HImPs are used to priorities service development
- 40 NSF implementation is integrated with business planning and quality improvement programmes
- 41 External guidelines are critically appraised before local adoption or development
- 43 The organisation shares a common vision for clinical governance
- 44 Leadership skills are identified and developed through leadership training programmes
- 45 Clinical teams receive performance feedback
- 47 Staff have clear and shared objectives

- 48 There are clear processes for involving service users in service development
- 49 There are clear criteria for establishing user involvement groups
- 50 Service improvement activity focuses on the patient experience of care
- 51 Local health and social care agencies work jointly on clinical governance issues
- 52 Local partnerships with health and social care agencies have clear, shared purposes
- 54 Staff evaluate the best ways of training and learning from experience

### **'Outcome' items**

- 3 Where appropriate, staff modify their care processes to reflect the best practice of others
- 6 Research information is used consistently to inform our approach to quality improvement
- 13 Following identification of a problem from risk data, clinical quality is improved
- 18 Following identification of a problem from adverse events data, clinical quality is improved
- 21 Following identification of a problem from complaints data, clinical quality is improved
- 25 Clinical indicators are used to reflect on, review and integrate services
- 28 New skills gained through development activity are used in clinical settings
- 38 Decisions about service developments or cutbacks are made on clear criteria
- 46 Clinical teams respond to changes in their environment by reorganising their work processes
- 53 Staff question what they are doing, and are able to develop new and innovative models of service



### Aggregation of individual scores into trust means for trust-based analyses

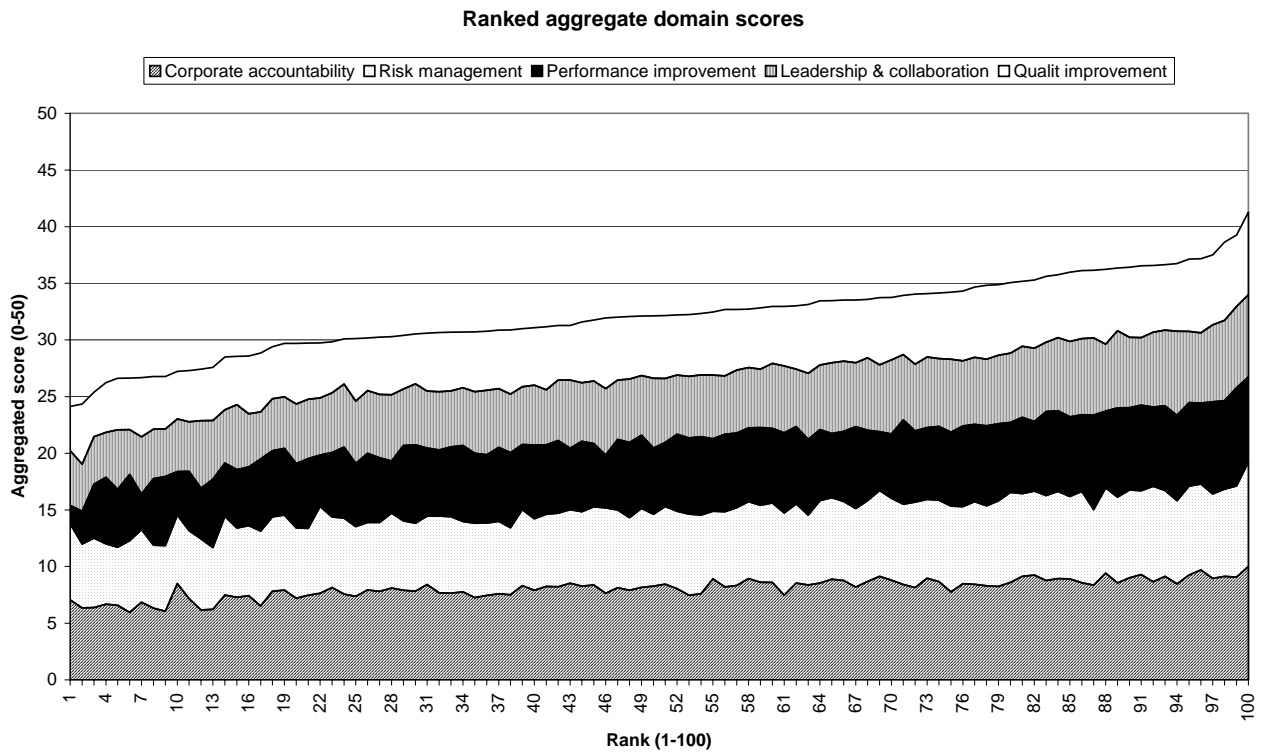
To facilitate comparisons between trusts, achievement scores were aggregated to produce trust means. The move from individual to organisational level analysis is only valid if there is more variation in scores of individuals *between* different trusts than there is in the scores of individuals *within* trusts. A simple one-way (non-repeated measure) analysis of variance tested this assumption, and results showed that the condition was satisfied for all domains.

**ANOVA: Achievement by trust**

		Sum of Squares	df	Mean Square	F	Sig.
Improving quality	Between Groups	473.791	99	4.786	2.604	.000
	Within Groups	1979.674	1077	1.838		
	Total	2453.465	1176			
Managing risks	Between Groups	520.994	99	5.263	2.606	.000
	Within Groups	2175.292	1077	2.020		
	Total	2696.286	1176			
Improving performance	Between Groups	1190.277	99	12.023	4.340	.000
	Within Groups	2983.481	1077	2.770		
	Total	4173.758	1176			
Corporate accountability	Between Groups	794.347	99	8.024	4.196	.000
	Within Groups	2059.495	1077	1.912		
	Total	2853.842	1176			
Leadership & collaboration	Between Groups	635.322	99	6.417	3.340	.000
	Within Groups	2069.364	1077	1.921		
	Total	2704.686	1176			

## Trust-based analysis

For each trust, mean scores on each domain (0-10) were summed to produce a single global score (0-50), then ranked to produce the graph below. Scores fell between 24 and 41 showing middling achievement across all domains, which is consistent with the aggregated data above; even the best performing trust could score no higher than 41 out of 50. Trusts with the lowest global aggregated scores scored particularly poorly on leadership & collaboration, quality improvement and performance improvement domains. Quality improvement and leadership domains showed most room for improvement across



the entire sample.

## Subgroup analyses

Differences in mean domain scores between CHI-visit status and trust type were examined using one-way (single factor, non-repeated measure) analysis of variance.

Differences in domain scores by board member status were examined using t-tests.

### (a) Achievement by CHI-visit status

Trusts were assigned one of three CHI-visit statuses: none received; undergoing visit process; or received report 3+ months previously. There was no significant effect ( $p < 0.05$ ) of CHI visit status on improving quality, managing risks, or leadership & collaboration domains. However, corporate accountability and performance improvement scores were slightly higher in trusts that were undergoing the CHI-visit process. This suggests a temporary heightening of activity in these domains which falls away once CHI reports.

**ANOVA: Achievement by CHI visit status**

		Sum of Squares	df	Mean Square	F	Sig.
Improving quality	Between Groups	4.129	2	2.064	.989	.372
	Within Groups	2449.336	1174	2.086		
	Total	2453.465	1176			
Managing risks	Between Groups	3.900	2	1.950	.850	.428
	Within Groups	2692.386	1174	2.293		
	Total	2696.286	1176			
Improving performance	Between Groups	36.647	2	18.323	5.200	.006
	Within Groups	4137.111	1174	3.524		
	Total	4173.758	1176			
Corporate accountability	Between Groups	28.463	2	14.232	5.914	.003
	Within Groups	2825.379	1174	2.407		
	Total	2853.842	1176			
Leadership & collaboration	Between Groups	1.654	2	.827	.359	.698
	Within Groups	2703.032	1174	2.302		
	Total	2704.686	1176			

Multiple Comparisons

Scheffe

Dependent Variable	(I) CHI'd?	(J) CHI'd?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Improving quality	none	none					
		undergoing visit process	-.1559	.1109	.373	-.4278	.1160
		published report 3+ mths	-6.5126E-02	9.621E-02	.795	-.3009	.1707
	undergoing visit process	none	.1559	.1109	.373	-.1160	.4278
		undergoing visit process					
		published report 3+ mths	9.078E-02	.1101	.712	-.1791	.3606
	published report 3+ mths	none	6.513E-02	9.621E-02	.795	-.1707	.3009
		undergoing visit process	-9.0780E-02	.1101	.712	-.3606	.1791
		published report 3+ mths					
Managing risks	none	none					
		undergoing visit process	-.1454	.1163	.458	-.4304	.1397
		published report 3+ mths	-2.2114E-02	.1009	.976	-.2693	.2251
	undergoing visit process	none	.1454	.1163	.458	-.1397	.4304
		undergoing visit process					
		published report 3+ mths	.1233	.1154	.566	-.1596	.4062
	published report 3+ mths	none	2.211E-02	.1009	.976	-.2251	.2693
		undergoing visit process	-.1233	.1154	.566	-.4062	.1596
		published report 3+ mths					
Improving performance	none	none					
		undergoing visit process	-.4455*	.1442	.009	-.7989	-.922E-02
		published report 3+ mths	-.2743	.1250	.091	-.5807	3.215E-02
	undergoing visit process	none	.4455*	.1442	.009	9.217E-02	.7989
		undergoing visit process					
		published report 3+ mths	.1712	.1431	.489	-.1795	.5219
	published report 3+ mths	none	.2743	.1250	.091	-.322E-02	.5807
		undergoing visit process	-.1712	.1431	.489	-.5219	.1795
		published report 3+ mths					
Corporate accountability	none	none					
		undergoing visit process	-.4028*	.1191	.003	-.6948	-.1108
		published report 3+ mths	-9.5916E-02	.1033	.650	-.3492	.1573
	undergoing visit process	none	.4028*	.1191	.003	.1108	.6948
		undergoing visit process					
		published report 3+ mths	.3069*	.1183	.035	1.704E-02	.5967
	published report 3+ mths	none	9.592E-02	.1033	.650	-.1573	.3492
		undergoing visit process	-.3069*	.1183	.035	-.5967	-.170E-02
		published report 3+ mths					
Leadership & collaboration	none	none					
		undergoing visit process	-5.5071E-02	.1165	.894	-.3407	.2306
		published report 3+ mths	4.265E-02	.1011	.915	-.2051	.2903
	undergoing visit process	none	5.507E-02	.1165	.894	-.2306	.3407
		undergoing visit process					
		published report 3+ mths	9.772E-02	.1157	.700	-.1858	.3812
	published report 3+ mths	none	-4.2649E-02	.1011	.915	-.2903	.2051
		undergoing visit process	-9.7720E-02	.1157	.700	-.3812	.1858
		published report 3+ mths					

\*. The mean difference is significant at the .05 level.

(b) Achievement by trust type

The study included acute, ambulance and mental health / learning disability / social care (MH/LD/SC) trusts. There were significant differences ( $p < 0.05$ ) between trust types on the domains:

- MD/LD scored higher than acute trusts on quality improvement and leadership & collaboration;
- MD/LD and acute scored higher than ambulance trusts on performance improvement and managing risks;
- Acute scored higher than ambulance trusts on corporate accountability.

**ANOVA: Achievement by trust type**

		Sum of Squares	df	Mean Square	F	Sig.
Improving quality	Between Groups	24.501	2	12.251	5.921	.003
	Within Groups	2428.964	1174	2.069		
	Total	2453.465	1176			
Managing risks	Between Groups	15.866	2	7.933	3.474	.031
	Within Groups	2680.420	1174	2.283		
	Total	2696.286	1176			
Improving performance	Between Groups	122.774	2	61.387	17.790	.000
	Within Groups	4050.984	1174	3.451		
	Total	4173.758	1176			
Corporate accountability	Between Groups	20.651	2	10.325	4.279	.014
	Within Groups	2833.191	1174	2.413		
	Total	2853.842	1176			
Leadership & collaboration	Between Groups	16.476	2	8.238	3.598	.028
	Within Groups	2688.209	1174	2.290		
	Total	2704.686	1176			

Multiple Comparisons

Scheffe

Dependent Variable	(I) Trust type	(J) Trust type	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval		
						Lower Bound	Upper Bound	
Improving quality	acute	acute						
		ambulance	9.549E-02	.1550	.827	-.2844	.4754	
		MHLD/Social care	.3600*	.1046	.003	.1035	.6165	
	ambulance	acute	-9.5491E-02	.1550	.827	-.4754	.2844	
		ambulance						
		MHLD/Social care	.2645	.1733	.312	-.1602	.6892	
	MHLD/Social care	acute	-.3600*	.1046	.003	-.6165	-.1035	
		ambulance	-.2645	.1733	.312	-.6892	.1602	
		MHLD/Social care						
	Managing risks	acute	acute					
			ambulance	-.2743	.1628	.242	-.6734	.1247
			MHLD/Social care	.1920	.1099	.218	-.747E-02	.4615
ambulance		acute	.2743	.1628	.242	-.1247	.6734	
		ambulance						
		MHLD/Social care	.4664*	.1820	.038	2.021E-02	.9125	
MHLD/Social care		acute	-.1920	.1099	.218	-.4615	7.739E-02	
		ambulance	-.4664*	.1820	.038	-.9125	2.12E-02	
		MHLD/Social care						
Improving performance		acute	acute					
			ambulance	1.1857*	.2002	.000	.6951	.6763
			MHLD/Social care	.2157	.1351	.280	-.1155	.5470
	ambulance	acute	-1.1857*	.2002	.000	-1.6763	.6951	
		ambulance						
		MHLD/Social care	-.9699*	.2238	.000	-1.5184	.4214	
	MHLD/Social care	acute	-.2157	.1351	.280	-.5470	.1155	
		ambulance	.9699*	.2238	.000	.4214	.5184	
		MHLD/Social care						
	Corporate accountability	acute	acute					
			ambulance	.4669*	.1674	.021	5.665E-02	.8772
			MHLD/Social care	.1465	.1130	.432	-.1305	.4235
ambulance		acute	-.4669*	.1674	.021	-.8772	5.67E-02	
		ambulance						
		MHLD/Social care	-.3204	.1872	.231	-.7791	.1383	
MHLD/Social care		acute	-.1465	.1130	.432	-.4235	.1305	
		ambulance	.3204	.1872	.231	-.1383	.7791	
		MHLD/Social care						
Leadership & collaboration		acute	acute					
			ambulance	-6.1635E-02	.1631	.931	-.4613	.3380
			MHLD/Social care	-.2953*	.1101	.028	-.5651	2.55E-02
	ambulance	acute	6.164E-02	.1631	.931	-.3380	.4613	
		ambulance						
		MHLD/Social care	-.2337	.1823	.440	-.6805	.2132	
	MHLD/Social care	acute	.2953*	.1101	.028	2.548E-02	.5651	
		ambulance	.2337	.1823	.440	-.2132	.6805	
		MHLD/Social care						

\*. The mean difference is significant at the .05 level.

(c) Achievement by board membership status.

There were minor yet statistically significant ( $p < 0.05$ ) differences between board members and non-board members' scores of achievement in all domains. Non-board members score achievement slightly lower than board members on all domains other than improving performance, where the position was reversed.

**Means: achievement by board membership status**

	boardmember?	N	Mean	Std. Deviation	Std. Error Mean
Improving quality	Yes	555	5.5181	1.3495	5.728E-02
	No	622	5.2900	1.5171	6.083E-02
Managing risks	Yes	555	6.9672	1.3371	5.676E-02
	No	622	6.6713	1.6448	6.595E-02
Improving performance	Yes	555	6.1610	1.7645	7.490E-02
	No	622	6.4132	1.9782	7.932E-02
Corporate accountability	Yes	555	8.2796	1.3532	5.744E-02
	No	622	7.9447	1.7055	6.839E-02
Leadership & collaboration	Yes	555	5.7984	1.3743	5.834E-02
	No	622	5.4354	1.6150	6.475E-02

**T-Test: Achievement by board membership status**

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Improving quality	Equal variances assumed	9.077	.003	2.712	1175	.007	.2281	8.411E-02	6.310E-02	.3932
	Equal variances not assumed			2.730	1174.989	.006	.2281	8.356E-02	6.419E-02	.3921
Managing risks	Equal variances assumed	22.953	.000	3.361	1175	.001	.2959	8.803E-02	.1232	.4686
	Equal variances not assumed			3.400	1165.111	.001	.2959	8.701E-02	.1251	.4666
Improving performance	Equal variances assumed	8.257	.004	-2.297	1175	.022	-.2522	.1098	-.4677	-3.68E-02
	Equal variances not assumed			-2.312	1175.000	.021	-.2522	.1091	-.4663	-3.82E-02
Corporate accountability	Equal variances assumed	26.490	.000	3.702	1175	.000	.3349	9.047E-02	.1574	.5125
	Equal variances not assumed			3.750	1159.448	.000	.3349	8.931E-02	.1597	.5102
Leadership & collaboration	Equal variances assumed	15.400	.000	4.127	1175	.000	.3630	8.796E-02	.1904	.5355
	Equal variances not assumed			4.164	1172.406	.000	.3630	8.716E-02	.1919	.5340



#### **Appendix 4: Computing scale scores**

The five scales of the OPGC contained different numbers of items. For ease of comparison, scale scores were computed between 0-10 using the following formula:

$$\text{Scale score} = (\text{sum of all items in the scale} - \text{No. of items}) / (5 * \text{No. of items}) * 10$$

The same formula was used to compute score for structure, process and outcome domains.