Improving Quality and Safety: Progress in implementing Clinical Governance in Primary Care Trusts

REPORT TO THE NATIONAL AUDIT OFFICE

Peter Spurgeon
Fred Barwell
Tim Freeman
Patti Mazelan

Health Services Management Centre
Applied Research Ltd

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Executive summary

Introduction

This report presents findings of an analysis of a survey of NHS primary care trusts (PCTs) in England, designed to provide a comprehensive assessment of achievement in primary care clinical governance, lessons learned, and what remains to be done. The survey was undertaken on behalf of the National Audit Office as part of their remit to report to Parliament on the use of public funds. The report is divided into ten main sections, as follows:

- Policy background
- Survey methodology and response rates
- Functioning of the PCT
- Usefulness of guidance and support in clinical governance implementation
- Structures and processes for clinical governance
- Progress on clinical governance issues related to 'Standards for Better Health'
- Chief executives' perspectives on the progress of clinical governance
- Impact of clinical governance on the quality of patient care
- Board and PEC perspectives on the progress of clinical governance
- Staff experience of clinical governance climate

Policy Background

The NAO's examination of the importance of clinical governance in primary care is part of a continuing theme of its work. The NAO previously conducted a study of the implementation of clinical governance in acute trusts, which led to the publication of the report *Achieving Improvements through Clinical Governance: A progress report on implementation by NHS Trusts* (HC 1055, September 2003). The NAO has also conducted a number of studies relating to patient safety and clinical governance, including *Improving Patient Care by Reducing the Risk of Hospital Acquired* Infection (HC 876 2004) and *Reforming NHS Dentistry: Ensuring effective management of* risks (HC 25 November 2004). This study forms part of the broader NAO study examining whether PCTs are achieving improvements in patient care through better clinical governance designed to provide a comprehensive assessment of what has been achieved, what lessons have been learned and what more needs to be done.

Publication of *Commissioning a Patient Led NHS* in July 2005 indicated widespread changes to the form and function of PCTs. The number of PCTs will fall from around 300 to somewhere in the region of 100 – 120, depending on the options approved. While there is no requirement for PCTs to relinquish their provider roles, the new environment will require PCTs' clinical governance arrangements to be capable of assuring quality among a diverse range of providers, typically through enhanced commissioning arrangements. The present study provides a snapshot of PCT achievements in clinical governance to date, and provides an indication of their readiness to undertake governance of diverse providers.

Methodology

The study comprised a census survey of clinical governance arrangements in all NHS Primary Care Trusts (PCTs) in England in September / October 2005. The census frame was validated by contacting each Strategic Health Authority (SHA) and seeking confirmation of contact details of a lead person for clinical governance to whom the survey should be directed.

The study consisted of three elements: Questionnaire A is a new instrument developed in partnership with the NAO, and Questionnaires B and C were modified from pre-existing instruments developed by HSMC. Each were reviewed and subsequently approved through the Department of Health's Review of Central Returns (ROCR) process. Questionnaire (A), mailed to all 303 PCTs on our validated database, was for completion by the Chief Executive Officers in combination with the Clinical Governance Leads. Items on Questionnaire A required a corporate response on PCT functions; the perceived usefulness of clinical governance guidance; structures and processes for clinical governance; issues related to 'Standards for Better Health'; perceived progress in clinical governance; and impact on clinical care. In addition to Questionnaire A, each trust also received ten copies of a Questionnaire B, for completion by multiple PEC and Board members. Questionnaire B consists of a modified version of HSMC's Organisational Progress in Clinical Governance (OPCG) schedule, a previously validated instrument that 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.

While both Questionnaire A and Questionnaire B were ultimately concerned with perceptions of corporate systems and processes for clinical governance, the study team were keen to explore the 'lived experience' of clinical governance by front-line staff. Consequently, a small sample (n = 30) of front-line staff in a random sample of 12 trusts received a copy of Questionnaire C. These 12 PCTs were asked to identify a liaison person within their provider unit arm (Learning Disability, Mental Health or Community Units) and these individuals were then asked to distribute Questionnaire C forms to 30 front line staff on a random basis. Questionnaire C is a modified form of the 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.

Of the 303 PCTs mailed, completed Questionnaire A forms were received from 240 in all (i.e. a 79% response rate). Given the uncertainty surrounding many PCTs and the associated poor morale and motivation this was deemed to be a satisfactory response rate for the purposes intended.

Summary findings and conclusions

PCT functioning

- Most executive directors with responsibility for clinical governance in PCTs have clinical roles;
- PCTs in which the clinical governance director lacks HR or commissioning experience may face difficulties in developing clinical governance arrangements that are consistent with the enhanced role of PCT commissioning as envisaged in C*ommissioning a Patient-Led NHS.* Currently, only 11% of directors with responsibility for clinical governance are directors of HR, and only 6% directors of commissioning;
- While time and resources present a marginally greater constraint to implementation than lack of information, none of these posed more than moderate difficulties for the majority of respondents

Guidance and support in implementation

- Experience of external review systems such as the CNST scheme and CHI reviews is typically reported as positive;
- A majority of respondents identified DH (73%) and SHA (82%) support as helpful;
- Specialist support provided by the CGST such as the Board Development Programme for Clinical Governance had been reasonably widely used (39%) and was generally well regarded.

Structures and processes

- An overwhelming majority of PCTs have structures, process and lead members of staff for clinical leadership, capacity, risk management, multi-professional audit, public involvement, care quality and service improvement;
- In terms of the perceived effectiveness of each of these structures and processes, respondents identified moderate to good ability in risk management and improving patient experience across each of the above elements;
- Respondents identified the PCT as the organisational unit most likely to contain explicit structures for each of the elements identified above (between 79% and 93% for specific elements). Structures were available at sub-PCT level in between 40% to 51% of PCTs depending on the element, and at the Pan-PCT level in only 21% - 39% of PCTs;
- Lack of Pan-PCT arrangements and concentration at the PCT level may require considerable redesign of clinical governance arrangements as a results of reconfiguration and an enhanced duty for PCTs to shape (and internally manage) emerging markets of multiple providers.

Progress on clinical governance issues related to 'Standards for Better Health'

- While in terms of implementation planning many of the *Standards for Better Health* core standards relating to clinical governance appear to be in place, comparatively weaker areas for future improvement reflect aspects of inter-agency collaboration and commissioning (e.g. ensuring that commissioning arrangements take account of clinical risks; supporting commissioning for quality; and facilitating health and social care agency influence over governance issues);

- In terms of coverage and achievement, relatively weak areas include leadership development, sustaining strategic partnerships, and developing practice-based commissioning. As with implementation, the aspects with poorest coverage and lowest perceived effectiveness included those aspects concerned with commissioning for quality

Chief executives' perspectives on progress of clinical governance

- CEO's rating of the importance of, and achievement against, a range of organisational clinical governance competencies reveals that the areas with greatest perceived risk to progress include training in EBP, benchmarking of commissioning practices, joint working between health and social care agencies, and leadership development;

- Areas identified as posing moderate risk to progress included care pathways development and quality improvement activity in service delivery;

- Risk management and appraisal activities, while judged as very important, were seen as less of a risk to progress given high levels of perceived achievement;

- The moderate relative perceived importance of benchmarking for commissioning may mean that it could become overlooked, with attention diverted to areas perceived as more important yet with greater perceived achievement.

Board and PEC perspectives on progress of clinical governance

- PEC and Board members indicated moderate to good achievement against 20 organisational competencies selected from the full OPCG measure reported for CEOs in section 8 above. Benchmarked against other PCTs, least achievement was indicated for commissioning, leadership skills and service user involvement;

- When responses were compared between PEC and Roles/Job-titles of Board members, PEC members were found to report lower achievement levels than any of the Board level groupings;

- Disaggregating PEC scores by individual staff group indicates that GPs consistently gave the lowest estimates of perceived achievement compared to other PEC members on virtually all items, other than on item 10 'service provision is benchmarked against other providers';

- Factor analysis suggests that those organisational competencies relating to external assurance, (including benchmarking of commissioning and provision and involvement of service users in service development), were perceived by both Board and PEC members to be less well developed than internal (PCT-specific) processes such as use of clinical audit and risk management of provision.

Staff experience of clinical governance climate

- Data collected from 'front-line' staff from a sample of 12 PCTs using the Clinical Governance Climate Questionnaire (CGCQ) to explore the 'lived experience' of clinical governance revealed moderate to good progress in embedding clinical governance practices. Of the six aggregated domains, the area with the least progress was a planned and integrated quality improvement programme, with rather more achievement indicated in risk management and avoidance of an unjust 'blame' culture;

- Considering individual items in the scales, it is clear that staff report a variety of 'day to day' pressures that compromise their effectiveness and conspire to make the pursuit of clinical governance and quality goals difficult. On the other hand, it is clear that many staff report a genuine attempt to establish a learning culture and share good practice.

Summary of Findings from Phase II of the Analysis

Assessing Progress in Clinical Governance

It has been possible to develop an assessment of progress that discriminates between PCTs and is based upon an estimate of the degree of coverage in staff groups achieved on 26 key tasks (associated with clinical governance and the core standards for better health). Two banding methods are used: "Average Percentage Banding" and "Progress Index Banding" (to accommodate non-normal distribution of scores in some PCTs). There is considerable overlap when the different banding methods are used, but the "Progress Index Banding" is perhaps the more discriminating.

Using these PCT bands a variety of processes are then identified as being linked to relatively high or low levels of progress in Clinical Governance. These include:

External Processes

- Participation in CHI reviews
- Having written implementation strategies in place, with a named individual accountable for implementation

Structures for Managing Risk to Service Delivery & Improving Patient Experience

The lowest banded PCTs (Band E) are associated with limited coverage in virtually all areas.
Highly performing PCTs are linked with:

- ensuring effective clinical leadership
- ensuring the quality of patient experience
- improving services based on lessons from complaints
- improving services based on lessons from patient safety incidents/near misses

Structures for Managing Risk & Improving Patient Experience and Standards for Better Health

PCTs in Bands A & B are associated with greater effectiveness in many areas.
Particular items here include;

- *Ensuring compliance with Continuing Professional Development (CPD) requirements*
- *Supporting arrangements for the appraisal of clinical staff*
- *Developing Performance and Development Review (PDR) for staff*
- *Developing leadership at every level of the organisation*
- *Supporting development of multi-disciplinary clinical care*
- *Developing wider PEC understanding of clinical governance duties*
- *Ensuring effective clinical risk management strategies*
- *Ensuring effective infection control*
- *Supporting access to NSF guidance*
- *Providing information on Evidence Based Medicine*
- *Developing protocols and guidelines for clinical care*
- *Facilitating local health & social care agency influence over PCT governance issues*
- *Sustaining local strategic partnerships*
- *Developing shared vision with collaborating organisations*
- *Involving local communities in the PCT*
- *Ensuring use of QOF data in making service improvements*
- *Supporting commissioning for quality*
- *Ensuring that commissioning arrangements take account of clinical risk*
- *Benchmarking commissioning against other organisations*
- *Developing Practice based commissioning*
- *Benchmarking provision against other organisations*
- *Ensuring that Public Health informs PCT policy*

Progress would not seem to be due to action on one aspect in isolation but on the creation of a culture that enables action to be taken across a range of areas.

Perceived Risk to Progress

Risk is based on a combination of ratings of achievement and ratings of importance.

Based on the Progress Index Banding approach key areas, high performing PCTs (Bands A and B) appear to be significantly better with respect to:

- *Leadership skills are developed at every level*
- *Primary care clinical staff work as a multi-disciplinary team*
- *Published research is used to inform quality improvement*
- *Staff modify their care processes to reflect emerging 'best practice'*
- *Service delivery plans include quality improvement activity*
- *NSF implementation is integrated with business planning and quality improvement programmes*
- *Training identified in staff development plans matches individual needs to organisational needs*
- *Service users are involved in service development*
- *Care pathways are developed with colleagues in secondary care*
- *All staff are appraised against an agreed work and development programme*
- *Clinical teams respond to changes in their environment by reorganising their work processes*
- *Local and national priorities are used to priorities service development*
- *Clinicians use professional networks to identify emerging 'best practice'*
- *New skills obtained through development activity are used*

Overall Risk to Progress in Clinical Governance

Items carrying the highest level of overall risk are generally less well managed by PCTs in Bands D and E, the lower performance groups.

The six highest risk items which are better managed by PCT Bands A & B and poorly managed by PCT Bands D & E are:

- *Local health and social care agencies work jointly on clinical governance issues*
- *Staff benchmark provision against other PCTs*
- *Service users are involved in service development*
- *Published research is used to inform quality improvement*
- *Service improvement activity focuses on the patient experience of care*
- *Clinical teams respond to changes in their environment by reorganising their work processes*

Progress in Governance as Perceived by PCT and PEC Boards

PCTs in Bands A & B consistently perceived greater endorsement from their Board members about their level of engagement in various areas of clinical governance activity.

Some of the key issues as perceived by Board members include;

- *Information to support evidence based medicine is available and easily accessible*
- *All staff are appraised against an agreed work and development progression*
- *Service users are involved in service development*
- *Clear action plans are developed in response to clinical risks*
- *Underperformance by clinical staff is addressed by clear management procedures*

Managing the Culture of Clinical Governance

Examples of clinical governance initiatives aimed at improving patient care suggest that higher band PCTs (A & B) are more effective in managing the change process itself, irrespective of the content of the change.

It appears that the effective implementation of clinical governance is about sustaining an ongoing cultural transformation rather than pursuing specific and possibly isolated activities.

1. Introduction

This report presents findings of an analysis of a survey of NHS primary care trusts (PCTs) in England, designed in response to a commission by the National Audit Office to provide a comprehensive assessment of achievement in primary care clinical governance, lessons learned, and what remains to be done. The report is divided into ten main sections, as follows:

- Policy background
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Conclusions are identified at the end of each of the results sections, a final section providing a concise summary of the main messages.

2. Policy background

The NAO's examination of the importance of clinical governance in primary care is part of a continuing theme of its work. The NAO previously conducted a study of the implementation of clinical governance in acute trusts, which led to the publication of the report *Achieving Improvements through Clinical Governance: A progress report on implementation by NHS Trusts* (HC 1055, September 2003). The NAO has also conducted a number of studies relating to patient safety and clinical governance, including *Improving Patient Care by Reducing the Risk of Hospital Acquired* Infection (HC 876 2004) and *Reforming NHS Dentistry: Ensuring effective management of* risks (HC 25 November 2004). This study forms part of the broader NAO study examining whether PCTs are achieving improvements in patient care through better clinical governance designed to provide a comprehensive assessment of what has been achieved, what lessons have been learned and what more needs to be done.

The study took place at a time of emerging policy changes concerning the future of primary care commissioning and provision. Publication of *Commissioning a Patient Led NHS* in July 2005 indicated widespread changes to the form and function of PCTs and a commitment to involve all practices in practice based commissioning by the end of 2006. The plans subsequently submitted to the Department of Health by Strategic Health Authorities (SHAs) indicate that the number of PCTs will fall from around 300 to somewhere in the region of 100 – 120, depending on the options approved. PCTs will support devolution of commissioning to practices with the aim of securing greater clinical engagement and a more robust approach to demand management, and it is likely that practice based commissioning (PBC) will focus on groups of practices in localities with PCTs retaining responsibility for contracting on behalf of practices. It is envisaged that the new PCTs will be coterminous with local authorities in most parts of the country, in order to facilitate partnership working between the NHS and local government. While *Commissioning a Patient Led NHS* indicated that PCTs would be expected to give up their provider functions by 2008 to enable them to focus on their other responsibilities and open up the provider services of PCTs to choice and contestability subsequently, in the face of criticism, the Secretary of State for Health announced that there would be no requirement for PCTs to relinquish their provider roles. At present the policy direction remains unclear, and it is expected that the white paper on care outside hospital, due to be published in early 2006, will offer further clarification.

To support PCTs and practices in undertaking commissioning, the Department of Health has announced plans to establish regional contract management arrangements. The nature of these arrangements has not been specified and options currently include bringing in private sector expertise to provide contract management and collaboration between PCTs to pool their expertise. The changes being made to commissioning are driven by a belief that many PCTs have struggled to discharge their responsibilities effectively, and a major development programme is planned to support PCTs in their new role and to promote effective practice based commissioning.

Given these policy developments, PCTs in the future are likely to be involved in:

- Negotiating and monitoring contracts with self-employed contractors;
- Providing local community health services, where appropriate in partnership with the relevant local authority;
- Assessing health needs from the analysis of quantitative and qualitative data;
- Undertaking public health initiatives that link with the local authority and the local voluntary sector; and
- Engaging local clinicians and communities in leading and shaping local healthcare priorities and practices.

Some PCT functions might be undertaken by the private sector and by regional contract management arrangements as proposed (but not specified) in *Commissioning a Patient Led NHS*. Whatever the emergent arrangements for PCT commissioning and contracting, much will depend on the way in which practice based commissioning develops. Current indications are that the degree of interest in and commitment to practice based commissioning is highly variable with practices falling broadly into three groups: the enthusiasts, the undecided and the opposed. The size of each group varies between areas with most practices as yet undecided or unpersuaded that practice based commissioning will offer real benefits to them and their patients.

Against this background our review of primary care clinical governance provides a snap-shot of quality assurance and improvement structures, processes and practices on the cusp of wide-reaching policy initiatives proposing new roles of market management within the commissioning function of PCTs. Given the immanent nature of PCT reconfiguration, we explicitly identified the level (practice; PCT-wide; multiple PCTs) at which clinical governance structures and processes were operating at the time of the census. This allows us to map those elements of clinical governance for which there is experience of organisation across multiple PCTs, potentially very important in a reconfigured environment which is likely to involve a reduced direct provider role for PCTs and enhanced commissioning and market management functions.

3. Methodology

Our aim to undertake a census survey of clinical governance arrangements in all NHS Primary Care Trusts (PCTs) in England was complicated considerably by the level and pace of local and national organisational change in the NHS as considered above, particularly given an immanent round of PCT reconfigurations in the light of *Commissioning a Patient-led NHS* (2005). Given the fluidity of the organisational environment, we approached each Strategic Health Authority (SHA) to validate the census frame of PCTs and confirm contact details of a lead person for clinical governance to whom the survey should be directed. Following validation of our census frame, we undertook the survey in September / October 2005.

The study consisted of three elements: Questionnaire A is a new instrument developed in partnership with the NAO, and Questionnaires B and C were modified from pre-existing instruments developed by HSMC. Each were reviewed and subsequently approved through the Department of Health's Review of Central Returns (ROCR) process. Questionnaire (A), was mailed to all 303 PCTs on our validated database, was for completion by the Chief Executive Officer in combination with the Clinical Governance Lead. Items in Questionnaire A required a corporate response on PCT functions; the perceived usefulness of clinical governance guidance; structures and processes for clinical governance; issues related to 'Standards for Better Health'; perceived progress in clinical governance; and impact on clinical care. In addition to Questionnaire A, each trust also received ten copies of a Questionnaire B, for completion by multiple PEC and Board members. Questionnaire B consists of a modified version of the Organisational Progress in Clinical Governance (OPCG) schedule, a previously validated instrument that assesses respondents' perceptions of achievement on a series of organisational competencies related to clinical governance. Developed through a combination of literature reviews and qualitative research with expert groups, 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. Scores from PEC and Board respondents in each trust are then aggregated to produce a summary score based on respondent perceptions.

While both Questionnaire A and B are ultimately concerned with perceptions of corporate systems and processes for clinical governance, the study team were keen to explore the 'lived experience' of clinical governance by front-line staff. Consequently, a small sample (n = 30) of front-line staff in (n=12) trusts received a copy of Questionnaire C. A random sample of 12 PCTs within the total sample were asked to identify a liaison person within their provider unit arm (Learning Disability, Mental Health or Community Units) and these individuals were then asked to distribute the Questionnaire C forms to 30 front line staff on a random basis. Completed forms were returned direct to the researchers in stamped addressed envelopes. Questionnaire C is a modified form of the Clinical Governance Climate Questionnaire (CGCQ), which is a self-completion instrument developed for use with medical, other clinical and managerial health care staff groups. It 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. Each of these sub-scales are scored between 0–100 (the higher the score the more positive the climate for clinical governance).

In addition to the quantitative items, Questionnaire A included open questions and specifically questions seeking descriptive exemplars of good practice in clinical governance implementation. Data analysis and report preparation were undertaken using SPSS for Windows and Excel as appropriate.

Distribution of questionnaires and response rates

All 'sets' of Questionnaires (i.e. A, B and C), were posted to the named PCT Chief Executive. Questionnaire A was to be completed and signed off by the Chief Executive in conjunction with the PCT Clinical Governance Lead. Copies of Questionnaire B were distributed to members of the PCT Board, whilst Questionnaire C was sent to a link person within the provider arm. Two rounds of follow-up contacts were made with PCTs who had not returned Questionnaire A within the initial deadline.

Of the 303 PCTs mailed, completed copies of Questionnaire A were received from 240 respondents in all (i.e. a 79% response rate). Given the uncertainty surrounding many PCTs and the associated poor morale and motivation this was deemed a more than satisfactory response rare for the purposes intended. Moreover the basic characteristics of the PCTs replying (see below) suggest that they may be accepted as characteristic of the total.

The average size of the population served by the PCTs was 175,940 ranging from 70,000 (lowest) to 540,000 (highest). The full distribution of populations is presented in **Table 3.1** below.

Table 3.1: PCT Population Bands

Less than 100,000	=	27 (11.3%)
Between 100 – 150,000	=	61 (25.4%)
Between 150 – 200,000	=	73 (30.4%)
Between 200 – 250,000	=	38 (15.8%)
Between 250 – 300,000	=	22 (9.2%)
Over 300,000	=	14 (5.8%)
Missing datapoints	=	*5 (2.17%)*

In terms of location 41% described themselves as Mainly Urban, 16% as Mainly Rural, and 42% as Mixed. Approximately 96% of the sample reported having directly provided services with employed staff.

4. Functioning of the PCT

Lead responsibility for Clinical Governance

The survey collected information about the individual or job title with lead responsibility for clinical governance within the PCT and this relatively simple set of questions revealed considerable variation.

In response to the question 'Does the PCT have a Medical Director?' – 50.4% said yes, and 49.2% said no, with one missing datapoint. Of those PCTs with a Medical Director, only 30% had the responsibility for clinical governance.

In order to explore where the focus of leadership for clinical governance was located two questions were asked – the job title of the executive director with the lead for governance at Trust Board level, and the job title of the clinical governance lead if it was not the Trust Board Lead. The replies to the first question are presented in **Table 4.1**.

Table 4.1 Job title of the nominated executive director leading on clinical governance at Trust Board level

	n	%
Chief Executive	8	3.3
Director of Public Health	36	15.0
Medical Director	22	9.2
Director of Nursing	18	7.5
Director of Nursing and Clinical Governance/Quality	16	6.7
Director or Nursing and other divisions	15	6.3
Director of Quality	8	3.3
Director of Clinical Services	14	5.8
Director of Primary Care	7	2.9
Director of Patient Services	4	1.7
Director of Operational Services/Operations	11	4.6
Chair people	3	1.3
Director/Lead Clinical Governance	13	5.4
Director of Human Resource/Development	26	10.8
Director of Quality Service Improvement	17	7.1
Director of Service Commissioning	14	5.8
GP	1	0.4

To some extent these results reflect differences in nomenclature, yet they also reveal some important substantive differences. Although most executive directors with responsibility for clinical governance in PCTs held clinical roles, in a minority of PCTs this responsibility is held by either a director of HR (11%) or service commissioning (6%). The former result implies that clinical governance is viewed as an aspect of organisational development with respect to encouraging new ways of working and delivering services; and the latter result suggests that clinical governance is less a way for a corporate organisation to internally and externally assure provision than the means by which a service commissioner governs the clinical quality of provision by multiple (external) providers. This latter sense of clinical governance is more consistent with the extended commissioning role for PCTs envisaged by *Commissioning a Patient-Led NHS*.

In 56% of the cases this person was also the clinical governance lead across the whole PCT. Where this was not the case (43%), some 2-11% reported a specific job title of Director of or Head of Clinical Governance or Clinical Governance Lead. General Practitioner (8%) was the only other job group to emerge as a significant player as having Clinical Governance Lead responsibility.

Implementation

Respondents were asked to identify the extent to which clinical governance implementation was hampered by time, other resources and lack of information (**Table 4.2**).

Table 4.2 Constraints upon the Organisation Implementing Clinical Governance

	Not at all				Very much	
	1	*2*	*3*	*4*	*5*	
lack of time	8.8%	41.3%	30.0%	15.0%	2.5%	*[6]*
lack of resources	7.9%	37.5%	31.7%	16.7%	4.2%	*[5]*
lack of appropriate information	28.8%	36.7%	22.5%	8.3%	0.8%	*[7]*

missing datapoints

The data suggests that time and resources present a marginally greater constraint than information, although none of these posed more than moderate difficulties for the majority of respondents.

Summary Conclusions

- Most executive directors with responsibility for clinical governance in PCTs have clinical roles;
- PCTs in which the clinical governance director lacks HR or commissioning experience may face difficulties in developing clinical governance arrangements that are consistent with the enhanced role of PCT commissioning as envisaged in C*ommissioning a Patient-Led NHS.* Currently, only 11% of directors with responsibility for clinical governance are directors of HR, and only 6% are directors of commissioning;
- While time and resources present a marginally greater constraint to implementation than lack of information, none of these posed more than moderate difficulties for the majority of respondents

5. Usefulness of guidance and support

Experience of external reviews

84 (35%) of PCTs reported receiving a CHI review in the last three years. Additionally, respondents were requested to identify the perceived effectiveness of CHI reviews, 'stars' and CNST reviews in driving clinical governance forward. These were typically regarded as largely positive with the CNST scheme as seen as especially helpful (**Table 5.1**).

208 (87.1%) respondents indicated specific targets for demonstrating improvements in clinical governance had been set.

If respondents had answered 'yes' to C4 (*Has your trust set any specific targets for clearly demonstrating improvements in clinical governance?*), they were asked to specify in their own words what these targets were. These open responses were coded and the results are shown in the box below.

28 [11.7%] gave no answer
109 [45.4%] one answer & 103 [42.9%] gave more than one answer

Targets are mainly associated with….

Action plans	**144 [60.0%]**
Local & national standards	**74 [30.8%]**
Clinical performance indicators & targets	**63 [26.3%]**
Quality & service	**21 [8.8%]**
Staff development & inter-professional working	**17 [7.1%]**
Contracting & commissioning	**13 [5.6%]**
Specific initiatives	**6 [2.5%]**

Table 5.1 Usefulness of External Reviews

	Not at all effective 1	2	3	4	Extremely effective 5	
CHI Review	0.0%	1.3%	7.5%	18.3%	7.9%	*[156]*
NHS CNST	0.4%	5.8%	17.5%	48.8%	17.1%	*[25]*
NHS Performance Reviews ('Stars')	3.8%	18.8%	28.3%	23.3%	10.8%	*[36]*
Other	0.0%	2.9%	10.4%	20.0%	6.7%	*[144]*

missing datapoints

PCTs were asked about the support and monitoring received in implementing clinical governance from the Department of Health, their Strategic Health Authority and their participation in Clinical Governance Support Team events. The overall usefulness of these systems was also assessed, and responses are presented in **Table 5.2** below. Results indicate that a majority of respondents identified both the DH and SHAs as providing helpful support for clinical governance implementation (73% and 82% respectively), although its usefulness was judged a little less favourably, with over 40% of respondents indicating only moderate usefulness. A similar picture is indicated for the performance monitoring undertaken by respondents' - SHAs; largely viewed positively but with room for some improvement.

The more specialist support developed by the Clinical Governance Support Team (CGST) was also considered, and was shown to have been widely known and generally well regarded. The Board Development Programme had been undertaken by 39% of respondents and well regarded by participants. Of the wider CGST programme, half of all respondents indicated some involvement, and again these were judged favourably. Respondents were also asked to identify other types of assistance, guidance and support not currently provided, and these are identified below.

Qu E6 was an open question *("What other types of assistance, guidance or support would be useful"*) and the results were coded and are shown in the box below.

91 [37.9%] gave no answer
103 [42.9%] one answer & 46 [19.2%] gave more than one answer

Specific Assistance:

Examples of good/best practice, model sharing & templates	**37 [15.4%]**
Benchmarking/guidelines/care standards	**12 [5.0%]**
Workshops/forums/virtual forums	**9 [3.8%]**
Areas of roles & responsibility	**6 [2.5%]**
Practitioner level guidance in specific areas (prison/pharmacy/etc)	**4 [1.7%]**
Documents/publications & helplines	**3 [1.3%]**
Clinical governance development programme	**3 [1.3%]**

General Assistance:

Regional/local practical support	**15 [6.3%]**
Resources (rather than guidance)	**5 [2.1%]**
Development/training (website/other more user friendly)	**5 [2.1%]**
Involvement of service users/patient led NHS	**2 [0.8%]**

Raising Awareness/Understanding:

General Support/guidance	**28 [11.7%]**
Integrated governance "that fits together"/Risk management	**23 [9.6%]**
Healthcare standards/national framework/policy	**20 [8.3%]**
Commissioning for quality	**10 [4.2%]**
Maintaining networks	**6 [2.5%]**
Request for timely guidance rather than specific content	**5 [2.1%]**
Time for CG to embed/reduction in monitoring & bureaucracy	**4 [1.7%]**
Learning from incidents/accidents/complaints	**2 [0.8%]**

Summary Conclusions

- Experience of external review systems such as the CNST scheme and CHI reviews is typically reported as positive;
- A majority of respondents identified DH (73%) and SHA (82%) support as helpful;
- Specialist support provided by the CGST such as the Board Development Programme for Clinical Governance had been reasonably widely used (39%) and was generally well regarded

Table 5.2

			Usefulness					
			Not at all useful				Extremely useful	
			1	*2*	*3*	*4*	*5*	
Is the Department of Health providing helpful support in implementing clinical governance?	Yes 175 (72.9%)	No 53 (22.1%)	2.5%	16.7%	40.0%	25.4%	3.3%	*[26]*
Is the Strategic Health Authority providing useful support in terms of PCTs developing effective clinical governance systems?	Yes 197 (82.1%)	No 36 (15.0%)	3.3%	13.8%	34.2%	32.5%	7.9%	*[20]*
Does the Strategic Health Authority monitor performance of PCTs in terms of implementing clinical governance?	Yes 230 (95.8%)	No 7 (2.9%)	3.0%	13.3%	34.5%	29.6%	8.8%	*[23]*
Has your PCT participated in the NHS Clinical Governance Support Team (CGST) Board Development Programme (ie the Strategic Leadership of Clinical Governance in PCTs programme?	Yes 94 (39.2%)	No 140 (58.3%)	0.4%	2.1%	9.6%	15.0%	8.3%	*[155]*
Has your PCT participated in other programmes offered by the CGST (eg recent virtual workshop on 'The Draft Declaration on Standards Compliance and the CG role'?)	Yes 119 (49.6%)	No 117 (48.8%)	0.8%	2.5%	11.7%	13.8%	10.0%	*[147]*

missing datapoints

6. Structures and processes for clinical governance

The study sought to identify the available structures and organisational arrangements for implementing and managing a range of clinical governance arrangements; the ability of structures to manage risks to service delivery and improve patient experience; and the organisational level at which structures were available (practice level, PCT-wide and/or across multiple PCTs).

Available structures and organisational arrangements for clinical governance

The overwhelming majority of respondents indicated the existence of structures and processes for each of the identified aspects of clinical governance considered below, including clinical leadership, risk management, clinical audit, patient involvement, and service improvement. A similarly high proportion of respondents identified the existence of a named lead member of staff. A small number of aspects, including use of 'intelligent information' in clinical care and effective clinical leadership, were less often supported by written strategies; however, structures and processes, in the sense of institutional working practices, were still identified as present.

Table 6.1 Structures and organisational arrangements for clinical governance

Aspects of Clinical Governance	Is there a written strategy in place?		Is there a named lead?		Are structures & processes in place	
	Yes (n)	%	Yes (n)	%	Yes (n)	%
Ensuring effective clinical leadership	164	68.3	230	95.8	230	95.8
Maintaining the capability and capacity to deliver services	184	76.7	220	91.7	221	92.1
Pro-actively identifying clinical risks to patients and staff	234	97.5	236	98.3	236	98.3
Collecting and using 'intelligent information' on clinical care	125	52.1	106	85.8	216	90.0
Involving professional groups in multi-professional clinical audit	210	87.5	227	94.6	229	95.4
Involving patients and public in the design and delivery of PCT services	227	94.6	237	98.8	236	98.3
Ensuring the quality of the patient experience	179	74.6	226	94.2	229	95.4
Improving services based on lessons from complaints	221	92.1	235	97.9	236	98.3
Improving services based on lessons from patient safety incidents / near misses	230	95.8	238	99.2	235	97.9

Effectiveness of available structures and processes

While the existence of formal governance processes and accountabilities for areas of practice are important, they are only valuable to the extent that individuals in the workplace enact them. Thus respondents were asked to assess the ability of available structures and processes to manage risks to service delivery and improve patient experience. Each was scored between 1 (i.e. completely ineffective) and 7 (i.e. fully effective). Results indicate moderate to good ability in both risk management and improving patient experience across all aspects, with slightly better perceived effectiveness in use of safety incidents in improving services than using intelligent information in patient care (**Table 6.2**).

Table 6.2 Overall Effectiveness of Available Structures and Processes

	Managing service risks		Improving patient experience	
	Mean	**SD**	**Mean**	**SD**
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
Pro-actively identifying clinical risks to patients and staff	5.66	0.79	5.31	0.95
Collecting and using 'intelligent information' on clinical care	4.56	1.20	4.39	1.26
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
Ensuring the quality of the patient experience	4.89	1.13	5.08	1.08
Improving services based on lessons from complaints	5.57	0.92	5.48	0.94
Improving services based on lessons from patient safety incidents / near misses	5.62	0.91	5.34	0.98

Levels at which structures are available

We were interested in the extent to which PCTs had both sub-PCT level structures to support their clinical governance work, and also structures spanning multiple PCTs that could form the basis of clinical governance frameworks post reconfiguration. To explore this issue, respondents were asked to identify all of the levels (practice, PCT, and across multiple PCTs) at which structures were available for addressing the aspects of clinical governance identified above (see **Table 6.3**).

Respondents identified the PCT as the organisational unit most likely to contain explicit structures for each of the aspects of clinical governance, with between 79% and 93% of respondents identifying structures for the various aspects at that level. Rather less well supported structurally was the underpinning at sub-PCT level, with 40% and 51% of respondents indicating structures at that level. Least of all developed were structures spanning multiple PCTs, with between 21% and 39% of respondents identifying such structures. This is not to suggest that structures are required for each aspect at each level – indeed, governance arrangements are likely to be required at different levels for the different aspects, and the principle of subsidiarity may usefully be applied here, so that functions should be devolved to the lowest level where they can be effectively discharged. Results indicate that at present, the PCT level seems to be the 'primary' level at which clinical governance is being discharged. This may become difficult to sustain in the context of a reduced provider role for PCTs and the requirement for commissioners to shape (and internally manage) emerging markets.

Table 6.3 Levels at which Structures are available

	Multiple PCTs		PCT-wide		Sub PCT level	
	Yes (n)	%	Yes (n)	%	Yes (n)	%
Ensuring effective clinical leadership	65	27.1	212	88.3	123	51.3
Maintaining the capability and capacity to deliver services	77	32.1	197	82.1	104	43.3
Pro-actively identifying clinical risks to patients and staff	64	26.7	212	88.3	120	50.0
Collecting and using 'intelligent information' on clinical care	84	35.0	189	78.8	99	41.3
Involving professional groups in multi-professional clinical audit	93	38.8	202	84.2	110	45.8
Involving patients and public in the design and delivery of PCT services	62	25.8	220	91.7	104	43.3
Ensuring the quality of the patient experience	50	20.8	212	88.3	94	39.2
Improving services based on lessons from complaints	65	27.1	221	92.1	103	42.9
Improving services based on lessons from patient safety incidents / near misses	75	31.3	223	92.9	114	47.5

Summary Conclusions

- An overwhelming majority of PCTs have structures, process and lead members of staff for clinical leadership, capacity, risk management, multi-professional audit, public involvement, care quality and service improvement;
- In terms of the perceived effectiveness of each of these structures and processes, respondents identified moderate to good ability in risk management and improving patient experience across each of the above elements;
- Respondents identified the PCT as the organisational unit most likely to contain explicit structures for each of the elements identified above (between 79% and 93% for specific elements). Structures were available at sub-PCT level in between 40% to 51% of PCTs depending on the element, and at the Pan-PCT level in only 21% - 39% of PCTs;
- Lack of Pan-PCT arrangements and concentration at the PCT level may require considerable redesign of clinical governance arrangements as a results of reconfiguration and an enhanced duty for PCTs to shape (and internally mange) emerging markets of multiple providers.

7. Progress on issues related to 'Standards for Better Health'

The study identified a range of issues related to clinical governance with direct relevance to the core of the Healthcare Commission's regulatory framework, the *Standards for Better Health* core standards. For each, we considered the existence of an implementation plan and named responsible individual; and an estimation of current coverage of the standard. (see **Table 7.1** below)

Table 7.1 *Standards for Better Health* Core Standards implementation

	Is there an implementation plan?		Is there a named lead with responsibility for implementation?	
	Yes	**No**	**Yes**	**No**
1. Ensuring compliance with CPD requirements	87.1%	11.7%	95.4%	2.9%
2. Supporting arrangements for appraisal of clinical staff	94.6%	4.6%	98.3%	0.4%
3. Developing performance and development review for staff	93.0%	3.8%	96.3	0.8%
4. Developing leadership at every level of the organisation	75.4%	23.3%	91.3%	7.9%
5. Supporting development of multi-disciplinary care	64.2%	33.8%	83.3%	14.2%
6. Developing wider PEC understanding of clinical governance	64.2%	33.3%	91.7%	6.3%
7. Ensuring effective clinical risk strategies	97.1%	2.1%	98.3%	0.8%
8. Promoting reporting of errors & adverse incidents	97.9%	1.3%	98.3%	0.4%
9. Acting on patient feedback and complaints	96.7%	2.1%	98.3%	0%
10. Ensuring effective infection control	98.3%	0.8%	97.9%	0.8%
11. Providing clear guidance on medicines management	94.2%	4.2%	97.9%	0.4%
12. Supporting access to NSF guidance	81.3%	18.3%	95.8%	2.5%
13. Providing information on Evidence based practice	77.9%	20.8%	92.9%	4.2%
14. Developing protocols and guidelines for clinical care	83.3%	16.3%	94.6%	4.2%
15. Facilitating local health and social care agency influence over governance issues	60.4%	35.4%	79.6%	15.4%
16. Sustaining local strategic partnerships	89.6%	8.8%	95.8%	0.8%
17. Developing shared vision with collaborating organisations	80.8%	16.7%	90.4%	5.4%
18. Involving local communities in the PCT	92.1%	5.0%	94.6%	2.1%
19. Ensuring use of QOF data in making service improvements	72.1%	25.4%	94.6%	2.9%
20. Promoting multi-disciplinary audit against national standards	87.9%	11.3%	95.0%	4.2%
21. Supporting commissioning for quality	66.3%	31.3%	92.5%	5.4%
22. Ensuring that commissioning arrangements take account of clinical risk	62.5%	33.3%	89.6%	6.3%
23. Benchmarking commissioning against other organisations	41.3%	51.7%	72.9%	20.8%
24. Developing practice-based commissioning	96.7%	2.1%	98.3%	0.4%
25. Benchmarking provision against other agencies	45.8%	47.1%	66.7%	27.1%
26. Ensuring that public health informs PCT policy	92.9%	5.4%	97.9%	0%

Implementation plan and named lead individual

For the most part, aspects of the implementation plan (**Table 7.1**) are in place but there are some relatively low (or weak) areas that certainly should be the target for future improvement, and these are identified in the box below. Crucially, many of these areas reflect inter-agency collaboration and commissioning, areas that will need to be substantially strengthened if reconfigured PCTs are to discharge an enhanced commissioning role requiring them to shape and manage markets of multiple primary care providers.

Areas to target future improvement activity

No. 5	Supporting development of multi-disciplinary clinical care
No. 6	Developing wider PEC understanding of clinical governance
No. 15	Facilitating local health and social care agency influence over governance issues
No. 21	Supporting commissioning for quality
No. 22	Ensuring that commissioning arrangements take account of clinical risk
No. 23	Benchmarking commissioning against other organisations
No. 25	Benchmarking provision against other agencies

Coverage and achievement

Coverage and achievement are considered in **Table 7.2** below. There would appear to be key issues around item 4 'Developing leadership at every level in the organisation' which is estimated at only 37%, item 16 'Sustaining local strategic partnerships (65%), item 18 'Involving local communities in the PCT (66%), item 20 'Promoting multi-disciplinary audit against national standards (61%), item 22 'Ensuring that commissioning arrangements take account of clinical risk (63%), item 23 'Benchmarking commissioning against other organisations (50%), item 24 'Developing practice based commissioning (48%) and item 25 'Benchmarking provision against other organisations (48%). As with implementation above, those aspects of clinical governance with the poorest coverage and perceived effectiveness included those concerned with commissioning for quality and the policy environment heralded by *Commissioning a Patient-Led NHS* to require urgent attention.

Summary conclusions

- While in terms of implementation planning many of the *Standards for Better Health* core standards relating to clinical governance appear to be in place, comparatively weaker areas for future improvement reflect aspects of inter-agency collaboration and commissioning (e.g. ensuring that commissioning arrangements take account of clinical risks; supporting commissioning for quality; and facilitating health and social care agency influence over governance issues;
- In terms of coverage and achievement, relatively weak areas include leadership development, sustaining strategic partnerships, developing practice-based commissioning. As with implementation, the aspects with poorest coverage and lowest perceived effectiveness included those aspects concerned with commissioning for quality

Table 7.2 *Standards for Better Health* Core Standards coverage and achievement

	Coverage (%)	Achievement			
		Managing risk		Patient experience	
		Mean	SD	Mean	SD
1. Ensuring compliance with CPD requirements	86.2	5.3	1.0	5.0	1.1
2. Supporting arrangements for appraisal of clinical staff	79.7	5.2	1.0	4.9	1.1
3. Developing performance and development review for staff	75.0	5.1	1.0	4.8	1.1
4. Developing leadership at every level of the organisation	37	4.7	1.1	4.6	1.2
5. Supporting development of multi-disciplinary care	77.2	5.1	0.9	5.2	0.9
6. Developing wider PEC understanding of clinical governance	88.6	5.3	1.1	5.1	1.1
7. Ensuring effective clinical risk strategies	95.9	5.8	0.9	5.3	1.0
8. Promoting reporting of errors & adverse incidents	98.0	5.8	0.8	5.4	1.0
9. Acting on patient feedback and complaints	99.1	5.8	0.8	5.7	0.9
10. Ensuring effective infection control	98.1	5.8	0.8	5.5	1.0
11. Providing clear guidance on medicines management	96.9	5.7	0.9	5.4	1.0
12. Supporting access to NSF guidance	94.4	5.1	0.9	5.1	1.0
13. Providing information on Evidence based practice	91.6	5.1	1.0	4.9	1.1
14. Developing protocols and guidelines for clinical care	84.7	5.4	0.9	5.1	1.0
15. Facilitating local health and social care agency influence over governance issues	73.4	4.7	1.2	4.7	1.2
16. Sustaining local strategic partnerships	66.1	5.1	1.0	5.1	1.0
17. Developing shared vision with collaborating organisations	75.8	5.0	1.0	5.0	1.0
18. Involving local communities in the PCT	67.0	4.8	1.0	5.1	1.0
19. Ensuring use of QOF data in making service improvements	82.2	5.2	1.1	5.1	1.1
20. Promoting multi-disciplinary audit against national standards	61.4	4.8	1.1	4.7	1.1
21. Supporting commissioning for quality	67.2	4.6	1.1	4.5	1.1
22. Ensuring that commissioning arrangements take account of clinical risk	62.7	4.5	1.3	4.3	1.3
23. Benchmarking commissioning against other organisations	50.1	4.0	1.4	3.9	1.4
24. Developing practice-based commissioning	48.4	4.2	1.5	4.1	1.4
25. Benchmarking provision against other agencies	47.8	4.0	1.4	3.9	1.4
26. Ensuring that public health informs PCT policy	80.9	5.0	1.0	4.9	1.1

8. Chief executives' perspectives on progress in clinical governance

Chief Executives were asked to identify both the relative importance of, and the level of achievement of their PCT against, the OPCG competencies as outlined in the methodology section. These competency statements concern a series of organisational competencies related to clinical governance. Average ratings provided by the Chief Executive of each PCT are shown on **Table 8.1**, where A% refers to the 'Shortfall of Achievement' (perceived importance – perceived achievement rating expressed as a percentage), and I% refers to the importance rating attached to each item (expressed as a percentage). Thus for example item 5 (at the bottom) is seen as very important – 94% - but as 84% suggest that this is achieved the 'Shortfall in Achievement' is low (16%). For each individual PCT rating the derived A% and I% ratings have been multiplied together and then divided by 100 to make an individual risk rating for each item in each PCT. These have then been averaged to produce an overall risk assessment across all PCTs (R%). Items in the table are ordered in terms of decreasing risk (R%), so that items at the top may be considered as most in need of attention.

Interestingly, items indicated as requiring the most urgent action according to the risk index include the quality improvement of commissioning functions and inter-organisational joint-working on clinical governance, as indicated in the previous section on coverage and achievement of Standards for Better Health Core Standards. While respondents accorded these items only moderate importance (which is interesting given the new policy context) their high risk index was due to high achievement shortfalls. While the data clearly indicates the importance of the commissioning agenda, this only becomes apparent once relative importance and perceived achievement shortfalls are taken into account. It should be noted that despite the urgency of development of both joint working and commissioning aspects of clinical governance, their moderate relative perceived importance may mean that they could become overlooked, with attention diverted to areas perceived as more important with greater perceived achievement.

Summary conclusions

- CEO's rating of the importance of, and achievement against, a range of organisational clinical governance competencies reveals that the areas with greatest perceived risk to progress include training in EBP, benchmarking of commissioning practices, joint working between health and social care agencies, and leadership development;
- Areas identified as posing moderate risk to progress included care pathways development and quality improvement activity in service delivery;
- Risk management and appraisal activities, while judged as very important, were seen as less of a risk to progress given high levels of perceived achievement;
- The moderate relative perceived importance of benchmarking for commissioning may mean that it could become overlooked, with attention diverted to areas perceived as more important yet with greater perceived achievement

Table 8.1

Average 'Achievement Shortfall' (A%), Average 'Importance' (I%) & 'Average Perceived Risk to Progress' (R%) for all PCTs.

(Section H: Questionnaire A)*

High

'Risk to Progress' rank order

Low

		A%	I%	R%
4	Staff are trained in evidence-based practice	47.52	83.95	39.06
16	Staff benchmark commissioning against other PCTs	53.65	76.73	38.96
21	Local health and social care agencies work jointly on clinical governance issues	49.25	81.80	38.81
43	Staff benchmark provision against other PCTs	48.81	80.09	37.68
2	Leadership skills are developed at every level	43.83	87.64	37.63
25	Clinical indicators are used to review services	43.77	86.14	36.69
24	Staff are trained in clinical audit	45.68	82.76	36.61
29	Service users are involved in service development	40.36	91.40	36.09
11	Published research is used to inform quality improvement	42.80	83.85	35.08
17	Staff modify their care processes to reflect emerging 'best practice'	39.65	88.36	34.21
40	Service improvement activity focuses on the patient experience of care	37.85	91.16	33.54
35	Clinical teams respond to changes in their environment by reorganising their work processes	38.38	88.64	33.39
31	Care pathways are developed with colleagues in secondary care	36.61	91.39	32.83
10	There are clear criteria for establishing user involvement groups	42.37	82.25	32.71
14	Staff share common objectives	38.76	86.80	32.49
18	Service delivery plans include quality improvement activity	37.16	89.56	32.49
3	Organisation-wide clinical governance systems are underpinned by local systems	37.18	88.70	32.31
28	Training identified in staff development plans matches individual needs to organisational needs	37.05	89.08	31.99
12	Clinical audit topics are selected according to their potential impact on care quality	38.03	86.74	31.61
8	Primary care clinical staff work as a multi-disciplinary team	35.78	89.85	31.55
9	The Local Medical Committee (LMC) are involved in clinical governance	49.46	70.63	31.41
38	New skills obtained through development activity are used	37.31	86.25	31.34
33	All staff are appraised against an agreed work and development programme	36.32	88.78	31.23
7	Staff are trained in the use of risk management systems	34.85	91.33	31.22
41	Clinical leads use professional networks to build support for clinical governance	35.78	85.96	29.83
37	Clinicians use professional networks to identify emerging 'best practice'	34.81	87.40	29.49
6	Staff appraisal is used as an opportunity to reflect on progress and plan future development	32.10	90.58	28.39
32	Partnerships with local health and social care agencies have shared purposes	31.62	91.14	28.18
22	There is a common vision for clinical governance	31.96	89.89	28.07
15	Following identification of a problem from complaints data, clinical quality is improved	30.90	92.32	27.92
20	NSF implementation is integrated with business planning and quality improvement programmes	32.26	88.97	27.81
23	Clinical issues are not dominated by any single profession	31.38	89.72	27.46
1	There is a 'fair and just culture' around reporting adverse events and near misses	28.87	94.48	27.00
26	All staff development plans identify training opportunities	31.21	89.39	26.86
13	Evaluation of adverse events are used to improve service quality	28.09	94.62	26.05
30	There is an annual staff appraisal process for most staff	26.40	94.86	24.60
39	Clear action plans are developed in response to identified clinical risks	26.10	94.64	24.22
19	There are local arrangements to collate information for the clinical governance committee	28.15	87.82	23.76
42	There are clear management processes for addressing underperformance by clinical staff	25.53	94.94	23.53
36	Local and national priorities are used to priorities service development	26.02	91.19	23.12
34	There is an executive director with responsibility for developing the clinical governance agenda	17.99	95.80	16.64
27	There is a formal clinical governance committee, reporting to the board	16.75	96.28	15.66
5	There is a nominated clinical lead for clinical governance	16.15	94.90	15.16

* Based on full responding PCT sample (n = 240; 81% coverage)

9. Impact of clinical governance on the quality of patient care

Asked whether the implementation of clinical governance had delivered clear benefits to the quality of patient care, 195 (82%) said 'yes' with none endorsing that there had been 'no measurable impact'. In terms of whether clinical governance had delivered efficiency savings the picture was less positive with only 20% saying 'yes', 66% 'maybe, but not fully assessed', and 12% saying 'no'. If respondents answered 'yes' to this question they were asked to provide examples in their own words. These open-ended responses were coded and the results are shown in the box below.

136 [56.7%] gave no answer
79 [32.9%] one answer & 25 [10.4%] gave more than one answer

Prescription management	
Cost effective/streamlined prescribing	**31 [12.9%]**
Equipment/prosthetics management	**3 [1.3%]**
Risk management	
Litigation reduction	**8 [3.3%]**
More systematic use of resources	**8 [3.3%]**
Reducing infection rate	**6 [2.5%]**
Reduction of incidents/near-misses	**5 [2.1%]**
Complaints reduction	**2 [0.8%]**
Secondary care use	
Reduction in unnecessary hospital attendance	**11 [4.6%]**
Improved referral/appointment systems	**6 [2.5%]**
Service Redesign	
Specific initiatives (eg podiatry, mental health etc)	**11 [4.6%]**
Clinical audit/best practice	**9 [3.8%]**
Patient care pathways	**8 [3.3%]**
Commissioning/implementing services	**5 [2.1%]**
Evidence-based practice	**3 [1.3%]**
Resource Issues	
Staff utilisation & training	**11 [4.6]**
Cost savings not a CG goal	**9 [3.8%]**
Clinical governance implementation	**5 [2.1%]**
Effective information use	**1 [0.4%]**

10. Board and PEC perspectives on progress in clinical governance

In this part of the survey Questionnaire B, (a slightly shortened version of the OPCG discussed above) was distributed to the remaining members of the PCT Board and to members of the PEC Committee. The patterns of respondents for the PCT Board and PEC Committee (**Table 10.1**) and for the PEC Committee only (**Table 10.2**) are shown below. Together, these reveal that a little over 1/3 (34%) of respondents were PEC members, around ¼ were Non-Executive Directors; around 1/5 (22%) were Executive Directors and the remainder were Chairs and/or Managers. Of those who were PEC members the largest professional groups were GPs (29%), nurses (25%) and AHPs (11%).

Table 10.1 Sample Composition – PCT Board & Professional Executive Committee

	freq	*%*
PEC Members	1120	34.6
Chair/Vice Chair	340	10.5
NED (Non Executive Directors)	855	26.4
Head/Manager	98	3.0
Director (Finance/HR/PH/Nursing/Services etc)	708	21.9
no information provided	*116*	*3.6*
Total	**3237**	**100.0**

Table 10.2 Sample Composition – PEC Members

	freq	*%*
GP/Medic	327	29.2
AHP representative	123	11.0
Pharmacy/Prescribing represenative	77	6.9
Nurse representative	278	24.8
Practice Manager representative	29	2.6
Dental representative	44	3.9
Clinical Governance Lead	53	4.7
Ophthalmic representative	20	1.8
no specific information provided	*169*	*15.1*
Total	**1120**	**100.0**

PEC and Board respondents' perceptions of achievement in clinical governance

Table 10.3 identifies perceived achievement in 20 clinical governance competencies drawn from the OPGC measure used in full in section 8 above. Respondents were asked to rate their PCT's achievement in each item on a 7 point scale. Items are reported arranged in ascending order of perceived achievement. As we were keen to explore differences in perceived achievement in clinical governance competencies between PEC and board members, **Table 10.3** additionally reports a cumulative presentation of the position of each group on the items across all PCTs. Thus on item 1 'Adverse incidents and errors can be freely reported without fear of reprisal', Managers and Directors agree with this quite strongly, but Chairs, Non-Executive Directors and finally PEC Committee members disagree significantly. There is a significant difference between the staff groups when the shading of the grouping changes on the cumulative display. Largely it can be see that it is the PEC members who are least positively disposed to the items. However one must be cautious as the maximum and minimum scores are not always very discrepant and although a statistically significant difference means the difference is 'real' it does not always mean that the difference is important.

Table 10.3 Progress in clinical governance as perceived by all respondents (n= 3237) categorised into 5 groups on the basis of job position / title

In this PCT……..	stronger agreement →					Range based on mean ratings for 5 groups	
						min	*max*
11 Commissioning is benchmarked against other PCTs	Dir	PEC	NED	Ch	H/M	*4.50*	*4.93*
10 Service provision is benchmarked against other PCT providers	Dir	PEC	NED	H/M	Ch	*4.52*	*4.80*
19 Leadership skills are developed at every level	PEC	H/M	Dir	NED	Ch	*4.92*	*5.23*
14 Service users are involved in service development	PEC	H/M	Ch	Dir	NED	*4.94*	*5.24*
17 Underperformance by clinical staff is addressed by clear management procedures	PEC	NED	Ch	Dir	H/M	*4.94*	*5.63*
3 Information to support evidence based medicine is available and easily accessible	Dir	NED	H/M	PEC	Ch	*4.99*	*5.24*
15 Care pathways are developed in collaboration with those in secondary care	PEC	NED	Ch	Dir	H/M	*5.02*	*5.49*
4 All staff are appraised against an agreed work and development programme	PEC	H/M	Dir	NED	Ch	*5.09*	*5.48*
12 Local health and social care agencies work closely together	PEC	Ch	NED	Dir	H/M	*5.13*	*5.78*
13 Performance indicators and clinical outcomes are used to review services	PEC	Dir	H/M	Ch	NED	*5.24*	*5.67*
9 Patient feedback and complaints guide clinical quality improvements	PEC	Ch	NED	Dir	H/M	*5.27*	*5.84*
16 Clear action plans are developed in response to clinical risks	PEC	Dir	Ch	NED	H/M	*5.36*	*5.82*
6 Clinical audit is a key part of the clinical risk management strategy	PEC	Dir	Ch	H/M	NED	*5.39*	*5.92*
20 We have effective leadership	PEC	Dir	H/M	Ch	NED	*5.46*	*5.96*
7 Clinical audit is used to improve patient care	PEC	Dir	Ch	NED	H/M	*5.47*	*5.85*
5 Clinical care is managed and delivered using multidisciplinary teamwork	PEC	Ch	Dir	H/M	NED	*5.52*	*5.74*
18 All PEC members clearly understand the implications of clinical governance issues	Dir	NED	PEC	Ch	H/M	*5.57*	*5.90*
8 Errors and adverse events are monitored and evaluated to improve services	PEC	Ch	NED	Dir	H/M	*5.62*	*6.12*
2 Clinical governance systems provide assurance to the PCT Board	PEC	Ch	NED	Dir	H/M	*5.72*	*6.14*
1 Adverse incidents and errors can be freely reported without fear of reprisal	PEC	NED	Ch	Dir	H/M	*5.77*	*6.43*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

KEY:
PEC = PEC Members (n = 1120)
CH = Chair/Vice Chair (n = 340)
NED = Non Executive Directors (n = 855)
H/M = Head/Manager (n = 98)
Dir = Director [Finance/HR/PH/Nursing etc](n = 708)

PEC Committee members were then disaggregated into specific staff groups and the same cumulative data is presented (**Table 10.4**). This indicates that GPs consistently gave the lowest scores than other PEC members on virtually all of the OPCG items, other than item 10 'service provision is benchmarked against other providers'.

Table 10.4 Progress in clinical governance as perceived by PEC members (n = 1120) further categorised into 8 sub-categories

In this PCT……..	stronger agreement →									Range based on mean ratings for 8 groups	
										min	*max*
11 Commissioning is benchmarked against other PCTs	CGL	GP	AHP	PM	Nrs	Dnt	Phm	Opth	*ns*	*4.19*	*4.90*
10 Service provision is benchmarked against other PCT providers	AHP	PM	CGL	Dnt	GP	Nrs	Phm	Opth		*4.33*	*5.15*
19 Leadership skills are developed at every level	GP	Dnt	Phm	CGL	AHP	Opth	PM	Nrs		*4.62*	*5.29*
17 Underperformance by clinical staff is addressed by clear management procedures	GP	PM	Phm	Opth	AHP	Dnt	Nrs	CGL		*4.64*	*5.70*
15 Care pathways are developed in collaboration with those in secondary care	Dnt	AHP	GP	PM	Phm	Nrs	CGL	Opth		*4.73*	*5.55*
3 Information to support evidence based medicine is available and easily accessible	Opth	Dnt	AHP	GP	CGL	PM	Nrs	Phm		*4.74*	*5.64*
14 Service users are involved in service development	GP	PM	AHP	CGL	Dnt	Nrs	Phm	Opth		*4.75*	*5.20*
4 All staff are appraised against an agreed work and development programme	Dnt	Phm	GP	Opth	AHP	CGL	Nrs	PM	*ns*	*4.83*	*5.29*
12 Local health and social care agencies work closely together	GP	Dnt	Phm	CGL	AHP	PM	Opth	Nrs		*4.84*	*5.41*
13 Performance indicators and clinical outcomes are used to review services	AHP	Dnt	GP	PM	CGL	Nrs	Phm	Opth		*4.89*	*5.60*
9 Patient feedback and complaints guide clinical quality improvements	Dnt	GP	PM	Phm	AHP	Opth	CGL	Nrs		*4.93*	*5.54*
16 Clear action plans are developed in response to clinical risks	GP	Dnt	Phm	AHP	Opth	Nrs	CGL	PM		*5.06*	*5.69*
6 Clinical audit is a key part of the clinical risk management strategy	GP	CGL	AHP	Phm	Dnt	PM	Nrs	Opth		*5.17*	*5.95*
8 Errors and adverse events are monitored and evaluated to improve services	Dnt	GP	Phm	Opth	PM	AHP	CGL	Nrs		*5.18*	*5.97*
20 We have effective leadership	GP	AHP	Dnt	Phm	Nrs	PM	CGL	Opth		*5.20*	*6.00*
5 Clinical care is managed and delivered using multidisciplinary teamwork	Dnt	Phm	GP	AHP	CGL	Nrs	PM	Opth		*5.27*	*6.00*
7 Clinical audit is used to improve patient care	GP	CGL	AHP	Dnt	Phm	PM	Nrs	Opth		*5.28*	*5.70*
18 All PEC members clearly understand the implications of clinical governance issues	Dnt	GP	Opth	CGL	AHP	Phm	PM	Nrs		*5.41*	*6.11*
2 Clinical governance systems provide assurance to the PCT Board	Dnt	GP	AHP	Phm	Opth	PM	Nrs	CGL		*5.43*	*6.06*
1 Adverse incidents and errors can be freely reported without fear of reprisal	Dnt	Phm	GP	PM	Opth	AHP	CGL	Nrs		*5.45*	*6.03*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

KEY:
GP = GP/medic (n = 327)
AHP = AHP rep (n = 123)
Phm = Pharmacy/Prescribing (77)
Nrs = Nurse rep (n = 278)
PM = Practice Manager (n = 29)
Dnt = Dental rep (n = 44)
CGL = Clinical Governance Lead (n = 53)
Opth = Ophthalmic rep (n - 20)

A factor analysis of the reduced set of OPCG items above was conducted, identifying two strong stable factors (**Table 10.5**). Factor I appears to relate to internal procedures, whilst Factor 2 appears related to external systems. As earlier sections of the report have suggested, this data from PEC and board members supports the idea that these latter competencies seem rather less well developed.

Table 10.5 Two Independent Factors Extracted Through Factor Analysis of Questionnaire B Ratings (PC Extraction + Varimax Rotation)

Factor 1: Internal Assurance (variance explained 47.3%)

	In this PCT…….. (disagree/agree with following items)	F1 Factor Loading
8	Errors and adverse events are monitored and evaluated to improve services	0.797
2	Clinical governance systems provide assurance to the PCT Board	0.747
1	Adverse incidents and errors can be freely reported without fear of reprisal	0.738
16	Clear action plans are developed in response to clinical risks	0.726
9	Patient feedback and complaints guide clinical quality improvements	0.697
7	Clinical audit is used to improve patient care	0.689
6	Clinical audit is a key part of the clinical risk management strategy	0.675
17	Underperformance by clinical staff is addressed by clear management procedures	0.647
20	We have effective leadership	0.634
5	Clinical care is managed and delivered using multidisciplinary teamwork	0.623
18	All PEC members clearly understand the implications of clinical governance issues	0.596
19	Leadership skills are developed at every level	0.566
4	All staff are appraised against an agreed work and development programme	0.551
15	Care pathways are developed in collaboration with those in secondary care	0.463
12	Local health and social care agencies work closely together	0.443
3	Information to support evidence based medicine is available and easily accessible	0.433

Factor 2: External Assurance (variance explained 6.4%)

	In this PCT…….. (disagree/agree with following items)	F2 Factor Loading
11	Commissioning is benchmarked against other PCTs	0.860
10	Service provision is benchmarked against other PCT providers	0.842
13	Performance indicators and clinical outcomes are used to review services	0.605
14	Service users are involved in service development	0.489

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Summary conclusions

- PEC and Board members indicated moderate to good achievement against 20 organisational competencies selected from the full OPCG measure reported for CEOs in section 8 above. Least achievement was indicated for commissioning being benchmarked against other PCTs, leadership skills and service user involvement;

- When responses were compared between PEC and roles / Job titles of Board members, PEC members were found to report lower achievement levels than any of the board level groupings;

- Disaggregation of PEC scores by individual staff group indicates that GPs consistently gave the lowest scores of perceived achievement than other PEC members on virtually all items, other than item 10 'service provision is benchmarked against other providers';

- Factor analysis suggests that those organisational competencies relating to external assurance, including benchmarking of commissioning and provision and involvement of service users in service development, were perceived by board and PEC members to be less well developed than internal (PCT-specific)processes such as use of clinical audit and risk management of provision.

11. Staff Experience of Clinical Governance

Questionnaire C was distributed to a small sample of front-line staff (30 staff in 12 PCTs), in order to assess the "lived experience" of clinical governance underneath the corporate level structures & processes outline in the earlier part of this report. The measure was developed initially with secondary care to operate as an assessment of organisational culture with particular reference to clinical governance. It is organised into 6 domains;-

- A planned and integrated Quality Improvement programme
- Proactive risk management
- Climate of blame and punishment
- Working with colleagues
- Training and development opportunities
- Organisational learning

The items forming each of these sections are presented in the Appendix.

A total of 170 questionnaires were returned from the 360 distributed (just under 50%) and across a range of staff groups, with eleven out of the twelve PCTs participating. Some staff groups had no returns and hence are not included in the table.

The data has been analysed at two levels

a) whole domain by total sample and by staff group, and
b) each of the items within the domains.

Whole domain by total sample and staff group

The results of the first analysis are shown in **Table 11.1**. The minimum and maximum ranges of mean scores are shown with the higher score indicating more positive endorsement of the concept. Within these ranges the different staff groups are shown in the cumulative table such that a difference in colour shading denotes a significant difference between staff groups and the position towards the far right of the table indicating the most positive view. Thus managerial staff are the most positive in terms of "A planned and integrated Quality Improvement programme" and "Proactive risk management". AHP staff and Nurses are the least positive on the whole across the range of domains. No significant differences were found in terms of "Working with colleagues". The Consultant/Modern Matron group of staff, although small, appears rather more positive than their colleagues.

Table 11.1 Questionnaire C: 'Progress in Clinical Governance on the Six Scales of the CGCQ as Perceived by Type of Staff in Provider Organisations Delivering Services (n = 173)'

6 CGCQ Scales	greater scale endorsement →						Range based on mean ratings for 6 types of staff: *min mean*	*max mean*
1 A planned and integrated QI programme	AHP	NsSp	HV/DN	C/M	TL	Mgmt	*57.18*	*68.97*
2 Proactive risk management	AHP	HV/DN	NsSp	TL	C/M	Mgmt	*66.91*	*80.95*
3 Climate of blame and punishment	NsSp	HV/DN	AHP	TL	C/M	Mgmt	*72.07*	*84.26*
4 Working with colleagues	NsSp	AHP	Mgmt	HV/DN	C/M	TL	*68.68*	*78.47*
5 Training and development opportunities	NsSp	HV/DN	AHP	TL	Mgmt	C/M	*60.43*	*71.58*
6 Organisational learning	AHP	HV/DN	NsSp	TL	Mgmt	C/M	*62.04*	*80.00*

(theoretical range 1-100)

KEY

TL = Team Leader (clinical) [n = 24]
HV/DN = HV/DN/Community Nurses [n = 39]
NsSp = Nurse Specialist/Senior Nurses [n = 32]
C/M = Consultant/Modern Matron [n = 12]
Mgmt = Managerial [n = 24]
AHP = AHP (Occupational Therapist/Physiotherapist/Podiatrist) [n = 21]

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

CGCQ items

The individual items (**Table 11.2**) show the mean score and standard deviation for the whole group. In the final column an index of Positive Perception had been developed indicating the strength of endorsement for the positive aspect of the item. This essentially means that negatively worded items are transformed and made consistent with positive items and the key areas – both those where the cultural aspects seem to be developing well and those where more work is required (at the bottom of the scale) are easily identified. Thus on a 7 point scale one might consider items about 5.00 to be viewed positively and those below 4.00 to be of concern. In this instance it is clear that the staff feel a variety of day to day pressures are overwhelming them making the pursuit of clinical governance and quality goals difficult. On the other hand they seem to feel that there is a genuine attempt to establish a learning culture and to share good practice (the highly rated items).

Table 11.2 Questionnaire C: "Mean Rating Score, Standard Deviation & Strength of Positive Perceptions on all Items Ranked by All Respondents (n = 173) to the CGCQ

		Strength of Positive Perception = level of ***agreement*** with a ***positive*** item ***OR*** Strength of Positive Perception = level of ***disagreement*** with a ***negative*** item	***Mean Rating Score*** *(1= Disagree - 7= Agree)*	***SD***	***Strength of Positive Perception Score -*** *Theoretical Range (1 - 7)*
*	7	Staff appraisals are used to punish staff	1.61	1.19	6.39
*	3	Error reporting systems are basically a stick to beat clinicians with	2.39	1.47	5.61
*	26	We work in an atmosphere of blame	2.41	1.64	5.59
*	19	Colleagues are dishonest with each other	2.42	1.53	5.58
	54	When something fails, it is used as a learning opportunity	5.34	1.28	5.34
*	10	It is unsafe to be open and honest with colleagues	2.68	1.62	5.32
	43	Clinical risk policies are shared throughout the organisation	5.30	1.49	5.30
	14	We collect information on clinical risks	5.28	1.59	5.28
	11	The emphasis is on **how** an incident happened, not **who** made the mistake	5.24	1.57	5.24
	40	There is mutual respect for everyone's contribution	5.24	1.46	5.24
*	21	Identified clinical risks simply remain unaddressed	2.80	1.63	5.20
*	5	People involved in clinical incidents are made to feel guilty	2.82	1.65	5.18
	13	We work together across teams to make quality improvements	5.17	1.55	5.17
	16	When there is an error, we look for failures in systems rather than blame individuals	5.15	1.36	5.15
*	27	We don't collect information on the clinical risks that matter most	2.88	1.67	5.12
	8	People have a good knowledge of the skills of their colleagues	5.10	1.48	5.10
	12	People who make mistakes are supported	5.07	1.53	5.07
	57	People are motivated to improve quality	5.06	1.43	5.06
	52	Risk assessment processes are updated in the light of clinical incidents	5.05	1.42	5.05
*	30	There is no common approach to risk management	2.99	1.75	5.01
	35	When a clinical risk is identified, there is always action to address it	4.98	1.60	4.98
	6	Career development needs are addressed alongside strategic needs of the service	4.96	1.58	4.96
*	45	People don't know what their colleagues expect of them	3.04	1.53	4.96
	44	Clinical risk information is used routinely to inform decisions	4.94	1.38	4.94
*	53	Colleagues don't seem to understand each others role's	3.07	1.72	4.93
*	17	Appraisal does not identify the real development needs of staff	3.08	1.70	4.92
	37	We systematically assess clinical risks	4.91	1.44	4.91
*	28	There is no training available in searching for research evidence	3.16	1.72	4.84
	23	People share practice issues with others in different parts of the organisation	4.82	1.61	4.82
*	1	When things go wrong, there is an automatic assumption that 'someone is to blame'	3.20	1.60	4.80
	22	Clinical risks are examined in a systematic way	4.80	1.57	4.80
	60	People are highly motivated to make changes to clinical practice	4.78	1.51	4.78
	2	Good practice ideas are shared with others outside the organisation	4.76	1.54	4.76
	31	Teams from different parts of the organisation share their good practice	4.75	1.61	4.75
*	58	There are few opportunities to use new skills learned as part of development	3.26	1.60	4.74
*	42	We don't address the accidents waiting to happen	3.34	1.72	4.66
*	46	People don't seem to have shared service goals	3.34	1.67	4.66
*	24	There is no support to deliver service changes	3.35	1.63	4.65
	49	Development needs are regularly assessed	4.65	1.57	4.65
	4	Critical appraisal skills training is available to those who want it	4.61	1.72	4.61
	15	Technical help with evidence based practice is available	4.61	1.58	4.61
	39	People share a common vision of service delivery	4.56	1.57	4.56
*	20	Good practice stays isolated in pockets	3.45	1.79	4.55
*	25	There is no clear vision of what it is that the organisation is trying to achieve	3.50	1.90	4.50
	32	People devote time to disseminating good practice	4.38	1.62	4.38
*	33	The first we know of quality improvements elsewhere in the organisation is when we feel their effects	3.69	1.57	4.31
*	34	Service improvements tend to be crisis-led	3.77	1.85	4.23
	55	Everyone has the same standing, regardless of professional background	4.22	1.88	4.22
*	56	We react to problems, rather than try to prevent them	3.81	1.84	4.19
*	36	Quality improvement is imposed from above rather than built from below	3.85	1.63	4.15
*	59	People are forced into making service changes, rather than encouraged to make them	3.85	1.64	4.15
*	51	Quality improvement activity is largely a response to external pressure	3.97	1.71	4.03
*	29	There are lots of quality improvement initiatives, but little real change	4.00	1.68	4.00
*	48	People don't know about good practice taking place in other parts of the organisation	4.03	1.75	3.97
	47	There is time to reflect on practice	3.88	1.77	3.88
*	41	There is pressure to 'solve' problems quickly rather than take time and do it properly	4.19	1.73	3.81
*	38	There is no time to get together to share ideas	4.23	1.85	3.77
	9	We have protected time for quality improvement activity	3.50	1.91	3.50
*	18	Long-term planning for quality improvement gets lost in the day-to-day	4.66	1.65	3.34
*	50	Immediate pressures are always more important than quality improvement	4.78	1.57	3.22

Most Positive

'Strength of Positive Perception' rank order

Least Positive

* Negative items

Summary conclusions

- Data collection from 'front-line' staff from a sample of 12 PCTs using the Clinical Governance Climate Questionnaire (CGCQ) to explore the 'lived experience' of clinical governance revealed moderate to good progress in embedding clinical governance practices. Of the six aggregated domains, the area with least progress was a planned and integrated quality improvement programme, with rather more achievement indicated in risk management and avoidance of an unjust 'blame' culture;

- Considering individual items in the scales, it is clear that staff report a variety of 'day to day' pressures that compromise their effectiveness to pursue clinical governance and quality goals. On the other hand, it is clear that staff report a genuine attempt to establish a learning culture and share good practice

12. Summary of conclusions

Conclusions were noted at the end of each of the previous sections. These are summarised below, in order to draw together key findings.

PCT functioning

- Most executive directors with responsibility for clinical governance in PCTs have clinical roles;

- PCTs in which the clinical governance director lacks HR or commissioning experience may face difficulties in developing clinical governance arrangements that are consistent with the enhanced role of PCT commissioning as envisaged in C*ommissioning a Patient-Led NHS.* Currently, only 11% of directors with responsibility for clinical governance are directors of HR, and only 6% directors of commissioning;

- While time and resources present a marginally greater constraint to implementation than lack of information, none of these posed more than moderate difficulties for the majority of respondents.

Guidance and support in implementation

- Experience of external review systems such as the CNST scheme and CHI reviews is typically reported as positive;

- A majority of respondents identified DH (73%) and SHA (82%) support as helpful;

- Specialist support provided by the CGST such as the Board Development Programme for Clinical Governance had been reasonably widely used (39%) and was generally well regarded.

Structures and processes

- An overwhelming majority of PCTs have structures, process and lead members of staff for clinical leadership, capacity, risk management, multi-professional audit, public involvement, care quality and service improvement;

- In terms of the perceived effectiveness of each of these structures and processes, respondents identified moderate to good ability in risk management and improving patient experience across each of the above elements;

- Respondents identified the PCT as the organisational unit most likely to contain explicit structures for each of the elements identified above (between 79% and 93% for specific elements). Structures were available at sub-PCT

level in between 40% to 51% of PCTs depending on the element, and at the Pan-PCT level in only 21% - 39% of PCTs;

- Lack of Pan-PCT arrangements and concentration at the PCT level may require considerable redesign of clinical governance arrangements as a results of reconfiguration and an enhanced duty for PCTs to shape (and internally mange) emerging markets of multiple providers.

Progress on clinical governance issues related to 'Standards for Better Health'

- While in terms of implementation planning many of the *Standards for Better Health* core standards relating to clinical governance appear to be in place, comparatively weaker areas for future improvement reflect aspects of inter-agency collaboration and commissioning (e.g. ensuring that commissioning arrangements take account of clinical risks; supporting commissioning for quality; and facilitating health and social care agency influence over governance issues);

- In terms of coverage and achievement, relatively weak areas include leadership development, sustaining strategic partnerships, and developing practice-based commissioning. As with implementation, the aspects with poorest coverage and lowest perceived effectiveness included those aspects concerned with commissioning for quality.

Chief executives' perspectives on progress of clinical governance

- CEO's rating of the importance of, and achievement against, a range of organisational clinical governance competencies reveals that the areas with greatest perceived risk to progress include training in EBP, benchmarking of commissioning practices, joint working between health and social care agencies, and leadership development;

- Areas identified as posing moderate risk to progress included care pathways development and quality improvement activity in service delivery;

- Risk management and appraisal activities, while judged as very important, were seen as less of a risk to progress given high levels of perceived achievement;

- The moderate relative perceived importance of benchmarking for commissioning may mean that it could become overlooked, with attention diverted to areas perceived as more important yet with greater perceived achievement.

Board and PEC perspectives on progress of clinical governance

- PEC and Board members indicated moderate to good achievement against 20 organisational competencies selected from the full OPCG measure reported for CEOs in Section 8 above. Least achievement was indicated for commissioning being benchmarked against other PCTs, leadership skills and service user involvement;

- When responses were compared between PEC and Roles/Job-titles of Board members, PEC members were found to report lower achievement levels than any of the board level groupings;

- Disaggregation of PEC scores by individual staff group indicates that GPs consistently gave the lowest scores of perceived achievement than other PEC members on virtually all items, other than item 10 'service provision is benchmarked against other providers';

- Factor analysis suggests that those organisational competencies relating to external assurance, including benchmarking of commissioning and provision and involvement of service users in service development, were perceived by board and PEC members to be less well developed than internal (PCT-specific) processes such as use of clinical audit and risk management of provision.

Staff experience of clinical governance climate

- Data collection from 'front-line' staff from a sample of 12 PCTs using the Clinical Governance Climate Questionnaire (CGCQ) to explore the 'lived experience' of clinical governance revealed moderate to good progress in embedding clinical governance practices. Of the six aggregated domains, the area with least progress was a planned and integrated quality improvement programme, with rather more achievement indicated in risk management and avoidance of an unjust 'blame' culture;

- Considering individual items in the scales, it is clear that staff report a variety of 'day to day' pressures that overwhelm them and conspire to make the pursuit of clinical governance and quality goals difficult. On the other hand, it is clear that staff report a genuine attempt to establish a learning culture and share good practice.

13. Establishing Differential Levels of Progress in Clinical Governance

Section G of Questionnaire A completed by the Chief Executive/Clinical Governance Lead comprises 26 questions. These are key areas of clinical governance and directly relevant to the core standards for better health. For each question, the respondent was asked to:

a) state whether an implementation plan existed,

b) identify if a named individual had been given responsibility for implementation, and

c) rate each item with respect to level of achievement in terms of managing risk and also to patient experience.

The final requirement of Section G was for the Chief Executive/Governance Lead to estimate the extent to which specific staff groupings had been covered in terms of the activity. So for example Issue 3 'Developing performance and development review (PDR) for staff' was associated with the coverage statement 'Percentage of PCT staff with Personal Development Plans' and Issue 5 'Supporting development of multi-disciplinary clinical care' was associated with an estimate of the 'Percentage of clinical staff working in multi-disciplinary teams'. In this way each estimate of coverage provides an indication of Clinical Governance progress with respect to the 26 issues.

By combining the estimates for all 26 issues it has been possible to group the complete sample of PCTs into distinct 'bands' with each band containing a subset of PCTs with a particular level of progress in Clinical Governance. The banding process was conducted according to two different principles.

The first method of combination was based on the average percentage coverage for each PCT. The distribution of these average percentages was split into five bands (A-E) on the basis that each band should contain about one-fifth (i.e.20 %) of the total number of PCTs. In other words:

	Mean Bandwidths
Band A: PCTs above 80th. percentile	84.7 - 100
Band B: PCTs between 60th and 80th. percentile	80.2 - 84.7
Band C: PCTs between 40th and 60th. percentile	75.0 - 80.2
Band D: PCTs between 20th and 40th. percentile	69.1 – 75.0
Band E: PCT's below 20th. percentile	52.3 – 69.1

This method of 'banding' would have been sufficient if all of the percentage coverage distributions were approximately 'normal' in shape. In reality, only some of the distributions could be considered 'normal' and it was apparent (through visual inspection) that there was a significant number that were broadly 'bimodal'. In other words some PCT's were associated not only with high percentage coverage scores for some of the 26 issues but also with low percentage coverage scores for others.

This necessitated another method of determining PCT 'banding'. In order to account for distribution bimodality, the percentile bandwidths were calculated for ***all 26 issues*** independently. This meant that with respect to coverage, any PCT could be characterised as a frequency distribution as shown in the following example,

	Band E Issues	**Band D Issues**	**Band C Issues**	**Band B Issues**	**Band A Issues**	**Missing**
Frequency	**7**	**0**	**6**	**2**	**10**	**1**

The Progress Index is calculated as freq. (A+B)/freq. (E+D). In this example, the Progress Index = 1.7.

The distribution of these Progress Indices for all PCTs was split into five bands (A-E) on the basis that each band should contain about one-fifth (i.e.20 %) of the total number of PCTs. In other words:

	Index Bandwidths
Band A: PCTs above 80th. percentile	above 3.20
Band B: PCTs between 60th and 80th. percentile	2.00 - 3.20
Band C: PCTs between 40th and 60th. percentile	1.38 – 2.00
Band D: PCTs between 20th and 40th. percentile	0.82 – 1.38
Band E: PCT's below 20th. percentile	below 0.82

For the sake of simplicity, the first method of banding is referred to as 'Average Percentage Banding' and the second method of banding is referred to as 'Progress Index Banding'.

Utilising the Clinical Governance Progress Bands

The derived bandings enable statistical analysis to be undertaken to explore differences between PCTs (in the different bands) on Questionnaire A, and then to look for relationships between Questionnaire A and B (PEC Board and Trust Board members). The latter allows for the possibility that the progress level as indicated by the Chief Executive/Clinical Governance Lead in Questionnaire A may or may not be the same as perceived by the PEC Board and Trust Board members.

In terms of the statistical analyses used where categorical questions are involved Chi-square has been used. For rating questions (treated as continuous data) analyses include independent analysis of variance followed by multiple comparison of means to locate differences between bands, where appropriate.

All results have been calculated using both types of PCT banding and although they are often similar, there are instances where the results differ markedly. In these instances a more detailed examination of the underlying data and analysis assumptions is required before any firm conclusions are drawn. The table below (**Table 13.1**) shows the frequency of PCTs cross-tabulated against the two sorts of banding.

Table 13.1: PCT distribution for two types of 'banding'

Total PCTs = 240		**Average Percentage Bands**					
		A	**B**	**C**	**D**	**E**	**Total**
Progress Index Bands	**A**	35	12	0	0	0	47
	B	9	23	9	1	0	42
	C	2	13	26	9	4	54
	D	2	1	8	26	9	46
	E	0	0	4	12	35	51
	Total	48	49	47	48	48	240

Interpreting the Results

Table 13.2 below examines the relationship between categorical questions within Questionnaire A and the PCT bandings (shown for both approaches to the banding formula). In principle the higher stated PCTs on both bandings are more associated with a 'Yes' endorsement to the question, and lower rated PCTs with a 'No' endorsement. There are limited but quite interesting significant results.

For example the experience of a CHI review is significantly linked to high banding – both formulae – suggesting a positive impact on further Clinical Governance. Slightly less strong but significant is

a) receiving useful support from the Strategic Health Authority (Progress Index Banding only), and

b) participation in CGST activity (Average Banding only).

Finally a view that efficency savings have been delivered is significantly associated with high banding (both formulae).

Table 13.2: Chi^2 Association between Clinical Governance Progress Bands (A-E) and Categorical Data for Questionnaire A

	Question		*Categories*	χ^2	*df*	*significance*	
Average % Banding	PCT Size	6	6 size bands	25.43	20	ns (0.19)	
Progress Index Banding		6	6 size bands	22.10	20	ns (0.34)	
Average % Banding	PCT Location	3	urban/rural/mixed	5.95	8	ns (0.65)	
Progress Index Banding		3	urban/rural/mixed	9.28	8	ns (0.32)	
Average % Banding	Does PCT have a Medical Director	2	yes/no	2.53	4	ns (0.64)	
Progress Index Banding		2	yes/no	4.77	4	ns (0.31)	
Average % Banding	External Review - CHI	2	yes/no	14.68	4	sig p <0.01	*
Progress Index Banding		2	yes/no	15.33	4	sig p <0.01	*
Average % Banding	External Review - Litigation Scheme	2	yes/no	7.45	4	ns (0.11)	
Progress Index Banding		2	yes/no	4.91	4	ns (0.30)	
Average % Banding	External Review - Performance Review	2	yes/no	2.11	4	ns (0.72)	
Progress Index Banding		2	yes/no	2.57	4	ns (0.63)	
Average % Banding	External Review - Other	2	yes/no	5.48	4	ns (0.24)	
Progress Index Banding		2	yes/no	4.59	4	ns (0.33)	
Average % Banding	E1 DOH helpful support	2	yes/no	6.18	4	ns (0.19)	
Progress Index Banding		2	yes/no	3.08	4	ns (0.54)	
Average % Banding	E2 SHA useful support	2	yes/no	3.91	4	ns (0.42)	
Progress Index Banding		2	yes/no	12.99	4	sig p <0.05	*
Average % Banding	E3 SHA monitor	2	yes/no	2.18	4	ns (0.70)	
Progress Index Banding		2	yes/no	3.79	4	ns (0.40)	
Average % Banding	E4 PCT participated in CGST dev prog	2	yes/no	2.75	4	ns (0.60)	
Progress Index Banding		2	yes/no	4.74	4	ns (0.31)	
Average % Banding	E5 PCT participated in other CGST	2	yes/no	10.37	4	sig p <0.05	*
Progress Index Banding		2	yes/no	7.92	4	ns (0.09)	
Average % Banding	E7 CG delivered benefits to patient care	2	yes/maybe	8.67	4	ns (0.07)	
Progress Index Banding		2	yes/maybe	6.79	4	ns (0.15)	
Average % Banding	E8 CG delivered efficiency savings	3	yes/maybe/no	19.35	8	sig p <0.05	*
Progress Index Banding		3	yes/maybe/no	25.01	8	sig p <0.01	

* All significant Chi^2 values denote that the association between the questionnaire categories and the CG Progress Bands are such that the higher progress bands tend to be more associated with a 'YES' endorsementand the lower progress bands tend to be associated with a 'NO' endorsement

These categorical questions are displayed in **Table 13.3 and Table 13.4** for each of the banding approaches separately. The tables present a cumulative process whereby differential shading indicates a significant difference from the next shade (or group pf PCTs). Where an all white pattern is presented there are no differences between the PCTs. We can see quite clearly that the top rated PCTs (Band A) almost always appears at the right hand extreme of **Tables 2 and 3** and are significantly different from all, or some of the other bands of PCTs. Some items seem to differentiate PCTs more than others, for example Item 1 (experience of CHI reviews) and 4 and 6 (Written strategies in place for clinical governance) are singularly associated with the highest banding.

Table 13.3: One-Way ANOVA of Progress Index Bands (A-E) with respect to Total Number of 'Yes' Endorsements on 'Linked Categorical' Questions in Questionnaire A

		More affirmative						Range based on mean ratings for 5 groups	
								min	*max*
1	C3. Experience of external reviews of clinical governance the Trust had in the past three years (up to 4 possible 'yes' endorsements)	E	D	C	B	A		*2.46*	*3.00*
2	E1-5. Usefulness & participation of various sources of guidance & support (up to possible 'yes' endorsements)	B	E	D	C	A	*ns*	*3.30*	*3.69*
3	F(a)1-9 Are there written strategies in place for aspects of clinical governance (up to 9 possible 'yes' endorsements)	E	D	C	B	A		*6.92*	*7.93*
4	F(b)1-9 Are there named lead persons for aspects of clinical governance (up to 9 possible 'yes' endorsements)	E	C	D	B	A		*8.27*	*8.81*
5	F(c)1-9 Are structures & processes in place for aspects of clinical governance (up to 9 possible 'yes' endorsements)	E	C	D	A	B	*ns*	*8.46*	*8.83*
6	G(a)1-26 Are there implementation plans for Clinical Governance Issues (up to 26 possible 'yes' endorsements)	E	D	C	B	A		*19.38*	*23.86*
7	G(b)1-26 Is there someone with responsibility for ensuring implementation of Clinical Governance Issues (up to 26 possible 'yes' endorsements)	D	E	C	B	A		*23.64*	*24.91*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

Table 13.4: One-Way ANOVA of Average Percentage Bands (A-E) with respect to Total Number of 'Yes' Endorsements on 'Linked Categorical' Questions in Questionnaire A

		More affirmative						Range based on mean ratings for 5 groups	
								min	*max*
1	C3. Experience of external reviews of clinical governance the Trust had in the past three years (up to 4 possible 'yes' endorsements)	E	C	D	B	A		*2.39*	*3.00*
2	E1-5. Usefulness & participation of various sources of guidance & support (up to possible 'yes' endorsements)	E	B	D	C	A	*ns*	*3.22*	*3.76*
3	F(a)1-9 Are there written strategies in place for aspects of clinical governance (up to 9 possible 'yes' endorsements)	E	C	D	B	A		*6.67*	*8.27*
4	F(b)1-9 Are there named lead persons for aspects of clinical governance (up to 9 possible 'yes' endorsements)	E	C	D	B	A		*8.22*	*8.88*
5	F(c)1-9 Are structures & processes in place for aspects of clinical governance (up to 9 possible 'yes' endorsements)	E	C	D	B	A		*8.41*	*8.85*
6	G(a)1-26 Are there implementation plans for Clinical Governance Issues (up to 26 possible 'yes' endorsements)	E	D	C	B	A		*17.72*	*24.22*
7	G(b)1-26 Is there someone with responsibility for ensuring implementation of Clinical Governance Issues (up to 26 possible 'yes' endorsements)	E	D	C	B	A		*22.91*	*24.81*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

The ratings data is then examined using analysis of variance followed by multiple comparisons. This is done for both banding procedures separately, and the cumulative shading again indicates a significant difference between bands of PCTs.

Table 13.5 and Table 13.6 show from Section F of Questionnaire A the relationship between bands (A-E) and structures for Managing Risk to Service Delivery and Improving Patient Experience. There are some differences between the different banding procedures but on the whole it is clear that band E (lowest banding) are least effective in almost all of these activities. Similarly bands A and B are generally seen as very effective in terms of these same activities. At times A alone or A and B are significantly different from all other bands, and on other occasions, it is only the lowest band (E) that appears different.

On the whole the averaging banding procedure is less discriminating and therefore it may be appropriate to focus more on the Progress Index Banding in drawing conclusions. In this way items such as 'ensuring effective clinical leadership'; 'ensuring the quality of the patient experience'; 'improving services based on lessons from complaints' and 'improving services based on lessons from patient safety incidents/near misses' may be key.

Table 13.5: One-Way ANOVA of Progress Index Bands (A-E) with respect to Responses to Section F in Questionnaire A: 1. Managing Risks to Service Delivery and 2. Improving Patient Experience

	1. Managing Risks to Service Delivery	More effective →						Range based on mean ratings for 5 groups	
								min	*max*
1	Ensuring effective clinical leadership	E	C	D	B	A		*4.89*	*5.54*
2	Maintaining the capacity and capability to deliver services	E	C	D	B	A		*4.78*	*5.68*
3	Pro-actively identifying clinical risks to patients & staff	E	C	D	B	A		*5.50*	*5.93*
4	Collecting and using 'intelligent information' on clinical care	E	C	D	B	A	*ns*	*4.32*	*4.85*
5	Involving professional groups in multi-professional clinical audit	C	E	D	B	A	*ns*	*4.75*	*5.07*
6	Involving patients and public in the design and delivery of PCT services	E	C	D	A	B		*4.29*	*5.10*
7	Ensuring the quality of the patient experience	E	C	D	B	A		*4.44*	*5.43*
8	Improving services based on lessons from complaints	E	D	C	B	A		*5.25*	*5.88*
9	Improving services based on lessons from patient safety incidents / near misses	E	C	D	B	A		*5.31*	*6.00*
	2. Improving Patient Experience	More effective →							
								min	*max*
1	Ensuring effective clinical leadership	D	E	C	B	A		*4.60*	*5.44*
2	Maintaining the capacity and capability to deliver services	D	E	C	B	A		*4.53*	*5.28*
3	Pro-actively identifying clinical risks to patients & staff	D	C	E	B	A	*ns*	*5.24*	*5.55*
4	Collecting and using 'intelligent information' on clinical care	E	C	D	B	A	*ns*	*4.04*	*4.68*
5	Involving professional groups in multi-professional clinical audit	E	C	D	B	A	*ns*	*4.32*	*5.02*
6	Involving patients and public in the design and delivery of PCT services	E	C	D	A	B		*4.85*	*5.51*
7	Ensuring the quality of the patient experience	E	C	D	B	A		*4.49*	*5.63*
8	Improving services based on lessons from complaints	E	D	C	B	A		*5.17*	*5.95*
9	Improving services based on lessons from patient safety incidents / near misses	E	D	C	B	A		*5.06*	*5.70*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

Table 13.6: One-Way ANOVA of Average Percentage Bands (A-E) with respect to Responses to Section F in Questionnaire A: 1. Managing Risks to Service Delivery and 2. Improving Patient Experience

	1. Managing Risks to Service Delivery	More effective →						Range based on mean ratings for 5 groups	
								min	*max*
1	Ensuring effective clinical leadership	E	D	C	B	A		*4.76*	*5.38*
2	Maintaining the capacity and capability to deliver services	E	C	D	B	A		*4.59*	*5.59*
3	Pro-actively identifying clinical risks to patients & staff	E	C	D	B	A	*ns*	*5.54*	*5.88*
4	Collecting and using 'intelligent information' on clinical care	E	D	C	B	A		*4.15*	*4.95*
5	Involving professional groups in multi-professional clinical audit	E	D	B	A	C	*ns*	*4.62*	*5.04*
6	Involving patients and public in the design and delivery of PCT services	E	D	C	B	A		*4.16*	*5.15*
7	Ensuring the quality of the patient experience	E	C	D	B	A		*4.35*	*5.51*
8	Improving services based on lessons from complaints	E	D	C	B	A		*5.13*	*5.85*
9	Improving services based on lessons from patient safety incidents / near misses	E	D	B	C	A		*5.28*	*5.98*
	2. Improving Patient Experience	More effective →							
								min	*max*
1	Ensuring effective clinical leadership	E	D	C	B	A		*4.40*	*5.20*
2	Maintaining the capacity and capability to deliver services	E	C	D	B	A		*4.36*	*5.15*
3	Pro-actively identifying clinical risks to patients & staff	E	A	D	C	B	*ns*	*5.15*	*5.62*
4	Collecting and using 'intelligent information' on clinical care	E	D	C	B	A		*3.78*	*4.76*
5	Involving professional groups in multi-professional clinical audit	E	D	C	B	A		*4.22*	*4.98*
6	Involving patients and public in the design and delivery of PCT services	E	C	D	A	B		*4.93*	*5.15*
7	Ensuring the quality of the patient experience	E	C	D	B	A		*4.54*	*5.51*
8	Improving services based on lessons from complaints	E	D	C	B	A		*5.02*	*5.85*
9	Improving services based on lessons from patient safety incidents / near misses	E	D	C	B	A		*4.96*	*5.98*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

In the next section of Questionnaire A (Section G) the issues of Managing Risk and Improving Patient Experience were examined in terms of the 'Standards for Better Health'. The links between these items and PCT bands is shown in **Table 13.7 and Table 13.8** (Progress Index Bands) and **Table 13.9 and Table 13.10** (Average Percentage Bands). Once again the cumulative presentation clearly indicates the higher banded PCTs A and B are associated with greater effectiveness in many of these areas. There are again some differences between the different banding procedures. But looking at the Progress Index Band only one might highlight Items, 1, 2, 3, 7, 9, 15, 16, 17, 18, 22, 23 and 25 as being of particular interest. The number of items listed here suggests, as might be expected, that progress in an activity such as Clinical Governance, is not due to one process alone but a culture whereby the appropriate actions are taken across a range of areas.

Table 13.7: One-Way ANOVA of Progress Index Bands (A-E) with respect to Responses to Section G in Questionnaire A: Managing Risk

	Managing Risk	More effective						Range based on mean ratings for 5 groups	
								min	*max*
1	Ensuring compliance with Continuing Professional Development (CPD) requirements	E	D	C	B	A		*5.00*	*5.59*
2	Supporting arrangements for the appraisal of clinical staff	E	C	D	B	A		*4.85*	*5.51*
3	Developing Performance and Development Review (PDR) for staff	E	C	D	B	A		*4.74*	*5.41*
4	Developing leadership at every level of the organisation	E	D	C	A	B		*4.25*	*5.17*
5	Supporting development of multi-disciplinary clinical care	E	C	D	B	A		*4.77*	*5.51*
6	Developing wider PEC understanding of clinical governance duties	E	C	D	A	B		*4.79*	*5.54*
7	Ensuring effective clinical risk management strategies	E	D	C	A	B		*5.60*	*6.10*
8	Promoting error and adverse incident reporting	E	D	C	B	A	*ns*	*5.68*	*6.05*
9	Acting on patient feedbacks & complaints	E	D	C	B	A		*5.47*	*6.02*
10	Ensuring effective infection control	E	D	B	C	A		*5.47*	*6.13*
11	Providing clear guidance on medicines management	C	E	D	B	A	*ns*	*5.59*	*5.95*
12	Supporting access to NSF guidance	E	C	D	B	A		*4.88*	*5.43*
13	Providing information on Evidence Based Medicine	E	D	C	B	A		*4.85*	*5.56*
14	Developing protocols and guidelines for clinical care	E	C	D	A	B		*5.06*	*5.67*
15	Facilitating local health & social care agency influence over PCT governance issues	D	E	C	B	A		*4.24*	*5.20*
16	Sustaining local strategic partnerships	E	C	D	B	A		*4.65*	*5.66*
17	Developing shared vision with collaborating organisations	E	D	C	B	A		*4.62*	*5.51*
18	Involving local communities in the PCT	E	D	C	B	A		*4.46*	*5.21*
19	Ensuring use of QOF data in making service improvements	E	D	C	B	A		*4.76*	*2.78*
20	Promoting multi-disciplinary audit against national standards	E	D	C	B	A	*ns*	*4.61*	*5.07*
21	Supporting commissioning for quality	E	C	D	B	A		*4.07*	*5.10*
22	Ensuring that commissioning arrangements take account of clinical risk	E	D	C	B	A		*3.89*	*5.28*
23	Benchmarking commissioning against other organisations	E	D	C	A	B		*3.38*	*4.73*
24	Developing Practice based commissioning	D	E	C	A	B		*3.62*	*4.94*
25	Benchmarking provision against other organisations	D	E	C	A	B		*3.43*	*4.77*
26	Ensuring that Public Health informs PCT policy	E	D	C	B	A		*4.58*	*5.64*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

Table 13.8: One-Way ANOVA of Progress Index Bands (A-E) with respect to Responses to Section F in Questionnaire A: Patient Experience

	Patient Experience	More effective						Range based on mean ratings for 5 groups	
								min	*max*
1	Ensuring compliance with Continuing Professional Development (CPD) requirements	E	D	B	C	A		*4.60*	*5.33*
2	Supporting arrangements for the appraisal of clinical staff	E	C	D	B	A		*4.60*	*5.34*
3	Developing Performance and Development Review (PDR) for staff	E	C	D	B	A		*5.54*	*5.25*
4	Developing leadership at every level of the organisation	D	E	C	A	B		*4.12*	*5.07*
5	Supporting development of multi-disciplinary clinical care	E	C	B	D	A		*4.94*	*5.56*
6	Developing wider PEC understanding of clinical governance duties	E	C	D	B	A		*4.57*	*5.44*
7	Ensuring effective clinical risk management strategies	E	C	D	A	B		*4.94*	*5.62*
8	Promoting error and adverse incident reporting	E	C	D	B	A	*ns*	*5.17*	*5.68*
9	Acting on patient feedbacks & complaints	E	D	C	B	A	*ns*	*5.40*	*5.95*
10	Ensuring effective infection control	E	D	C	B	A		*5.04*	*5.88*
11	Providing clear guidance on medicines management	E	D	B	C	A	*ns*	*5.15*	*5.61*
12	Supporting access to NSF guidance	E	C	D	B	A		*4.83*	*5.43*
13	Providing information on Evidence Based Medicine	E	D	C	B	A		*4.58*	*5.34*
14	Developing protocols and guidelines for clinical care	E	D	C	A	B		*4.83*	*5.41*
15	Facilitating local health & social care agency influence over PCT governance issues	E	D	C	A	B		*4.16*	*5.20*
16	Sustaining local strategic partnerships	E	C	D	B	A		*4.68*	*5.63*
17	Developing shared vision with collaborating organisations	E	D	C	A	B		*4.64*	*5.44*
18	Involving local communities in the PCT	E	D	C	B	A		*4.69*	*5.49*
19	Ensuring use of QOF data in making service improvements	E	C	D	B	A		*4.65*	*5.68*
20	Promoting multi-disciplinary audit against national standards	E	C	D	B	A	*ns*	*4.46*	*4.92*
21	Supporting commissioning for quality	E	C	D	B	A		*3.96*	*4.90*
22	Ensuring that commissioning arrangements take account of clinical risk	E	D	C	B	A		*3.56*	*4.95*
23	Benchmarking commissioning against other organisations	E	D	C	A	B		*3.31*	*4.62*
24	Developing Practice based commissioning	D	E	C	A	B		*3.68*	*4.75*
25	Benchmarking provision against other organisations	D	E	C	B	A		*3.46*	*4.57*
26	Ensuring that Public Health informs PCT policy	E	D	C	B	A		*4.25*	*5.59*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

Table 13.9: One-Way ANOVA of Average Percentage Bands (A-E) with respect to Responses to Section G in Questionnaire A: Managing Risk

	Managing Risk	More effective						Range based on mean ratings for 5 groups	
								min	*max*
1	Ensuring compliance with Continuing Professional Development (CPD) requirements	E	D	C	B	A		*4.91*	*5.53*
2	Supporting arrangements for the appraisal of clinical staff	E	C	D	B	A		*4.78*	*5.50*
3	Developing Performance and Development Review (PDR) for staff	E	C	D	B	A		*4.67*	*5.55*
4	Developing leadership at every level of the organisation	E	C	D	B	A		*4.13*	*5.16*
5	Supporting development of multi-disciplinary clinical care	E	D	C	B	A		*4.70*	*5.69*
6	Developing wider PEC understanding of clinical governance duties	E	D	C	A	B		*4.70*	*5.66*
7	Ensuring effective clinical risk management strategies	C	E	D	B	A		*5.55*	*6.18*
8	Promoting error and adverse incident reporting	E	C	B	D	A	*ns*	*5.60*	*6.03*
9	Acting on patient feedbacks & complaints	E	D	C	B	A		*5.44*	*6.05*
10	Ensuring effective infection control	E	C	B	D	A		*5.49*	*6.13*
11	Providing clear guidance on medicines management	D	C	E	B	A	*ns*	*5.58*	*6.05*
12	Supporting access to NSF guidance	E	C	D	B	A		*4.76*	*5.39*
13	Providing information on Evidence Based Medicine	E	C	D	B	A		*4.80*	*5.55*
14	Developing protocols and guidelines for clinical care	E	C	D	A	B		*5.02*	*5.67*
15	Facilitating local health & social care agency influence over PCT governance issues	E	D	C	A	B		*3.84*	*5.30*
16	Sustaining local strategic partnerships	E	C	D	B	A		*4.65*	*5.75*
17	Developing shared vision with collaborating organisations	E	D	C	B	A		*4.36*	*5.53*
18	Involving local communities in the PCT	D	E	C	B	A		*4.27*	*5.33*
19	Ensuring use of QOF data in making service improvements	E	D	C	B	A		*4.41*	*5.80*
20	Promoting multi-disciplinary audit against national standards	E	D	C	B	A		*4.42*	*5.13*
21	Supporting commissioning for quality	E	D	C	B	A		*3.88*	*5.23*
22	Ensuring that commissioning arrangements take account of clinical risk	E	D	C	B	A		*3.67*	*5.35*
23	Benchmarking commissioning against other organisations	E	D	C	B	A		*2.90*	*4.97*
24	Developing Practice based commissioning	D	E	C	A	B		*3.62*	*4.80*
25	Benchmarking provision against other organisations	E	D	C	A	B		*3.20*	*4.71*
26	Ensuring that Public Health informs PCT policy	E	D	C	B	A		*4.42*	*5.68*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

Table 13.10: One-Way ANOVA of Average Percentage Bands (A-E) with respect to Responses to Section F in Questionnaire A: Patient Experience

	Patient Experience	More effective						Range based on mean ratings for 5 groups	
								min	*max*
1	Ensuring compliance with Continuing Professional Development (CPD) requirements	E	D	C	B	A		*4.69*	*5.21*
2	Supporting arrangements for the appraisal of clinical staff	E	D	C	B	A		*4.49*	*5.23*
3	Developing Performance and Development Review (PDR) for staff	E	D	C	B	A		*4.47*	*5.23*
4	Developing leadership at every level of the organisation	E	D	C	A	B		*4.11*	*5.17*
5	Supporting development of multi-disciplinary clinical care	E	D	C	B	A		*4.93*	*5.58*
6	Developing wider PEC understanding of clinical governance duties	E	D	C	A	B		*4.48*	*5.47*
7	Ensuring effective clinical risk management strategies	E	D	C	A	B		*4.93*	*5.68*
8	Promoting error and adverse incident reporting	E	D	C	A	B	*ns*	*5.11*	*5.66*
9	Acting on patient feedbacks & complaints	E	D	C	B	A		*5.38*	*5.93*
10	Ensuring effective infection control	E	D	C	B	A		*4.96*	*5.87*
11	Providing clear guidance on medicines management	E	D	C	B	A		*5.16*	*5.75*
12	Supporting access to NSF guidance	E	D	C	A	B		*4.85*	*5.35*
13	Providing information on Evidence Based Medicine	E	C	D	A	B		*4.41*	*5.33*
14	Developing protocols and guidelines for clinical care	E	C	D	A	B		*4.65*	*5.59*
15	Facilitating local health & social care agency influence over PCT governance issues	E	D	C	A	B		*3.84*	*5.40*
16	Sustaining local strategic partnerships	E	D	C	B	A		*4.78*	*5.69*
17	Developing shared vision with collaborating organisations	E	D	C	B	A		*4.43*	*5.47*
18	Involving local communities in the PCT	E	D	C	B	A		*4.59*	*5.53*
19	Ensuring use of QOF data in making service improvements	E	D	C	B	A		*4.41*	*5.64*
20	Promoting multi-disciplinary audit against national standards	E	D	C	A	B		*4.30*	*4.94*
21	Supporting commissioning for quality	E	D	C	B	A	*ns*	*3.76*	*4.93*
22	Ensuring that commissioning arrangements take account of clinical risk	E	D	C	B	A		*3.36*	*5.03*
23	Benchmarking commissioning against other organisations	E	D	C	B	A		*2.97*	*4.63*
24	Developing Practice based commissioning	E	D	C	A	B		*3.65*	*4.50*
25	Benchmarking provision against other organisations	E	D	C	B	A		*3.24*	*4.56*
26	Ensuring that Public Health informs PCT policy	E	D	C	B	A		*4.24*	*5.51*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

In an earlier section of this report a 'Perceived Risk to Progress' score was described as having been derived from combining individual achievement and importance ratings. This 'Perceived Risk to Progress' measure has been related to PCT Boards (**Table 13.11 and Table 13.12**). The cumulative presentation is in this instance reversed such that the extreme right column is associated with more risk. This is readily apparent when inspection of **Table 13.11 and Table 12.12** show PCT bands D and E largely located in this 'more risk' column. There is slightly less discrimination in this set of results, for either banding procedure, and it may be as well to focus on items where PCT band A (alone) or A and B are significantly different from others. For the Progress Index Band we might for example look at Items, 2, 8, 11, 17, 18, 20, 28, 29, 31, 33, 35, 36, 37 and 38.

Table 13.11: One-Way ANOVA of Progress Index Bands (A-E) with respect to Perceived Risk to Progress derived from Achievement & Importance Ratings in Section H; Questionnaire A.

		More risk						Range based on mean ratings for 5 groups	
								min	*max*
1	There is a 'fair and just culture' around reporting adverse events and near misses	A	C	D	B	E		*24.2*	*31.0*
2	Leadership skills are developed at every level	A	D	B	C	E		*33.0*	*43.4*
3	Organisation-wide clinical governance systems are underpinned by local systems	A	B	D	C	E	*ns*	*30.7*	*34.3*
4	Staff are trained in evidence-based practice	D	A	C	B	E		*35.0*	*43.8*
5	There is a nominated clinical lead for clinical governance	B	A	E	C	D	*ns*	*14.4*	*15.2*
6	Staff appraisal is used as an opportunity to reflect on progress and plan future development	A	B	D	C	E		*24.9*	*33.5*
7	Staff are trained in the use of risk management systems	D	A	B	C	E		*27.2*	*35.4*
8	Primary care clinical staff work as a multi-disciplinary team	A	B	D	C	E		*27.2*	*36.0*
9	The Local Medical Committee (LMC) are involved in clinical governance	A	D	C	B	E	*ns*	*28.3*	*34.0*
10	There are clear criteria for establishing user involvement groups	A	B	C	D	E		*27.6*	*38.7*
11	Published research is used to inform quality improvement	A	C	B	D	E		*29.4*	*39.9*
12	Clinical audit topics are selected according to their potential impact on care quality	A	D	B	C	E	*ns*	*29.3*	*34.1*
13	Evaluation of adverse events are used to improve service quality	D	A	B	C	E		*23.3*	*31.0*
14	Staff share common objectives	A	D	C	B	E		*29.1*	*37.2*
15	Following identification of a problem from complaints data, clinical quality is improved	A	D	B	C	E		*23.7*	*31.3*
16	Staff benchmark commissioning against other PCTs	A	D	B	E	C	*ns*	*34.4*	*41.3*
17	Staff modify their care processes to reflect emerging 'best practice'	A	B	D	E	C		*31.4*	*36.5*
18	Service delivery plans include quality improvement activity	A	B	C	D	E		*28.6*	*36.5*
19	There are local arrangements to collate information for the clinical governance committee	A	D	B	C	E	*ns*	*20.6*	*25.7*
20	NSF implementation is integrated with business planning and quality improvement programmes	A	D	C	B	E		*21.7*	*32.6*
21	Local health and social care agencies work jointly on clinical governance issues	A	B	C	D	E	*ns*	*34.2*	*41.4*
22	There is a common vision for clinical governance	A	D	B	C	E		*24.2*	*30.0*
23	Clinical issues are not dominated by any single profession	A	C	D	B	E	*ns*	*24.7*	*31.2*
24	Staff are trained in clinical audit	B	D	A	E	C	*ns*	*33.3*	*39.6*
25	Clinical indicators are used to review services	D	A	B	C	E	*ns*	*34.9*	*38.2*
26	All staff development plans identify training opportunities	B	A	D	C	E		*23.6*	*32.8*
27	There is a formal clinical governance committee, reporting to the board	A	E	B	D	C	*ns*	*14.7*	*16.4*
28	Training identified in staff development plans matches individual needs to organisational needs	A	B	D	C	E		*27.7*	*35.1*
29	Service users are involved in service development	A	B	D	C	E		*31.3*	*41.5*
30	There is an annual staff appraisal process for most staff	B	A	C	D	E		*20.3*	*31.0*
31	Care pathways are developed with colleagues in secondary care	A	B	D	C	E		*27.9*	*38.0*
32	Partnerships with local health and social care agencies have shared purposes	B	C	A	D	E		*25.0*	*34.1*
33	All staff are appraised against an agreed work and development programme	A	B	D	C	E		*26.8*	*36.7*
34	There is an executive director with responsibility for developing the clinical governance agenda	C	B	A	E	D	*ns*	*15.9*	*17.9*
35	Clinical teams respond to changes in their environment by reorganising their work processes	A	B	D	C	E		*29.7*	*38.1*
36	Local and national priorities are used to priorities service development	A	B	D	C	E		*19.4*	*27.7*
37	Clinicians use professional networks to identify emerging 'best practice'	A	B	D	C	E		*26.4*	*32.0*
38	New skills obtained through development activity are used	A	C	D	B	C		*26.4*	*33.2*
39	Clear action plans are developed in response to identified clinical risks	A	B	C	D	E	*ns*	*21.5*	*27.4*
40	Service improvement activity focuses on the patient experience of care	B	A	C	D	E		*29.8*	*39.9*
41	Clinical leads use professional networks to build support for clinical governance	A	C	D	B	E	*ns*	*26.9*	*32.3*
42	There are clear management processes for addressing underperformance by clinical staff	B	D	A	C	E		*18.8*	*27.2*
43	Staff benchmark provision against other PCTs	A	C	B	D	E	*ns*	*35.6*	*39.5*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

Table 13.12: One-Way ANOVA of Average Percentage Bands (A-E) with respect to Perceived Risk to Progress derived from Achievement & Importance Ratings in Section H; Questionnaire A.

		More risk →						Range based on mean ratings for 5 groups	
								min	*max*
1	There is a 'fair and just culture' around reporting adverse events and near misses	B	A	C	D	E		*24.6*	*32.1*
2	Leadership skills are developed at every level	A	B	D	C	E		*31.8*	*40.8*
3	Organisation-wide clinical governance systems are underpinned by local systems	A	C	B	D	E	*ns*	*29.7*	*34.9*
4	Staff are trained in evidence-based practice	A	C	D	E	B	*ns*	*36.4*	*40.3*
5	There is a nominated clinical lead for clinical governance	C	A	D	B	E	*ns*	*13.5*	*16.1*
6	Staff appraisal is used as an opportunity to reflect on progress and plan future development	A	C	B	D	E		*23.6*	*33.1*
7	Staff are trained in the use of risk management systems	A	C	D	B	E	*ns*	*29.0*	*34.6*
8	Primary care clinical staff work as a multi-disciplinary team	A	B	C	D	E		*26.7*	*38.2*
9	The Local Medical Committee (LMC) are involved in clinical governance	C	A	E	B	D	*ns*	*28.0*	*33.9*
10	There are clear criteria for establishing user involvement groups	A	C	B	D	E		*28.3*	*38.9*
11	Published research is used to inform quality improvement	A	B	C	D	E		*29.2*	*42.0*
12	Clinical audit topics are selected according to their potential impact on care quality	A	B	D	C	E	*ns*	*29.2*	*34.7*
13	Evaluation of adverse events are used to improve service quality	A	D	B	C	E		*23.8*	*30.1*
14	Staff share common objectives	C	A	B	D	E	*ns*	*29.6*	*35.9*
15	Following identification of a problem from complaints data, clinical quality is improved	A	B	D	C	E		*24.2*	*32.3*
16	Staff benchmark commissioning against other PCTs	A	C	B	D	E	*ns*	*33.3*	*42.2*
17	Staff modify their care processes to reflect emerging 'best practice'	A	B	C	E	D	*ns*	*31.3*	*36.4*
18	Service delivery plans include quality improvement activity	A	C	B	E	D		*27.4*	*36.4*
19	There are local arrangements to collate information for the clinical governance committee	A	C	D	B	E	*ns*	*21.0*	*24.9*
20	NSF implementation is integrated with business planning and quality improvement programmes	A	C	B	D	E		*22.9*	*32.1*
21	Local health and social care agencies work jointly on clinical governance issues	A	B	C	D	E		*35.3*	*45.4*
22	There is a common vision for clinical governance	A	C	D	B	E	*ns*	*25.4*	*28.9*
23	Clinical issues are not dominated by any single profession	C	A	B	D	E	*ns*	*27.3*	*30.5*
24	Staff are trained in clinical audit	C	D	A	B	C	*ns*	*33.8*	*39.1*
25	Clinical indicators are used to review services	C	D	A	B	E		*33.2*	*41.4*
26	All staff development plans identify training opportunities	A	C	D	B	E		*23.0*	*34.0*
27	There is a formal clinical governance committee, reporting to the board	E	C	D	A	B	*ns*	*14.9*	*16.5*
28	Training identified in staff development plans matches individual needs to organisational needs	A	C	B	D	E		*26.9*	*36.0*
29	Service users are involved in service development	B	A	C	D	E		*32.2*	*42.6*
30	There is an annual staff appraisal process for most staff	A	C	D	B	E		*22.2*	*32.7*
31	Care pathways are developed with colleagues in secondary care	A	B	C	D	E		*29.3*	*38.4*
32	Partnerships with local health and social care agencies have shared purposes	B	C	D	A	E		*23.3*	*35.9*
33	All staff are appraised against an agreed work and development programme	A	C	B	D	E		*27.1*	*38.4*
34	There is an executive director with responsibility for developing the clinical governance agenda	C	A	B	E	D	*ns*	*14.8*	*18.2*
35	Clinical teams respond to changes in their environment by reorganising their work processes	A	C	B	D	E		*29.1*	*39.5*
36	Local and national priorities are used to priorities service development	A	B	C	D	E		*20.8*	*26.2*
37	Clinicians use professional networks to identify emerging 'best practice'	A	D	C	B	E		*26.4*	*32.9*
38	New skills obtained through development activity are used	A	B	D	C	E		*26.6*	*33.4*
39	Clear action plans are developed in response to identified clinical risks	B	C	A	D	E		*22.0*	*27.5*
40	Service improvement activity focuses on the patient experience of care	A	B	C	D	E		*28.8*	*38.4*
41	Clinical leads use professional networks to build support for clinical governance	A	D	C	B	E	*ns*	*26.8*	*32.8*
42	There are clear management processes for addressing underperformance by clinical staff	B	A	C	D	E		*20.4*	*27.6*
43	Staff benchmark provision against other PCTs	A	C	B	D	E	*ns*	*34.4*	*40.8*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

This same data is illustrated even more clearly in **Table 13.13 and Table 13.14** where the ranked order of risk is related to each PCT band. Thus the items at the top of the ranking are those derived from the combined achievement/importance measure and present the greatest risk to progress in Clinical Governance. The remaining columns show how each of the PCT bands (A-E) are located on each of these items. In order to relate each PCT to the same base level 'z' scores have been calculated and hence the higher positive score represents the worst position and the higher negative score the best position. Thus for Item 4 (the highest level of risk) PCTs in band A should have the lowest score (on positive scale) and the highest where the scores are negative. This relationship can be seen for the majority of items on the ranked risk items.

Table 13.13: Perceived Risk to Progress (R%) Ranked for all PCTs ands 'z' scores for all 'Perceived Risk to Progress Percentages for Progress Index PCT Bands (Section H: Questionnaire A)

High

'Risk to Progress' rank order

Low

			Progress Index Bands				
		R%	A	B	C	D	E
4	Staff are trained in evidence-based practice	39.06	1.09	1.53	1.43	0.79	2.16
16	Staff benchmark commissioning against other PCTs	38.96	0.69	1.57	1.77	1.24	1.67
21	Local health and social care agencies work jointly on clinical governance issues	38.81	0.66	1.26	1.54	1.62	1.78
43	Staff benchmark provision against other PCTs	37.68	0.88	1.17	1.09	1.36	1.48
2	Leadership skills are developed at every level	37.63	0.46	0.99	1.38	0.73	2.10
25	Clinical indicators are used to review services	36.69	1.04	1.07	1.12	0.77	1.28
24	Staff are trained in clinical audit	36.61	0.94	0.52	1.50	0.54	1.35
29	Service users are involved in service development	36.09	0.21	0.46	1.07	1.05	1.80
11	Published research is used to inform quality improvement	35.08	-0.10	0.74	0.64	1.04	1.55
17	Staff modify their care processes to reflect emerging 'best practice'	34.21	0.23	0.31	1.02	0.88	0.95
40	Service improvement activity focuses on the patient experience of care	33.54	0.11	-0.03	0.48	0.71	1.54
35	Clinical teams respond to changes in their environment by reorganising their work processes	33.39	-0.04	0.41	0.55	0.50	1.27
31	Care pathways are developed with colleagues in secondary care	32.83	-0.32	0.23	0.59	0.44	1.25
10	There are clear criteria for establishing user involvement groups	32.71	-0.37	0.31	0.33	0.39	1.36
14	Staff share common objectives	32.49	-0.14	0.50	0.34	0.08	1.13
18	Service delivery plans include quality improvement activity	32.49	-0.22	0.18	0.40	0.50	1.01
3	Organisation-wide clinical governance systems are underpinned by local systems	32.31	0.11	0.15	0.47	0.31	0.67
28	Training identified in staff development plans matches individual needs to organisational needs	31.99	-0.36	-0.24	0.54	0.50	0.80
12	Clinical audit topics are selected according to their potential impact on care quality	31.61	-0.10	0.10	0.42	0.02	0.64
8	Primary care clinical staff work as a multi-disciplinary team	31.55	-0.43	0.17	0.26	0.19	0.93
9	The Local Medical Committee (LMC) are involved in clinical governance	31.41	-0.27	0.37	0.26	0.18	0.63
38	New skills obtained through development activity are used	31.34	-0.55	0.47	0.19	0.38	0.50
33	All staff are appraised against an agreed work and development programme	31.23	-0.49	-0.34	0.31	0.28	1.05
7	Staff are trained in the use of risk management systems	31.22	-0.12	0.03	0.54	-0.44	0.85
41	Clinical leads use professional networks to build support for clinical governance	29.83	-0.48	0.07	-0.09	-0.06	0.36
37	Clinicians use professional networks to identify emerging 'best practice'	29.49	-0.55	-0.37	0.26	-0.19	0.31
6	Staff appraisal is used as an opportunity to reflect on progress and plan future development	28.39	-0.79	-0.52	-0.12	-0.28	0.54
32	Partnerships with local health and social care agencies have shared purposes	28.18	-0.44	-0.78	-0.56	-0.27	0.64
22	There is a common vision for clinical governance	28.07	-0.90	-0.08	-0.06	-0.83	0.01
15	Following identification of a problem from complaints data, clinical quality is improved	27.92	-0.99	-0.50	0.09	-0.55	0.21
20	NSF implementation is integrated with business planning and quality improvement programmes	27.81	-1.29	-0.14	-0.23	-0.37	0.41
23	Clinical issues are not dominated by any single profession	27.46	-0.82	-0.34	-0.59	-0.48	0.19
1	There is a 'fair and just culture' around reporting adverse events and near misses	27.00	-0.90	-0.43	-0.74	-0.52	0.15
26	All staff development plans identify training opportunities	26.86	-0.98	-1.00	-0.43	-0.60	0.44
13	Evaluation of adverse events are used to improve service quality	26.05	-1.00	-0.74	-0.72	-1.05	0.15
30	There is an annual staff appraisal process for most staff	24.60	-1.05	-1.51	-0.97	-0.76	0.16
39	Clear action plans are developed in response to identified clinical risks	24.22	-1.33	-1.15	-0.96	-0.79	-0.40
19	There are local arrangements to collate information for the clinical governance committee	23.76	-1.47	-0.95	-0.92	-1.00	-0.67
42	There are clear management processes for addressing underperformance by clinical staff	23.53	-1.06	-1.75	-0.78	-1.21	-0.44
36	Local and national priorities are used to priorities service development	23.12	-1.65	-1.22	-1.04	-1.19	-0.35
34	There is an executive director with responsibility for developing the clinical governance agenda	16.64	-2.19	-2.20	-2.20	-1.88	-1.95
27	There is a formal clinical governance committee, reporting to the board	15.66	-2.38	-2.24	-2.13	-2.18	-2.31
5	There is a nominated clinical lead for clinical governance	15.16	-2.35	-2.43	-2.32	-2.32	-2.33

'z' scores

Table 13.14: Perceived Risk to Progress (R%) Ranked for all PCTs ands 'z' scores for all 'Perceived Risk to Progress Percentages for Average Percentage PCT Bands (Section H: Questionnaire A)

			Average Percentage PCT Bands				
		R%	A	B	C	D	E
High	4 Staff are trained in evidence-based practice	39.06	0.98	1.65	1.13	1.55	1.55
	16 Staff benchmark commissioning against other PCTs	38.96	0.50	1.41	1.21	1.73	1.88
	21 Local health and social care agencies work jointly on clinical governance issues	38.81	0.81	1.01	1.15	1.48	2.36
	43 Staff benchmark provision against other PCTs	37.68	0.67	1.29	0.80	1.41	1.66
	2 Leadership skills are developed at every level	37.63	0.27	0.91	1.41	1.34	1.66
	25 Clinical indicators are used to review services	36.69	0.89	1.20	0.48	0.85	1.75
	24 Staff are trained in clinical audit	36.61	0.80	1.32	0.59	0.77	1.40
	29 Service users are involved in service development	36.09	0.39	0.33	0.80	1.15	1.94
	11 Published research is used to inform quality improvement	35.08	-0.12	0.57	0.61	0.87	1.85
	17 Staff modify their care processes to reflect emerging 'best practice'	34.21	0.20	0.50	0.80	0.97	0.90
	40 Service improvement activity focuses on the patient experience of care	33.54	-0.19	0.18	0.33	1.18	1.29
	35 Clinical teams respond to changes in their environment by reorganising their work processes	33.39	-0.15	0.40	0.28	0.65	1.45
	31 Care pathways are developed with colleagues in secondary care	32.83	-0.12	0.13	0.24	0.69	1.29
	10 There are clear criteria for establishing user involvement groups	32.71	-0.27	0.18	0.18	0.54	1.36
	14 Staff share common objectives	32.49	-0.01	0.46	-0.07	0.55	0.91
	18 Service delivery plans include quality improvement activity	32.49	-0.41	0.21	0.12	0.99	0.90
	3 Organisation-wide clinical governance systems are underpinned by local systems	32.31	-0.05	0.34	-0.04	0.67	0.75
	28 Training identified in staff development plans matches individual needs to organisational needs	31.99	-0.49	0.30	-0.16	0.68	0.91
	12 Clinical audit topics are selected according to their potential impact on care quality	31.61	-0.12	0.06	0.35	0.09	0.73
'Risk to Progress' rank order	8 Primary care clinical staff work as a multi-disciplinary team	31.55	-0.51	-0.18	0.17	0.36	1.27
	9 The Local Medical Committee (LMC) are involved in clinical governance	31.41	-0.07	0.50	-0.32	0.59	0.41
	38 New skills obtained through development activity are used	31.34	-0.53	0.17	0.41	0.31	0.51
	33 All staff are appraised against an agreed work and development programme	31.23	-0.45	-0.05	-0.13	0.21	1.29
	7 Staff are trained in the use of risk management systems	31.22	-0.16	0.29	0.00	0.08	0.70
	41 Clinical leads use professional networks to build support for clinical governance	29.83	-0.50	-0.01	-0.04	-0.11	0.43
	37 Clinicians use professional networks to identify emerging 'best practice'	29.49	-0.56	0.03	0.03	-0.42	0.45
	6 Staff appraisal is used as an opportunity to reflect on progress and plan future development	28.39	-1.00	-0.21	-0.46	0.04	0.47
	32 Partnerships with local health and social care agencies have shared purposes	28.18	-0.05	-1.04	-0.99	-0.13	0.91
	22 There is a common vision for clinical governance	28.07	-0.71	-0.19	-0.43	-0.35	-0.18
	15 Following identification of a problem from complaints data, clinical quality is improved	27.92	-0.89	-0.54	-0.24	-0.34	0.34
	20 NSF implementation is integrated with business planning and quality improvement programmes	27.81	-1.11	-0.34	-0.37	-0.13	0.32
	23 Clinical issues are not dominated by any single profession	27.46	-0.50	-0.42	-0.77	-0.42	0.07
	1 There is a 'fair and just culture' around reporting adverse events and near misses	27.00	-0.75	-0.84	-0.75	-0.43	0.32
	26 All staff development plans identify training opportunities	26.86	-1.09	-0.58	-0.79	-0.65	0.61
	13 Evaluation of adverse events are used to improve service quality	26.05	-0.97	-0.80	-0.74	-0.81	0.01
	30 There is an annual staff appraisal process for most staff	24.60	-1.20	-1.04	-1.14	-1.05	0.40
	39 Clear action plans are developed in response to identified clinical risks	24.22	-1.19	-1.24	-1.24	-0.52	-0.40
	19 There are local arrangements to collate information for the clinical governance committee	23.76	-1.39	-0.81	-1.05	-0.95	-0.79
	42 There are clear management processes for addressing underperformance by clinical staff	23.53	-1.23	-1.49	-1.23	-0.73	-0.38
	36 Local and national priorities are used to priorities service development	23.12	-1.42	-1.38	-1.06	-0.90	-0.60
Low	34 There is an executive director with responsibility for developing the clinical governance agenda	16.64	-2.20	-2.14	-2.35	-1.82	-1.86
	27 There is a formal clinical governance committee, reporting to the board	15.66	-2.19	-2.08	-2.31	-2.22	-2.34
	5 There is a nominated clinical lead for clinical governance	15.16	-2.33	-2.29	-2.55	-2.31	-2.16
			z' scores				

In contrast, Item 5, which carries the lowest risk of all is negative for all bands of PCTs – thus it is a low risk and virtually all PCTs do it. These areas carrying the highest levels of risk – towards the top of the scale – are generally least well managed by PCTs in bands D & E. Thus the theme is consistent with the other tables presented in this section where the best performing PCTs in band A (and band B) tend to be better on a range of issues and this is in contrast with PCTs in bands D and E.

The final set of data in this section, **Tables 13.15 and Table 13.16**, examine how the banding of PCTs relates to how a set of items representing progress in Clinical Governance are seen by PCT Board and PEC Board members (Questionnaire B). The cumulative pattern again confirms significant differences between PCTs with PCTs (bands A and B) located towards the right hand column indicating greater endorsement by their Board members that they are engaged in these activities.

Some differences exist between the two methods of banding but there are items that emerge as of importance to progress (as perceived by individuals other than the Chief Executive/Clinical Governance Lead). For example, in the Progress Index Banding 'information to support evidence based medicine is available and easily accessible'; 'all staff are appraised against an agreed work and development programme'; 'service users are involved in service development'; 'clear action plans are developed in response to clinical risks' and 'underperformance by clinical staff is addressed by clear management procedures' are all linked significantly to band A PCTs. It is worth noting in terms of validation of the assessment system that band E PCTs are virtually always the least active in the areas listed.

In summary the material utilising the bands to differentiate PCTs is suggesting that there are a set of activities and processes that are more likely to be observed in the best/better PCTs (A and B) and least likely in the poorer performing PCTs (D and E). No single magic bullet item emerges but this is entirely consistent with the view of Clinical Governance as a cultural process and one of transforming organisational practice.

Table 13.15: One-Way ANOVA of Progress Index Bands (A-E) with respect to responses to Questionnaire B (Items + Factors)

	In this PCT……..	stronger agreement →						Range based on mean ratings for 5 groups	
								min	*max*
1	Adverse incidents and errors can be freely reported without fear of reprisal	E	D	B	C	A		*5.86*	*6.19*
2	Clinical governance systems provide assurance to the PCT Board	E	D	C	B	A	*ns*	*5.75*	*6.02*
3	Information to support evidence based medicine is available and easily accessible	E	C	B	D	A		*5.01*	*5.29*
4	All staff are appraised against an agreed work and development programme	E	C	B	D	A		*5.00*	*5.52*
5	Clinical care is managed and delivered using multidisciplinary teamwork	E	C	D	B	A	*ns*	*5.55*	*5.77*
6	Clinical audit is a key part of the clinical risk management strategy	E	C	D	B	A	*ns*	*5.50*	*5.66*
7	Clinical audit is used to improve patient care	E	C	D	B	A	*ns*	*5.50*	*5.66*
8	Errors and adverse events are monitored and evaluated to improve services	E	D	C	B	A		*5.69*	*5.95*
9	Patient feedback and complaints guide clinical quality improvements	E	D	C	B	A		*5.24*	*5.60*
10	Service provision is benchmarked against other PCT providers	E	B	C	D	A		*4.49*	*4.75*
11	Commissioning is benchmarked against other PCTs	E	C	B	D	A		*4.48*	*4.81*
12	Local health and social care agencies work closely together	E	A	B	C	D		*5.18*	*5.60*
13	Performance indicators and clinical outcomes are used to review services	E	C	A	B	D		*5.21*	*5.51*
14	Service users are involved in service development	E	C	D	B	A		*4.82*	*5.27*
15	Care pathways are developed in collaboration with those in secondary care	E	C	A	D	B		*5.06*	*5.39*
16	Clear action plans are developed in response to clinical risks	E	C	D	B	A		*5.40*	*5.79*
17	Underperformance by clinical staff is addressed by clear management procedures	E	C	B	D	A		*5.10*	*5.41*
18	All PEC members clearly understand the implications of clinical governance issues	E	D	C	B	A	*ns*	*5.62*	*5.83*
19	Leadership skills are developed at every level	E	D	C	B	A		*4.88*	*5.28*
20	We have effective leadership	E	D	C	B	A		*5.49*	*5.95*
	Factor 1: Internal Assurance	E	D	C	B	A		*-0.15*	*0.15*
	Factor 2: External Assurance	E	C	B	A	D		*-0.15*	*0.09*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

Table 13.16: One-Way ANOVA of Average Percentage Bands (A-E) with respect to responses to Questionnaire B (Items + Factors)

	In this PCT……..	stronger agreement →						Range based on mean ratings for 5 groups	
								min	*max*
1	Adverse incidents and errors can be freely reported without fear of reprisal	E	D	B	A	C		*5.77*	*6.16*
2	Clinical governance systems provide assurance to the PCT Board	E	D	A	C	B		*5.72*	*6.00*
3	Information to support evidence based medicine is available and easily accessible	E	B	D	C	A		*4.97*	*5.25*
4	All staff are appraised against an agreed work and development programme	E	D	C	B	A		*5.01*	*5.51*
5	Clinical care is managed and delivered using multidisciplinary teamwork	E	D	C	A	B	*ns*	*5.53*	*5.76*
6	Clinical audit is a key part of the clinical risk management strategy	E	D	C	A	B	*ns*	*5.46*	*5.70*
7	Clinical audit is used to improve patient care	E	D	C	A	B	*ns*	*5.46*	*5.70*
8	Errors and adverse events are monitored and evaluated to improve services	E	D	C	B	A		*5.64*	*5.96*
9	Patient feedback and complaints guide clinical quality improvements	E	D	C	A	B		*5.18*	*5.59*
10	Service provision is benchmarked against other PCT providers	E	B	D	A	B		*4.45*	*4.79*
11	Commissioning is benchmarked against other PCTs	E	B	C	D	A		*4.41*	*4.79*
12	Local health and social care agencies work closely together	E	A	D	C	B		*5.20*	*5.60*
13	Performance indicators and clinical outcomes are used to review services	E	A	D	C	B	*ns*	*5.21*	*5.49*
14	Service users are involved in service development	E	D	C	A	B		*4.84*	*5.27*
15	Care pathways are developed in collaboration with those in secondary care	E	D	C	A	B		*5.10*	*5.42*
16	Clear action plans are developed in response to clinical risks	E	D	C	A	B		*5.34*	*5.77*
17	Underperformance by clinical staff is addressed by clear management procedures	E	D	C	B	A	*ns*	*5.14*	*5.33*
18	All PEC members clearly understand the implications of clinical governance issues	E	D	A	C	B		*5.58*	*5.83*
19	Leadership skills are developed at every level	E	D	C	B	A		*4.83*	*5.27*
20	We have effective leadership	E	D	C	A	B		*5.44*	*5.99*
	Factor 1: Internal Assurance	E	D	C	A	B		*-0.19*	*0.17*
	Factor 2: External Assurance	E	B	C	D	A		*-0.16*	*0.08*

Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

14. Impact of Clinical Governance on the Quality of Patient Care

In Section I) Questionnaire A, Chief Executive Officers/Clinical Governance Leads were asked to describe up to three examples of how changes in PCT structure or processes driven by the Clinical Governance agenda have impacted (directly or indirectly) on the quality of patient care.

The table below shows the frequency of PCTs cross-tabulated against the two sorts of performance banding (described earlier).

Table 14.1 Frequency of PCTs in two types of performance banding

Total PCTs = 240		Average Percentage Bands					
		A	**B**	**C**	**D**	**E**	
Progress Index Bands	**A**	35	12	0	0	0	
	B	9	23	9	1	0	**Total for Shaded Cells**
	C	2	13	26	9	4	
	D	2	1	8	26	9	
	E	0	0	4	12	35	
							145

The shaded cells show the frequency of PCTs who fell in the same banding whether determined by average percentages or by the progress index. From each of these cells ten PCTs were randomly selected to give 50 PCTs in all (representing 34.5% of those PCTs who simultaneously occurred in the same bands using both types of banding procedure). Each PCT had provided 1, 2 or 3 descriptions of organisational initiatives, which were part of the Clinical Governance agenda.

Coding Procedure - Quality of Information and Evidence Provided

All problem-solving activities have two things in common; firstly they specify a goal and secondly the goal is not immediately achievable. Organisational change can be considered to be a form of problem solving where typically four sorts of information are brought into play. The problem-solver or organisational innovator needs to consider what information is available in four broad domains. These four domains are the initial state (or current organisational situation), the goal state (or the intended objectives of change), the allowable operators (or the actions allowed and constrained) and assessing the solution (information about the outcomes of the actions). For well-defined problems there may well be a surfeit of relevant information at all of the stages whilst for ill-defined problems, there may well be little or no relevant information in any of the four broad domains.

In this way, four stages in the organisational approach to innovation were identified (A.B, C and D listed below).

A) Statement of Initial State/Current Situation
B) Statement of Change Objectives/Intended Changes
C) Statement of Actions Initiated/Restrictions
D) Statement of Outcomes/Results

Briefly, these stages were used as a simple framework to rate the three examples of how changes in PCT structure or processes driven by the Clinical Governance agenda have impacted (directly or indirectly) on the quality of patient care. (Questionnaire A - section I).

At each of these four stages, two members of the research team independently rated the descriptions of change in accord with the following;

0 = Information Assessment Not Mentioned/Absent/Unclear
1 = Information Assessment Implied *or* Vaguely-Stated
2 = Information Assessment Clearly-Stated
3 = Information Assessment Clearly-Stated *and* Elaborated

Average scores for each PCT example could range from 0 (i.e. Ill-Defined) to 12 (i.e. Well-Defined). The rating of the examples of organisational change therefore focused upon the quality of the information assessment process at each of the four stages **not the amount of available information.** In this way, the ratings were intended to reflect ***quality of information processing*** at each of the four stages irrespective of the availability of information.

As we can see in **Table 14.2** there is a very clear difference between all stages with PCTs in bands A and B being superior in the way they completed the change actions (or at least in the quality of their evidence about the process of change). PCTs in bands D and E were consistently significantly worse across each area, and for the fifth combined category. The validation of the banding structure is powerful here with confirmation that overall better performance in managing Clinical Governance processes is reflected in the analysis and implementation of change. It was clear from examining the type of changes provided in the examples that the content of changes was broadly similar across PCT Progress Bands. In this way, the content is to some extent arbitrary whilst the depth of information processing about the change process may well be crucial.

As an example of the differences in quality of information processing across the Progress Bands, the following verbatim descriptions have been extracted from the change examples provided by PCTs in the top (i.e. Progress Bands A and B) and bottom performance bands (i.e. Progress Bands D and E) and these are included below to illustrate the differences between PCTs with respect to the presented quality of information processing about organisational problem solving.

Progress Band (A - E)	Stage in Organisational Change (A –D)	Information Assessment Rating (0 - 3)
A	**A: Current Situation**	**3**
"Initially developed an organisational flow chart to include clinical governance. The flow chart was remodelled to reflect not only the key functions of clinical governance but the flow of information vertically and horizontally throughout the organisation."		

Progress Band (A - E)	Stage in Organisational Change (A –D)	Information Assessment Rating (0 - 3)
D	**A: Current Situation**	**1**
"Incidents/PALS/ complaints are dealt with separately in the PCT "		

Progress Band (A - E)	Stage in Organisational Change (A –D)	Information Assessment Rating (0 - 3)
A	**B: Intended Changes**	**3**
"To reduce manual handling risk and increase monitoring. To identify changes in operational procedure to be implemented. Review of current practice - identification of concerns. Survey of clinical staff on best practice. Department discussion on these with proposals. Patient satisfaction also considered."		

Progress Band (A - E)	Stage in Organisational Change (A –D)	Information Assessment Rating (0 - 3)
E	**B: Intended Changes**	**0**

"Aim to drive increased quality improvement work trustwide."

Progress Band (A - E)	Stage in Organisational Change (A –D)	Information Assessment Rating (0 - 3)
A	**C: Actions/Restrictions**	**3**
"An action plan was put into place with the equipment service and key performance criteria agreed. (This service's contract was originally managed by another agency on behalf of the PCT), which would be monitored closely by the Senior Management Team. The PCT also cleared the backlog through more local contracts. The equipment service was resistant to improving services and had a high turnover of staff. Strategies have been put in place to reduce this."		

Progress Band (A - E)	Stage in Organisational Change (A –D)	Information Assessment Rating (0 - 3)
D	**C: Actions/Restrictions**	**1**
"This resulted in an action plan being developed which was monitored at the next annual visit."		

Progress Band (A - E)	Stage in Organisational Change (A –D)	Information Assessment Rating (0 - 3)
B	**D: Outcomes/Results**	**3**
"New training for all nurses **➢ Reviewed and updated protocols** **➢ Improved care for patients** **➢ Action plan monitored at Clinical Safety Committee** **➢ Less adverse events and better patient care** **➢ Improved partnership working with local Hospice"**		

Progress Band (A - E)	Stage in Organisational Change (A –D)	Information Assessment Rating (0 - 3)
E	**D: Outcomes/Results**	**0**
"Greater coverage of implementation across clinical directorates."		

All of the examples shown above confirm the association between progress in clinical governance (i.e. as indicated by Progress Band affiliation) and Quality of information Processing (i.e. as indicated by the Information Assessment Rating).

However, this association did not hold for all of the examples of change. Indeed, not only were there a number of examples of high quality information processing from 'low progress' PCTs, the converse was also true. 'High progress' PCTs also presented examples of organisational change that did not suggest high quality information processing. An example of each of these non-associated changes is shown below.

Progress Band (A - E)	Stage in Organisational Change (A –D)	Information Assessment Rating (0 - 3)
E	**C: Actions/Restrictions**	**3**

"New service developed. Nurse-led community service. GPs can refer all COPD patients to service. Patients call service directly if unwell. Guaranteed response in 2 hours. Patients visited in home. Some GP's resistant to service. Their admission rates high. Number of admissions for other GPs falling. Patients happy with service. Service works across primary/secondary interface – short listed for national award."

Progress Band (A - E)	Stage in Organisational Change (A –D)	Information Assessment Rating (0 - 3)
B	**B: Intended Changes**	**1**
"The change was needed to influence best practice – cost and effectiveness."		

Although the association between PCT progress and quality of information processing was apparent (see tables below) it was far from perfect. Furthermore, the fact that there did seem to be some sort of association tells us nothing about the causal direction in this relationship. Nevertheless, the CEO's of PCTs within the better Progress Bands tended to present a clearer exposition of the process of organisational change possibly suggesting that they had better integrated the meaning of clinical governance into their own mental models of change.

Table 14.2: One-Way ANOVA of PCT Progress Bands (A-E) with respect to Quality of Information & Evidence Rated in 'Examples of Impact of Clinical Governance on the Quality of Patient Care. (Section I: Questionnaire A)

	Clarity of problem-solving →					Range based on mean ratings for 5 groups	
						min	*max*
1 Quality of Information & Evidence for "Initial State/Current Situation"	E	C	D	B	A	*1.07*	*2.90*
2 Quality of Information & Evidence for "Change Objectives/Intended Changes"	E	D	C	B	A	*0.69*	*2.43*
3 Quality of Information & Evidence for "Actions Initiated/Restrictions"	E	D	C	B	A	*1.45*	*2.97*
4 Quality of Information & Evidence for "Outcomes/Results"	E	D	C	B	A	*1.38*	*2.93*
5 Quality of Information & Evidence for "Total [all 4 problem-solving stages]"	E	D	C	B	A	*4.59*	*11.23*

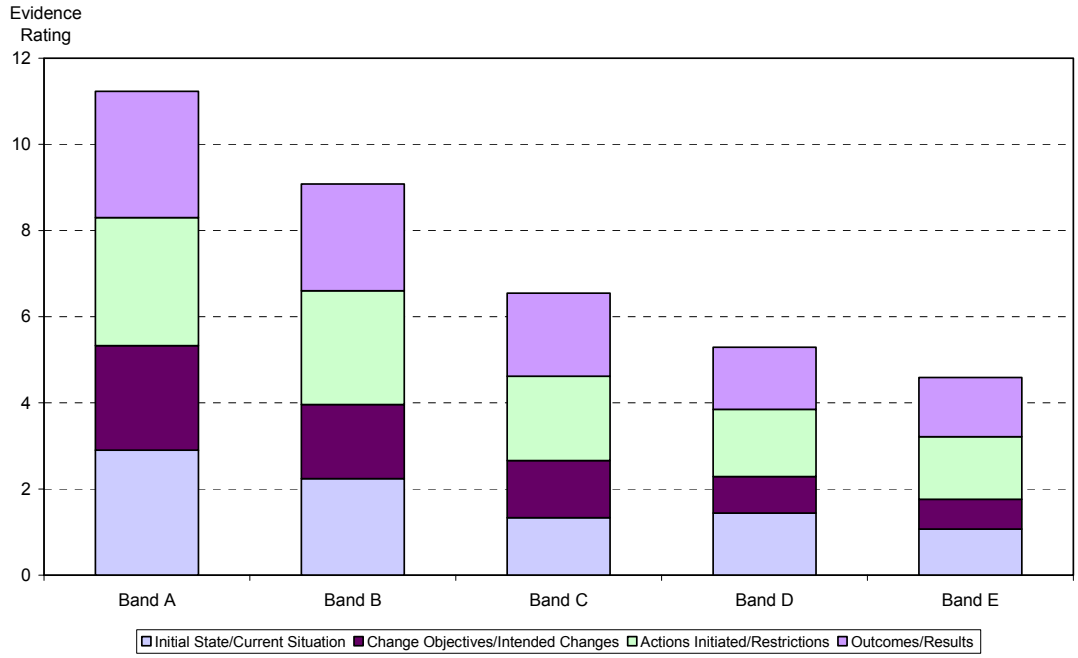
Within each item:-
Identical shading indicates no significant difference between groups
Different shading indicates broad pattern of significant differences between groupings

This superiority of PCTs A and B on the management of change processes relating to Clinical Governance is further illustrated in **Table 14.3** where for each of the elements of the process PCTs A and B have a higher mean score. The stacked histogram (see **Figure 14.1**) presentation of this data makes this clear.

Table 14.3: Rated Quality of Information & Evidence in Four Problem-Solving Stages (Mean & SDs) for Ten PCTs in each of the Progress Bands (A-E).

	Band A		Band B		Band C		Band D		Band E	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
1 Initial State/Current Situation	2.90	0.31	2.24	0.83	1.33	0.88	1.44	0.75	1.07	0.75
2 Change Objectives/Intended Changes	2.43	0.68	1.72	0.61	1.33	0.62	0.85	0.72	0.69	0.93
3 Actions Initiated/Restrictions	2.97	0.18	2.64	0.64	1.96	0.71	1.56	0.64	1.45	0.63
4 Outcomes/Results	2.93	0.25	2.48	0.71	1.93	0.73	1.44	0.85	1.38	0.78
Total [all 4 problem-solving stages]	11.23	0.97	9.08	2.04	6.56	1.74	5.33	2.18	4.59	2.47

Figure 14.1: Mean Quality of Information & Evidence Rated in 'Initial State/Current Situation' by PCTs in Progress Bands (A-E)



Working towards the improvement of quality and safety through the implementation of clinical governance in the PCTs is part-and parcel of radical transforming the old NHS organisational culture. The progress that has been made as traditional working practices give way to a new 'patient-first' perspective is one of evolutionary rather than revolutionary advancement. In other words, this type of organisational change is patchy and fragmented and occurs in diverse contexts and at different rates. This variability does not mean that progress cannot be assessed. This report has demonstrated that the rate of change across different PCTs can be measured by assessing 'progress' on a large series of 'clinical governance related' activities and initiatives that taken together can be considered to characterise the practical reality of this large-scale cultural transformation.

Ultimately, this cultural transformation will be complete when the staff in all PCTs fully understand the meaning of clinical governance not only in terms of its impact on their own working practices but also with respect to how they view the organisation and what it means to their values and beliefs. These modifications of the working mental models of staff will not only determine how the PCT is construed but will also shape the core activities of representing, planning and tackling organisational change.

Appendix

Items and α values for scales

	-ve	
		Factor 1: A planned and integrated QI programme (α = .95) 21 items
29	✓	There are lots of quality improvement initiatives, but little change
58	✓	There are few opportunities to use new skills learned as part of development
48	✓	People don't know about good practice taking place in other parts of the organisation
50	✓	Immediate pressures are always more important than quality improvement
46	✓	People don't seem to have shared service goals
51	✓	Quality improvement activity is largely a response to external pressure
33	✓	The first we know of quality improvements elsewhere in the organisation is when we feel the effects
18	✓	Long-term planning for quality improvement gets lost in the day-to-day
56	✓	We react to problems, rather than try to prevent them
25	✓	There is no clear vision of what the organisation is trying to achieve
59	✓	People are forced into making service changes, rather than encouraged to make them
34	✓	Service improvements tend to be crisis led
38	✓	There is no time to get together to share ideas
60		People are highly motivated to make changes to clinical practice
24	✓	There is no support to deliver service changes
36	✓	Quality improvement is imposed from above rather than built from below
57		People are motivated to improve quality
42	✓	We don't address the accidents waiting to happen
20	✓	Good practice stays isolated in pockets
39		People share a common vision of service delivery
41	✓	There is pressure to 'solve' problems quickly rather than take time and do it properly
		Factor 2: Proactive risk management (α = .90) 11 items
22		Clinical risks are examined systematically
14		We collect information on clinical risks
37		We systematically assess clinical risks
27	✓	We don't collect information on the clinical risks that matter most
52		Risk assessment processes are updated in the light of clinical incidents
44		Clinical risk information is used routinely to inform decisions
35		When a clinical risk is identified, there is action to address it
43		Clinical risk policies are shared throughout the organisation
30	✓	There is no common approach to risk management
54		When something fails, it is used as a learning opportunity
21	✓	Identified risks simply remain unaddressed

Items and α values for scales

		Factor 3: Climate of blame and punishment (α = .90) 9 items
5	✓	People involved in clinical incidents are made to feel guilty
11		The emphasis is on how an incident happened not who made the mistake
26	✓	We work in an atmosphere of blame
1	✓	When things go wrong there is an automatic assumption that 'someone is to blame'
3	✓	Error reporting systems are basically a stick to beat clinicians with
7	✓	Staff appraisals are used to punish staff
16		When there is an error, we look for failure in systems, rather than blame individuals
10	✓	It is unsafe to be open and honest with colleagues
12		People who make mistakes are supported
		Factor 4: Working with colleagues (α = .85) 6 items
8		People have a good knowledge of the skills of their colleagues
53	✓	Colleagues don't seem to understand each other's roles
45	✓	People don't know what their colleagues expect of them
55		Everyone has the same standing, regardless of professional background
40		There is mutual respect for everyone's contribution
19	✓	Colleagues are dishonest with each other
		Factor 5: Training and development opportunities (α = .81) 8 items
28	✓	There is no training available in searching for research evidence
4		Critical appraisal skills training is available to those who want it
15		Technical help with Evidence Based Practice is available
6		Career development needs are addressed alongside the strategic needs of the service
49		Development needs are regularly assessed
9		We have protected time for quality improvement activity
17	✓	Appraisal does not identify the real development needs of staff
47		There is time to reflect on practice
		Factor 6: Organisational learning (α = .87) 5 items
23		People share practice issues with others in different parts of the organisation
2		Good practice ideas are shared with others outside the organisation
32		People devote time to disseminating good practice
31		Teams from different parts of the organisation share their good practice
13		We work together across teams to make quality improvements