SECTION EIGHTEEN

CLINICAL GOVERNANCE AND THE SERVICES COMMISSIONED BY THE PCT

This section considers:

- clinical governance duties and responsibilities in relation to all of the services that the PCT commissions
- the extent to which the PEC, the Clinical Governance Committee and Public Health staff actively engage with the commissioning process
- collaboration with provider organisations and investment in developing new forms or patterns of care.

The challenge of commissioning

The duty of quality imposed upon the Boards of all NHSTs extends, so far as PCTs are concerned, to:

- all services they commission on behalf of their local communities
- all services provided directly from within the PCT professional community.

Most PCTs commission care from a number of NHS, private health sector and voluntary organisations. Their Boards and PECs must ensure that all commissioning arrangements identify how joint accountability will be managed in practice. They also need to show how collaboration will:

- secure the quality and safety of current provision
- foster development activities that will help the PCT achieve its longer term strategic vision for improved patterns of care.

These accountabilities and processes will need to be negotiated either separately with each provider or through a consortium/consortia of providers. In either case, commissioning activities need to include:

- an assessment of the organisational and clinical 'fitness for purpose' of contracting organisations to provide safe and high quality care
- the specification of accountability arrangements in service level agreements
- quality measures, monitoring, evaluation and feedback in service level agreements and, where these do not yet exist, assurance that they will be negotiated and included in future ones

- the systematic and documented involvement of the Clinical Governance Committee, PEC, Public Health staff and PCT clinicians in the commissioning process, to ensure an adequate health needs and clinical focus as well as a financial and organisational one
- explicit linkage to the PCT's longer term vision of service reconfiguration so that this can be built in to commissioned partnership arrangements, rather than being bolted on at some point in the future.

PCTs are now responsible for spending 75% of the total NHS budget. This represents a challenging agenda. Not surprisingly, to date, the picture that emerges from national analysis is not a uniform one.

'Overall, 60% of respondents thought that their PCT was either fully or fairly effective in its commissioning role, while 40% thought that it was either not very effective or not effective at all. Reflecting these results, only 62% thought that they could exert direct pressure on their local Acute Trust to improve services and even less (33%) felt that their PCT was able to exert sufficient leverage in terms of finding an alternative provider. 23% of respondents thought that their PCT had no successful means available of ensuring that satisfactory services were provided..... PCTs and lead clinicians now need headroom to develop robust commissioning systems. That will require the inclusion of primary care professionals at all stages and full ownership at the clinical frontline.'

NHS Alliance National Survey, 2003

Key learning from the pilot programme

A significant number of PCTs had failed, hitherto, to recognise that their clinical governance duties and responsibilities cover services they commission as well as services they provide.

In these cases, as in many others, commissioning continues to be driven primarily by concerns with cost and volume to the exclusion of quality, 'best value', and longer-term service improvement considerations.

Many PCTs do not believe that, notwithstanding their potential commissioning leverage, they are able to exercise significant influence within local health economies that continue to be driven by the financial and other demands of acute care providers.

In addition, many PCTs lack the breadth and depth of expertise in commissioning for quality that would enable them to make the best use of the leverage that they do have. All would welcome support and guidance in developing their ability to commission for quality.

For all the PCTs in the pilot programme the section on Commissioning was predictably challenging, scoring only 4.75 on the progress scale (range 3.5 to 6.8).

There was little difference between the 25 PCTs that were under a year old when they completed the questions and the remainder of the pilot sample, with the newer scoring 4.6 compared with 4.9 from the more mature.

A number of PCTs in the pilot had not realised, prior to their participation, that their duty of quality extended to their commissioned services.

Even those that had understood the overall duty in principle found it difficult to know how they should, in practice, exercise this duty. The balance that needs to be struck between the duty of the PCT as commissioner and the duty of quality that is imposed upon the organisations from which care was commissioned proved to be a frequent topic of debate in the feedback workshops.

At the point when the pilot questionnaire was completed most PCTs felt that they lacked robust information about the safety and quality of the services that they commissioned (4.6). The majority also felt that they did not yet exercise in practice the influence and leverage within their local health economies that is implied in Shifting the Balance of Power.

In part this reflected the historical 'weight' attached to the views of acute providers and their CEOs, compared to those of primary care organisations. It also reflected the pre-occupation of many SHAs with financial deficits, most of which were generated by their acute providers. Despite the intentions of Government, PCTs do not believe that in reality they have yet been allowed to become:

' the cornerstones of the NHS'

or to exercise:

' the power that has been devolved to PCTs ...and local communities to make strategically important decisions about their own health services'

Reid, 2003.

PCTs do recognise that these 'external' factors are compounded by the fact that many themselves lack the breadth and the depth of expertise (and thus the confidence) to engage in fundamental debates about the quality of commissioned care, let alone to seek through commissioning fundamental shifts in the location, patterns or nature of provision. Such exemplary improvements as had occurred were more likely to have been led by debate and action at the level of the clinical condition (e.g. around NSFs) leading to changes that were then reflected in commissioning arrangements.

All PCTs recognised that the additional challenge imposed by the need to enter into new forms of outcome-based contracts with new Foundation Trusts in conjunction with the 'choice' agenda, would place further demands upon their capacity and capability.

In the light of all of this, it is unsurprising that all PCTs would welcome national and local support and guidance on commissioning for quality. A key element of the ongoing engagement with the pilot sites will be the provision of workshops and networks designed to support the launch of the NatPaCT 'Commissioning Friend'.

The duty of quality

The major responsibility for commissioning services has only recently been transferred to PCTs. Nevertheless, the clinical governance guidance has always made explicit provision

for clinical governance accountabilities and principles to extend to the services an organisation commissions as well as those it provides. Boards have always been responsible for:

'making sure that clinical governance principles are developed and applied which cover the full range of services they provide, and those that are delivered by other providers on their behalf.'

Department of Health, 1999

REFLECTION

What evidence exists to show the extent to which the Board and PEC have actively scrutinised the quality of commissioned services?

Are there specific challenges that result from the quality of provision made by the current provider network?

The PCT need not assume sole or exclusive responsibility for care delivered by other providers; there should be joint responsibility. This responsibility should be specified in and through the commissioning process. Boards must have in place mechanisms for:

'assuming joint accountability for clinical governance of services which are delivered on a multi-sector, multi-agency basis'

Department of Health, 1999

This emphasis upon quality marks a fundamental shift in the principles that should underpin commissioning decisions and agreements.

'No longer will the main emphasis be on cost and activity. Instead, quality of care and the needs of patients will be every bit as important as the need to ensure efficiency and cost-effectiveness.'

Department of Health, 2002a

This places a significant challenge in the way of any PCT that, because of accidents of geography, is reliant upon an acute NHST provider experiencing major problems in terms of access or governance. In this situation, the PCT will need to work pro-actively with the SHA in seeking to reconcile its immediate duty of quality with the practical realisation that even a PCT-led investment in quality improvement will take time before it is translated into measurable improvements in standards and outcomes. In such cases continued investment will need to be tied, through the commissioning process, to explicit targets for evidenced quality improvements within specified time scales.

Breadth of PCT commissioning responsibilities

Shifting the Balance of Power has already brought about fundamental changes in the structural distribution of and accountability for the NHS budget.

'In future PCTs will take responsibility for securing the provision of the full range of services for their local population.'

Department of Health, 2001a

With effect from 1st April 2002, PCTs have taken on a broad swathe of responsibilities and duties that arise from their new key role as commissioners.

'PCTs' Commissioning Responsibilities

The arrangements for commissioning services reflect the need to:

- plan services at the most local level, near the patient;

- co-operate and co-ordinate across boundaries, involving all relevant parties;
- commission specialist services for the appropriate size of population often covering several PCTs.

Department of Health, 2002a

In order to discharge these functions safely and effectively, PCTs have needed to strengthen their public health capability and capacity so that they can identify:

'the health needs of all parts of the community they serve and secure services for them. They may do this by directly providing the service or by commissioning it from health or social care bodies or the voluntary or private sectors.'

Department of Health, 2002a

REFLECTION

To what extent do public health perspectives shape and inform the commissioning agenda of the PCT?

Having identified the nature and the extent of need within their local community, the PCT must identify:

- those services it can best and most effectively provide from within its own professional community resources
- the range, scope and extent of the services they need to commission from other providers.

'PCTs will assume the responsibility for securing the provision of:

- primary care, community health, mental health and acute secondary care services;
- Personal Medical Services including out of hours and walk-in centres;
- medical, dental, pharmaceutical and optical services;
- emergency ambulance and patient transport services;
- the health contribution to child protection services, working in partnership with local authorities and other agencies;
- all primary care development including supporting practices and other contractors and development of Teaching PCTs;
- managing and regulating the contracts of all family health services providers covering medical, dental, pharmaceutical and optical services;
- managing clinical performance with the PCT;
- developing a strong coherent modern nursing service bringing together both FP and PCT-employed nurses and providing both clinical and public health functions.'

Department of Health, 2001a

Commissioning and the 'choice agenda'

PCTs must give due consideration to the individual patient in the commissioning process. They need to have open and transparent processes for setting priorities for:

- commissioning patient care
- considering appeals from individuals
- evaluating and deciding on whether or not to fund new therapies as they arise.

Blanket bans on treatments are a clear violation of the Human Rights Act and could leave the PCT open to legal action and redress, but PCTs must also give more pro-active consideration to meeting the needs of marginalised and disadvantaged groups within their commissioned as well as their provided services.

As the Secretary of State has argued powerfully:

'a uniform public service has failed to create equality'

Reid, 2003.

The 'choice' agenda is a response to this recognition. To translate it from an aspiration into a reality will demand flexibility, creativity and imagination not only from PCTs, but across the entire NHS and health and social care community. The extent to which this challenge is met will be a key concern of the new CHAI, which will explicitly seek to:

'promote equal citizenship by ensuring that the well-being and healthcare of vulnerable groups, including children, older people, people with learning disabilities and people with mental illnesses (particularly those detained under the Mental Health Act 1983), are fully reflected in our assessments and that their rights are safeguarded.'

CHI, 2003

PCTs must also stay abreast of the additional specific commissioning responsibilities they are required to discharge as other new policy initiatives are launched or as specific shortcomings in existing patterns of service are identified.

'Each health authority and each PCG or PCT should designate a senior member of staff who should have responsibility for commissioning children's health care services locally. (Recommendation 170)

Bristol Royal Infirmary Inquiry, 2001

DoH Response to Recommendation 170

'We agree. During 2002, as new structures are developed, each PCT will ensure that a senior member of staff has designated responsibility for commissioning children's services. Strategic health authorities will need to have monitoring arrangements to ensure that appropriate commissioning of services for children is in place.'

Department of Health, 2002c

REFLECTION

What evidence exists to show that the PCT's current management infrastructure is sufficient to discharge the commissioning functions safely and appropriately?

Does the PCT have an appropriate senior member of staff with designated responsibility for commissioning children's services?

Commissioning and collaboration

With increasing emphasis upon patient and public involvement and the seamless care that clinical governance is designed to promote, commissioning is not an activity that any PCT can undertake in isolation from the context of its own clinical staff group, its local community or the local health economy.

'Most PCTs appeared to have systems for taking account of clinician views on service development. In 90% of PCTs there appeared to be systems for taking on board the views of frontline GPs and nurses, a little fewer took on the views of allied professionals (80%) but considerable less (65%) had systems for taking account of the views of local people and the public. In two thirds (65%) systems for taking account of clinician views appeared to be effective, while in a third (31%) these systems were not very effective.'

NHS Alliance, 2003

Not least because of the need to reflect the complexity of the total patient experience, PCTs also need to work in collaborative commissioning partnerships within their local health economy.

'PCTs will need to work with public and patients' groups, other PCTs, NHS Trusts and local authorities to provide patient-focussed and 'joined up' plans and services.

This will mean:

- involving local people in the process of shaping local services
- collaborating with neighbouring PCTs to commission services and work as part of consortia
- joint arrangements with local authorities
- building good relationships and a good understanding of the services and potential of local NHS Trusts and other providers in order to help influence and develop services as well as commission effectively.'

Department of Health, 2002b

As part of this partnership arrangement, clinical and management staff from the PCT must also work actively with managers, clinicians and carers in the organisations from which they commission care. This arrangement is necessary to ensure:

- the development and consistent implementation of common understandings of clinical governance accountabilities – and of clinical governance in concrete practice
- the development and consistent implementation of integrated care pathways that span the primary, community and secondary care sectors
- collaborative activity to identify and manage risk at points of transition between the different sectors
- co-ordinated progress towards the generation of common patient record systems and the collection of common data sets
- the development and application of multi-disciplinary and cross-sectoral clinical audit projects
- the development, in collaboration with the local Workforce Confederation, of inter-organisational training priorities and activities
- common approaches to research implementation and common understandings of clinical effectiveness.

Inevitably, given the scale and the scope of the agenda, although much good work has begun, progress is still variable.

REFLECTION

What evidence is there that these sorts of pathway-focussed dialogues occur with staff of key providers of commissioned services?

Are the benefits and the costs of such arrangements kept under active review by the PEC?

'Most PCTs have a forum where primary and secondary care clinicians can discuss and plan service development (78%). The effectiveness of this forum is variable (e.g. 54% felt that this was fairly effective and 19% that is was not very effective). Only 20% of these forums included lay people. A little less than half (47%) of PCTs were commissioning along care pathways and although two thirds of those that did so thought this was fully or fairly effective, a third felt that this was not effective.'

The development of effective partnership arrangements requires PCTs and their partners to make significant investments in time. The demand for management and other time is considerably increased for PCTs that rely upon a complex network of provider relationships – as opposed to those that have one major or predominant partner.

Securing improvement whilst ensuring stability

PCTs now have the opportunity to exercise significant influence within their local health economies. They have the freedom to buy care from the most appropriate provider, whether public, private or voluntary.

'The principle of devolution means that PCTs should take control of the main revenue allocation, giving them the necessary power to shape the development of local services.'

Department of Health, 2001a

However, not all PCTs across the system have the confidence, the capacity or the competence to exercise this freedom yet.

'Currently, the relationship between commissioner and provider is unequal. Acute service providers have, on the whole, better information than their PCT commissioners and a much longer experience of the process. PCT commissioning may be largely about partnership – particularly between PCTs and Acute Trusts and primary care clinicians – but this can be an unequal partnership, when the vested interests remain on either side of the partnership and the level of experience on either side is also quite different ..... 23% of PCTs thought they had no successful means of leverage in terms of commissioning satisfactory services for their patients.'

NHS Alliance, 2003

Boards and PECS need actively to ensure that the voice of the PCT is a strong one within these commissioning discussions – and to monitor how positively their own clinical community believe the commissioning process to be and how actively they felt that they are engaged with it.

'Clinicians varied in their responses on commissioning effectiveness from just one PCT, where the clinician felt that commissioning was fully effective to four, where the clinicians felt that commissioning was not effective at all. Part of this variability may have something to do with the maturity of the PCTs, which ranged from six months to two and a half years old. Nevertheless, around half of the clinicians felt that they had "fairly effective" commissioning systems in place and most felt that PCTs took their views into account and had reasonably effective means of doing so.'

NHS Alliance, 2003

In order to effect fundamental and sustainable improvement, PCTs may need to make commissioning decisions that will have a significant impact upon the whole nature and shape of a local health economy

'This may involve developing or changing services to improve quality, access, responsiveness and outcomes.'

Department of Health, 2001a.

This corporate freedom allows PCTs to think and act differently. At the same time, moves towards patient choice may see individual patients receiving information on alternative providers and being empowered to choose the provider that can guarantee them the quickest or the best quality care. It will make no difference whether that provider is part of the local, regional or even national provider network.

Taken together, these factors could introduce turbulence that might threaten the overall viability of local health economies which are, by their nature, financially and often clinically interdependent.

If PCTs are not to pursue their own competitive organisational advantage at the expense of the local system as a whole, they will

'need to behave in a mature and co-operative fashion, working closely with one another and health and social care organisations to deliver effective health care.'

Department of Health, 2001a

In determining their commissioning priorities and in pursuing longer-term strategic attempts to improve and transform patterns of service provision, PCTs will need to work closely with SHAs and other partners to strike a careful balance between:

- the need to produce significant improvement and change,
- the need to ensure that there is sufficient stability within the system to secure existing standards of quality
- enabling providers to have sufficient confidence in the future to invest in development and in longer term quality improvement.

REFLECTION

What evidence exists of any significant risks to the stability of the local health economy that arise from issues related to resource, access or CHI?

Long Term Service Agreements

To build this degree of stability into the system, the NHS is committed to the introduction of Long Term Service Agreements (LTSAs) between commissioners and providers. By this means, they enter into a sustained partnership and collaboratively pursue service improvements.

'Long Term Service Agreements provide the key for unlocking the potential within health care to provide a patient-centred service.'

Department of Health, 2000

'Properly constructed LTSAs will:

- reflect an ongoing dialogue between clinicians, users and carers as well as managers;
- engage all those who contribute to a pathway of care, to build a mutual understanding of the contributions that both primary and secondary care and, where appropriate, social care are to make, and how these can best meet patients' needs;
- be dynamic, incorporating incentives for improving quality and cost-effectiveness; and as part of this, they will reflect clear responsibility for risk management, ensuring activity does not get out of kilter with funding.'

Department of Health, 2002a

Sustained relationships show the best return on investment since time is needed, in the first instance, to forge effective collaboration. They also ensure that resource (that could be better employed in the direct provision of services, or invested in service improvement initiatives) is not consumed year after year in formal processes of contract negotiation.

LTSAs, alongside sustained attempts by PCTs and others to develop inter-organisational forms of clinically governed care, provide a major opportunity to develop truly seamless care for individual patients.

'[LTSAs] will be based upon integrated care pathways focusing on services or client groups rather than organisations; they will reflect the developing National Service Frameworks to deliver a quality based service; they will be developed in partnership from real dialogue involving all parties with an interest in the service; they will identify quality and outcomes rather than being dominated by cost and volume issues; they will be truly reflective of local priorities.'

Department of Health, 2002a

The outcome of these negotiations will have a significant overall impact upon the performance rating achieved by the PCT.

'They are currently preparing their plans for the next three years and this year's star ratings and performance payments will reflect the standard of secondary services that they have been able to commission (as well as primary care services).'

NHS Alliance, 2003

REFLECTION

What evidence exists to indicate how well prepared the PCT is to enter into LTSAs?

Pending the formal creation of Foundation Trusts and the generation of expertise in the construction, management and monitoring of contractual arrangements between them and PCTs, it is not clear how this need for stability will be reconciled with the greater freedoms and flexibilities that (subject to legislation) may extend over the coming years to most providers of acute, and other, core services.

Commissioning for quality and improvement – pilot work in primary care

Understandably, the commissioning agenda to date has been largely shaped by financial considerations and by national targets rather than by local priorities or improvement initiatives.

'Key factors in shaping commissioning decisions were achieving financial balance (95%), patients' access to services (93%), national policy targets (93%), and NSFs (89%).'

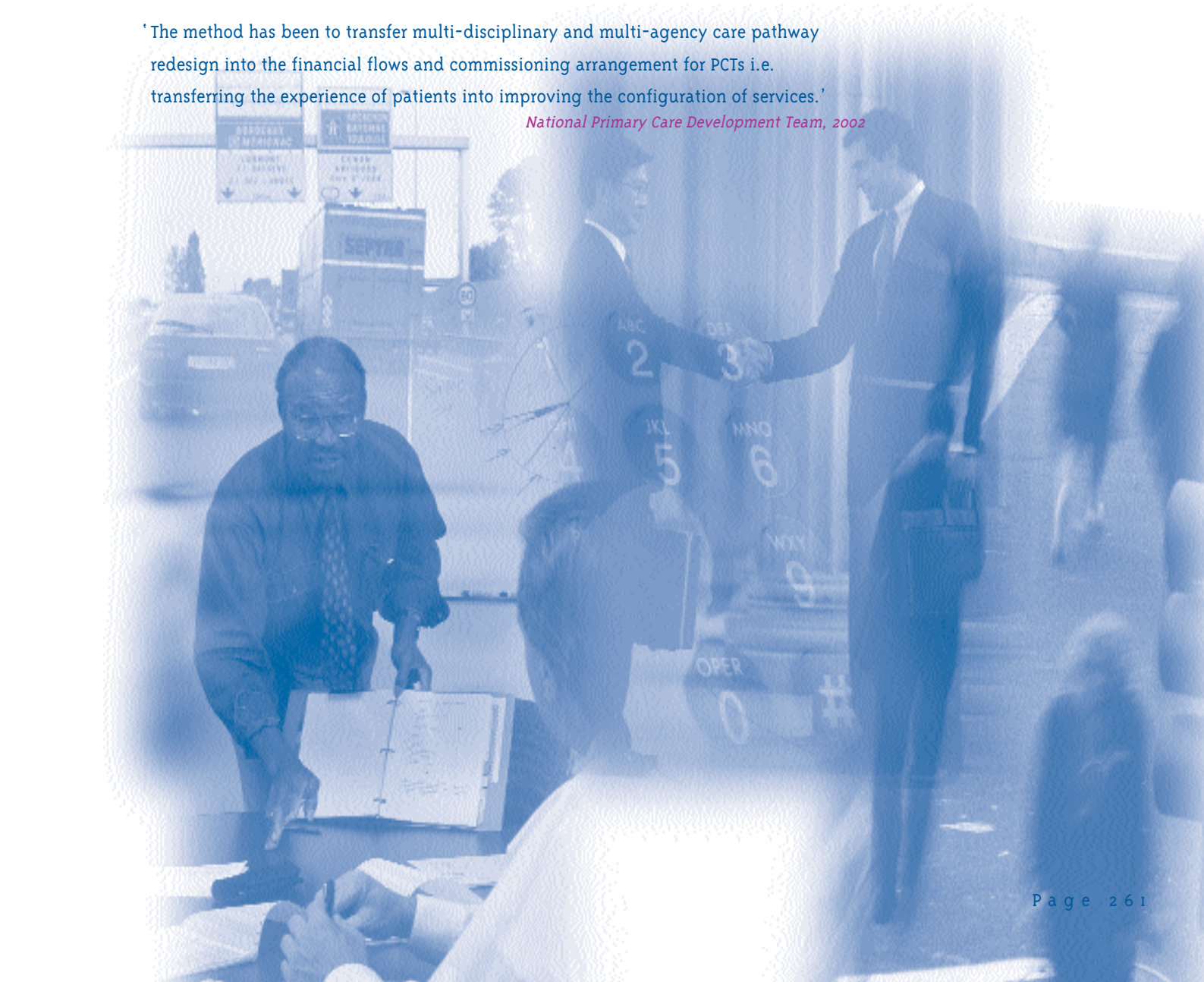
National Primary Care Resource and Development Centre, 2002

Nevertheless important pilot work has been undertaken on good commissioning practice under the auspices of the National Primary Care Collaboratives.

One of the three main topics of the NPCC is capacity and demand management between primary and secondary care. 80 PCTs have been involved in pilot activity to explore an effective primary care-led approach to capacity and demand management. The work has sought to align financial and clinical realities.

'The method has been to transfer multi-disciplinary and multi-agency care pathway redesign into the financial flows and commissioning arrangement for PCTs i.e. transferring the experience of patients into improving the configuration of services.'

National Primary Care Development Team, 2002



REFLECTION

What evidence is there to indicate that the Board and PEC are providing active leadership of the 'commissioning for improvement' agenda?

This work is being enhanced by 'Smart Care' – a programme which explores and develops the relationships and skills necessary for change between primary and secondary care. Details of this work can be found in the recent report, The NPCC – The First Two Years.

Important outcomes include:

- indications of ways patients can be involved in service redesign
- the development of expertise in contractual/commissioning for improvement processes
- specific examples of how careful and collaborative planning can change and improve patterns of local care provision

'Redesigning the pathway in partnership with the local acute trust, a PCT-employed GP with a Specialist Interest in dermatology (GPwSI) was introduced to manage patients not requiring a Consultant opinion.'

National Primary Care Development Team, 2002

From the perspective of Boards, a key outcome of the work has been to identify the crucial importance of effective leadership from the Chairs and CEOs of all partners in the collaborative process.

Commissioning for quality and improvement – the Local Authority experience of Best Value

If the ambitious goals set for LTSAs are to be achieved, PCTs need to draw upon:

- commissioning experience and ideas from the commercial sector (where partnership resourcing and supply chain development have become key factors in securing sustainable growth in rapidly evolving markets)
- experience in the public sector where, for a number of years, Local Authorities have been involved in 'commissioning for quality' activities that have generated the Best Value model.

'Local councils have been required, since April 2000, to develop Best Value performance plans and to review all their services over a five-year period applying Best Value principles.'

Department of Health, 2001b

Experience of the implementation and initial evaluation of Best Value suggests that the Boards and PECs of PCTs need to ensure that they make wise choices, at the outset, in determining:

- the precise nature of the services that they need to commission
- who their long term provider partners should be.

Failure to do so can result in a PCT being 'locked in' to an agreement that generates unregulated cost and/or unmanageable risk. Experience also suggests that commissioning agreements must explicitly enable commissioners to continue to exercise appropriate oversight, scrutiny and influence upon the quality of commissioned care. This should happen throughout the lifetime of a long-term arrangement.

The underpinning principles of Best Value are that commissioning agreements should be 'challenge-' and not 'precedent-' based. In other words, the commissioner should consider a series of fundamental questions about the *need for services* — not about how (or by whom) they have been provided in the past.

> 'Best Value is an effective way of addressing the Government's social care modernisation agenda and delivering Quality Protects and the national service frameworks;
>
> Best Value reviews are most effective when they are wide-ranging, service user focused and address questions about what service is required before considering who can provide it most effectively;
>
> All stakeholders, including service users, councillors and staff need to be involved throughout the process to gain common ownership.'
>
> *Department of Health, 2001b*

The process provides guidance to commissioners and suggests that, in the first instance, they consult widely with all of their stakeholders to determine:

- their needs
- their view as to whether a particular service is essential, desirable, or unnecessary
- their views of current provision
- their own preferences in terms of provider
- the improvements they would like to see in terms of access, responsiveness and quality.

Commissioners should also define key characteristics of:

- current provision — cost, output and quality measures, together with measures of user involvement
- fair access
- sustainability.

They should then identify gaps between the current quality and the desired quality, the current cost and the desired cost. Only when they have firm answers to all of these questions should they embark upon formal commissioning negotiations. Within the partner Local Authority/ies of the PCT, there may well be considerable experience and expertise in terms of commissioning for improvement and for quality.

Overall Best Value Question to Commissioners – Challenging the existing pattern of provision

Is there a robustly evidenced need for the service and is the current way of providing it the only way?

Key supporting questions for Commissioners – Challenging the existing pattern of provision

1 Are the aims of the service being commissioned clear and challenging?

2 Have patients been consulted to ascertain their views about the nature, location and the standard of the service they require?

3 Has the overall purpose, demand and need for the service been realistically assessed?

4 Has the service been broken down into its constituent parts (process mapping) and has each part been challenged?

5 Has the cost of the service been compared with the costs charged by other possible providers?

6 Can the cost of the service be justified?

7 What are the advantages and disadvantages if the service or activity were to be supplied by an alternative provider?

8 What would be the consequences of removing or reducing the level of service?

REFLECTION

What benefit, if any, might ensue from a dialogue with the local authority about the quality/ commissioning interface?

Priorities for action

Now that you have finished reading through this section, please identify three priorities for the PCT in relation to commissioning.

1

2

3

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National Primary Care Resource and Development Centre 2002. *National Tracker Survey of Primary Care Groups and Trusts 2001/2002: Taking Responsibility?* Manchester: NPCRDC

Reid, J. 2003. *Localising the National Health Service: gaining greater equity through localism and diversity.* London: New Local Government Network.

Resources

Audit Commision – a range of publications including Services for Disabled Children and their Families www.audit-commission.gov.uk/disabledchildren

NHS Alliance – the organisation that represents the views of PCTs. A variety of publications includes: What is the State of Commissioning in PCT Trusts: An NHS Alliance survey of lead clinicians, 2002; Vision in Practice, March 2002; Refocusing Commissioning for PCTs, 2002; Survey of PEC Chairs, 2002; Driving seat or back seat? GPs views on and involvement in Primary Care Groups and Trusts, 2003; Engaging GPs in the New NHS, 2003 www.nhsalliance.org

Every Child Matters consultation paper from Department of Education and Skills www.dfes.gov.uk/everychildmatters

Regan, E. L., Smith, J. A., Goodwin, N., McLeod, H., Shapiro, J. 2001. Passing on the Baton. Final report of a national evaluation of Primary Care Groups and Trusts, Birmingham: HSMC, University of Birmingham

Rating the PCT's current stage of development

Please rate the PCT's current stage of development in relation to the following questions.

Remember to use the Response Sheet provided for your answers.

18.1 To what extent do the Board and PEC take 'all reasonable care' to assure the quality of the services commissioned by the PCT?

18.2 To what extent do the Board and PEC understand the relationship between their clinical governance duties and responsibilities and those of the organizations from which they commission care?

18.3 To what extent are the PEC and the clinical governance committee actively engaged with the commissioning process?

18.4 To what extent are local communities actively engaged with the commissioning process?

18.5 To what extent does the commissioning process promote the delivery of seamless care?

18.6 To what extent does the PCT's commissioning strategy promote transformation to the models and patterns of care necessary to achieve *The NHS Plan*.