



House of Commons  
Committee of Public Accounts

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**Improving quality and  
safety—Progress in  
implementing clinical  
governance in primary  
care: Lessons for the new  
Primary Care Trusts**

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**Forty–seventh Report of Session  
2006–07**

*Report, together with formal minutes, oral and  
written evidence*

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## The Committee of Public Accounts

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## Summary

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Following serious concerns about clinical and organisational failures in the NHS during the 1990s (such as Alder Hey, the Bristol Royal Infirmary and Shipman), the Government identified the need for a more systematic approach to improving quality and safety in healthcare. In response, the Department of Health introduced a ten year programme to improve the overall standard of clinical care. Its centrepiece is clinical governance; a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.

The Health Act 1999 (and 2003) introduced a statutory 'duty of quality' for services commissioned and provided by all NHS Trusts, for which trust Chief Executives are accountable. The Department expects this duty of quality to be discharged, at trust level, through the implementation of clinical governance. The Health Act 1999 also gave the Department the authority to establish Primary Care Trusts (PCTs) which are responsible for providing primary care services and commissioning services on behalf of their local health economy. In all some 303 PCTs were established between 2001 and 2002.

In July 2005, the Department identified the need for significant organisational change to enable primary care to respond more effectively to key national initiatives such as patient choice, payment by results and practice-based commissioning. The Department therefore announced that the number of PCTs would be reduced and reconfigured to 152, with effect from 1 October 2006.

On the basis of a report by the Comptroller and Auditor General,<sup>1</sup> we examined the Department's progress in implementing clinical governance in primary care; the lessons learned; and the risks that will need to be managed if quality and safety are to be embedded in the new PCTs. We took evidence from the Chief Executive of the NHS, the Deputy Chief Medical Officer and the NHS Director General of Commissioning.

We found that clinical governance is not as well established in primary care as in secondary care, largely because of the complexity of PCTs role in both commissioning and providing care; and the independence of contractors delivering healthcare, particularly General Practitioners (GPs). Primary care has also been slower in adopting a structured approach to quality and safety, evident for example in the lack of compliance with national systems reporting of clinical incidents. There is a lack of clarity between PCTs and their contractors as regards accountability for ensuring quality and safety, and scope for greater involvement of patients and the public in ensuring that primary care services are safe and of high quality.

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<sup>1</sup> C&AG's Report, *Improving quality and safety: Progress in implementing clinical governance in primary care – lessons for the new primary care trusts*, HC (2006-07) 100

## Conclusions and recommendations

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1. **PCTs do not routinely include outcome measures for quality and safety in their commissioning arrangements.** In developing its guidance for PCT commissioning, the Department should include the need for PCTs to include clear outcome measures on quality and safety in their contracts so that the performance of healthcare providers can be monitored and evaluated.
2. **One of the areas particularly associated with improving quality and safety was effective clinical leadership, yet members of PCTs' Professional and Executive Committees often lacked effective leadership skills.** PCTs should put training and development programmes in place which focus on developing leadership skills for those responsible for managing the commissioning and provision of services. Priorities should be given to developing skills in:
  - (i) Management and leadership skills for the Professional Executive Committee members, so that these Committees can play a strategic role in embedding quality and safety in the PCT Board agenda in relation to commissioning and provision of services;
  - (ii) Joint working methods, to improve interaction between health and social care and also with voluntary and other local agencies,
  - (iii) Patient and public engagement, which focus on involving service users more actively in service design and development across primary care.
3. **Not all GPs understand the concept of clinical governance and how it relates to their day to day work.** PCTs need to use the opportunity presented by the new commissioning arrangements to communicate more effectively with their independent contractors on the importance of clinical governance systems and processes, and how the various components contribute to maintaining the quality and safety of healthcare provision.
4. **Patient and public involvement is less well developed than other aspects of clinical governance.** PCTs need to have a clear strategy for consulting patients and the public on service design and delivery. Where PCTs obtain the views of patients and the public they need to show how they have acted on these views, including how these views have impacted on their commissioning decisions.
5. **Of the 14 voluntary groups surveyed by the National Audit Office, all felt that PCTs could engage more effectively with their client groups.** PCTs should identify where they can achieve efficiency gains and more consistent support to patients and their carers from closer joint working with voluntary groups, including joint provision of information to healthcare providers about support available to patients. They should routinely consult patient organisations and carer groups to capture and learn from their experiences and identify areas for improvement.

- 6. Patients in primary care are often unclear about how to complain or how their complaints will be dealt with, whilst staff are not always informed of the outcome.** PCTs need to work with their Patient Advice and Liaison Service and other local patient advocacy groups to develop and put in place an effective complaint handling process. They should communicate the processes to staff, independent contractors, patients and carers; including what to expect in terms of timely feedback on the outcome of complaint handling. PCTs should also implement strategies for communicating effectively with patients and carer groups who may be unable to frame their complaint or present it effectively because of cultural, language or literacy issues.
- 7. Only 4% of GPs report untoward events and clinical incidents to the National Patient Safety Agency's National Reporting and Learning System resulting in limited sharing of learning either locally or nationally.** PCTs should include in their contracts a requirement that all providers have an active incident reporting system that links to the national reporting system. PCTs should undertake regular audits, including cross referencing to complaints, to ensure that incidents and untoward events are being captured, and also benchmark performance to help identify under-reporting, whether by types of staff or by types of incidents. PCTs should require reports on the root causes of serious or recurring incidents and draw out themes so that solutions and risk reduction strategies can be developed.

# 1 Accountability for quality and safety

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1. A statutory ‘duty of quality’ for all providers of NHS services was introduced in 1999 following the tragic Shipman, Bristol Royal Infirmary and Alder Hey cases.<sup>2</sup> The Chief Executives of NHS trusts are accountable to trust boards for delivering this statutory duty of quality, which is largely discharged through clinical governance. Clinical governance is a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.<sup>3</sup>

2. This approach sees quality and safety not only as the professional responsibility of individuals, but also as a responsibility to be embedded at all levels of an organisation. Whilst such measures cannot guarantee that cases such as Shipman will never happen again, the Department believes that having the right systems, processes and culture in place will make it easier for them to be detected, and provide assurance to patients that the services they receive are safe and of sufficient quality.<sup>4</sup>

3. Between 2001 and 2002, 303 Primary Care Trusts (PCTs) were established<sup>5</sup> with responsibility both for providing primary care services, and for commissioning services from independent contractors and other providers on behalf of their local health economy. The 303 PCTs varied considerably in the geographical and socio-economic nature of the areas they served, with the size of population covered ranging from 64,000 to 367,000.<sup>6</sup> In 2005–06, £23 billion was spent on primary care services, 78% of which was spent on commissioning services from independent contractors and other providers, including some 35,000 GPs.<sup>7</sup> 800,000 people use primary care services each day, with nine out of ten NHS patients diagnosed and treated entirely within primary care.<sup>8</sup> About 20% of people who work in the NHS now work in primary care.<sup>9</sup>

4. Accountability for PCT performance, including quality and safety, rests with the Chief Executive who is directly accountable for all the services the trust provides, whether provided directly or commissioned from other providers.<sup>10</sup> PCT Boards are responsible for setting the strategy and monitoring the performance of the trust. A Professional Executive Committee (PEC) assists the Board in the management of the PCT by providing clinical leadership and advice on quality and safety.<sup>11</sup> The Chair of the PEC is a member of the PCT Board and the PEC members are elected by their peers. Membership of the PEC can vary but will normally comprise a majority of primary and community care professionals.<sup>12</sup>

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2 Qq 23, 25

3 C&AG’s Report, para 1.5

4 Qq 1, 25

5 Q 44

6 C&AG’s Report, para 1.11

7 Qq 26, 27

8 C&AG’s Report, Figure 2

9 Q 78

10 Qq 2, 91; C&AG’s Report, summary para 1

11 Qq 95; C&AG’s Report, para 1.12

12 C&AG’s Report, Figure 5

PCT line management responsibilities for commissioned services are diffuse with limited power over individual contractors despite PCT Chief Executives being accountable for the quality of care (**Figure 1**).

5. The relationship between the PCT Board and PECs is important to overall progress in improving quality and safety. The involvement of PECs appears to some to have been an afterthought, however, and PEC members are generally less positive about the progress that has been made.<sup>13</sup> The GPs among those PEC members that responded to the National Audit Office survey (29% of the respondents) consistently gave lower achievement scores.<sup>14</sup> PECs are intended to engage GPs in the leadership and management of PCTs and, prompted by the NHS Alliance's 2004 report *Making a Difference—engaging clinicians in PCTs*, the Department has recently reviewed both their form and function.<sup>15</sup> The Alliance report found that PECs did not have a clear remit and that PEC members often lacked leadership and strategic skills.<sup>16</sup> After a three month consultation period,<sup>17</sup> the Department published guidance to strengthen PECs, to be implemented by PCTs by 1 October 2007.<sup>18</sup>

6. In October 2006, the number of PCTs was reduced from 303 to 152.<sup>19</sup> This significant organisational change forms part of the wider NHS reform agenda and is intended to enable PCTs to fulfil their responsibilities for implementing key national initiatives such as patient choice, payment by results, and practice-based commissioning and for managing independent contractors such as GPs, dentists and pharmacists.<sup>20</sup> The new PCT configurations are intended to lead to benefits for patients, and the Healthcare Commission's next Annual Health Check is expected to provide evidence of quality and safety improvements across primary care.<sup>21</sup>

7. Weaknesses in contract management and communication links between PCTs and independent contractors do not give confidence that quality and safety will be addressed as the NHS moves towards a greater diversity of providers under practice-based commissioning.<sup>22</sup> This new system will involve GPs taking responsibility for commissioning services, with practices holding an 'indicative budget' from the PCT which enables them to 'buy' services for patients from a range of providers.<sup>23</sup> If commissioners do not specify the requirements for quality and safety into contracts at the time of commissioning healthcare services, there is a real risk that the principles and accountability for quality and safety will not be in place for those commissioned services.<sup>24</sup>

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13 Q9; C&AG's Report, para 2.10

14 Q 124

15 Qq 9–10

16 Qq 10, 124

17 Department of Health public consultation on the document, *Fit to Lead, a Review of the PEC*

18 Q 10; *Primary Care Trust Professional Executive Committees. Fit for the Future*, Department of Health, March 2007

19 Qq 44, 57

20 C&AG's Report, summary para 5

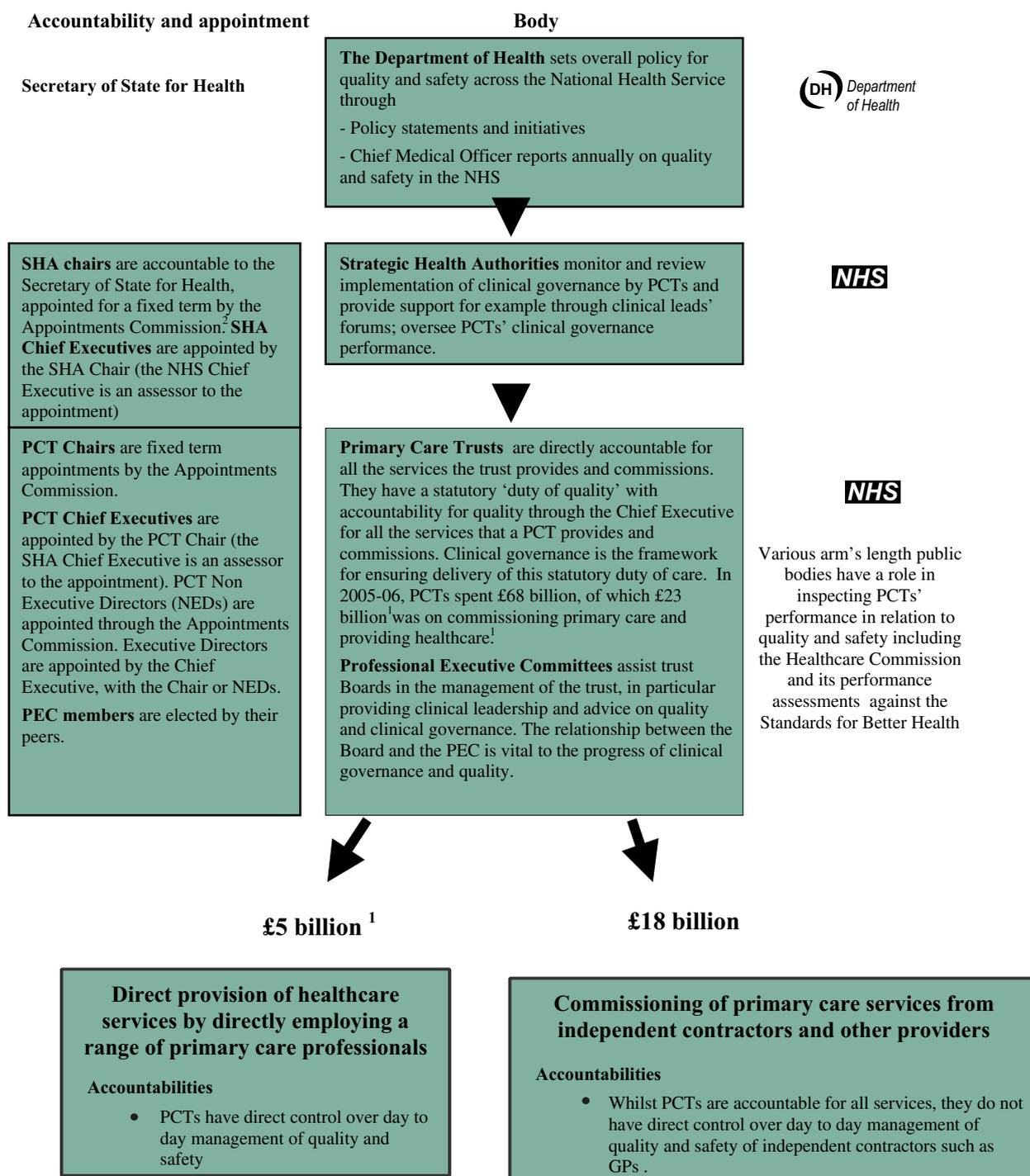
21 Qq 19, 58

22 Q 11

23 C&AG's Report, para 1.15

24 Q 19

Figure 1: Roles, responsibilities and accountabilities for quality and safety of primary care services



**Patients and the Public** use primary care services - 800,000 people each day; with 9 out of 10 NHS patients diagnosed and treated entirely within primary care.

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

Note 2: The Appointments Commission is a national body. It has nine regional commissioners, each of whom appoints the chairs and non-executive directors of the various health bodies in that region

Source: National Audit Office and Department of Health

## 2 Progress in improving quality and safety

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8. 82% of PCTs surveyed by the National Audit Office considered that clinical governance had helped raise the quality of patient care, for example through improved staff training and better complaints management.<sup>25</sup> The Department told us that the Quality and Outcomes Framework (QOF), which is part of the new GP contract, shows that the quality of primary care is improving.<sup>26</sup> Under the QOF, introduced in April 2004, GP practices score points for achievement against a range of 146 evidence-based indicators and are paid according to the points achieved. These data, however, are primarily collected for payment purposes, linking remuneration to evidence of the quality of service. In 2006, each practice on average achieved 96% of the points available—or 1011 out of a possible 1050.<sup>27</sup> Although the QOF is focused on inputs rather than outputs, the Department believes there is good clinical evidence, that for between 60 and 70% of the QOF measures, these inputs will result in improved outcomes.<sup>28</sup> The Department also told us that patients are becoming increasingly satisfied with the local primary care services provided.<sup>29</sup>

9. Front-line staff surveyed by the National Audit Office reported a variety of day to day pressures which acted as barriers to the effective implementation of clinical governance and pursuit of quality goals, such as lack of time, financing and staff.<sup>30</sup> Some PCTs had, however, managed to get over these barriers so they should not necessarily prevent clinical governance progressing. Nonetheless, the Department was reviewing the progress of each PCT as part of a fitness-for-purpose programme, where each PCT will agree with its Strategic Health Authority how it will improve its performance over the next year.<sup>31</sup> PCTs also need to work together where PCT boundaries are not coterminous with Local Education Authority boundaries and gaps in the provision of healthcare could arise.<sup>32</sup>

10. Clinical governance links between PCTs and independent contractors such as GPs and pharmacists are undeveloped.<sup>33</sup> Contractors consider that they are not getting adequate support from PCTs to embed quality and safety into their procedures and raise the levels of clinical governance.<sup>34</sup> Strategic Health Authorities found the independence of contractors a major challenge in working with PCTs to implement clinical governance.<sup>35</sup> Under practice-based commissioning, greater diversity of providers will bring greater complexity to the implementation of clinical governance.<sup>36</sup> In order to build quality and safety into

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25 Q 55; C&AG's Report, paras 16, 2.33

26 Q 1

27 C&AG's Report, para 2.13

28 Q 80

29 Qq 1, 24

30 C&AG's Report, para 15

31 Q 20

32 Qq 21–22

33 C&AG's Report, para 14

34 Qq 47, 51–52, 59

35 Q 7; C&AG's Report, para 2.11

36 Q 11

commissioning the Department recognised the need for openness and transparency in commissioning decisions; appropriate channels for whistleblowers to voice concerns; and vigilance in the monitoring of incentives offered to contractors.<sup>37</sup>

11. The Department recognised that PCTs need to rise to the challenge of providing adequate support to help independent contractors, particularly in terms of developing skills in new areas.<sup>38</sup> Looking forward, independent contractors would be engaged more clearly in contracting and identifying quality and safety in both primary and secondary care under practice-based commissioning.<sup>39</sup> Contract management and commissioning skills needed to be improved across PCTs and within the NHS as a whole, and outside agents from the private or independent sectors might be used to help improve commissioning.<sup>40</sup>

12. It takes 7–9 years to train a GP and costs around £250,000,<sup>41</sup> but arrangements for ensuring that their professional skills are up to date rely largely on self-assessment and peer review.<sup>42</sup> The Chief Medical Officer's July 2006 report *Good doctors, safer patients* highlights the actions that are available to PCTs to investigate and deal with concerns about GP performance.<sup>43</sup> Although more than three-quarters of primary care spending is directed at independent contractors, the level of intervention with poorly performing GPs is very low, with only 66 GPs out of 35,000 currently under suspension.<sup>44</sup> Mechanisms for monitoring quality and safety have contributed to better identification of poor performance, but PCTs do not have direct line management of independent contractors.<sup>45</sup> So although PCTs now have greater powers to take action with poorly performing GPs, many PCTs have failed to take local action to address their concerns,<sup>46</sup> reinforcing doubts about monitoring and control of the quality of GPs.<sup>47</sup>

13. The Department believed that GPs were held to account more than they used to be, but had nonetheless been concerned about the willingness of PCTs to manage performance at a local level. As a result, medical regulations had been reviewed and the Chief Medical Officer's paper *Good doctors, safer patients* had drawn up a list of 44 recommendations to change the regulatory framework within which doctors operate.<sup>48</sup> The Government's response to these recommendations was published on 21 February 2007.<sup>49</sup>

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37 Qq 59–71

38 Q 52

39 Q 49

40 Q 11

41 Qq 4, 112

42 Qq 78, 82, 85

43 C&AG's Report, para 2.25

44 Qq 5, 26–27

45 Q 119

46 Qq 36, 119

47 Q 28, 35

48 Qq 28, 36, 120

49 A White Paper, *Trust Assurance and Safety—The Regulation of Health Professionals in the 21st Century*, Department of Health, February 2007. This document sets out the Government's programme of reform for the regulation of all health professionals

14. 94% of GPs responding to the National Audit Office survey have incident reporting systems in place.<sup>50</sup> However, only 4% of GPs routinely reported adverse incidents to the National Patient Safety Agency, with more than three quarters saying they did not.<sup>51</sup> The Healthcare Commission's 2006 report on the state of healthcare found that safety received less attention in primary care than in acute trusts and that the systems for reporting were generally not as well developed and less widely used.<sup>52</sup> The Department is currently working with the Royal College of General Practitioners to develop guidance to encourage and support GPs in the reporting of incidents. It is setting up patient safety action teams at strategic health authorities to improve communications and thus make incident reporting easier.<sup>53</sup>

15. Although it suggested that in the NHS it has not traditionally been considered possible to improve quality and reduce costs at the same time, the Department believes that clinical governance will drive out significant efficiency savings throughout the NHS.<sup>54</sup> The NAO's survey of GPs found that 15% of GPs considered that clinical governance had helped them to deliver efficiency savings.<sup>55</sup> 20% of PCTs considered that clinical governance had delivered efficiency savings across five broad areas (**Figure 2**) and a further 66% considered that it might have delivered efficiency savings though they had not been fully assessed.<sup>56</sup> The Department considered that although GPs regard quality and safety as central to their activities, activities such as listening to patients, responding to complaints, and learning from incidents are not necessarily recognised as being about clinical governance.<sup>57</sup>

16. The Department took some assurance from the Healthcare Commission's assessment under the Standards for Better Health. In 2005–06, 92% of PCTs considered themselves to be compliant with the Department's Standards for Better Health.<sup>58</sup> This assessment system, which requires PCTs to assess their own performance, replaced the 'star-rating' system which had been used until 2004–05.<sup>59</sup> The use of self-assessment in the NHS contrasts with the direct inspection of schools by Ofsted. The Department, however, is concerned to strike the right balance between holding people to account, line management and providing GPs with the autonomy to maximise productivity. It was therefore using levers for quality improvement, such as practice-based commissioning and patient choice.<sup>60</sup>

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50 Q 122

51 C&AG's Report, para 2.16

52 C&AG's Report, para 2.16

53 Q 39

54 Q 55–56

55 C&AG's Report, para 2.36

56 Q38; C&AG's Report, para 2.36

57 Qq 38, 125

58 Q 116

59 C&AG's Report, para 2.18

60 Qq 118, 121

**Figure 2: Examples of how clinical governance has helped PCTs deliver efficiency savings**

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

Source: C&AG's Report, Health Services Management Centre census of PCTs, Autumn 2005

17. At a higher level, we also found that no Chief Executive from any of the PCTs had been called in by the Department for failing to meet their statutory duty of quality.<sup>61</sup> The Healthcare Commission had powers enabling it to recommend the application of 'special measures' to the Secretary of State when it had a concern regarding quality of care in a part of the NHS.<sup>62</sup> The Commission's Annual Health Check had identified 24 PCTs about which it had serious concerns over quality and financial performance,<sup>63</sup> and where action had been taken by each PCT board and Chief Executive with supervision from the Strategic Health Authority.<sup>64</sup>

61 Qq 33, 34

62 Qq 28, 35

63 Q 33

64 Q 35

## 3 Engaging patients and the public in improving quality and safety

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18. A key objective of the NHS reform agenda is to improve the patient experience by strengthening the involvement of patients and the general public in shaping the future provision of services. Patient and public involvement and the quality of the patient experience are two important components of clinical governance.<sup>65</sup> The National Audit Office found, however, that patient and public involvement is relatively less well developed than other aspects of clinical governance. It also found that the level of engagement with voluntary organisations supporting patients is low.<sup>66</sup>

19. The Department believes that public and patient representatives and speciality groups should have a say in the criteria against which doctors' capability will be assessed. The development of criteria by the Royal Colleges, speciality groups, and local participation groups showed how patients were increasingly having a say in how doctors' capability would be judged. The consultation on the role of PECs also identified the importance of PECs engaging with the voluntary sector in a way that they might not have been done previously.<sup>67</sup>

20. Unless patients are more involved in the process it will not be possible to develop an adequate machinery of monitoring and control to assess GPs' performance and how well they are listening to patients. At present only 30% of general practices have patient participation groups within them, but the Department is working with the National Association for Patient Participation to increase this to 100% over the next few years.<sup>68</sup> Its Expert Patients Programme also aims to train 30,000 patients with the intention that patients will be able to engage in real dialogue with their doctors over the future of their care.<sup>69</sup>

21. The quality of patients' experience depends in part upon smooth transitions between healthcare providers and 'seamless' delivery of service from the different organisations they come into contact with as they receive care.<sup>70</sup> Patients often have an unsatisfactory experience as they move between different parts of the NHS. Nine out of ten decisions that affect patients' lives and incur costs are made in primary care but 60 to 70% of the costs are in hospitals. The Department therefore aims to get primary care more involved in discussions which make a difference to pathways of care by providing incentives through practice-based commissioning.<sup>71</sup> Any savings made as a result of commissioning decisions

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65 C&AG's Report, para 3.1

66 C&AG's Report, paras 3.8, 3.10

67 Q 88

68 Q 126

69 Q 88

70 C&AG's Report, para 3.2

71 Qq 89–90

made under practice-based commissioning can be used by practices for the benefit of patient care.<sup>72</sup>

22. One of the Department's key initiatives in the area of patient and public involvement is the development of Local Involvement Networks (LINks) to replace patient forums.<sup>73</sup> The Department told us that LINks will be larger, more networked organisations that will provide a better patient and public voice than patient forums centred around small executive teams. In the present system patient forums are also closely linked to individual organisations, whereas LINks will cover geographical localities and will therefore be able to address issues that cut across organisations.<sup>74</sup>

23. Part of improving PCT engagement with patients and carers involves effective complaints procedures so that information can be fed back and incorporated into future service design.<sup>75</sup> Although the NHS complaints procedure is an important mechanism through which patients can give feedback on the quality of care they receive, and 35,431 written complaints were received by GP practices in 2004–05,<sup>76</sup> the channels available for patients to complain about ill-treatment by a GP are inadequate.<sup>77</sup> The National Audit Office's survey of GPs also found that where GPs were involved in complaints, just half of GP respondents were routinely informed of the outcome of these complaints by the PCT. The Department agreed that this situation was unsatisfactory and that PCTs needed to learn how better to use complaints as a fundamental part of quality improvement.<sup>78</sup>

24. Patients have also experienced particular difficulties in registering complaints that cut across services provided by a GP, PCT and a hospital.<sup>79</sup> The majority of complaints to GPs are dealt with relatively quickly to the satisfaction of both the patient and the GP involved. Some complaints are not dealt with effectively, however, especially those which cross the dividing lines between primary and secondary care, or health and social care.<sup>80</sup>

25. The need for a complaints system which crosses organisational boundaries was highlighted in the White Paper *Our health, our care, our say*.<sup>81</sup> The Department would be consulting on proposals for a new complaints system shortly after our hearing.<sup>82</sup> A complaints procedure that links health and social care is expected to be in place by 2009.<sup>83</sup> Legislation aimed at improving the NHS complaints procedure came into force on 1 September 2006.<sup>84</sup>

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72 C&AG's Report, para 1.15

73 Q 14

74 Q 109

75 C&AG's Report, para 3.26

76 C&AG's Report, para 3.26

77 Qq 13, 127

78 Q 16

79 Q 13

80 Q 13

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

82 Q 13

83 Q 15

84 *The NHS (Complaints) Amendment Regulations 2006* (SI 2006 No. 2084)

## Formal minutes

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**Monday 9 July 2007**

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon

Mr David Curry

Mr Ian Davidson

Mr Philip Dunne

Ian Lucas

Mr Austin Mitchell

Mr Don Touhig

### **Draft Report**

Draft Report (Improving quality and safety—Progress in implementing clinical governance in primary care: Lessons for the new Primary Care Trusts), proposed by the Chairman, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 25 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

*Resolved*, That the Report be the Forty-seventh Report of the Committee to the House.

*Ordered*, That the Chairman make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned until Wednesday 10 October at 3.30 pm.]

## Witnesses

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**Monday 5 February 2007**

**David Nicholson CBE**, Chief Executive, and **Duncan Selbie**, Director General Commissioning, NHS, and **Professor Martin Marshall**, Deputy Chief Medical Officer, Department of Health

Ev 1

## List of written evidence

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Department of Health

Ev 16

## List of Reports from the Committee of Public Accounts 2006–07

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First Report	Tsunami: Provision of support for humanitarian assistance	HC 25 (Cm 7018)
Second Report	Improving literacy and numeracy in schools (Northern Ireland)	HC 108 (Cm 7035)
Third Report	Collections Management in the National Museums and Galleries of Northern Ireland	HC 109 (Cm 7035)
Fourth Report	Gas distribution networks: Ofgem's role in their sale, restructuring and future regulation	HC 110 (Cm 7019)
Fifth Report	Postcomm and the quality of mail services	HC 111 (Cm 7018)
Sixth Report	Gaining and retaining a job: the Department for Work and Pensions support for disabled people	HC 112 (Cm 7019)
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The reference number of the Treasury Minute to each Report is printed in brackets after the HC printing number

# Oral evidence

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## Taken before the Committee of Public Accounts

on Monday 5 February 2007

Members present:

Mr Edward Leigh, in the Chair

Annette Brooke  
Mr David Curry  
Mr Philip Dunne  
Helen Goodman  
Mr Sadiq Khan

Mr Austin Mitchell  
Dr John Pugh  
Mr Don Touhig  
Mr Iain Wright

**Sir John Bourn KCB**, Comptroller and Auditor General, **Tim Burr**, Deputy Comptroller and Auditor General, and **Karen Taylor OBE**, National Audit Office were attendance.

**Paula Diggle**, Treasury Officer of Accounts, was in attendance.

### REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

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

*Witnesses:* **David Nicholson CBE**, Chief Executive, and **Duncan Selbie**, Director General Commissioning, NHS, and **Professor Martin Marshall**, Deputy Chief Medical Officer, Department of Health, gave evidence.

**Q1 Chairman:** Good afternoon and welcome to the Public Accounts Committee. Today, we shall be looking at the Comptroller and Auditor General's Report, *Improving Quality and Safety—Progress in Implementing Clinical Governance in Primary Care: Lessons for the New Primary Care Trusts*. Given the scandals at Alder Hey and Bristol, and Shipman in the 1990s, it is particularly important that we take the opportunity to examine how well quality and safety are being addressed in primary care. We welcome back David Nicholson, Chief Executive of the National Health Service, who is appearing before us as an Accounting Officer, and Professor Martin Marshall, Deputy Chief Medical Officer at the Department of Health. Can you give us an assurance that the clinical governance that you are trying to put in will make it easier to detect another Shipman in future?

**David Nicholson:** Certainly. Over the past few years, we have been trying to move from a situation in which quality and safety were essentially professional responsibilities for individuals and their professional organisations to one that is based within an organisation. Clinical governance is a set of processes and systems within an organisation that gives assurance to patients, as well as to the organisation, that services are safe and of sufficient quality for our patients. We have done a series of things over the past few years to make that happen, most of which are reflected in the National Audit Office Report, which shows that we are making good progress to improve the position throughout our primary care trusts. We also have good evidence in respect of the Quality and Outcomes Framework, which is part of the new GP contract. It shows that the quality of primary care is improving. The

experience of our patients is increasingly showing that they are more satisfied with the services that they are getting in primary care and we now have things in place to deal with the poor performance of general practitioners and primary care staff in general.

**Q2 Chairman:** You have a PCT Chief Executive and, apparently, he is accountable for quality and safety, is he not?

**David Nicholson:** Yes.

**Q3 Chairman:** I wonder whether you are raising expectations that cannot be fulfilled. After all, how many GPs are there—35,000?

**David Nicholson:** Yes.

**Q4 Chairman:** All independent contractors. How long does it take to train them? Seven to nine years? They are professional people. How much difference can such a bureaucratic structure make on the ground when you are dealing with 35,000 GPs, each of whom has been trained for between seven and nine years and is an independent, professional person? Do we trust them?

**David Nicholson:** Of course we do. What I said about organisations is over and above the professional responsibility and quality that we would expect. As for the PCT Chief Executive, you will be aware that PCTs have been given a duty to provide quality, which has been written into the arrangements to support them. Now, when a PCT Chief Executive is appointed, as well as receiving a letter setting out their responsibilities for finance, they get clear

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guidance and recommendations about what their relationship for quality is. They will do that in a variety of ways, many of which I have explained.

**Q5 Chairman:** Give us some practical examples of when a GP might fall foul of such arrangements. For instance, if there are 35,000 GPs, how many have been suspended in the past year?

**David Nicholson:** The NAO did a Report on suspensions of medical staff some time ago. This year, 66 GPs are under suspension.

**Chairman:** That is not a high proportion.

**Professor Marshall:** I can give you a practical example of how things might work on the ground in an area of poor performance. Let us say that a GP has a bad attitude and bad communication skills with their patients. In the past, they might have just been accepted. What happens now is that, first, their partners within the practice take specific responsibility under clinical governance for the quality of care provided by each other, so they would be pointing it out and commenting if one of their GPs was not performing.

If that was not working sufficiently, performance panels at PCT level would keep a close eye on the performance of all their independent contractors. They would collect information such as complaints data, prescribing data, comments and soft information from other people in the local community. They would have a picture of how well their GPs were performing. Above that are additional measures. For example, the National Clinical Assessment Service can be called in if performance problems are obvious and are not being dealt with at a local level.

**Q6 Mr Wright:** When reading the Report, it struck me that the reason why we cannot raise the game of GPs is poor contract management. Is that the case?

**David Nicholson:** That is not necessarily the case. The interesting issue about GPs generally is that this is a contract for service between the PCT and a small business. It is different from the usual employment arrangements that we would see in the NHS. We have a lot of experience of such matters. The increasing difference over the past three or four years is that contract management has been about not only expenses and the number of things that a particular GP would have done, but quality through the Quality and Outcomes Framework.

**Q7 Mr Wright:** But it is not working, is it? Paragraph 2.15 suggests that there is a lack of communication, and paragraph 2.11 gives the independence of primary care contractors as an excuse. Given that the brave new world of the NHS will see a diversity of provision as we move forward, with contractors from the independent sector and the voluntary sector—the Report itself says that discussions between the voluntary sector and PCTs are not good—as well as GPs and dentists, who we have had decades to talk to, the contract management is very inadequate. In the light of the Report, I am very disturbed and concerned about how we will raise the level of clinical governance.

**David Nicholson:** There are no doubt some issues about contract management, and I am sure that Duncan will want to talk about them. However, just in terms of how successful we are at the moment, if you look at the last couple of years or so, you will see that, on most of the measures that you would like to identify, general practice has been doing better—in terms of the quality of outcomes framework and the number of points that GPs get for doing a variety of things to improve the quality of service to their patients. The position in the past two years has improved significantly, so I do not think that it is necessarily—

**Q8 Mr Wright:** But paragraph 2.24 says, “the power of PCTs to investigate and deal with concerns about a General Practitioner’s performance or conduct are different to those in hospitals, mainly due to the independent contractor status.” If I was in the private sector and was not happy with the quality of the services that I had commissioned from somebody, I would just stop contracting with them if I had built quality clauses into the contract. Why do PCTs, strategic health authorities or the Department of Health not do that?

**Duncan Selbie:** The diagram on page 7 of the Report sets out the nine features of an improving system, and a good-performing PCT will be doing each of those things. That relates to issues such as clinical leadership, clinical audit, responding to complaints and ensuring that the patient voice is heard. Those map very well on to the standards for better health that the Healthcare Commission rates annually. They also fit with the capability work that we have been doing in taking PCTs through a review over the past nine months.

We will have completed all that by the end of February, and action plans will be in place by the end of March. So, we are seeing a number of things coming together, and the NAO has said, “If you get these things into place, performance will be moving north.” You could be more assured than you are today that it is safe and that quality is the driving concern.

**Q9 Mr Wright:** But the involvement of professional clinicians is absolutely key. Paragraph 2.10 refers to the involvement of Professional Executive Committees, but that seems—given the reconfiguration debacle that we have had over the past year or so—to have been very much an afterthought. That is certainly the impression from reading paragraph 2.10. Is that not the case?

**Duncan Selbie:** The PEC (professional executive committee) is very much part of engaging clinicians in the leadership and management of PCTs. There have been terrific examples of that around the country, and there has also been some variation, where it has not been so good.

**Q10 Mr Wright:** So why are we saying that “their form and function would be reviewed following a consultation exercise . . . with new arrangements planned to come into effect from April 2007”? That indicates to me that the Department said that we

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need to reconfigure PCTs, but then thought, “Oh hell, we need to do something with the PECs as well.”

**Duncan Selbie:** That is a great question. The issue is not an afterthought, I can assure you; it has been raised by PECs, the NHS Alliance and the bodies representing GPs. They say, “Look, we want PECs. We need PECs. We need clinical engagement and leadership.” That is one of the nine things that the NAO says we have to strengthen, and we are reviewing the issue.

The NHS Alliance has consulted general practice and asked, “Is this fit for purpose?” This is about making sure that we have learned from the best and that it is rolled out to everyone. The closing date for that consultation is Wednesday of this week. We will have to have a few weeks to think about what has been said and to talk to the profession—it is not just doctors, of course, who are involved. We will then get some further guidance out to the service. There will not be national prescription or a blueprint, but there will be some principles, which will guide people. At the heart of that is clinical engagement.

**Q11 Mr Wright:** But there is a perception of weak contract management and poor communication LINKs. The Government want to put diversity of provision in place and practice-based commissioning will be absolutely key in my area, as well as, I imagine, in others. However, the weaknesses that the Report has found really gives us no confidence whatever that practice-based commissioning will work.

**David Nicholson:** That is not necessarily the case. The issue about PECs, of course, is much less to do with the reconfiguration of PCTs and more to do with practice-based commissioning. PECs were the only clinical engine in PCTs before practice-based commissioning; now there are a series of such engines. We are trying to relate one to the other. There is no doubt that we must significantly up our game on commissioning and contract management. We have worked with the new PCTs that nearly conform on the fitness for purpose work to which Duncan referred, but there is still quite a lot to be done with commissioners to get them up to speed. That work is not only for the organisations themselves: the Department needs to see whether there are sufficient skills in the NHS to undertake a lot of the contract management. That is one of the reasons why we are considering the possibility of using outside agents from the private or independent sectors to help us to get commissioning absolutely right.

**Q12 Mr Wright:** A final line of inquiry: is there not an inherent conflict and tension between what we say about clinical governance—glove governance—and patient and public involvement? Clinical governance means that everybody is involved, but a clinician will always be able to stop something dead by invoking clinical safety. That is not necessarily only in the primary care sector, but in the acute sector, referring to my constituency. I think Helen Goodman’s

constituency has the same type of organisation. You can say all you like and raise as much public involvement as you like, but if a clinician says, “Actually, that is not safe,” the public involvement goes out of the window, does it not?

**Professor Marshall:** What you are describing is how things used to be—it is not like that anymore.

**Mr Wright:** It was in Hartlepool about three hours ago.

**Professor Marshall:** The delivery of health care is very much about the partnership between clinicians and patients. That has developed in the 20 years since I qualified. You are not going to empower patients and disempower clinicians overnight, but gradually we are seeing decisions made in partnership with patients. I do not accept your point that clinicians will always have the upper hand.

**Mr Wright:** Thank you, but I disagree.

**Q13 Annette Brooke:** Complaints procedure is an important part of giving feedback on quality. In the past, it has been difficult for people to register a complaint that straddles the GP, PCT and hospital. Can you tell me when the Department will make it easier for patients and carers to complain about primary care? How are you going to improve the effectiveness of handling complaints?

**David Nicholson:** We are doing quite a lot already to communicate to patients the ways to complain and dealing with those complaints. The vast majority of complaints to primary carers are dealt with relatively quickly and to the satisfaction of both the GP and the patient involved. However, some are not, and I agree that we have difficulties when complaints go across the dividing lines between hospital and primary care, and between primary care and social care, which is increasingly an issue. We identified that in the White Paper, *Our health, our care, our say*, in which we said that we need a new complaints procedure that will go across the dividing lines. We are about to consult on that, because it is an important part of what we need to do.

**Q14 Annette Brooke:** When do you think that that is going to happen? We seem to have had a gap in complaining about health services for ever and a day. When I first became an MP in 2001, I recall asking when a York University study on the matter would be published, so the debate has been going on a long time. Meanwhile, people are suffering, and some dreadful cases are going on and on.

**Professor Marshall:** It is happening right now in some areas. From the Department of Health’s perspective, the important thing is to make sure that we have the systems in place to allow complaints to be dealt with effectively, particularly those that cross organisational boundaries. The key initiative, which we are about to introduce, is the development of local involvement in health networks—local improvement networks that will replace patients forums. Patients forums are linked to organisations and are the voice of patients as far as complaints and

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other issues are concerned. However, because they are linked to organisations, they tend to perpetuate—

**Q15 Annette Brooke:** What is your time scale for having an effective complaints procedure in place everywhere in the country? What is the time limit?

**Professor Marshall:** A procedure that LINKs health and social care complaints will be in place in late 2008 or in 2009. An effective system for complaints within the health care system is being put in place right now. Legislation that improves the complaints process was passed in September 2006, so it is happening right now in the service.

**Q16 Annette Brooke:** Paragraph 14 on page 9 of the Report says: “Our survey of GPs found that where GPs were involved in complaints reported to their PCT, just half of GP respondents were routinely informed of the outcome of complaints by the PCT.” That does not sound very satisfactory if the new system is in place.

**Professor Marshall:** I agree that that is unsatisfactory. It is something that the PCTs need to work on very hard. The new complaints system that is being introduced right now will address those issues. We believe that learning from complaints is a fundamental part of quality improvement.

**Q17 Annette Brooke:** Given that the whole philosophy of clinical governance is best implemented at PCT level, what incentives are there for PCTs to co-ordinate with each other and disseminate the criteria down to the individual contractors?

**David Nicholson:** That is obviously the key role of a PCT. Generally speaking—you can see from the information produced by the NAO and the Healthcare Commission—well-managed PCTs seem to be very good at doing that. It is about leadership and general management.

**Q18 Annette Brooke:** You said “see”. Is there evidence?

**David Nicholson:** There is. If you look at the organisations in the NAO Report that self-assess that they are doing well at clinical governance, you will see that they are almost always the same PCTs that come out well on both quality and financial management in Healthcare Commission publications. You see a pattern of well-managed PCTs being very good at that.

**Q19 Annette Brooke:** With respect, that evidence does not tell me that they have transposed the clinical governance model or spread it downwards to all their contractors. That picks up on the point made by Mr Wright. If all those principles are not written into the contract at the time of commissioning—we suggest that that is not occurring—it is just not going anywhere.

**Duncan Selbie:** To the extent that the Quality and Outcomes Framework—Professor Marshall might say something about that later—is a device to drive improvement in primary care, we are seeing improvements across the board.

The annual health check from the Healthcare Commission takes the seven standards for better health and maps them on to what the NAO says we have to get right. When we did it for the first time in 2005–06, 24 PCTs out of 303 scored the lowest score. There was a full range, but there were 24 such organisations. Each one has had careful attention from the local and the strategic health authority to look at what it is going to do to drive improvement. We expect that, when the annual health check is done for the current year, we will see improvement across the board. If you are looking for evidence of improvement or of lessons being promulgated across the system, there will be external validation of that in October this year.

**Q20 Annette Brooke:** Another point in the Report suggests that there are barriers to achieving good implementation of clinical governance. Not surprisingly, staff time and money are mentioned specifically. What is being done to address the barriers? Those barriers are the root causes of why clinical governance is not getting right down to the contractors.

**David Nicholson:** What we can see across the whole variation that Duncan Selbie has just been talking about is that some PCTs manage quite effectively to get over those barriers, so money and time and all the rest of it are not necessarily issues that should stop people taking things forward.

What we are doing is reviewing the progress of each PCT individually as part of a fitness-for-purpose programme. Each PCT has to agree with the strategic health authority on a set of ways in which it will improve its performance over the next year. The strategic health authority will identify the resource it is going to put into the PCT, and we will measure progress over the year. We are in a good position to measure progress and identify what support organisations need. It is often about leadership and information.

**Q21 Annette Brooke:** Finally, may I ask one more question that does not strictly keep to the text in front of us? The Report obviously covers the fact that we now have 150 PCTs, but in my area, PCT boundaries are not coterminous with those of local education authorities. Children with special needs who live in one part of my constituency are forced to go to school on the other side of the county because they are not allowed into the next LEA area. That takes them into different PCT areas and they are saying that they are not responsible for providing the necessary therapeutic services. What do you think about that lack of joined-up thinking and adherence to the *Every Child Matters* agenda in Dorset?

**David Nicholson:** Obviously, I cannot comment on the individual case, but it seems to me that we should take that away and have a look at it.

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**Q22 Annette Brooke:** As well as looking at the individual performances of PCTs, however, I think that it is necessary to look at how they work together when boundaries are not coterminous.

**David Nicholson:** I think that that is very important and we are encouraging PCTs to work together, not just on those kinds of issues, but on contract management, so that they can pool abilities when dealing with one organisation. That is one of the reasons why in the operating framework we have identified that there should be a lead PCT to deal with each acute hospital.

**Q23 Mr Khan:** May I get something clear? Can I gather from the Report that, up until 1999, there was no statutory duty of quality on any of our NHS providers? Obviously, there was a common law tortious duty of negligence, but no statutory duty up until 1999.

**David Nicholson:** That is right.

**Q24 Mr Khan:** Obviously, you have read the Report. The National Audit Office is pretty pleased that most PCTs now have policies and structures in place. How are those being implemented on the ground? Presumably, somebody deserves a big pat on the back: we started from a standing position in 1999, when we implemented the statutory duty of quality, but in six years we have made so much progress. Are you reasonably pleased with that progress?

**David Nicholson:** Well, there has been progress. On the main areas of consideration—what patients say about the service and the Quality and Outcomes Framework—we are pleased, because we have shown significant improvements in services to patients in the localities. The most important thing for us is to get the whole organisation geared up in order to do that. That is what the duty of quality is about.

**Q25 Mr Khan:** I understand that the motivating factors behind the statutory duty of quality were the tragic Shipman, Bristol Royal infirmary and Alder Hey cases. Quite patently, these changes will not guarantee that such things will never happen again. However, the sort of changes that you have been talking about—below those tragic cases—have been an additional benefit. The quality of care received by a patient, irrespective of the provider, has now got a national minimum standard.

**David Nicholson:** Increasingly, that is a very important, if not the most important part of an NHS board's agenda. That is reinforced by the responsibilities of Chief Executives. Increasingly, we want Chief Executives and managers of the NHS to talk about quality and safety rather than other things that they have talked about in the past.

**Q26 Mr Khan:** I share a concern referred to by Mr Wright. Some £23 billion is being spent on primary care services, 78% of which is spent commissioning independent contractors. How much control can you have from the centre over the quality of service provided by those contractors to constituents? In

answer to a question from the Chairman, you mentioned that only three dozen GPs have been suspended—

**David Nicholson:** 66.

**Q27 Mr Khan:** 66—I beg your pardon. Out of how many thousand GPs?

**David Nicholson:** Some 35,000.

**Q28 Mr Khan:** That reinforces concerns about how you can ensure that there is proper control of the quality of those lower down the food chain. How can you reassure us that you have got robust systems in place to do that?

**David Nicholson:** Partly through the sort of things that Professor Marshall was talking about earlier—the various connections between how partners operate, how PCTs operate and how the professional standards organisations will work. All those things assure us that things are being done. Suspension is not the only way in which we would respond to poor performance.

**Q29 Mr Khan:** I was going to reach that point. How many PCTs are there in the country?

**Duncan Selbie:** There are 152.

**Q30 Mr Khan:** So are there 152 Chief Executives, then?

**Duncan Selbie:** Not quite.

**Q31 Mr Khan:** There are some job shares, are there?

**Duncan Selbie:** In a small number of cases, there are arrangements to have a joint Chief Executive, but I would have to get the precise number for you.

**Q32 Mr Khan:** Let us say for argument's sake that there are 125 Chief Executives.

**Duncan Selbie:** No, it is higher than that. Let us say 140.

**Q33 Mr Khan:** Out of those 140, how many have you called in because they are failing to meet their statutory duty of quality? You said suspension is not the only option; another is calling them in. How many have you called in?

**David Nicholson:** For failing their statutory duty of quality?

**Mr Khan:** Yes.

**David Nicholson:** One way in which we can measure that is the Healthcare Commission's annual health check, which identified none of the existing PCTs as giving concern. There were 24 PCTs about which there were serious issues of quality and financial performance. Each of those—

**Q34 Mr Khan:** And none of those were called in on the duty of quality?

**David Nicholson:** No.

**Q35 Mr Khan:** So our constituents now have a double concern. First, only 60 GPs out of thousands have been suspended, and secondly no Chief Executive of any of our 120 or 130 PCTs has been called in because of the duty of quality. That leads to

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one of two conclusions: either a fantastic, consistent, excellent quality of service is being provided around the country, or there are problems with your system of monitoring.

**Duncan Selbie:** The Healthcare Commission has a power to recommend what are known as special measures, which it has exercised on two or three occasions. Whenever it has a concern about the quality of care in part of the NHS, it can say, "Look, we want you to apply special measures." On each occasion the Secretary of State has agreed. So when we say that the Healthcare Commission did not raise a profound concern about quality in the annual health check when it identified the 24 organisations, that is not to say that there were not concerns. The Commission rated those organisations as weak in the four options from excellent down to weak. The action that has been taken by each PCT board and Chief Executive, supervised by the strategic health authority—

**Q36 Mr Khan:** But is that right? Paragraph 2.25 refers to the Chief Medical Officer's 2006 report, which found that "although PCTs now have much stronger powers to deal with poorly performing GPs, these have only been in place for a short time, and many PCTs feel unable to take local action themselves, relying instead on the General Medical Council to deal with concerns about poor performance." Is that not a case of people shirking responsibility from pillar to post?

**Professor Marshall:** There have been concerns about the willingness of PCTs to manage poor performance at a local level. That is perhaps why they have been called in at a higher level by the General Medical Council. That is one of the reasons why medical regulations have been reviewed, and the paper produced by Sir Liam Donaldson last July, *Good doctors, safer patients*, came up with a series of 44 recommendations to change the regulatory framework within which people operate. The Government's response to those recommendations will be published towards the end of this month, and it will make specific recommendations that will bring the regulatory process down to a much more local level.

**Q37 Mr Khan:** You will have seen in paragraph 2.16 that only 4% of GPs reported adverse incidents to the National Patient Safety Agency. Cause for alarm?

**David Nicholson:** If you compare secondary and primary care, there is no doubt that there is much more of a culture of reporting such things nationally in secondary care. We have a lot to do in primary care. That is not to say that individual events are not investigated locally, but the information is not sent in nationally. That is a problem, because—

**Q38 Mr Khan:** I am sorry to cut you short, but you will know that our time is limited. I have just been given an aggressive note by my lovely Chairman about time being short. My concern is whether GPs have bought into the importance of the duty of quality. Let me tell you why. We know that 20% of

PCTs have done the cost-benefit analysis and think that clinical governance is an excellent thing—they have made efficiency savings and think that they are a great thing—and a further 66% suspect that it has delivered efficiency savings but have not done the empirical work. The reference is in paragraphs 2.35 and 2.36. Only 2% of GPs have undertaken that cost-benefit analysis.

I suspect that the level of monitoring of GPs is not great, and that the quality of care that my constituents and Mr Wright's receive—although it is obviously not as bad as the Shipman murders—is not as great as it could be. You are missing a trick. I do not think that GPs realise what a useful tool it is. You have done the hard work of establishing policies with the support of this fantastic Government, but the problem on the ground is that GPs might not realise what an invaluable tool it is.

**David Nicholson:** Going around talking to GPs is part of my job. One of the things that I hear is that some of them do not recognise that what they are engaged in is clinical governance. Quality and safety is central to all of them, but they do not necessarily recognise that their activities are called clinical governance. That is broadly what we have found as we have gone around.

**Q39 Mr Khan:** That is interesting. What are you doing about it?

**David Nicholson:** We tell them so. As part of the process that has come out of the NAO Report, the Reports for each individual PCT have been fed back. We expect PCTs to act as part of that. We are encouraging GPs in particular to report incidents, and we are working with the Royal College of General Practitioners on guidance to encourage and support them. We are also setting up patient safety action teams at each of the strategic health authorities to make connections between general practice and the centre much easier so that kind of reporting can be done.

**Q40 Mr Touhig:** Mr Nicholson, the Report in the middle of paragraph 9 on page 8 says: "Our preliminary work in developing the survey questions for the primary care study revealed that PCTs were unable to provide any estimate of the cost of clinical governance structures and processes or the management time taken up in implementing them." If PCTs cannot provide any cost estimates of clinical governance structures or the time that management spend implementing them, how can we be sure that we are getting value for money?

**David Nicholson:** There are a couple of ways. Looking at figure 3 on page 7—the nine things that come under the umbrella of clinical governance in primary care—you could almost say about primary care trusts, "Well, what else would they do?" It seems to me that those are almost all the general management functions of the primary care trust. The NAO has worked with PCTs to try to identify the specific time out of all those functions, but it is incredibly difficult. I think that the NAO came up with a figure of £90 million across both secondary

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and primary care when it was done. As you can see, it is remarkably difficult to do, given that it is probably 70% or 80% of what a primary care trust would do.

**Q41 Mr Touhig:** Remarkably difficult, but you created the structure.

**David Nicholson:** But in a sense, we are trying to embed it in a general—

**Q42 Mr Touhig:** Can you tell me, then, whether you can demonstrate that we are getting value for money as a result of your policy in developing clinical governance structures?

**David Nicholson:** What I can demonstrate is that the quality of service provided to patients by general practice has improved during the past two years. We can show that on almost every heading that you would like to describe—from access and time that patients spend with general practitioners to indicators in the Quality and Outcomes Framework—patients are more satisfied with their general practitioner services this year than last year.

**Q43 Mr Touhig:** So you have not measured it? You have measured quality and delivery of service, but you have not measured whether we are actually getting value for money as a result of the structure that you introduced and your objectives.

**David Nicholson:** I thought that I just did that.

**Mr Touhig:** You did.

**David Nicholson:** You can put huge amounts of effort into teasing out from an individual PCT exactly when a GP was engaged in offering choice to a patient, and whether it was part of clinical governance activities, general activities or general management activities. The NAO has tried to do that, but it is much more sensible to talk about it in the terms that I have just described—the quality of service to our patients and patient satisfaction.

**Q44 Mr Touhig:** I still have difficulty understanding your point that PCTs cannot tell us how much management time is being spent on implementing that work.

**Duncan Selbie:** It is difficult. Our argument is that clinical governance is not a discipline or a function; it is the whole point. It is about safety and quality, and there is clearly an argument for value in that. The study looked at when we had 303 organisations purposely to capture the lessons and take them into the new organisations that we have been forming over the four or five months since last October. Through that change from 303 organisations to 152, we have saved about £250 million in management costs, which are going to go into the front line.

**Q45 Mr Touhig:** Is it easier now you have 100-odd bodies?

**Duncan Selbie:** Part of the argument for doing that was about creating a number of organisations in which we are capable of creating great teams.

**Q46 Mr Touhig:** So you created too many in the first place?

**Duncan Selbie:** It is just easier to conceive how we can do that when we have 152. Major savings are being made and we are, as Mr Nicholson says, seeing improvements over time in the quality and outcomes of our work.

**Q47 Mr Touhig:** Paragraph 14, on page 9, says that clinical governance LINKs between PCTs and independent contractors are underdeveloped. What are you doing to bring the implementation level of clinical governance among independent contractors up to the level of those that are directly employed?

**Professor Marshall:** There are a number of activities that we are doing. This relates to other questions about how easy it is to do that with independent contractors as opposed to direct-line employees. My response to that—

**Q48 Mr Touhig:** We have had independent contractors. GPs have been independent since Nye Bevan created the NHS. That is not a new problem.

**Professor Marshall:** Absolutely; I agree with that. A number of things are being done to improve the performance of general practices. We should say, first of all, that performance in a number of areas is very good in the quality and outcomes frame that we keep coming back to. At the level of providing evidence-based clinical care, the performance of general practices is extremely high. Indeed, it is enviable as far as other countries in Europe are concerned. We have some evidence that patient experience is improving, and we are measuring that as part of the Quality and Outcomes Framework. We also have evidence that the organisation of general practices is improving. So there are a number of areas where things are improving as a result of providing incentives and much clearer infrastructure within which general practice operates.

**Q49 Mr Touhig:** We all know about the incentives that you have managed to give GPs.

**David Nicholson:** May I add to that? The other issue is practice-based commissioning, which is the big difference that will develop in the next two or three years. General practice will be engaged much more clearly in contracting and identifying quality and safety in how we deliver secondary care, as well as primary care.

**Q50 Mr Touhig:** These various strands that you both talk of—this is your strategy, effectively? You see it as one seamless strategy?

**David Nicholson:** Yes.

**Q51 Mr Touhig:** The C&AG's Report tells us in paragraph 2.12, on page 23, that contractors feel that they are not getting adequate support to "embed" clinical governance practices into the way they operate. What are you doing about that?

**David Nicholson:** Sorry, I am lost. What was that?

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**Q52 Mr Touhig:** On page 23, paragraph 2.12, the Report indicates that contractors feel that they are not getting adequate support to embed clinical governance practices into their procedures. What steps are you taking?

**Professor Marshall:** PCTs need to rise to that challenge. It is a legitimate concern that they have systems in place within their own organisations but are not, at the moment, providing adequate help to general practices, particularly in terms of skilling them up in new areas. It is a legitimate comment that needs to be taken on board. All of the processes that we have described already in terms of helping PCTs are aimed at doing that.

**Q53 Mr Touhig:** So, it is down to PCTs? Why do I get the impression at these sessions that Departments in Whitehall come up with big-picture ideas and then leave it to people on the ground to take certain decisions, which is fine, without getting very involved in whether or not they are achieving the outcomes?

**David Nicholson:** I do not think that that is right at all. To be frank, part of my job is to prevent Departments from getting involved in the detail of how these things are managed. In my experience, it is much better if local organisations are left to organise themselves. There are mechanisms by which we can assure ourselves that these things are happening.

**Q54 Mr Touhig:** I accept that it is often good to let local organisations take the initiative, but this needs to be policed and it needs to have a co-ordinated strategy to ensure that we are getting an overall structure developed and a system that is equally good across the country.

**David Nicholson:** That is absolutely right. That is why we have the Healthcare Commission and the inspections that it carries out, the standards for better health and the fitness-for-purpose process that we are going through with PCTs. It is also why we monitor the performance under the Quality and Outcomes Framework nationally. It is why we do all of those things. They are good ways to monitor whether things are actually happening in the way in which we hope and think that they are.

**Q55 Mr Touhig:** On page 9, paragraph 16 says that 82% of PCTs believed that clinical governance has helped to improve the quality—this is a point I queried with you earlier—of patient care, while only 20% said that they had managed to make efficiency savings. Does that mean that somewhere down the track you will need a new strategy for efficiency, beyond clinical governance?

**David Nicholson:** No, I do not think that that is the case. This gives you an idea about the road that we have to travel. The NHS is quite unusual in the sense that in most of the rest of the economy, and in life generally, it is perfectly possible to improve quality and reduce cost at the same time—those things are part of the same process—whereas it has traditionally not been seen like that in the NHS.

**Q56 Mr Touhig:** I am getting the impression that it is not the process with clinical governance: you are not looking at efficiency savings in the way that you might otherwise do.

**David Nicholson:** Well no. One of the things about clinical governance is that it will drive out significant efficiency savings throughout the system.

**Q57 Mr Touhig:** My time is almost up. You had 300 PCTs as a result of the Health Act 1999 and you reduced that to 105 in July 2005. Have you had enough of reorganisation now?

**David Nicholson:** There are 152, I think.

**Q58 Mr Touhig:** You have had enough of reorganisation?

**David Nicholson:** We now have a good configuration, which I think will deliver benefits.

**Mr Touhig:** You suffer from reorganisation fatigue, like most of the NHS.

**David Nicholson:** I think we are now in a place where—

**Mr Touhig:** I can tell by the look on your face that you are suffering from it.

**David Nicholson:** Well, I myself have been abolished a number of times in my career—I have been round this one for 30 years, so I have been through them all over the last period. In fact, I have had five jobs in the past six months, as I believe was mentioned in another Committee of Public Accounts meeting. We now have a good figuration that will mean big benefits for patients over the next few years.

**Mr Touhig:** Thank you.

**Q59 Dr Pugh:** All my remarks are directed towards the commissioning by PCTs of private or independent contractors. I was drawn to a point made on page 9: “Clinical governance LINKs between PCTs and independent contractors are undeveloped.” I assume that it is common ground between all of us that a commissioning-and-go approach by PCTs is undesirable, and that they need to have good vigilance in place to spot weaknesses in any private contractor that they commission. Correct? If it is correct, how much transparency should there be in their knowledge of the private contractor? Should they know things such as what type of contracts the staff who are working for the private contractor have, what the finances of the private contractor look like, what kind of profits it makes, and what incentives there might be for employees of that contractor? How much financial transparency should there be before a PCT goes ahead and commissions from a private contractor?

**David Nicholson:** Are we talking about private contractors in general or GPs as independent contractors?

**Dr. Pugh:** I am not talking about GPs.

**David Nicholson:** We would want a high degree of transparency between the NHS and any organisation that we contracted. We would contract not just for an outcome, but for a series of issues, so we would expect a high degree of transparency.

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**Q60 Dr Pugh:** I understand that. Clearly you must know what you are buying, but how much must you know about the internal workings of an organisation?

**David Nicholson:** We would want to know what kind of incentives the organisation was operating within it, and what profit it was making. We would want to know all those things.

**Q61 Dr Pugh:** Can I be specific? The out-of-hours services that are provided by a number of private companies are controlled by the Carson rules and regulations, which are fairly strict and stringent, are they not?

**David Nicholson:** Yes.

**Q62 Dr Pugh:** In fact, more stringent, in some respects, than some other governance rules? Am I correct in thinking that as well?

**David Nicholson:** I do not know whether they are more strict, but they are strict.

**Q63 Dr Pugh:** In Liverpool, we have a private contractor called UC24 providing out-of-hours service. The IT director resigned because he had reservations about the IT system it was using in the call-handling system it was operating with, but he could not state his reasons or his reservations because of terms in his contract that prohibited whistleblowing for at least a year or so. Is that desirable?

**David Nicholson:** I do not think that is desirable, no.

**Q64 Dr Pugh:** You do not think that is desirable. Do you think it would have been appropriate for the PCT to have made inquiries about that type of contractual clause?

**David Nicholson:** I have to say that I do not know the details underlying the example you have just described, but we would not look well against organisations that had those whistleblowing factors within them because we would expect those to be available to people in the NHS. We would expect to be excluded if it was something commercially confidential, but if it was about safety we would absolutely want to know what it was.

**Q65 Dr Pugh:** Okay. Well, we are going to find out more about that specific issue because Liverpool PCT has commissioned a report on it. Do you believe that such a report should be a public document if the issue has been raised in public in the first place? In other words, if there is an assessment of this private contractor, should that be something that we, as concerned members of the public, can get our hands on?

**David Nicholson:** Again, I cannot comment on the details. What I can say is that anything to do with quality and safety has to be publicly available. How else would we get the confidence of the general public that what we are doing is the right thing?

**Q66 Dr Pugh:** Okay. Given that there is that concern, how would you view the decision of Sefton PCT to take on the same contractor for clearly

financial reasons in the absence of a report that was going to clarify whether there were any reservations about the call-handling system?

**David Nicholson:** That is very difficult because I genuinely do not know about this and I do not know whether anyone else knows. I genuinely do not feel that I can respond. I am happy to give you a note on it.<sup>1</sup>

**Q67 Dr Pugh:** But if there was a question mark against a particular contractor and the contractor was then going to be employed by another PCT, would you expect that PCT to have all the assurances required?

**David Nicholson:** I would expect that PCT to be fully assured that the quality and safety of services to their patients were adequately protected.

**Q68 Dr Pugh:** And not just look at the cost and the bottom line.

**David Nicholson:** No, no.

**Q69 Dr Pugh:** Right. What would your response be if I told you that it had replaced a GP-run service, which was more expensive, and that the doctors who were still employed in dealing with out-of-hours calls complained to the PCT and asked it to remove the contractor, but the PCT did not do so? I accept that you do not know all the details.

**David Nicholson:** I think it would depend on a whole series of things, because they may be in some way commercially in competition with the contractor. I cannot comment on that.

**Q70 Dr Pugh:** Difficulties with the triaging system were reported. One doctor had a patient with bowel cancer who was kept waiting for eight hours. He was eventually admitted and went immediately into surgery. That led to the doctors resigning because they could not get an adequate or appropriate response from the PCT. My point is that it should not really need those circumstances to get clinical governance issues properly aired. I should not really know all this. It should all, in a sense, have been processed, should it not?

**Duncan Selbie:** As Mr Nicholson said, the only grounds over which you could have commercially sensitive information would be very tight indeed; it would be agreed in advance. When we get to hear about this issue, could any of this—what you have said—be secret? This is at the heart of quality, safety and accountability in the NHS. All organisations have that duty; they cannot cede it to anybody else—they must satisfy it themselves. Once we know more, we shall be able to respond.

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<sup>1</sup> *Note by witness:* UC24 are commissioned by Knowsley, Sefton and Liverpool PCTs who jointly manage the contract. A formal PCT review of UC24 and the organisation's compliance against the National Quality Requirements for the delivery of out-of-hours services was carried out during September and October 2006. The report will go to the Board of Liverpool PCT at the meeting scheduled for March 2007. I would be happy to put a copy of the report in the House of Commons Library when it has been formally released. Sefton PCT is commissioning an additional review.

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**Q71 Dr Pugh:** My point is that those doctors had serious reservations about the triaging system, which they believed would put life and limb at stake. However, they were working for the PCT, so they needed to resign to create the necessary impression. I do not think that that is satisfactory and I hope that you do not either.

Do you think that checks on whether there has been transfer of staff from PCTs to private contractors should be made when work is commissioned by a private contractor? Is that something that you would want to keep an eye on? Clearly, when there is a transfer of staff or when people are moved across from one to the other, the relationship between a private organisation and a PCT can be more cosy than it ought to be.

**David Nicholson:** If staff are doing a job that is transferred to the private sector, it is perfectly reasonable that those staff should transfer with the job.

**Q72 Dr Pugh:** Yes, but a more common model is that somebody leaves a PCT after an unblemished career and founds an organisation that the PCT commissions to do work. There is then a relationship between the commissioning individuals and that organisation that is personal as well as professional.

**David Nicholson:** The PCT has to satisfy itself that its actions fall within the scope of its standing financial instructions. It is subject to the same kind of rules as any other organisation.

**Q73 Dr Pugh:** But you would not keep an eye on that. You would assume that everything in that kind of arrangement was all right and that the PCT would operate in such a way that, regardless of who it was dealing with, it would make the right decision in the interests of the health of the community.

**David Nicholson:** Yes, but we would expect it to be audited in the normal way.

**Q74 Dr Pugh:** One final question: PCT trust members obviously have a key role in maintaining vigilance and good clinical governance, and in ensuring that all the checks are in place. How many PCT trust members would you guess to be political appointees and is there a breakdown of the numbers?

**David Nicholson:** There is, but I do not have it in front of me.<sup>2</sup>

**Q75 Dr Pugh:** Could you let us know?

**David Nicholson:** Yes. We can get that from the Appointments Commission.

**Q76 Dr Pugh:** The data exist?

**David Nicholson:** Yes, the numbers are publicly known—people have to make a declaration.

**Q77 Helen Goodman:** It has been quite clear for some time that standards of clinical governance in the primary sector are not as high as in the secondary sector. However, the risks are higher, because people

practise on their own more than is the case in hospitals. So, when you renegotiated the GP contract did you not miss a bit of a trick by not addressing clinical governance?

**David Nicholson:** General practice is changing, though, is it not? Going back 10 or 15 years, it was a solitary experience and people often worked on their own. Increasingly, however, it is about teams, and the number and range of practice staff is extraordinary. Most health centres and clinics have a range of physiotherapists, dieticians, speech therapists and nurses, which they did not in the past.

**Q78 Helen Goodman:** You are not suggesting, surely, that a nurse or physiotherapist could provide adequate peer review for a GP, are you?

**David Nicholson:** The annual report says that multidisciplinary audit is part of what people do these days. The point that I am making, albeit in a somewhat slow way, is that the difference between primary and secondary care is narrowing rather than getting greater, because of the scale of the primary care enterprise. About 20% of people who work in the NHS now work in primary care, which is a significant shift over the past few years. Primary care bodies are much bigger enterprises than they were.

**Q79 Helen Goodman:** But how did you use the GP contract to improve clinical governance?

**David Nicholson:** Most obviously through the Quality and Outcomes Framework (QOF). It is only one indicator of clinical governance, but it is a good indicator of improvement in quality of service.

**Q80 Helen Goodman:** Do you not think that the quality and outcome, or whatever it is called—I cannot keep all the jargon in my head.

**David Nicholson:** The Quality and Outcomes Framework.

**Helen Goodman:** My reading of the document is that it was rather input-focused rather than outcome-focused. The number of jabs, for example: it is good to get that number right, but it is not an outcome measure, is it?

**Professor Marshall:** I think that it does not matter as long as the inputs are very clearly related to outputs in the evidence. You know that if you measure and improve a diabetic's blood pressure, the outcome will be better in terms of reduced heart attacks and strokes. That is the case for at least 60 or 70% of the indicators in QOF. There is sound, clinical evidence from good, randomised, controlled trials that the inputs will result in improved outcomes, so the link is there.

**Q81 Helen Goodman:** What is the requirement for general practitioners to keep up to speed with their training?

**Professor Marshall:** It is an increasingly strong requirement. GPs now have to undergo appraisal on an annual basis. It is organised by their local PCT and focuses very strongly on their performance.

**Q82 Helen Goodman:** Who does it? Does one GP appraise another?

<sup>2</sup> Ev 16–17

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**Professor Marshall:** Each PCT tends to have a group of trained appraisers who would usually be GPs in the trust, so they would be known to, if not well known by, the GP. A small number of well trained GPs provide an annual appraisal for all other GPs in the PCT.

**Q83 Helen Goodman:** My question was not about what the appraisal system is. What is the requirement for GPs to keep up to speed with retraining and new developments?

**Professor Marshall:** That is part of the requirement. There is also a professional requirement as part of being a doctor, as outlined by the General Medical Council, to keep up to date and ensure that all your skills are appropriate.

**Q84 Helen Goodman:** Can you be a bit more specific? What exactly do GPs have to do to every year? How much time do they have to devote to learning new things?

**Professor Marshall:** There used to be a series of points that you had to get for improving particular areas of clinical practice. That has stopped now, so there is no specific requirement to do a certain number of hours or collect a certain number of points for a particular area. There is a general professional responsibility, which is upheld up by the GMC and by local appraisal processes, to ensure that you keep up to date in areas where you know you have deficiencies.

Each individual is expected to identify their learning needs. For example, I might say, "This year, I am seeing a lot of diabetics. I am not sure that I am managing very well, so I will ensure that I focus my learning on diabetes this year." You then agree process for doing that with your appraiser, who holds you to account for it at the end of each year.

**Q85 Helen Goodman:** So that relies on GPs being good at self-assessment. It does not sound very robust.

**Professor Marshall:** It relies on GPs being professional. That is what being a professional means: being able to identify your learning needs and meeting them.

**Q86 Helen Goodman:** Why does not the Department of Health or the NHS centrally have blitzes on things when you know that care is not as good everywhere as it is in the best places?

**Professor Marshall:** That is something that we are considering. Coming back to Sir Liam Donaldson's report, *Good doctors, safer patients*, part of the re-validation process that will be introduced will be about assessing GPs according to their licence to practise and their certification to practise a particular specialty. That process will become more objective over the next few years.

**Q87 Helen Goodman:** In doing that, will you give a role to the voluntary sector?

**Professor Marshall:** In what particular aspect?

**Q88 Helen Goodman:** For example, a year ago I got involved in a campaign that was run by Epilepsy Action, which found that people were not taking their medicine. The reason was that GPs tended to over-prescribe, which made people feel dozy. They knew that they were being over-prescribed, but they did not know what their dose should be. There was general mismanagement across the board.

Epilepsy is not a rare condition. I am not sure of the exact figure, but 500,000 or 1 million people suffer from it in this country. If there is a general problem with something so common, that makes me wonder. What are you going to do about problems such as that?

**Professor Marshall:** There is no doubt that the public and patient representatives or specialty groups such as that which you describe need to have a say in the criteria on which doctors will be judged. Part of the process of developing the criteria, which is being carried out by the Royal Colleges, is done in conjunction with speciality groups, as you describe, and with local patient participation groups. So, increasingly, patients are having a big say in the criteria by which doctors' capability will be judged.

**David Nicholson:** May I add two things? One of them is that the part of the consultation on the Professional Executive Committee has indicated the importance of PECs engaging with the voluntary sector in a way that perhaps they have not done before. We think that that part of the guidance that we will send out will be very strong about the Professional Executive Committees in that respect. The second issue is the whole Expert Patient Programme, of which epilepsy is a part. We are now talking about 30,000 patients being trained. That is a massive strategic priority for us over the next period—both to engage more patients and to have a real dialogue with their doctors about the future of their care.

**Q89 Helen Goodman:** I want to ask you about one last thing, which is the patient pathway and the way in which, quite often, people have a rather unsatisfactory experience as they move between different parts of the NHS. Sometimes, for them it is just one thing: they go from the GP to the specialist to the hospital and back to the specialist. However, it is over-complex. What are you going to do to smooth the patient pathway?

**Duncan Selbie:** There is a whole piece in the Report about commissioning for quality, and at the heart of that, there is a—

**Chairman:** Could you speak up a little? It is quite difficult to hear you from this end of the room.

**Duncan Selbie:** Yes, of course.

A big drive behind what the National Audit Office has said is care closer to home and what we call redesigning pathways of care. From the patient's perspective, as you say, they do not recognise all these other organisations, and expect a bit of co-ordination. If I can bring you back to practice-based commissioning, nine out of 10 decisions that affect people's lives and incur costs happen in primary care, and 60% to 70% of costs are in hospitals. Practice-based commissioning is about giving more

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and more authority to primary care to get engaged in those conversations and to make a difference about the pathways of care. They are spending the money, but they do not have the authority aligned with that today to get involved in making sure that the pathways of care are more seamless than they are. That is what practice-based commissioning is about; it is trying to make a difference there.

**Q90 Helen Goodman:** So are you telling me that if, for example, you have had an operation and—as often happens at the moment—the physio does not happen on time because the hospital cannot get its act together or manage itself properly, the GP is then meant somehow to manage the hospital? That does not sound credible.

**Duncan Selbie:** Hospitals need to manage themselves to protocols that are agreed. In primary care, we would expect—as is increasingly happening today—agreements about what should happen and by when. It begins and ends in primary care, so we would expect primary care to be involved and to know when those things are not working. It is about incentivising primary care through practice-based commissioning to get involved, and if it is not working, to do something about that—if a hospital is not providing good care and is not following the agreements, to say to the patient, “Well, go to another hospital, because there they will do it properly.”

**Helen Goodman:** Thank you.

**Q91 Mr Dunne:** I would like to understand the structure of accountability through the PCT. If you look at the summary in chart 2 on page 6, it says that the primary care trusts are accountable through the Chief Executive. It says under that that they are “directly accountable for all the services the trust provides”. Who appoints the Chief Executive of a PCT?

**David Nicholson:** The Chair appoints the Chief Executive to the PCT, and the Strategic Health Authority Chief Executive is a professional assessor on the panel.

**Q92 Mr Dunne:** Who appoints the Chair?

**David Nicholson:** The Chairs are appointed by the Appointments Commission.

**Q93 Mr Dunne:** And the Appointments Commission is a national body, or is it within the Strategic Health Authority?

**David Nicholson:** No, it is a national body, chaired at the moment by Sir William Wells.

**Q94 Mr Dunne:** So the Chief Executive then appoints the directors of each PCT?

**David Nicholson:** Normally they would appoint them with the chair or the Non-Executive Directors.

**Q95 Mr Dunne:** And the non-executive directors are appointed by whom?

**David Nicholson:** By the Appointments Commission.

**Q96 Mr Dunne:** At national level?

**David Nicholson:** Yes. Sorry. The Appointments Commission has someone who chairs it, and there are nine regional commissioners, each of whom appoints the chairs and non-executive directors of the various health bodies in that region.

**Q97 Mr Dunne:** Who has the responsibility to fire any directors, either executive or non-executive?

**David Nicholson:** The executive directors would be fired by the Chief Executive; the non-executive directors and chair would be fired by the Appointments Commission.

**Q98 Mr Dunne:** On advice from whom?

**David Nicholson:** On advice from whomever they wanted. It could be the strategic health authority, Ministers, the local public, the local authority. It could be a whole series of people.

**Q99 Mr Dunne:** And how many executive directors have been fired from PCTs for poor performance in a recent year?

**David Nicholson:** I do not collect that information nationally and, to be frank, it has been quite difficult over the last 12 months or so, as you can imagine, because we have been literally shifting most of the organisations into new ones.

**Q100 Mr Dunne:** Has there been a history of poor performance being dealt with through removal?

**David Nicholson:** There are examples of it, although PCTs are still relatively new bodies to the NHS, going back only to 2001. However, there are examples.

**Q101 Mr Dunne:** And in the process of shrinking from 300-odd to 150 PCTs, has everybody’s job been re-advertised for the PCTs?

**David Nicholson:** All the Chief Executive jobs were advertised nationally. The Executive Directors’ jobs were, generally speaking, advertised regionally. But there has been open competition for all of those in the new PCTs, and we are just working through that process.

**Q102 Mr Dunne:** So it is not quite finished yet?

**David Nicholson:** It is not finished yet, no.

**Q103 Mr Dunne:** Going up a level to the strategic health authority, can you explain the accountability there? Who appoints there?

**David Nicholson:** The chairs of the strategic health authorities are appointed by the Appointments Commission. Normally, the Chief Executive would be appointed by the chair, and I, as the NHS Chief Executive, would be an assessor to that appointment. The current round of SHA Chief Executive appointments were, however, made by a national panel, because we were filling all posts at the same time, and many of the Chairs were not in place. They were done before the Chairs, but normally you would expect the Chairs to be appointed. The Chairs are accountable to the Secretary of State.

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**Q104 Mr Dunne:** Has anybody been fired from a strategic health authority?

**David Nicholson:** They have been working only since 1 October.

**Q105 Mr Dunne:** A large number of their predecessors have been around. I do not imagine that anybody has been fired since 1 October. If they had, I would be very worried.

**David Nicholson:** Yes, so would I. Fired from an SHA? I cannot remember. I cannot recall any, can you?

**Duncan Selbie:** The SHA changes happened in July. It was the PCTs that were formed in October. Probably the question, if we are allowed, is better directed at the Appointments Commission. You can reasonably assume that conversations were had with chairmen over time about performance, which led to the termination of their period of office, or its non-renewal at the time when that was due.

**David Nicholson:** Chairs' appointments are fixed term, as opposed to Executives', which are not.

**Q106 Mr Dunne:** The purpose behind the question is that there is the perception among the public that a number of the trusts that got into the greatest difficulty did so as a result of having boards composed primarily of political appointments, to pick up Dr Pugh's point. Do you think that is a fair perception?

**David Nicholson:** I have seen no connection between poor management and political appointments.

**Q107 Mr Dunne:** I encourage you to look at some of the trusts in my area. I would be happy to identify them to you outside this meeting.

Turning to patient involvement, have you, as the NHS, been giving evidence or advice to the Government about the establishment of LINKs?

**David Nicholson:** I am sure the NHS has.

**Professor Marshall:** Yes, they have.

**Q108 Mr Dunne:** Have you given evidence to the Public Bill Committee? Have you, as the NHS, been invited by the Government?

**Chairman:** Could you speak up a bit, Mr Dunne? It is quite difficult to hear, because you are facing away from me and speaking quite softly.

**Mr Dunne:** Apologies, Chairman.

**Chairman:** I heard some vague something about political appointments, but it rather passed me by, and it is quite an important subject.

**Mr Dunne:** I shall send you the transcript. You do not want us to go over that question, do you?

**Chairman:** No, it is all right. Just speak up please.

**David Nicholson:** I personally have not given any evidence in relation to LINKs. I am sure that people within the Department will have done it. I have not.

**Q109 Mr Dunne:** I am not sure that they have in relation to the Public Bill Committee. That is a source of some concern to members of the NHS.

How do you think the LINK will provide greater public involvement in determining clinical priorities in local areas, compared with the existing forums that are about to be abolished?

**Professor Marshall:** Yes. There are several differences between patient fora and LINKs. One is that patient fora are relatively small organisations; LINKs will be much larger, more networked organisations, so they will bring in a range of different voices, not just within a small executive team. Secondly, patient fora are very closely lined to organisations and therefore do not address the issue of patients crossing organisations; LINKs are very much about geographical localities, rather than particular organisations. Those are probably the two key differences between LINKs and why we think that they will provide a better patient and public voice than fora have done in the past.

**Q110 Mr Dunne:** In determining clinical governance at a national level, presumably the NHS assesses how many doctors you will need from year to year as the cohorts mature and develop?

**David Nicholson:** Yes.

**Q111 Mr Dunne:** Have you therefore formed a view on the consequences of the financial deficits in the trusts and their impact on trainee doctors coming out of the system? Will they have jobs to go to?

**David Nicholson:** We have. As you can imagine, the numbers we are talking about across the NHS as a whole are very large and when we get to operational practice relatively small differences can be significant to individuals, but we have a process to do that. We are broadly on plan to deliver what we need, but obviously the NHS is moving very quickly in terms of the way that it provides services.

**Q112 Mr Dunne:** How much does it cost to train a doctor?

**Professor Marshall:** £250,000.

**Q113 Mr Dunne:** And to train a surgeon?

**Professor Marshall:** I do not know.

**Q114 Mr Dunne:** But more than that.

**Professor Marshall:** Yes. It is a seven or eight-year training process after qualification.

**Q115 Mr Dunne:** Would you comment on the current Remedy UK report in the papers that approximately 1,000 surgeons will be unemployed at the end of February?

**Professor Marshall:** I think that is highly unlikely. One of the problems is that the current training scheme trains people to become specialists in a particular area without us necessarily knowing whether we are going to need them. For example, we have trained a lot of cardiothoracic surgeons, whereas, in fact, dealing with heart problems is much more a medical problem than a surgical problem. That is why we are introducing a new training regime called *Modernising medical careers*,

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which is much more about linking the training places to the surgeons that the service will need in the future.

**Chairman:** Thank you very much. Your last questioner is Mr Mitchell.

**Q116 Mr Mitchell:** I must say I am not very happy with all this. It is such vague stuff. Clinical governance is a vague concept and a lot of it is decided by the tick-box mentality and self-assessment. I notice that 92% of PCTs consider themselves compliant. That is very nice for them. When the Chief Whip calls me in in the next couple of weeks to ask what she should report about me to the Grimsby Labour party about my reselection, she will find that I am compliant in everything—in loyalty, party enthusiasm and missionary endeavour, I am very compliant, because it is self-assessment. That is a barmy, comparatively feeble structure to deal with what I have certainly found to be a very powerful, self-protecting local mafia.

When I was first elected—with Gladstone; it was about 1892—there was a series of local mafias which ran themselves pretty well. There were the teachers, local government, the lawyers and the doctors. We have chained up the teachers. We have broken local government and centralised it all. The lawyers tell me that they in the tumbrel from the weight of poverty because of the legal aid reform. But the doctors are still all-powerful. These feeble control structures cannot penetrate that self-protecting group of people who never snitch on each other—much—and always support each other, and who are backed by an expensive defence system.

**Chairman:** Answer that—go on.

**David Nicholson:** Right. I shall start. The alternative is—what?

**Q117 Mr Mitchell:** Direct inspection, such as that to which every other organisation is liable.

**David Nicholson:** The Government are going to put out their response to Sir Liam Donaldson's report—what was it called?

**Professor Marshall:** *Good doctors, safer patients.*

**David Nicholson:** Right. I cannot talk about that—I am sure that Martin can say a little about the generality—but I think that it will deal with some of the issues that you have described. However, we are talking about a shift. There is no doubt that it will take time to put in place processes for those organisations to ensure that doctors do what we want them to do—that is, to provide good-quality, safe services to patients. We are beginning to see evidence that that is moving.

We have talked about the Quality and Outcomes Framework. Now, there are a lot of data that show that the services that patients get from doctors are improving in a measured way that you certainly do not see in terms of lawyers and some of those other groups.

**Q118 Mr Mitchell:** But for schools we have Ofsted. I do not think that, by any assessment, the strategic health authorities emerge as effective controllers or auditors. Certainly, the primary care trusts do not

think of them as such—only 40% found the strategic health authority useful. That overall superintending eye is ineffective in this situation. Why should the doctors not be inspected directly like the schools?

**Professor Marshall:** Your question is an important challenge. We have to look at what levers we have for improvement. Clinical governance is an overarching concept that matches those different levers to the different aims that we are trying to achieve. Inspection and regulation play an important role—inspection through the Commission for Health Improvement at organisational level, and inspection of professionals through the regulatory bodies such as the General Medical Council for doctors. It has a role, but it also has disadvantages. We know the disadvantage of heavy-handed regulation, so we have to look at other levers such as commissioning, patient choice, and internally driven, provider-driven quality improvement. Clinical governance is about providing an overall framework for each of those levers.

**Q119 Mr Mitchell:** But for hospitals you have a more effective machinery of control and even there it is difficult to manage and control the specialists, who still seem very powerful. This is not like that, however. We are passing more power down to the general practices. It is very difficult to supervise and control that. Like Sadiq, I cite paragraph 2.25, which says that “many PCTs feel unable to take local action themselves, relying instead on the General Medical Council . . . whilst local clinical governance systems have contributed to better identification of poor performance . . . PCTs do not have direct line management authority” to do anything about it. So we have the local, self-protective mafia and feeble PCTs.

**Professor Marshall:** I think that if you talk to most general practitioners, they will almost certainly say that they have less autonomy than they used to have.

**Q120 Mr Mitchell:** Oh well, they are always whinging about that. Everybody is.

**Professor Marshall:** General practices are held much more to account now than they were five or 10 years ago.

**Q121 Mr Mitchell:** But not enough.

**Professor Marshall:** It is a process—a journey. It is a question of getting the right balance between holding people to account and line-managing them, and getting the best out of them. That is difficult balance.

**Q122 Mr Mitchell:** Why can they not be encouraged to snitch more on each other? In my experience, they never do. Patients go from one doctor to another feeling that they have been badly treated, but the second never complains about the behaviour of the first; nothing is said about it. Only expert evidence would make the patient effective. I notice that paragraph 2.16 reports that 94% of GP respondents had “a patient safety incident reporting system in place . . . two thirds of GPs and nurses . . . had

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reported an incident and one third of GPs had reported an incident to their PCT.” I bet those are mainly incidents of patients being aggressive towards them rather than of them failing their patients. Can you tell us whether they are?

**Professor Marshall:** I do not have specific data on the nature of the incidents.

**Q123 Mr Mitchell:** It is a self-protection mechanism, in other words.

**Professor Marshall:** I agree that in the past doctors have not been very good at what you call snitching on each other, but that is changing. Clinical governance is part of that process; it is about taking responsibility for your colleague’s practice, as well as your own.

**Q124 Mr Mitchell:** But I notice that the Professional Executive Committees are much less satisfied than anybody else with the progress that has been made, and paragraph 2.9 says that committee members give it lower scores than anybody else. There is a fashion for denigrating these professional executive bodies. “Making a Difference”, from the NHS Alliance, disparaged them, and the Department clearly thinks that they are less effective than they should be. However, they could be right, could they not? They are the people at the patient face. They know what is going on and whether the controls are effective. The Report says that “GPs (making up 29% of PEC respondents) consistently gave lower scores”. PECs could be Reporting accurately, whereas the PCTs could be puffing up their own performance.

**Duncan Selbie:** The NHS Alliance says that we need PECs, and that that is why they are being reviewed, strengthened and made fit for purpose. We will have something to share with you in the next few weeks. The consultation ends on Wednesday.

We should remember that the National Audit Office Report is about looking back, and there is nothing the matter with that, because it is about capturing the lessons. However, the new organisations are stronger and more able. I spoke to two PCT Chief Executives last week about underperforming doctors. One case was very clear; it was a problem about sexual behaviour, and the doctor was suspended. The other was about attitude and communication difficulties, and the doctor was suspended. These people—PCT Chief Executives and boards—are not in doubt. Every board has a sub-committee looking at this issue all the time, and it is simply not the case—

**Q125 Mr Mitchell:** Is the assessment from the PECs at the patient face more accurate than the self-assessment of the PCTs?

**Duncan Selbie:** I prefer what front-line people have to say.

**Mr Mitchell:** I will stop you there.

**Duncan Selbie:** May I continue?

**Mr Mitchell:** Time is pressing, but yes.

**Duncan Selbie:** Mr Khan said that people do not always recognise that they are doing what we ask, because of the language that we use, and a number of people have remarked on that. When we say clinical governance, they say, “What is that?” However, when we say, “Listening to patients, responding to complaints and looking at incidents and learning from them,” they say, “Oh yes, we do that.”

**Q126 Mr Mitchell:** Okay. That leads to my next question, which is whether we can develop an adequate machinery of control and checking to assess performance as well as to assess whether they are listening to patients and are doing the job properly, unless we involve patients more in the structures. Frankly, we seem to have been pathetic in that direction. The PCTs do not seem to involve them effectively. Although the Government are talking about democratisation and making the NHS accountable, it is not really accountable by any means. Can we do the job without involving patients more?

**David Nicholson:** No, we cannot. PCTs are increasingly realising that that is the case. It is not just at PCT level; it is at the practice level. About 30% of our practices currently have patient participation groups within them. We are working with the National Association for Patient Participation to make that 100% over the next few years. At the practice level, we will have the input, knowledge and understanding to make such things happen. You are absolutely right. There is no doubt that we will never be able to assure ourselves that things are okay unless the patients say that they are and are engaged in such matters.

**Q127 Mr Mitchell:** I am glad to hear that. Given that we are paying GPs so much more, now is a good time to discipline them more. In conclusion, I am not suggesting a structure of “turn in your GP for fun and profit”, but the channels now available for patient complaints about ill treatment by GPs are totally inadequate.

**David Nicholson:** I hope that you will be reassured by what the Government announce in the next week or so.

**Chairman:** That concludes our hearing. It has been a difficult hearing for us. I am sure that the processes are in place but, as Mr Mitchell has made clear, it is not entirely apparent how responsive GPs are. Equally, one wants to avoid the effects of heavy-handed regulation. We have to trust professionals to a certain extent. It is therefore a difficult area, but thank you very much for assisting us.

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**Supplementary memorandum submitted by the Department of Health**

Question 74 (Dr John Pugh): *One final question: PCT trust members obviously have a key role in maintaining vigilance and good clinical governance, and in ensuring that all the checks are in place. How many PCT trust members would you guess to be political appointees and is there a breakdown of the numbers*

The table below shows the number of PCT board members who had declared political activity within the last five years, as at 1 December 2006, broken down by strategic health authority and major political party.

<i>Parent SHA</i>	<i>Party</i>	<i>Primary Care Trust board members</i>
East Midlands	No political activity	48
	Conservative	3
	Independent	1
	Labour	8
	Liberal Democrat	1
	Other	0
	Total	61
North East	No political activity	50
	Conservative	0
	Independent	0
	Labour	9
	Liberal Democrat	1
	Other	0
	Total	60
North West	No political activity	118
	Conservative	2
	Independent	0
	Labour	34
	Liberal Democrat	3
	Other	0
	Total	157
West Midlands	No political activity	87
	Conservative	5
	Independent	0
	Labour	19
	Liberal Democrat	3
	Other	2
	Total	116
Yorkshire and The Humber	No political activity	66
	Conservative	0
	Independent	0
	Labour	13
	Liberal Democrat	1
	Other	0
	Total	80
East of England	No political activity	55
	Conservative	5
	Independent	1
	Labour	6
	Liberal Democrat	0
	Other	0
	Total	67
London	No political activity	136
	Conservative	8
	Independent	0
	Labour	53
	Liberal Democrat	6
	Other	0
	Total	203
South Central	No political activity	48
	Conservative	0
	Independent	0
	Labour	3

<i>Parent SHA</i>	<i>Party</i>	<i>Primary Care Trust board members</i>
	Liberal Democrat	3
	Other	0
	Total	54
South East Coast	No political activity	46
	Conservative	5
	Independent	1
	Labour	3
	Liberal Democrat	0
	Other	1
	Total	56
South West	No political activity	75
	Conservative	1
	Independent	0
	Labour	7
	Liberal Democrat	2
	Other	0
	Total	85
Total	No political activity	729
	Conservative	29
	Independent	3
	Labour	155
	Liberal Democrat	20
	Other	3
	Total	939