

Discussion paper:

**Quality Improvement
Strategy for
Public Hospitals**

September 2001

Ad hoc group to develop a discussion document on a quality improvement strategy for public hospitals

Discussion Paper: Quality Improvement Strategy for Public Hospitals

| | |
|---|-----------|
| <u>INTRODUCTION</u> | <u>3</u> |
| <u>HOW TO RESPOND TO THIS DISCUSSION DOCUMENT</u> | <u>4</u> |
| <u>WHAT IS QUALITY?</u> | <u>5</u> |
| <u>WHY FOCUS ON QUALITY IMPROVEMENT?</u> | <u>6</u> |
| <u>QUALITY IMPROVEMENT DEVELOPMENTS IN NEW ZEALAND</u> | <u>8</u> |
| <u>DEVELOPING AN ALL-ENCOMPASSING QUALITY IMPROVEMENT STRATEGY</u> | <u>10</u> |
| <u>SETTING UP SYSTEMS FOR CLINICAL GOVERNANCE</u> | <u>11</u> |
| <u>CLINICAL LEADERSHIP - CHANGING THE CULTURE</u> | <u>12</u> |
| <u>INVOLVING CLINICIANS</u> <u>TEAM WORKING</u> <u>QUESTIONS</u> | |
| <u>CLINICIAN-COMMUNITY PARTNERSHIP</u> | <u>16</u> |
| <u>COMPLAINTS</u> <u>BLAME CULTURES...</u> <u>SAFETY CULTURES...</u> <u>QUESTIONS</u> | |
| <u>PERFORMANCE MANAGEMENT</u> | <u>19</u> |
| <u>INDIVIDUAL PERFORMANCE</u> <u>DEPARTMENTAL PERFORMANCE</u> <u>MULTI-PROFESSIONAL CLINICAL AUDIT</u> <u>QUESTIONS</u> | |
| <u>EVIDENCE-BASED PRACTICE</u> | <u>23</u> |
| <u>QUESTIONS</u> | |
| <u>LIMITATIONS OF TIME</u> | <u>25</u> |
| <u>QUESTIONS</u> | |
| <u>ACCOUNTABILITY AND RESPONSIBILITY</u> | <u>26</u> |
| <u>CLINICAL BOARD</u> <u>HEADS OF DEPARTMENT</u> <u>EXTERNAL AUDITOR</u> <u>CHIEF EXECUTIVE</u> <u>CLINICAL ACCOUNTABILITY</u> <u>MONITORING AND REPORTING</u> <u>QUESTIONS</u> | |
| <u>REFERENCES</u> | <u>29</u> |
| Appendix 1 | 30 |
| Appendix 2 | 33 |
| Appendix 3 | 34 |
| Appendix 4 | 36 |

Introduction

This discussion document has been produced by an ad hoc group^a established by Associate Minister of Health Hon Ruth Dyson with the intent of establishing a quality improvement strategy for public hospitals that is primarily developed and implemented by clinicians in collaboration with patient advocates, and with the support of hospital management.

The strategy would be focused primarily at the clinical team level and would complement the new standards regime that will be introduced next year after the passing of the Health and Disability (Safety) Bill.

This document assumes current and forecast funding levels. It does not cover issues concerning registration and regulation of health professionals (which are being addressed through proposed legislation). And it does not cover issues about access to services.

The terms of reference^b suggest this document may be further developed through a workshop involving broad health sector and patient representation or through a preliminary round of consultation with health professional and patient advocacy groups, prior to being released for public discussion.

However, the group is conscious of the other developmental work on quality issues currently in progress – including work by the Ministry of Health and the National Health Committee (which the group endorses) – and recommends that the various strands, including feedback from this document, be brought together in the development of a national quality strategy.

The group recommends that the coordination of this work be undertaken by a working group, including representatives of the key organisations currently working on quality issues, as well as representatives of clinical groups, managers, Maori and patient advocacy groups.

This document does not look at quality issues specific to Maori. Discussion on these issues is included in a separate discussion document on the Maori Health Strategy, released by the Ministry of Health in April 2001. The outcome of that discussion in relation to quality of hospital services must be taken into account in the development of the strategy.

The group also felt strongly that, for reasons explained in the document, the strategy should be developed from the "bottom up", that it expresses a clear vision, and has an emphasis on practical action.

The group recommends this paper is made available to a range of interested individuals and organisations, including professional bodies, patient advocacy groups, affected unions and colleges.

a. Appendix 4 b. Appendix 3

How to respond to this discussion document

This discussion document is being distributed to interested parties.

You can provide comments by making a written submission on your own behalf or as a member of an organisation. Submissions may be made anonymously.

All submissions received will be available to be requested under the Official Information Act 1982. Please note that correspondence may be the subject of a request under the Official Information Act 1982. If there is any part of your correspondence that you consider could *properly* be withheld under the Act, please include comment to that effect and give reasons why you would want it withheld.

Submissions should be sent to:

The Quality Improvement Strategy for Public Hospitals Team
Professional Regulation and Quality
Personal and Family Health Directorate
Ministry of Health
PO Box 5013
WELLINGTON

Comments should be received by 2 November 2001.

What is quality?

The definition of quality is often related to the needs and expectations of the user of the service¹. In addition, health professionals, health and disability service managers and, in a publicly funded service, the community at large and politicians all have a legitimate interest in the quality of service. Given the sometimes conflicting interests of these groups, the definition of quality can be controversial as it can have different meanings for each.

Klein² has identified 10 dimensions of quality pertinent to health:

- Effectiveness
- Efficiency
- Equity
- Access
- Acceptability
- Appropriateness
- Respect
- Choice
- Availability of information, and
- Technical competence

Each of these dimensions can be interpreted differently from different positions of interest³. For example, a patient's view of efficiency may well be different from that of a service manager. Furthermore, many health professionals tend to view quality primarily as pertinent to their own professional care and treatment services. So while everyone may wish to see improvements in the quality of services, success may depend on a person's viewpoint.

This paper acknowledges that all viewpoints on the meaning of quality must be taken into account in any quality improvement strategy. However, it proposes that the first and foremost perspective is that of the patient. It also suggests that the fact that there are widely different perceptions of what quality improvement means is itself a quality issue which may be improved through developing more effective information and communication systems.

Why focus on quality improvement?

The focus on quality internationally has been driven by a number of factors, including increased public expectations and knowledge, rapid technological advances and new patterns of professional education. But the most compelling and visible reason relates to a number of high profile scandalous service failures³. In New Zealand these include case that led to the Cartwright Inquiry and major inquiries into hospital services in Christchurch and Gisborne.

In addition, research studies in the USA, Australia and, more recently, in New Zealand⁴, suggest a significant number of patients die or are permanently disabled due to preventable causes in hospitals.

Though clinical risk management is reasonably well developed within the health service, the effectiveness of individual risk management systems is hard to gauge.

The main reasons why unnecessary risks occur have been identified as⁵:

1. System failures (eg ill-defined or the lack of appropriate processes, policies, procedures and clinical guidelines).
2. Staff taking short cuts due to heavy workload, pressure of work and lack of support
3. Breakdown of communication....

One or more of these factors are usually involved when hospital errors are reported.

Such reports and research pointing to failings in safety standards reduces public confidence in the hospital system and - especially when there is poor accountability - a negative and hostile press. This in turn hinders quality improvement (and accountability) since the incentive is for hospital staff to cover up errors for fear of retribution, when quality improvement requires openness and cooperation.

This cycle must be broken. The initial crucial steps is to develop the culture of organisations to be conducive to supporting quality improvement systems. This includes replacing the punitive approach to errors with a more supportive approach aimed at eliminating those errors.

Traditionally, governments have tended to use regulatory mechanisms to ensure safety standards, based on prescribing certain "inputs" into services, such as minimum nursing staff levels measured against the number of hospital beds. However, there has been no system-wide approach to safety or quality that is based on the outcomes for patients. In order to develop a system of continuous quality improvement in services, providers must attend to not only the service inputs but also the processes and consequences for patients.

Taylor has noted that more effective health and disability services can be achieved through disciplined, well informed and intelligent application of quality improvement tools.¹ Such tools have been introduced in parts of the

sector in New Zealand but there is not yet widespread and consistent implementation of quality improvement strategies among service providers. Consistent application of quality improvement processes and tools throughout the health and disability sector has the potential to reduce harm to patients and to produce a more efficient, cost-effective service.

Quality improvement developments in New Zealand

New Zealand over recent times has seen developments aimed at improving public accountability (Code of Rights), education (National Health Committee, clinical guidelines), and service coordination (“best practice” database).

Some hospitals have individually introduced quality improvement systems (though reports from clinical staff suggest there is much room for improvement). One hospital has a “clinical governance” structure and continuous quality improvement measures such as measuring the time taken from admission to administration of medication for thrombolysis (clot dissolving) for heart attack victims. Intensive care units and renal units participate fully in Australasian quality assessment activities.

A system of “credentialling” medical practitioners is being developed by the Ministry of Health in consultation with the medical profession. This system is widely used in the USA and is designed to ensure medical practitioners are competent (credentialled) to practice in their particular fields. It will mean, for example, a cardiac surgeon will be credentialled to perform certain kinds of operations up to a certain level of complexity at designated hospitals with a specified number and mix of support staff and equipment.

This system will be reinforced through provisions of the Professionals' Competency Assurance Bill. The proposed legislation will replace 11 occupational regulation statutes, many of which are out of date, with a new framework that is designed to empower registration bodies to ensure practitioners maintain their competence.

The Ministry is also devising a “Sentinel Event System” to tighten procedures for reporting serious errors focusing on systematic problems rather than assigning blame to individual doctors.

Many service providers have signed up to voluntary accreditation programmes where services undergo a regular assessment to evaluate the quality of services and participate in a process of continuing quality improvement.

Not least, the current hospital licensing regime, which focuses on only some causes of safety risk and lacks clarity as to who is responsible for safe services, is to be replaced by a national safety standards regime through the Health and Disability (Safety) Bill. Under the new legislation, hospitals and aged care facilities will be required to undergo regular assessments in order to comply with recently developed Health & Disability Sector Standards. The Sector Standards are based on minimum safety measures and do not necessarily require continuing quality improvement. However, providers may continue to sign up to voluntary accreditation programmes which include progressive quality improvement.

A Health Workforce Advisory Committee has been established to advise the Government on key health workforce issues and strategies. This committee will provide advice on national goals for the health workforce, and will recommend strategies to develop an appropriate workforce capacity.

The Ministry of Health is also developing, in consultation with key sector groups, mandatory nursing staff specifications to address staffing level issues, initially for high risk providers. The staff specifications, will reflect quality issues such as staff training and qualifications, as well as staffing levels.

Other initiatives include work being done by:

- ◆ the Clinical Leaders' Association (CLANZ) on leadership and quality;
- ◆ the Council of Medical Colleges on health workforce development in Northland;
- ◆ Health Care Aotearoa on development of a quality improvement and accreditation tool for use with community-controlled primary care organisations;
- ◆ "third sector" organisations on development of a strategy for health and research and organisational learning for the sector.

Developing an all-encompassing quality improvement strategy

Each of the above measures play a part in improving safety and quality in our health and disability services. However, there is still no coherent, all-encompassing national strategy for improving quality. There is no specific initiative aimed at fostering a culture of quality improvement within organisations. While better monitoring and reporting are needed, with a focus on quality, no monitoring system will pick up every fault, no matter how timely the spot check or hospital survey.

To complement external monitoring systems, hospitals need to develop their own frameworks which draw together all local activity for minimising errors and improving quality into a single coherent programme. Furthermore, the highly complex nature of clinical care at the individual level calls for a bottom-up approach to planning and implementing quality improvement activities to complement organisational standards.

Support from clinicians is essential for any quality improvement plan to succeed and this support is unlikely unless the development of the plan involves clinicians themselves.^{6,7,8,9,10} Nor are strategies likely to succeed without cooperation and collaboration between clinicians, managers, government agencies and the patients.

This discussion paper's main purpose is to promote discussion on the best way to develop an overall strategy for improving quality services, pulling together and developing current initiatives where appropriate, and developing new measures where necessary. It is limited to hospital services because it is primarily written with reference to the Health and Disability Services (Safety) Bill, which relates initially only to hospital and residential aged care services, and because hospital services have attracted most public concern over quality and safety. Similar quality improvement developments focusing on other health and services will also be needed to create a comprehensive quality improvement strategy for the health system.

The clinical governance model, introduced into the NHS in the UK, is used as a basis from which to develop the strategy, taking into account New Zealand conditions.

The paper recognises some of the weaknesses experienced in the implementation of the clinical governance model during its early development. It also recognises that the measurement of quality is a far from exact science and that, because of the very human nature of health service delivery, any strategy for quality improvement will be an uneven, evolutionary process.

For the purpose of discussion, the key issues are focused on separately, though in practice many of the issues overlap, and all should be considered as part of a whole.

Setting up systems for clinical governance¹¹

Three key steps to setting up a system of clinical governance - or, in the New Zealand context, a quality improvement strategy – are:

1. Audit of quality and safety systems and processes already in place at the clinical unit level.

Many of the systems required for "clinical governance" already exist within organisations. A starting point, therefore, would be to look at which systems need strengthening, and what are the barriers to quality that need addressing.

2. Examine the culture within which clinicians are working.

Multi-disciplinary working relationships, networking, collaboration and practical support at all levels are vital elements of an effective quality management system. The involvement of all clinical and non-clinical staff is important in developing and "enabling" environment.

3. Infrastructure to support quality improvement

The third step is to identify the infrastructure needed to support quality improvement. This is about allowing clinicians the opportunity to participate actively in the quality improvement process and to identify the individual training and development needs of staff.

The following sections are written in the context of these three steps.

Clinical leadership - changing the culture

Clinical leadership spans the whole health sector – individual staff, service level and organisational level.... [The components must] be integrated and work well together. Central prescription must be balanced with local empowerment and guided autonomy, external regulation must be balanced with internal morality of the health professions. The perspectives and contributions of managers and clinicians must be balanced with those of representatives and advocates from health interested organisations and groups in the community.

For clinical leadership to work effectively and to achieve its full potential the basic concept must be widely shared and understood both within and beyond the health sector. On the basis of this understanding there must be a general willingness among the key stakeholders to work together to achieve the goals of clinical leadership. For this to happen will require a major shift in the prevailing culture within the health system.

- Dr George Salmond, Towards clinical leadership in New Zealand, Clinical Leaders' Association of New Zealand, January 2001

Changes to the health system during the 1990s attempted to introduce market principles as a way of improving efficiency and of financial accountability of managers of health services. This saw the development of a corporate, managerial culture which many clinicians feel has had the effect of overriding their own health professional ethos. Two major inquiries^{12,13} by the Health and Disability Commissioner have also drawn attention to this development:

"Many decisions were driven by financial imperatives without sufficient regard to the provision of a quality service by a highly motivated workforce. Many legitimate concerns raised by staff fell on deaf ears." And: "Senior doctors and nurses felt disenfranchised, unable to exercise an effective clinical voice in management decisions."

– H&D Commissioner report on Gisborne Hospital 1999-2000.

Perhaps the most challenging aspects of getting a quality improvement strategy to work - and among the most important - are in ensuring the right culture is in place, with the right clinical leadership, to nurture the kind of environment in which clinical excellence will thrive.

In the UK's health care quality strategy, cultural transformation is a primary driver to delivering improved quality of care: "Achieving meaningful and sustainable quality improvements in the NHS requires a fundamental shift in culture, to focus effort where it is needed and to enable and empower those who work in the NHS to improve quality locally..." (A first class service: quality in the New NHS, Department of Health, UK) The first task has been "getting clinical professionals on board".¹⁴

Support from clinicians is essential for any quality improvement plan to succeed and this support is unlikely unless the plan is developed and "owned" by clinicians themselves.^{6,7,8,9,10}

Involving clinicians

Gisborne has responded to the lack of clinicians' involvement in fundamental decision-making at the hospital by establishing a clinical board which will have a strong say in the setting and progressing of clinical policy. The board meets weekly and comprises the clinical directors, the CEO and representatives from nursing, allied health, quality, Maori health and GPs.¹⁵

The board aims to focus on quality issues and wants to see a return of leadership to nursing and medical groups, and involvement in devolvement of hospital budgets.

Clinical boards have also been established in some other hospitals, most notably Middlemore, which has a well established focus on continuous quality improvement, and has broad support from clinicians and management.

Middlemore has shown that such boards do not only play a key role in re-establishing a strong clinical culture in the day-to-day running of hospitals but also in strengthening collaborative relationships between clinicians and management.

However, the sense of marginalisation among some clinicians is not only owing to the rise in managerialism over recent times but is also based on the traditional hierarchical structures within and across the health professional groups themselves.

This point is illustrated in a survey of operating and intensive care unit staff about attitudes concerning error, stress and teamwork. The survey found differing perceptions of teamwork among team members. For example, surgeons perceived teamwork and communication in the team to be of a higher quality than the rest of the team. Similarly, in intensive care, although 77% of doctors reported high levels of teamwork with nurses, only 40% of nurses reported high levels of teamwork with doctors. In surgical services there was also a reluctance of senior theatre staff to accept input from junior members.¹⁶

To ensure clinical boards are best placed to represent the views, knowledge and expertise of clinicians of all levels throughout the organisation, and to encourage broad involvement, a democratic means of selecting membership may be needed.

Some clinicians have proposed that clinical board members are elected by the hospital's clinicians.⁶ The board, which would also include the CEO, would be responsible for clinical policy, planning and quality improvement activities, and would have executive power. The positions of heads of department would be rotated among senior clinicians within each department, rather than filled by a permanent management appointee.

Possible roles and accountabilities might be described as follows:

- ◆ The clinical board would be accountable to clinical staff. Its role would include:
- ◆ Advising and reporting on clinical policy, planning and quality systems
- ◆ Providing strategic direction of clinical governance within the facility.
- ◆ Establishing links with the central agencies, such as the National Health Committee, to receive and disseminate information on innovative practice, clinical guidelines, research etc.
- ◆ To receive and appraise regular quality audits from the clinical groups, prior to collation for the chief executive and the organisation's governing committee.

All clinical advice and reports to the chief executive would be open to staff and public scrutiny.

A democratically elected clinical board would provide a mechanism by which the full range of clinicians' knowledge and experience is drawn upon at all levels of decision-making, by-passing the communication barriers that often exist in traditional hierarchies and between professional groups. It would also help to foster openness and inclusive debate and help to avoid potential "capture" of the board by individuals or small groups whose interests may not necessarily reflect those of the clinical staff as a whole.

A disadvantage of a clinical board with executive power would be the potential confusion over responsibilities and accountability, since clinical policy and planning decisions will impact on other parts of the hospital's operation.

A board with an advisory role only, may not be regarded by clinicians as having real power. This may be less of an issue, however, with the new district health board arrangements which require greater openness and public accountability. In this set-up, the board's advice - and the executive's response to that advice - would be open for public scrutiny and question.

Team working

Support for the effective functioning of multi-disciplinary teams and professional incentives is crucial in developing quality.

New approaches to health professionals' education, such as the introduction of problem-based learning and joint education across professional disciplines, should in time improve team-working skills. Though these approaches need to be further developed. In aviation, for example, once it had become recognised that most accidents in modern planes were related to breakdowns in crew coordination, communication and decision-making, airlines began moving away from training the individual pilot to training the entire crew. Pilots began to be selected not only for technical skills but also for their ability to coordinate activities, learn from error, and recognise that others can contribute to problem solving. In other words, good leadership skills. Further, the aviation approach is to deal with errors non-punitively and proactively, and this approach defines behavioural strategies taught in crew resource management training.¹⁷

Development of the team approach in the education and training of health professionals needs also to be reinforced in clinical policy development in the clinical settings and emphasised in quality performance assessments. This includes ensuring that teams include the appropriate mix of skills and experience.

Good leadership, with a strong focus on team work, is inextricably linked with motivation, and successful leaders bring out the best in people. The most important part of achieving motivation is to attend to the most important needs of the people you are leading. These include the need to be valued and respected, to see the results of one's actions, and to have some degree of control¹⁸.

The establishment of a democratic process for clinical staff on planning, policy and quality issues, better collection and feedback of quality data, and a stronger emphasis on teamwork may therefore be important motivators for improving quality of clinical leadership and services.

Questions

1. Do you agree or disagree that a change of culture is needed in our hospital services to ensure more effective clinical leadership and high quality clinical service? If you agree, what are the main features of the culture that you believe needs to be developed?
2. What is required to ensure a strong commitment from senior management and clinicians to a quality improvement strategy?
3. What measures are needed to strengthen the multi-disciplinary team focus?
4. Would hospital clinical boards help to improve clinical leadership and clinical quality? If so: (a) Should they be mandatory for all large and medium-sized hospitals? How should members be selected? (b) Should they have an advisory role only or have executive power?

Clinician-community partnership

The strength of the working relationship between the health professionals in the team and between health professionals and managers will be at the heart of a successful quality strategy. But other partnerships will also be crucial. Developmental progress will depend on effective partnerships between clinicians and managers and service users and the broader community through health interest groups, local authorities, patients' advocacy groups, and voluntary organisations, as well as partnerships with educational institutes.

Quality in health care often tends to be defined by clinicians in terms of clinical effectiveness, and by managers in terms of the range of efficiency measures that have been developed.¹¹ However, the ultimate measure of improvement is whether or not it helps the users of services (patients, families, communities) as they see it.¹⁹ A prime measurement of quality therefore must reflect the perspective of the user.

This can be achieved by ensuring that the service users' perspective is built into the range of activities for improving quality.

Partnership with the community can be strengthened with:

- better public access to information on the performance of local services and developments in evidence-based practice;
- clear public accountability arrangements for the overall quality of clinical care, with designated responsibilities for boards, chief executives and clinicians;
- more involvement by service user representatives in quality improvement activities, including involvement in service audits;
- a spirit of openness from clinicians reinforced by a move away from the "blame culture", which encourages clinicians to cover up errors for fear of retribution, and a move towards better management and systematic learning from mistakes and complaints in a supportive environment.

Improved involvement at the level of individual patient care can be achieved by:

ensuring the patient (and, where appropriate, family, carers etc) is provided with sufficient information to be an active partner in making decisions about their health care. This includes information about their condition, both short- and long-term, about how they could or should modify their lifestyle; about treatment choices and services available – information to which the patient has a right under the Health and Disability Code of Rights.

Clinicians often raise concerns about the potential for raising patients' anxiety when providing more information. The complexities of what individual may need or be able to take in at any particular stage in their treatment, or may find alarming, imply a need for sufficient time and subtle judgement of the part of clinicians. A coordinated clinical team approach to providing information through the process of treatment and care and may help to overcome some of those difficulties.

Complaints

A process for dealing with complaints is well established under the Health and Disability Commissioner Act, which gives users of services legally enforceable rights, including the right to complain. Complainants may lodge a complaint with the Commissioner, though the Commissioner's approach is to encourage complaints to be addressed directly between the users and providers of services in the first instance.

The Code of Rights sets out specific requirements for the complaints process, including requirements to facilitate fair, simple, speedy and efficient resolution of complaints and to keep the complainant informed.

One study of complainants found that the three main reasons for complaining about health services were:²⁰

- ◆ so that this type of incident will not happen again
- ◆ to raise the awareness of staff concerning the problems
- ◆ to get an explanation of what went wrong.

The wish to discipline the staff responsible for the incident was lower down the order. Nevertheless, it is often difficult for staff to come clean about clinical incidents, especially if a patient suffers as a result. The same study found that half of the complainants required further treatment as a result of the incident complained about, and in 40% of cases the patient's condition had deteriorated. The style of treatment by the media of such cases makes it doubly difficult.

Yet openness and honesty are crucial if lessons are to be learned from mistakes and errors are to be reduced. If clinical staff and provider organisations are to make themselves vulnerable by being more open about mistakes, then we must move away from the "blame culture" to a more constructive "safety culture". This will require more trusting relationships between the relevant parties – especially between service providers and the media.

Blame cultures...

- Encourage people to cover up errors for fear of retribution
- Act against the identification of the true causes of failure
- Focus heavily on individual actions
- Largely ignore the role of underlying systems

Safety cultures...

- Encourage open reporting
- Can have a positive and quantifiable impact on the performance of organisations.

Questions

The UK's NHS strategy for working collaboratively with patients should have four overall aims:

At the level of individual care:

- To promote user involvement in their own care, as active partners with professionals
- To enable patients to become informed about their treatment and care and make informed decisions and choices about it if they wish.

At the level of overall service development:

- To contribute to the quality of health services by making them more responsive to the needs and preferences of users
 - To ensure that users have the knowledge, skills and support to enable them to influence health service policy
1. Do the above aims adequately reflect the needs in the New Zealand health service?
 2. Acknowledging some progress has been made at the level of individual care through the introduction of the Code of Rights, what measures and processes are needed to progress further towards the above aims?

Performance management

Individual performance

There are a number of developments under way aimed at improving quality at the individual level, including the development of the "credentialling" system, the Professionals' Competency Assurance Bill (PCAB) and the "sentinel events system", described earlier.

The PCAB proposes that registering authorities have the discretion to review the competence of a health professional at any time and. If necessary, the registering authority may require a practitioner to undertake a "competence programme", which may include examinations, practical training, experience, or instruction.

The Medical Practitioners' Act 1995 introduced the concept of quality assurance activities, where the intention was to give medical practitioners a forum to discuss freely problems they may have encountered in their work, without fear of recrimination. The MPA defines a quality assurance activity as an assessment or evaluation of any health services provided by a medical practitioner, where the assessment is carried out for the purpose of improving practices or competence of the medical practitioner.

Quality assurance activities include wide range of activities, including peer review, clinical audit of the outcome of treatment, systems reviews and academic studies of adverse events.

Currently the MPA is the only health occupational regulation statute that contains quality assurance provisions. Because health and disability services are very often delivered by multi-disciplinary teams, the PCAB proposes that quality assurance provisions be extended to all professions.

Departmental performance

Effective performance management of clinicians and managers is seen by many as the key to achieving effective quality improvement. Indicators of quality, clinical performance and risk are seen as important parts of routine performance management reports from hospital departments or clinical groups.

The limitations of these indicators are also well recognised. One of the difficulties of performance management is seen to be the potential for missing or misinterpreting data that in the initial stages will often be of poor quality. One way to alleviate this is to ensure maximum professional participation in the generation of the data in the first place.⁷

Comprehensive quality improvement is dependent on good information from a number of sources, including:¹¹

- ◆ Local clinical audit data;
- ◆ national comparative data;
- ◆ local clinical pathways, guidelines and protocols;
- ◆ national clinical guidelines;
- ◆ international research evidence.

Multi-professional clinical audit

Many health professionals recognise the need to perform clinical audit to check that what they think they are doing is what is actually happening.

Clinical audit has been defined as "the systematic and critical analysis of the quality of clinical care, including the procedures for the diagnosis, treatment and care, the associated use of resources and the resulting outcome and quality of life for the patient."¹

Essentially, it is an examination of data – usually from patients' notes – in order to evaluate the actual clinical care against a defined standard. Regular audits are needed to ensure the quality of care and treatment is maintained or improved.

Effective clinical audit can lead to significant improvements and cost-efficiencies in the delivery of care. In the UK, one clinical audit led to vast improvements in asthma management which in turn led to a 68% reduction in acute asthma attacks. In one A&E department, X-rays of nasal fractures are no longer routinely taken since an audit showed that they did not influence subsequent treatment. An audit into the management of gastrointestinal bleed led to the introduction of a shared protocol between primary and secondary care and a reduction in mortality from 13% to 4%. An audit of the effectiveness of a multidisciplinary pain relief service in a hospital led to the appointment of a clinical nurse specialist and subsequent improvement of 20% in the management of pain.²¹

Despite the demonstrated benefits of multidisciplinary clinical audit, its application in New Zealand is currently ad hoc and of varied quality. Deficiencies in clinical audits are considered to be a major factor in sub-optimal ward care leading to adverse events in hospitals. An investigation into the quality of care given to patients prior to their admission to the intensive care unit indicated 54% of patients had received sub-optimal care. The authors concluded that the main causes were failure of organisation, lack of knowledge, failure to appreciate clinical urgency, lack of supervision and failure to seek advice.²²

There is evidence indicating medical and nursing training pertaining to the recognition and management of the critically ill patient is inadequate; especially at the undergraduate level.^{23, 24}

And in some areas inappropriate deployment of staff can undermine quality and safety. For example:

"The current structure of acute medical teams can separate the sickest patients from the most experienced staff. After hours it is often the case that unstable patients are managed by the most junior medical staff. Furthermore, a reduction in the hours worked by junior staff has led to the erosion of continuity of patient care."

– Paul Frost, *Optimising ward care of physiologically Unstable patients (unpublished)*

Poor continuity of care has been described as the biggest single problem affecting standards of patient care and patient safety: "Patients will never be safe if (as happens now) registrars and house officers are moved from team to team at great speed while patients are moved from ward to ward at great speed."²⁵

A proposed strategy for one New Zealand metropolitan hospital is for a multi-disciplinary taskforce to be set up with its first priority being to formulate a suitable clinical audit to enable an intervention package to be developed.²⁶

Currently there are no requirements for regular and specifically defined clinical audit in hospitals where it is appropriate. (The Health Sector Standards and draft audit tool include a standard for review of service delivery in which clinical audit is listed as one possible measure.) There are a number of potential barriers to carrying out quality clinical audit, including²⁷:

- Workload pressures and lack of allocated time for auditing
- Lack of good quality data
- Hierarchical relationships between health professionals
- Lack of commitment from senior clinicians or managers
- Lack of practical support
- Lack of knowledge and skills to undertake effective audit

Most of the barriers can be summed up as time and resources. In the UK's NHS, the value of audit has been recognised with specific funding for the process. There is also a contractual obligation for health professionals in hospitals to participate in clinical audit.

Questions

1. Should regular multidisciplinary clinical audit, where appropriate, be a requirement in hospitals?
2. If so:
 - (a) How should clinical audit be defined? (Is the above definition of clinical audit appropriate?)
 - (b) Should funding be set aside for the process?
 - (c) How is local clinical audit information that may be useful for other providers best disseminated?

Data collection

The importance of clinical record keeping is well established. The collection and analysis of routine patient data has been a central part of the health service's planning and administration. However, the emphasis on data collection - particularly at the macro level - during the changes of the 1990s was on the number of treatments, length of stay and cost of care. There are substantial failings in the completeness of some of the vital clinical data. A renewed commitment to the accuracy, appropriateness, completeness, and analysis of health information will be required if judgements about clinical quality are to be made and the impact of quality strategies is to be assessed.²⁸

Current deficiencies in national collection and analysis of comparative data on clinical performance must be acknowledged in any performance monitoring system, but they should not prevent the use and development of the system.

For example, an analysis of treatments for fracture of the neck of femur in 20 New Zealand hospitals showed variation in what interventions are used, and variations in mortality from complications.²⁹ No judgement on the quality of care could be made from this analysis, though the initial findings signalled a need for more detailed analysis taking into account all relevant variables.

It needs to become part of the continuing maintenance of professional competence that practitioners expect to lodge information on their patterns of treatment. Colleges have already made significant progress in this area. Going beyond the formal requirements of competence testing, there is evidence that providing comparative information to doctors on their patterns of practice can produce change in behaviour.³⁰

There is a wide range of views on the extent to which such information should be publicly available. Key clinical performance indicators – popularly called "league tables" - for hospitals have been made available to the public in some overseas systems.

"There are both technical and practical difficulties here; technical because of the need to provide fair comparisons, controlling for severity and risk; practical because there is the danger tht clinicians and institutions will game the system rather than accepting the legitimacy of data of this kind and attending to deficiencies. Nevertheless, where clinicians and provider organisations are involved in the development of indicators and believe that they are valid and legitimate, public disclosure can lead to striking improvements."

– Peter Davis, inaugural lecture, Christchurch School of Medicine, 2000

Questions

1. What sort of data is most useful to feed back to clinicians to assist in quality improvement?
2. How should this data be made available to clinicians?
3. In what form should this data be made available to the public?

Evidence-based practice

- Evidence-based medicine is "the process of systematically reviewing, appraising and using contemporaneous research findings as the basis for clinical decisions".³¹
- Evidence-based health care aims to "provide the means by which current best evidence from research can be judiciously and conscientiously applied in the prevention, detection and care of health disorders".³²

Applying research evidence to clinical practice is not an easy process. Often the research evidence sits around for a number of years before it is taken up in routine practice. There are a number of reasons for this, including³³:

- The size and complexity of the research
- Difficulties in developing evidence-based clinical policy
- Difficulties in applying evidence due to:
 - (a) Poor access to best evidence guidelines
 - (b) Organisational barriers
 - (c) Poor continuing education programmes
 - (d) Poor compliance to treatment by patients

As well as the above, behavioural changes are needed among some clinicians and managers in order to ensure successful implementation of guidelines.

The first two points above concern questions on how to best equip clinicians and managers with critical appraisal skills to assess the research evidence as well as taking note of systematic reviews that have been done by institutions such as the Cochrane Centre.

Critical appraisal is a very specific skill, and there are critical appraisal tools available that provide a systematic way of assessing the validity and results of a published article, and its usefulness to the local population.

Many clinicians do not have the opportunity to develop these skills during their training. Public interest groups and patient advocacy groups also need to be partners in the process of care, so they also need skills to understand the evidence. Lack of helpful information for patients can be a serious limitation on the quality of care. Good information is crucial in assisting people to adjust to their condition, and for improved levels of treatment compliance.

Access to best evidence guidelines and organisational barriers are essentially communications issues. These can be improved through hospitals employing an identified "knowledge coordinator" to disseminate information to the rest of the organisation. (See evidence-based management, below.)

The use of clinical guidelines are now a familiar part of routine health care as one way of ensuring clinicians deliver health consistently and according to best evidence. (Guidelines have also been used for rationing purposes.) Guidelines provide information on the expected outcomes of treatment in the majority of cases. However, it is not appropriate for clinicians to follow blindly

the steps in the guidelines, setting aside their clinical expertise and experience without reference to the patient in front of them. Rather, they provide a general reference point for the minimum expected standards of care.

Evidence-based management is also important to ensure best use of resources and to ensure that the necessary support is in place to enable the clinicians to provide a good quality service. There have been examples in the past of poorly considered management decisions, such as implementation of resource management or investment in new computer systems that have failed, leading to a huge waste of money. It is important, therefore, to take a systematic and scientific approach in this area. There needs to be a culture of working in collaboration with all clinical staff to find, appraise and use research-based knowledge, complemented by the clinical staff's expertise and experience in specific areas.

Questions

1. What measures are needed to ensure clinicians and managers are well equipped with critical appraisal skills?
2. What measures are needed to ensure (a) the public interest groups and (b) patients are kept informed about issues concerning the quality of treatment and care?
3. How can access to best-evidence guidelines be improved?
4. What is needed to foster a culture in which managers and clinicians are encouraged to work more cooperatively to ensure good management decisions?

Limitations of time

The most commonly identified barrier to maintaining or improving quality is limited time. Time for clinical groups to meet, to understand the task, to consider best practice, to address the difficulties of collecting data and agree changes in practice.

A national way of enabling organisations to draw upon clinical cover may need to be found. Such a rethink would require a radical questioning of the current patterns of service delivery in order to allow clinical staff time out to learn and engage in new thinking about defining best practice, setting and monitoring standards, and changing work patterns as a team.⁷

In one initiative, the Association of Salaried Medical Specialists is seeking a guarantee from district health boards that at least 30% of senior doctors' time for routine duties is ring-fenced for non-clinical duties not directly associated with the direct care of an individual patient.³⁴ Non-clinical work might include peer review, teaching, professional development and education, quality improvement initiatives and journal reading.

If the health system spends money on assuring the quality of key services then that money is not available for the provision of other services. At both national and local levels transparent processes will be needed to identify and weigh up the real opportunity costs of quality and manage the implementation of standards. Integral to this are explicit statements about where money will be taken from or how priorities will be adjusted to accommodate change.

A combination of motivators could also be considered. For example:

- Providing opportunities for clinical groups to share any savings they make through efficiency - eg a portion of savings could be channelled back into the unit's continuing education programmes, research projects, staff resources etc.
- Public scrutiny of service units' quality audits. [A requirement to meet specific quality standards could be combined with the above measure to guard against potential cost-shifting or corner-cutting to save money.]
- Establishment of a "quality and innovation fund", which clinical units can apply for each year, based on their quality performance. Innovative practices could be rewarded through this fund as well as through public recognition – eg, a unit's or individuals' names would be acknowledged with any information on innovative practice which is disseminated nationally (and internationally).

Questions

- 1 What measures are needed to ensure clinicians have adequate time to engage in the necessary activities to ensure quality standards?
- 2 How should the question concerning more cost or less service be resolved?

Accountability and responsibility

Every activity performed by people who work in our hospitals must be robust enough to stand up to close public scrutiny and professional codes of conduct.

In the restructured health service, the boards of district health boards are responsible to the Minister of Health for the overall performance of their services; they are also accountable to the public. Communities will be involved in the deliberations of boards wherever possible. Board meetings are open to the public, and communities will be involved in the DHBs' planning processes. DHB performance reports will also be publicly available. They are required to develop strategic plans in consultation with their communities (and endorsed by the Minister), and annual plans, which will be agreed with the Minister, and monthly reports against the annual plan.

The chief executive is responsible to the board for routine management matters relating to the district health board.

In addition, clear lines of accountability and responsibility will be needed within hospitals to ensure that systematic quality improvement takes place.

It is not necessary to have direct control over something to be accountable for it. But authority is needed over those people who do control the part of the system to which the accountability refers.⁷

If chief executives are made responsible for clinical quality, they are also accountable for poor performance. Some might argue that such accountability would only be symbolic because chief executives neither have the knowledge nor time to police each and every clinical intervention within their hospital. However, there are many examples of leadership that involve accountability for the professional actions of others. After all, chief executives are usually not accountants and do not check every invoice but they are still financially accountable.

Chief executives would minimise their risk of being made accountable for poor quality by ensuring that the organisation develops in a way that significantly reduces the chances of poor clinical quality slipping through unnoticed by colleagues, patient complaint, routine audit, or effective performance management.

Being open with data would also mean being open about data quality. There are well documented concerns about the quality of comparative data on health outcomes and methodological difficulties in casemix adjustment that otherwise might make information meaningful. These concerns will need to be taken into account when information is shared with the public. This information will need to be consistent across hospitals, using consistent definitions and in a format that is understandable and meaningful.

[See Appendix for charts on information flows and accountability]

Possible roles and accountabilities might be described as follows:

Clinical Board

The clinical board would be accountable to clinical staff. As described earlier, its role would include:

- Advising and reporting on clinical policy, planning and quality systems
- Providing strategic direction of clinical governance within the facility.
- Establishing links with the central agencies, such as the National Health Committee, to receive and disseminate information on innovative practice, clinical guidelines, research etc.
- To receive and appraise regular quality audits from the clinical groups, prior to collation for the chief executive and the organisation's governing committee.

All clinical advice and reports to the chief executive would be open to staff and public scrutiny.

Heads of department

Heads of department would be rotated among senior staff (not just medical) within the department. HoDs are responsible for operational matters. They are accountable to the chief executive. They would also be responsible for producing regular quality performance reports for the clinical board, including an explanation of any shortfall in safety standards.

The content of performance reports would be decided by individual clinical departments, though they should include key performance measurements against the nationally agreed core standards that are established for the particular clinical area.

External auditor

An external auditor could reinforce the internal clinical monitoring systems. The auditor would report to both the chief executive and the clinical board. The chief executive would be responsible for dealing with any discrepancies between the external auditor's and the HoDs' reports. Any discrepancies, and the action taken to address them, would be reported to the hospital's governance committee.

Chief executive

The chief executive is responsible for the safety and quality of services in the facility. This includes responsibility for addressing any safety or poor quality concerns raised by the clinical board/governance committee and possibly an external auditor.

Clinical accountability

The central objective in this strategy is to assure the quality of clinical care. Ultimately this has to be done by individual clinicians and clinical teams. The essential purpose of the rest of the framework is to support and enable these individuals and teams to reflect on their practice.

Individual clinicians have responsibilities to their patients, and to their professional codes that require them to reflect on the quality of their own work and to find ways of managing clinical quality within teams.

At another level, clinicians share accountability and responsibility with managers, via clinical leaders and heads of department. Good, collaborative relations between clinicians and managers, complemented by effective monitoring and data collection, and an open, supportive environment, will help to clarify these lines of responsibility and accountability.

Monitoring and reporting

Monitoring of quality would be done through a combination of self-regulation and peer review, and external audit. Regular reports would measure progress against the performance indicators [noting the difficulties mentioned above]. The head of department would be responsible for producing these reports for the clinical board for appraisal, before being passed on to the chief executive. These would be open to public scrutiny.

The performance results from these reports would be used in the auditing of the organisation against the "Sector Standards".

Questions

- 1 What would you see as the pros and cons of the above proposed roles and accountabilities?
- 2 What other ways can you suggest of ensuring clear lines of accountability and responsibility within the hospital service?

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Appendix 1

Setting up systems for clinical governance¹¹

Establishing a system of clinical governance in hospitals would be an evolving process. Progress would depend in part on what systems are already in place in each facility, including data systems, and the time made available to staff to focus on quality improvement. These points should be borne in mind when considering the following three initial steps to setting up a clinical governance framework within a facility.

1. Audit of quality and safety systems and processes already in place.

This can be used at any level from the clinical team level upwards.

Example of a checklist for setting up an audit

| Elements | |
|---|--|
| ➤ Are the right frameworks in place? | <ul style="list-style-type: none">• Multi-professional clinical audit• National reporting systems• Evidence-based practice• Clinical supervision |
| ➤ Are they working well? | <ul style="list-style-type: none">• Management and systematic learning from complaints• Clinical risk management• Clinical incident reporting• Management of adverse events |
| ➤ How could they be improved? | <ul style="list-style-type: none">• Continuing professional development• Clinical leadership development• Patient/user feedback systems |
| ➤ Points for action | <ul style="list-style-type: none">• Identification and management of poor clinical performance• Quality of data for monitoring clinical care |

2. Examine the culture within which clinicians are working.

Multi-disciplinary working relationships, networking, collaboration and practical support at all levels are vital elements of an effective quality management system.

The processes to consider:

| | |
|---|---|
| <p>Processes</p> <ul style="list-style-type: none">➤ Are the right frameworks in place?➤ Are they working well?➤ How could they be improved?➤ Points for action | <ul style="list-style-type: none">• Patient/user focused approach• Integrated approach to managing and improving quality• Effective multidisciplinary team work• Information sharing and networking• Open and supportive culture; learning from mistakes. |
|---|---|

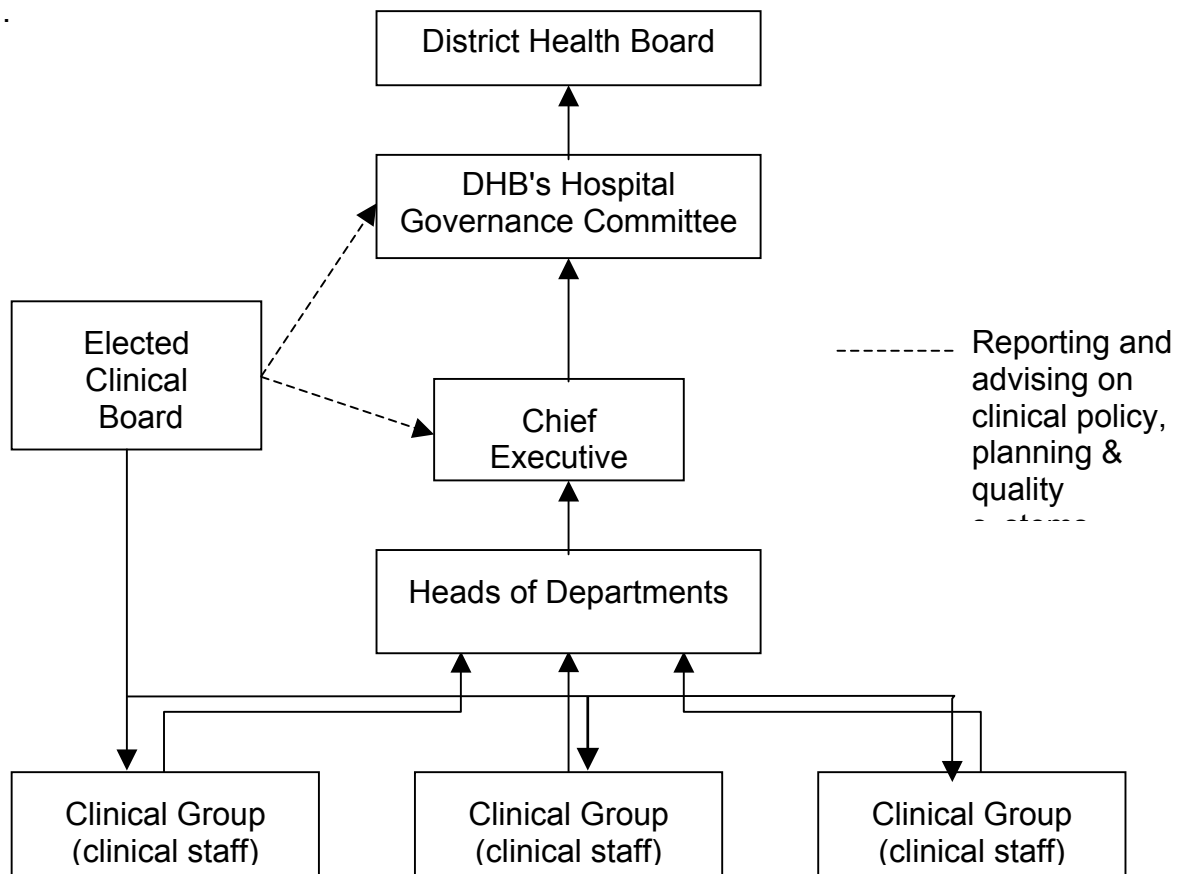
3. Infrastructure to support clinical governance

The third step is to identify the infrastructure needed to support clinical governance. This is about allowing clinicians the opportunity to participate actively in the quality improvement process and to identify the individual training and development needs of staff.

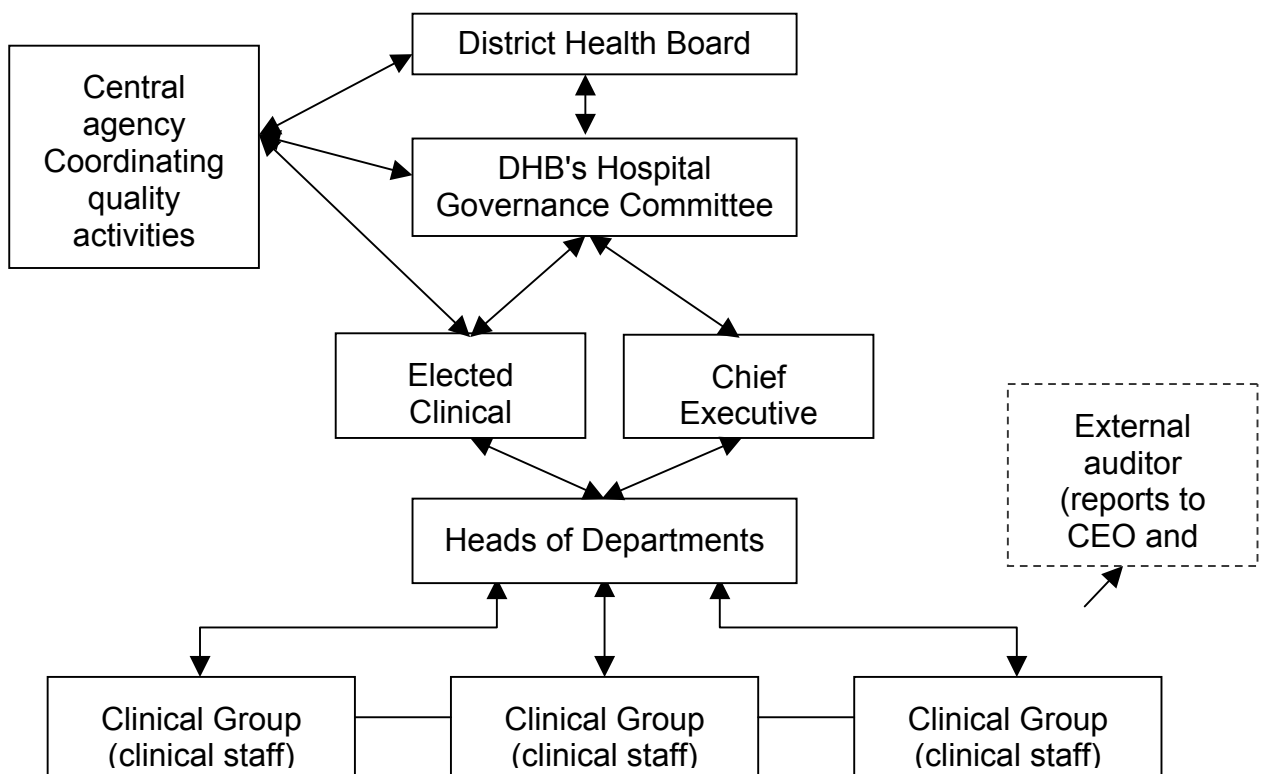
| | |
|---|--|
| <p>Infrastructure</p> <ul style="list-style-type: none"> ➤ Are the right frameworks in place? ➤ Are they working well? ➤ How could they be improved? ➤ Points for action | <ul style="list-style-type: none"> • Time allowed for staff to get involved • Access to continuing professional development • Access to information – guidelines, libraries, journals etc • Information sharing and networking • Open and supportive culture; learning from mistakes. • Adequate staffing levels and skill mix |
|---|--|

Appendix 2

Structure – accountability



Structure – information



Appendix 3

Terms of Reference

Background

These terms of reference have been produced by the Associate Minister of Health, Hon Ruth Dyson, to guide the development of a draft discussion document for a national quality improvement strategy for public hospital services.

The strategy will be focused primarily at the clinical team level and will complement the new standards regime which will be introduced after the passing of the Health and Disability (Safety) Bill.

Objectives

To produce a draft discussion document which includes the following:

1. Identification of the key measures needed to create an effective system of quality improvement that can be applied consistently in public hospitals nationally.
2. A description of quality measures currently in place relating to provision of service at the individual and clinical team level. (Information to be provided by the Ministry of Health.)
3. Discussion on ways in which current quality measures can be improved upon and complemented by other measures in order to fill any gaps identified between what is currently provided and what is needed for an effective, comprehensive quality regime.
4. Consideration of the pros and cons of each approach.
5. Indication of priorities and consideration of what can be practically achieved in the short term, medium term and long term.
6. Questions around each issue to assist in promoting feedback and discussion on the relevant issues.

This draft discussion document may be further developed either through a workshop involving broad health sector and patient advocacy representation, or through a preliminary round of consultation with health professional and patient advocacy groups. The final discussion document will be released for public feedback.

The intent is to establish a national quality strategy that is primarily developed and implemented by clinicians in collaboration with patient advocates, and with the support of hospital management.

Scope

The discussion document will be concerned specifically with developing a strategy to improve the quality of services provided in public hospitals, assuming current and forecast funding levels. It will not cover issues

concerning registration and regulation of health professionals (which are being addressed through the Health Professionals' Competency Assurance Bill). It will not cover issues about access to services, though any (negative or positive) effects on access resulting from a proposed quality improvement activity will need to be recognised.

References

Reference should be made to the Health and Disability (Safety) Bill and, in particular, the Health and Disability Sector Standards regime, which the quality strategy will complement.

Issues

Specific issues that may need to be addressed in the discussion document include:

- Issues affecting staff morale
- Multi-professional clinical audit
- Application of evidence-based practice
- Identification and management of poor clinical performance
- Systematic learning from complaints
- Professional development
- Quality of clinical data
- Monitoring and reporting of quality measures
- Quality of information provided to patients
- Patient/user feedback systems
- Inter-disciplinary communication
- Clinical incident reporting
- "Credentiailling"
- Clinical leadership
- Clinician-management relationships
- Lines of accountability for individuals
- Ongoing monitoring and evaluation of the quality strategy

Discussion of issues around staff morale should include consideration of measures to give individual clinicians greater opportunity to influence clinical policy and planning, and to give clinicians collectively greater oversight of policy and planning.

Timeline

It is envisaged that the group should meet two or three times, with further communication by email. A draft document should be received by the Associate Minister of Health by 15 December 2000.

Appendix 4

Ad hoc group membership

Helen Snell – Practising clinician

Trish Dore – Quality manager

Susanne Trim – NZ Nurses Organisation

Christine Wood – Patient advocate

Dr David Galler – Practising clinician

Dr George Salmond – Health researcher and consultant

Dale Oliff - (proxy for Mary Bonner, CEO Southland DHB)

Ian Powell – Association of Salaried Medical Specialists

Lyndon Keene – Associate Minister of Health's office

National Health Committee and Ministry of Health staff also assisted the group and the development of this document.