CLINICAL LEADERSHIP AND CLINICAL GOVERNANCE: A REVIEW OF DEVELOPMENTS IN NEW ZEALAND AND INTERNATIONALLY

Report commissioned by the Clinical Leaders Association of New Zealand for the Ministry of Health

Lyn Wright, Consultant
Laurence Malcolm, Professor Emeritus and Consultant
Aotearoa Health

Pauline Barnett, Senior Lecturer.
Department of Public Health and General Practice
Christchurch School of Medicine

Chris Hendry, Postgraduate Midwifery Lecturer
Health Service Development Consultant

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PREFACE AND ACKNOWLEDGEMENTS

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Disclaimer

The views expressed in this literature review do not reflect those of CLANZ or the Ministry of Health.
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1. EXECUTIVE SUMMARY

Background and objectives

Addressing clinical quality issues, especially adverse events, has become an international movement. Clinical leadership is seen to be an essential element of emerging strategies, widely labelled as clinical governance, to address quality issues.

This project, funded by the Ministry of Health through the Clinical Leaders Association of New Zealand (CLANZ), has been commissioned to review these developments, both within New Zealand and internationally, in order to contribute to a national strategy for quality of which clinical leadership might be a key component.

The review has sought to document both New Zealand and international experience in clinical leadership and clinical governance and its intersection with quality. It is based upon;

- a wide ranging literature/document search
- discussions with key stakeholders and experts in the field, both in New Zealand and internationally, and
- extensive health sector experience of the authors.

Categories of quality issues

Four categories of quality issues have been identified as needing to be addressed within a clinical governance framework. These are;

- the few but highly publicised ‘bad apples’
- adverse events, the main driving force behind international clinical improvement initiatives the key feature of these categories being patient harm
- ‘best practice’ clinical issues, in which there may not be patient harm but significant inefficiencies and access problems
- wider system issues affecting quality, eg building a culture of safety rather than blame as a key strategy to address quality issues.

Is quality an investment?

The literature has been studied to examine the question of whether quality is an investment. There is abundant evidence that poor quality is expensive. There is also increasing evidence that better quality, with lower costs, can be achieved through changing clinical behaviour. Clinical leadership is a key factor in changing this behaviour.

Trends in clinical leadership

An analysis has been made of the changing relationships between clinicians and managers. There has been a marked decline of traditional clinical autonomy with the rise of managerial control which in some situations has led to serious conflict, such as during the commercially driven reforms in New Zealand during the 1990s.
Clinical leadership has a critical role in building a new and necessary culture of collaboration. Such collaboration, with convergence of corporate and clinical values and cultures, is a critical factor in the successful implementation of clinical governance.

Major changes in the evolution of clinical leadership within New Zealand are reviewed. More recently there has been significant collaboration between clinicians and management. Clinical leadership has rapidly advanced within the primary care sector in recent years.

Clinical governance within the United Kingdom

Definitions of governance and clinical governance are examined. What is new about clinical governance, compared with previous quality initiatives, is the focus on leadership, organisational culture, organisational quality strategies, and corporate accountability for clinical quality.

The implementation of clinical governance in the UK is reviewed including the support systems that are being put into place to facilitate and monitor implementation. A widespread implementation process is underway in both primary care and the hospital sector. There is strong support for clinical governance from nurses.

The systems and processes of clinical governance in the UK focus upon the following:

- professional education and development
- clinical risk management
- clinical audit
- clinical effectiveness and knowledge management
- a whole systems approach to quality improvement.

Although there have been a wide range of projects reviewing and evaluating clinical governance there is little evidence, as yet, of significant improvement in quality outcomes.

Quality and clinical leadership in the United States of America (US)

Clinical governance type developments in the US were reviewed. Initiatives to improve quality there are heavily intertwined with a commercially driven health system. There is a wealth of literature on quality initiatives but little evidence that these have worked in improving health outcomes. A key limiting factor is that quality initiatives have been largely administratively rather than professionally driven.

Within the US there is a continuing conflict between corporatised medicine and professional values. Organised professional medicine is weak and fragmented with little or no power to effectively influence corporate values and goals other than through financial strategies. Hence the limited relevance of the term clinical governance.

Quality and clinical leadership and clinical governance in Australia

In Australia major initiatives, including clinical governance, are underway led by the Australian Council for Safety and Quality in Health Care. These include the beginnings
of state-wide programmes for clinical governance and emerging developments within divisions of general practice. There is a strong focus upon consumer participation in quality initiatives in Australia.

Clinical governance developments in New Zealand

A wide range of clinical governance and related quality initiatives had been reviewed in New Zealand. The most advanced are those within primary care organisations (PCOs), with clinicians in a governance role. There is a strong emphasis on quality initiatives within PCOs including moves towards community participation.

Clinical governance is being planned and implemented in a number of DHBs. These developments, from discussions with DHB senior staff, include the bringing together of existing fragmented activities and promoting a key role for clinical leadership.

Despite many important initiatives there is, as yet, relatively little sharing of this developing experience, either between PCOs or DHBs.

The ‘quality jigsaw’ and clinical governance as a key piece

There are many agencies and associated processes promoting quality within the New Zealand health sector. There is widespread concern about lack of coordination of the various components of what has been called the ‘quality jigsaw’. Some of the pieces of this jigsaw are already in place but others are still in construction.

Clinical governance may be a key and central piece of this jigsaw. It can bring together the various quality organisations and influences to bear upon improved patient care and safety.

A New Zealand model of clinical governance

This review has indicated a widespread interest in clinical governance and a desire to formulate a New Zealand definition and strategy. Clinical governance, as it is emerging in New Zealand, differs markedly from the UK model. In New Zealand it is;

- largely a bottom-up process
- driven strongly by clinical leadership
- associated with significant convergence between clinical and corporate cultures and goals, especially in PCOs
- inclusive of accountability for resource management.
- associated with significant progress towards community participation.

Clinical leadership development as a key part of a national quality strategy

There is a clear need for developing clinical leadership as well as managerial leadership, including the establishment of a national centre for health leadership development. This could bring together clinical leaders, management and DHB board members to share experience and to develop competency in leadership. There is also need for a national research, development and evaluation strategy in health leadership development, which might be associated with such centre.
Above all there is a clear need for a national strategy for clinical quality, of which clinical leadership and clinical governance might be a centrepiece. The Ministry of Health, together with the National Health Committee, and assisted by organisations such as CLANZ, need to collaborate to identify and bring together the many pieces of the quality jigsaw in developing this strategy.
2. INTRODUCTION

Action to address clinical quality has become an international movement. Clinical governance, and related initiatives, is being implemented in a number of countries as a key strategy in this action. Clinical leadership is seen by many to be a critical factor in the successful implementation of clinical governance.

The development of clinical leadership within New Zealand has been fostered in recent years by the Clinical Leaders Association of New Zealand (CLANZ). Although a relatively new organisation, formed only in 1998, it has taken an active role in bringing together clinical leaders and those concerned with the development of clinical leadership. Its mission is;

‘to foster and develop clinical leadership for the purpose of improving health and disability services, thereby advancing the health and independence of New Zealanders’ (CLANZ, 2000).

It is a multidisciplinary body bringing together clinicians from a range of disciplines, managers and others concerned with promoting clinical leadership.

The role of CLANZ was recognised by the Ministry of Health in a contract with CLANZ, signed in December 2000 which amongst other requirements required CLANZ;

- to clarify and strengthen clinical leadership and its relationship with service quality in the New Zealand health sector: and
- to clarify perspectives on clinical governance and leadership including appropriate, useful and practical terminology and guidelines.

An initial review of clinical leadership and clinical governance was undertaken early in 2001 to bring together as much relevant material as possible. On the basis of this review, and after extensive discussion and consultation, CLANZ has established what has been termed the ‘Leadership for Health’ project. This project includes the following;

- a broad overview of clinical leadership and clinical governance, including a literature review, and developments within selected District Health Boards (DHBs) and Primary Care Organisations (PCOs)
- detailed studies of clinical situations involving clinical leadership within DHBs as a basis for change management
- a study of leadership in Maori organisations.

While clinical leadership is acknowledged to be multidisciplinary, the majority of the literature on the topic is medically focused. From the UK additional perspectives have emerged from nursing (Castledine, 2000) and midwifery (Johanson and Rigby, 1999) but there is a paucity of literature from the allied health professions.

Particular attention has been given in this project to issues such as consumer participation and its intersection with clinical leadership.
This literature and document review is the first part of this “Leadership for Health” project. The overall purpose of this part of the project is:

‘... to review, from published and available literature and other documentation, New Zealand and international experience in clinical quality related to clinical leadership/ governance, with an emphasis upon practical application within the New Zealand health sector, and promotion of discussion on the findings.’

The other parts of this section of the Leadership for Health project include a broad scan of clinical leadership and clinical governance initiatives within New Zealand’s health sector in selected DHBs and PCOs. It is intended that the findings from these reviews be discussed in workshops and provide a basis for a preliminary study of the education and training needs of clinical leaders.

There have been increasing calls for a national strategy to assemble what has been described as the fragments of the ‘quality jigsaw’. The health sector is currently being challenged with many unco-ordinated quality activities. Clinical leadership, bringing together clinical accountability for quality within operational settings, may be a key if not the central piece of this quality jigsaw. It may offer a new strategy for building coordinating links between the many activities and initiatives seeking to influence patient care and safety.

Clinical governance, as a new and more formal expression of clinical leadership, defined most succinctly as ‘corporate accountability for clinical performance’, appears to be advancing rapidly in some New Zealand settings. It could become a key part of a coordinating national strategy. It is widely seen as a multidisciplinary activity involving all clinical professionals and managers and providing a mechanism for enabling and advancing clinical leadership.

This review has explored both international and New Zealand developments in clinical leadership and clinical governance and their intersection with clinical quality. It has sought to bring the findings together in a form that we hope will be readable, understandable and applicable in the building of this key piece of the ‘quality jigsaw’.

Within the limited time available to us we have attempted to cover a wide range of international experiences in the field of clinical leadership, clinical governance and its intersection with quality. However there are important issues we have not been able to address. Of particular relevance to the New Zealand situation is the development of Maori leadership, especially health leadership, and the potential application of Maori concepts of health and wellbeing to mainstream practice.

Firstly this area is one of considerable complexity and ongoing debate. Secondly, the recent important development in Maori health services at the primary care level has been driven largely by community rather than clinical leadership.

The development of Maori leadership within the overall Leadership for Health project will be a separate subproject.

The literature review sought to establish an evidence base for clinical governance, what it is, what it might achieve and why it should be implemented in New Zealand.
Unsurprisingly this review has found, like many others, that research-based evidence on these topics is scarce. What is presented is mostly descriptive material and opinions expressed in published sources including the internet.
3. SOURCES OF INFORMATION/METHODS

3.1 Source of information and methods

There is an abundance of literature on clinical governance. It has become almost unmanageable in its volume since the introduction of clinical governance in United Kingdom (UK) four years ago. This abundance provides an unparalleled opportunity for the rest of the world to be able to learn from the UK experiences. But it also presents challenges to those seeking to understand and apply what so far has been learnt.

The earliest publications were concerned with defining clinical governance and explaining what it is about. Succeeding work consisted mainly of proposed models, many of which are discussed below, and some work on baseline assessment. Evidence on what is actually happening and the evaluation of that evidence has only just started appearing late in 2000 and early in 2001. This is unsurprising as the UK efforts are part of a ten year plan and it would be unusual to see much in the way of changed outcomes at this stage.

The literature review was conducted using the following methods:

1) A literature search was initiated with the Ministry of Health seeking material after 1998/9 from the UK, Australia, United States of America (USA) and Canada and, in particular, anything dating from 2000 onwards. A computer search was undertaken of Medline and CINAHL abstract files. The following terms were searched:

- clinical leadership
- clinical governance
- clinician management partnership relationships
- clinical service leaders
- health service quality and governance
- health service quality and leadership
- quality and clinical
- clinician leader and quality
- consumer and health service governance and quality
- consumer and clinical leadership
- community and clinical leadership/governance

2) Internet searches were carried out of local, national, and international organisations in any of the countries identified above. The addresses of relevant web sites are appended.

3) The review has also drawn upon reviews and work done previously. An important resource was the Masters dissertation on clinical governance in New Zealand by Moss (2000). An extensive literature research focusing more on quality in primary care, including clinical governance developments, by King and Wilson (2000) of Monash University was a valuable source of reference material.
4) Key people in UK, USA and Australia were approached to recommend sources of information critical to review and also to supply these where we could not obtain from libraries and/or web sites. These people included Aidan Halligan and Kieran Walshe (UK), Donald Berwick and Sheila Leatherman (USA) and Julian King (Australia).

5) Reference lists of articles and sources acquired for this review were perused for further relevant information sources.

6) The information acquired was examined and synthesised. A plethora of information was available on some aspects of the study e.g. clinical governance definitions, suggestions for and descriptions of projects in the UK. Conversely, a limited amount was found for some other aspects such as: quality as an investment, evaluations of clinical governance projects, clinical governance in secondary care.

This review has also drawn up work undertaken previously as part of the CLANZ project including the review referred to earlier and a paper published on the ‘quality jigsaw’ in Health Manager (Malcolm and Hendry, 2001). It has also drawn upon the extensive experience of the authors in working in the New Zealand health system over more than two decades.

3.2 Presentation of this report

The literature search framework described above has been used in structuring this report. For ease of reading the report uses a number of different formatting styles to indicate different types of information:

- **Direct quotes from literature**

  *Direct quotes from literature are italicised and indented.*

- **Significant insights**

  A white text box like this one contains insights of significance based, for example, on case studies or conclusions from articles where either a research method is not given or not stated.
4. ISSUES GENERATING ACTION ON QUALITY INITIATIVES

4.1 A definition of quality

In this review we have used the definition of quality of the US Institute of Medicine. In 1990 an IOM committee defined quality of care as ‘the degree to which health services for individuals and populations increase likelihood of desired health outcomes and are consistent with current professional knowledge (Becher and Chassin, 2001).

4.2 Clinical quality: an international movement

Addressing clinical quality issues has become an international movement (Leape and Berwick, 2000). They comment, in an editorial introducing a special issue of the BMJ devoted to medical errors, that;

‘...in Britain the Bristol inquiry has continued to focus professional and public attention on patient safety in a manner unprecedented both for its depth and for the extent of professional involvement. In the United States the recent publication of the report ‘To Err is Human’ by the Institute of Medicine of the National Academy of Sciences received extraordinary media coverage as well as prompt responses to its recommendations from the President and Congress.’

They note that the error prevention ‘movement’ has clearly accelerated (Leape and Berwick, 2000). There has been an escalating growth in the numbers of papers, journals, reports and conferences devoted to clinical quality in recent years. Some clinicians have been concerned about quality for decades. But the recent interest in quality has been fuelled by two particular factors. First, there is the problem of ‘bad apples’. Secondly, the identification of adverse events especially associated with hospitalisation.

Concern in New Zealand has being generated not only by the 2000/2001 Gisborne cervical screening enquiry but also the ongoing exposure of medical failings such as the Whangarei gynaecologist Graham Parry and ACC claims for medical misadventure, medical mishap and medical error.

But these problems may only be the tip of a large iceberg. A wider classification of issues generating the need for clinical governance is set out in Table 4.1.

4.3 ‘Bad apples’

The most prominent of the factors driving the concern about quality is what might be called the ‘bad apples’, i.e. a one-off event due to individual failure. The most prominent of these in England in recent years have been the Bristol Royal Infirmary Inquiry into paediatric cardiac surgical deaths and the exposure of general practitioner Harold Shipman, found guilty of unlawful killing of 15 of his elderly patients.
Table 4.1 A classification of clinical quality issues, which might be addressed by clinical leadership and clinical governance

<table>
<thead>
<tr>
<th>Quality category</th>
<th>Characteristics</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Bad apples’</td>
<td>Infrequent but high media profile, - may be serious patient harm and deaths, ? tip of the iceberg</td>
<td>Bristol, Gisborne cervical screening</td>
</tr>
<tr>
<td>Adverse events</td>
<td>Common and partly preventable – patient harm</td>
<td>Recent study of adverse events in Auckland hospitals</td>
</tr>
<tr>
<td>‘Best practice’ issues eg, need for improving effectiveness, efficiency, acceptability, equity, access</td>
<td>May be no patient harm but less than desirable patient outcomes</td>
<td>Poor access, inappropriate variation, waste of resources, patient dissatisfaction, etc</td>
</tr>
<tr>
<td>System issues</td>
<td>Organisational quality issues which affect the whole system of care</td>
<td>Need for; integration of care, of clinical disciplines, of clinical with financial accountability, a culture of safety rather than blame and improved consumer participation, etc</td>
</tr>
</tbody>
</table>

In New Zealand the most significant exposure in the last two decades led to the Cartwright inquiry of 1988 and more recently the Gisborne cervical screening enquiry. These failings have led to high political, public and media attention. There has been much media and public concern about recent gynaecologist failings in Whangarei. However Coddington (2001) has pointed out the complexities of this case. Media and public demands for blame and compensation fail to appreciate the stresses on individual clinicians exposed to sometimes impossible pressures. These demands also make much more difficult the development of a culture of safety rather than blame.

As noted these failures tend to be just one-off, although they may signal system failure as was clearly shown in the Gisborne inquiry (Duffy et al, 2001), as will be discussed below.

4.4 Adverse events

The second set of factors driving quality concerns has been published studies of adverse events associated with the provision of clinical care, especially hospital care. Iatrogenic illness has been a concern of the medical profession for decades, prominently publicised by Illich in the 1970s. However medical professional reluctance to openly consider and investigate the issue has recently led to the formal undertaking of studies into adverse events.

An adverse event is defined as;

- unintended injury or unintended complication
- resulting in temporary or permanent disability including increased length of stay and/or financial loss to the patient
- that was caused by health care management rather than the underlying disease process (Davis et al, 2001).
Two widely quoted studies are the Harvard Medical Practice Study (Brennan et al, 1991) and the Quality in Australian Health Care Study (Wilson et al, 1995). In New Zealand Davis et al (2001) has recently published a feasibility study of adverse events in Auckland hospitals. A small pilot was also undertaken in England in 2000 (Department of Health, 2000: Alberti 2001). Some findings of these four studies are summarised in Table 4.2.

<table>
<thead>
<tr>
<th>Study</th>
<th>Proportion of inpatient episodes leading to harmful adverse events</th>
<th>Proportion of inpatient episodes resulting in permanent disability or death</th>
<th>Extra days/costs in hospital care resulting from the adverse event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harvard Medical Practice Study, 1991</td>
<td>3.7%</td>
<td>0.7%</td>
<td>At least $US 2 billion per year</td>
</tr>
<tr>
<td>Quality in Australian Health Care Study, 1995</td>
<td>16.6%</td>
<td>3%</td>
<td>Up to $A1 billion per year, 2-3% of the hospital budget</td>
</tr>
<tr>
<td>Adverse Events Regional Feasibility Study, 2001</td>
<td>10.7%</td>
<td>1%</td>
<td>6.7 days</td>
</tr>
<tr>
<td>United Kingdom pilot study of adverse events in hospitalised patients, 2000</td>
<td>10%</td>
<td>3-4%</td>
<td>1 billion pounds per year</td>
</tr>
</tbody>
</table>

The finding of these as yet limited studies are broadly similar and indicate that;

- adverse events are relatively common
- they may result in significant permanent disability and death
- they are associated with significant health service as well as social costs
- some 50% are preventable.

4.4.1 UK National Health Service developments

In the UK these findings are backed up by confidential inquiries into a range of services especially in mental health services, inquiries into maternal and postoperative deaths and an increasing volume of complaints about clinical treatment and claims for clinical negligence (Department of Health, 2000). For example in the UK the cost of litigation for medical negligence in National Health Service (NHS) hospitals grew at the rate of 7% per annum in the 1990s. Other estimates put this figure to be much higher (Dineen and Walshe, 1999). Concern has also focussed on repeated deaths from drugs wrongly administered by spinal injection, resulting in 13 patients dying or being paralysed. The particular question raised by these incidents is ‘why does the NHS not learn from its failures’.

These and other questions led to an important review of the issues chaired by the NHS Chief Medical Officer, Liam Donaldson, the report being appropriately entitled “An Organisation With a Memory” (Department of Health, 2000). The report presents and analyses issues relating to adverse events and their consequences. It identifies significant changes in the systems needed to ensure the NHS learns from failure. Of particular
importance, as will be discussed below, is the need for an organisational culture based on 'safety' rather than 'blame'. It sets out new strategies for reporting systems upon which effective learning might be based.

In commenting on this report Barach and Small (2000) note the administrative barriers facing the implementation of known solutions.

‘Beliefs, attitudes, and values nourish a culture of blame and superficial analysis and thereby perpetuate the cycle. Free lessons from near misses, and more expensive ones of litigation, are largely lost. Positive change and improvement do exist, but the effort is slow, disorganised, and costly’.

As will be discussed later clinical governance is being implemented as the key strategy in addressing not only adverse events but other fundamental quality issues.

4.4.2 US developments

Within the US increasing concerns about quality have been generated around the Institute of Medicine, National Quality Report on Health Care Delivery report of 2000 ‘To Err is Human: Building a Safer Health System” (IOM, 2000). The report noted that as many as 98,000 people die in any given year for medical errors in US hospitals. This is more than from motor vehicle accidents, breast cancer or AIDS, conditions that receive far more public attention. More people die from medication errors than from workplace injuries.

The report breaks the silence that has surrounded medical errors and their consequences. However it does so not by pointing fingers at individual health care professionals who make honest mistakes. As the report title states ‘to err is human’. More importantly the report sets out a national agenda for reducing medical errors and improving patient safety through the design of a safer health system. As in the UK report an answer is sought to the question ‘how can we learn from mistakes’? The report seeks to address the question of how bad systems, not bad people, can be made safer.

The IOM Committee followed this up with two further reports in March 2001 (Kelly and Tucci, 2001). The first of these, ‘Crossing the Quality Chasm: a New Health System for the 21st Century’, sets out specific proposals for building a safer health system based on six key aims and 10 simple rules (Kelly and Tucci, 2001) - as follows.

Six key aims . . .

1) Safe - avoiding injuries to patients
2) Effective - based on scientific knowledge (avoiding overuse and underuse)
3) Patient centred - respectful of and responsive to individuals' preferences, needs, and values
4) Timely - reducing wasteful delays
5) Efficient - avoiding waits
6) Equitable - the same quality care provided to all, regardless of race, gender, geographic location, or ability to pay
... and 10 simple rules
1) Care based on continuous healing relationships
2) Customisation based on patient needs and values
3) The patient as the source of control
4) Shared knowledge and the free flow of information
5) Evidence based decision making
6) Evidence as a system property
7) The need for transparency
8) Anticipation of needs
9) Continuous decrease in waste
10) Cooperation among clinicians.

However Kelly and Tucci (2001) comment that,

‘the report fails to adequately explore the barriers and incentives to change in complex systems such as the US health system. To influence the elements of a complex adaptive systems such as health care, one must understand how such systems differ from machines.... It is unfortunate that the institute’s report does not explore this key concept because it lies at the heart of why our health care system has not changed. Such change cannot occur without understanding and using the values and needs of those who directly care for patients. Quality initiatives have largely failed to engage the participation of physicians’.

A second report ‘Envisioning the National Health Care Quality Report’ (IOM, 2001)(see http://www.iom.edu) again sets out the major quality issues needing to be addressed and a conceptual framework for a National Health Care Quality Report which should be able to demonstrate progress in achieving quality goals.

The quality agenda in the US is being assisted by the Agency for HealthCare Research and Quality (formerly HealthCare Policy and Research) indicating a new quality emphasis (see http://www.ahrq.gov). In its report ‘The Challenge and Potential for Assuring Quality Health Care for the 21st century’ (1998), it identified four particular quality problems, underuse, overuse, misuse and variation in services. Along with the Institute of Medicine it is working towards the National Health Care Quality Report.

However the creation of safer systems of care in the US face formidable barriers. These include, in the view of Becher and Chassin (2001);

- Little demand for higher quality including from consumers or their representatives
- A lack of information technology to bring together the myriad sources of information
- Skewed financial incentives in a system driven more by profit than quality of care outcomes as the bottom line.

They see provider leadership as a key factor in achieving better quality outcomes. McGlynn and Brook (2001) share these concerns noting the difficulty of keeping quality on the policy agenda in the US. These concerns will be further discussed later.
4.5 ‘Best practice’ issues

Most public and professional concern has focused on the first two categories above, ‘bad apples’ and adverse events. A third set of quality issues, a much larger part of the quality iceberg, have received little publicity. These can be conceptualised as ‘best practice’ and have been summarised in a number of ways. One example is the widely quoted quality framework used by Maxwell (1984, 1992) which includes effectiveness, acceptability, efficiency, access, equity, and relevance. Another classification is that listed above of the US Agency for Healthcare Research and Quality above, and includes underuse, overuse, misuse and variation in services.

Examples are; inappropriate and ineffective care, the wide variation in clinical activity, eg in prescribing and intervention rates, the wastage associated with inappropriate care, quite apart from adverse events. Work being done on guidelines and credentialling, etc, are attempts to address these dimensions. There may be no patient harm in this dimension. But patients and the wider community may suffer in other ways such as inappropriate or poor access to care.

Wide variation in quality has been consistently noted. Donaldson (2000) suggests that if we had a simple composite measure of quality we would see health care organisations distributed along a bell curve with the worst performance on the left-hand tail and the best performance on the right-hand tail. As with any bell curve of normal distribution the bulk of performance is clustered in the middle on either side of the average – see Figure 4.1.

![Figure 4.1: Variation in the quality of organisations (from Donaldson, 2000)](image)

Donaldson argues therefore that the greatest impact on quality would be achieved by shifting the average towards the right. This does not however mean that the two tails of the distribution curve can be ignored.

4.6 Organisational issues affecting quality

A fourth set of quality issues is organisational in character and reflects the need to address failing health systems as well as poorly performing individuals. Smith (1998) in a British Medical Journal editorial ‘All changed, changed utterly’ commenting on the Bristol case stated;
“The Bristol case may be a once in a lifetime drama. The case has thrown up a long list of important issues that British medicine will take years to address….. There must be mechanisms for responding to doctors whose performance has deteriorated to an unacceptable level, but such mechanisms will never bring about the systemic improvements that we need.”

He lists many strategies to address these issues. The following is derived from this list and other sources.

- Appreciation of the importance of factors, other than purely clinical, that can affect clinical judgment, performance, and outcomes
- The responsibility of a consultant to take appropriate action in responses to concerns about his or her performance
- Ways in which people concerned about patients’ safety can make their concerns known
- Coping with, and prioritising, increasing scientific and technological advances
- Managing new relationships between key stakeholders
- Building a culture of collaboration between clinicians, eg primary and secondary
- Integrating clinical with general management
- Clinical involvement in resource management and priority setting
- Building a culture of safety rather than blame in dealing with adverse events
- Ensuring consumer and community participation in health sector decision-making.
- Better information systems, including clinical
- Integrating, multi-disciplinary approaches to clinical management.

Smith (1998) comments ‘Evidence is growing that where patients become equal partners in the doctor-patient relationship outcomes and satisfaction improve and costs fall. If the Bristol case hastens the move to patients being treated as equals it will have produced real benefit’.

King and Wilson (2000) believe that the so-called poorly performing doctors are likely to be working in areas with problems that are system wide. The characteristic issues of such organisations include:

- **Individual** – e.g. A lack of skills, bad team-working, poor motivation and attitude.
- **Organisational** – e.g. Poor communication, a lack of coherent strategies, weak management systems and sparse infrastructure.
- **Cultural** -- there is weak leadership with little sense of responsibility for patient care or staff welfare, education and research are undervalued, there are often cliques and factions.
- **External relations** – defensive about criticism, a fortress mentality with limited professional contact outside the organisation and little collaboration.

The recent Report of the Ministerial Inquiry into the Under-reporting of Cervical Smear Abnormalities in the Gisborne Region (Duffy et al, 2001) documents an important
example of systemic issues in the New Zealand health system. The Committee found problems which went far beyond Gisborne. These included:

- Failures of New Zealand laboratories to follow quality control processes or to be accredited with an independent quality control authority
- The government policy for cervical screening in relation to laboratories not well-designed
- The National Cervical Screening Register was not functioning optimally
- There were no performance standards for laboratories and no reliable data on laboratories performance
- Health authorities did not take heed of the warnings provided by the failures of screening programmes in other countries.

The Committee concluded that the group of factors relating to cytological services in New Zealand were all indicative that the problem ‘has a systemic origin’.

Similar conclusions about system failure might be drawn from ‘A Report by the Health and Disability Commissioner, Gisborne Hospital 1999-2000 (HDC, 2001). Although adverse events had drawn attention to Gisborne Hospital it was found by the Commissioner that;

“Tairawhiti Healthcare was an unhappy organisation in 1999-2000, marked by suspicion and distrust between management and staff. Some doctors and nurses felt powerless and thought that patients’ safety was at risk. It is time for clinical staff and management to make a fresh start in the co-operative endeavour that should be at the heart of a hospital: safe and effective care for patients.”

4.7 The need for and role of clinical leadership/governance

The foregoing discussion has drawn attention to a wide range of quality issues. Addressing these requires significant if not major changes in clinical behaviour and accountability. These impose particular challenges on clinical leadership, organisations and governments.

There are both external and internal relationships and action to be addressed in the development of this accountability. To an increasing extent governments are being pressured by media and public concern to intervene in clinical quality issues, in part because of a perceived failure of clinicians to address these issues. Is there a role here for clinical leadership/governance?

Paul (2000) presented a useful discussion of this issue. Drawing upon the Cartwright enquiry, and related events, she discusses what she describes as the balance between internal and external morality in medicine in addressing quality issues. Internal morality is defined as ‘those values, norms and rules intrinsic to the practice of medicine. External morality is ‘the view from outside reflecting the ethos of the wider society’ and expressed through legal and regulatory frameworks.

Paul argues that demands for government intervention in New Zealand have been strengthened by the failure of the medical profession to establish effective procedures for
internal control. Although both are needed, an effectively functioning internal morality must balance the ‘blunt instruments’ of external control.

Salter in ‘Medical Regulation and Public Trust’, (Kings Fund, 2000) states that governments have been motivated to intervene through failure of internal regulatory processes. Failure is due to ‘institutional rivalry, territorial conflicts, elite divisions and frequent confusion between certification and registration functions…. The changes made have been essentially cosmetic: the institutional landscape remains the same, as do the values of clinical autonomy on which they rest’.

He argues for a much better understanding of the political power balances involved but offers few solutions to the State’s dilemma as to whether, and if so how, to intervene and, through accepting responsibility, becoming the ‘target of citizen discontent’.

Neither of these analyses, however, notes that there are two forms of internal control. Their discussion addresses only the first, i.e. those strategies used by the medical profession, e.g. clinical colleges, the Medical Council, etc to regulate the behaviour of its members, but still external to the organisational work setting.

This second form, within an organisation, may be more effective. This is clinical leadership, through clinical governance, offering operational control over clinical behaviour. The importance of this will be discussed later.
5. QUALITY AS AN INVESTMENT

5.1 Poor quality is expensive

Improving quality is sometimes seen by management and others to be an extra cost burden on the health system. Better quality is seen as a trade-off between quality and cost. Is better quality an additional cost or is there evidence that better quality is an investment, which reduces costs?

Firstly there is clear evidence that poor quality is expensive. The UK Department of Health (2000) report ‘An Organisation with a Memory’ provides the following information.

- An estimated 850,000 adverse events occur each year in the NHS hospital sector resulting in 2 billion pounds direct cost in additional hospital days alone.
- The NHS paid out around 400 million pounds in clinical litigation settlements in 1998/99 and has a potential liability of around 2.4 billion pounds.
- The costs to the NHS of hospital acquired infections had been estimated at nearly one billion pounds a year.

The recently published New Zealand study of adverse events showed that more that 10% of hospital admissions were associated with such events, adding an average of nearly seven days stay (Davis et al, 2001). A significant proportion of events was preventable.

In Australia, Roughhead notes that it has been estimated that in Australia inappropriate medication use results at least 80,000 hospital admissions each year at a cost of around $350 million. Around half of these admissions are estimated to be potentially preventable (Roughhead, 1999).

There is increasing concern about rising rate of caesarean sections, now in some DHBs over 20% of all deliveries. Guidelines indicate that a much lower figure would be more clinically appropriate, with a significant reduction in morbidity for postnatal women and also a corresponding saving in health service costs.

New Zealand studies have shown consistently, across many PCOs, that there is wide variation in prescribing and related expenditure, especially between practices within PCOs (Malcolm et al, 1999; Malcolm et al 2001). Even after adjustment for need factors, age, income etc, the top 10% per capita cost practices generate three times the expenditure of those in the bottom 10% (Figure 1).

There is increasing evidence that better quality care is to be found in the lower spending practices (Malcolm et al, 1999). Higher prescribing rates may be associated with high consultation rates, high laboratory referrals, polypharmacy, higher risk of drug interactions, adverse effects such as falls, fractures and excessive hospital admissions (Malcolm and Medawar, 2001). High volumes of unused drugs end up in bathroom cabinets. From a patient perspective there is clear evidence that patients would prefer fewer prescriptions and more time with their GP. Prescribing may be used as quick but poor quality and expensive way to achieve high patient throughput.
A puzzling feature of this issue however is that, both in New Zealand and internationally, despite strong and consistent evidence of wide variation, little research appears to have been done to show any relationship between this variation and quality. If, as seems to be the case, lower and therefore less expensive utilisation is associated with better quality, then investment in quality could have a major pay-off in both quality as well as reduced cost outcomes.

5.2 Better quality can be achieved with lower costs

There is increasing evidence that better quality clinical behaviour, along with less expensive care can be achieved. Evidence for this comes from studies of budget holding behaviour in New Zealand's PCOs (Malcolm et al, 2000; Malcolm et al 2001). Although generating savings was one objective of budget-holding, this was generally subservient to quality related objectives. For example Pegasus Medical Group was able to demonstrate savings of 23% in the laboratory expenditure as a result of a comprehensive quality strategy involving personalised feedback, guidelines, group discussions and incentives, with clinical leadership being an important facilitator (Kerr et al, 1996).

A recently published review of pharmaceutical management in ProCare Health Limited showed that a strong quality focus, using a similar comprehensive strategy, resulted in savings of 5-10% in pharmaceutical expenditure. The cost of implementing the strategy was only about 5% of the estimated savings (Malcolm et al, 2001). However is also clear that changing clinical behaviour is difficult, especially among those most needing to change. Practitioners performing to high quality standards, with least need to change, are in fact more receptive to change than their more poorly performing colleagues.

There is clear evidence from New Zealand experience that clinical leadership, exercised through PCOs, has achieved significantly better quality in the prescribing of antibiotics at lower costs (Pharmac, 2000). The campaign to change antibiotic prescribing behaviour, especially to avoid antibiotics for influenza and colds, was initiated through PCOs in the Auckland area in 1998. It was expanded by Pharmac to a national program in 1999. As a consequence there was a marked downward trend in the use of broad spectrum drugs and an overall decline in antibiotic use and associated costs.

Pharmac estimates that savings of up to $2 million were achieved in one year for an outlay of only $100,000 together with some expenditure incurred by PCOs, eg pharmacy facilitators. Antibiotic prescribing was reduced by 14.8% (Pharmac, personal communication). Again better quality outcomes were achieved with substantial savings, with the investment costs well below the actual savings generated.

In the 1990s clinical leadership in Christchurch hospital initiated and implemented quality prescribing guidelines. This resulted in not only better quality prescribing but substantially lower costs with expenditure dropping from an estimated growth figure of 46-65% to 20% (Pearce and Begg, 1997). There are many more examples from the New Zealand experience.

Following a Cochrane systematic review Lahdensou (1999) found strong evidence that when adults with asthma are active participants in their care there is a reduction in hospital admissions, emergency room visits, unscheduled visits to the doctor, days off work or school, and nocturnal asthma. Such active participation in care means patients
undergoing self-management education, and being supported by written action plans. Cost effectiveness studies have shown that approximately $11.22 can be saved for $1 spent.

Similar results have been obtained by the Stanford University School of Medicine (Lorig et al, 1999) with their randomised controlled trial of 952 patients with heart disease, lung disease, stroke, or arthritis undergoing a chronic disease self-management programme. An important focus in these studies has been consumers’ participation in their care, a factor that will be discussed later.

A corporate wide strategy approach to quality is reported by Miller (1994). A non-profit making organisation, the Memphis and Business Group on Health (MBGH) implemented, within an HMO model, a set of activities including preferred providers, a utilisation and quality management programme, comprehensive care activities including psychiatric and substance abuse and healthy lifestyle programs. Research showed that whereas the average growth of health-care costs across the USA was 14.7% over five years the MBGH sustained cost increases of around 6%.

However a study of the cost of continuous quality improvement upon the costs of treatment by Dranove et al. (1999) showed no significant relationship between investment in quality and the cost of hospital inpatient treatment for specific procedures. They concluded that ‘hospital managers can be expected to insist on evidence that quality improvement interventions produce tangible benefits’.

The international experience relating to this issue from published literature appears to be limited. Despite a wealth of literature on cost effectiveness and other economic analyses, few studies were found which actually explored whether better quality was an investment in savings generated and the cost of achieving these savings. Berwick (2001), of the Boston Institute for Healthcare Improvement (IHI), in a personal communication, stated

‘The question of the financial consequences of improvement is important and pervasive. The IHI has just begun a project on "the business case for quality" with Commonwealth Fund support’.

5.3 The role of clinical leadership in this investment

Clinical leadership has been a key factor in promoting better quality and ensuring that the best possible quality outcomes from limited resources. Budget holding pharmaceutical and laboratory and, now in the case of Pegasus Health in Christchurch, global budget holding for a wide range of services, is seen by progressive PCOs as an essential component of quality management.

Promoting quality care, as an investment, can really only be undertaken effectively by clinical leadership. The evidence is clear from PCO experience in New Zealand that clinical leadership has played a critical role in promoting better quality GP behaviour (Malcolm et al, 2000). Many PCOs have quality committees and/or a quality strategy. Budget holding is seen as a means to promote quality with savings being derived largely in order to pursue quality objectives.
Clinicians can play a key role in identifying poor quality care, including where such care is leading to waste of resources. Furthermore they have a key role in influencing the behaviour of their colleagues. A comprehensive range of strategies have been implemented by PCOs to achieve better outcomes at lower cost.

This integration of clinical with financial management, is now fully accepted by most PCO leadership and an increasing number of secondary care clinical leaders. This is a relatively new development in clinical culture, as will be discussed in the next section.
6. DEVELOPMENTS IN CLINICAL LEADERSHIP AND QUALITY

6.1 Clinical and managerial leadership

In this review clinical leadership is defined as leadership by clinicians of clinicians. The term 'clinician' in this context means all health professionals including doctors, nurses, midwives, therapists and allied health professionals involved in direct patient care. Clinical leaders are those who still retain a clinical role but, at the same time, may participate in management, including resource management.

This differs from the concept of clinicians who have become managers, ie those who have changed roles from clinicians to become full time managers and are no longer engaged in the actual clinical care of patients.

Our discussion about the developing role of clinical leadership internationally and within New Zealand focuses upon clinical leaders, ie those who remain as clinicians but participate to a varying extent in management.

To be successful this implies a process of convergence. This involves moves by clinicians, led by clinical leadership, towards acknowledging and participating in accountability for resource management. On the other hand there is movement by management towards accepting and participating in achieving clinical goals of better patient and community health outcomes. The importance of this convergence of partnership will be discussed later.

6.2 Clinical leadership and clinical autonomy

Clinical autonomy has for long been a treasured preserve of the medical profession. However in 1983 eminent cardiologist Hampton declared in a British Medical Journal editorial.

"Clinical freedom is dead, and no one need regret its passing. Clinical freedom was the right - some seemed to believe the divine right - of doctors to do whatever in their opinion was best for their patients. In the days when investigation was non-existent and treatment as harmless as it was ineffective the doctor’s opinion was all that there was, but now opinion is not good enough. If we do not have the resources to do all that is technically possible then medical care must be limited to what is of proved value, and the medical profession will have to set opinion aside (Hampton, 1983)."

He went on to say ‘We must welcome its (clinical freedom) demise and seize the opportunities now laid out before us’. Hampton's announcement was echoed by others including Hoffenberg (1987) who stated that:

“…there is no such thing is clinical freedom..... Personal, moral, ethical and even legal constraints should be observed. To these must now be added the constraints of limited resources.”
These and other views signalled a watershed in the changing role and scope of clinical leadership. The ‘conflict of cultures’ between the desire of clinicians to achieve the best outcomes for patients, whatever the cost, and the increasing demands by managerial and, in some countries, commercial interests for control over clinical behaviour, has been felt internationally, including in New Zealand. Clinical leaders had to walk an uneasy path between the claims for autonomy by their clinical ‘rank-and-file’ at the same time as developing an accommodation with management and its demands for clinical accountability.

There is now widespread acceptance of the need for collective professional accountability, exercised through clinical leadership, in improving quality. Events such as the Bristol experience in England and the Cartwright enquiry in New Zealand have had a powerful influence in diminishing clinical autonomy. But clinical accountability for financial management is still widely seen as compromising better patient care. Yet integration between clinical and financial management would seem to be essential if a more collaborative relationship were to be built between clinicians and managers.

Clinical leadership is more than just an accommodation between clinical leadership and management. There is still a strong view that those who take on a clinical leadership role are seen to have crossed sides and ‘joined the enemy’. Hafferty and Light (1995) note that ‘those moving from clinical into management ranks shift their identity and commitments from the medical profession to the organisation for which they work. Management identity intensified as time and involvement in administrative duties increased’.

If clinical leadership is to be effective then it must be true leadership in which clinicians, whatever their views on clinical autonomy and financial management, are both behind and supported by their clinical leaders. Clinical leadership in PCOs has expressed some concern, where enthusiasm for promoting PCO development and improving quality may run the risk of leaving the rank-and-file behind. However, a survey of a representative national sample of PCO members in 1999 found that only 14.3% felt that they had less control over clinical decisions, and only 18.2% reported that being in the PCO had limited their choice of pharmaceuticals (Barnett, 2001).

This suggests that clinical autonomy is not seen as compromised in IPAs and that clinical leadership is incorporated into the management culture. Furthermore, 69.6% of GPs agreed that their IPA leadership was ‘overall, doing a good job’ and 64.8% confirmed that ‘philosophically ‘in tune’ with their approach to practice’.

There is an emerging view that clinical autonomy can be enhanced by financial accountability, at least in a collective sense. This is most evident in PCOs with budget holding, which some have found to be an empowering experience. Financial management gives them the opportunity to shift resources from less to more important services. Nowhere is this perhaps more evident than in Pegasus Health in Christchurch where an $80 million global budget has given major flexibility to implement new programmes with a strong focus upon quality and better health outcomes.
6.3 Multidisciplinary leadership

Associated with the decline of medical autonomy and dominance has been a rise of multidisciplinary relationships, including teamwork. Important trends both within New Zealand and internationally have been the decline of medical, nursing and administrative hierarchies and devolution of clinical and financial decision making to service teams. Clinical leaders play a key part in this devolution.

Of particular importance has been the dismantling of the nursing hierarchy with this devolution. This has raised questions of how nursing can be integrated into service teams as equal partners. A common pattern of leadership is clinical leadership, usually medical, and managers, a relationship that may disempower nursing leadership. In some cases the managers have had a nursing background but, despite this, cannot be seen to be representing nursing interests. An alternative is the development of a team of three, medical, nursing and management with the key partnership being between medical and the nursing leadership, supported by management, as is being proposed in Canterbury DHB.

A search of the literature for information on multidisciplinary leadership and clinical governance revealed little. Fox (2000) states that ‘hierarchies are the enemies of clinical governance and need to be replaced with new forms organisation’. There is evidence that working in teams enhances and organisations effectiveness. Teamwork has been shown to produce better care through increased staff motivation and improved delivery of care (King and Wilson, 2000).

6.4 Leadership concepts

Walshe (2000a) notes that ‘there is a vast and daunting literature on leadership, which both attempts to describe the characteristics or attributes of effective leaders and to analyse the processes or methods which leaders use’. He sees that for those engaged in the development of clinical governance the ideas of transformational leadership may be helpful. These leaders exhibit what may be essential ingredients of real leadership. They;

- have a vision of the ultimate goal
- excel in communicating this vision and values to others
- inspire trust and confidence
- help others to feel capable and to realise their own potential
- have enormous energy and drive, and are action-oriented.

This contrasts with transactional leadership, which stresses more formal systems and processes, clear objectives, planning and process design, accountability and monitoring.

Walshe also notes that the organisational and cultural dimensions of clinical governance seem to demand greater attention to the transformational component of leadership including from boards and management generally.

Detmer and Ford (2001) stress that leadership is not something separate from clinical practice. ‘Leadership is a continuous and everyday activity that is an explicit part of all senior clinical roles’. Many clinicians see that leadership is somebody else's business and
that clinicians should not be troubled by having to manage their services. Effective clinical leaders, through their relationships and actions, make a broader contribution to patient well-being well beyond their individual impact as clinicians. They show personal courage, take personal risk and accept responsibility. This form of leadership takes an intelligence, knowledge and wisdom significantly broader than that of even the most expert practitioner.

Detmer and Ford (2001) note that ‘despite the scientific and technological sophistication of clinical services virtually all clinicians are ill-prepared for the leadership aspects of their work’. Recent developments in health systems demand much greater leadership and management from all clinicians of whatever discipline. They see this as the central message of clinical governance.

Clinical leadership must be appreciated and valued by boards and top management. Weiner et al, (1997) in a study of 2193 acute care hospitals, found that top board and management leadership for quality was a critical factor in promoting clinical leadership, especially in quality improvements. Active staff physician involvement in governance showed positive significant relationships with clinical involvement measures. They concluded that leadership from the top is a critical factor in promoting clinical involvement in quality.

6.5 Quality, clinical leadership and learning organisations

Worldwide, the literature on clinical governance emphasises the need to change the culture in health care organisations. Degeling (1998), from work in UK, Australian and New Zealand hospitals, has shown that medical clinicians prefer an opaque and personalised form of accountability and resist work process control mechanisms, eg evidence-based guidelines.

Senge (1990) believes that there are three basic dysfunctions of large organisations that can cause a profound 'learning disability':

- fragmentation,
- competition,
- reactive behaviours.

These problems were a feature of some New Zealand hospitals during the 1990s health reforms.

Argyris (1993) states that real learning takes place, not simply when an organisation refines its processes, which he calls "single-loop learning", but when it refines its theories and assumptions about the way the world works, engaging in "double loop learning". Learning organisations are built by communities of people who lead because they choose to serve. This “service” is directed at one another as well as seeking to serve a higher purpose.

The need for learning organisations was stressed in the UK Department of Health report ‘An Organisation with a Memory’ (Department of Health, 2000) prepared by an expert group on learning from adverse events in the NHS. The report noted that organisational culture was central to every stage of the learning process, from ensuring that incidents
were identified and reported through to embedding the necessary changes deeply into practice. It noted that ‘safety cultures’ are much more positive learning environments than those with a ‘blame culture’.

However the report is almost silent on the role of clinical leadership in promoting a learning organisation. Perhaps this is not surprising. Initiatives within the NHS are driven more by top-down political and managerial leadership, rather than clinical leadership. This contrasts markedly with developments in New Zealand, as will be discussed below. In PCOs important initiatives are being driven by clinical leaders within what in many cases are well designed learning organisations with a strong commitment to quality.

6.6 The development of clinical leadership internationally

There is an extensive literature covering more than two decades on the involvement of clinical staff in management. Successful progress in this relationship was widely recognised in Johns Hopkins Hospital in Baltimore, as reported by Heysel et al in 1984. This was extended, with some success, into the UK in the 1980s under the title of resource management initiatives, which following the Griffiths general management reforms of 1984. As in New Zealand progress towards clinician involvement through decentralised/devolved management was set back by the commercially driven, internal market reforms of the early 1990s.

In the US, with managed care, there has been increasing subservience of clinical to commercial goals and hence increasing conflict between commercial and professional values. Despite this there appears little acceptance of the need for clinical leadership for both quality and cost (Kassirer, 1998). Shortell et al (1998) discussed the “double agent” challenge facing US physicians in an increasingly commercial environment. They see the need to move towards a wider accountability framework, including to the community and the organisations for which they work.

In Australia clinicians remain largely organised within their separate hierarchies with divergent attitudes towards one another and to management (Degeling et al, 1998). There is strong opposition from bodies such as the Australian Medical Association (AMA) to clinicians becoming engaged in financial management.

In a few hospital situations there has been progress towards decentralisation and clinical accountability, eg the Royal Adelaide Hospital, but this progress has been dependent on clinical leadership. Degeling et al (1998), in a study of professional subcultures in Australian hospitals found that those clinicians who had moved into management positions demonstrated a clearly different cultural perspective, much more aligned with management perspectives, than those who remained as clinicians. However in a comparative study of Australian and New Zealand hospitals he found significantly greater involvement of clinicians in resource management in New Zealand, at least at leadership level, and that this was seen as “enhancing their autonomy” (Degeling et al, 1999).
6.7  The evolution of clinical leadership within New Zealand

6.7.1 Clinical leadership in the public secondary care sector

Health leadership and management in the public, largely secondary, care sector in New Zealand has changed remarkably over the last two decades. Table 6.1 summarises these developments, including those in clinical leadership. In the 1970s management leadership was divided into the executive ‘tribal’ hierarchies of medical, nursing and administration. This was swept aside following the State Sector Act of 1988 and the implementation of general management at executive and service level. For the most part clinical leadership, both medical and nursing at the top level, has become advisory rather than executive, eg chief medical and nursing advisors are now found in most DHBs.

Table 6.1  Key events/processes and associated outcomes in the evolution of clinical leadership in the public secondary care sector New Zealand

<table>
<thead>
<tr>
<th>Date</th>
<th>Event/process</th>
<th>Result/Outcome</th>
</tr>
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<tbody>
<tr>
<td>1975-1988</td>
<td>Traditional hierarchies of medicine, nursing and administration</td>
<td>Lack of service integration and accountability</td>
</tr>
<tr>
<td>1980</td>
<td>Formation of the New Zealand College of Community Medicine</td>
<td>Integration of medical leadership functions and a new training programme</td>
</tr>
<tr>
<td>1983</td>
<td>Area Health Boards Act</td>
<td>Moves towards leadership and service integration in a single entity</td>
</tr>
<tr>
<td>1988</td>
<td>State Sector Act</td>
<td>General management at both top and service level, leadership integration</td>
</tr>
<tr>
<td>1989</td>
<td>Health Services Management Development Unit (HSMDU) formed</td>
<td>Integrated national multi-disciplinary leadership development, strong moves towards integrated service management</td>
</tr>
<tr>
<td>1991-96</td>
<td>Commercially driven reforms</td>
<td>Rise of commercial leadership and devaluing of clinical leadership, conflict of goals/cultures in CHEs and the sector generally, but growth of primary care leadership</td>
</tr>
<tr>
<td>1996-1999</td>
<td>‘Reform of the reforms’ and moves towards a more collaborative system</td>
<td>Some convergence in leadership with emergence of clinical leaders in some HHSs but continuing conflict of goals between divided sectors</td>
</tr>
<tr>
<td>2000-2001</td>
<td>Labour government reforms, national health strategy with national health goals, DHBs as integrating entities</td>
<td>Common goals within the sector, explicit valuing of clinical leadership, both primary and secondary, moves to devolve quality and cost accountability to clinical groupings, emergence of clinical governance as a key quality strategy</td>
</tr>
</tbody>
</table>

Leadership at the clinical level has evolved largely within a framework of service groupings based upon clinical specialties, eg medicine, surgery, mental health, child health and primary care, etc (Malcolm and Barnett, 1994). This service structure, initiated by service development groups in the 1970s, facilitated three trends: decentralisation/devolution; integration; and accountability.

Under area health boards (1989-91) there was some decentralisation or devolution to service groupings under service managers. This also occurred at the sub-specialty level, to clinical directors (Malcolm and Barnett, 1995).
Within this there was some integration of service divisions across hospitals, of clinical and financial management and, in some situations, of hospital and community-based care, eg in mental health.

A significant setback to these trends occurred as a consequence of the reforms of the early 1990s. The government appointed commercially focused boards to Crown Health Enterprises (CHEs) with the expectation that they be successful businesses and achieve returns on the shareholders (government’s) assets (Malcolm and Barnett, 1994). Boards in turn appointed CEOs from the business sector often with little understanding of the ‘business of health’.

In many cases this commercial focus led to a significant conflict with clinicians whose primary goals were better patient outcomes (Hornblow, 1997). The subsequent clash of commercial and professional cultures led, in many cases, to progress in clinical leadership being sidelined. The most public expression of this clash was in Canterbury Health, leading to the Stent investigation reported in 1998 (HDC, 1998; Foate et al. 1999).

This conflict was exacerbated by the funding arrangements of Regional Health Authorities/HFA. The conflicting mix of fee-for-service and capped budgets reduced incentives for managers to maximise the use of shareholders assets. For clinicians there was little incentive or opportunity to become involved in the management of clinical activity. Those who did were seen to be taking a ‘soft line’ with management. Following the 1996 election CHEs were restructured into Hospital and Health Services (HHS) and the commercial pressures somewhat modified.

There was some progress towards clinical leadership development in the Hospital and Health Services, but there was little clarity of goals within HHSs and significant conflict of goals between clinicians and the business focused boards.

The new district health board system presents an important opportunity for clinical leadership. Key factors in this new situation are:

- A set of common goals, including a greater focus upon health outcomes, which could unite boards, management and clinicians in a common endeavour.
- A clear commitment by government to building a collaborative health system and to bring all components together, government and non-government, primary and secondary, health and disability, public and personal.
- Moves by boards and management in many DHBs to work more closely with clinicians and to devolve decision-making relating to quality and cost to clinical groupings.

As a consequence there appears to be a clear convergence of managerial and clinical values and goals, which may be helpful in the implementation of clinical governance.

6.7.2 Clinical leadership in primary care sector

Despite the ups and downs of clinical leadership in secondary care there has been major progress in clinical leadership development within the primary care sector.
The formation of the Royal New Zealand College of General Practitioners (RNZCGP) in 1972, the subsequent development of the Family Medicine Training Programme.

The implementation of capitated funding in 1979 and subsequently taken up by a number of general practices including union health centres in the 1980s (Seddon et al 1985; Crampton, 1999).

The undertaking of 10 pilot projects which were intended to explore alternative methods of funding and managing primary health care services, including multi-practice arrangements and budget holding (Kirk, 1994).

The Uniservices Report, (Uniservices, 1992) which explored the prospects for Independent Practitioner Association (IPA) development and became the basis for early initiatives.

The formation of IPAs in 1992, based on these developments.

An important factor in these developments, and especially the remarkable progress in recent years, has been general practice clinical leadership. Progressive clinical leaders had to defend their actions against the indifference and often strong hostility from the majority of general practitioners (GPs). The main opposition was voiced by the GP Action Group and to a lesser extent, for short period, by the New Zealand General Practice Association and New Zealand Medical Association (NZMA). In the main objections were based on a perceived loss of clinical autonomy and especially budget holding. Financial management by doctors was seen to be quite inappropriate by the majority of doctors as represented by the NZMA.

Despite this opposition clinical leaders in these front line IPAs, believing in the importance of their mission, pressed on. The more proactive had a high level of political awareness and recognised the potential benefits of achieving their vision. Support for their actions rapidly grew so that by 1996 some 60% of GPs were represented by their PCO (Malcolm and Powell, 1996; MOH, 1998). Numbers in IPAs grew to over 70% at the end of 1998 (Malcolm et al, 1999) with some 85% of GPs in some form of PCO by 2000.

The important lesson from this experience is that a conservative medical profession can, when faced with particular challenges, become quite progressive. The critical factor in achieving this radical change of culture was clinical leadership among a few, countering reluctance and even hostility of many colleagues. The key initial motivating factor was the threat of a powerful contracting regional health authority. Motivation changed to a more positive vision of a future for general with a strong emphasis upon improving quality.

This expression and achievement of clinical leadership, exercised through boards of directors elected by the rank and file of GPs, may be a pure form of clinical governance. Table 6.2 summarises the findings of a survey of IPAs by Malcolm, Barnett and Wright (2000) noted the following as key functions and achievements of IPAs relevant to the concept of clinical governance.
Table 6.2  Key functions and achievements of IPAs and similar groups relevant to the concept of clinical governance

- Developing collective professional accountability for the management of clinical activity of members to improve quality and make better use of primary care resources.
- Managing new integrating relationships between members, between other primary care professionals and the community and between primary and secondary care.
- Implementing a primary care infrastructure including staff appointments, an information system to computerise, merge and manage practice registers, analyse laboratory and pharmaceutical data and provide personalised feedback to members.
- Peer group formulation of clinical guidelines and monitoring of performance to promote better quality, evidence-based practice.
- Managing corporately an increasing set of primary and some secondary care resources to achieve better health outcomes for patients and communities.

6.7.3 Clinical governance applied to clinical leadership developments in New Zealand

The term clinical governance is now being applied in a number of district health boards and PCOs to the process of bringing clinicians into a stronger leadership role within in the changing health system. While there are still uncertainties about the meaning and scope of clinical governance it is clear that there are wider concerns about quality and major efforts being made or contemplated to build clinical leadership potential to address quality issues.

A discussion of the term clinical governance as applied to clinical leadership within this context will be presented later. Also discussed will be the question of whether clinical leadership in the private sector is significantly different from that in the public sector. PCOs, in their clinical governance roles, are functioning as quasi-public bodies in that their functions are very largely the management of public resources to achieve public goals.
7. CLINICAL GOVERNANCE: WHAT IS IT?

7.1 Definitions of governance

In clarifying possible definitions and roles for clinical governance it is first important to look at the definition and meaning of the term corporate governance. Scally and Donaldson, the key initiators of clinical governance in the UK state that,

*The new concept has echoes of corporate governance....... The resonance of the two terms is important, for if clinical governance is to be successful it must be underpinned by the same strengths as corporate governance: it must be rigorous in its application, organisation wide in its emphasis, accountable in its delivery, developmental in its thrust, and positive in its connotations. The introduction of clinical governance, aimed as it is at improving the quality of clinical care at all levels of health care provision, is by far the most ambitious quality initiative that will have ever have been implemented in the NHS (Scally and Donaldson, 1998)*

Corporate governance has become a major topic for investigative research and development in recent years along with its role in organisational behaviour. Corporate governance has been widely considered in both business as well as not-for-profit entities. The OECD (1999) defines corporate governance as;

*‘the system by which business corporations are directed and controlled. The corporate governance structure specifies the distribution of rights and responsibilities among different participants in the corporation, such as, the board, managers, shareholders and others stakeholders, and spells out the rules and procedures for making decisions on corporate affairs. By doing this, it also provides the structure through which the company objectives are set, and the means of attaining those objectives and monitoring performance’* (OECD,1999).

The term policy governance has been advocated by Carver, to stress the difference between governance and management (http://www.carvergovernance.com). He defines the purpose of governance as ensuring, on behalf of some ownership, that the organisation achieves what it should and avoids what is unacceptable. He defines boards as being responsible for ends whereas management is responsible for means.

Shortell and Kaluzny (1994), widely regarded internationally as key exponents of health sector organisation and management, define governance as;

*‘the function which holds management and the organisation accountable for its actions and which provides management with overall strategic direction in guiding the organisation’s activities’* (Shortell and Kalunzy, 1994)

Putting these and other views together indicate that the key features of corporate governance are;

- setting vision and values
- setting organisational goals/objectives
- strategic policy leadership
- continuous improvement of quality
- accountability to both the wider community and shareholders
- corporate/organisation wide functions including governance of resources.

### 7.2 Clinical governance

Clinical quality, and its links with clinical governance, was presented in a WHO Report (1983) as having four dimensions;

- professional performance (technical quality)
- resource use (efficiency)
- risk management (the risk of injury or illness associated with the service provided)
- patient satisfaction with the service provided.

The term clinical governance was formally introduced, as government policy, to the UK NHS in 1997. The working definition of clinical governance now widely used there is;

> ‘Clinical governance is a system through which NHS organisations are accountable for continuously improving quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish’ (Scally and Donaldson, 1998).

Lugon and Secker-Walker (1999) state that clinical governance can be defined as:

> “…the action, the system or the manner of governing clinical affairs. This requires two main components; an explicit means of setting clinical policy and an equally explicit means of monitoring compliance with such policy.”

King and Wilson (2000) state that the underlying principle is parallel to the concept of corporate governance (sound business and financial management), thus giving equal weight to the quality of clinical care provided by the organisation. In the light of this, responsibility for quality of clinical care is shared between clinicians and managers. Clinical quality is not solely the preserve of physicians, but quality becomes everybody's business.

Derry (1999) sees this shared responsibility as a two-way process. While physicians may initially be concerned about managers looking at quality of clinical care managers must now consider the effect of their decisions on clinical quality. The systems and processes for achieving this are not new. Each of the five essential building blocks for clinical governance has been implemented to some degree and with some effectiveness previously. These building blocks are;

- clinical audit
- clinical risk management
- clinical effectiveness and knowledge management
- professional education and development
- whole systems approaches to quality improvement.
Van Zwanenberg & Edwards (2000) do not see clinical governance as a particularly new idea. They see most of the components as already, at least partially, in place. The importance of clinical governance, however, is to consolidate the essential concepts and to promote and marshal organisations to develop a comprehensive approach to quality.

Donaldson (2000) sees clinical governance as including learning from both good and poor clinical practice. This involves addressing the diverse aspects of quality improvement which are carried out to varying degrees in most organisations, but ensuring that they are performed well and systematically everywhere and carried out within an integrated strategy.

Walshe (2000a) states that clinical governance is a new “umbrella” term for describing quality improvement activities in health care organisations. He adds that the term seems not to have been used in the literature at all before the current National Health Service (NHS) policy initiative. Walshe notes that there is no shortage of existing terminology in the area -- quality assurance, continuous quality improvement, clinical audit etc. however, there are some characteristics of clinical governance, which make it distinctive and useful, these are:

- Corporate accountability for clinical quality
- Clinical quality becomes an organisational priority thus balancing clinical governance with corporate governance
- A ‘whole systems’ approach to quality improvement -- past efforts at quality assurance in health care have tended to be piecemeal and uncoordinated rather than a coherent whole. Clinical governance asserts the value of a whole system approach to quality improvement and organisational leadership, culture, and systems are crucial to achieving it.
- The integration of quality improvement activities -- as noted above previous quality activities tended to be a patchwork of separate and sometimes overlapping initiatives. Under clinical governance is expected that coordination and coherence will improve effectiveness and give better value for money in quality improvement
- Alignment with corporate governance -- in the past the principles of good governance tended to relate to the body corporate, clinical governance extends this accountability, integrity, and explicitness into the clinical domain in health care organisations.

Walshe notes that it is the organisational dimension of clinical governance that is new, including a focus on leadership, organisational culture, organisational quality strategies and corporate change. The systems and processes by which this will be achieved e.g. clinical audit, risk management, continuing professional development complaint mechanisms already exist although they may not be used to best effect.

Clinical governance in New Zealand is still an evolving concept. Malcolm and Mays (1999) suggest that the term covers a wide perspective and implies a corporate level accountability to both community and within organisations. Malcolm (2000) suggests a short and wider definition as "the exercise of corporate accountability, both external and internal, for the management of clinical performance throughout the health service organisation". A major difference in New Zealand is that the concept extends to include financial governance.
Clinical governance can be regarded as a quality system. Baker and Lakhani (2000) describe a process of the development of quality system where typically an organisation starts by using one method to improve quality – see figure 7.1.

**Figure 7.1 – The development of quality systems (from Baker and Lakhani, 2000)**

However, one method is rarely enough, because the range and scope of the problems to be solved are unable to be addressed by a single method. Once the organisation is applying a range of methods these are usually brought together through an over-arching quality strategy.

"*If quality is to be guaranteed, the entire organisation needs to be constructed to ensure quality performance. This means that the quality system must become integrated with, and virtually indistinguishable from, the general management system.*" (Baker and Lakhani, 2000)
8. INTERNATIONAL PROGRESS ON CLINICAL GOVERNANCE

8.1 United Kingdom

8.1.1 Policy context and implementation strategy

While the concept of clinical governance was first advanced by the World Health Organisation (WHO, 1983) it re-emerged in the United Kingdom in 1997 to underpin a national strategy for quality improvement (Scally & Donaldson, 1998; Cooper-Liversedge, 1999). The use of the concept and policy on clinical governance were first announced in the paper "A First Class Service" (1998) and implemented in March 1999 (NHS Executive, 1998 & 1999a, Penny, 2000a). The policy placed quality and accessibility of health care at the centre of health services (Department of Health, 1997). Inappropriate variations in performance and practice were said to be “unfair” and “wasteful” and a 10-year modernisation strategy outlined to overcome these.

The modernisation strategy had five main components:

- The setting, delivering and monitoring of quality standards thus providing a national framework for assessing performance, with an action plan containing specific timeframes within which changes would be achieved and quality improved.
- The setting of clear national standards expected for the quality of health care, to be supported by evidence-based medicine and consistently implemented throughout the NHS.
- A National Institute of Clinical Excellence (NICE) was to be established as well as a National Service Framework (NSF) to produce "care blueprints". (Walshe, 1997; Penny 2000a)
- These blueprints were to be made available to current and prospective patients so that they were informed of the health services available to them.
- The delivery of consistent quality standards nationally was to be ensured through the new system of clinical governance including life-long learning to ensure competent and professionally accountable NHS staff equipped to deliver skilled care.

Quality standards were to be monitored nationally through three new mechanisms:

- The Commission for Health Improvement (CHI), a new statutory body set up to provide independent assessment of local service quality, to review the implementation of the new regime and the strength of local clinical governance programmes. (CHI, 2001a & b)
- A national framework for assessing NHS service-wide performance focused on six key areas: health improvement, access, effective delivery of health care, efficiency, patient and carer experience and health outcomes. These performance measures were to be benchmarked to enable comparisons to be made.
- A national annual survey of patient and health care user experience to provide indicators of service quality. These surveys were to be reported to the NHS
Executive to ensure consumer satisfaction was achieved and maintained. (Penny, 2000a)

The monitoring of clinical governance implementation and performance was to be undertaken via Regional NHS Executive Offices, the Commission for Health Improvement (CHI) and statutory regulatory bodies for health professionals.

Penny (2000a) and Halligan and Donaldson (2001) note that a successful implementation plan for clinical governance is outlined in broad terms as:

- The development of a new culture throughout the NHS, one which embraces constructive criticism and new ideas and eschews blame.
- A commitment to high quality care, shared by staff and managers, supported by local human and financial resources and skill development, e.g. "the right number of people, with the right skills to deliver the quality agenda".
- A collaborative ethos with multi-disciplinary teams working at all levels in the organisation grounded in evidence-based clinical decision-making.
- The availability of good information to identify scope for improvement, to plan and monitor progress, to make comparisons between services, to provide information to the public and to monitor adverse outcomes.
- The provision of three major new initiatives in NICE, Commission for Health Improvement (CHI) and the National Electronic Library for Health to promote clinical cost effectiveness, source and access scientific knowledge and to monitor quality.

The General Medical Council (GMC) was to assist in addressing poor performance by strengthening procedures for monitoring the clinical performance of individual practitioners through revalidation every five years. This required each individual medical practitioner to maintain certain required standards in order to stay on the medical register.

The NHS Executive (1999a) also saw learning from experience as a crucial element of a clinical governance structure and processes, based on continuous quality improvement together with the adoption of "good practice" through networking opportunities. "Beacons", where service provision was selected as a "particularly good example" of excellence, were to be given additional financial support to enable them to disseminate learning about their high quality service and practice (NHS Executive, 1999b).

Primary Care Groups (PCGs)/trusts and National Health Service (NHS) trusts all had similar roles and responsibilities. These included the four key implementation steps: establishing leadership and accountability arrangements; making a baseline assessment; developing action plans; and reporting arrangements across all services. The reporting arrangements were to ensure joint accountability for clinical governance based on a multi-sector, multi-agency approach within a climate of open learning relationships. In addition, NHS hospitals were to ensure that all hospital doctors took part in national clinical audit.

These four steps once completed would begin the process of putting into place the framework for clinical governance. Scally (2000) has described such a framework in the
reporting requirements of NHS trusts and PCGs in the South West of England. That framework incorporates the following (Penny, 2000a; Scally, 2000):

- A baseline assessment of current activities relating to clinical quality, risk management and development plan.
- Working arrangements for leadership and accountability that ensure that clinical governance is implemented from the board level down.
- Development of the clinical governance arrangements across community health.
- Information and reporting systems developed for ensuring clinical governance is in place and monitored effectively.
- Roles and resources (time) allocated to designated lead and senior management support.
- A clinical audit infrastructure with multidisciplinary involvement, programme development and management, plus patient/carer participation and corrective actions.
- Risk management infrastructure, complaint and adverse event procedures put in place including health and safety procedures. Mechanisms are established to ensure that lessons are learnt from complaints, adverse events and incidents together with reporting mechanisms to board level.
- Organisation-wide human resource strategies, including workforce planning, underpin clinical governance.
- Continuing professional development relating development programmes to the need both of the individual and the services.
- Consumer involvement and strategies incorporating consumer experience.
- Development of clinical indicators to monitor the performance of clinical service provision and any appropriate follow-up action.
- Information management and technology with all staff having access to information and evidence-based practice.
- Research on effectiveness of clinical governance and its impact on the culture and creation of best practice.
- Accreditation progress and status.
- Links with clinical governance and the health improvement programme as well as implementation of national guidelines from NSF and NICE.

The Department of Health (2000) also identified the need to learn from adverse events as well as the need for health professionals to report bad practice, i.e., "whistle blowing". This is to sit in the context of a “no blame culture” to ensure maximum learning from such events to drive down the risk for future patients (NHS, 2001).

### 8.1.2 Support Systems for clinical governance for England and Wales

The implementation of these changes relied on the development of support systems for clinical governance, cooperation from the medical and nursing professions, plans for implementation within the sector and the empowerment of patients.

A number of organisations are responsible supporting clinical governance in England and Wales. This section lists and briefly comments on their functions. Further information is presented in Appendix 1.
• National Institute for Clinical Excellence (NICE)
The role of NICE is to provide patients, health professionals and the public with authoritative and reliable guidance on current “best practice”.

• Commission for Health Improvement (CHI)
CHI works at both national and local level of NHS organisations to monitor and improve clinical care throughout England and Wales. It examines serious system failures within the NHS related to the management, provision, quality and availability of health care and undertakes investigations to assist organisations improve patient care.

• Clinical Governance Support Team (CGST)
The CGST was set up in August 1999 to provide additional support, training and development for organisations and staff involved with clinical governance.

• Joint work by government, Department of Health and the medical profession
The government, Department of Health and the medical profession have worked jointly to develop and disseminate clear standards for professional practice and national service frameworks (NHS, 2001).

8.1.3 Nursing and clinical governance

The Royal College of Nursing in the UK has been an active supporter of nurses in clinical governance including the production of papers on the Council’s policy position on clinical governance.

Nurses in the UK see clinical governance as everyone’s business in all professions and at all levels of staff and also as a balancing of the scales between quality and quantity or costs and a way of drawing together all the various quality initiatives into single coherent framework (Jones, 2000).

Experience to date indicates that nurses have been involved in a number of ways. At an organisational level, some nurses in trusts and primary care groups have taken on the role of clinical governance lead. Within primary care groups this has mostly been in partnership with a general practitioner colleague and sometimes also lay representative. Jones (2000) observes that clinical level nurses have not always been fully involved by the organisations in getting started with clinical governance.

Nurses appear to see themselves as well-placed to participate in clinical governance drawing on their long history in quality improvement, particularly in standard setting, monitoring, clinical audit, and more recently in the use of evidence based practice. They have been involved in risk management, complaint handling and incident reporting (Jones, 2000; Royal College of Nursing 1998 & 2000; Carne, 2001) These writers also observe that nurses have similar professional self-regulation and development requirement to medical clinicians.

As nurses constitute the largest professional group in England and Wales, then by sheer numbers alone they could also make up the largest collective power to create the effective change (Castledine, 2000).
8.1.4 Essential culture change for clinical governance

Many commentators have offered suggestions as to what constitutes the “right” culture for clinical governance (Donaldson, 2000; Marks and Hunter, 2000; Stead et al, 2000; Roland and Baker, 1999; Garside, 1998). There are few systematic studies in the health field although management science has plenty. Several authors have identified cultural elements that underpin “good” clinical governance (Stead et al, 2000; Roland and Baker, 1999; Garside, 1998; Marks and Hunter, 2000; Donaldson, 2000), and their findings are summarised below:

- **Continuous quality improvement**: Seeking ways of improving care as a matter of routine, learning from both good and poor, providing routine feedback on performance, investing in clinical and management information systems and making good use of the information generated from the systems.

- **No-blame culture and system awareness**: A *system failure* approach rather than focusing on individual fault.

- **Teamwork**: recognising that patients do not see individual members of staff, but various members of the health care team, using flexible project teams to tackle complex processes which cross ‘departmental’ or professional boundaries.

- **Communication**: good internal and external communication, with strong partnerships and time set aside for getting teams into a room on a regular basis to discuss significant events; sharing of information and skills normally the province of professionals and professions.

- **Ownership**: stakeholders involved in change but not having it “imposed” on them, ensuring an inclusive approach leading to the development of collective responsibility so that ‘issues’ are shared and team members are willing to acknowledge their problems; team members feel valued in their work.

- **Leadership**: A clear vision from leaders as to what is to be achieved i.e. a clear agenda for action, project management capacity, open and participative style; a strong executive management team.

- **Continuous learning**: Education, personal development and research are valued and there is an investment in knowledge management.

- **Patient focus**: A patient and user focus which recognises the importance of the patient’s experience of care.

8.1.5 Systems and processes of clinical governance

Literature assessing the evidence for the effectiveness of the systems and processes of clinical governance is limited. Walshe (2000a, 2000b, and 2000c) has reviewed progress to date and this section draws heavily on his work.

- **Professional education and development**

The culture of the NHS is dominated by professions and professional models of change, focused on education and continuing professional development (CPD), are widely used (Walshe, 2000a). Walshe notes that an effective programme of continuing professional education and development is likely to based on:
• good mechanisms for both individual and organisational assessment,
• use of a competence or performance based model for design and delivery,
• some flexible incentives to encourage participation,
• routine evaluation of the impact of interventions.

• Clinical risk management

Clinical risk management aims to create and maintain safe systems of care, minimise the risk to patients and others and contribute to improved quality (Walshe, 2000b). Clinical risk management has undergone rapid development in the NHS over the last ten years, largely in response to litigation. National guidance on clinical governance in the UK stresses the importance of having effective systems for risk management, and highlights the prevention of adverse events and reduction of risk. Walshe identifies four main components in risk management systems:

- strategic direction and corporate accountability for risk
- systems for identifying risk
- systems for analysing risk.
- systems for controlling and reducing risk.

While clinical risk management is used in many countries little is known about its effectiveness in either controlling or reducing risk, or about the relevant merits of the different methods and approaches. (Lindgren, 1992; Mills & Bolschwing 1995)

• Clinical audit

Clinical audit is perhaps the most widely used NHS approach to quality improvement. In 1989 it became a requirement for all medical staff in hospitals and community services to participate in some form of audit. The form and structure of local arrangements for clinical audit varies widely but most organisations have systems for managing and directing clinical audit, systems for monitoring and reporting on its progress, and structures to do it.

While the development of audit has been quite widely studied and evaluated (Lord and Littlejohns, 1997), research shows that its impact is uncertain (Johnston et al, 2000). Walshe (1995) looked at the characteristics of successful clinical audit and Walshe and Spurgeon (1997) provide systems for evaluating these. Walshe (2000a, 2000c) suggests that research on clinical audit has valuable lessons for clinical governance.

- Effective well-managed NHS organisations appear to be much better at establishing clinical audit arrangements. This is also true of department or clinical teams. Clinical governance is likely to be similarly affected and therefore a lack of progress with clinical governance may be an indicator of wider or deeper organisational difficulties.
- The progress of clinical governance should be monitored carefully and prospectively -- it should not be assumed that it is effective. The progress of clinical audit in different organisations and within organisations varied widely.
- Measures of clinical audit need to go beyond structures and activities to look at processes and how well initiatives are working
- Senior manager and board level involvement sends a strong message about the ownership and commitment. In its absence clinical audit efforts had far less impact.
Clinical governance will need to be accompanied by strong mechanisms for change. A major challenge to the success of clinical audit has been difficulty in implementing the resulting recommendations so that real changes in practice ensued.

**Clinical effectiveness and knowledge management**

Over the last decade there have been increasing efforts to improve clinical effectiveness and introduce evidence-based health care. The NHS developed a system wide research and development function to identify information needs, gather, manage, and disseminate material to make effectiveness information readily available. (Appleby et al 1995). This was accompanied by investment in libraries, information services, knowledge management staff, networked clinical databases, guideline development, and other initiatives. Topics or areas where work was initiated sometimes related to pre-existing clinical audit arrangements or where there was a perception that current practice was not reflecting the evidence base (Walshe & Ham, 1997; Wallace & Stoten 1999).

The Kings Fund instituted a programme - Promoting Action on Clinical Effectiveness (PACE) - involving 16 NHS organisations undertaking projects aimed at changing areas of clinical practice based on available evidence. The success of the projects varied widely, with critical success factors including: the availability of strong evidence; the presence of supportive the leaders in each organisation; and the integration of work on effectiveness within the organisation. Other influences included perceptions of the need for change locally, the management of the projects and resourcing.

The scientific biomedical foundation for thinking on evidence-based health care sometimes leads to an overly simplistic and linear model of implementation undervaluing the social complexities of organisations and people. (Dopson et al, 1999; Ferlie et al 2000; Ferlie et al 1999). There was no research evidence was found on the effectiveness of the National Institute for Clinical Excellence (NICE) and the use of national service frameworks.

Walshe (2000a, 2000c) draws these lessons from the literature on clinical effectiveness:

- Individual pilot projects such as demonstration projects are not a substitute for wider action.
- Clinical issues are complex and not every question can be addressed by evidence. A pragmatic approach combines clinical epidemiology, practical clinical experience and takes into account the uncertainty inherent in many clinical situations.
- The rational scientific model can be misleadingly simplistic and may not be empirically supported by research. It is of limited value in the social world of organisations and people

**Whole systems approaches to quality improvement**

The policy guidance on clinical governance cited above draws heavily on whole systems approaches to quality improvement. In many ways clinical governance can easily be seen as a relabelling and reshaping of ideas on continuous quality improvement related to health services. In particular the focus on board, senior manager and clinical leadership for clinical governance plus the emphasis on robust systems are all familiar components of continuous quality improvement (CQI). Blumenthal and Kilo (1998) and Walshe (2000a & c) note some lessons for clinical governance from whole systems approaches.
Clinician involvement is a key factor in successful quality improvement.

- An initial focus on clinical issues or priorities where quick and visible gains can be made for both patients and staff encourages clinicians participation and support
- Invest in clinical governance and recognise the value of the work by allocating time for it – clinicians should not be expected to undertake this work in their lunch break or “after hours”.
- Use terminology that incorporates all disciplines, avoid jargon which can confuse and/or alienate.
- Target training for clinical governance to identified skill and knowledge deficits at the point in the organisation where they will be used. Avoid general training and awareness raising programmes – they have little long-term impact and can breed cynicism.
- The board and senior management need to own clinical governance and be involved in it. This type of leadership demonstrates the value placed on clinical governance.

In conclusion, Walshe highlights three key lessons about the implementation of clinical governance:

- There are no “hard and fast” rules about which systems are the most effective – the effectiveness of systems relates to the organisational context, culture and the people involved.
- The processes and resulting outcomes from quality improvement measures need to routinely monitored and evaluated.
- Lastly, the success or otherwise of quality improvement systems provides important clues about the organisation as a whole – better managed organisations are more likely to succeed.

Despite the development of comprehensive structures, there are reservations about the effectiveness of highly prescriptive ‘top-down’ frameworks. Wallace et al (2001) report that the implementation of clinical governance in 47 hospitals and trusts in the West Midlands was undermined by the failure:

“to take a systematic approach to the design and implementation of organisational interventions that could impact on the culture change goals of clinical governance….It seems that the key goal of clinical governance, building a shared culture, has been left to chance.”

A valuable lesson to have learnt early in a 10-year programme of developing and implementing clinical governance.

8.2 Canada

Health reform within Canada is significantly constrained by the Canada Health Act 1984 and by competing and conflicting federal and provincial roles in health care funding and provision. Almost all funding is on a fee-for-serve basis in primary health care with little progress toward capitation or collective accountability for the cost of health services.

The literature is almost silent upon clinical quality assurance and governance in Canada. The main efforts in this regard appear to lie in pilot and demonstration projects set up in most of the Canadian Provinces since the mid-1990s (Hutchison et al, 2001) to promote co-ordination in primary care. Hutchison notes that there is a high degree or variability in the extent which each Province has been expected to adhere to the requirements for these projects.
8.3 United States of America

8.3.1 Quality in a commercially driven health system

Reference has already been made to the recent quality initiatives driven by both the Institutes of Medicine (IOM) and other reports on adverse events. In contrast to Britain, where quality initiatives and clinical governance are driven by government policy, in the US quality initiatives are heavily intertwined within a commercially driven health system.

Robinson (1999) reported that ‘The traditional [US] health care system, dominated by the professional guild and financed by indemnity insurance, has been shattered beyond any possibility of repair’. Medicine has been almost entirely corporatised. For the first time, through the corporate system, the health care industry is being subjected to systematic monitoring of quality and service levels. Robinson notes that whereas organised care has demonstrated a remarkable ability to moderate inflation costs, it is difficult to ascertain its influence on health care quality with the inherent difficulties in measuring outcomes. He sees quality improving more from improved clinical performance than changes in markets and organisation.

Corporatised health care, through various models of managed care includes the following quality initiatives (Gosfield, 1998):

- Utilisation management systems monitoring health professional activity. Although cost-driven these techniques have reduced inappropriate treatment and some of the variability in practice.
- Case management is used to track inpatients, especially those requiring expensive or complex treatment.
- Stand-alone review companies which contract their services to managed care organisations to review and recommend the clinical need and appropriateness of services ordered for/provided to patients.
- Pharmaceutical company and disease management vendors aim to influence prescribing patterns and introduce proactive clinical management techniques for such diseases as diabetes, and asthma.
- Clinical practice guidelines and appropriate software provide proprietary and intellectual property as a basis for clinical decision-making.

Leatherman et al (2000) notes that the market approach to the delivery of health care has led to the concentration of quality efforts at the level of corporate governance and operational management. As a consequence many of the approaches to quality improvement used within the American health care system have their origins in American business improvements eg continuous quality improvement (CQI) and total quality management (TQM) (Moss et al, 2000).

Enthoven (1993) asserts that HMOs address quality issues such as: costly adversarial relationships between doctors and payers, accountability for health outcomes and the associated information systems, quality and efficiency in doctors' practice, matching of the numbers and types of doctors to the needs of enrolled populations, enabling the practice of total quality management/continuous quality improvement, a focus on
prevention and early diagnosis, and the treatment and effective management of chronic conditions.

8.3.2 Have quality initiatives worked in the US system?

Blumenthal and Kilo (1998) undertook a study of the outcomes of continuous quality improvement in the US system. The views of key stakeholders and national experts were sought regarding the outcomes of the CQI movement. They found that; there had been a transformation of the language about quality, the creation of a new focus on the customer in health care and that the quality movement had motivated health care organisations to initiate many individual quality improvement projects.

However they also concluded that the quality improvement movement had not had the impact that many advocates and observers anticipated. None of the national quality experts could identify a health care organisation that had fundamentally improved its performance through CQI. Many were unable to cite evidence of improvement within their own organisations. They found that there was a paucity of peer reviewed literature on CQI. Perhaps of most importance they found that it was administrators not clinicians who are the first to incorporate CQI methodologies into health care.

They concluded that ‘At the core of quality improvement is a struggle for the hearts and minds of health professionals’. A key recommendation arising from their study was to involve physicians early in the effort to improve quality. These findings are supported by Shortell et al, (1998) who, from a review of the literature on the effectiveness of CQI in the US, found a critical factor in the success of CQI is recognising its high compatibility with professional values. They say clinical quality improvement is likely to be more effective by appointing capable leadership and creating relationships of trust with physicians.

Dudley et al (1998) undertook an extensive study into whether financial incentives had an impact on quality of health care. From a literature search they developed a scoring system to show whether HMO type care was different from fee-for-service (FFS) on indicators such as mortality, morbidity, consumer satisfaction, preventive services utilisation, etc.

They found that there was little evidence of any consistent difference in clinical quality between FFS and HMO care. This was especially true when coverage by HMOs on preventive service measures were separated from other from issues of quality. They stated that ‘Many fundamental issues must be solved before we can develop a quality-focused health care market’. In theory positive financial incentives could provide a great stimulus for quality. In health care however because of the difficulty in measuring quality and the lack of correction for risk, the financial incentives do not encourage health plans to maximise quality.

8.3.3 Clinical autonomy, professional incentives and leadership

The autonomy and influence of physicians in the corporatisation of US medicine has been seriously marginalised. US physicians have only reluctantly accommodated to the growth of corporatised medicine. Where inclusion has occurred it is within the prevailing financial rather than the professional incentive model.
Professional incentives have become largely subservient to financial incentives. King and Wilson (2000) note that a number of writers have identified the tendency of the US programmes to make strong use of financial incentives otherwise aimed at motivating physicians to change their behaviour. There was reportedly relatively little physician input and unsurprisingly physicians are sceptical, if not downright resistant, to such incentives (Gosfield, 1998).

More positively Gosfield (1998) sees that the development of new primary care models and approaches have been creating new opportunities for physicians. He makes a number of observations about the selection of relevant clinical leaders, identifying critical basic traits:

- Leaders should be doctors who are in current practice, who experience the reality of the working lives for those who they lead.
- Physician leaders must be doctors with standing amongst their peers.
- They must be able to focus on the broader good and be able to rise above personal or parochial goals.
- They will be good communicators to their peers and others.
- Clinical leads should also have a willingness to learn the skills necessary for effective performance and have the ability to teach others how to relate with in the broader clinical culture of the organisation.
- Clinical leads should also expect to be held accountable themselves for their contributions to the new culture that they are creating.

Gosfield (1998) makes important point that adding the role of clinical leaders to the existing responsibilities means recognising the economic value of such participation. However he also notes that financial rewards can also colour the views of the physician constituency with respect to the loyalties of a leader.

### 8.3.4 Nurses and quality

Organisational changes in health care in the US have increased the contribution of nurses to the development of quality, particularly in primary care (Mundinger et al, 2000). Many managed care plans in the US now have nurses acting as the interface between physicians and HMO type plans. Utilisation review nurses are employed, using computer-based protocols, to determine if proposed treatments are eligible for payment under the patient’s HMO.

There has also been an increase in the clinical skills and roles of many nurses leading them into positions such as nurse practitioners. Mundinger et al compared the quality of patient outcomes between patients seen by physicians and nurse practitioners. They found that nurse practitioners’ patient outcomes were comparable where the nurses had the same authority, responsibilities, productivity and administration requirements, and patient population, as primary care physicians.

### 8.3.5 Consumer satisfaction

The extent to which patients are satisfied with the changes in American health care is unclear because the evidence is conflicting. Gosfield (1998) believes that there is some
apprehension about the level to which quality of care has been compromised by managed care. Robinson (1999) notes that

‘Patients are worried lest the emphasis on cost control reduced the quality of the care they receive. Consumers are annoyed with every obstacle to obtaining what they want when they want it’.

He also notes that the early emphasis in corporatised medicine was upon cost containment. Consumer demand is shifting the emphasis of the corporate system to developing methods for measuring and improving service. For the first time the health care industry is being subjected to systematic monitoring of quality and service levels, with the intention promoting clinical comparisons and quality conscious consumer choice.

8.3.6 Overview and comment

Despite an enormous literature on the US healthcare system studies on the effectiveness of quality initiatives, clinical leadership involvement in quality and clinical leadership generally appear to be quite limited. The following conclusions may be drawn from the above and the literature generally.

- The US healthcare system is almost entirely corporatised and therefore driven by commercial rather than social or professional values.
- Physicians are also under threat from nurses engaged in controlling their access to referred services and undertaking tasks which previously were those of physicians.
- Although there have been major initiative to promote quality the evidence of successful outcomes from these initiatives appears to be quite limited.
- Clinical involvement in quality initiatives has been limited and success has been restricted by the failure to engage clinicians in the quality movement.
- There continues to be a major divide between corporatised medicine on the one hand and professional values on the other.
- As in New Zealand during commercially driven health reforms of the mid-1990s this continuing ‘conflict of cultures’ is unlikely to lead to any significant accommodation between clinical and managerial goals in values.
- Professionally organised and driven medicine appears to be weak and fragmented with little or no power to counter or effectively influence corporate values and goals other than financial.

Organised medicine outside the commercial model within the US, ie as developed by New Zealand PCOs, appears to be very limited. As a consequence effective clinical leadership, representing professional values and managing resources to achieve public rather than commercial goals, would also appear to be very limited.
8.4 Australia

8.4.1 Australian Council for Safety and Quality in Health Care

As in the US and Britain quality initiatives are being driven by concerns about adverse events. The widely quoted study by Wilson et al., (1995), referred to above, identified a significant level of adverse events in the acute health care sector. In response, the Health Ministers' Conference established the Task Force on Quality in Australian Health Care. The Task Force recommended the redesign of health care processes and systems to strengthen the focus on consumers (see http://www.health.gov.au).

Following the Task Force report, two groups were formed in 1997, the National Expert Advisory Committee on Safety and Quality in Australian Health Care and the Consumer Focus Collaboration. The report of the former group, presented at the August 1999 meeting of Australian Health Ministers Conference, led to the establishment of the Australian Council for Safety and Quality in Health Care (ACSHC). The Council was established in January 2000 and is chaired by Professor Bruce Barraclough. The Council's report, ‘Safety First’, to the July 2000 Australian Health Ministers Conference was endorsed with funding of $50 million over five years.

The role of the Council is to lead national efforts to provide systemic improvements in the safety and quality of health care in Australia, with a particular focus on minimising the likelihood and effects of error.

In the introduction to Safety First the Council pointed out that the cost of unsafe care in Australia had been estimated at between $867 million and over $1 billion a year. The report states:

‘The example of medication problems is telling. It has been estimated that in Australia inappropriate medication use results at least 80,000 hospital admissions each year at a cost of around $350 million (Roughead, 1999). Around half of these admissions are estimated to be potentially preventable.’

8.4.2 The Consumers Focus Collaboration (CFC)

The CFC arose from a recommendation of the Task Force on Quality in Australian Health Care as a key component of quality improvement in the Australian health system (see http://www.health.gov.au). This development is consistent with the strong focus upon consumer participation in which the Australian health system appears to lead in the world.

The Commonwealth Department of Health and Aged Care (DHAC) established the CFC. Its aim is to progress work at all levels of the Australian health care system on consumer issues. It involves a number of key stakeholders working to progress consumer participation issues at all levels. Its members are drawn from consumer organisations, professional associations, complaints commissioners, State and Territory governments and the private sector.
CFC has established a wide range of consumer participation activities, including the National Resource Centre for Consumer Participation in Health (NRCCPH) based at the University of La Trobe, Melbourne. It is seen as a centre of excellence in consumer participation where clients can seek advice and assistance to develop, implement and evaluate feedback and participation methods and models.

8.4.3 Clinical quality and governance in Australian hospital services

The Australian ACSQHC has promoted action within states focusing largely upon risk management resulting in significant developments within the hospital sector towards implementing clinical governance. A one-day conference on ‘Demystifying risk management and clinical governance’ was held in Canberra on 10 April 2001 sponsored by the Australian Resource Centre for Hospital Innovations. It included presentations from a wide range of those involved in clinical governance and related activities in Australia (ARCHI, 2001 – see http://www.archi.net.au).

Given the ACQSHC perspective the focus has been upon the development of standards education and compliance measures in priority areas. The Chairman of the ACQSHC Professor Barraclough noted that ‘as yet the implementation of clinical governance at the doctor/patient interface is very patchy’.

A number of states have established state-wide strategies for promoting clinical governance and related activities. However as yet these seem to be in a very early stage of development. Nevertheless it seems clear that the term is being used to an increasing extent to include a range of quality promoting activities especially risk management.

8.4.4 Clinical quality assurance and governance in primary health care

Unlike Britain and New Zealand, Australia has not yet embarked on exploring or implementing clinical governance. However there are a number of initiatives in clinical quality and governance that are of interest. The available literature focuses largely on primary health care.

Quality initiatives have largely centred around divisions of general practice. Similar in some respects to New Zealand’s IPAs and England’s primary care groups they were promoted by the profession during the 1980s as a strategy to provide GPs with a stronger voice at both local and national levels. In 1992, a recommendation of “The Future of General Practice: a Strategy for the Nineties and Beyond” (National Health Strategy 1992) led to funding to establish divisions in the 1992–93 budget. By 1993, there were 100 divisions, covering about 80% of Australia; this has increased slowly to the present number of 123. Membership is now reported to be over 80%, depending on the definition of membership.

The government is seeking the following quality related outcomes from the Divisions of General Practice Program (DHFS, 1998):

- Improved evidence-based patient care;
- A sustainable and effective network of divisions of general practice;
- General practice involvement in addressing population health issues;
- Effective and ethical use of public resources; and
- Provision of performance information on population health, services to patients, services to members and infrastructure.

Initially divisions were funded through a system of project grants, which included provision for the setting up of consumer liaison groups. However, in 1996, planning began to move divisions to ‘outcome-based funding’. This method of funding, implemented in 1998, is based upon a long-term strategic plan and a business plan. This has had important implications for consumer participation, as discussed below.

A national body supports divisions, the Australian Divisions of General Practice Limited (ADGP), State-based organisations (SBOs) and rural workforce agencies (RWAs). ADGP is owned by and represents all 123 divisions of general practice. ADGP’s mission is to represent and support general practitioners through local divisions of general practice to improve the health of Australians (DHAC 2000).

Divisions to date showed little interest or involvement in corporate accountability for broader issues of quality including financial and cost-effectiveness. Such involvement is strongly opposed by the AMA, as it was in New Zealand by the NZMA in the early stages of budget holding.

However six divisions have recently applied for and received funding for pilot studies of clinical governance. Although not prominent in their proposal, this is inclusive of financial management, especially of pharmaceuticals. These initiatives, with a strong focus on quality but inclusive of financial accountability, signal a major change in the culture of the Australian medical profession. They have been significantly motivated by corporate and clinical governance developments in New Zealand’s PCOs and elsewhere.

8.5 Summary: the need for a change of culture

International experience discussed above shows a high degree of variability in the experience of clinical governance and clinical leadership. Some countries, such as the UK, have well-developed structures and others report little in the way of structures, such as the pilot and demonstration projects set up in Canada to promote coordination of primary care. (Hutchison, 2001). There is evidence even from countries active in the field (UK, US and Australia) that there is a need for further change in the culture of health organisations.

Where health care organisations are willing to change, heavily prescriptive approaches or those that serve primarily commercial needs are unlikely to encourage such change. Alternative strategies that rely on the concept of the ‘learning organisation’ (Senge, 1990) may be helpful here, and are reflected, for example, in the promotion of the concept in the NHS of the ‘organisation with a memory’ (Department of Health, 2000).
9. DEVELOPMENT OF CLINICAL GOVERNANCE AND RELATED QUALITY INITIATIVES IN NEW ZEALAND

9.1 Overview

It would seem to be important, for reasons elaborated on later, to distinguish between quality initiatives within provider organisations and quality initiatives external to the actual delivery of clinical care. However at this stage it needs to be stated that clinical governance may be a key part of a national clinical quality strategy, involving organisations external to the actual delivery system. But it can only effectively be implemented within the organisations actually delivering clinical services.

This section discusses developing initiatives within provider organisations both primary and DHBs. It also discusses the many initiatives external to clinical service organisations that have been developed, or are being developed, to promote quality within provider organisations.

9.2 Quality and clinical governance developments in PCOs

The term clinical governance has only been used in New Zealand since 1999. The most advanced form of clinical governance in New Zealand is found in PCOs. Some 85% of GPs are now in a variety of PCO structures, including IPAs, contracting practices, loose networks and community owned and driven organisations such as those represented by Healthcare Aotearoa. Studies of these developments have been undertaken and published (Malcolm and Mays, 1999; Malcolm, Barnett and Wright, 2000) and in a comprehensive report for the MOH and Treasury in 1999 (Malcolm, Wright and Barnett, 1999).

The key elements regarding clinical leadership/governance activities within PCOs, as shown by these studies, are as follows.

- Development of collective professional accountability for the management of clinical activity of members to improve quality and make better use of primary care resources.
- Management of new integrating relationships between members, between other primary care professionals and the community and between primary and secondary care.
- Implementation of a primary care infrastructure including staff appointments, an information system to computerise, merge and manage practice registers, analyse laboratory and pharmaceutical data and provide personalised feedback to members.
- Peer group formulation of clinical guidelines and monitoring of performance to promote better quality, evidence-based practice.
- Management corporately of an increasing set of primary and some secondary care resources to achieve better health outcomes for patients and communities
- Establishment of new forms of community and consumer participation.

Many of these developments have been established within a framework of budget holding for pharmaceutical and laboratory services. These involve a comprehensive range of strategies such as peer group discussions, formulation of guidelines, personalised
comparative feedback on utilisation, personal visiting by facilitators to promote quality behaviour, organisational incentives and developed within a clinical governance framework. Although financial savings were an important part of budget holding the primary goal was the promotion of quality use of these services.

Surveys of PCOs (Malcolm, Wright and Barnett, 1999; Malcolm, Barnett and Wright, 2000; Houston et al, 2001) have identified the following quality initiatives:

- **Quality and staff development**: These include continuing medical and nursing education, peer review groups, training for GPs in such items such as minor surgery, Maori consultation skills, motivational interviewing, business skills and professional accreditation.
- **Evidence-based service delivery**: Most PCOs are using strategies such as guidelines for prescribing and disease management, analysis and feedback on laboratory and pharmaceuticals, and disease and risk registers.
- **Clinical safety and effectiveness**: Establishment of risk registers and guidelines for disease management eg diabetes, asthma, respiratory illnesses, and registers and recall systems for screening and immunisation.
- **Cultural appropriateness**: Increasing attention to training in cultural appropriateness, including Maori consultation skills.
- **Responsiveness to consumer needs**: Increasing attention to this with a range of models including complaints policies and procedures, satisfaction surveys, setting up consumer liaison committees, conducting market research to establish needs and satisfaction levels.
- **Reducing access barriers**: Includes free services eg. terminal care, ultrasound, hardship funds and/or special situation benefits, reduction of barriers and linkages to a wide range of ethnic and community groups.
- **Management systems**: Many PCOs had developed or were developing a management system to provide continuous quality improvement, clinical safety effectiveness, computerisation to support registration recall, risk registration, the allocation of NHIs and patient enrolment.

Clinical governance developments in PCOs appeared to be so advanced in comparison, for example, with UK developments that Malcolm and Mays (1999) in a BMJ paper described IPAs/PCOs as working models of clinical governance. Anecdotal evidence indicates that these developments have continued to progress but slowly with ongoing discussion about the establishment and implementation of the national primary health care strategy, funding and contracting relationship for PCOs within DHBs and working out appropriate methods for funding and budget holding.

More recently the PCO First Health has given formal endorsement to clinical governance as a key quality strategy throughout its organisation. Other PCOs are also considering the use of the term clinical governance.

### 9.3 Quality and clinical leadership in community owned and driven PCOs

In recent years a number of non-government and non-profit organisations, described as “third sector”, have developed. They provide better access to primary health care services
for low income, Maori and Pacific populations with governance arrangements giving primacy to patients and consumers. Health Care Aotearoa (HCA) is a national organisation that brings together many PCOs providing third sector services for a population of over 100 000. Other non-HCA Maori and Pacific people PCOs serve another 50-60 000 people.

Important features of these third sector PCOs are that they:

- Serve predominantly low income, disadvantaged populations with high health needs
- Are all community owned and driven and subsidised both by community funding and voluntary labour
- Are providing care under adverse financial circumstances, with limited patient ability to pay fees, which compounds their disadvantage.
- Employ medical and other staff on a salaried basis which, with capitated/bulk funding, is fostering a team-based approach to primary health care
- Provide a wide range of new and culturally appropriate support services including health promotion and education.

There is clear evidence that such organisations are responding to meeting their community’s high health needs through providing comprehensive and integrated primary health care with a strong emphasis on quality (Crampton, 1999).

For example HCA has developed a comprehensive and well-organised quality programme, Te Wana, with significant funding from the MOH. It is based upon an Australian programme Community Health Accreditation Standards Programme (CHASP) adapted for use in New Zealand, including cultural appropriateness and recognition of the Treaty of Waitangi. Trained review teams visit and review member organisations based upon a process of self-assessment against standards. Each organisation is then scored and, where appropriate, recommendations made for improvements.

Community owned and driven PCOs are markedly different in their governance structures from GP-led PCOs. Leadership by clinicians may be perceived as relatively unimportant as clinicians, including doctors, are employed entirely on a salaried basis. However, the leadership role of individuals within organisations is not dependent on employment arrangements, and the collaborative approach of such PCOs will provide important models for multidisciplinary leadership and the involvement of communities. Maori PCOs have unique approaches to this and there are interesting initiatives where GP-led PCOs are working in collaboration with Maori PCOs, for example in West Auckland and North Shore.

9.4 Clinical governance and quality developments within DHBs

Clinical governance within HHSs/DHBs has been much more recent and tentative. This is not surprising. HHSs have been undergoing a major transition process to DHBs. However many if not most DHBs have considered the meaning and application of the term. For example Counties Manakau DHB has established a Clinical Board with broad ranging membership concerned with continuous quality improvement, clinical safety and effectiveness, adverse events and commitment to consumer participation. Counties Manakau DHB defines clinical governance ‘as the means by which the organisation
ensures the provision of quality care by making individuals accountable for setting, maintaining and monitoring performance standards (Malcolm, 2001).

Health Waikato has established a Clinical/Shared Governance Framework providing for clinical staff involvement in decision-making, comprehensive quality improvement, clinical audit, adverse events, etc. (Malcolm, 2001).

9.5 The role of DHBs and the non-government sector

Earlier discussions (Malcolm, 2001) indicated an emerging commitment on the part of DHBs to take responsibility for clinical quality/governance throughout the district, not just the traditional HHS structure. DHBs are seen as accountable for both clinical quality within the services they own as well as those within its contracting and integrating relationships in the non-government sector.

As yet few, if any, DHBs have progressed to the establishment of joint primary/secondary care clinical board/governance structures. The formation of such joint accountability arrangements for clinical leadership governance will be an important factor in integrating primary and secondary care which necessarily is dependent upon good-quality clinical relationships committed to better quality outcomes for the district as a whole. It would seem essential for DHBs, in their planning of quality and clinical governance strategies, to draw upon what has been learnt about clinical leadership/governance in primary care.

9.6 The Office of the Health and Disability Commissioner

The Cartwright inquiry of 1988 perhaps led to the most fundamental challenge to medical autonomy within New Zealand. It also led directly to the establishment of the Office of the Health and Disability Commissioner (HDC). Two reports from the HDC have played an important part in generating ongoing concern and action about quality in the New Zealand Health system. These are the report on Canterbury Health Limited (HDC, 1998) and Gisborne Hospital 1999-2000 (HDC, 2001). Both reports found organisations that were under considerable stress with serious conflict between clinical staff and management. As indicated above these system problems were responsible for, or were likely to lead to, the adverse events reported which led to in the initiation of the investigations.

The Annual Report of the Health and Disability Commissioner, 2000 (Paterson, 2000) notes that ‘the HDC complaints process is bogged down with relatively minor matters that do not warrant the time and expense of investigation by an independent public agency’. Follow up discussions with the Commissioner indicated a desire to see health service organisations, within a risk management, clinical governance strategy, to be developing procedures which ensure that complaints are dealt with as close to the source as possible. A process for reporting on adverse events and for dealing with complaints within DHBs, PCOs and other provider organisations needs to be part of a wider quality strategy.
9.7 The New Zealand Quality of Healthcare Study (NZQHS) and adverse events

The recently published pilot study of Auckland hospitals showed that adverse events were associated with 10% of hospital admissions (Davis et al, 2001). These findings were similar to those found internationally. Adverse events result in actual patient harm and were found to add nearly seven days to the hospital length of stay (Davis et al, 2001). Work is continuing on a New Zealand wide study.

Action arising from these studies should lead to the development of structures and processes focusing on prevention, recognising that what can be prevented should be. The action arising needs to be handled within a culture of ‘safety’ rather than a culture of ‘blame’.

As Davis points out, the unique no-fault environment in New Zealand has both its strengths and weaknesses in its effect on quality (Davis et al, 2001). Litigation is much less here than elsewhere. Although complaints to the Health and Disability Commissioner have steadily risen, the number going on to disciplinary proceedings has plummeted. The no-fault environment may reduce incentives for individuals and organisations to address quality, although evidence from studies indicates that this incentive is relatively weak (Davis et al, 2001).

Cull, in her ‘Review of processes concerning adverse medical events’ (Cull, 2001) states;

“Currently 14 organisations potentially can each undertake an investigation into the same adverse medical events, contemporaneously or cumulatively without reference to the other. This has led to a lengthy process with a multiplicity of agencies processing the same complaints, making the complaint process confusing, cumbersome, and difficult to access and costly, both financially and emotionally.”

She advocates of a range of solutions both immediate and long-term including ‘mandatory reporting of practitioners whose practice is below acceptable standards’. However these solutions appear to be much more focused on the ‘culture of blame’ rather than a ‘culture of safety’ which clinical governance requires. Coates (2001) states ‘in attempting to create the open, trusting and learning environment that will ultimately benefit patients, mandatory reporting may well be a step in the wrong direction’.

Resolving the issues identified would appear to require action within provider organisations, within a clinical governance strategy, before complaints reach the many external agencies identified.

The consultation document ‘Toward Clinical Excellence: Learning from Experience’ (Ministry of Health, 2001) has set out a system of reportable events which should begin to establish ways of identifying and addressing at least part of this problem. This must closely involve clinical leadership/governance functions within DHBs. Many if not most DHBs have established a system of reportable events but it is far from clear as to how effectively these are working.

Anecdotal evidence suggests that these systems may just be part of a fragmented system of quality initiatives, not part of an overall quality plan. As indicated above, adverse
events, along with ‘bad apples’ may only be a small part of the total quality picture. There are many other issues needing to be addressed within an overall framework of quality improvement. There is an obvious need for DHBs to be learning from one another, not only about risk management but also in progress towards developing comprehensive quality improvement strategies.

9.8 Credentialling

One of the most important and advanced national processes under way to promote quality improvement within the health system is the credentialling framework developed by the Health Funding Authority (HFA) and now the MOH. The resulting MOH/HFA document ‘Toward clinical excellence: a framework for credentialling of Senior Medical Officers in New Zealand (MOH, 2001) sets out a national framework for implementation, largely by DHBs.

Credentialling is defined in the document as:

“a process used to assign specific clinical responsibilities (scope of practice) to medical practitioners on the basis of their training, qualifications, experience and current practice, within an organisational context”.

This context includes the facilities and support services available and the service the organisation is funded to provide.

Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient. It is an employer responsibility, with a professional focus, that begins at appointment and continues throughout the period of employment.

It is seen as being linked to, but separate from, performance review. It is about competence to practice, not assessing performance as such. It is a clinically driven process that must involve clinical leadership/governance. Although substantial work has been completed on the development, and wide acceptance, of a national policy and strategy, implementation is still limited. Although only a minority of DHBs have made significant progress in implementing credentialling requirements it appears to be being actively promoted and is being linked to the accreditation process.

Credentialling is but one part of the jigsaw discussed below. In comparison with the many other actions and initiatives listed it is largely a process internal to the organisation rather than external. Furthermore it is essentially clinically, rather than managerially, led. Implementation, as for many other quality initiatives, will be critically dependent upon the development of an effective clinical leadership/governance accountability structure.

9.9 Quality Health New Zealand (QHNZ)

Quality Health New Zealand is the trading name of the New Zealand Council on Health Care Standards (QHNZ, 2001). It is the national accreditation body established by the health sector to help improve standards and performance of health and disability services. QHNZ undertakes surveys and audits and awards accreditation status to DHBs, hospitals, rest homes, mental health services, community and home care services, hospices,
disability services, primary care services, Maori health providers and non-profit organisations.

It is financed by fees paid by members of the Health Accreditation Programme for New Zealand (HAPNZ). It is governed by board of five independent directors nominated by the membership. It is part of and maintains close links that with an international network of accreditation bodies especially including Australia.

The HAPNZ is based upon QHNZ standards. These have evolved significantly over the last decade from a focus on structures through to the 2001 standards based upon six principles: client focus, leadership, teamwork, continuous quality improvement, best practice and process and outcomes management. The standards reflect government priorities in the national health strategy by incorporating:

- a service continuum structure
- a focus on the integration or coordination and linkages of services
- a wellness approach.

Accreditation now applies to a large proportion of New Zealand health services including services provided by DHBs. It is now widely regarded as a standard to be sought and valued. One limitation in the past is that it has being seen by some as largely driven by administrative rather than clinical values and hence did not achieve buy-in especially from medical staff. The new standards, with a much stronger clinical focus, should be perceived differently. They have an organisation-wide clinical focus, including credentialling, clinical risk management, clinical audit, etc, ie a broad clinical governance approach to promoting quality.

Furthermore the new standards are cross-referenced not only to the previous standards but also to the standards of the Health and Disability Safety legislation. It is understood that QHNZ accreditation will lead to certification under the legislation thus bringing some coordination within the quality jigsaw as discussed below.

9.10 The National Health Committee

The National Health committee has now become actively involved in the quality movement in New Zealand. A national workshop on quality was organised by the Committee in February 2001. The Report on the Workshop (National Health Committee, 2001) stressed:

- the need for a shared understanding and language relating to quality
- a national approach to quality to ensure consistency and avoid duplication
- the need to bring together the many initiatives currently underway
- the need for meaningful consumer participation at all levels
- special quality requirements for maori
- explicit recognition of the quality/cost trade-off
- the need for leadership at national level and within organisations.

The National Health Committee was given a mandate to take a leadership role in establishing a coordinated national approach to quality in health issues.
9.11 The New Zealand Guidelines Group

The New Zealand Guidelines Group was established by the National Health Committee in 1996 as a formal network of expertise and information on guideline development and implementation (see http://www.nzgg.org.nz). It became an incorporated society in 1999.

The primary purpose of the group is to train health and disability professionals and consumers in the development and implementation of evidence-based best practice guidelines. The long-term aim is to help facilitate a culture change among all stakeholders in health care and disability support to improve the quality, effectiveness and equity of service provision.

How far the Group is succeeding in achieving these aims is far from clear. No formal evaluation has been undertaken of their activities. Anecdotal evidence, along with evaluation of pharmaceutical management, and the place of guidelines in this management in PCOs, suggests that unless guidelines are part of a comprehensive strategy their effectiveness may be limited. Clinical leadership, using clinical guidelines as part of a comprehensive clinical governance process, would appear to be essential in achieving better quality outcomes.

9.12 The Clinical Colleges: the example of the Royal New Zealand College of General Practitioners (RNZCGP)

The clinical colleges are a key piece of the quality jigsaw referred to below. The RNZCGP however appears to be the first to state its support for clinical governance. The RNZCGP Council recently resolved that the College shall work with primary health organisations to develop a framework for clinical governance in New Zealand (Wiles, 2001).

The College sees clinical governance as including the following:

- Extending the work of GPs through continuing medical education and continuous quality improvement
- Responding to increasing demands for public accountability from all parts of the health sector, both public and private.
- Increasing the quality of service provided to patients eg through improving immunisation rates
- Introducing systems for detecting, discussing and learning from significant events
- Involving patients in discussions about performance measures.

They see clinical governance as having potential to improve quality of care and reinforce patient confidence in quality. Requirements to further these aims include the need for additional resources to be invested in promoting clinical governance and a national framework as part of the implementation of the primary care strategy.
Wiles (2001) states,

“While we have some misgivings as to the term clinical governance whether the term clinical governance accurately explains the process, we not nonetheless support the concept.”

The College, in order to promote quality in general practice, has embarked upon promoting accreditation of general practices (RNZCGP, 2000). A set of standards have been produced with 49 indicators including; the rights and needs of patients, access and availability, barriers to access, practice facilities and systems, practice and patient management, human resource management, professional development and research. It is understood that this is still being piloted.

These indicators, however, are much more focused upon structures, and to some extent processes, rather than the outcome focused indicators established by some PCOs.

9.13 The need for integration: the ‘quality jigsaw’

In an article ‘Accepting the Challenge’ former HFA Board Chairman Syd Bradley (Health Funding Authority, 2000) lists and discusses the many current initiatives to address quality. He describes them as pieces of the jigsaw in the quality picture.

‘The health system has not focused in a comprehensive manner on issues of quality. Some pieces of the quality picture are now in place and others are under construction. But substantial gaps remain and many of these are becoming increasingly apparent both to the sector and to the New Zealand public.’

The above discussion lists some of these pieces of the jigsaw. Other listed by Bradley as pieces in place or ‘construction’ are;

- the Health Professionals Competency Assurance Bill, bringing all registered health professionals under one regulatory umbrella and promoting ongoing professional development.
- the ACC, investigating claims for medical error and misadventure.
- the medical council, investigating complaints about professional practice.
- the Health and Disability Services Safety Bill, which will replace current licensing requirements and introduce national standards.

He might also have added;

- the clinical colleges as accrediting and re-certification bodies,
- the nursing council and other accrediting and standard setting professional bodies
- and possibly others.

As discussed above, the important feature about almost all of these legislative, accrediting and related functions is that they are largely external to the clinical service organisation in addressing clinical quality.
Clinical governance would appear to have a unique role in bringing all of these quality initiatives together at the operational level and placing implementation within the hands of clinical leaders.

Bradley goes on to state;

“Perhaps the biggest gap in healthcare quality is the absence of an overarching strategy for quality improvement that will determine the major quality vision and framework. This could provide a platform for agreement about what is good, what is bad, and what needs to be changed if we want to ensure quality in the New Zealand health system.”

He concludes by stating that

“the challenges for the central agencies are to bring together the pieces of the jigsaw and to make sure that - when the jigsaw pieces are assembled - we have constructed a comprehensive picture of quality.”

The need for this ‘overarching framework’ eg a national policy and strategy, was taken up by the National Health Committee in a national workshop on quality referred to above.

Clinical leadership and clinical governance may be an important, perhaps central piece of the jigsaw. Figure 9.1 sets out an overview of various jigsaw pieces showing how these influences can be brought together, through clinical leadership, to impact on good quality patient care. The figure also shows increasingly demanding political, legislative and consumer influences seeking to impact upon quality. These actions are external to the health system and hence remote from the actual delivery of patient care.

9.14 A role for CLANZ

Given the international move towards clinical governance CLANZ was invited, in its first contract with the MOH, to produce a discussion paper on the topic. Robin Youngson prepared this after broad-based consultation with a range of the key stakeholders and CLANZ members. The final discussion document was produced in February 2000 (CLANZ, 2000).

Important features of this discussion document were:

- A definition of quality of care and its relationships to hospital accreditation, patient satisfaction surveys, etc
- The use of the New South Wales quality of care categories, i.e. effectiveness, appropriateness, patient safety, access, consumer participation, efficiency
- A discussion of the characteristics of quality in health care organisation
- Stressing the importance of a systems approach to quality.
The document discussed the meaning of governance and proposed the following definition of clinical governance for New Zealand.

“Clinical governance is organisational accountability for clinical performance, health outcomes and effective use of resources, including the systems which regulate clinical activity, ensure patient safety and promote the highest standards of patient care.

Clinical governance focuses on health outcomes, requires consumer participation and supports organisational learning and development.

Clinical governance ensures that the limited resources are utilised to maximise the health gain of people served by the Hospital Health Service. Strategic business planning must include the development of clinical services to achieve objectives in health status as well as financial performance.”
The document stressed the importance of organisational learning and growth. It pointed out that, whereas in the UK a number of organisations were responsible for clinical governance, no such organisation existed in New Zealand. It called for a national body to be responsible for the implementation of clinical governance and promoting and sharing information between organisations.

CLANZ would appear to be in a unique position to promote and develop clinical leadership development within New Zealand for the following reasons;

- although a new body it already has a significant track record in promoting clinical leadership
- it has been financially supported by the Ministry of Health as a significant body in addressing quality and clinical leadership issues
- it has undertaken a series of projects to promote clinical leadership
- it is establishing strategic relationships with many key stakeholders in the health sector
- it is the main national body actively working to promote clinical leadership development within clinical care settings
- it is a multi-disciplinary body bringing together a wide range of clinical, managerial, governance, policy and research expertise and experience.
- it has taken a strong advocacy role in promoting consumer participation.
10. CLINICAL GOVERNANCE: AN OVERVIEW AND WHERE NEXT?

10.1 Clinical governance - an overview

The above discussion has demonstrated that the term clinical governance, although originating within the UK and accepted as government policy there, is now being widely used both within Australia and New Zealand. Within New Zealand the term has been formally adopted by the RNZCGP, a number of DHBs and PCOs.

However uncertainties remain because:

- It is seen by some as a clinical takeover of corporate functions, ie governance by rather than of clinicians
- It may be seen by clinicians as a corporate takeover of the control of their clinical decision making.

There is clearly a need for a New Zealand definition and strategy for clinical governance.

There is a close relationship between clinical leadership and clinical governance. Clinical governance is a substantially broader concept than clinical leadership. Clinical leadership is encompassed within clinical governance. Clinical governance formalises the role of clinical leadership within an organisational setting. Clinical leadership can exist without clinical governance, but clinical governance is vitally dependent upon clinical leadership.

Clinical governance based upon a convergence and integration between corporate and clinical values and goals.

10.2 What is new in clinical governance?

Some have said that clinical governance is nothing new: it is just old wine in a new bottle! This is only partly true. While clinical governance contains many elements of clinical quality strategies, eg clinical risk management, clinical audit, continuous quality improvement, etc, the new feature of clinical governance is that it is a comprehensive, organisation wide strategy. As discussed above by Walshe (2000a) the key elements are;

- Corporate accountability for clinical quality, bringing clinical governance into corporate governance
- A whole systems approach to quality improvement and delivered as an organisation wide strategy
- Integration of all quality improvement activities in a co-ordinated and coherent structure.

10.3 Comparison of clinical governance in New Zealand and elsewhere

Clinical governance as it is emerging in New Zealand shows some fundamental contrasts with the UK as shown in Table 10.1. One key difference is that policy within the UK
NHS is handed down from government. In contrast most New Zealand developments in health, at least those that have been successful, have evolved from a bottom-up approach.

Table 10.1 Contrasts between clinical governance in the UK and New Zealand

<table>
<thead>
<tr>
<th>Feature</th>
<th>UK</th>
<th>NZ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driven by</td>
<td>Government policy</td>
<td>Bottom up development</td>
</tr>
<tr>
<td>Clinical leadership</td>
<td>Usually involved</td>
<td>Key driving factor especially in primary care</td>
</tr>
<tr>
<td>Integration</td>
<td>Substantial with top down approach</td>
<td>Poorly fitting pieces of a jigsaw</td>
</tr>
<tr>
<td>Clinical accountability for quality</td>
<td>Increasing</td>
<td>Substantial</td>
</tr>
<tr>
<td>Clinical accountability for cost</td>
<td>Slight</td>
<td>Significant and increasing</td>
</tr>
<tr>
<td>Organisational accountability</td>
<td>Tends to be passed down to lead</td>
<td>Driven from governance level especially in PCOs</td>
</tr>
</tbody>
</table>

Similarly clinical leadership/clinical governance within New Zealand has developed largely within provider organisations, especially in primary care. There has been relatively little government funding, or even recognition of the value, of clinical leadership. The funding of CLANZ has been an important breakthrough. There still appears to be a lack of understanding that clinical leadership in primary care is driven by professional rather than commercial values.

Developments within the UK have been part of a coherent national strategy with comprehensive support systems and significant funding being put by government into implementation and evaluation of the strategy.

Another important contrast is that clinical accountability, for both quality and cost, is much more advanced in New Zealand than in the UK. Halligan (personal communication, June 2001) stated:

“With regard to clinicians seeing the management of quality as inclusive of financial management, there is a commitment to convergence of clinical governance and controls assurance under an umbrella of corporate governance. The mutual paranoia (clinicians versus managers), although much better hidden than previously, rears its unpleasant face at various times in this convergence, depending on which of the two agendas appears to have the upper hand at a given moment.

My impression is that, ultimately, and sooner than people think, the two will converge. However, everything is about timing and if the academic intellectualisation of convergence was to precede the winning of hearts of minds (particularly among clinicians) on convergence, then there is a real chance there could be disengagement by clinicians of corporate accountability for clinical performance. “

This convergence of clinical and corporate values is also a critical factor in New Zealand. However there are indications that this convergence is advancing in many DHBs. It has
been inherent within PCOs for a number of years with clinicians being both clinical and corporate leaders.

10.4 Clinical governance and community participation

The discussion above noted that a key part of governance is accountability to the community served by the organisation. It also noted the important developments towards community and consumer participation developing especially in PCOs, a few of which are community owned and driven. The New Zealand national primary health care strategy seeks to build on these trends.

Evidence is accumulating from New Zealand and overseas that community and consumer participation is a key component of a quality driven health system (Malcolm and Medawar, 2001). Recent reports from the Consumer Focus Collaboration, referred to above as a key part of the Australian national strategy for quality, provide evidence that active consumer participation and decision making lead to:

- improvements in health outcomes
- more accessible and effective health services
- can be achieved through a range of models and methods
- can involve those traditionally marginalised by mainstream health services
- is integral to the successful development, implementation and evaluation of health strategies and programmes (Consumer Focus Collaboration, 2001).

An Australian review of consumer participation in the quality use of medicines noted the importance of not only involving consumers but also bringing consumers and clinical leaders together through, for example, divisions of general practice (Malcolm and Medawar, 2001). This could be an important factor in achieving gains in both quality use of medicines and reducing the current dramatic growth in medicine costs.

Relatively little work has been undertaken in New Zealand to explore and document consumer participation. There has been some documented progress in this area, for example, the partnership between the Wellington Mental Health Consumers’ Union, Capital Coast Health and the Wellington Independent Practitioners Association (WIPA, 2000). The evaluation of the national pilot programmes for integrated care (Health Services Research Centre, 2001) demonstrated the importance of consumer and community involvement, particularly in relation to Maori. The report noted that levels of engagement varied, and that true partnerships developed only when there was involvement at all levels of decision-making: operational, management and governance. Clinical leadership can be a critical factor in driving such developments.

There is a need in New Zealand for an independent body to promote consumer participation, eg modelled on the Australian Consumers Health Forum. Consumer participation should be an important part of the national strategy on quality discussed below.

10.5 Developing clinical leadership

The discussion above has consistently noted the importance of clinical involvement through clinical leadership as a key factor in the successful implementation of quality
improvement strategies. However it has also noted that education and training to develop skills in clinical leadership have been widely neglected. Within New Zealand there is almost no sharing between DHBs or PCOs of the wide experience which clinical leadership has accumulated or of quality developments generally.

The successful development of clinical leadership and clinical governance in New Zealand could be the centrepiece of a national strategy for quality improvement. CLANZ can contribute to developing concepts of clinical leadership and clinical governance, and promoting clinical leadership. A key part of a national strategy might be the establishment of a national centre for health leadership development bringing together clinical leaders, management and DHB board members to promote the convergence referred to above.

Such investment by government in health leadership would appear to be fundamental to the further successful development of the New Zealand health system and implementation of a national strategy for quality. Associated with this is the need for a national research, development and evaluation strategy for clinical leadership development. Despite its importance relatively little is as yet known, either in New Zealand or internationally about effective models of clinical leadership and what works in addressing quality issues, including how to change clinical behaviour.

10.6 The need for a national strategy

As noted above there is widespread concern about the current fragmented efforts to promote quality within New Zealand health system. Bradley (Health Funding Authority, 2000) sees the need to bring the fragmented pieces of the ‘quality jigsaw’ together to build a complete picture of a quality strategy. A key central piece of this jigsaw is clinical leadership and clinical governance, a piece which is still under construction.

The New Zealand Public Health and Disability Act 2000 requires the Minister of Health to determine a strategy for standards and quality for health services and consumer safety and to report annually on progress in implementing the strategy. A number of initiatives are underway to develop the strategy, the lead role at this stage being with the National Health Committee.

Some of the key components of such a strategy, particularly clinical leadership and clinical governance, have been referred to above. The experience of other countries, particularly the UK and Australia will be of relevance to a New Zealand strategy. As noted quality improvement within health systems, including New Zealand, has become an international movement. Further work is already underway, as part of this ‘Leadership for Health’ project, to document the many quality initiatives within DHBs and PCOs.

It is now the job of the Ministry of Health, together with the National Health Committee, to identify and draw on the many pieces of the ‘quality jigsaw’, and to bring these together to build the quality picture which is now urgently needed within New Zealand health system.
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Appendix 1 Support Systems for Clinical Governance for England and Wales

1. National Institute for Clinical Excellence (NICE)

The role of NICE is to provide patients, health professionals and the public with authoritative and reliable guidance on current “best practice”. Such guidance focuses on relevant technologies (medicines, diagnostic techniques and procedures) and the clinical management of specific conditions. To achieve this NICE has established a web-site for electronic help, publishes clinical guidelines, has established “referral practice pilots” and appraises technologies. (Information from web-site http://www.nice.nhs.uk/, accessed June 2001)

2. Commission for Health Improvement (CHI)

The Health Act 1999 set up this commission to periodically review clinical governance arrangements in the NHS. CHI works at both national and local level of NHS organisations to monitor and improve clinical care throughout England and Wales. Part of its work is to examine serious system failures within the NHS related to the management, provision, quality and availability of health care. However, it also undertakes investigations to assists organisations improve patient care. This is done through a four year rolling programme of visits to every NHS Trust and health authority. The organisation has designed a review process that allows it to assess:

- Who is accountable for the quality of patient care and making the accountability systems work
- The systems and processes for monitoring services
- The systems and processes for improving services.

CHI works in conjunction with health professional councils and societies as the police, coroners, universities, the Health Service Ombudsman, NHS regional offices and other regulatory and professional organisations. This is achieved through regular meetings with these bodies (Penny 2000a; CHI, 2001a & b)

3. Clinical Governance Support Team (CGST)

The CGST was set up in August 1999 to provide additional support, training and development for organisations and staff involved with clinical governance. It arose because early commentators on progress noted that difficulties were being experienced in the implementation of clinical governance (Penny, 2000b). Wright et al (1999), Fitz-Cohens (1999), and Baker et al (1999) all observed that despite the overall atmosphere of goodwill there were large issues regarding cultural change, upskilling of staff and clinical leads relative to leadership and communication for example. They also identified a shortage of time, insufficient knowledge about clinical governance and evidence-based practice etc. The CGST has three main aims (NHS, 2000a & 2000b: Halligan and Donaldson, 2001):

- To heighten the awareness of clinical governance by the provision of information
- To provide a practical development programme for health care professionals
To aid in the acceleration of the implementation clinical governance. The CGST is based in Leicester and offers practical support such as: training programmes, a help-line to deal with general enquiries and to provide information on its activities, and a web-site with up-to-date information on clinical governance and its implementation, examples of best practice and on-line access to the CGST.

4. Joint work by government, Department of Health and the medical profession

The government, Department of Health and the medical profession have worked jointly to develop and disseminate clear standards for professional practice and national service frameworks (NHS, 2001). The GMC has developed proposals for a new five yearly check before renewing a doctor’s licence to practice in conjunction with annual NHS performance appraisals. The professional medical colleges have established continuing professional development programmes to support individual staff in extending their knowledge and skills.

5. Guidance and support from the Royal College of Nursing

The Royal College of Nursing in the UK has been an active supporter of nurses in clinical governance. In 1998 a round of discussion groups was held with senior nurses. The feedback from these sessions was used to inform the council’s policy position on clinical governance and then to shape an initial guidance paper for nurses (Royal College of Nursing, 1998).

More recently the council held a second round of discussion groups to explore experiences to date with clinical governance. Discussions have covered such items as how nurses have been involved, areas where they feel they are doing well, barriers that had been encountered, and skills they feel they mostly to development. The early results of this led to a second guidance paper on clinical governance (Royal College of Nursing, 2000)

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