

CLINICAL LEADERSHIP AND QUALITY IN DISTRICT HEALTH BOARDS IN NEW ZEALAND

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

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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

1. District health boards (DHBs) are the centrepiece of the Labour/Alliance government's health reforms. They bring together, in one organisation, almost all the funding and provision of health and disability services for their defined populations. Their primary goal, within the New Zealand Health Strategy, is to achieve better health outcomes for their district populations.
2. As part of the international movement to achieve better clinical quality outcomes there is an expectation and requirement that DHBs build an integrated, quality driven culture. There is emerging evidence of significant quality initiatives and of the important role which clinical leadership is playing in their promotion and implementation. Clinical leadership may be defined as leadership by clinicians of clinicians.
3. However almost no studies have been undertaken to document these quality initiatives, to identify the key drivers and the extent of progress. This project, scanning clinical leadership and quality initiatives in selected DHBs, seeks to fill this gap. It was commissioned by the Clinical Leaders Association of New Zealand (CLANZ) as part of its contract with the Ministry of Health.
4. It is the third of a 'trilogy' of studies, the first examining quality initiatives and clinical governance internationally, the second a parallel study of clinical leadership and quality developments in primary care organisations (PCOs).
5. The overall aim of this study was to document and analyse organisational arrangements within 10 selected DHBs, the role of clinical leadership within the changing arrangements, clinical quality initiatives and processes, and to seek views on the use and meaning of the term clinical governance.

Development of DHBs

6. Clinical leadership has evolved over the last 20 years within a framework of service groupings based upon clinical specialties, medical, surgical, child health, etc. This development has seen increasing involvement of clinicians in management and a new form of collective professional accountability, replacing the traditional individual autonomy of the medical profession.
7. Progress towards this accountability was set back in some situations with the 'clash of cultures' experienced during the commercially driven reforms of the 1990s. As a consequence there were serious effects upon clinical quality from which recovery is still in progress.
8. In line with the New Zealand Health Strategy DHBs provide a new and important opportunity for clinical leadership to work with management to achieve quality improvements. These include new structures and processes, progressive devolution to

clinical services for defined responsibilities and building new and integrating relationships especially between primary and secondary care.

Methods and sources of information

9. In order to achieve the objectives of this project all DHBs were contacted and invited to comment and participate. Ten DHBs was selected representing a broad range of populations and settings and were personally visited for discussions regarding the project.
10. There was full co-operation in setting up interviews, providing information including a 'signed off' report. Reports upon which the following overview is based were received from; Northland, Auckland, Counties Manakau, Waikato, Lakes, Hutt Valley, Capital and Coast, Nelson/Marlborough, Canterbury and Otago.

DHB organisation

11. It was consistently stated that accountability for clinical quality was located within the clinical divisions. An understanding was therefore needed of the organisation of clinical services within the DHB provider side.
12. The most common organisational model, under the CEO, is a COO or general manager of the provider side. Reporting to the CEO or COO is a chief medical officer/advisor (CMO/A) and chief nursing officer/advisor (CNO/A) or equivalent. These were seen in most DHBs to be key positions, particularly in the promotion of clinical quality throughout the organisation.
13. Under the CEO or equivalent, all DHBs had some form of clinical organisation, both major clinical divisions and clinical subdivisions. However the number and composition varied widely.
14. In almost all situations there is a strong emphasis upon a partnership, either actual or developing, between clinical leaders/directors and management. Accountability for both quality and cost is seen to be a joint activity to which both managers and clinicians are 'signed up'.
15. There is increasing devolution of decision-making to clinical services for both clinical and financial accountability. However the scope and implementation of devolution varies widely. Direct service expenditure, including nursing, is largely devolved but only in a minority of DHBs is there devolution of clinical support services and overheads.
16. Nursing budgets are largely devolved to clinical service groupings, thus removing the CNO/A from direct nursing management. Only in a minority of DHBs is a nursing director partnered with the clinical (medical) director and manager. There is much variability and consequent uncertainty in the way nursing services are being organised. The pros and cons of a more devolved nursing service are reviewed.

Quality initiatives and achievements in DHBs

17. Most DHBs have now established, or are establishing, formal organisational support systems for quality improvements including; clinical boards/groups, clinical improvement/advisory/executive committees and associated quality and risk managers. Some DHBs are including the non-government sector in quality improvement strategies.
18. While all DHBs have quality plan requirements as part of their contract only five mentioned these. There is increasing commitment to, and implementation of, quality and risk management programmes, accreditation, clinical audit, credentialling and developing quality frameworks. Integration of clinical and financial management is seen to be an important part of quality.
19. A wide range of quality achievements were reported by DHBs. These included;
 - changes in the organisational culture, eg greater openness and moves towards a culture of safety
 - a growing partnership between clinicians and management including a move away from a strictly 'business' approach to quality
 - integrating previously disparate quality efforts into single coherent quality system
 - implementation of an effective adverse incident system, working towards accreditation, credentialling and clinical audit
 - appointment of staff dedicated to quality.
20. Factors that facilitated these achievements included;
 - experience of accreditation, appointment of specific staff to be responsible for quality, the ability to provide resource tools and incentives, the integration of clinical and financial management, adverse events giving greater attention to quality.
21. On the other hand progress was hindered by;
 - resource constraints, inadequate time for clinicians to participate, shortage of leadership skills and past conflicts leading to mistrust between clinicians in management.

Clinical advisory functions

22. The establishment of CMO/A and CNO/A positions at the senior executive level of the DHB on the provider side, has led to a new avenue for clinical advice. These positions are also seen to be important in providing clinical leadership for quality improvements in DHBs.
23. Medical advice and participation is increasing with the involvement of clinical staff at leadership level in management. This is resulting in a diminishing need for medical and other staff associations. However there is still a sense of disempowerment among some clinicians, aggravated by continuing and increasing funding shortages.

Clinical governance

24. Only three DHBs, Auckland, Counties Manakau and Waikato have formally adopted clinical governance as a policy and are using the UK definition, or a modified version. However almost all DHBs surveyed are implementing typical clinical governance processes driven strongly by clinical values and aspirations, with clinical leadership playing a key part.

Overview and reservations

25. Reservations need to be expressed about the nature and quality of information drawn upon. Funding and time constraints precluded a more detailed review. The views presented may not be those of others in the organisation, including of clinicians generally. Perceptions of relationships, and progress with quality initiatives, may vary widely between different levels within DHBs.
26. Nevertheless the views from the top, including of CEOs and other key people are important. They represent a commitment, to if not actual achievements, in quality and relationships. A more detailed review is needed of the actual roles and responsibilities of key leaders, both clinical and management and perceptions from other levels within the DHBs, to gain a better picture of progress with quality improvements.

Organisational devolution

27. There is a clear continuing, but widely varying, trend towards devolution of decision-making to clinical groupings. The interests of both managers and clinicians are advanced with this process. There is increasing evidence that better quality is not necessarily associated with higher lower costs. Only clinicians are in a position to know whether foregoing a particular intervention will impair quality and where the resources saved might be used to achieve significant health gains.
28. There are continuing uncertainties about the devolution of nursing budgets and management to service groupings. Advantages include nurses becoming recognised as full members of health care teams and the flexibility of including nursing in the overall clinical budget. Disadvantages include limiting flexibility in the overall use of the nursing workforce and possible subservience of nursing skills and perspectives to medical and management interests.
29. These disadvantages may be minimised with a clear leadership role from the CNO/A, appointment of nursing directors to full partnership in service management, the use of nurse consultants working with service divisions and after regular hours nursing distribution coming under the CNO/A.

Organising for quality and sharing experience

30. It is clear that all DHBs are making significant efforts to improve clinical quality and have made important progress. However there is continuing uncertainty about the best forms of structuring quality processes and how they should be organised, managed and funded.

31. Despite these initiatives and emerging achievements there is a remarkable lack of sharing of this experience and the lessons learnt. Relatively little appears to have been done to document quality achievements in DHBs, either by DHBs or national bodies. There is a serious lack of evaluation in the New Zealand health 'culture'.

Clinical leadership - a new role for clinicians

32. This review has noted the growing importance of clinical leadership as a critical factor in promoting clinical quality. It has also noted that clinical leadership may be found at three levels; executive ie CMO/A and CNO/A bringing a medical, nursing and broader clinical perspective into top executive decision-making.
33. Secondly clinical leadership is found at a broad service level where it is significant and demanding. At the third subservice level clinical leadership may be less demanding and less developed. A key feature of clinical leadership at all levels is the need to maintain a respected and valued relationship with 'rank-and-file' colleagues.

Towards a convergence of governance/management and clinical cultures

34. In almost all DHBs there is evidence of an intention to build a partnership between governance/management and clinical cultures. Progress with this partnership is dependent upon a shift on the part of both cultures. A successful partnership will be based upon common goals, a commitment of both parties to clinical and financial accountability and to better health outcomes for patients and communities.
35. A convergence is also needed within clinical cultures, ie between disciplines, primary and secondary care and personal and disability care. Important lessons in developing this convergence, including accountability for quality and cost, can be drawn from primary care.

Building a new leadership culture

36. Despite the wide range of quality initiatives being implemented there is a remarkable lack of sharing of the experience being gained. It is clear from the study that there is a need for a national research, development and evaluation strategy for clinical leadership development, including learning from and building on this experience.
37. Building a new leadership culture, not only within the DHB system but also in primary care, would appear to be a critical factor in the success of DHBs. It would assist in bringing together the currently divergent cultures of primary and secondary care, personal, public health and disability and of different disciplines.

2. INTRODUCTION

2.2 Factors leading to this study

District health boards (DHBs) are the centrepiece of the Labour/Alliance government's health reforms. Established in December 2000 they bring together, in one organisation, almost all funding and provision of health and disability services for their defined populations. Within the framework of the New Zealand Health Strategy the primary goal of the DHB system is to achieve better health outcomes for populations of DHB districts.

DHBs replaced the former system of separate purchasers and providers. Although all purchasing functions were integrated under one funder, a commercial focus led to a fragmented provider system. In some situations it also resulted in a conflict of goals between governance and management cultures on one hand and clinical cultures on the other. This conflict had serious adverse consequences for clinical quality, as will be discussed further below.

DHBs are a fundamental contrast to the system they are replacing. There is a strong emphasis upon integration of hospital and community care, of primary and secondary care and personal, public health and disability support services. Anecdotal evidence has been emerging that the new system is building relationships of a kind which are likely be much more successful in achieving a quality, outcome focused culture. There is increasing evidence of the important role which clinical leadership is playing in building new accountability arrangements in this culture. Clinical leadership is defined in this review as leadership by clinicians of clinicians.

Concerns about clinical quality in health service organisations and attempts to improve quality have become an international movement. Major initiatives, such as quality committees, credentialling and a system of reportable events, have been established within DHBs to promote clinical quality. Clinical leadership plays an important part in such initiatives.

There have been major recent initiatives to improve quality within the New Zealand health system. These have been reviewed in Wright et al (2001). A bibliography of published reports and discussion documents is attached. The National Health Committee has just produced a discussion document Safe Systems Supporting Safe Care (National Health Committee, 2001). The Government is currently seeking feedback on a discussion paper 'Quality Improvement Strategy for Public Hospitals'(2001).

Despite these important developments almost no studies have been undertaken to:

- specifically document and analyse these quality initiatives
- identify key drivers
- determine the extent of progress in quality initiatives.

2.2 This project

This project scanning clinical leadership and quality initiatives in selected DHBs was commissioned by the Clinical Leaders Association of New Zealand (CLANZ). It is one

of a 'trilogy' of studies to examine and extend the role of clinical leadership in promoting clinical quality within New Zealand and internationally. The two other reports are:

- a literature and experience review of New Zealand and international experience in this field (Wright et al, 2001),
- a scan of clinical leadership and quality initiatives in 12 selected primary care organisations (PCOs) paralleling the current study (Malcolm et al, 2001).

Given the limitations of time and funding a scan of 10 selected DHBs, rather than a detailed study, was all that could be realistically undertaken.

The overall aim of this study was to:

- document and analyse the organisational arrangements within 10 selected DHBs
- document the role of clinical leadership within the changing arrangements and the clinical quality initiatives and processes
- seek views on the use and meaning of the term clinical governance.

More specific objectives were to review and report on:

- the background, development and organisation within each DHB
- the range of quality initiatives being implemented
- the role of clinical leadership in initiating and driving quality
- the main achievements in quality and the associated facilitating and limiting factors
- education and training programmes to promote quality
- the extent to which clinical governance, either formally or informally, is being developed within DHBs.

3. THE DEVELOPMENT OF DISTRICT HEALTH BOARDS

3.1 Historical background

A previous publication in this ‘trilogy’ has discussed the historical background to the development of the current DHB system (Wright et al, 2001). Table 3.1 from this report summarises developments from the 1970s, 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 both top management and service level.

Table 3.1 Key events/processes and associated outcomes in the evolution of clinical leadership in the public secondary care sector New Zealand

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

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). Progress towards devolution to these groupings was being achieved through area health boards during their brief existence from the late 1980s to 1992.

An important development, which did much to progress a more integrated learning culture in area health boards, was the formation of the Health Services Management Development Unit (HSMDU) in 1989. This brought together, within a learning environment, top and middle managers from boards and the Department of Health to share experiences, to

develop managerial competence and to build a more devolved and population-focused health system. It also did much to promote and clinician involvement in management.

A 1993 survey of top managers, just prior to the formation of Crown Health Enterprises (CHEs) showed that 71% felt they were operating within a general management model and only 9% within a clinical directorate model (Malcolm and Barnett, 1995). The clinical directorate model appeared then to be more applicable to the sub-groupings of medicine, surgery etc, i.e. cardiology, orthopaedics etc. There was increasing involvement of clinical leadership in these developments.

3.2 The 1990s reforms

A significant setback to these trends occurred as a consequence of the reforms of the early 1990s. The government appointed commercially-focused CHE boards and 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 chief executive officers (CEOs) from the business sector often with little understanding of the 'business of health'.

An MBA became the preferred qualification for senior management appointments. HSMDU was disbanded on the grounds that commercially driven incentives would support management development activities, an assumption that proved to be flawed. Commercial sensitivity reduced collaboration and sharing between CHEs.

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 (Health and Disability Commissioner, 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 commercially-focused boards remained.

The new DHB system presents an important opportunity for clinical leadership. Key features in this new situation are:

- A set of common goals, as specified in the New Zealand Health Strategy, 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.

This project has sought to explore these features in 10 DHBs.

3.3 DHB establishment and structure

The New Zealand Health Strategy, announced by the government in 2000, strongly emphasises health system goals, equity in access, capped population-based funding and the decentralisation of operational decision-making to DHBs (Minister of Health, 2000). There is a full commitment to integration. The government has stressed accountability at all levels including the accountability of clinicians for the quality of the health care they provide.

At the governance level the government has specified through legislation that DHBs have a mix of elected and appointed members. Three advisory committees are required:

- hospitals
- primary and community services
- disability support services.

However, each DHB can decide on its own organisational structure. Most DHBs have decided to operate a separate contracting/funding section under a general manager, reporting to the CEO, and the continuation of the provider side under a chief operating officer (COO) also reporting to the CEO.

Some DHBs have indicated an intention to move beyond this interim structure. Northland for example has already moved to establish two basic divisions — primary and secondary care. The general manager primary care is responsible for overall leadership and strategic planning of the whole primary health care sector, both government and non-government.

3.4 Progress with DHB development

Since their formation there has been steady progress with DHB development. This includes the establishment of governance structures and committees, progressive devolution of funding for defined responsibilities and initiation of strategic planning functions. Also, for most DHBs, it has meant the development of new relationships and partnerships, including with primary care.

However progress has been restricted by severe financial limitations with many DHBs expecting to increase their debt by borrowing to cover their operations for the current financial year. These restrictions have raised anxieties amongst clinical staff and may have interfered with progress towards the developing partnerships between clinicians and management. As will be discussed later these constraints may have placed clinical leaders in a more difficult position in attempting to build these partnerships.

4. METHODS AND SOURCES OF INFORMATION

In order to achieve the objectives outlined in section 2.2 above, a detailed plan was prepared by the study group. A background statement (Appendix 1) was prepared and sent to all DHBs inviting comment and participation. A relatively low level of response was received from this initial contact.

It was decided that 10 DHBs would be approached individually and invited to participate through personal discussions and visits. A list of topics considered important to achieve the objectives was prepared and presented to DHB management in the course of face to face discussions. Discussions almost always included the CEO, COO, chief medical officer/advisor, chief nursing officer/advisor and the quality manager.

In many cases discussions were taped as were follow-up telephone interviews with key informants from each DHB. Documents were requested including annual reports, strategic and quality plans and other relevant information. Web-sites were also visited where available. Draft reports were prepared and sent back to nominated individual(s) for additions or amendments and subsequent ‘signing off’.

The DHBs visited are as follows. Reports relating to individual DHBs are contained in Appendix 2.

- Northland
- Auckland
- Counties Manakau
- Waikato
- Lakes
- Hutt Valley
- Capital and Coast
- Nelson/Marlborough
- Canterbury
- Otago

Despite the pressures on DHBs, all the DHBs approached by the authors offered full support. There was full cooperation in setting up interviews and providing follow-up information. Despite this the actual finalisation of reports following the personal visits still took, in most cases, well over three months.

The information presented in the following sections, whether in the text or in the tables, is indicative rather than comprehensive. The absence of information on a particular topic does not necessarily mean that a DHB is not undertaking work in the area. Alternatively, discussion of related work across a number of DHBs does not imply uniformity in provision. Ultimately the material presented is only as good as the information provided. In a study which is a “scan” the information, by its very nature, can only be indicative.

5. DISTRICT HEALTH BOARD ORGANISATION

5.1 Organisational overview

To understand the management of quality, an understanding is needed of the way in which DHB services are organised, especially on the provider side. It was consistently stated that accountability for clinical quality was firmly located within the clinical divisions. Information was therefore sought on the overall organisation of the DHB, how clinical services were organised and the nature and extent of their accountabilities.

The following discussion highlights that in some DHBs there is continuing review of organisational arrangements. There is also continuing uncertainty and hence lack of clarity in clinical services organisation. Perceptions of clinicians and even clinical leaders appear to differ from those presented by top management, in some situations this difference is quite marked. It is important to note, as will be discussed later, that the extent to which real clinical decision-making has been devolved to clinical groupings is dependent both upon the willingness of management to devolve and the acceptance of devolution by clinicians.

Table 5.1 presents an overview of the clinical organisational arrangements in the 10 DHBs. The most common organisational model is, under the CEO, a COO or general manager for the provider side. In Hutt Valley DHB there were two basic divisions under the CEO primary and secondary each with a general manager. Northland had progressed even further with a general manager for primary and secondary care but with the general manager primary care being responsible for overall leadership of the diverse and fragmented primary care sector, both government and non government, including the rural hospitals.

Reporting to the CEO in all the DHBs surveyed except Canterbury, was a chief medical officer/advisor (CMO/A) and chief nursing officer/advisor (CNO/A) or equivalent. These were seen to be important positions for the promotion of clinical quality throughout the organisation. The CMOs/As had a key medical leadership role that was only partly executive. In many cases it involved a continuing clinical role seen to be important in maintaining credible relationships with clinical staff.

In a number of cases these were relatively recent appointments and were seen to be part of the recovery from the former system which had devalued this form of clinical leadership. CNOs/As also played a critical role especially with the devolution of nursing to clinical groupings. This is further discussed below.

5.2 Organisation of clinical services

Under the COO, or equivalent, all DHBs had some form of clinical organisation, both to major clinical divisions and clinical subdivisions. The number of major clinical divisions varied from three in Northland to 11 in Otago. In Canterbury DHB this is still under discussion, although has been well-established for a number of years in the former Healthlink South HHS.

Table 5.1 Summary overview of the clinical organisational arrangement in the 10 DHBs

DHB	Organisation overview – provider side	Top medical and nursing positions	Clinical organisation – major	Clinical subdivisions	Across hospital campuses
Northland	CEO and GMs primary and secondary care	CMA and DON	3 secondary divisions with group managers partnered with 13 clinical directors for each speciality		Yes in primary care
Auckland	CEO and COO	CMO(PT) and DON	Clinical leaders in partnership with general managers	Clinical directors in partnership with service managers	In new hospital plan
Counties-Manakau	CEO and COO	CMO and DNP Chair Clinical Board	8 clinical divisions GM in partnership with clinical medical director and clinical nurse director	Clinical heads in partnership with clinical nurse leaders and service managers	No
Waikato	CEO and COO	CMA and DON	Mental Health – clinical directors and service managers in partnership, Community Services – service managers in liason with clinical directors, Waikato Hospital – 7 clinical groupings with service managers and clinical unit leaders in partnership	Clinical director	Yes
Lakes	CEO and providers GM	MD(PT) and DON	5 clinical divisions with medical HOD and clinical nurse leaders	NA	Yes
Hutt Valley	CEO and GMs secondary and primary	CMA(PT) CNA and allied health	6 secondary clinical directorates with service managers in partnership with medical HODs and clinical nurse managers – 5 community, inc mental	Medical HODs and clinical nurse managers	No
Capital and Coast	CEO and GM	CMA(PT) and DONM	6 clinical divisions with clinical directors in partnership with business managers	Clinical leaders in partnership with service leaders	Yes
Nelson/Marlborough	CEO and GM provider	CMA and Nursing Adviser at both Nelson and Blenheim	Regional service managers for mental health, intellectual disability and public health	NA	Some services
Canterbury	CEO and COO	None	Current system of clinical directors under discussion - partnership of general manager and clinical director in mental health and older persons health	Under discussion	No
Otago	CEO and COO	CMO and CNO	15 clinical practice groups –clinical leader in partnership with service manager	Some HODs	Yes

Abbreviations: CEO chief executive officer, COO chief operating officer, GM general manager, CMO/CMA chief medical officer/adviser (PT part time clinical), CNO/A chief nursing officer/adviser, CNO/A chief nursing officer/adviser, DONP director of nursing practice, DONM director of nursing and midwifery HOD head of department, SM service manager, CUL clinical unit leader, CD Clinical director

Most clinical divisions follow a pattern of surgical, medical, child health, women's health, mental health, etc. In larger centres there is the usual range of clinical subdivisions of medical and surgical services, eg cardiology, renal, orthopaedics, urology. Others such as Otago have a complex mix of service or specialty subdivisions

A variety of disciplinary relationships are found at both service and sub-service level. In a number of situations the medical clinical director or leader is partnered with a general or service manager and nurse director. In other situations nursing is not seen to be an equal partner but is involved in other ways eg through nurse consultant participation.

In almost all cases there is a strong emphasis upon a partnership, either actual or developing, between clinical leaders/directors and management. Accountability for both quality and cost is seen to be a joint activity to which both managers and clinicians are 'signed up'.

In many DHBs, where there are multiple hospital sites, the service organisation cuts across hospital campuses or, as in the case of Auckland, is planned to do so in the new hospital system. Only in Canterbury is there a continuing commitment to a hospital-based system of clinical organisation. The integration of hospital services across multiple campuses is an important development as it facilitates a more population-based approach to service delivery.

5.3 Devolution of clinical service accountability

The term devolution has been used in this study in the sense that it is beginning to be commonly used within the New Zealand health system. It applies to the delegation by top management of decision-making to clinical service groupings for both clinical and financial accountability. However, this accountability is quite variable in its content ranging from only direct service costs to the full range of clinical support services and overheads. As indicated elsewhere promoting clinical quality is dependent upon the integration of clinical with financial accountability.

Table 5.2 presents a summarised overview of the devolution of decision-making to service and subservice groupings within DHBs. In almost all cases there is complete devolution of nursing services to service groupings with these services coming under the management of the service-based system. Their implications of this will be further discussed below.

In a minority of DHBs devolution includes the funding of clinical support services, eg laboratory, radiology, etc which are purchased from clinical service budgets. Some DHBs are considering the inclusion of these within service budgets. Half of the DHBs include some form of overhead expenditure in service budgets.

The extent to which this accountability of clinical directors is functioning effectively varies both between and within DHBs. In general, devolution appears to be working effectively at the service level but perhaps less so at a sub-service level. Some DHBs mentioned that there had been a retreat from clinical participation as a consequence of the current serious budgetary restrictions. Successful devolution also depends upon the prevailing culture within an organisation and, as will be discussed later, the extent of

Table 5.2 Devolution of decision-making to service and subservice groupings within DHBs

DHB	Devolution of decision making to services	Includes nursing services	Includes clinical support services	Included overheads	Extent of accountability of clinical directors
Northland	To clinical departments	Complete	No	No	Varies
Auckland	To service and subservice levels	Complete	Yes	Yes	Varies
Counties Manakau	To service and subservice levels	Complete	No – being worked on	No – being worked on	Good at service but less at subservice
Waikato	To service and being considered for subservices	Mixed	No	Yes	Varies
Lakes	To service and subservice levels	Yes but being reviewed	No	Yes	Varies
Hutt Valley	To services and subservices	Complete	Yes	Yes	Good
Capital and Coast	To service and subservice levels	Complete	Yes	Yes	Varies
Nelson/Marlborough	Some	Complete	No	No	NA
Canterbury	Only significant in Mental and Older Persons Health	Yes in these services	No	No	NA
Otago	To clinical practice groups but not subgroups	Complete	No	No	Good

recovery from damage done during the commercialisation era and the build up of trust between clinicians and management.

5.4 Organisation of nursing services

Nursing is the largest single workforce within DHBs. Table 5.3 summarises the organisation of nursing services, including nursing involvement at executive level, on the provider side and participation in clinical advisory boards/committees. Table 5.3 also summarises the devolution of nursing services within service budgets and indicates whether a nurse is part of the management partnership within service groupings.

A DON or equivalent is found in eight of the 10 DHBs. Nelson Marlborough has a divided system because of its geography with a nurse advisor in each setting. Only Canterbury does not have a DON at the top executive level on the provider side.

There is a mixed pattern of devolution of nursing services management of the budget for nursing services to service groupings. The predominant pattern is complete devolution in six DHBs. Devolution is being proposed in Canterbury, is mixed in Waikato and being reviewed in Lakes. However associated with this devolution is limited nursing partnership in the clinical management team with nurse directors at service level only in Counties Manakau and Lakes, although being considered in other DHBs, eg Canterbury.

Table 5.3 Organisation of nursing services within DHBs

DHB	DHB provider side	Clinical/quality Advisory Board	Devolution of nursing services	Nursing partnership at service and subservice level
Northland	DON Secondary DON Primary	Yes	Complete	Being considered
Auckland	DONM	Yes	Complete	No
Counties Manakau	DONP	Yes	Complete	Clinical nurse directors
Waikato	CAN	Yes	Mixed	Under review
Lakes	DON	Yes	Yes but being reviewed	Nurse/midwife consultants and clinical nurse/midwife leaders
Hutt Valley	CAN Secondary CAN Primary	Yes	Complete	?
Capital and Coast	DONM	Yes	Complete	No but nurse consultants
Nelson/Marlborough	Hospital only	-	No	No
Canterbury	Hospital only	Yes	Only in some services	Being reviewed
Otago	CNO	Yes	Complete	No but nurse consultants

Abbreviations: CNO/A chief nursing officer/adviser, DONP director of nursing practice, DONM director of nursing and midwifery

It will be obvious from Table 5.3 there is still much variability and uncertainty in the way nursing services are being organised. Devolution of nursing budgets to service groupings is resulting in radical change in the roles and responsibilities of the DON, or equivalent, at the top executive level. There is a continuing trend away from the classical centralised model of a nursing hierarchy in which a DON has full control over nursing budgets and services throughout the organisation.

The DON role is hence changing from executive management of the whole nursing workforce to a new leadership role. The DON is responsible for professional nursing development, participating in appointments of nurses to key positions and may be using nursing consultants working at the service level to foster the development of quality nursing practice. Another issue concerning some DONs is the need to consider the extension of nursing leadership to be inclusive of DHB wide functions, both the provider and contracting sides.

Although devolution has advantages it may have a serious downside. Of considerable concern to nurses and others seeking to build an effective team at the service level is the way in which nursing management is secured at this level. Devolution may reduce efficient management of the overall nursing workforce to cover patient acuity particularly in the acute hospital setting. These problems have become more urgent with the current shortage of the nursing workforce and higher nursing turnover.

The pros and cons, and related implications of a more devolved nursing service, will be discussed later in section 11.

6. QUALITY INITIATIVES IN DHBs

6.1 Organisational support for quality improvement

Table 6.1 provides details of the organisational support for quality improvement identified by the 10 DHBs in this study. Five of the DHBs, Auckland, Counties-Manukau, Waikato, Lakes and Nelson-Marlborough, indicated that they are reviewing their current situation and planning to make changes to the current organisational support. In general DHBs either had in place, or were considering the implementation of, a single integrated quality system. Where these systems were being considered they appeared to incorporate previously disparate quality components.

Seven of the 10 DHBs had either put in place or were planning to implement an over-arching board or committee with responsibility for either quality alone or quality among other things. Those DHBs without any such body were Lakes, which is currently evolving a new quality structure to include this, Nelson-Marlborough and Hutt DHB, the latter having four committees with a focus on quality. In the majority of DHBs these committees relate to the provider side of DHB business. Only Auckland appeared to have a wider quality focusing. It was setting up a Population Funding Effectiveness Council with responsibility for addressing quality issues on its funding side.

The membership of these over-arching committees generally included clinical directors, senior executive staff eg CEO, COO plus CMO/A and DNO/A or equivalent, where they existed. Some DHBs had representatives from nursing, midwifery, allied health staff, cultural advisers and, in two places, general practitioner input (Hutt and Counties Manakau). As noted above, seven of the 10 DHBs in the study also employed staff with specific quality responsibilities. These ranged from dispersed junior staff, through a registrar employed specifically for clinical audit, to senior level Quality and Risk Managers.

The overall picture is one of DHBs revisiting their previous quality practices in the light of:

- the demands of the transition from HHS to DHB status
- the growing external demands and attention to quality in health care.

This latter factor reflects a growing interest in the principles of clinical governance, a heightened awareness of quality issues arising from participation in accreditation, as well as the adverse incident experiences of Northland, Tairāwhiti and elsewhere.

6.2 Quality initiatives in DHBs

Nine DHBs, as shown in Table 6.2, were undertaking credentialling programmes. In some such as Auckland and Counties Manakau this was well advanced. Lakes, Northland, Capital and Coast were in the early stages of developing their credentialling programme. Nelson-Marlborough had successfully completed credentialling in three of its departments and established a Credentialling Committee.

Table 6.1 Organisational support for quality improvement

District Health Board	Proposed	Operating	Description
Northland		✓	<ul style="list-style-type: none"> ▪ Clinical Board - Members: clinical directors, Secondary Care GM, CMA, DON, CEO, Maori Director - Role – general forum for provider arm, reviewing clinical policies, quality one focus among many
Auckland	✓	<i>Under review</i>	<ul style="list-style-type: none"> ▪ Provider arm – Quality and Safety Manager reporting to COO, Clinical Quality Council (existing) being expanded to cover all aspects of clinical quality management, membership may become expertise rather than representative based. Multidisciplinary quality committees at hospital and clinical unit level. ▪ Funding arm – Population Funding Effectiveness Council to address quality issues
Counties-Manukau	✓	✓	<ul style="list-style-type: none"> ▪ Clinical Board reporting to CEO - Members: Clinical Board Facilitator, COO, CMO, clinical directors, DONP, representatives of nursing, midwifery and allied health, cultural advisers. - Roles/responsibilities: wide range of quality improvement activities eg vision/ values, policies, guidelines, etc. - Clinical Quality Improvement Committee to assist the Clinical Board ▪ Clinical Facilitator to assist the Clinical Board chairman
Waikato	✓	✓	<ul style="list-style-type: none"> ▪ Executive Clinical Board (Provider side focus) with Quality/Audit Sub- Director of Clinical Audit to provide leadership for provider side quality ▪ Existing : Clinical Unit Leaders/ Directors and Service managers jointly responsible for quality and resource management
Lakes	✓	✓	<ul style="list-style-type: none"> ▪ Quality managed via heads of departments, nurse consultants & service-based clerical Quality Co-ordinators. ▪ Clinical Council planned to be responsible for quality among other things.
Hutt		✓	<ul style="list-style-type: none"> ▪ Quality & Risk and Patient Safety Committees report to CEO; Medical Quality and Physicians Audit Committees ▪ Clinical Audit Registrar appointed ▪ Clinical Heads of Department responsible for quality with support of service managers
Capital & Coast		✓	<ul style="list-style-type: none"> ▪ Quality Improvement Group reporting to CEO ▪ Support from a Quality Support Group comprising 8.5 currently dispersed quality staff.
Nelson/Marlborough	✓	✓	<p>Existing: About 20 committees each focussing on an aspect(s) of quality – under review. Under discussion: an overarching Clinical Council with quality as one of its responsibilities.</p>
Canterbury		✓	<ul style="list-style-type: none"> ▪ Clinical Advisory Committee reporting to CEO, membership covers all services in the Operating Division ▪ Corporate Quality & Risk Manager ▪ GMs of each division are accountable for quality ▪ Divisional quality committees (medical incidents/complaints, OSH, infection control, medical appointments, medicines advisory, clinical QA groups)
Otago		✓	<ul style="list-style-type: none"> ▪ Clinical Improvement Committee - Membership: CEO, COO, CMO, CON, cross-section of managers, medical/nursing/allied health staff and a GP - Responsibilities: various, quality one of a number. ▪ Clinical Improvement Co-ordinators

Where two ✓s are shown there is an existing mechanism which is being reviewed

The board was in the process of reviewing credentialling achievements before proceeding to implement it at Wairau Hospital. In Waikato DHB credentialling is also well-established and has become the responsibility of the clinical director in each service division and includes both the unit as well as individual staff.

Nine of the DHBs also identified a quality including a risk management focus. Within this there was considerable variance. The focus on quality management took many forms. Seven of the DHBs had established or were working on establishing a clear framework for this. This included such things as a developing a vision and/or values, a set of relevant definitions, quality and risk policies, with links to organisational support and serving as a context within which the quality plans were being developed. While all DHBs will have quality plan requirements as part of their contract, only a few mentioned their quality plans during discussions about quality and risk management.

All DHBs interviewed had either already been accredited in full or in part eg Nelson-Marlborough and Waikato, or were aiming for accreditation or re-accreditation in the near future e.g. Capital and Coast and Otago. Most of those interviewed felt that accreditation itself had made a positive contribution to the growing awareness of quality issues within their organisations. However, this view was not uniformly held eg Waikato noted a danger in achieving accreditation without developing a “full and ongoing commitment to quality”.

All organisations reported programmes and initiatives related to clinical audit. The focus on these varies between DHBs with some appearing much stronger than others. For example in Hutt DHB there is a Physicians’ Audit Committee, a registrar has been appointed to drive clinical audit, and each clinical head of department has a job description requiring the promotion of clinical audit with the support of the a service manager.

Similarly most DHBs appear to have put considerable effort and work into integration of clinical and financial management. While most DHBs agreed that this was an important part of quality there were some caveats expressed. For example, Auckland and Counties-Manukau noted that there is still some discomfort with this among some of their clinicians especially where resources are constrained. A further constraint for some DHBs is making the time available for clinicians to participate (Lakes and Nelson-Marlborough).

Information technology systems are also need to keep pace with this development so that costs can be tracked down to patient level. In a number of cases this work had not yet been done hindering the analysis and feedback which could further assist quality initiatives. Hutt has achieved this but Auckland and Waikato recognised that they had more work to do in this area. On the other hand Nelson-Marlborough was clear that they had some way to go before achieving integration of clinical and financial management. Canterbury is still discussing this issue.

Almost all DHBs mentioned the implementation of patient safety (adverse incident, incident/accident reporting programmes). Discussion of such projects almost invariably were linked with the need to establish a “no blame” culture” so that

physicians feel safe discussing mistakes freely and working to prevent their recurrence.

Table 6.2 Quality initiatives underway in District Health Boards

Quality Initiatives	Northland	Auckland	Counties-Manukau	Waikato	Lakes	Hutt	Capital Coast	& Nelson/Marlborough	Canterbury	Otago
Quality & Risk management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality Standards – including guidelines		✓	✓	✓	✓	✓		✓	✓	✓
Clinical audit	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical Indicators		✓	✓	✓		✓			✓	✓
Peer review					✓	✓		✓	✓	✓
Incident/Accident Reporting (patient safety)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality Improvement Programmes	✓	✓	✓	✓	✓	✓		✓		✓
Performance Indicators		✓	✓	✓		✓			✓	✓
Benchmarking			✓	✓		✓			✓	✓
Credentialling	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Accreditation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complaints resolution/ consumer feedback	✓	✓	✓	✓	✓	✓		✓		✓
Medicines Committee		✓	✓	✓		✓	✓	✓		✓
Integration of clinical and financial management	<i>Work in progress</i>	✓	✓	✓	✓	✓	✓	✓		✓
Quality Plan	✓	✓	✓	✓	✓	✓		✓		✓
Quality Framework – including discussion documents		✓	✓	✓	✓	✓	✓	✓	✓	✓

NB These are just examples of quality initiatives mentioned in the DHB reports and do not necessarily represent the full spectrum of quality initiatives within the DHBs listed.

Less frequently mentioned initiatives include the development of quality standards and guidelines, clinical indicators, benchmarking, medicines advisory projects, and peer review.

7. QUALITY ACHIEVEMENTS

DHBs views of their achievements in quality focussed on a small range of items often unique to the individual DHB as shown in Table 7.1. Significantly, half of the DHBs in the study identified as an achievement changes in the organisational culture eg greater openness, moves towards a culture of safety with clinicians able to discuss mistakes and develop ways of preventing them without being “punished”. These DHBs were Northland, Auckland, Counties-Manukau, Waikato, Hutt and Capital and Coast.

Other culture changes cited included a growing partnership between clinicians and management as identified by Northland, Auckland and Hutt DHBs. Waikato also noted a move away from strictly "business" approach to a culture of quality.

Another commonly cited achievement was integrating previously disparate quality efforts into a single coherent quality system as noted by Waikato, Capital and Coast, Otago and Counties-Manukau.

Other achievements identified related to individual quality components, for example the implementation of the strong adverse incident system, achieving/working towards accreditation, credentialling progressing well, clinical audit well established, the appointment of staff dedicated to quality, and information technology developments allowing for cost monitoring at patient level.

Factors that facilitated quality development:

- the experience of accreditation leading a much greater awareness of quality
- appointment of specific staff whether with a specific quality focus (eg Hutt) or specific clinical staff (eg clinical nurse directors appointed at service level in Counties-Manukau)
- the ability to provide resource tools and incentives (eg Hutt which has invested money in education and training, and quality related videos, manuals, journals etc. for staff use)
- the ability to integrate clinical and financial management
- past adverse events “opening up” the need to develop new responses and new organisational cultures.

Factors seen as hindering progress with quality:

- resource constraints impinging on the integration of clinical and financial management
- the difficulties in making time for clinicians to participate in management and quality initiatives in some DHBs
- shortage of leadership skills
- past adverse events leading to mistrust between clinicians and management
- the lack of a shared understanding of quality i.e. what it means to the organisation, and what methods are available to improve quality
- not making full use of the information available, eg incident / complaint / patient satisfaction information
- lack of integration of quality planning into the service planning process..

Table 7.1 District health board quality achievements

District Health Board	Achievements in quality
Northland	<ul style="list-style-type: none"> ▪ Changing culture – clinicians now more open to discussing “mistakes” and developing ways of preventing them ▪ Partnership between clinicians and management ▪ Employment of clinical co-ordinators to improve clinical documentation
Auckland	<ul style="list-style-type: none"> ▪ All hospitals and Mental Health and Community Services accredited twice ▪ Established quality structure supporting multidisciplinary approach and focus on no blame culture ▪ Credentialling established ▪ Partnership between clinicians and managers at service level with increasing medical leadership in quality activities
Counties-Manukau	<ul style="list-style-type: none"> ▪ One coherent quality structure ensuring co-ordination ▪ Twice accredited ▪ Strong adverse incidents system linked with parallel complaints processing and resolution ▪ Developing a “learning organisation” with a culture of “safety”.
Waikato	<ul style="list-style-type: none"> ▪ Moving away from a strictly “business” approach to a culture of quality in an environment of “safety and trust” for clinicians. ▪ Recognition of the need for and developing a single coherent quality system, with protocols, pathways and guidelines ▪ Credentialling well established
Lakes	<ul style="list-style-type: none"> ▪ Plan for integrating accountability for quality and clinical activities developed and under discussion ▪ Trialled new Hospital and Disability Sector Standards, received commendation for their efforts
Hutt	<ul style="list-style-type: none"> ▪ Gradual culture change leading to current staff “buy in” and “bottom up” initiatives ▪ Greater awareness of quality issues, accreditation processes built on earlier organisation work ▪ Increasing focus on clinical audit and appointment of Registrar in Clinical Audit ▪ IT developments allowing for the monitoring of costs at patient level
Capital & Coast	<ul style="list-style-type: none"> ▪ Consultation document and ensuing discussion on the integration and co-ordination of existing activities, potential benefits and a culture change.
Nelson/Marlborough	<ul style="list-style-type: none"> ▪ Strong progress on credentialling ▪ Good audit programmes in most departments ▪ Two rounds of accreditation have developed a strong awareness of and interest in quality, especially among nursing staff ▪ Iwi networking established and working well ▪ Well developed medicines advisory initiative
Canterbury	<ul style="list-style-type: none"> ▪ Strong structural support for some aspects of quality
Otago	<ul style="list-style-type: none"> ▪ An integrated quality support structure in place ▪ A quality framework has been established with a quality plan

- Credentialling making very good progress and expected to be completed November 2001

8. CLINICAL ADVISORY FUNCTIONS

The establishment of CMO/A and CNO/A positions at the top executive level of a DHB, on the provider side, has provided an important, and in many cases, new avenue for clinical advice to be provided at the highest levels of management. In some DHBs this advice has provided directly through to the Boards and/or the hospital advisory committee. Some CMO/As saw their continued clinical involvement as being important to their credibility to represent medical interests at executive level rather than being seen as just part of management.

There is also increasing involvement of allied health leadership in clinical advisory functions. For example within Waikato DHB allied health staff have been appointed widely as part of the multidisciplinary clinical teams in all divisions and provide clinical advice at all levels in the organisation.

It was also noted by some CMO/As and CNO/As that this advisory function should extend beyond just the provider side to the whole DHB. However some DHBs have established, or are establishing, separate clinical advisory functions for their contracting/funding arms.

CMO/As and CNO/As were also seen to have a key role in leading quality initiatives within DHBs. They were key participants in clinical advisory committees, promoting credentialling, clinical audit and handling reportable events.

A wide range of clinical advisory committees and groups had been formally established within DHBs to provide not only clinical advice and but also to drive quality initiatives. Some of these were well established and had played a key part in the quality improvement process, eg in Counties-Manakau. Others were still relatively new and were developing membership and roles which were beginning to address quality strategies.

It was repeatedly noted that, although most DHBs have medical and other staff associations, the importance of these is seen to be diminishing. This is seen to be a direct consequence of an increasing involvement of clinical staff in devolved clinical service arrangements and the growing partnership between management and clinicians.

However as noted elsewhere in this report there are widely varying views about how far this partnership has progressed. There is a sense of disempowerment and disenfranchisement amongst some clinicians, despite the clear government commitment to a collaborative model.

9. LEADERSHIP DEVELOPMENT PROGRAMMES

9.1 Education and training programmes

Most DHBs had education and training programmes supported by their human resources departments. For some it was a requirement that clinical leaders participate in programmes. However a key limiting factor was the pressure on clinical leaders with their joint clinical and management responsibilities. Programmes such as those provided by the Health Leaders Network were being supported but were seen to be very expensive and Australian based.

An interesting example of a DHB commitment to training was found in Hutt Valley DHB. From 'organisational savings' of \$3 million a sum of \$200,000 had been set aside for professional development and research, including leave and continuing education. This may be one of many examples of the incentives to achieve clinical savings which could both benefit quality and achieve further cost savings.

9.2 The need for clinical leadership development

There was almost universal recognition of the need for clinical leadership development along with other leadership development activities. It was also recognised that is considerable value in bringing together a range of leaders from different disciplines, geographic areas and service divisions, such as primary and secondary, to build a new leadership culture.

A number of key people recalled the Health Services Management Development Unit of the early 1990s as an appropriate model, which might be restored. However a broader role would be needed inclusive of clinical leaders and the broad range of sectors now coming within the scope of the DHB system.

10. CLINICAL GOVERNANCE - THE ROLE OF CLINICAL LEADERSHIP

DHBs were asked about the term clinical governance and its application to the development of quality processes within their services. Table 10.1 summarises statements from DHBs regarding this question. Only three DHBs, Auckland, Counties-Manakau and Waikato had formally adopted clinical governance as a policy and were using the UK definition, or a modified version. However almost all DHBs were implementing what could be described as typical clinical governance processes.

Table 10.1 Summary of statements by DHB is about clinical governance

DHB	Stage of clinical governance
Northland	Term not specifically used but process being established and seen to be alive and growing
Auckland	Being adopted as a term and based upon the UK definition. Is inclusive of all clinical quality programmes. Includes financial management
Counties Manakau	Definition modelled on the UK and formally adopted as a policy and strategy. Is strongly supported as are processes involved
Waikato	Adopted UK definition. Formal commitment to clinical governance. The quality plan is based upon a clinical governance framework
Lakes	No policy as yet but there is a clear commitment to it as shown by various activities involving clinicians in quality developments
Hutt Valley	The term is not used but the quality strategy is a model of clinical governance at work
Capital and Coast	The term has not been adopted by the DHB although many of the organisational developments are consistent with clinical governance
Nelson/Marlborough	Definition and process not yet established
Canterbury	No formal policy as yet adopted but the term is being increasingly used in quality discussions
Otago	No formal policy but the term is widely used in discussions and policy statements about quality developments

Clinical governance is a process largely driven by clinical values and aspirations, with clinical leadership playing a strong part in this process. Also of importance, and in key contrast to the UK model, is that clinical governance is widely seen to be inclusive of resource management.

Furthermore and again in contrast to the top-down UK model clinical governance is driven much more from the ‘middle-up’, ie by clinical leadership.

11. DISCUSSION:QUALITY DEVELOPMENTS IN DHBS

11.1 Information sources: tensions and limitations

As stated earlier, this project presents the results of a scan of a selected number of DHBs. Funding and time constraints precluded a more detailed review. The authors therefore have reservations about the nature and quality of the information drawn upon. This review is based on information supplied by top management and clinical advisers, complemented by follow-up discussions, both personally and by telephone.

The views presented, therefore, may not be representative of others in the organisation especially given the 'conflict of cultures' referred to below. Uncertainties remain as to how far plans for quality initiatives have been successfully implemented. Discussions with clinical leaders and clinicians generally indicate that perceptions of relationships and progress vary widely between different levels within the DHB organisation. Some clinicians, perhaps with 'axes to grind', have expressed views which differ markedly from those of top management.

Recent editorials in the New Zealand Medical Journal have taken a negative line with regard to governance and management cultures although the views expressed appear to apply largely to Canterbury DHB (Bagshaw et al, 2001). A study of clinical and management staff in Auckland and Wellington hospitals by Sage et al (2001) showed wide differences in attitudes between clinicians and managers. Clinical leaders occupied an intermediate position in their attitudes towards accountability issues.

Nevertheless the views of CEOs, and other key people within DHBs, are important. They represent a commitment to, if not as yet actual achievements, in quality improvement. Furthermore there is a level of consistency in what has been presented showing a significant trend towards improved relationships and in clinical quality which appears to be substantially more advanced than even 12 months ago. It is clear that some DHBs are well ahead of others in building a partnership culture.

What is needed to complement this review is more detailed studies of the actual roles and responsibilities of both clinical and management leaders within selected DHBs. This would assist in clarifying the nature and extent of progress towards better relationships, the potential and actual impact upon continuing quality improvements and the expanding role of clinical leadership in this progress.

11.2 Devolution of decision making

This review has documented a clear and continuing trend towards devolution of decision-making to clinical groupings. Again the extent to which this is progressing varies widely between DHBs. The motivation to devolve varies between DHBs and between management and clinicians.

In general it appears that the interests of both managers and clinicians are advanced with devolution. For managers, this means involving clinicians in decision making about priorities and accountability for financial management. For clinicians, it means having the power to shift resources from less to more important needs. Only clinicians are in a

position to know whether or not foregoing a particular investigation, drug or extra days of inpatient care would impair quality and whether the resources so saved would be better spent in other service provision.

In other words, quality clinical decision making necessarily involves decisions about the use of resources. Given the wide variability in such decision-making and increasing evidence that better quality may not be associated with higher expenditure, the potential for quality outcomes at lower costs could be considerable (Wright et al, 2001). Real devolution to clinical groupings is the first step in securing such gains.

This strategy, however, implies devolution not only of direct costs but also of clinical support services, eg laboratory, radiology, operating theatre, etc. It also involves indirect costs such as overheads use of beds, associated hotel services and capital costs. As yet only a minority of the DHBs studied had progressed to devolution of either clinical support services or overheads.

The reasons for this remain unclear, and they were not explored in detail. It is in part due to the quality of information systems involved and the lack of experience of clinical groups in managing the wider range of resources involved. There is also concern about the potential impact upon support services of such complete devolution. There is also continuing debate about devolution of revenue as compared with costs, an issue which should be resolved with the move to population-based funding and hence removal of the disincentives associated with revenue type funding.

11.3 Towards a successful nursing organisation

This review has also shown that there is progressive, if tentative, devolution of nursing resources, including budgets, to service groupings (Section 5.3). Moves towards this devolution are occurring in other countries such as Australia. However the issues are complex and the whole process is subject to ongoing debate. Advantages of devolution may be summarised as;

- nurses becoming fully recognised as members of health care teams
- the integration of patient care within a multidisciplinary settings, important in both long-term care services and acute care
- the ability to manage all aspects of care effectively, including nursing, within a service division, especially with nursing being the largest single item within a service budget
- the ability to shift resources, including nursing, within a service budget to ensure the best use of resources
- flexibility in the use of nursing services between hospital and community, eg midwives, paediatric intensive care and renal dialysis nurses providing home care
- the development of specialised care nursing as part of the clinical team.

These advantages are likely to become more important with the development of the DHB system and moves towards community-based care and service integration including the integration of government and the non-government services.

However there may be important disadvantages associated with devolution. These include;

- nursing resources becoming dissipated and fragmented resulting in a task focus at service level
- a lack of flexibility of the nursing workforce to meet acuity needs especially in acute settings with widely variable and unpredictable needs
- subservience of nursing skills and perspectives to medical and managerial dominance
- a possible weakening of the overall influence and professional contribution of nurses within the organisation
- a lack of overview caused by limited opportunities for professional networking
- a lack of nursing leadership and role modelling of leadership restricting the development of innovative nursing practice and sharing of nursing knowledge
- a lack of a nursing career structure with nurses tending to move into service management positions where they no longer directly influence the development of nursing.

As documented in this review, and from other sources, these disadvantages may at least in part be overcome through;

- firm leadership from the DON, or equivalent, bringing a nursing perspective into the top management team and providing overall nursing leadership throughout the DHB
- the DON promoting the role of nursing throughout the organisation and close working relationships between nurses and other clinicians
- the appointment of nursing directors to the service and sub-service levels in full partnership with the management team at this level, while maintaining clear links to the DON
- the DHB having an organisation-wide policy in place to ensure that the nursing role is valued
- a system of nurse consultants working with service divisions to promote and assess nursing development and integration co-ordinated or facilitated by a DON
- flexibility in the use of the nursing workforce with nursing distribution after regular hours coming under the DON.

The success of devolution therefore depends upon two key factors;

- the DHB having an organisation-wide policy which acknowledges and promotes nursing as a key service component in partnership at all levels including at the executive level
- finding the right person to fill the role of the DON.

11.4 Review of quality developments –incentives, achievements

This review has shown that all DHBs are making significant efforts to improve clinical quality. All have either a formal structure and process in place for quality improvement or have plans for such establishment. Much discussion is currently under way about the best forms of structuring quality processes and how they should be organised, managed and funded.

DHBs also report a wide range of quality initiatives, either planned or under way. At organisational level there is increasing commitment to accreditation which, especially

with the new format, is seen to be an important stimulus to overall quality improvement. There is wide and increasing support for:

- credentialling of medical staff (from both medical staff and management)
- quality and risk management processes
- clinical audit.

Other developments appear to be less well advanced.

However, as indicated above, there are uncertainties in the information provided as to the gap between planning and implementation. DHB quality managers, although in general feeling that their activities are now more valued and recognised, are also constrained as to what can be achieved with funding limitations. There are uncertainties about who is actually accountable for quality activities and the relationship between quality departments and clinical services. It appears that quality departments are now being seen, perhaps appropriately, in a support role to clinical service divisions which, with their increasing accountabilities, are now assuming a more direct role in quality management.

An important development has been the development of structures and processes to ensure integration of quality initiatives within DHBs. Integration is being achieved through quality boards, committees and groups.

Despite important developments in clinical quality there is a remarkable lack of sharing of this experience and the lessons learnt. Relatively little appears to have been done to document or evaluate quality achievements in DHBs. As far as is known this is the first attempt to bring this experience together and provide an overview of these important developments.

There is a serious lack of evaluation in the New Zealand health 'culture' a concern noted by the National Health Committee (NHC) document 'Safe Systems Supporting Safe Care'.

11.5 Clinical leadership – a new role for clinicians

This review, along with other reports in this trilogy, has noted the growing importance of clinical leadership as a critical factor in promoting clinical quality. Clinical leadership may be 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 may come from any of these disciplines.

Clinical leaders are those who still retain a clinical role for a proportion of their time. This leadership may be found within DHBs at three levels. At the top executive level, and reporting to the CEO and/or COO, CMO/As and CNO/As bring a medical, nursing and broader clinical perspective into executive decision-making.

In some cases CMO/As retain a part time clinical responsibility which they see as necessary for acceptance by their clinical colleagues. In other words they are still clinicians even if a part of top management. They have not, as did previous 'medical

superintendents' crossed to the 'other side', or in the view of some clinicians 'joined the enemy'. This new form of clinical leadership is being increasingly recognised as critical to the building of a quality culture. A key role of CMO/As is to provide overall leadership in quality improvement strategies within the organisation.

The importance of the role of the CNO/A is discussed above in Section 11.3. It is clear that with a more devolved nursing structure this role becomes even more important than in a centralised nursing management model.

At the second level are those who are clinical leaders or directors for an overall service level, ie medical, surgical, mental health. Accountability at this level is significant and demanding, may occupy up to 5/10ths time and is seen to be in a relatively formalised relationship with management. This partnership may include both medical and nursing leadership.

At the third level, are subdivisions of medicine, surgery, mental health, eg cardiology, respiratory medicine, orthopaedics, child psychiatry for example, where clinical leadership responsibilities may occupy 2/10ths time, be less formalised and perhaps less developed. Again the partnership at this level may include both medical and nursing leadership, in partnership with non-clinical service managers.

As discussed below, effective clinical leadership at any of these levels requires a partnership with management. Clinical leadership is more than just an accommodation between clinical leadership and management. Clinical leaders are required to walk an uneasy path between claims for autonomy by their clinical 'rank-and-file' colleagues at the same time as developing a relationship with management and its demands for clinical accountability.

11.6 Towards a convergence of governance/management and clinical cultures

The study by Sage et al (2001) of management and clinical staff in Auckland and Wellington hospitals showed a wide divergence in attitudes towards accountability issues. However this study has demonstrated that, in almost all DHBs, there is a willingness, intention and actuality in building a partnership between governance/management and clinical cultures. In some DHBs this partnership is well-established a notable example being Counties-Manakau where there was little, if any, conflict arising from the commercially-oriented reforms of the 1990s. In others, eg Capital and Coast, where there was serious conflict, specific recent efforts have been made to build up this partnership with progress being evident although not necessarily well accepted as yet.

Not surprisingly, with the very public conflicts of the 1990s leading to the Stent report, Canterbury DHB is perhaps the least advanced in building up this partnership. The 'clash of cultures' experienced at that time led to a serious breakdown in relationships (Hornblow, 1997). A process of recovery from this conflict has only recently been established and will require a willingness and commitment to build a partnership from both 'sides'.

However this partnership requires a shift in both governance/management as well as clinical cultures. The required shift in the **governance/management culture** requires the following;

- a full and unambiguous commitment to the ‘bottom line’ of the organisation being better health outcomes for patients and communities as required in the New Zealand Health Strategy
- a recognition that resource/financial management is a means to achieve this, not an end in itself
- a firm commitment to achieving clinical quality as a governance/management issue
- a willingness to work with clinicians and to devolve clinical and financial accountability to clinical service groupings
- an acceptance that every clinical decision is a financial decision and that clinicians must be involved in financial management
- a recognition that financial management is part of overall clinical quality management and not a separate function
- clear responsibilities and accountabilities for decision-making and clinical quality
- provision of reliable and valid information relating to clinical quality.

On the other hand a change in the **clinical culture** is required in building this partnership as follows;

- a commitment to work in partnership with management to achieve organisational goals as set out in the New Zealand Health Strategy
- acceptance of collective professional accountability for clinical quality and the key role of clinical leadership in exercising this accountability
- commitment to a collective process in building a quality culture inclusive of all aspects of clinical governance
- an acceptance that every clinical decision is a financial decision and that clinicians must be involved in financial management
- a recognition that clinical quality management is inclusive of financial management and not a separate function.

It will be obvious from the findings of this review, and the general experience of clinicians and managers, that there are managers who have yet to begin to move along the pathway of convergence. There are other managers who are tentatively moving and others who are fully committed to, and are building, a partnership.

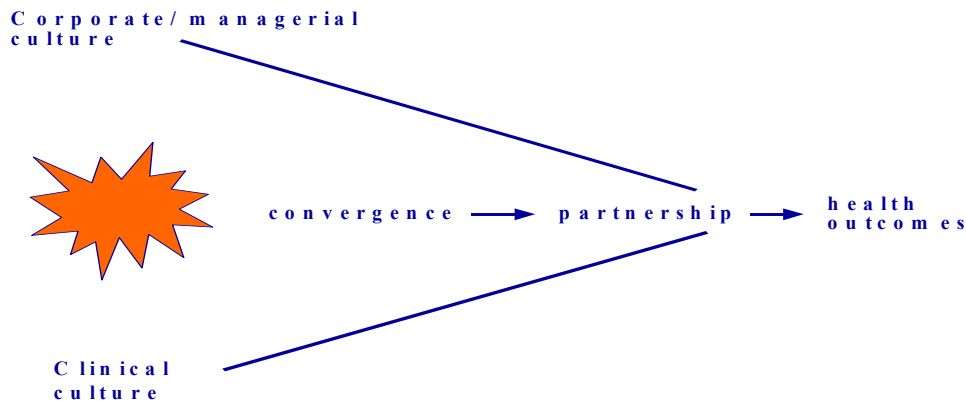
On the other hand it will be equally obvious that there are many clinicians who have yet to embark upon a pathway of convergence. Such clinicians hold to traditional, if outdated, notions of individual clinical autonomy and their right to make resource-free decisions which they see as necessary for the benefit of their patients.

Clinical leaders may also be at different stages along the pathway, some already building a partnership with management, others still unsure and perhaps unwilling to be seen by more conservative colleagues to be joining the ‘other side’.

However real clinical leadership is not about taking sides. It is about bringing clinicians, perhaps reluctantly, to understand that the clinical quality improvements, now being

sought by patients, communities and governments, can only be achieved within an organisation seeking to achieve common goals to which both governance/management and all clinicians are committed.

Figure 11.1 Model of the converging relationships between the governance/managerial cultures and clinical cultures towards a partnership to achieve common goals



A convergence of cultures is also needed within the clinical culture. As has been presented in this review, devolution of decision-making to clinical groupings has, to an increasing extent, brought nursing into the clinical team. However the extent to which this is occurring varies widely despite an increasing commitment to it.

Of equal importance is the need for a convergence in secondary and primary care cultures discussed below under wider DHB responsibilities for quality. As has been discussed elsewhere convergence within PCOs is almost total (Malcolm et al, 2001). Clinicians there are also involved in governance. Significant improvements in quality are being achieved as a direct consequence of their governance and leadership roles.

There may be important lessons to clinicians in secondary care from developments in PCOs. Clinical leaders in the latter settings have a much stronger sense of clinical empowerment and even clinical autonomy. They have the power, within defined budgets, to make decisions about priorities and to shift resources from less to more important services for the benefits of their patients and communities.

12. CONCLUSION: CONTINUING DEBATES

While the convergence of clinical and managerial culture is probably the most significant development for quality in recent times, there are continuing issues that need to be addressed.

First, the maintenance of a trusting relationship between clinicians and management will require a sense of reciprocity. Unfortunately, there have been occasions in the past when management has withdrawn any significant savings achieved from budget holding efforts. Firm agreements of how savings might be spent, and an acknowledgement that quality is an investment rather than a cost to the system, will both need to be part of a sound partnership relationship.

Second, besides their role in managing the quality of their provider units, DHBs will also be required to ensure clinical quality in the contracted sector. Some DHBs are establishing more formal relationships to promote quality including the involvement of the government and non-government sectors in joint committee structures, although this process is still quite limited.

Northland has established a general manager for primary health care to exercise of overall leadership, strategic planning and promoting integration between public and non-public sectors, a model other DHBs might consider. A quality strategy for service areas with a significant proportion of non-government providers, eg primary health care, care of the elderly, mental health and disability will be needed to encourage integration – a challenge to all DHBs.

A third issue is the extent to which DHBs can discharge their quality responsibilities while maintaining a clinical governance process based largely on clinical values, driven more by the ‘middle-up’ New Zealand way rather than the ‘top down’ processes experienced in the UK. The question arises as to whether clinical governance should be incorporated into a national strategy for quality.

This study, along with the parallel PCO study (Malcolm et al, 2001), has found that clinical governance is being widely practiced in DHBs and PCOs even if not formally adopted as policy. The recently issued National Health Committee (NHC) document ‘Safe Systems Supporting Safe Care’ also noted that PCOs and a number of hospitals have promoted clinical governance as an approach to improving quality (National Health Committee, 2001).

Finally, there is the need to consider how a stronger and more pervasive leadership culture can be built. The NHC stresses the need for strong leadership for quality improvement (National Health Committee, 2001) and sees leadership from within health care organisations and teams as crucial. It suggests the promotion ‘of leadership for quality improvement by training interdisciplinary teams of professionals, managers and board members in leadership development and quality improvement approaches’.

However it is also clear that there is relatively little sharing of emerging experience. It is also apparent from this and the other studies, that clinical leaders, along with managers, need education and training programmes to support them in their new roles.

Opportunities for shared learning among health professionals, managers and consumers are crucial to the development of 'learning organisations'. The reforms of the 1990s have left a legacy of 'learning deficits' among health care providers, and devising national and local mechanisms to restore these will be a significant future challenge.

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Appendix 1 A review and analysis of clinical leadership/governance in addressing issues of quality the New Zealand health system

A project being undertaken by a team funded by the Ministry of Health through the Clinical Leaders Association of New Zealand (CLANZ) 19 April 2001

Contact: Laurence Malcolm laurence.malcolm@cyberxpress.co.nz Ph 03 329 9084

CLANZ, established in 1998, has been contracted by the Ministry of Health to undertake a number of clinical leadership development projects. One of these is a review of the development of clinical leadership and governance within New Zealand and its potential to address quality issues. CLANZ has contracted with a project team led by Laurence Malcolm and including Lyn Wright, Pauline Barnett, Chris Hendry and Michael Powell. The team brings together a wide range of New Zealand qualifications and experience in this field.

The promotion of clinical quality has become a critical international issue. The most immediate concerns in New Zealand arise from the Gisborne Hospital 1999/00 and recent cervical screening inquiries. However there are many wider issues including; preventing adverse events, bringing clinical leaders into new forms of accountability for quality and cost, and addressing clinical quality at governance and 'system' levels eg in health service organisations, such as DHBs.

The project will link closely with initiatives are being undertaken by the Ministry of Health, National Health Committee, DHBNZ, Independent Practitioners Association Council (IPAC) and other organisations. It will seek to contribute to a national consensus in building an integrated picture of the 'quality jigsaw' and the role that clinical leadership might play in addressing quality within clinical operational settings. We intend that the results be widely shared and discussed in workshops. It is expected that the project will lead to the provision of clinical leadership training programmes.

The project includes three key parts, the first being a literature and document review. This will draw upon both New Zealand and international experience in the development of clinical leadership and clinical governance and its intersection with clinical quality.

Secondly the project will include an analysis of quality programmes within primary care organisations (PCOs) and the role of clinical leadership here. Previous work by members of the team, undertaken for the Ministry of Health in 1999, showed substantial progress towards a developing model of clinical governance. However, further documentation is needed of progress PCOs are showing in quality initiatives. In conjunction with IPAC, and other PCO representatives, some 10 PCOs will be selected for further study. We believe that this project will substantially improve the availability of information and evidence to assist both PCOs and the wider health sector in understanding and hence promoting successful initiatives.

Thirdly the project will seek to document and analyse clinical leadership related to quality developments within DHBs. We appreciate that DHBs are currently under major developmental pressures. In order to minimise work we are initially seeking existing documentation, followed up with questionnaires to key informants from both management and clinicians. Again we want to work closely in conjunction with the Ministry and DHBNZ. From a DHB perspective we expect that this project will provide

valuable assistance to DHBs through sharing of information on experience to date and how clinical quality, in conjunction with clinical leadership, can be more successfully promoted in DHB settings.

We believe this to be a key project in promoting the success of clinical quality initiatives. We welcome further comment on this project and your full support in its implementation.

Appendix 2

District Health Board Reports

- 2.1 Auckland
- 2.2 Canterbury
- 2.3 Capital and Coast
- 2.4 Counties-Manukau
- 2.5 Hutt Valley
- 2.6 Lakes
- 2.7 Nelson-Marlborough
- 2.8 Northland
- 2.9 Otago
- 2.10 Waikato

2.1 AUCKLAND

The following information was provided from discussions with Chief Operating Officer (COO) Neil Woodhams, General Manager (GM) Graeme Benny and from documents supplied particularly relating to the Quality and Risk Implementation Project.

1. Background

The Auckland District Health Board (ADHB) serves a population of 369,700 and provides services through four main hospitals, mental health and community services and provides about 50% of its volumes to residents of other District Health Boards (DHBs).

Its mission statement is;

“Healthy communities, quality healthcare.”

As for many other DHBs Auckland is facing major funding issues which could limit effective implementation of quality initiatives.

2. The organisation of ADHB services

The organisational structure within the DHB is based upon service divisions, women's health, child health, medical, surgical, mental health, etc. Under the Chief Executive Officer (CEO) is a COO who oversees the hospital-based provider services each of which is managed by a general manager partnered by a medical and nurse leader. Under the Health Services Delivery Plan (HSDP) service managers will work across hospital campuses.

The relationship between clinical leaders and their manager counterparts is seen to be a full partnership. Both clinical leaders and managers are signed up to be accountable for cost and quality. There is full devolution of financial responsibility to clinical groupings. This devolution includes direct and indirect costs, including payment for clinical support services, eg laboratory, radiology, overheads and depreciation. Over the years there has been on-going focus on managing the utilisation of support services but there is an absence of an advanced savings incentive process (eg whereby savings are returned to the services). The main incentive is to conform to agreed utilisation benchmarks (e.g. previous year volumes) and coming within budgets. This system or its predecessors have been in place for over five years.

At the sub-specialty level, ie cardiology, orthopaedics, there are clinical directors who work with service managers. Again, in general, clinical directors take full responsibility for all aspects of a service including quality and financial performance. Financial responsibility is fully devolved although there are problems with full devolution of indirect costs to this level.

There is limited flexibility within budgets to shift from one priority to another. There is cautious but limited buy-in by clinicians to budget holding arrangements. The continuing, and more recently, serious funding constraints have exacerbated the difficulty of managing and balancing budget performance and patient care. Clinicians have some difficulty in having to make ‘rationing’ decisions at a clinician-patient level in the

absence of wider, public understanding of the pressures under which they are operating and without a national framework of priority setting.

At the service level there is seen to be full accountability of the clinical leader and general manager for service quality and cost. Clinical leaders on average spend 5-6/10ths of their time in their clinical management role, the remainder on clinical work. At the sub-speciality there is a similar level of accountability for clinical quality but somewhat lesser ability to manage cost. Clinical directors with large directorships eg Emergency, Anaesthesia and Operating Rooms spend 4-10ths, others, and sub optimally, 1/10th.

Nursing leadership. There is a director of nursing (DON) who reports to the COO and who handles professional relationships in nursing. Direct management responsibility for nursing is through the general manager of the service. All clinical leaders and directors are medically qualified which means that there could be problems with nursing representation. However, several of the GMs have a health professional background and the DON is an active participant in senior management activities in each Service (but there is senior nurse representation at the management level. However clinical leaders are said to be ‘bending over backwards’ to work closely with other disciplines, including nursing.

3. Quality initiatives implemented by ADHB

3.1 The Quality and Risk Implementation Project

A Quality and Risk Implementation Project quality plan is being developed. This is based upon wide consultation and input (from clinicians and all staff groups) and also has strong CEO and Board support. It arose from an earlier clinical effectiveness review, and a request from the Board about management of risk. . The initiative is working from the premise of leveraging and extending the existing expertise within the hospital (Provider) services across the DHB to ensure consistent DHB-wide quality and risk management services. It is seen as supporting clinicians in their endeavours to improve clinical effectiveness and quality via their daily clinical practice.

The Quality and Safety Manager reporting to the COO will manage the Quality and Safety Unit. This will be a shared service for the DHB both provider and funding arms. The current structure of multidisciplinary quality groups at each hospital and service level will remain. The programme is based on the “Framework for Quality Improvement”. A new advisory group the Population Funding Effectiveness Council is to be established and will address quality issues in the funding arm of the DHB.

The Quality and Risk Implementation Project is still in a formative stage but it seeks to establish a comprehensive and integrated approach to clinical quality management. The plan is integral to service management and managed by the services described above. It is to be board-wide with engagement from the DHB board and needing to be aligned with external views, requirements and needs, eg from the MOH.

The existing Clinical Quality Council (CQC) is being expanded. All aspects of clinical quality management will be channelled through it, and be managed by it. It will report to the COO and will work with the provider arm Quality Manager. Discussions are currently being undertaken to determine whether it should move from its members being

representative or based on expertise. A problem with such a shift is managing changed expectations.

Quality and risk management reporting is to be emphasised as part of the regular service monthly reporting systems, be consistent across the DHB and will be accorded priority within the DHB.

As part of the strategy a set of definitions has been adopted relating to clinical governance, clinical audit, clinical pathways, clinical effectiveness, etc,

Clinical audit and credentialling will also come under the CQC. There is continuing progress with credentialling, with 32 of the 54 clinical units completed or are in the process of being credentialled. The process has been in place for nearly three years and is overseen by a Credentialling Committee. There is good acceptance that it is a useful strategy but progress is limited by time and funding support. It is not seen as either onerous or inappropriate.

Accreditation is seen to be an important strategy for bringing about an integrated process of quality improvement. All hospitals and mental health services have been accredited twice. There is increasing support and acceptance for it as an organisation-wide strategy. There is now strong support for the standards as set out in the accreditation process.

3.2 Achievements in quality initiatives

An important achievement has been the development of the partnership between managers and clinicians at the service level. Few parts of the organisation now do not have this partnership. It is seen to be fundamental towards progressing towards quality improvements and has been a key factor in avoiding some of the 'us-them' conflicts that have occurred in other Hospital and Health Services (HHSs). It appears to have led to some change in the overall clinical culture although this may be sliding backwards now with the current financial stringencies.

The information systems are still limited and are better for financial than quality measurement. There is very limited data on individual patient costs, many of which are only disaggregated to the service, not patient level. This limits analysis of quality and expenditure related to particular disease categories.

4. Clinical advisory functions

For the most part clinicians are represented through the formal organisational structure of clinical leaders and clinical directors. A Chief Medical Adviser appointment has been made. A chief nursing adviser represents nursing interests through a formal appointment to this position.

That there is also an established role of Medical Advisor Quality who works in partnership with the Quality Manager, who leads the credentialling programme and also chairs the Clinical Quality Council.

A number of professional advisory groups represent different disciplines, Medical Advisory Council representing Senior Medical Officers, Nursing and Midwifery Advisory Council and an Allied Health Advisory Council.

5. Education and training for quality and leadership

ADHB sees itself as having a leading role in education, training and research. There are some internal learning development and training programmes, including strategic planning, but many clinical leaders find it impossible to attend these because of time demands. There is a need for a national programme to bring clinical leaders together with managers and to share learning across DHBs.

6. Clinical governance within ADHB

Clinical governance is being adopted as a term within the DHB and is based upon the UK definition. It is inclusive of all clinical quality programmes, eg the quality and risk management framework, clinical effectiveness, the CQC and clinical leaders partnering with managers.

There have been some misconceptions about clinical governance, eg that it is doctors sitting on boards, but this has been clarified. Financial management is included within clinical governance. There is a need for a national strategy inclusive of clinical governance and for national clarity and consistency of what is meant by it.

2.2 CANTERBURY

The following report was prepared from discussions with Chief Executive Officer (CEO) Jean O'Callaghan, Chief Operating Officer (COO) Bill McDonald, Corporate Quality & Risk Manager, Jan Nicholson, from Canterbury District Health Board (CDHB) documents and web site, the Stent Report and other sources.

1. Overview of CDHB

Canterbury District Health Board (CDHB) was formed on 1 January 2001 following the merger of the two Christchurch based HHSs Canterbury Health Limited and Healthlink South Limited. It serves a total population of 434,000, the largest of the DHB populations, spread over an area ranging from Kaikoura to Ashburton. The Maori population is 6.8% of the total.

Hospital-based clinical services are provided at: Christchurch Hospital - a tertiary institution, the Women's Hospital (being merged with Christchurch Hospital), Burwood, Princess Margaret, Ashburton, Hillmorton (formerly Sunnyside) and six rural hospitals.

The vision of CDHB is:

"Working together for the best health and well-being of the people of Canterbury"

The mission is:

"To provide high quality health care services for our patients / turoro and consumers / tangata whaiora"

2. The organisation of CDHB clinical services

2.1 Organisational overview

CDHB follows the almost standard pattern of DHBs with operating and contracting arms/divisions under the CEO. The Operating Division comes under the general management of the COO who is responsible to the CEO for all clinical services. There is no designated chief medical officer or advisor although there are two medical advisors located within Christchurch Hospital whose responsibilities are to provide advice and direction on organisation wide matters. There is no overall Director of Nursing, only directors of nursing reporting to the general managers of the hospitals.

2.2 Historical background

A service-based model of clinical organisation has for a long time been a feature of clinical service organisation in Canterbury. The Canterbury Area Health Board formed in 1989 led to the implementation of service management. However progress was to some extent reversed during the commercially-driven reforms of the 1990s. Despite clinical staff opposition, services were divided into two Crown Health Enterprises (CHEs). Clinical directors were appointed within the hospital system but were not given any significant financial delegation. Changes imposed led to diminishing trust between

clinicians and management with senior medical staff feeling disenfranchised. These conflicts eventually threatened patient safety and led to the Stent investigation.

Since 1998 there has been progressive recovery from the 'clash of cultures' including implementation of the recommendations arising from the Stent Report. However management control remained centralised until recently and has been a source of continuing tension between clinicians and management. In Healthlink South, which provides mostly Mental Health and Older Persons Health services, there were similar but much less public tensions. Recently there has been progress to a well-developed accountability structure with good working relationships between clinicians and managers.

The new DHB has placed a high priority on improving morale and building better relationships throughout the organisation. A commitment to common goals, expressed in the New Zealand Health Strategy, appears to be important in shaping a new culture. An important continuing issue is the dominance of Christchurch Hospital in the DHB system and the need for staff to take a broader population-based view, as required in the Strategy.

2.3 Current discussions

The organisation of clinical services is currently undergoing a major review. In July the COO, with the support of the Board, sent out a discussion document inviting submissions on a proposal for change, focusing on devolution of budgets and clinical responsibilities to service clusters. The objectives included:

- achieving the best possible health outcomes for the population of Canterbury
- the development, within clinical service divisions, of collective professional accountability for both quality and cost of services within a defined set of resources
- promotion of close working relationships between clinicians and management
- integration of clinical divisions/disciplines, of hospital and community-based care and of government and non-government sectors.

Stage 1 of the devolution would include three clusters/groupings; internal medicine, child health and haematology/oncology within Christchurch Hospital. Further devolution is expected to follow for other clusters. At the service level would be a medical Chief/Chair, a Nursing Director both and a Business Manager. The Chief/Chair would have responsibility for medical resources and treatment-related costs, the Nursing Director for nursing, technician and allied health resources and the Business Manager for supporting these two in business and administrative functions.

Although financial accountability was the initial thrust of the proposed devolution the focus is now clearly on the integration of both quality and financial management. Discussions are currently continuing but it is reported that there is general support at least for the principles of this devolution.

2.4 Nursing organisation

The reforms of the 1990s led to major changes in nursing organisation with the appointment of patient care managers and nurse facilitators, replacing the previous

system of charge nurses who, in general, were service-based with good working relationships with medical staff. This reorganisation further impaired relationships between medical staff and management. Nursing control and budgeting was located largely within a nursing hierarchy framework. There was no overall Director of Nursing for the CHE/HHS, only for the separate hospitals.

Current discussions propose full devolution of nursing budgeting and control to the directors of nursing at the service/cluster level. There are understandably concerns that this might lead to some disempowerment of nursing. These concerns could be alleviated by the formal appointment of a Director of Nursing accountable for overall nursing leadership, standards, supporting the integration of nursing into service divisions and contributing to quality development programmes. Current discussions do not as yet propose the establishment of such a position.

2.5 The Clinical Advisory Committee

In order to give a more effective voice to clinical staff, as a consequence of the relationship problems discussed above, a Clinical Policy and Planning Committee (CPPC) was established for Christchurch Hospital in 1997. More recently this has been renamed the Clinical Advisory Committee (CAC) and its membership broadened to include all services in the Operating Division.

It provides advice to the COO and to the DHB Hospital Advisory Committee on a wide range of clinical matters, of which quality is only one. However clinical quality is becoming a more important part of its activities. Questions remain as to whether it will become the lead body for promoting quality development programmes throughout the DHB.

3. Quality initiatives implemented by CDHB

3.1 The CDHB Quality Plan

The CDHB Operating Division Quality Framework is organised on the basis of the overall management structure with GMs of the various divisions being accountable for operational delivery of quality. The CEO is accountable for overall quality in the organisation.

The **Quality Framework states** that CDHB is committed to gaining recognition as a centre of excellence in the provision of quality health care to its patients/turoro and consumers/tangata whaiora by practising the principles of quality management throughout the organisation. The **principles of the framework** include:

- quality processes driven by patient and the user needs
- the involvement, training, empowerment and recognition of staff
- acceptance by all staff of their responsibility for quality outcomes
- the use of teamwork in the definition, documentation and promotion of best practice
- clear, measurable and well communicated objectives
- continuous improvement, systems and performance monitoring
- benchmarking for the organisation with either national or international sites.

3.2 Organisation and staffing for quality

Divisional quality committees are located in each division, eg hospitals, mental health and older persons health. The quality committees consist of medical, incidents and complaints, OSH, infection control, medical appointments, medicines advisory and clinical quality assurance (QA) groups. The overall management of the quality framework comes under the Corporate Quality and Risk Manager assisted by divisional quality managers, co-ordinators and facilitators.

3.3 Components of the Quality Plan

The Quality Framework includes the following components.

Quality and Risk Management

CDHB's risk management process is an integral part of its approach to quality. The continuous quality improvement activities associated with quality management anticipate and identify procedures to avoid or manage future risks. The CDHB has adopted a process of risk identification, assessment and reporting in compliance with the AS/NZ Risk Management standard. A risk register is being developed.

Quality Standards

Written standards form a benchmark for quality of care. They include national and internationally recognised standards, as well as legislative requirements, contract specifications and best practice guidelines. Standards are explicit, defined, documented and range from high level legislation to operational policies and procedures, compliance with standards is supported by policies, procedures, clinical guidelines and protocols.

CDHB has a framework and document control system for the development and implementation of the above standards. Development, review and sign-off require participation from the relevant inter-disciplinary group.

Monitoring and Audit

Monitoring activities include, but are not limited to:

- **Clinical Audit**

Clinical Audit Programmes are at varying stages of implementation across the DHB. To further develop this process, appropriate information systems are being sought. This is a key quality plan objective for 2001/2002.

- **Clinical Indicators**

CDHB participates in the Australian Council for Healthcare Standards (ACHS) Clinical Indicator Programme. The indicators selected from this programme reflect the type of services provided within each division. ACHS provides the DHB with quarterly reports and this information is incorporated into the divisions' quality improvement programmes.

- **Peer Review**

Within each division, a structured framework is in place to facilitate peer review. This process is managed by each professional disciplinary group.

- **Mortality & Morbidity Review**

There is a mortality review group that is managed by the Christchurch Hospital Staff Association. The purpose of this group is review deaths and to report to the appropriate Clinical Director when a reviewers findings differ to that stated by the Medical Officer.

- **Incident Accident Reporting**

There is a DHB Incident Reporting System. A joint Cardinal Healthcare/CDHB project has resulted in the development of a Risk Events Management (REM) database. This will be used across all divisions for reporting and monitoring of incident, complaints and patient information requested. Each division has an Incident Review Committee or review mechanism process. This group consists of medical, nursing, quality, allied health and legal representatives. For major adverse events an in depth investigation will occur.

A root cause analysis tool such as the Ministry of Health/Standards NZ Sentinel Events process is used. The incident reporting system provides initiatives eg. Medication Safety Project involving Christchurch & Burwood Hospitals. This project was a result of a high number of prescribing errors being reported. Through multiple campaigns including posters and bulletins circulated to all doctors, outlining aspects of prescribing legibility, legality, and generic prescribing, there has been a noted improvement in prescription practice.

- **Quality Improvement Programmes**

Each service has in place a quality programme that reflects the divisions and CDHB quality plan. This programme includes a comprehensive audit programmes. There is a formal reporting process of quality activities, which occurs on a monthly basis.

- **Performance Indicators**

Performance indicators are monitored at a divisional and DHB level. At the DHB level, Patient Satisfaction Survey results, Patient Falls, Emergency Triage Indicators and Medication Errors, Bloodstream Infections are reported on a quarterly basis to the Hospital Monitoring Directorate (HMD). A broad range of indicators including the above are reported monthly as part of each division's quality report.

- **Benchmarking**

Benchmarking occurs in the following ways:

- ⇒ HMD quarterly reports
- ⇒ ACHS Clinical Indicator Reports
- ⇒ CDHB Quality Reporting

CDHB is also a member of the Health Round Table through which Benchmarking activities occur.

- **Credentiailling**

Activities within CDHB include:

- ⇒ Establishment of a framework for credentiailling medical staff
- ⇒ Establishment of a credentiailling board
- ⇒ Piloting the credentiailling process within Christchurch Hospital Services
- ⇒ Preparation for rollout to other hospitals within the CDHB

- **Accreditation**

The organisation has made a commitment towards achieving Quality Health New Zealand Accreditation within all of its divisions. To date, accreditation status has been achieved in Ashburton and Community Health Services, Women's Health Division and Burwood Hospital.

CDHB recognises that the accreditation process

- ⇒ provides a quality system framework
- ⇒ embraces clinical governance
- ⇒ covers all aspects of the business
- ⇒ requires continuous quality improvement
- ⇒ seamless approach, expects a multi-disciplinary focus and integration with the community

▪ **Reporting on Quality**

There are quality reporting mechanisms at departmental divisional, corporate and board committee levels. Forums exist for the review of this information. External reports are also provided to ACHS and HMD.

4. Clinical advisory functions

Clinical advisory functions have been discussed. The CAC is now recognised as the formal advisory body. Questions remain regarding the establishment of the positions of chief medical and nursing advisers/directors.

5. Education and training within CDHB

CDHB has a well-established set of programmes for staff training and development. There is a felt need for more formal training programmes to bring clinical and other leaders together across the different sectors and throughout the country. There would be support for the establishment of a national training programme for health leadership, which might be modelled on the Health Management Services Development Unit of the early 1990s.

6. Clinical governance

No formal policies have been put in place with CDHB regarding clinical governance but the term is being increasingly used in discussions about the promotion of quality.

2.3 CAPITAL AND COAST

The following report is based upon interviews with the CEO and senior staff of the DHB and relevant documentation.

1. Overview of the DHB

Capital and Coast District Health Board (CCDHB) is a major provider and funder of health services with a district population of 248 000 and regional population of about 900 000. It operates one large hospital at Wellington, a medium hospital at Kenepuru, a small hospital at Paraparaumu, and a number of community bases.

2. The organisation of Capital and Coast services

2.1 Historical background

Progress towards a more devolved system of accountability, with clinicians becoming involved in financial management along of quality management, was advancing well in the early 1990s under the Wellington Area Health board. However with the implementation of the commercially led reforms in 1993 there was a serious setback to this progress, leading to a major gap developing between the corporate/management culture on the one hand and of clinicians on the other.

Some progress towards cultural convergence was being achieved from 1996 and has progressed rapidly over the last 12 months.

2.2 Overall organisation and devolution

Under the CEO is the General Manager, Health and Hospital Services (GMHHS), the equivalent of the COO in other DHBs. Also reporting to the CEO are the Chief Medical Advisor (CMA) and the Director of Nursing and Midwifery (DONM), Under the GMHHS are six clinical directors partnered with business managers. These are Women's Health, Child Health, Medical, Surgical, Mental Health and Clinical Support. Within the medical and surgical division are subspecialties such as cardiology, renal medicine, etc. At this level are clinical leaders partnered with service leaders. All clinical directors are medical with the exception of Child Health who has a nursing background.

The service structure covers all three hospitals, ie the three hospitals are treated as one campus under the GMHHS.

Budgets are devolved to clinical services and down to the subspecialties. Budgets include all direct and indirect costs, clinical support services and overheads. There is reasonable flexibility in transferring funds from one part of a budget to another although there are serious limits on purchase of capital expenditure with current funding constraints.

Financial management is part of the total quality picture and is essential for the overall management of the service. Budget management is an empowering experience. Although a budget is important in managing quality it is the quality of leadership that is the critical factor. Key people in the organisation agree that quality is an investment, ie that better quality saves money.

2.2 Nursing organisation

Overall nursing leadership comes under the DONM. With the devolution of budgets there is complete devolution of nursing budgets and staffing to services and sub-services. Senior nurses within the service are appointed in conjunction with the DONM. Although a number of business and service managers have a nursing background this does not mean that they continue to represent nurses. There may in fact be a conflict of interest.

There are potential advantages and disadvantages with devolution. Important disadvantages may be:

- fragmentation of the nursing workforce
- a lack of flexibility in being able to move nurses to where they are needed
- a possible weakening of the overall influence and professional contribution of nurses within the organisation.

On the other hand advantages are:

- nurses becoming full members of, and integrated into the service team
- an ability to effectively manage all aspects of care, including nursing, within the service division.

Effective integration has been facilitated in CCDHB through:

- firm nurse leadership from the DONM in a promoting the role of nursing throughout the organisation and close working relationship between nurses and other clinicians
- an organisation-wide policy to ensure that the nursing voice is heard and valued
- a system of nurse consultants who work with service divisions to promote and assist with nursing developments and integration
- flexibility is assisted with after hours nursing distribution coming under the DONM.

However moving from a culture of a separate nursing hierarchy to a culture of integration requires a great deal of effort. It places a particular strain upon DONM leadership. The model being developed in CCDHB has been fostered through a system of shared governance, building teams across the organisation based upon partnership, equity, accountability, and ownership.

The DONM stated 'Nursing will be a lot stronger for being integrated and interdisciplinary. Nurses become key players in the team and it can be seen just how much they can contribute. This has to be better'.

3. Quality initiatives in Capital and Coast

Clinical quality issues had previously come under the Clinical Quality Council of the DHB. Given that important changes were being made in the organisation of quality it was decided that a name change was desirable. The term 'council' implied a monolithic, bureaucratic structure. After considerable discussion it was decided to change the name to 'Quality Improvement Group (QIG)'. The QIG is supported by the Quality Support Group staffed by quality facilitators.

The chair is the clinical leader for the Emergency Department and a number of other departments with a total budget of \$60 million. As Chair he reports directly to the CEO for quality. He had previously worked in Bristol and this experience had been pivotal in shaping his views about the need for quality being central to DHB strategies.

In contrast to the previous council, which had a large representative membership, quality is now to be driven by those who are delivering the service. The membership is now the six clinical directors, DONM, director of operations, Maori health and DSD and will include a representative of primary care and consumers. It also reports to the Hospital Advisory Committee.

The group is to be responsible for the following;

- credentialling, which is now being implemented
- accreditation by 2004
- sorting out clinical policies throughout the organisation
- risk management, hazards and complaint handling, with tightening of the procedures in these areas, eg drug problems and prescribing
- clinical audit with standardisation of procedures across the organisation with a particular focus upon clinical outcomes and ensuring that audit findings are followed up.

As yet the organisation is not ready for clinical excellence.

There is continuing current discussion about the role of the QIG and its strategies. The Quality Support Unit has produced a consultation document that seeks to create the opportunity to improve patient care and service delivery through:

- identification of service deficits/service improvement areas and the ability to support staff in those areas to develop systems and processes to meet organisational quality requirements
- mentorship and accountability of all staff within service groups to undertake service improvement initiatives as part of their work
- improved focus on quality through appropriate and focused management of the quality support unit and quality facilitator group
- a focused approach and mandate for changing culture and work practices
- integration and consistency of quality activities at all levels
- provision of resources required to deliver quality outcomes
- potential financial benefits.

As yet these are largely plans awaiting implementation, which will take time, patience and much further discussion. It is hoped to bring together all quality functions under the direction of QIG. Quality functions will be led by a team leader reporting to QIG. There are currently some 8.5 quality facilitators across the organisation. It is hoped to bring these together under the QIG with some of the time of this group being service with accountability to the clinical leaders and some of the time with accountability organisationally to the QIG.

4. Clinical advisory arrangements

It is felt that there is now no need for a clinical advisory committee given the extensive involvement of clinicians in management. The QIC is an accountability structure for driving quality and ensuring good clinical input.

5. Education and training quality and leadership

There is a need for education and training programmes particularly focusing upon particular skills, eg managing conflict, relationships and to building networks of shared learning.

Senior executives expressed support for a national programme for leadership training. Reference was made to the important achievements over a decade ago through the Health Services Management Development Unit sponsored by the then Department of Health.

6. Clinical governance

The term clinical governance has not been adopted within the DHB as yet although it is clear that many of the organisational developments are highly consistent with clinical governance.

2.4 COUNTIES-MANUKAU

The following report has been put together based upon interviews with CEO David Clarke, Chief Operating Officer (COO) Brian Rousseau, Chief Medical Officer (CMO) Ian Brown, Director of Nursing Practice (DNP) Mary Gordon and documents supplied from a number of sources.

1. Background

The Counties-Manukau District Health Board (CMDHB) serves a total population of 375,800. Although there are some well-off areas the population is one of the most disadvantaged in the country with high proportions of Pacific Island people and Maori and with serious health needs. Secondary and tertiary care services are largely based at Middlemore Hospital but a wide range of community-based services are provided to meet the very diverse needs of this population.

CMDHB has been a national lead organisation in promoting integration of all health and disability care providers in its district. As indicated in the 2000/01 Business Plan the main driver of the integrated care system is not cost control but improved quality. It is seen that integration, by improving quality through improved population health, reduced waste and duplication, will result in both better quality as well as reduced costs.

CMDHB stresses the following **values**:

“Care and respect, teamwork, innovation, responsibility, partnership, quality, service, focus & action.”

There is a strong emphasis upon operational effectiveness and quality in a four-quadrant model of clinical quality, delivery quality, productivity, and financial. Each quadrant has a set of indicators in a ‘Balanced Scorecard’ model. CMDHB is becoming to be recognised nationally as a model of organisational quality.

2. Organisation of services in CMDHB

As for most district health boards (DHBs) CMDHB is divided under the CEO into a funding arm and an operating arm, the latter under a COO. Under the COO are two key positions, the CMO and DNP. At the executive level the COO, CMO and the DNP work very closely together.

The CMO has a key leadership role advising the COO on clinical matters, contributing to strategic planning, participating in the Clinical Board, developing and reviewing professional clinical leadership and management responsibilities and has a key role in quality management. The position has both executive as well as advisory functions.

The CMO works just for the provider side referred to below as South Auckland Health (SAH). There is another clinical adviser reporting to the CEO for the contracting side. The DHB is accountable for quality of all services, both those it provides and those it contracts out.

Organisation of services in SAH is based on service divisions, ie Women's Health, Surgical, Acute Care and Medicine, Mental Health, Child Health (Kidz First), Intermediary Care, Ambulatory Care, Clinical Support, with Maori and Pacific island Cultural Resource Units and corporate support services.

For each service there is a general manager in partnership with a clinical director (medical) and a clinical nurse director. At sub-specialty levels in medicine and surgery, eg, general medicine, cardiology, respiratory, diabetes, general surgery, plastics, orthopaedics, ophthalmology, etc, there are clinical heads in partnership with a service manager and clinical nurse leaders, senior nurses/charge nurses. Clinical Directors/Clinical Nurse Directors have shared accountability with the general manager. Clinical heads report to the clinical director and have joint accountability with their manager.

There is devolution of accountability to services for developing and keeping within budgets. This includes direct costs such as staffing. There is complete devolution of nursing staffing and funding to service and sub-service levels. There is no charging as yet for clinical support services or overheads, either at service or sub-service levels, although this is currently being worked on.

There is good "buy-in" to this devolution and accountability at the clinical director level but less so at the clinical head level. There continues to be tension between cost and quality issues, the balanced scorecard system attempts to resolve these issues. Accountability varies between services. In some it is complete and others less so. The CMO has a key role in establishing this accountability. There is also variable "buy-in" amongst the rank-and-file between individuals and services. As a consequence of current tough budgetary limits there is some retreat at present in this buy-in, both on the part of management as well as clinicians.

However in recent years there has been significant, if not major progress towards this greater clinical accountability. An important factor has been a strong emphasis upon working closely together within SAH, which has tended to attract staff with an interest in a strong service culture. SAH has also been fortunate having a commitment from executive leadership and this has been a critical factor in fostering a culture of accountability.

Nursing organisation. Overall nursing leadership comes under the DNP. There is full devolution of nursing budgets to services and sub-service divisions. An important step in improving nursing input to the actual service delivery, and ensuring professional standards are maintained, has been the appointment this year of clinical nurse directors to the service level. They function in partnership with the General Manager and Clinical Director and have shared accountability of services while remaining professionally accountable to the DNP. There is joint accountability within this partnership for all aspects of operational service delivery, including both quality and cost.

There is a serious dearth of strategic skills in nursing leadership especially between the levels of charge nurses and director of nursing services. The clinical nurse director's role was established to ensure that nursing leadership was actively involved at all levels of the organisation as well as taking joint accountability for operational service delivery and to also provide professional advice and leadership.

Nursing services are fully involved in the organisation, structures and processes to promote quality within SAH.

Attention is being given as to how allied health groups fit into the emerging organisational structure. A system of clinical directors has been established and there is representation of allied health groups on the Clinical Board. The problem has been the wide range of groups needing to be involved.

3. Quality initiatives

Apart from organisation-wide quality initiatives stressed by CMDHB/SAH, clinical quality has been promoted with a strong clinical input through the Clinical Board. This was established in 1993 to develop clinical policy to help maintain standard of clinical quality and to involve staff in the decision making process.

Other factors and steps in the development of quality initiatives within SAH have included:

- safety audits in medicine and surgery
- customer surveys
- dedicated funding for clinical audit
- reducing inappropriate variation in practice
- appointment of a Quality Facilitator
- adverse events project
- clinical documentation project
- complaints, and incidents audit

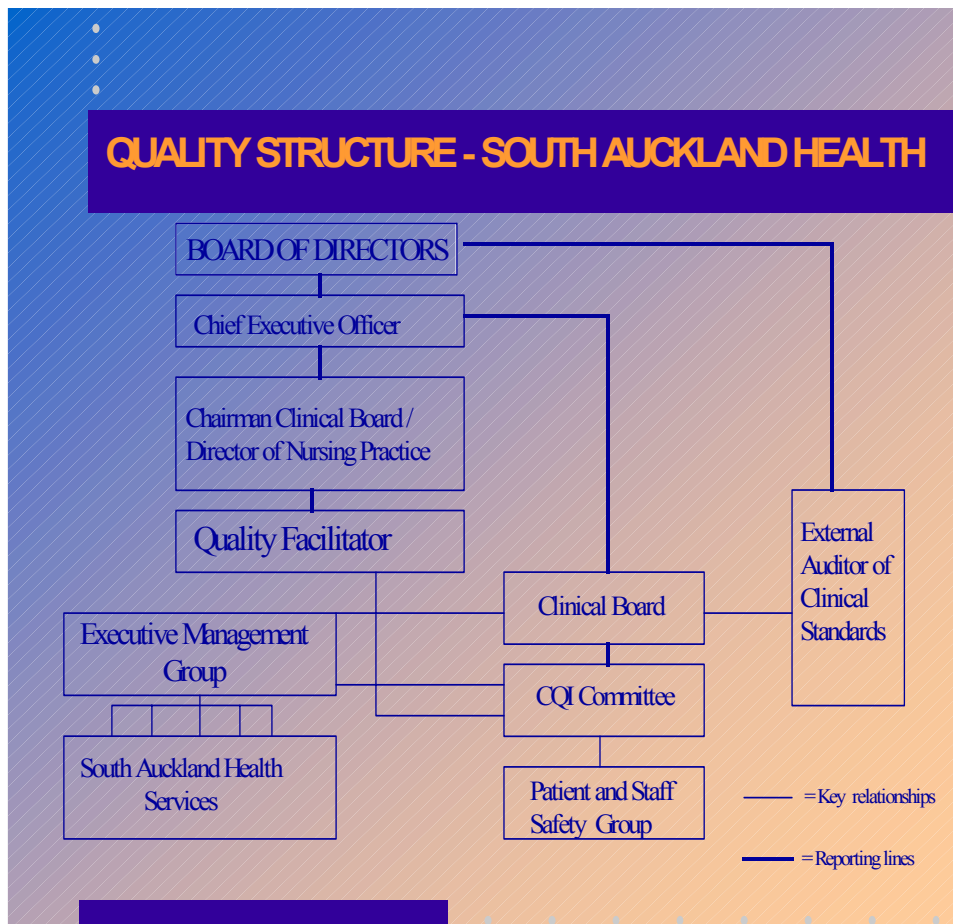
The Clinical Board membership consists of Clinical Board Facilitator, COO, CMO, clinical directors, Director of Nursing Practice, representatives of nursing, midwifery and allied health staff and cultural advisers.

The Clinical Board is now responsible for a wide range of quality improvement activities examples of which include; shared vision and values, accreditation policies, clinical policies including cultural policies, clinical indicators, guidelines and clinical pathways, credentialling processes, continuing education and clinical audit.

The Quality structure, as it was operating in 2000, is shown in Figure 1. There is continuing discussion and organisational change affecting the governance and management of quality. The Clinical Board is an overall advisory body shaping policies relating to quality. A continuous quality improvement committee that acts as a resource to the Clinical Board assists it in its functions. Implementation of policy is handled by the Quality Council and the Clinical Board Executive. Actual delivery of quality functions, however, is through the clinical service groupings. A Manager of Clinical Quality has been appointed to work with the Board and Executive.

All quality functions are hence handled under one structure ensuring overall co-ordination. An essential feature of the quality process is that it is “bottom-up”. The governance and management functions are seen to be largely facilitatory to this process.

Figure 1 CMDHB Quality Structure



At the governance level there was an external audit committee but this has been replaced by a committee comprising the CMO, Quality Manager, Chairperson of Clinical Board, CEO, COO, Director of Nursing Practice and two members of DHB.

4. The most significant achievements in quality

- **Accreditation.** There is strong emphasis upon accreditation, which was a driving factor in the quality improvement process established by CMDHB. SAH was accredited in May 1999 and has just been re-accredited. .
- **Adverse incidents policy.** A comprehensive policy of notifying and addressing adverse events/incidents is in operation and is regularly monitored. The policy sets out categories of incidents, how they will be reported, informing patients, the responsibilities of different staff, investigation, feedback and resolving the incident.
- **Complaints process and resolution.** The complaints process and resolution system parallels the adverse incidents policy and defines the source and scope of complaints, provides definitions, and outlines the responsibilities of staff, investigations, incident prevention and feedback.

- **A learning organisation.** Progress is being made towards SAH becoming a learning organisation and developing a safety culture. In the New Zealand environment this is still difficult. Regarding adverse events there is a strong emphasis upon openness, offering an immediate apology and working with the patient and family.

5. Clinical advisory structures separate from management

There is a senior medical staff group within South Auckland Health. This group meets every 2-3 months and has a representative on the Clinical Directors meeting. It is more of a professional peer group meeting and although not directly involved in the structured governance system it can bring clinical issues to the Clinical Board or the Clinical Directors group.

6. Education and training within CMDHB for quality and leadership

There is a wide range of clinical training functions within the DHB in which the CMO has a key role. The CMO is responsible for facilitating the leadership training of clinical directors and other leaders. All clinical directors/leaders are encouraged to go through a leadership programme.

There is strong support for a national leadership development centre to bring leaders together.

7. Clinical governance

Clinical governance is defined by SAH as

‘The means by which the organisation ensures the provision of quality clinical care by making individuals accountable for setting, maintaining and monitoring performance standards’.

There is strong support for the concept of clinical governance and the processes involved in it.

2.5 HUTT VALLEY HEALTH (HUTT DHB)

Discussion with the CEO, Stephen McKernan and the Quality Manager, Helen Smith provided much of this information. In addition Hutt DHB provided a copy of their quality plan.

1. Background

Hutt DHB serves a population of 134, 850 in a relatively small geographic area comprising the two cities of Upper and Lower Hutt plus Wainuiomata. The DHB provides hospital and clinical services through the 250 bed Hutt hospital. In addition it provides community services, mental health services, a regional dental service for the greater Wellington area and a regional public health service covering the greater Wellington area plus the Wairarapa District Health Board. The on-site tertiary services are burns/plastic surgery and rheumatology.

2. The organisation of Hutt DHB's services

The DHB is organised into two provider clinical divisions and a funding group. The clinical divisions, each with a General Manager, are Secondary Health (hospital and clinical services including the two tertiary services) and Primary Health including public health, primary health, mental health, community services and the regional dental health service. A range of advisers e.g. Chief Medical (CMA), Chief Nursing (CAN, allied health advisers (OT, physiotherapy and speech language therapy) and a Maori Health Adviser complement the two service groups. (See section 4 below for further detail on these.) The clinical heads of department report to the CMA on professional issues.

Each clinical division has a number of internal clinical directorates with clinical heads of department. For example, in secondary services clinical directorates include surgical, medical, paediatrics, obstetrics and clinical support. Within primary health the clinical directorates include public health, dental health, breast screening, mental health, community nursing, and integrated care.

There is a partnership between clinical heads of departments and generic service managers for financial management and quality but the service manager has the overall accountability for the budget. A service manager in medicine, for example, could be working with and be accountable for a number of the subdivisions. Service managers may have a non-clinical background although the majority comes from either a nursing or a health technical background.

Fully devolved budgets to relevant cost centres, eg surgery, plastic surgery, intensive care, emergency department, coronary care, cardiology for secondary services enable service managers to charge key services such as laboratory, radiology and other clinical support.

Clinicians involvement in financial management derives from their history of involvement in contract negotiations with the HFA and current participation in project work, information systems, and monitoring of project implementation and associated costs. Clinicians have thus owned their service problems, participated in the development of solutions to these and benefited from that process.

Financial incentives for service areas are less important than ‘organisational’ performance where surplus funds are invested back into service and other areas. Decisions on the use of such surplus funds are made by staff and union groups. The DHB has invested in information systems, professional development and research and established some scholarships for education/training.

Hutt DHB has achieved its excellent operating performance through:

- a fair result in securing revenue and endeavouring to obtain an equitable deal with funding authorities
- modest collective contract settlements with staggered timeframes over a number of years leading to a settled industrial environment, the “modesty” of the settlements being balanced by an investment in professional development
- lean management structures with good accountability and an understanding of what effective management is about
- clinician “buy in” and partnership arrangements with generic management.

3. Quality initiatives implemented by Hutt DHB

3.1 Quality in practice

The organisation has undergone a significant cultural change related to quality. Clinicians have seen that the organisation is committed to both quality and audit and they have joined in. There have been a number of incentives, some of them financial. Physicians have developed an audit template which states that audit and credentialing are required of physicians and clinicians developed and implemented a variety of performance measures – a “bottom up” initiative which is proving to be effective.

Quality has a high profile throughout the organisation thanks to the amount and frequency of feedback from relevant committees and management, and direct information from surveys, and other feedback from service users. Internal publication of quality projects and regular items in staff newsletters add to this.

Integration of quality and financial management is important for getting good-quality outcomes. For example, each clinical head of department is expected to foster clinical audit and has performance measures directed at achieving that. The service manager is available to support such initiatives. Individual accountabilities come together across the organisation leading to good-quality outcomes. For example, in a recent initiative to review the use of laboratory services service managers worked with clinical heads of department to determine appropriate and inappropriate use of laboratory services. While this is a cost issue the overarching principle was what is best for patient care. Quality and cost are two sides of same coin, with good quality being less expensive.

A registrar has been appointed to provide leadership in clinical audit. The organisation now knows the overall state of clinical audit, which areas are doing well, and what constitutes good clinical audit. Clinical audit became widespread throughout the organisation, although the effectiveness of implementation varies between areas at present.

A senior physician became the quality co-ordinator in medicine as part of his job. A designated portion of his time is devoted to working in partnership with the service manager to lead quality and audit activities in medicine. A recently established medical quality committee along with the physicians audit committee has closed the “quality loop” in medicine. Junior staff are encouraged and assisted to be involved.

A comprehensive set of resources and tools are available to assist in the quality programmes including: small monetary rewards, a variety of quality manuals, educational material such as videos, reference books and journals, and paid staff time for meetings.

3.2 Formal supports for quality

- ***The quality and risk management plan***

Hutt DHB has a combined quality and risk management plan that is updated annually. The primary focus is to minimise clinical risk through the provision of systems, audits and programmed activities. Hutt DHB identified risks with the greatest potential to impact negatively on the organisation’s goals. The key priority area was to deal with the negative impact of poor patient care outcomes. The plan relates to all areas of the organisation – clinical, non-clinical and administrative support and covers contracted out services e.g. cleaning services, visiting health professionals. Responsibilities are outlined from the Board right through to staff such as the quality improvement nurse. These requirements are in turn reflected in individual performance measures throughout the organisation. Individual service quality plans linked to business plans support the overall quality plan.

Consumer input is sought in a number of ways eg consultation, feedback by satisfaction surveys, patient and the client focus groups, and complaints feedback procedure. A specific mechanism is available for Maori feedback through a regional board. The Mental Health Service employs a consumer representative. General practitioner feedback is sought and GPs are represented at some clinical meetings and on the Mortality and Morbidity committee.

- ***Committee structure***

The two main committees supporting the quality initiatives are the Quality and Risk Committee and the Patient Safety Committee. The Quality and Risk committee is the overall monitoring body regarding compliance with risk quality programs and clinical audits. It recommends changes to/development of new policy in associated areas and reports regularly to the senior management team providing feedback and reports on patient safety, risk management, quality programmes, mortality, morbidity, and clinical audit.

3.3 External quality participation

Quality Health New Zealand (QHNZ) recently accredited Hutt DHB. The quality action plan from now on will be based on the QHNZ process and reflected throughout the service structure. The accreditation process was very important in shaping the quality culture within the DHB in that it built upon all the other quality initiatives. Four clinicians are qualified as QHNZ surveyors. Hutt DHB benefits from their surveying experiences.

Monitoring of provider quality is also part of the DHB Shared Support Agency, which has a Technical Advisory service with quality and audit as part of its activities in the region.

4. Most significant achievements in quality

The increasing focus on clinical audit has been significant. The appointment of a Registrar in Clinical Audit provided a valuable support for the process.

Hutt DHB staff have a much greater awareness of quality and risk management across a wide variety of activities than, say, two to three years ago. The recent accreditation process with QHNZ has built on the existing activities within the organisation and further heightened awareness.

The accompanying developments in the information systems allow the monitoring of costs at individual patient level. Not only is there data available but people are interested in what it means and want to put it to use to improve quality and cost outcomes.

Staff “buy in” at all levels is enabling “bottom up” solutions to issues. The money that Hutt DHB has set aside for staff scholarships for education and training and for staff development assists this.

5. Clinical advisory functions

As noted above, a range of advisers complement the two provider clinical divisions. These advisers include; medical, nursing, allied health advisers (OT, physiotherapy and speech language therapy) and Maori Health. The medical and nursing positions report directly to the CEO but work closely with the provider general managers in the appointment of clinical staff and professional leadership issues. There are no professional hierarchies. The responsibility for the operational and day-to-day management of staffing lies at the service level.

6. Education and training for quality leadership

In addition to the standard core training, CME commitments and human resource training and development budget, Hutt DHB has further resources available from their “organisational savings” of \$3 million. Of this \$200,000 is set aside for professional development and research. In addition to on-site research projects this money is used for supporting leave and continuing education. Another \$200,000 is invested and the interest from this provides four community scholarships of \$3,500 per person annually for health education and training.

A nursing development unit reports directly to the CNA. This unit provides professional support working across all services for nursing development in leadership. Effectively the unit is a multi-disciplinary clinical staff development unit as many of projects are run in conjunction with and benefit other clinical staff.

7. Clinical governance within Hutt DHB

Hutt DHB focuses on the terms “quality”, “risk”, and “clinical activities”. The term clinical governance is not used. Effectively Hutt DHB is an example of clinical governance at work in clinicians are playing key roles in developing and implementing systems and processes to promote safety and deal with risk issues.

A co-ordinated national quality strategy would help as long as it is not prescriptive and it streamlines all the government-driven external audits into a coherent programme.

2.6 LAKES

The following report is based upon discussions with Chief Executive Officer (CEO) Cathy Cooney and senior staff including Medical Director (MD) Johan Morreau, Acting Director of Nursing and Midwifery (DONM) Monica Blaser and information from the DHB website.

1. Overview

The Lakes DHB is the main provider of publicly funded health services to the communities of Rotorua, Taupo and Turangi – a population of 100,966 people. It has a high percentage of Maori, twice that of New Zealand as a whole at 32.8 %. One third of the population live in the Taupo/Turangi areas.

The DHB is both a funder, and through its public hospitals and secondary community services at Rotorua and Taupo, a provider of health care services. The service provider division continues to be called Lakeland Health. Lakes emphasis is on population health gain with a commitment to work with community, iwi, consumers, and primary health providers to improve the health and disability status of its population.

The Lakes DHB has established the three priority strategic directions which are:

- To achieve continuing improvement in health outcomes for Maori in our area
- To target health issues that will ensure health gain amongst the deprived and disadvantaged sections of our community
- To achieve improvements in quality and efficiency in the delivery of core health services within the region across all providers including Lakeland Health

The strategic directions for Lakeland Health are:

- Deliver and support consumer focused clinical services
- Deliver services which are clinically and financially sustainable
- Through innovative solutions, ensure best practice standards and targets are achieved
- Develop centres of excellence
- Promote the development of health care partnerships between our services and with the community and other stakeholders
- Promote the concept of wellness

In acknowledgement of its commitment to the Treaty of Waitangi and partnership with Maori the Board will actively seek the involvement of Mana Whenua in the decision making process in order to address Maori health and disability service disparity issues. This will be at both a governance level with the two iwi groups within the Lakes region, Te Arawa and Tuwharetoa, and at an operational level through well established arrangements overseen by Te Whakaruruhau.

In contrast to the commercial era of the 1990s there is now willingness and a desire to share information and to work in collaboration with other DHBs towards best practice.

2. Clinical organisation of Lakes DHB

2.1 Clinical divisions

Under the CEO there is now a GM provider division (Lakeland Health). Under the GM, Lakeland Health is a Medical Director (MD) who also has a part-time clinical role. There is also a Director of Nursing and Midwifery (DONM) who provides clinical leadership for nurses and midwives. Clinical services are divided into five divisions each with an operations manager, clinical medical head and nurse/midwife consultant, with clinical nurse/midwife leaders for each unit.

These clinical divisions are; Surgical (including specialist services such as ENT, ophthalmology and orthopaedics), Medical and Diagnostic, Mental Health, Women Child and Family, and Clinical Support Services.

2.2 Devolution

Budgets have been devolved to service divisions and to a lesser extent subdivisions. This includes overheads but not clinical support services such as laboratory, radiology etc. Nursing/midwifery has been devolved to service groupings and is supported in these roles by nurse/midwife consultants. Current restructuring will clarify the extent to which nursing/midwifery budgets will be managed through a nursing/midwifery or management line of responsibility.

2.3 Clinical accountability

Clinical accountability for both quality and cost has grown in the DHB over the last decade, especially with the organisational upheavals that have occurred, including from area health board days.

This conflict was exacerbated by funding crises over the decade and led to the formation of clinically led service groupings. Clinicians became effectively involved in negotiations with funders. More realistic funding as well as significant savings were achieved through clinician management in most services. This integration of clinical with financial management is also seen to be important in gaining better quality outcomes.

There is now strong emphasis upon collaboration between management and clinical staff in the operational and governance structure. The present arrangements are seen to be a real partnership between management and clinicians, including nursing/midwifery, with joint accountability for quality and cost. However there is still reluctance on the part of some clinicians to become financially accountable, although in general clinical heads of departments are increasingly involved in all aspects of cost-quality. A limiting factor in the success of this is the availability of clinical head time. Participation requires continuing facilitation of clinician involvement in making cost-effective decisions.

2.4 A Clinical Council

Planning is underway to form a Clinical Council with representation from primary and secondary, iwi provider, disability and public health sectors. It will have a multi-disciplinary composition. This will advise the DHB CEO and wider DHB. Within the provider arm there is planned a Clinical Governance Group responsible for clinical advice and quality, reporting to the General Manager and inclusive of the MD, DONM, clinical heads of department, nurse consultants and professional advisers for allied health.

The detail is currently being clarified.

3. Quality initiatives in Lakes DHB

3.1 A quality plan

There is a strong and increasing emphasis upon promoting quality within Lakeland Health with good clinical input in the development of quality initiatives. A set of continuous quality improvement groups has, to differing degrees, been working now for some time to develop quality initiatives. One of the problems has been an uncoordinated approach to quality development and the need to bring activities together under the management of the new GM, MD and DONM. At this stage plans are still being developed. The plan will integrate Clinical and Quality Activity, and includes

- case review systems
- continuous quality improvement (CQI) activity (= implementation of recommendations)
- information technology developments eg Clinical Information Project, intranet development
- senior medical staff and service (department) credentialling
- accreditation
- clinical guidelines development
- clinical risk management and reporting
- clinical audit
- handling new “ideas”, reportable events and critical incident reporting
- clinical career pathways for nursing/midwifery and allied health.

The key ingredients of this plan will include;

- a quality system fully integrated with the clinical system
- a “no blame” culture to encourage participation in quality activity
- all of those clinicians needing to be involved in order to implement a solution linked to CQI activity and implementation
- Protected Case Review systems designed to produce
 - (a) recommendations, and
 - (b) information relevant to the timely counselling of families.

Quality management is through the nurse-midwife consultants and heads of departments supported by a service based clerical-quality coordinator. These roles will become fully aligned.

3.2 Credentialling

A credentialling system is being developed. The appointments committee has become the Appointments Credentialling Committee. This has been sorted out constitutionally and is being ratified by the medical staff. There is support from the medical staff who are close to it and a willingness to become involved from others with less understanding. Credentialling will be built into the quality system at the service level, facilitated by the Senior Medical Staff Committee and Medical Director.

3.3 Accreditation

Lakeland Health is not currently accredited. Accreditation has been deferred to enable it to be undertaken under the new system, which is much more quality focused. It is expected that the new quality system being established will flow on to facilitate accreditation by the end of 2002. Accreditation is seen to be useful in promoting quality at the service level with the bringing in of external reviewers to validate what is being done. There is a recognised need for audits to be devolved to QHNZ as part of the accreditation process rather than have the current situation where multiple audits are performed by a range of organisations nationally.

In May 1999, Lakeland Health was the Hospital and Health Service which trialled the audit of the new Health and Disability Sector Safety Standards and was commended for its participation.

4. The role of clinical leadership

The MD, DONM and Professional Advisors (Allied Health) roles are critical ones in the implementation of the quality system. Having a clinical role is critical to continuing credibility with other clinical staff.

The DONM and Professional Advisors (Allied Health) clinical leadership roles are strongly focussed on driving service delivery practice standards and building the profile, contribution and valuing of nursing/midwifery and allied health within the organisation. There have been nursing/midwifery and allied health strategic plans since 1998 which form the basis for guiding professional growth and development. The strategic plans guide quality activities.

5. Education and training for quality and leadership

There is a need for clinical leadership development programmes, especially peer group learning. Consequently there is a need to build up a network of people, both regionally and nationally, with whom learning experiences can be shared. Lakes offers in-house first line management training for clinical staff making the transition to management/leadership roles.

6. Clinical governance

There is not as yet a policy for clinical governance. However there is a clear commitment to it as shown by the various activities involving clinicians in quality development. There will be progressive development of clinical governance in conjunction with a new General Manager and the DHB CEO. Work pressures are the limiting factor re the extent of medical involvement in clinical governance and quality activities.

There is support for a National Health Leadership Development Centre although it would need to be structured well to ensure it added value to the “feeder” organisation’s own activities. It would also need to be funded in such a way as to enable time to be taken off for such learning activities.

2.7 Nelson-Marlborough (NMDHB)

Discussions with the Chief Executive Officer (CEO), Glenys Baldick, Chief Medical Advisor (CMA) (Nelson) Ed Kiddle, CMA (Marlborough) Maree Leonard and the General Manager Provider Division, Keith Rusholme formed the basis for this report. Other information included information from the Board's web-site ("Statement of Intent 2000/01" and "About us") and a paper on clinical governance currently under discussion within NMDHB.

1. Background

NMDHB serves a population of 121, 000 in a relatively large geographic area comprising the northernmost portion of the South Island. The district health board (DHB) provides hospital and clinical services through two general hospitals – one in Nelson and one in Blenheim. Other facilities include an acute mental health unit, Braemar Hospital (Disability Support Services), a psychogeriatric facility in Richmond and small community hospitals in Murchison Motueka and Takaka. Community health service bases exist in Picton, Havelock, Wakefield and Mapua while public health services are provided from bases in Nelson and Blenheim.

2. The organisation of Nelson Marlborough's services

The organisational structure within the DHB comprises a provider division, a planning, funding and population division, and a corporate group. A General Manager Provider Division (GMPD) manages regional provider services. He reports to the CEO and provides regional leadership for DHB. A range of regional service managers reports to the GMPD with the managerial responsibilities for services divided between the two bases. Mental health, intellectual disability support and public health are managed regionally. Surgical and medical/paediatrics/obstetrics are in both Nelson and Blenheim. Public health, emergency and diagnostic support, and therapeutic support service managers are in Blenheim. A number of other service groupings exist. The services with a formal clinical director are mental health and dental services.

Both Blenheim and Nelson hospital sites have a CMA and a Nursing Adviser. These are professional advisory roles and have no direct managerial accountabilities for staff. Medical and nursing day to day operational requirements are integrated at service level. The advisers are involved in providing professional leadership in quality issues. Service managers and professional staff, including therapy heads e.g. OT, Physiotherapists meet regularly on service issues.

Budgets are not devolved to a service level for either direct or indirect costs. Clinicians have yet to be either fully or formally involved in the accountability and responsibility for cost. They currently contribute to this via the relationships they develop with their service managers. Discussion and consensus on quality and resources occurs at department, hospital and regional level via committee structures. At present the committee structure is a mix of site-based and regional approaches and is being rationalised. Clinicians have expressed an interest in becoming more fully involved in resource issues. The NMDHB accepts that to achieve better quality clinicians will need to become more closely involved in both resource and quality issues.

The Board of Directors has expressed strong interest and commitment to advancing quality and the management of clinical risk.

3. Quality initiatives implemented by NMDHB

The DHB has several strands of work relating to quality at present. Examples include reviewing the current committee system, accreditation, and clinical risk management, pharmacy

3.1 Review of the current committee system

The DHB committee structure includes 60 committees and cross service groups. These are being grouped into a matrix with four main areas of focus: quality and risk (about one third of committees), management and communication, organisational development and service line committees. These groupings parallel the Quality Health New Zealand (QHNZ) groupings. The modus operandi of these committees is also under review (to eliminate duplication). Some may go out of existence, some will be regionalised and some will be maintained as is in Nelson and Blenheim. To function effectively on a regional basis and overcome the travelling time issues the DHB may increase the use of televideo meetings.

There is ongoing discussion about the committee system at present. Part of the discussion relates to the need for an overarching “clinical council” to facilitate quality/clinical governance. Such a body could have a brief to provide direction on clinical, ethical and quality issues, promote quality improvement and minimise patient risk, monitor the implementation of quality initiatives on an ongoing basis and ensure the best use of resources.

3.2 Accreditation

NMDHB has just been through a second round of accreditation with QHNZ. Although the process did not yield full accreditation across the DHB the process has raised awareness of quality issues in all services and sites and given a direction to quality activities within the board.

3.3 Clinical risk management reporting

Clinical risk management reporting of events is well developed with a reporting system that now focuses on analysis and feedback. Staff are working to advance a safe (“no blame”) culture and learning environment. The creation of improved information systems enabling analysis and widespread feedback will lead to good learning processes from incident reporting. A sentinel event process has recently been piloted in the DHB and also there has been a major review of the organisation’s incident reporting process that resulted in the development of a new form. Participation in this is hampered by the high level of operational work, which creates pressures and tensions around the time for quality activities.

3.4 Other quality initiatives

Other initiatives include regular audit programmes now operating in most clinical

departments. Presentations on these are made monthly but the level of audit activity now exceeds the ability to present them all and the challenge is to find ways of sharing the audit information and results between departments.

Credentialling is progressing well in Nelson where a Credentialling Committee has been in operation for almost two years. Three departments have worked through the credentialling process - surgery, orthopaedics and anaesthetics. The credentialling team comprises the CMA, Chairman of senior staff, one other senior staff member and two outside people. The department seeking credentialling prepares relevant information and then discusses a standard set of question with the credentialling team. NMDHB is currently reviewing progress before extending the process to other departments or to Wairau hospital.

4. Significant achievements in quality improvement

The most significant achievements in quality improvement for NMDHB include:

- Good progress made with credentialling
- Good audit programmes running in most departments
- A strong interest in quality from the nursing workforce stemming from their hard work for QHNZ accreditation among other things
- Going for accreditation by QHNZ twice has led to a quality conscious environment in recent years
- Iwi networking has been established and is working well
- Pharmacy involvement on the ward where the pharmacist is working with clinicians in reviewing medicines. The pharmacist provides feedback to clinicians and reports regularly to the Pharmaceutical Therapy Advisory Committee.

5. Clinical advisory functions

At both the Blenheim and Nelson sites there is a Chief Medical Adviser and a Nursing Advisers. There are senior medical staff committees in Nelson or Blenheim and similarly nursing professional advisory groups. The clinical “voice” is also heard through out the organisation via the service management process, the committee system, the CMAs and other advisers and from senior staff via the Chairman of Senior Staff.

On the whole staff and management have fairly harmonious relationships. Some tensions derive from resource shortages and associated heavy workloads in some areas creating a need for innovative ways to free up clinicians time and energy for projects beyond their usual everyday work.

6. Education and training for quality leadership

NMDHB supports education and training programmes for their staff. Continuing medical education is supported locally. At present clinicians are not seeking management training. The medium size of the DHB may be a factor in this as there is less scope for clinical managers than in a larger organisation.

A national programme to enable sharing of ideas and information between DHBs would be useful.

7. Clinical governance and a national quality strategy

A common understanding or definition of clinical governance is not yet established in Nelson Marlborough District Health Board. The focus is on quality including audit and risk management. NMDHB supports development of a national quality strategy provided it delineates broad general directions and is not as prescriptive as the NHS approach. New Zealand has lots of “grass roots’ developments which need to be encouraged.

2.8 NORTHLAND

The following information was provided from discussions with Chief Executive Officer (CEO) Ken Whelan, Chief Medical Adviser (CMA) Loek Henneveld and GM Primary Care Chris Farrelly.

1. Background

Northland District Health Board (NDHB) serves a population of about 142,000 with comprehensive community-based and secondary health services provided from a range of small clinics and four hospitals, the largest being situated at Whangarei with 225 beds. The population served has a high proportion of Maori (about 30%) and high levels of need in comparison with most DHBs.

2. The organisation of the Northland DHB services

2.1 Present organisation

The DHB is currently organised on the basis of two clinical divisions, primary and secondary. The GM Primary Care is responsible for the overall strategic direction and leadership of primary care services throughout the district and also the management of the DHB's primary care provider arm. Under the General Manager Secondary Care are three group managers; medical/surgical, maternity/paediatrics and mental health/clinical support. This is under review with a rethink of the role of clinical directors. Two of the group managers have a nursing and midwifery background.

Partnered with these group managers are clinical directors for each specialty, eg general surgery, urology, paediatrics, mental health, ENT, eyes dental, etc, totalling 13. There is only one clinical director for medicine including geriatrics.

Overall medical leadership is provided by the Chief Medical Adviser (CMA) and for nursing the Director of Nursing (DON).

2.2 Organisational review

The commercialisation of the system during the early-mid 1990s led to significant unhappiness on the part of clinicians. Managers became reluctant to involve clinicians and clinicians switched off and concentrated only on clinical issues. However this was seen to be a not 'very workable solution and caused a lot of problems which is why people have moved towards what is now being introduced'.

The roles of the clinical directors are currently under review as are other roles in the organisation. Clinical directors were introduced in 1992 and moved, in some services, into an equal partnership with group managers. The success of this varies with the personalities of clinical directors. The number of clinical directors might be rationalised, eg just one for surgery.

2.3 Devolution of management and including budgets

There is devolution of budgets not only to group managers but also to service departments. Clinicians are involved to varying degrees in financial management and this is currently under discussion through workshops but there is a continuing trend towards a partnership between clinical directors and managers to achieve common goals. There is a convergence towards this partnership on the part of both managers and clinicians with clinicians generally keen to see it develop.

Nursing management is devolved to clinical divisions working with the clinical director and managers. The nursing hierarchy has been abolished. The role of the DON is overall leadership and facilitation but not managing a nursing workforce with a separate budget.

All direct and most indirect costs are devolved to services. However there are some difficulties with the allocation of indirect costs. At present clinical support services are not costed to clinical services. It is hoped that budget allocations will lead to critical value for money decisions by clinicians on service expenditure.

2.4 Quality and devolution

Some clinical quality activities are being carried out separate from management, eg CME activities. However, the bringing together of clinicians with management is seen to be an important if not crucial development in promoting quality. The CMA has a leadership and facilitator role in promoting developments towards the partnership with management and is seen as a driver in improving quality standards.

2.5 Nursing and devolution

Nursing is fully involved in the current consultation process but it is not clear at this stage where they will fit into the new system. The present Director of Nursing (DON) is actively involved in the process and is representing nursing interests in the discussions and will ensure that nursing has an appropriate position.

While a lack of flexibility was an argument against devolution this did not occur in practice. Charge nurses are appointed to a service but staff nurses may be moved between services.

3. Quality initiatives implemented by Northland DHB

3.1 Quality plan

The DHB has a quality plan that is revisited every four months and updated annually. It covers clinical risk management and clinical audit and is a compilation of all quality initiatives being developed by service divisions for the following year such as; clinical pathways, review of re-admissions, non-attendance at outpatients, etc.

3.2 Clinical Board

There is a Clinical Board concerned with general clinical issues including quality. Its membership includes clinical directors, Secondary Care General Manager, CMA, DON, CEO and Maori director. It meets monthly providing a general forum for the provider arm, reviewing clinical policies and the organisational arrangements currently under discussion.

3.3 Accreditation

Northland was accredited nearly three years ago and is going for further accreditation in November 2001. Opinions vary regarding as to how important accreditation is in improving quality. It is not a purpose in itself but it is seen to be a good stimulus to ensure an ongoing focus upon quality. Some who do not agree with accreditation tend to see it as just a goal in itself when in fact it should be an only a stimulus to ongoing quality improvement.

3.4 Credentialling

A formal process of credentialling is underway for all departments and is included in the quality plan. It is now well accepted and there is commitment to it. The Clinical Board has taken on responsibility for credentialling.

3.4 Reportable events, critical incidents and complaints

A computerised system is in place for all such events and linked to the complaints system. Monitoring systems, which were a factor in the Graham Parry case, are now much more robust to actively monitor and handle audit type information. These will probably show up practitioner's failings, eg poor quality documentation. The current regular meetings identify failings.

The level of the workload undertaken by Dr Parry would now be totally unacceptable. A clinical audit co-ordinator has been appointed to ensure that that the information put into the clinical audit system is a fair reflection of the complications that have occurred. There is much more willingness to talk about failings. There is much now more of a 'culture of safety' in place although there is still some way to go.

The Parry case was helpful in encouraging clinicians to be more open and to discuss issues, to be more publicly aware, to learn from mistakes and develop ways to prevent them. On the other hand it also made people anxious to see to what extent a hard-working clinical career can be jeopardised and a clinician becoming a victim of a public vilification process.

3.5 Most significant achievements

The most important has been; the changing culture, and the move to a partnership with management, and the allocation of funds to employ clinical co-ordinators to improve clinical documentation.

4. Clinical advisory functions

There is a senior medical staff meeting that makes representations to the CEO.
There are no special organisational arrangements for allied health services although they are organised in professional groupings.

5. Education and training programmes

There is absolute need for these programmes now. Part of the current review process will be to identify the roles and expectations regarding the new positions and how training programmes can support these developments.

A national training programme would be important to bring leaders together and to bring top-class people to New Zealand.

6. Clinical governance

This term is not specifically used in Northland. The process being established, and which might be labelled clinical governance, is very much alive and growing.

There is a need for a national strategy for quality to support these developments.

2.9 OTAGO

The following report was prepared based upon personal discussions with Chief Executive Officer (CEO) Bill Adam, Chief Medical Officer (CMO) Dennis Pisk, former Chief Nursing Officer (CNO) Theresa Bradfield, from supplied documentation and the DHB web page.

2. Overview

The district health board (DHB) serves a population of 177,200 with its main base in Dunedin but spread over a wider rural area of coastal and central Otago. The main clinical centre is Dunedin Hospital with a subsidiary hospital at Wakari and community hospitals/trusts in the rural areas. Otago DHB (ODHB) **values** are as follows:

“We seek to be;

- *responsive to our patients physical, emotional and cultural needs*
- *innovative in providing patient focused care*
- *fair in access to services*
- *quality conscious in all aspects of service delivery*
- *open and collaborative in management with our staff, our community and other agents.”*

2. The organisation of Otago DHB services

2.1 Clinical organisation

As for other DHBs the Board services are divided into a provider arm and a contracting arm under the CEO. The COO and CMO report to the CEO. The COO's predominant responsibility is for the management of the provider arm. The CMO has cross-functional responsibilities for the provider arm and also provides some support for the CEO's funder function. The CNO reports to the COO.

The CMO has a wide ranging role as a member of the executive team including a mix of executive and advisory functions and a key leadership role in promoting quality improvement. A major part of the role is to manage critical/sentinel adverse events reporting. The CMO does not have a current clinical role. A key role is also to ensure appropriate linkages between clinical service groups.

2.2 Clinical divisions

There are some 11 Clinical Practice Groups (CPGs) under the COO grouped as follows:

- Care of the Elderly/General Medicine
- Oncology/Haematology/Radiation Oncology
- Cardiology/Endocrinology/Nephrology/Respiratory
- General surgery/Urology
- Mental Health
- Physical rehabilitation/Community health
- Healthlab Otago/Transfusion medicine

- Theatres
- Radiology/therapeutics
- Child Health/Women's Health
- Emergency
- Orthopaedics/Orthotics/Rheumatology/ENT/Eyes/Maxillofacial/
Neurosciences/ Allied Health /Public Health/Rural

Each CPG is made up of a clinical leader and manager. Some groups share the same manager. These groupings have been in place for some years. They include both Dunedin and Wakari Hospitals. The CPG structure represents a flat organisational structure. The provider arm Executive Committee has numerous members such that, on occasion the Executive is more of an information sharing forum.

Within the group subdivisions there are some heads of departments but most often those are recognised as a senior colleague representing the specialty. A clinical leader may represent a number of specialties. It is important to have clinical leaders who are also leaders of opinion.

While common interests are a factor in determining groupings the overall budget is also taken into account. The diverse mix of categories within some groups is unimportant. An important issue is the links between them. Good cross-linkages are essential in implementing quality systems.

All clinical leaders are medical with the exception of a midwife for Women's Health. Clinical leaders usually spend about 2/10ths time in their clinical leadership role. There is a need for formal recognition of the leadership role in job descriptions to establish an expectation of performance in this role. A performance review survey concerning clinical leaders is being implemented.

2.3 Accountability and relationships

The clinical leader is supported by a service manager with joint accountability for both quality and cost in what is called a 'duopoly' concerning the overall management of the group. There is a full partnership between clinical leader and management that is described as 'joined at the hip'. Job descriptions of clinical leaders include accountability for both quality and cost.

Although there are tensions, the close working relationships between clinical leaders and managers result in harmonious relationships within the organisation which is valued by clinicians generally. Clinical leaders have and are accorded a highly regarded status in the organisation. Their jobs are valued and are seen to be of senior status although finding an appropriate clinical leader can be a challenge. Appointments depend upon acceptance by clinical colleagues. It is felt to be important to have clinical leaders who are also opinion leaders.

There are problems in achieving a balance between the expectations of the clinical colleges and the practical demands of operational delivery. A clinical governance model, with its emphasis on organisational quality, could be a way of resolving of this issue.

2.4 Devolution

CPGs hold budgets for their service, which includes nursing services and other direct costs. The budget does not include clinical support services or overheads and is on a case-weighted basis. It is therefore based upon revenue rather than an actual budget. It is recognised that there may be perverse incentives with this activity-based funding but it does not appear to influence clinical decision-making. There is as yet little devolution to sub-groupings within the CPGs.

This structure, including financial devolution, is strongly supported by clinicians generally. Devolution enables a more critical look at what is being spent on service activities, although as yet this is not well developed. Most activity has focused on how to cope with budget cuts rather than to free up resources. CPGs have delegations to employ and appoint staff up to an agreed plan.

A downside is that devolution may lead to fragmentation and make more complex the building of collaborative relationships between the service divisions.

2.5 Nursing organisation

When the devolved structure was introduced some years ago it had a strong medical dominance with adverse implications for clinical leadership in other disciplines within the organisation, including nursing. Nurses felt that nursing organisation and infrastructure was compromised and, although nurses have an important management input at charge nurse levels, they had a lesser influence at executive levels. Only one of the formally designated clinical leaders (under consideration) is non-medical, ie a midwife. More recently this has been partly redressed with the appointment of the Chief Nursing Officer.

Although there are nursing educators associated with CPGs there is seen to be a requirement for improved nursing leadership concerning service provision, eg as in other DHBs that have nurse consultants involved in promoting and monitoring quality. Some managers have previously been nurses and although this achieves nursing input in part there may be a conflict of interest between the nursing and general management roles. Each service group would benefit from having either a nursing director or nursing consultant. A recent initiative has seen the establishment of charge nursing positions across the organisation and these positions have managerial responsibility and allow for the demonstration of nursing leadership.

The CNO has both an executive and advisory role although all nursing delivery functions are devolved to the CPGs. It is felt that this role needs to extend beyond the provider side to include the whole DHB with the large nursing component in the contracted sector.

3. Quality initiatives implemented by Otago DHB

3.1 The Clinical Improvement Committee (CIC)

The CIC was formed in mid 2000 to oversee the quality of clinical activities in the DHB. The CIC brings together what was previously a fragmented set of quality committees into an integrated structure. Its members include the COO, CMO and CNO, and a cross sectional multidisciplinary membership of managers, medical, nursing and allied health staff, a GP and consumer representative. The committee reports directly to the Board, the CEO and the COO. At present it only covers the provider side although consideration is being given to it being DHB wide.

The Committee is one arm of a developing quality framework to address clinical audit, clinical risk management, consumer feedback, continuing professional development, continuing medical education, credentialling and leadership development, ie all the functions of clinical governance.

There is a quality manager who has a facilitatory and integrating, but non-executive role. The accountability for quality is through the CPGs to the COO.

3.2 The quarterly quality cycle to the Clinical Improvement Committee

There is an established clinical improvement framework based on quarterly cycles with reporting by CPG groups on an agreed template. This includes complaints, incidents, etc, which are analysed to enable comparison of performance between groups and over time. This gives a good overview with a focus upon service improvement.

In the second quarter there is reporting on quality at an organisational level, including infection control, therapeutics, medical misadventure, coroners reports, etc. This is also cross-referenced to enable comparisons and to assess progress. The third quarter involves presentations to give advice and feedback to those involved in quality improvement projects. These are underpinned by quality improvement including research projects.

It should be noted that CPGs provide a monthly report to the COO that includes information concerning quality and risks.

3.3 A DHB quality plan

Largely, clinical values and concerns are driving the push for quality development. A DHB quality plan is to be developed as part of the Strategic Plan, bringing together the many current quality activities, inclusive of the various functions coming under the heading of clinical governance, eg;

- clinical guidelines, evidence-based health care
- clinical risk management including adverse events reporting
- clinical audit
- arrangements for ‘reportable events, critical incidents’ reporting.

The Clinical Improvement Committee will contribute to the DHB Strategic Plan

regarding quality across the DHB.

3.4 Credentialling

This is currently being implemented after extensive consultation throughout the organisation. It is well supported by medical staff. It is expected that credentialling will be completed by the end of November 2001. It is seen as a user-friendly approach in contrast to some other areas and involves peer review processes.

3.5 Accreditation

Plans are currently underway for the first accreditation to be undertaken by QHNZ in mid 2002. Some problems are perceived with accreditation particularly the high level of paperwork required. However it does offer incentives for promoting better quality care. There is a cost associated with achieving it especially with the very limited resources currently available. Accreditation is both an important process but an enormous challenge. Adequate resources have been mobilised to support the credentialling process.

4. Clinical advisory functions

Clinical advisory functions are now largely covered through the organisational structures referred to above, and the CIC.

5. Education and training for quality and leadership

There is a need for more extensive education and training programmes, including for clinical leadership. A National Health Leadership Development Centre, supporting, promoting and providing for clinical and overall leadership development generally, would be of great value.

6. Clinical governance

Clinical governance is an evolving concept for Otago DHB. The term is widely used in discussions and policy statements of about quality developments.

2.10 WAIKATO

The following report is based on discussions with The Chief Operating Officer (COO) John Mollett, Chief Medical Adviser (CMA) David Geddis, Chief Nursing Adviser (CAN) Jan Adams, and Manager, Quality and Clinical Risk Manager Barbara Crawford and from documents supplied.

1. Background

Waikato District Health Board (WDHB) is the funder of a wide range of non-government services and the key provider of integrated hospital and community-based health services to a population base of 326,400 in the central North Island of New Zealand. The population is both urban, eg Hamilton, and widely dispersed. Twenty-one per cent are Maori and with high health needs. Health care is provided through Waikato Hospital, the specialist regional base hospital in Hamilton, and a network of community hospitals and services throughout the region.

The Boards **Vision** is:

“Waikato District Health Board will improve the health and quality of life of the communities it serves by addressing the needs of the population, including the needs of the people with disabilities, rural, Maori and Pacific Peoples’ communities. The Board will ensure community involvement at all levels and will focus on:

- *promoting and protecting wellness*
- *ensuring equitable access to high quality health and disability support services.”*

2. The organisation of Waikato DHB services

2.1 Clinical organisation

As for other DHBs the broad divisions are a provider arm under a COO and a planning /contracting arm. Reporting to the CEO is a CMA, who does not have a clinical role within the DHB, and a CNA. Within the provider arm there are three broad service divisions, Waikato Hospital, community services including the four ‘Ts’, largely community hospitals, and mental health.

In the past, particularly during the ‘commercial era’ there was a serious divide between the corporate managerial culture on one hand and the clinical culture on the other. Relationships have improved markedly in recent times with a perception that, for the most part, there is good working relationship between clinicians and management although strained at times by the current serious resource limitations.

As discussed below, clinicians are involved in a partnership relationship with management at the service level. The limiting factor in this partnership is the availability of clinicians with time to undertake management responsibilities. However clinicians recognise the need to be involved more at the top executive level. There is active, current discussion on the formation of an Executive Clinical Board that would be involved in strategic decisions of a clinical nature. It would have a committee responsible for the integration and promotion of all quality activities, including clinical audit. This is further discussed below.

2.2 Clinical Divisions

Within the Waikato Hospital division there are seven clinical groupings, medical, surgical, women's health, child health, clinical support and clinical services. At this level there is a clinical unit leader (CUL) in partnership with a service manager who are joint budget holders with accountability for quality and resource management. All CULs are medical although half of the service managers have a nursing background.

Each CUL and service manager has job description, which includes key performance indicators (KPIs) which are currently being redefined to include a whole-of-hospital approach, and linked to price/volume indicators. There is a clinical director for every medical and surgical subspecialty eg cardiology, orthopaedics, etc. There is no service manager at this level.

2.3 Devolution

Budgets are devolved to the six clinical divisions including direct and indirect costs, including overhead costs. Consideration is being given to further devolution of budgets to sub-specialities of medicine and surgery, eg cardiology, possibly with the establishment of pilots. This is being sought by some of the clinical directors in some subspecialties. Devolution is seen to be important to achieve both quality as well as cost outcomes. The problem with devolving budgets is the possible impact upon services outside the particular service division. There are also questions of 'gaming' by avoiding admissions with unclear definitions. This is less likely where quality goals are paramount.

There is a mixed system of devolution of nursing resources to service groupings. Last December nursing was withdrawn from surgical and medical services to come under the DON to improve bed management and nursing management so that the Service Manager would contract for nursing resources with the DON. This compromise left nursing devolved only to the other service groupings a situation that is not seen to be particularly satisfactory. This is under review. Mental health however, is fully integrated. It includes both hospital and community services and has a clinical director and a general manager. Within Community Services division nursing services are devolved.

Quality and cost are line management responsibilities. However there are limitations in the information needed to measure quality but the provision of information has made an important difference to quality.

3. Quality initiatives implemented by Waikato DHB

3.1 Changing the culture

Previous HFA and current MOH contracts give little emphasis to quality. More recent contracts have focused upon the Health and Disability Sector Standards. However WDHB has established its own definitions of quality, of clinical governance and key components of quality. It is being internally driven by what is seen by the organisation to be relevant for quality. There is now a quality and risk framework for the organisation, for each of the three operating divisions and each of the service areas.

A fundamental change is needed from the previous culture, with a primary focus upon financial goals that had little clinical support, to a new culture of quality. Clinicians are more willing to collaborate if they can see that there is a commitment by the organisation to a culture of quality. There is a clear move towards a 'culture of safety' and trust. Evidence for this is a quadrupling of incident reporting over the last two years showing that staff feel more trusting about such reporting. The reporting system has been built largely within the organisation with very little experience being drawn on from elsewhere.

3.2 The quality plan

Much effort has been put into developing a quality framework and defining the clinical governance framework. The overall philosophy is based on a commitment to providing quality health care outcomes and to using cost-effective management systems to achieve these.

A mix of quality improvement approaches is being implemented including:

- clinical governance based on the UK definition but with joint clinical and management decision making accountability
- organisation-wide projects to address top priority issues relating to quality improvement and reduction in clinical risk
- specific quality improvement projects at divisional or service level to improve effectiveness and efficiency
- infrastructure to support ineffective quality and risk management systems.

The quality and risk management strategy is based on seven 'pillars' as follows;

- patient /customer focus, planning - with quality objectives
- total involvement of all staff, systems and processes to support better practices
- measurement to provide feedback, identify opportunities and monitor delivery
- systematic support with information,
- education and training advice, and external advice
- better management and an empowering environment
- continuous improvement as a dynamic process.

What is being planned goes well beyond that expected both by the MOH contract and QHNZ.

3.3 Clinical governance

The clinical governance framework includes the following key components;

- clinical staff involvement in decision making
- comprehensive quality improvement programme
- clinical risk management programme
- evidence-based clinical practice eg guidelines, pathways, protocols
- clinical audit
- adverse events, complaints, customer feedback
- clinical performance review, credentialling

- joint clinical management decision making environment
- monitoring effectiveness.

The quality plan sets out priorities for addressing each of these components.

3.4 Organisation for quality

It is recognised that much fragmented effort is going into clinical audit at present and a need for a systematic structure supported and funded by the organisation. As discussed above a Quality/Audit Committee could be established under the proposed Executive Clinical Board. It would become responsible for all quality activities within the provider arm including those listed above in section 3.3.

3.5 Accreditation

Three T hospitals are Quality Health accredited, plus several other services. However, Waikato Hospital failed accreditation last time. At present a timetable is being worked on for comprehensive accreditation late in 2002. The process being put in place is not seen to just to achieve accreditation but to establish a high standard tertiary hospital for the 21st century. The QHNZ process is not seen as particularly relevant to achieving such a standard. There is a danger in achieving accreditation without a full and ongoing commitment to quality. The main incentive for accreditation in the past has been the need to gain contracts rather than achieving quality gains.

3.6 Credentialling

A well-established process of credentialling is under way in the provider arm. Credentialling is the responsibility of the clinical director for each service division and includes both the unit as well as individual staff.

4. Clinical advisory functions

The CMA is neither a member of senior clinical staff nor of management. He is seen to be more of a facilitator in mediating relationships between clinicians and management. This position is now a reasonably workable one given the closer working relationships which are operating within Waikato Hospital. The CMA has a key leadership role in promoting quality initiatives within the organisation. Better relationships have led to a much-diminished need for a separate medical advisory function.

DON and Allied Health representative also provide clinical advice through their membership of the Clinical Advisory Group.

Waikato DHB has six Professional Advisors, with reporting access to the CEO on matters relating to their profession, for each of the following – Nursing and Midwifery, Medical, Social Work, Psychology, Occupational Therapy, Physiotherapy.

5. Education and training for quality and leadership

A variety of education and training programmes have being drawn upon but these are currently limited and expensive. There is a need for practically oriented programmes.

6. Clinical governance within Waikato DHB

There is commitment to clinical governance and the quality plan is based upon a clinical governance framework. Waikato DHB uses the NHS definition of clinical governance.