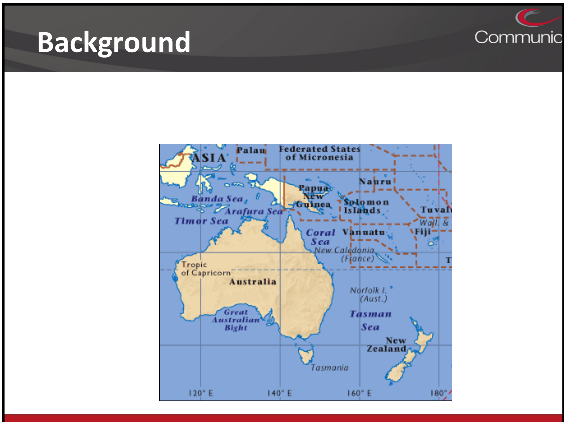
Study objectives

Communic

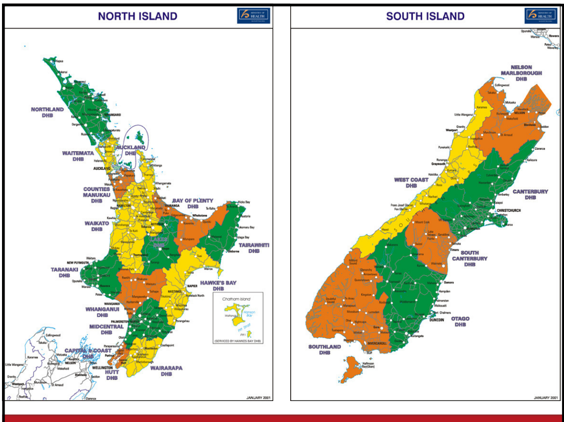
- Examine the clinical governance arrangements in 3 DHBs in New Zealand
- Examine how effective DHBs are in meeting the challenge of clinical governance

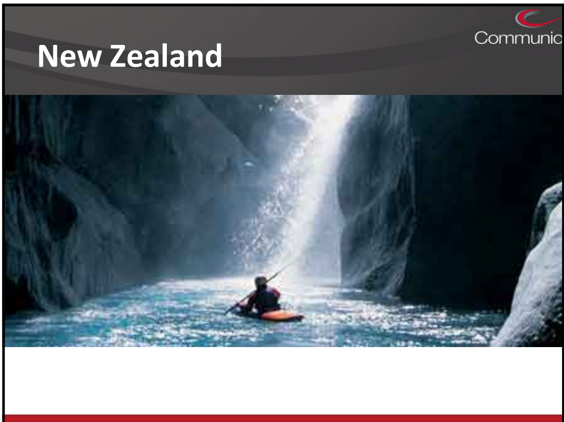


New Zealand

Communic

- Population approx 4,000,000
- Nationalised health system
- Ministry of Health
- 21 District Health Boards
  - Autonomous
  - Consistent in role and structure
  - Responsible for providing, or funding the provision of, health and disability services in their district.
    - Improving, promoting and protecting the health of communities
    - Promoting the integration of health services, especially primary and secondary care services
    - Promoting effective care or support of those in need of personal health services or disability support.
- Purchaser and provider
- No policy direction or requirement from Ministry re clinical governance





Communic

Review background

- 3 DHBs
  - DHB 1 - Request NHS CEO, concerns
    - Large, regional
  - DHB 2 – New CMO, concerns
    - Small, rural
  - DHB 3 – recommendation from accrediting agency, poor press
    - Medium – large metro

Method

Communic

- What is clinical governance?
- How should it be reviewed in a methodical way?
  - Different things to different people
  - To many people…………………

Method

Communic

- Governance OF clinicians
- Governance BY clinicians
- Governance WITH clinicians

Clinical Governance

Communic

The term used to describe a systematic approach to maintaining and improving the quality of patient care.

- "….**the framework** through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."

Scally and Donaldson, 1998

Method

Communic

- Determination of a practical framework
- "The Framework for Managing the Quality of Health services in NSW"

  NSW Health 1999 (Robinson principle author)
- Work of Australian Council for Safety and Quality in Health Care 2001-2005
- Work of NSW Health Quality and Safety Branch 2000 - 2005

Clinical Governance framework

Communic

- The policy framework (for clinical governance)
  - General and specific
- The organisational structure
  - Clearly articulated; designed for quality
  - "to ensure that responsibilities are appropriately divided across different roles and to ensure that diverse activities are integrated into a unified effort"
    - Bolman and Deal 1991
- Effective performance frame and monitoring processes accompanied by a reporting frame
  - Structure, process, content
- The Committee structure
  - Streamlined, interlinked, used for governance
- Organised clinical level activities
  - for measuring, reviewing and improving quality of care. Support processes
- The correct culture
  - Not formal

Method

Communic

- Multi method approach
  - Interviews
  - Focus groups
  - Attended key meetings
  - Document review
    - Board and committee minutes
    - Organisational documents
    - Reports
    - Quality plans
  - Performance data review
  - Policy review
  - Attended several sites

Method

Communic

	DHB 1	DHB 2	DHB 3	
Interviews	44	35	56	135
Focus groups	9	6	8	23
Approx # documents (incl policy)	56	47	36	139
Sites	5	3	2	10

Results - Policy framework

Communic

- General
  - All had many policies (162 + 5 Board)
  - All corporate governance, none clinical governance
  - All quality framework
    - Reviewed each year, none implemented
- Specific
  - Inadequate processes for credentialing and defining the scope of clinical practice
  - Difficulty developing and implementing performance reviews for medical practitioners. Better organised for nursing and allied health
  - No policy for the safe introduction of new interventions
  - Management of complaint or concern about a clinician
  - Incident management ad clinical risk management

Organisational structure

Communic

- Difficult
- Purpose to recommend improvements
- ? Recommend restructure

Bolman and Deal (1991)

- "The evidence that exists for the benefits of wholesale restructuring of organisations as at best scant"

Braithwaite, Westbrook and Iedema (2005)

Results - Organisation structure

Communic

- Separate medical nursing and allied health org structures
- No requirement to work together
- Lack of role delineation and understanding of responsibility for clinical governance
- Specific and different issues in each DHB
  - Eg 28 direct reports

Results - Committee Structure

Communic

- All recognised the importance in a large organisation
- All had committees that relate to clinical care
- 2 DHBs – a high level "clinical governance" ctee
  - 1 DHB all but one member doctors
  - One – policy development and approval
- Role, function, activities, reporting lines unclear
- None used their ctee structure effectively to govern the quality of clinical care

Results - Performance and Reporting Frames

Communic

- Little understanding by the Boards of the DHBs of their level of responsibility for the quality of clinical care
- Many indicators/date reported to each Board
- No reporting clinical quality data/ indicators/ standards compliance.
  - "Board members need to use a sixth sense sometimes in order to know what is going on"
- Some qualitative info
- No routine structured measurement of clinical quality and reporting results
- Some pockets, but little use of data for management of quality of clinical care and services
- All have tried – all are aiming for perfection and full agreement before introduction (2007 – 2009)

Results - Clinical level activities

Communic

- Siloed clinical practices
- Little multidisciplinary team work
- No organised processes for continually reviewing / evaluating and improving the quality of clinical care
- Few "support" processes for clinical teams to be able to review practice (data provision and technical support)

Results - The Culture

Communic

- Loyalty amongst providers; desire to provide high quality care
- Multiple barriers and boundaries between professional groups
- Low level of cooperation between clinicians and managers
- Poor separation of review of individuals and systems
- Quality and finances are NOT equal partners in healthcare
- More money will fix the quality of care.

Results - other factors

Communic

- A misunderstanding – doctor involvement and leadership
- A paresis brought on by media attention to incidents

In conclusion

Communic

- Some good, some not so
- Some mature processes and "structures"; some very immature or non existent
- ? representative of the rest of the country
- Good evidence now of what is required
- Why not implemented after 10 years?
- Needs a more methodological approach
- Not complex – needs to be simplified for users
- A national framework / standard