The study provided a baseline for more targeted studies and for quality improvement interventions and highlighted the need for similar research on the sources and characteristics of adverse events outside public hospitals. Despite widespread and continuing public concern about adverse events the media response to the studies was reasonably balanced. This may be due to increasing public understanding and acceptance that adverse events are to some extent inevitable and that an open and accepting approach is more likely to succeed in building a safety culture than the adversarial 'blame and shame' approach of the past.

4.3 Public concern about medical error/adverse events

Despite the relatively muted media and public response to the publication of the Davis et al studies public concern continues relating to particular clinicians and the failings associated with the care of particular individuals who were or are seeking redress from the consequences of these failings. This concern has translated into political action and the preparation of legislative changes which are expected to have wide ranging implications for registration and disciplinary procedures. This is know as the Health Practitioners Competence Assurance Bill which will receive much political professional and media attention later in 2002.

An initial draft of the Bill provided for mandatory reporting of medical error and clinical failure. However it became to be more recognised, even by consumer groups, that such reporting would continue a culture of blame rather than supporting the emerging culture of safety and the need to deal with clinical failings within a safe organisational setting. The importance of this changing emphasis will be discussed further below.

4.4 International influences

International influences have had some influence in shaping New Zealand developments. Of particular importance has been the events in Britain associated with Bristol and the implementation of clinical governances as a national policy there. The IOM report is widely referred to but, in general, US influences, other than the work associated with Professor Don Berwick and the Institute of Health Improvement, have been relatively unimportant in New Zealand developments (Wright et al, 2001).

5. DEVELOPING A NATIONAL POLICY AND PROGRAMME/GOVERNMENT AND STAKEHOLDER ACTION

This section discusses the range of national organisations which have a role in developing a quality culture and addressing medical error and adverse events. Each is only briefly discussed. For further information about these agencies and organisations the relevant web site listed should

be visited.

5.1 Ministry of Health

The Ministry of Health (www.moh.govt.nz) is the agency of central government with responsibility for overall leadership in addressing quality and safety issues. Its primary role is to provide advice to the Minister of Health on all aspects of health and disability services. Apart from its general oversight and leadership role it has two particular responsibilities relating to quality and safety, legislation and regulation including licensing and audit on one hand and developing and promoting standards relating to quality and safety on the other.

The Ministry has taken an active leadership role in developing a range of programmes designed to promote quality improvement which are discussed further below under the headings of credentialling, clinical audit and reportable events. A key factor in initiating these initiatives was the HDC enquiry into Christchurch Hospital.

5.2 National Health Committee

The National Health Committee (www.nhc.govt.nz) was established in 1992 as an independent body to provide advice to the Minister of a range of issues which now includes health care quality. A national workshop on quality was organised by the Committee in February 2001 in which the Committee was given a mandate to take a leadership role in establishing a coordinated national approach to quality in health issues.

In May 2002 it produced a Final Report on Health Care Quality Improvement in New Zealand 'Safe Systems Supporting Safe Care'. The report recommended a national approach to quality improvement with quality improvement being the prime focus of health care delivery. It recommended a systems approach to quality improvement focusing on improved communication and relationships between people at all levels. It identified five components of quality; safety, consumer-focus, aaccess, effectiveness and efficiency.

The Committee recommended four priorities for action;

- strong leadership
- improved responsibility for Maori
- greater consumer involvement
- better coordination.

However it did not recommend the establishment of a national body for quality arrangements as

in other countries such as England and Australia. Rather it saw the continuing development of a network of agencies and organisations needing to work in greater collaboration. This more decentralised model, in which quality improvements are seen to be driven from the bottom or 'middle up' is much more consistent with a New Zealand model of working than the more centralised approach of countries such as Britain.

5.3 New Zealand Medical Council (www.mcnz.org.nz)

The Medical Council registers doctors to practise medicine in New Zealand. Registration is evidence that a doctor has met a certain standard to achieve its primary purpose - protecting the health and safety of New Zealanders. The Medical Council operates under the Medical Practitioners Act 1995. It also has responsibilities for medical education, standards, conduct and health. Disciplining of doctors is not the Council's role. Discipline is carried out by a separate Medical Practitioners Disciplinary Tribunal. The Council has six members appointed by the Minister of Health and four elected by the medical profession.

Doctors must be registered with the Medical Council to practise medicine in New Zealand. Once doctors are registered, they are required to re-licence every year by applying for an Annual Practicing Certificate. Only doctors who maintain the necessary standard can renew their certificates, thus assuring the Council and the public of their continuing competence. The Council can decline registration on the grounds of a criminal conviction, a mental or physical illness or a past or present disciplinary action.

5.4 Clinical Colleges: the example of the Royal New Zealand College of General Practitioners (RNZCGP) (www.rnzcgp.org.nz)

The New Zealand clinical colleges have an key role in establishing competence in medical practice in wide range of medical specialties. Each College medical, surgical, pathology etc certify the attainment of specialist skills and experience which then enables a candidate to apply to the Medical Council for specialist registration.

The Royal New Zealand College of General Practitioners (RNZCGP) has been the first to state its support for clinical governance. The RNZCGP Council in 2001 resolved that the College work with primary health organisations to develop a framework for clinical governance in New Zealand.

The College sees clinical governance as including the following;

- Extending the work of GPs through continuing medical education and continuous quality

improvement

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

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

The College, in order to promote quality in general practice, has embarked upon promoting accreditation of general practices. A set of standards have been produced with 49 indicators including; the rights and needs of patients, access and availability, barriers to access, practice facilities and systems, practice and patient management, human resource management, professional development and research.

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

5.5 Professional associations

Another piece of the quality jigsaw referred to below is the professional associations representing doctors, nurses, physiotherapists etc. The key medical organisation is the New Zealand Medical Association www.nzma.org.nz which is the country's leading pan-professional medical organisation. Its members come from all disciplines within the medical profession and it is the largest doctors' organisation in New Zealand. Medical practitioners registered in New Zealand and medical students enrolled at a New Zealand university, are eligible for membership.

NZMA represents the medical profession in dealings with the Government and its agencies on issues affecting the medical profession including ethics and professional standards. It has an important contributory role in the promotion of clinical quality.

5.6 **Quality Health New Zealand (QHNZ)** www.qualityhealth.org.nz / **Standards New Zealand** www.standards.co.nz

Quality Health New Zealand is the trading name of the New Zealand Council on Health Care

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

QHNZ works closely with Standards New Zealand in its activities. Standards New Zealand is a national body for establishing and monitoring standards in a wide range of industry and service activities

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

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

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

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

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

5.7 Accident Compensation Corporation (www.acc.org.nz)

The Accident Compensation Corporation (ACC) administers New Zealand's accident compensation scheme, which provides accident insurance for all New Zealand citizens, residents and temporary visitors to New Zealand. In return people do not have the right to sue for personal injury, other than for exemplary damages. This includes the right to sue medical and health practitioners for damage as a consequence of treatment.

ACC is a Crown entity responsible for:

- preventing injury
- collecting accident insurance premiums
- determining whether claims for injury are covered by the scheme and providing entitlements to those who are eligible
- paying compensation
- buying health and disability support services to treat, care for and rehabilitate injured people
- advising the government.

Claims for damage as a consequence of treatment are considered under the title of **medical misadventure**. This is defined as personal injury that is suffered by the person seeking or receiving treatment given by or at the direction of a registered health professional. Medical misadventure is classified as either medical error or medical mishap.

Medical error is defined as a failure of a registered health professional to observe a standard if care reasonably to be expected in the circumstances. The error does not exist solely because desired results are not achieved or where subsequent events showed that different decisions might have achieved better results. Medical error includes the failure of an organisation to observe a standard of care reasonably to be expected in the circumstances and where the failure cannot readily be attributed to a particular registered health professional. Organisational error excludes failure attributable to resource allocation decisions of the organisation.

Medical mishap is defined as the consequence of treatment where treatment is given properly by or at the direction of a registered health professional and the consequence is rare and severe. Rarity is defined as 1% for less, eg an adverse reaction to a drug. Severity is defined as death, hospitalisation for 14 days or more, and serious disability.

ACC acts as a insurance organisation paying out compensation for medical error on the basis of claims by patients. The claims process involves a review of reports from the health professional and by an independent clinical adviser. Claims are paid by ACC based on a schedule related to the severity of the consequences of medical error. No compensation is paid for medical mishap.

Level of claims Since the establishment of this system some 10 years ago there have been about 6000 claims paid out for medical misadventure, and now settling at about 1000 per year. A total of some $92 million has been paid out in compensation over this period. By far the largest proportion of claims accepted 85% were for medical mishap which accounted for 86% of payments.

Given the findings are the Davis et al studies with some 13% of hospital admissions being associated with an adverse event it can be estimated that tee are some 80,000 adverse events associated with the more than 600,000 admissions annually to New Zealand's hospitals. This does not include non-hospital associated treatment. Hence only a very small portion of these adverse events result in a claim to ACC for compensation. It would appear that New Zealand patients have a very low tendency to claim compensation for adverse events experienced.

As a consequence of this no fault system New Zealand's insurance costs for medical and other health practitioners is lower than anywhere else in the world. The system is well regarded in New Zealand and is being looked at by other countries as an alternative to the legally dominated and long drawn out compensation procedures in other countries. These have serious adverse consequences for both practitioners and patients with the main beneficiaries in most countries being the legal profession.

5.8 **Health and Disability Commissioner** (HDC) (www.hdc.org.nz)

The HDC was established in 1994 by the Health and Disability Commissioner Act 1994. It is a key element in the new environment of consumer-focused and consumer-accountable health and disability services and has become the primary vehicle for dealing with complaints about any health or disability services provider in New Zealand.

The purpose of the Act is expressed as being "to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights" (s6). This objective is achieved through the implementation of a Code of Rights, the establishment of a complaints process to ensure enforcement of those rights and the ongoing education of providers and consumers.

Since the formation of the HDC all complaints regarding medical error/negligence are referred to the HDC. Referrals are by consumers directly and through a wide range of agencies such as the Medical Council and the ACC. During the year ending June 2001 a total of 1,397 complaints regarding medical and other health professional failings were received, the largest single

percentage of these being relating to general practice. The HDC responds to each individual complaint. Most, 74%, are dealt with by advocacy services and concern the following three issues:

- appropriate standards
- being fully informed
- effective communication.

12% of complaints remained unresolved with advocacy and were referred to the Commissioner. Only in 130 cases was it found that a breach of the Code had occurred. Action in these cases led to a recommendation for an apology in the majority of cases. In 26 cases the matter was referred to the Director of Proceedings to consider whether further action of a disciplinary nature should be taken.

In recent years there have been an increasing number of complaints associated with the increasing publicity relating to medical failings. Despite this the actual number of complaints in which there has been a breach of the Code have been diminishing. This suggests that the many strategies to improve quality may be having a significant effect in reducing medical error.

5.9 Community/consumer associations

New Zealand has a wide range of community and consumer associations. However there is no special consumer organisation for the promotion of quality as such. Nor is there an overarching consumer health body such as the Consumers Health Forum in Australia. In general consumer participation has tended to focus particularly upon special issues eg the failings of particular clinicians and consequential disability and death mainly in the area of women's health. Special-purpose organisations tend to be set up to deal with these issues.

5.10 Clinical Leaders Association of New Zealand (CLANZ) (www.clanz.org.nz)

CLANZ appears to be internationally to be a relatively unique organisation. Although formed only in 1998, it has taken an active role in bringing together clinical leaders and those concerned with the development of clinical leadership and with a particular focus upon improving clinical quality. Its mission is;

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

CLANZ is a multidisciplinary body with a membership now over 200 from a range of disciplines, managers and others concerned with promoting clinical leadership. It has been given substantial financial support by the Ministry of Health to carry out its mission. Its contracts with the MOH have required CLANZ;

- to clarify and strengthen clinical leadership and its relationship with service quality in the New Zealand health sector: and
- to clarify perspectives on clinical governance and leadership

CLANZ has established what has been termed the 'Leadership for Health' project. This project includes the following;

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

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

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

CLANZ is expected to have a increasingly significant role in promoting a quality culture in the future given the increasing recognition of the key role of clinical leadership in quality improvement programmes. Further work is currently being undertaken to explore in depth the roles and responsibilities of top medical and nursing leaders and quality and risk managers in DHBs.

6. INFORMATION SYSTEMS AND PROJECTS FOR QUALITY AND

SAFETY

6.1 Reportable Events

In September 2001 the Ministry of Health (2001) released a publication 'Reportable Events: Guidelines'. This report brought together work which had been carried out over a number of years to ensure the identification and reporting of events which had had or could have been expected to lead to adverse consequences and the need to learn from these events. The Introduction stated;

> 'There needs to be a fundamental rethinking of the way the health care sector approaches the challenge of learning from when things go wrong. Traditionally the sector has failed to learn the lessons from **reportable events** (as they will be called throughout these guidelines) and has an outmoded approach compared with other industries. The potential benefits of learning from our experiences are significant in terms of saved lives, harm prevented and resources freed up for the delivery of more and better care. This will require a concerted effort by health care professionals, organisations and regulators. Traditional boundaries and a culture of blame must be broken down. Most importantly, we must systematically design safety into the processes of care.
>
> To improve this outmoded approach successfully and move towards an environment that supports and encourages self-learning, the following are essential:
>
> - a standardised process for investigation, analysis and reporting
> - a culture of learning – not one of blame
> - a process for communicating the lessons learnt so others may benefit from this experience
> - ensuring systems and practice change as a result of the lessons learnt.
>
> Implementation of these guidelines will help to create an environment within health and disability services, both locally and nationally, that supports and encourages **self-learning** from analysing reportable events, and promotes the **redesign** of systems as the main method for improving safety. This requires supporting a **culture** where every health care worker takes personal responsibility for consumer safety, and where discovering and reporting problems, mistakes, and close calls is **rewarded**, not punished.'

The Report noted that having a reporting system in place for incidents/accidents provides:

- an accountability mechanism

evidence of a standardised sentinel event investigation, analysis and reporting system
- evidence of a systematic approach to the implementation of safety procedures
- an audit trail
- a record of risks, and information for the organisation's knowledge base.

Reportable events included a range of categories such as: those events that reflect an unsatisfactory situation in terms of the quality of clinical, practice, quality of operational management, or quality of service delivery systems.

Serious events were defined to include:

- a system failure resulting a reduction in the quality of service
- significant deviation from the organisation's usual process
- did not result in but has potential to result in significant harm
- an event that must be reported to regulatory bodies under statute
- an event that needs to be reported to the organisations insurance carrier
- the potential for adverse media attention.

A serious event is one that has the potential to result in death or major permanent loss of function, not related to the natural course of the consumer's illness or underlying condition.

Examples of serious events include those resulting from:

- missed or misdiagnosis
- incorrect or incorrectly performed procedure/medication
- contraction of notifiable blood-borne disease
- harm resulting in admission to intensive care unit from ward or transfer to another provider
- employment of a person fraudulently posing as a registered health professional
- absence without leave of a client who may be seen as a danger to themselves or others
- serious harm involving staff
- failure in emergency management procedures resulting in a major disruption to patient care.

Sentinel events are major events which include:

- major system failure
- multiple teams, departments or services are involved
- the potential for serious adverse media attention
- the potential to seriously undermine public confidence
- when a group of consumers have potentially suffered harm.

Examples of sentinel events are:

- an event which has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the consumer's illness/underlying condition/pregnancy/childbirth;
- one of the following events (even if the outcome was not death or major permanent loss of function):
  - suicide of a consumer while in intensive psychiatric care
  - infant abduction or discharge to the wrong family
  - invasive procedure or intervention on the wrong patient or wrong body part
  - attempted or alleged sexual abuse or rape
  - errors of omission or commission that result in significant additional treatment or are life threatening, for example, medication errors, iatrogenic injury, recall of patients.

However there is no mandatory reporting of these events. It is up to each DHB to act as appropriate using the Reportable Events: Guidelines schedule and an associated workbook as guidelines.

6.2 Quality and risk management reporting

All DHBs have appointed quality coordinators/quality risk managers who are responsible for overall promotion of quality programmes including the preparation of regular quality reports to their DHB. However very little has been done to document and analyse this information. A study examining this issue is currently being undertaken by CLANZ

6.3 Credentialling

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

Credentialling is defined in the document as:

> *a process used to assign specific clinical responsibilities (scope of practice) to medical practitioners on the basis of their training, qualifications, experience and current practice,*

within an organisational context".

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

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

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

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

6.4 Clinical improvement, audit and peer review

The Ministry Health (2002)has added to its series of publication on Towards Clinical Excellence with a further publication 'An introduction to clinical audit, peer review and other clinical practice improvement activities. The handbook is designed to help practitioners developing expertise in peer review and clinical audit as part of service delivery and to ensure improvements are implementing and evaluated. It sets out actual steps which clinicians might undertaken to improve their performance within an organisational setting.

7. LEGISLATIVE ACTION FOR QUALITY AND SAFETY

The New Zealand Health and Disability Act 2000 requires the Minister of Health determine a strategy for the development and use of;

- nationally consistent standards and quality assurance programmes for health services and consumer safety; and
- nationally consistent performance monitoring of health services and consumer safety against those standards and programmes.

The legislation also require the Minister to appoint a committee to advise the Minister on health epidemiology and quality assurance matters. This latter function has been taken up by the National Health Committee as discussed above.

In addition there are legally required licensing procedures which the Ministry of Health is required to undertake regarding institutions providing health and disability services. However current trends are towards the recognition of accreditation processes, also described above, as meeting the requirements the legal requirements for licensing.

As will be indicated elsewhere in this paper legislative action is, in general, less important in promoting quality activities than the wide range of actions emerging at the local provider level in ensuring quality.

8. DEVELOPMENTS AT THE PROVIDER LEVEL FOR QUALITY AND SAFETY

Reference has been made above to studies undertaken by CLANZ of quality developments in provider organisations specifically District Health Boards (DHBs) and primary care organisations (PCOs). This section discusses the results of these studies reporting particularly on organisational arrangements implemented to promote quality and the role of clinical leadership.

8.1 District Health Boards

Ten of the 21 DHBs (the six major tertiary service providers and four smaller and provincial boards) were selected for study (Malcolm et al, 2002a). The chief executive officers (CEOs) of the DHBs were contacted and sent a statement regarding the project, listing the information needed and inviting comment and participation. Project team members visited eight of the DHBs. Tape recorded interviews, with a prepared questionnaire format, were held with the CEOs and/or chief operating officers (COOs), with chief medical and nursing advisers and sometimes with quality managers. Documents relating to organisation and clinical quality were studied.

Clinical organisation It was consistently reported that accountability for clinical quality was located within clinical divisions. At the executive level and reporting to the CEO or COO was a chief medical officer/advisor and chief nursing officer/advisor. These were seen to be key

positions, particularly in the promotion of clinical quality and providing clinical leadership at the executive level. It was stressed that most chief medical advisors were still active clinicians.

All DHBs had some form of clinical organisation based upon service divisions (medical, surgical, mental health etc.). In almost all situations there was a strong emphasis upon an emerging partnership between clinical leaders/directors and management. Accountability for both quality and cost, to which both managers and clinicians had 'signed up', was being devolved to clinical divisions. In the case of nursing expenditure, nurse leaders were expected to be part of this partnership although there was much variability, and consequent uncertainty, in the way nursing services were organised.

Quality initiatives and achievements Most DHBs had established formal organisational support systems for quality improvement. These included clinical boards/groups, clinical improvement/advisory/executive committees and associated quality and risk managers. There was increasing commitment to, and implementation of, quality and risk management programmes, accreditation, clinical audit, credentialling and developing quality frameworks.

Quality achievements reported included; greater openness and moves towards a culture of safety, the growing partnership between clinicians (including non-medical clinicians) and management, the integration of previously disparate quality efforts into a coherent system, implementation of effective means of reporting adverse events, working towards accreditation, credentialling of senior medical staff, clinical audit systems, and appointment of staff dedicated to quality.

Facilitating factors were; experience of accreditation, appointment of specific staff responsible for quality, the ability to provide resources, tools and incentives, the integration of clinical and financial management and adverse events awareness promoting greater attention to quality. Progress was hindered by; resource constraints, inadequate time for clinicians to participate, shortage of leadership skills and past conflicts leading to mistrust between clinicians and management.

Quality improvement and risk managers All DHBs studied had appointed quality and risk managers who had a key role in developing a quality plan, providing overall leadership for quality improvement within the DHB and establishing a system of reportable events.

Clinical governance Only three DHBs had formally adopted clinical governance as a policy and were using the UK definition, or a modified version. However almost all DHBs surveyed were implementing typical clinical governance processes driven strongly by clinical values and aspirations, with clinical leadership playing a key part.

8.2 Primary Care Organisations

Twelve PCOs were also selected for study (Malcolm, 2002b). PCOs are collectives of primary care professionals seeking to impMove clinical performance and quality in a contract environment. They have features similar to primary care groups in the NHS. PCOs include both GPs as well as other health professionals. GP led PCOs now include in their membership some 90% of GPs.

Nine of the main GP-led organisations, were selected along with midwife and physiotherapy groups and an umbrella organisation that works with non-profit trusts providing GP and other services to low income populations. In most cases these PCOs were also personally visited, tape recorded interviews held and a range of documents sought for analysis.

Organisation for quality All PCOs had formal arrangements to develop and support quality initiatives through quality committees and individual managers. Committee membership included quality co-ordinators, managers and facilitators as well as GPs and practice nurses. In GP-led PCOs an important impetus for quality improvement arose out of budget holding for pharmaceutical and/or laboratory referred services. Other important drivers were professional values and clinical leadership.

Quality initiatives Quality initiatives ranged across personal health, population health and referred services management. Within personal health, disease management projects (eg diabetes) were important as were specific care packages (eg sexual health, mental health). Population health services included immunisation for children and older adults, screening programmes for cervical and breast cancer, smoking cessation and other lifestyle programmes. Quality improvement was an important focus in prescribing and laboratory referred services management, including the development of guidelines, information systems with personalised feedback, pharmacy facilitators and peer group review.

A range of quality indicators to measure practice performance was being explored and used in PCOs. These were based upon immunisation and screening levels, patient satisfaction and practice organisation and management. Some PCOs were developing scoring systems to identify practices needing assistance to achieve appropriate quality standards.

Quality achievements These included; some immunisation programmes with over 90% coverage in child immunisation, successful implementation of diabetic services with disease registers and high percentages of HBA1c being recorded and performance targeted, screening programmes for cervical and breast cancer with increasing levels of coverage, supported by recall systems, training programmes and information systems.

Facilitators and inhibitors of quality initiatives Facilitating factors mentioned included the national Primary Health Care Strategy, GP accountability and clinical leadership, continuing education programmes for GPs and nurses and a supportive infrastructure, including information systems. Financial incentives appeared to play a relatively minor role in the overall drive for quality. Key drivers were consistently stated as being professional, achieving better outcomes for patients and communities. Important barriers to quality achievements included; lack of appropriate funding, poor quality data for referred services management, low GP morale, lack of recognition by funders of achievements and an uncertain external environment.

Clinical governance Although only one PCO had formally adopted the term clinical governance, it was in fact practised widely in PCOs. Clinical leadership at governance level was found to be a critical factor in the quality achievements reported. It was also found to be important in the promotion of quality initiatives in the non-GP PCOs representing physiotherapists and midwives.

9. EDUCATION AND TRAINING

Education and training programmes for management, including quality and risk management and leadership generally, have been seriously neglected as a consequence of the market approach to the delivery of health services during the 1990s. There are currently no formal education and training programmes for quality and risk management.

Much of the development reported above has been driven by clinical leaders within provider organisations, both primary and secondary. Quality and risk managers have been meeting regularly and sharing experiences relating to their programmes. Many if not most have a clinical background such as nursing.

10. AN OVERVIEW OF QUALITY AND SAFETY IN NEW ZEALAND

10.1 Building a integrated system

The problem of medical error and adverse events is now seen as only part of a wider systems approach to addressing quality. Emphasis is being placed upon building a culture of safety rather than blame, in which medical error is seen as a valued learning experience rather than a problem leading to blame and discipline.

As indicated above promotion of clinical quality, including addressing medical error, is the responsibility of a wide range of national as well as local provider organisations.. The figure below shows these various organisations but with a central focus on patient safety as the core of

this whole process. These organisations have been described as pieces of an ill-fitting jigsaw in which there has been a significant lack of coordination and clarity of responsibility in dealing with medical error, including patient complaints

The new and central piece of this jigsaw, which is still under construction, is the rapidly emerging framework and process for addressing quality and safety within the provider organisations. This piece of the jigsaw is to an increasing extent being called clinical governance. Clinical governance is the integrating piece of the jigsaw which brings the influences of the many organisations with an interest in quality to bear upon clinical qualilty and safety within a clinical provider organisation.

Clinical governance

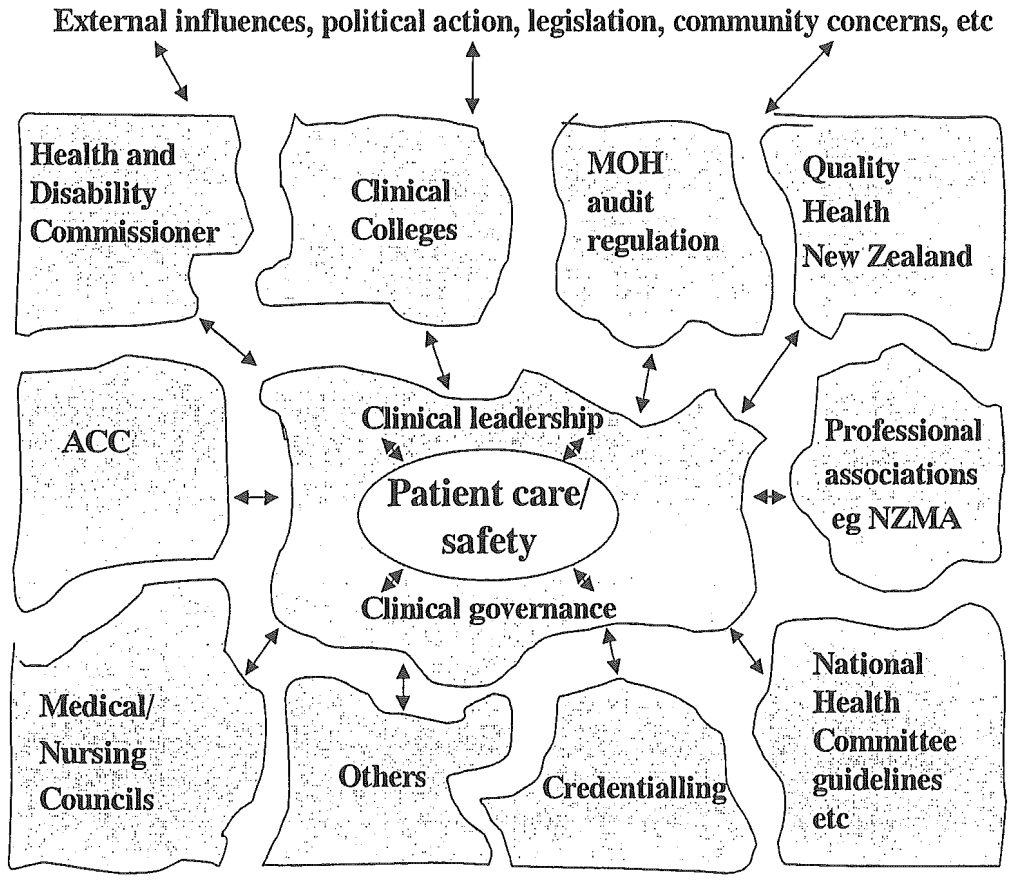
Although the term clinical governance has only been formally adopted by some provider organisations it is being widely practiced by almost all. There is a close relationship between clinical leadership and clinical governance. Clinical governance is a substantially broader concept than clinical leadership. Clinical leadership is encompassed within clinical governance. Clinical governance formalises the role of clinical leadership within an organisational setting. Clinical leadership can exist without clinical governance, but clinical governance is vitally dependent upon clinical leadership.

Clinical governance is based upon a convergence and integration between corporate and clinical values and goals. The key elements are;

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

Clinical governance as it is emerging in New Zealand shows some fundamental contrasts with the UK (Smith et al, 2001) as shown in the following Table. One key difference is that policy within the UK NHS is handed down from government. In contrast most New Zealand developments in health, at least those that have been successful, have evolved from a bottom-up approach.

The clinical quality jigsaw showing the external political influences, fragmented systems internal to health but still external to clinical care organisations and the direct impact that clinical leadership and clinical governance can have on patient care and safety



Clinical leadership

There is now increasing recognition of the importance of importance of clinical leadership as the key factor in the successful implementation of quality improvement strategies. The successful development of clinical leadership and clinical governance in New Zealand could be the centrepiece of a national strategy for quality improvement.

CLANZ is contributing to developing concepts of clinical leadership and clinical governance, and promoting clinical leadership. A key issue in the immediate future is education ad training for

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

Contrasts between clinical governance in the UK and New Zealand

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

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