# Health professional perceptions of clinical governance and the quality and safety environment in New Zealand DHBs:
# Report on the 2017 national survey

**Report to HQSC. April, 2018.**

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**Overview**

The work detailed in this report was commissioned by the Health Quality and Safety Commission (HQSC). It follows on from earlier work on clinical governance conducted by the authors, in 2010 and 2012, some of which was commissioned by government agencies. This 2017 study deploys the same survey method as the earlier studies, including a number of the same questions asked previously. It differs in that some questions from the 2012 study have been replaced by new questions of interest to HQSC and the New Zealand health sector. Key findings are that progress on questions asked in 2010 and 2012 has been limited; in many cases, respondents are less positive than they were in 2012. This may be due to a stronger focus in 2012 – nationally and across the DHB sector – on clinical governance development. This 2017 study has implications for health sector policy, governance and management as well as for health professionals. In particular, there may be a need to refresh the emphasis on clinical governance and aspects of the quality and safety environment nationally and within DHBs.


**Background**

Clinical governance has been an important foundation for health systems in a range of countries since around the mid-1990s when the term was first used in the English NHS.[1] The concept encapsulates an approach to health sector and service governance that is clinically-led. The terms 'clinical governance', clinical leadership' and 'clinical engagement' are often used in tandem, so it is useful to briefly define these. In adapting an earlier definition,[1] New Zealand's *In Good Hands* report (further described below) defined clinical governance as the system through which health and disability services are accountable and responsible for continuously improving the quality of their services and safeguarding high standards of care, thereby creating an environment in which clinical excellence will flourish.[2] The key point here is that clinical governance is 'the system'; 'clinical leadership' – leadership by individual health professionals and professional teams – is pivotal to building this system. Clinical engagement refers to the idea of an employee who does not see their role as narrowly and specifically defined, providing the minimum required of them, but rather as someone who appreciates and is proud of the organisation in which they work and wishes it to be seen as such by others. The engaged employee is then willing to do more than the minimum expectation, to 'go the extra mile' for the reputation of the organisation.[3]

Following on from the above, the goal of clinical governance is to create a system in which clinical leadership thrives and is supported, where clinicians are all integrally involved in working together on improvement activities; and, ultimately, to create an environment in which health professionals are responsible for the governance of service quality and patient safety, working continuously to improve this.[4] There are various requirements for strong clinical governance to happen including: an adequate policy focus and framework at the national and local service delivery levels; support for clinical governance development, including training and workplace support; and health professional willingness to get involved in clinical governance

with the outcome of recognising where the system fails patients and professionals and improving processes and services on their behalf.[5]

New Zealand's focus on clinical governance commenced in 2009 following the report of the Ministerial Task Group on Clinical Leadership.[2] This professionally-led group, appointed by and reporting to the Minister of Health, produced a series of recommendations including that:

- DHBs and their governing Boards create governance structures that ensured an effective partnership between clinical and corporate management, with quality and safety at the top of all meeting agendas;
- Each DHB CEO should enable strong clinical leadership and decision making throughout their organisation;
- Clinical governance should cover the entire patient journey, with clinicians actively involved in all decision making processes and with shared responsibility and accountability with corporate management for both clinical and financial performances;
- Decision making should be devolved to the appropriate clinical unit or teams within DHBs and their hospitals; and
- DHBs should identify and support actual and potential clinical leaders including investing in training and mentoring.

On receipt of this report, the then Minister of Health stated an expectation that all DHBs would work to implement these recommendations.[6] In 2010, the authors partnered with the Association of Salaried Medical Specialists (ASMS) in order to survey their members – around 90% of public hospital specialists employed by DHBs. The aim of that study was to gauge medical specialists' perceptions of the extent to which the Minister's instructions had been acted upon by DHBs. Questions developed for the survey study were designed to assess progress on key recommendations from the Ministerial Working Party, including those listed above. From the respondent data obtained, the authors developed a Clinical Governance Development Index (CGDI) which gave each DHB a score and, in turn, an overall score for NZ.[7]

In 2012, a follow-up study was conducted. This was commissioned by the then National Health Board (part of the Ministry of Health), HQSC and DHBs and included all registered health professionals in DHB employment.[8,9] It was the largest-ever health workforce survey conducted in New Zealand. The Clinical Governance Assessment Project (CGAP), as it was titled, saw some small modifications to the questions asked in 2010. The project also included some new questions as a result of HQSC involvement in the study. Two reports and a series of academic journal articles were published as a result;[4,8-14] findings were also presented in a major national meeting, with representatives from the commissioning agencies, all DHBs and other interested parties, held in Wellington in December 2012.

This 2017 study aimed to measure progress since 2012 and was commissioned by HQSC. Again, some modifications to the survey were made. Some questions from 2012 were removed, and others of interest to HQSC and the health sector added in. The modifications mean that it was not possible to create the CGDI used in 2010 and 2012. However, it is possible to chart progress

on key questions included in all three surveys and on questions included in 2012 and 2017. This 2017 study also means availability of baseline information on the new questions.

The focus on clinical governance and the quality and safety environment remains as important as ever. Indeed, there is a strong argument that robust clinical governance provides the 'organisational fuel' for safe, effective and efficient care; that the job of health professional training institutions, policy makers and managers is to focus on continual development and support of CG. A growing evidence-base supports the demand for such a focus.[15-19] In many ways, CG is the health care version of what is known as 'operational excellence'. In a generic sense, this means a concerted focus on key operational factors in terms of how work is organised. When organisations place an emphasis on these factors, associations with better product and service quality, reduced costs and improved performance have been found.[20]

Other factors related to CG are also important in the contemporary context of health care quality and safety improvement. These include the need for health professional employers to ensure that professionals undergo periodic credentialing, and that professionals discuss concerns about care with patients and their families.[21]

This report details the findings from the 2017 study and, where relevant, compares these with the findings from the earlier studies. The report is structured as follows. Next, the methods are described. The findings are then presented. Finally, the findings are discussed in the context of the broader literature and the 2010 and 2012 studies, along with some brief recommendations.


**Methods**

DHBs have been variously investing in quality improvement activities, often with support of HQSC and the Ministry of Health. Some have previously sought to evaluate their 'safety climate',[22,23] yet study findings are largely not publicly reported. The CGAP study was the first to investigate health professionals' perceptions of elements of quality and safety involving all DHBs and to publicly-report findings. The development of the survey tool used in the 2012 CGAP study is described in more detail elsewhere.[8] This 2012 tool was largely replicated for this 2017 study. In short, the 2012 tool involved limited adaptations to questions developed for the earlier 2010 ASMS study. Questions for this 2017 study involved some further minor adaptations. Some questions from 2012 were removed, and some new questions added. The new questions were developed to assess areas of interest to HQSC, namely around sharing patient outcome data (two new questions) and on DHBs defining health professional roles in patient safety (one new question). As noted, the removal of 2012 questions means it was not feasible to create a Clinical Governance Development Index (CGDI) score for the sector or for individual DHBs for 2017. However, this report does provide comparisons of performance over time where the same questions have been included in both 2012 and 2017.

All questions in the survey have undergone considerable review and validation as described in the 2012 report and the various peer-reviewed journal articles that stemmed from that project.

The new 2017 questions were included to assess particular areas of emphasis in HQSC's 2017 advisory document on clinical governance. In brief, a detailed review of international literature was undertaken. No relevant pre-existing questions were found, so the three new questions were developed. In an iterative process, these were subject to review by HQSC staff, discussed with the Otago research team and amended following feedback. The questions, therefore, meet the basic standard of content validity.

Several steps and processes were involved in conducting the 2017 survey, with all communications as standard as possible across the 20 participating DHBs. The process was exactly the same as in 2012, as follows:

1.  The DHB CEOs each agreed to generate an internal email list of all registered health professionals in their employment to be invited to participate in the survey. It was agreed that this would be more straightforward than random sampling and, for several smaller DHBs, staff numbers in some professional categories were too small to warrant random selection;

2.  Each DHB provided the total number of invitees in each professional category to the Otago researchers in the following format to enable calculation of response rates (illustrative example):

| Professional Category | |
|---|---|
| **Allied Count** | 76 |
| **Junior Doctor Count** | 12 |
| **Medical Count** | 30 |
| **Nursing Count** | 241 |

3.  A total of 53,105 health professionals were invited to participate across the 20 DHBs;
4.  From July-October 2017, with varying commencement dates, the DHBs each sent an email invite to their professional staff list containing a link to the survey website. The staff list generation and email invites were largely managed by the HR department in each DHB, in direct liaison with the Otago researchers;

5.  Three follow up emails were sent by the DHBs to their staff at weekly intervals after the launch date and the survey closed at the end of November;[1]

6.  The Otago researchers monitored response rates and provided weekly feed back to the DHBs;

7.  All data analyses were conducted by the Otago researchers.

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[1] One DHB sent out only one reminder to staff.

**Report overview**

The following sections present key findings from the 2017 survey, with 2012 comparisons where appropriate.

First, respondent demographics and response rate data are presented.

This is followed by findings on individual survey items by DHB. Where a 2017 question was exactly the same as in 2012, a comparative data table is included. These tables show how each DHB's score has changed over time. The tables also include 95% confidence intervals. These show that the changes reported are only statistically significant in cases where the confidence interval does not include 0 (in other words, the changes are not statistically different from 0 when the 95% confidence interval includes 0). Note that Canterbury DHB has been removed from comparative tables, since it was not involved in the 2012 survey. The comparative figures do not exactly match those from the 2012 study due to slight differences in calculation. Comparative data are inserted in the commentary under some tables with the caveat that the way in which questions were asked in 2012 and 2017 differed slightly; in these cases, there is no corresponding comparative table.

The third section presents data by professional group.

The fourth section presents a small number of the large volume of written comments provided by participants in the 2017 survey. These are illustrative of the general sentiments of respondents.

A discussion of key findings and limitations concludes the report.

# 1 Demographics

## 1.1 Demographics Table (respondents with missing DHB have been removed)

The table below illustrates: (a) how the mix of respondents differed across the 2012 and 2017 surveys; and (b) how well the 2017 survey respondents represent the broader health workforce in terms of demographic make-up. The 'Number of Respondents' and 'Percentage of All Survey Respondents' columns for 2012 and 2017 allows assessment of (a). Comparing the 'Percentage of All Survey Respondents' column to the 'Percentage of Workforce' column allows assessment of (b). For example, respondents in 2017 from Auckland DHB made up 6.4% of all survey respondents but workers in Auckland DHB composed 15.6% of the NZ health workforce, so comparatively speaking the Auckland DHB workforce is under-represented in the 2017 survey.[2]

Figures in the 'Percentage of Workforce' column were supplied by Technical Advisory Services and pertain only to those employed by DHBs and delivering services in the DHB provider arm. The figures listed are for variables which were comparable to those collected in the survey. **Survey respondents were not particularly representative of the wider workforce.** In particular:

* There were more Allied/Other in the survey and fewer nurses;

* The survey participants were slightly older, with fewer in the 20-39 age range and more in the 50-59 age range;
* The survey participants tended to have been in the workforce longer, with far fewer under 5 years and far more over 15 years. This may partly be an artefact of how TAS records experience (which is length of service, and only includes their present position); and
* There were fewer females amongst the survey participants.

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[2] At the time this clinical governance survey was conducted, Auckland DHB had recently conducted another staff survey and were not confident in obtaining a strong staff participation rate.

| | | 2017 | | | | 2012 | |
|---|---|---|---|---|---|---|---|
| | | Number of Respondents | Percentage of All Survey Respondents | Number in Workforce | Percentage of Workforce | Number of Respondents | Percentage of All Survey Respondents |
| DHB | Auckland | 578 | 6.4% | 8603 | 15.6% | 1751 | 17.0% |
| | Bay of Plenty | 508 | 5.7% | 3324 | 6.0% | 469 | 4.6% |
| | Canterbury | 422 | 4.7% | 6896 | 12.5% | 0 | 0.0% |
| | Capital and Coast | 346 | 3.9% | 4346 | 7.9% | 1097 | 10.6% |
| | Counties Manukau | 1051 | 11.7% | 4816 | 8.8% | 277 | 2.7% |
| | Hawke's Bay | 459 | 5.1% | 1694 | 3.1% | 766 | 7.4% |
| | Hutt Valley | 321 | 3.6% | 1551 | 2.8% | 605 | 5.9% |
| | Lakes | 412 | 4.6% | 1034 | 1.9% | 336 | 3.3% |
| | MidCentral | 349 | 3.9% | 1771 | 3.2% | 427 | 4.1% |
| | Nelson Marlborough | 130 | 1.5% | 1540 | 2.8% | 534 | 5.2% |
| | Northland | 374 | 4.2% | 2038 | 3.7% | 745 | 7.2% |
| | South Canterbury | 94 | 1.0% | 483 | 0.9% | 152 | 1.5% |
| | Southern | 892 | 10.0% | 2758 | 5.0% | 740 | 7.2% |
| | Tairawhiti | 179 | 2.0% | 641 | 1.2% | 239 | 2.3% |
| | Taranaki | 327 | 3.6% | 1302 | 2.4% | 363 | 3.5% |

|  |  | 2017 | | | | 2012 | |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Number of Respondents** | **Percentage of All Survey Respondents** | **Number in Workforce** | **Percentage of Workforce** | **Number of Respondents** | **Percentage of All Survey Respondents** |
|  | Waikato | 1248 | 13.9% | 5251 | 9.5% | 737 | 7.2% |
|  | Wairarapa | 131 | 1.5% | 514 | 0.9% | 92 | 0.9% |
|  | Waitemata | 945 | 10.5% | 5147 | 9.4% | 662 | 6.4% |
|  | West Coast | 50 | 0.6% | 582 | 1.1% | 143 | 1.4% |
|  | Whanganui | 147 | 1.6% | 745 | 1.4% | 168 | 1.6% |
|  | *Missing* | *0* | *0.0%* | *0* | *0.0%* | *0* | *0.0%* |
| **Profession** | Allied/Other | 2670 | 29.8% | 11469 | 20.8% | 3483 | 33.8% |
|  | Doctor | 1742 | 19.4% | 9081 | 16.5% | 1912 | 18.6% |
|  | Midwife | 343 | 3.8% | 1386 | 2.5% | 327 | 3.2% |
|  | Nurse | 4089 | 45.6% | 26661 | 48.4% | 4573 | 44.4% |
|  | *Missing* | *119* | *1.3%* | *0* | *0.0%* | *8* | *0.1%* |
| **Age** | 20-29 | 781 | 8.7% | 8284 | 15.1% | 861 | 8.4% |
|  | 30-39 | 1325 | 14.8% | 11375 | 20.7% | 1728 | 16.8% |
|  | 40-49 | 1993 | 22.2% | 11093 | 20.2% | 2832 | 27.5% |
|  | 50-59 | 2553 | 28.5% | 11429 | 20.8% | 2838 | 27.5% |
|  | 60 or over | 1133 | 12.6% | 6285 | 11.4% | 917 | 8.9% |
|  | *Missing* | *1178* | *13.1%* | *121* | *0.2%* | *1127* | *10.9%* |

|  |  | 2017 | | | | 2012 | |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Number of Respondents | Percentage of All Survey Respondents | Number in Workforce | Percentage of Workforce | Number of Respondents | Percentage of All Survey Respondents |
| **Experience** | Under 5 years | 1439 | 16.1% | 23171 | 42.1% | 1839 | 17.8% |
|  | 5-15 years | 2793 | 31.2% | 16144 | 29.3% | 3367 | 32.7% |
|  | More than 15 years | 3568 | 39.8% | 9282 | 16.9% | 3975 | 38.6% |
|  | *Missing* | *1163* | *13.0%* | *0* | *0.0%* | *1122* | *10.9%* |
| **Sex** | Female | 6136 | 68.5% | 38407 | 69.8% | 7135 | 69.3% |
|  | Male | 1656 | 18.5% | 10183 | 18.5% | 2042 | 19.8% |
|  | *Missing* | *1171* | *13.1%* | *7* | *0.0%* | *1126* | *10.9%* |
| **Total** |  | **8963** | **100.0%** | **48597** | **88.3%** | **10303** | **100.0%** |

# 2 Response rates

## 2.1 By DHB

| DHB | 2017 | | | 2012 |
| --- | --- | --- | --- | --- |
| | **Number of Respondents** | **DHB Workforce** | **Response Rate** | **Response Rate** |
| Auckland | 578 | 8603 | 6.7% | 22.7% |
| Bay of Plenty | 508 | 3324 | 15.3% | 22.4% |
| Canterbury | 422 | 6896 | 6.1% | 0.0% |
| Capital and Coast | 346 | 4346 | 8.0% | 35.7% |
| Counties Manukau | 1051 | 4816 | 21.8% | 6.6% |
| Hawke's Bay | 459 | 1694 | 27.1% | 48.0% |
| Hutt Valley | 321 | 1551 | 20.7% | 37.1% |
| Lakes | 412 | 1034 | 39.8% | 40.9% |
| MidCentral | 349 | 1771 | 19.7% | 23.4% |
| Nelson Marlborough | 130 | 1540 | 8.4% | 40.7% |
| Northland | 374 | 2038 | 18.4% | 35.5% |
| South Canterbury | 94 | 483 | 19.5% | 33.3% |
| Southern | 892 | 2758 | 32.3% | 30.0% |
| Tairawhiti | 179 | 641 | 27.9% | 49.1% |
| Taranaki | 327 | 1302 | 25.1% | 34.6% |
| Waikato | 1248 | 5251 | 23.8% | 19.7% |
| Wairarapa | 131 | 514 | 25.5% | 25.6% |
| Waitemata | 945 | 5147 | 18.4% | 14.1% |
| West Coast | 50 | 582 | 8.6% | 20.5% |
| Whanganui | 147 | 745 | 19.7% | 25.0% |
| **Total** | **8963** | **48597** | **18.4%** | **25.1%** |

## 2.2 By Profession

| Job | 2017 | | | 2012 |
| --- | --- | --- | --- | --- |
| | **Number of Respondents** | **Number in Workforce** | **Response Rate** | **Response Rate** |
| Allied/Other | 2670 | 11469 | 23.3% | 38.7% |
| Doctor | 1742 | 9081 | 19.2% | 25.1% |
| Midwife | 343 | 1386 | 24.7% | 21.5% |
| Nurse | 4089 | 26661 | 15.3% | 19.4% |
| **Total** | **8963** | **48597** | **18.4%** | **25.1%** |

Note: 'Midwife' does not include community-based LM

# 3 Questions by DHB

## 3.1 Clinical leadership is described as 'a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients'. How familiar are you with this concept?
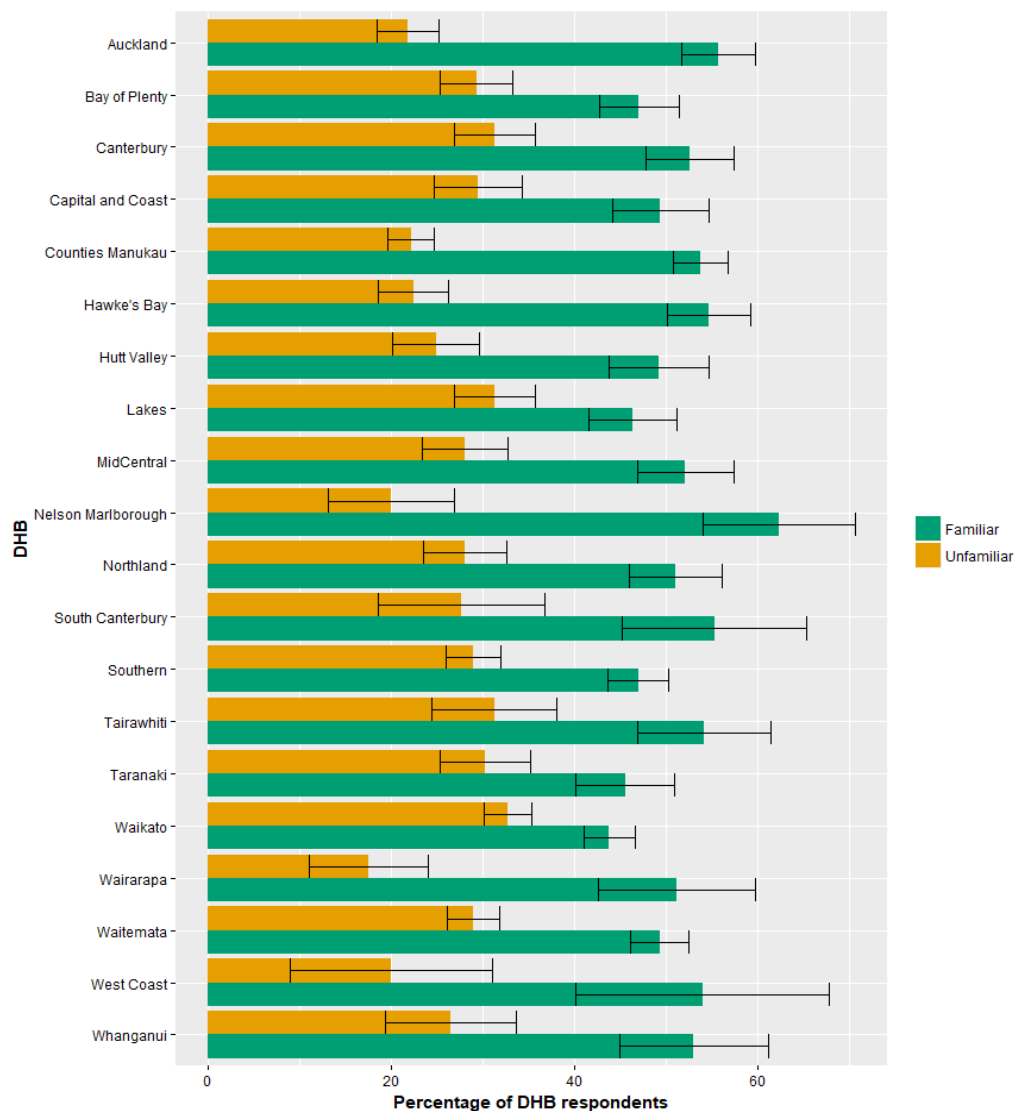


Overall, **4475 (50.5%;** 2012=47%**)** respondents were familiar with the concept. The mean across DHBs was **51.4% (SD: 4.3%)**. Familiarity ranged from **43.8% (Waikato)** to **62.3% (Nelson Marlborough)**.

**8869 (99%)** Respondents answered this question.

3.1a Clinical leadership is described as 'a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients'. How familiar are you with this concept? (2012 and 2017 compared)
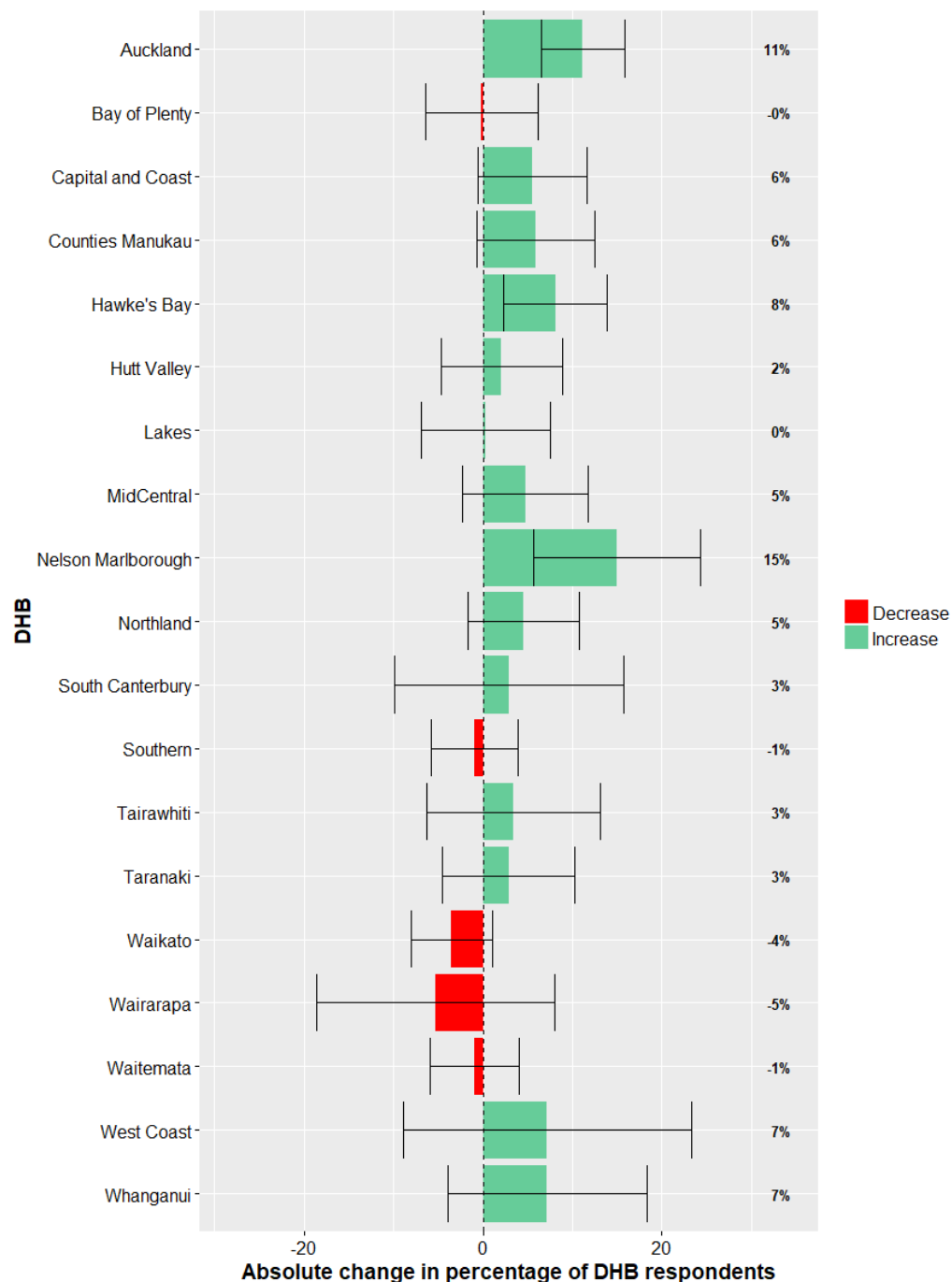


**47.1%** of respondents in 2012 reported that they were familiar with the concept of clinical leadership compared to **50.3%** of respondents in 2017 (an absolute increase of **3.2%**). The mean for DHBs increased (**48.2%** vs **51.9%**). The mean difference in the percentage of respondents giving a 'familiar' response to this question across DHBs was **3.7%** (**SD: 5%**). **Nelson Marlborough** had the greatest increase by 2017 (**15%**) and **Wairarapa** had the greatest decrease (**-5.3%**).

## 3.2 To what extent do you believe that your DHB has worked to enable strong clinical leadership and decision making throughout the organisation?
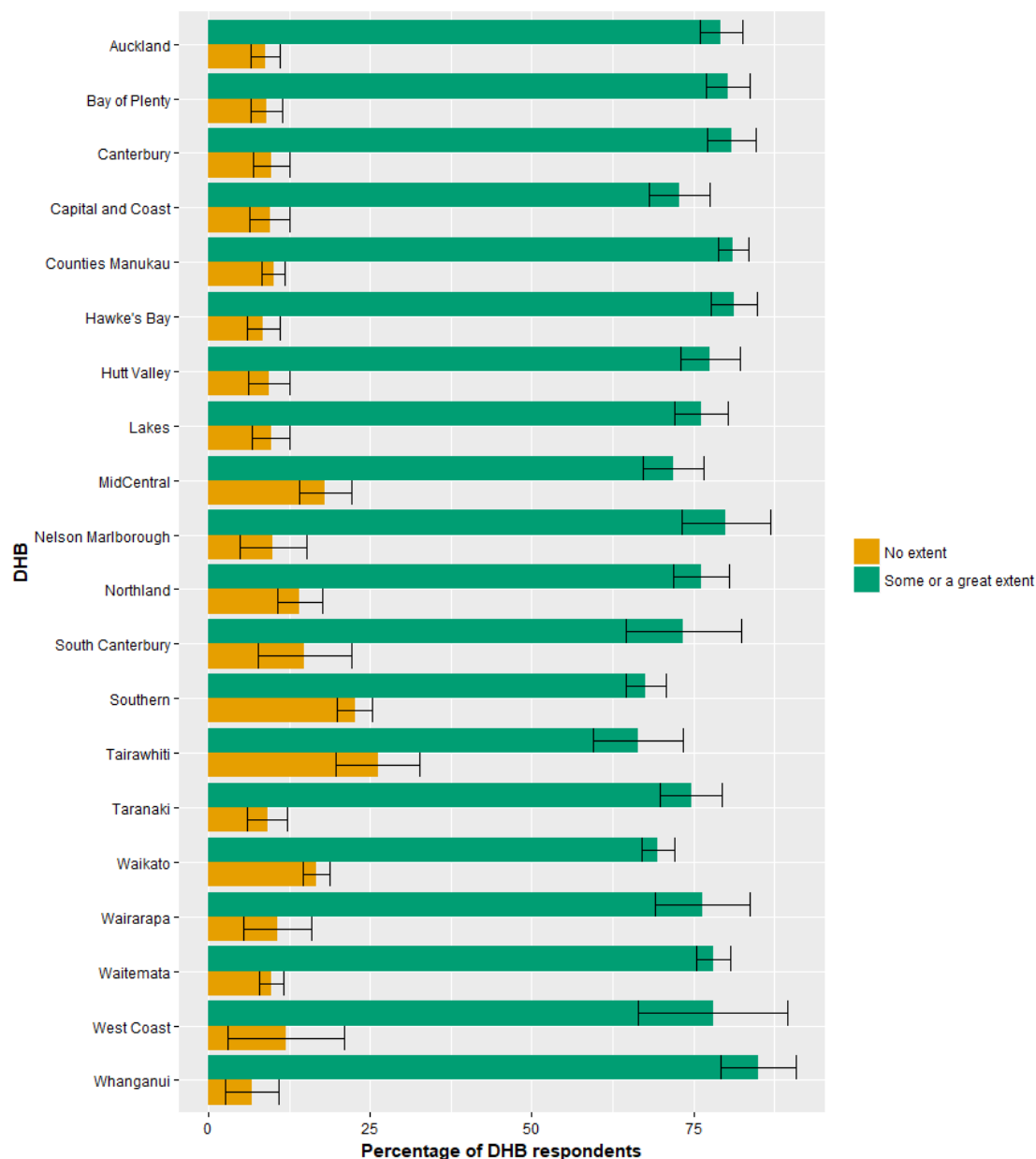


Overall, **6792 (77%**; 2012=78%**)** respondents felt their DHB was working to enable strong clinical leadership and decision making throughout the organisation. The mean across DHBs was **76.3% (SD: 4.9%)**. Agreement ranged from **66.5% (Tairawhiti)** to **85% (Whanganui)**.

**8819 (98.4%)** Respondents answered this question.

3.2a To what extent do you believe that your DHB has worked to enable strong clinical leadership and decision making throughout the organisation? (2012 and 2017 compared)
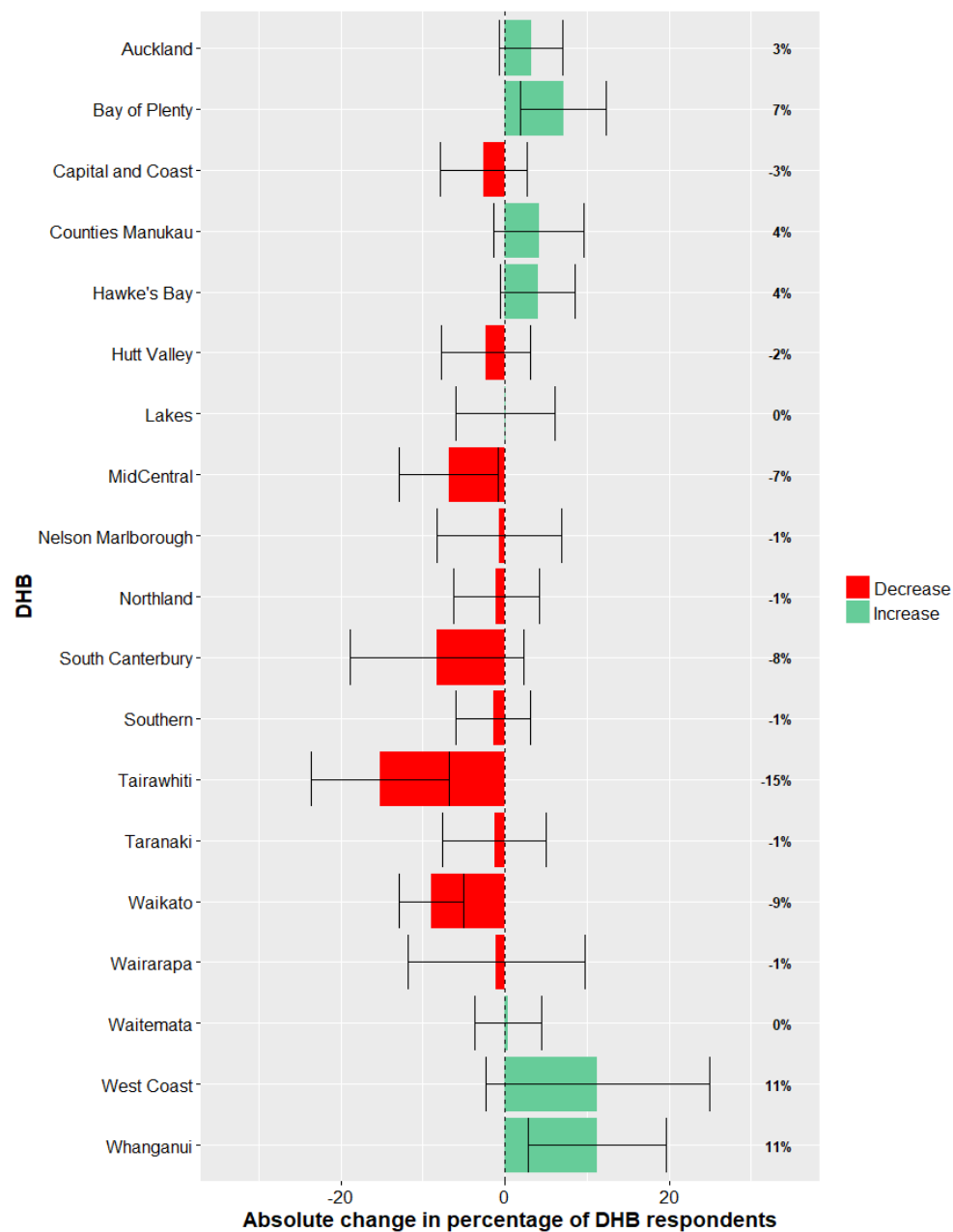


**77.7%** of respondents in 2012 reported that they believed their DHB had worked to enable strong clinical leadership and decisions making throughout the organisation to some or a great extent compared to **76.7%** of respondents in 2017 (an absolute decrease of **0.9%**). The mean for DHBs decreased (**77.9%** vs **77.5%**). The mean difference in the percentage of respondents giving a 'some or great extent' response to this question across DHBs was **-0.4% (SD: 6.6%)**. **West Coast** had the greatest increase by 2017 (**11.3%**) and **Tairawhiti** had the greatest decrease (**-15.2%**).

## 3.3 To your knowledge, does your DHB have an established governance structure that ensures a partnership between health professionals and management?
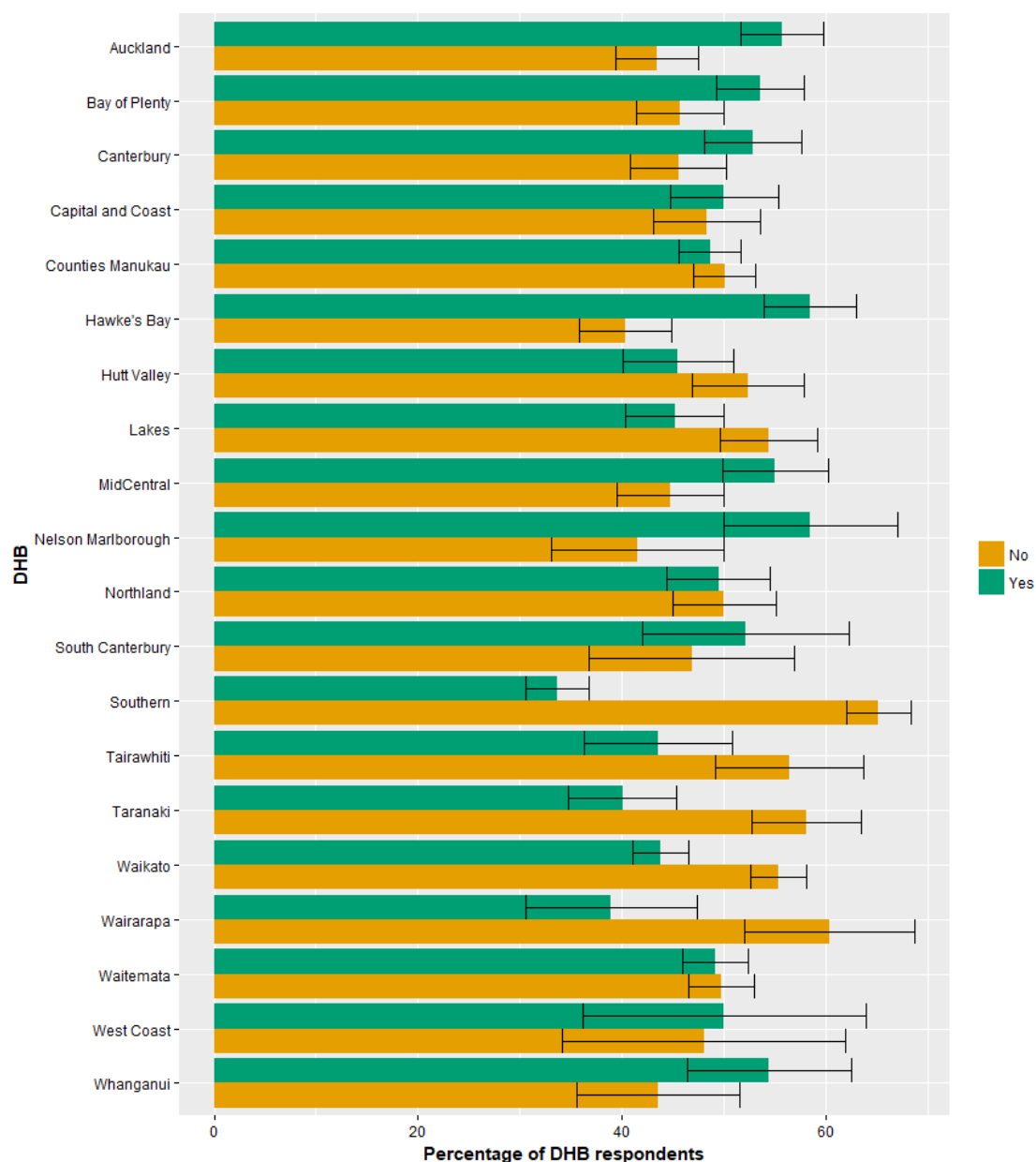


Overall, **4278 (48.3%;** 2012=45%**)** respondents thought their DHB has an established governance structure that ensures partnership between health professionals and management. The mean across DHBs was **48.9% (SD: 6.6%)**. Agreement ranged from **33.6% (Southern)** to **58.5% (Nelson Marlborough)**.

**8863 (98.9%)** Respondents answered this question.

3.3a To your knowledge, does your DHB have an established governance structure that ensures a partnership between health professionals and management? (2012 and 2017 compared)
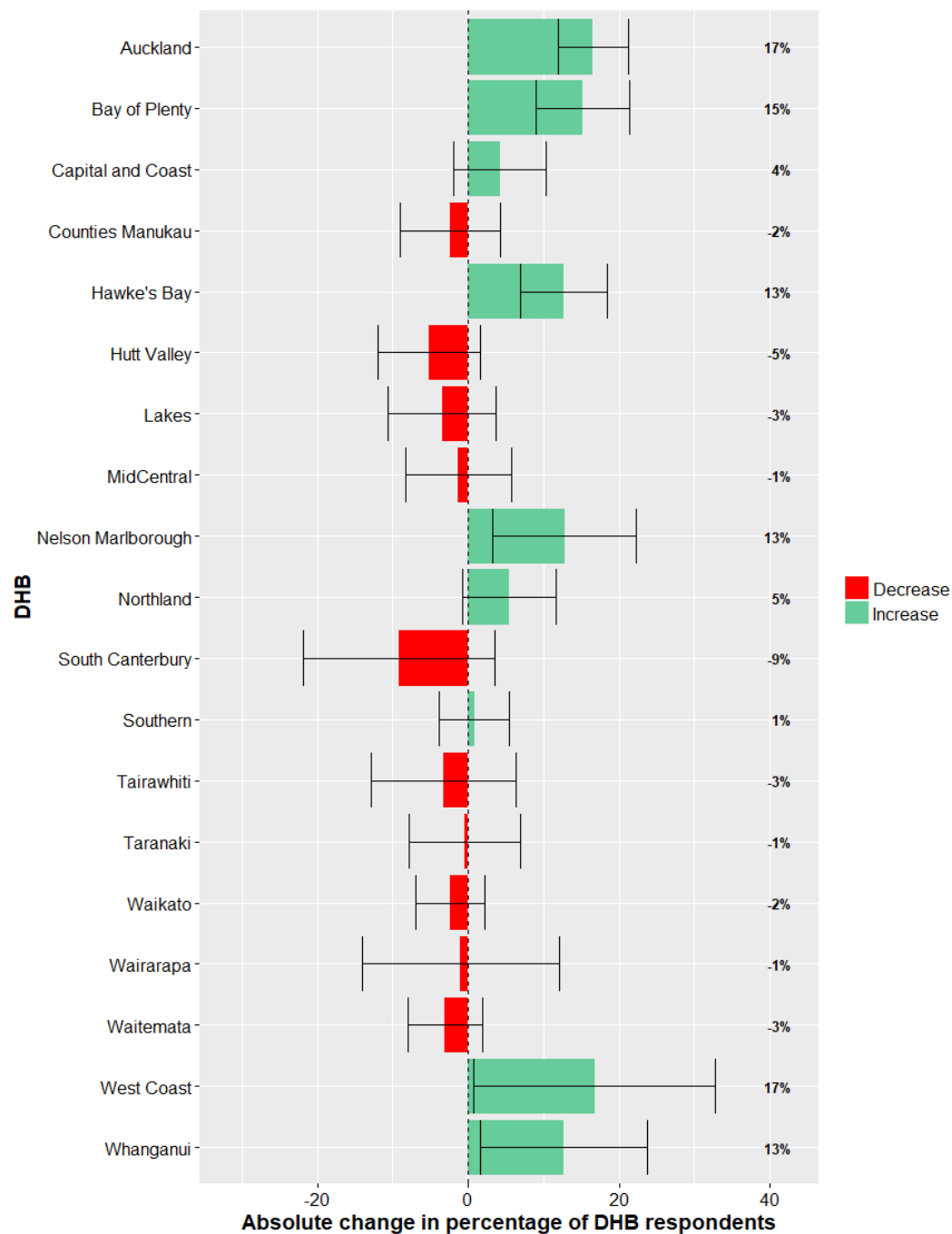


**44.9%** of respondents in 2012 reported that their DHB had an established governance structure that ensured a partnership between health professionals and management compared to **48%** of respondents in 2017 (an absolute increase of **3.1%**). The mean for DHBs increased (**45.8%** vs **49.2%**). The mean difference in the percentage of respondents giving a 'yes' response to this question across DHBs was **3.4% (SD: 8.3%)**. **West Coast** had the greatest increase by 2017 (**16.8%**) and **South Canterbury** had the greatest decrease (**-9.2%**).

## 3.4 To what extent has management within your DHB sought to foster and support the development of clinical leadership?
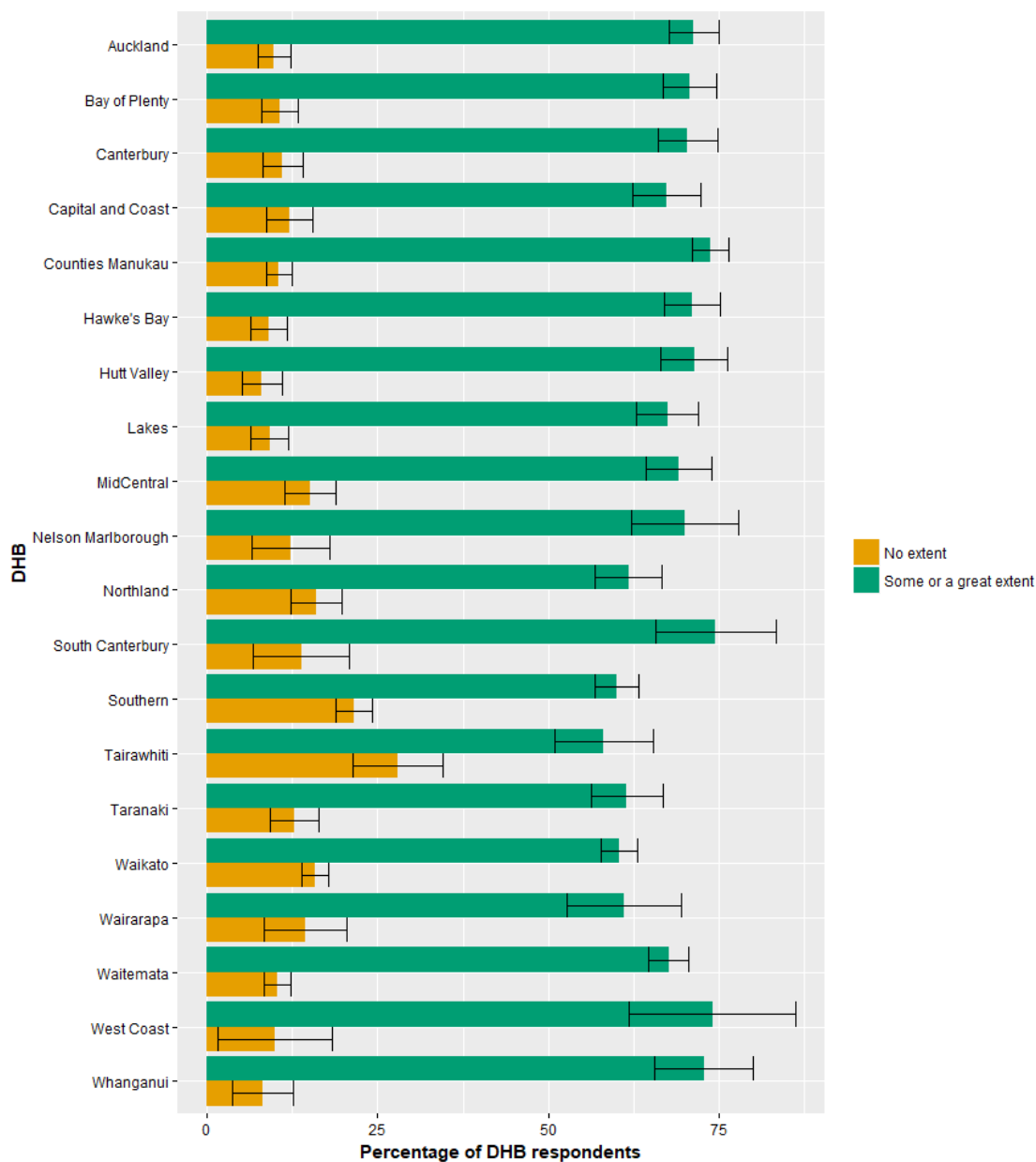


Overall, **5998 (67.3%**; 2012=63**%)** respondents felt their DHB had sought to foster and support the development of clinical leadership. The mean across DHBs was **67.7% (SD: 5.3%)**. Agreement ranged from **58.1% (Tairawhiti)** to **74.5% (South Canterbury)**.

**8915 (99.5%)** Respondents answered this question.

3.4a To what extent has management within your DHB sought to foster and support the development of clinical leadership? (2012 and 2017 compared)
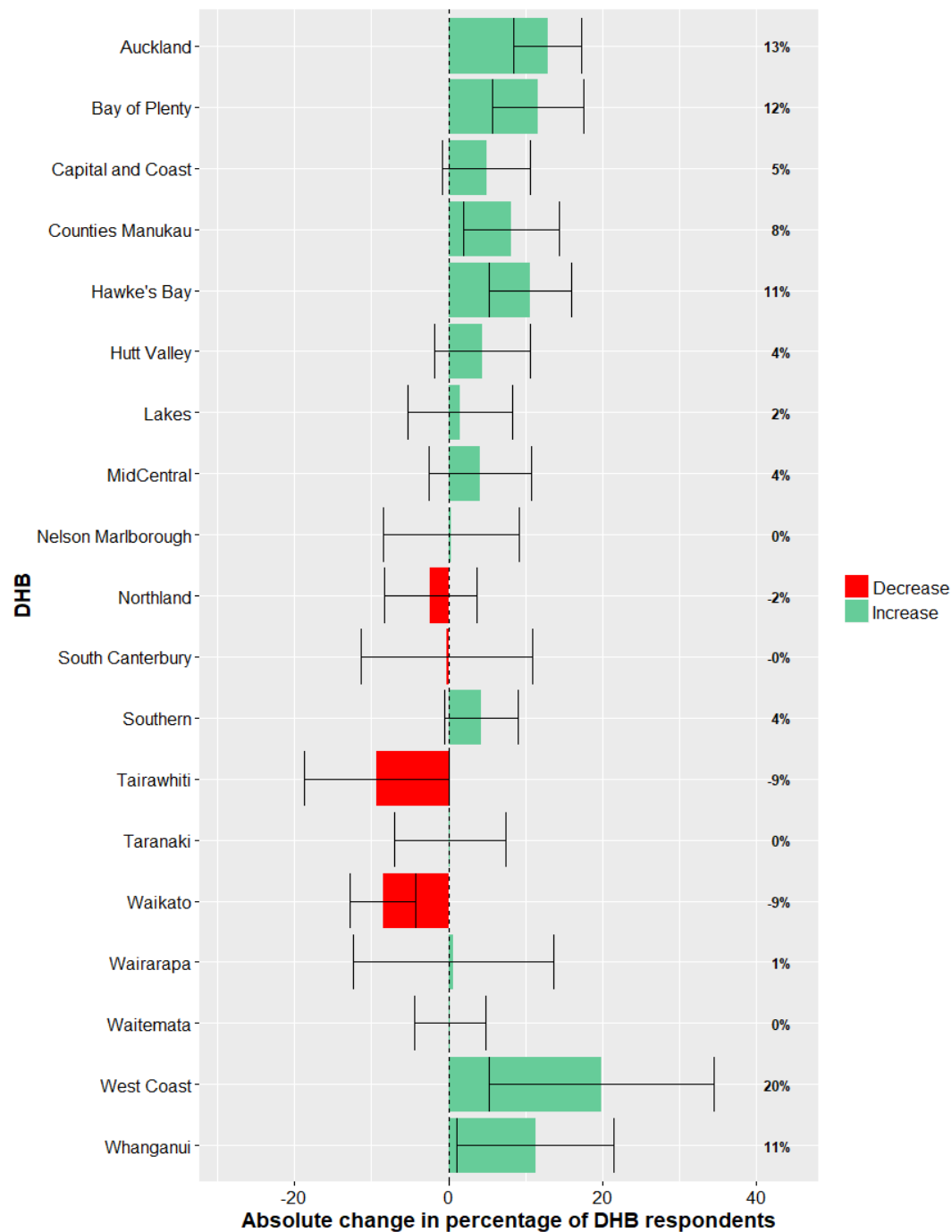


**63.3%** of respondents in 2012 reported that management in their DHB had sought to foster and support the development of clinical leadership to some or a great extent compared to **67.1%** of respondents in 2017 (an absolute increase of **3.8%**). The mean for DHBs increased (**64.1%** vs **68%**). The mean difference in the percentage of respondents giving a 'some or great extent' response to this question across DHBs was **3.9% (SD: 7.3%)**. **West Coast** had the greatest increase by 2017 (**19.9%**) and **Tairawhiti** had the greatest decrease (**-9.4%**).

## 3.5 To what extent have you been involved in working with other DHB staff, both clinical and managerial, to change the system where it would benefit patients?
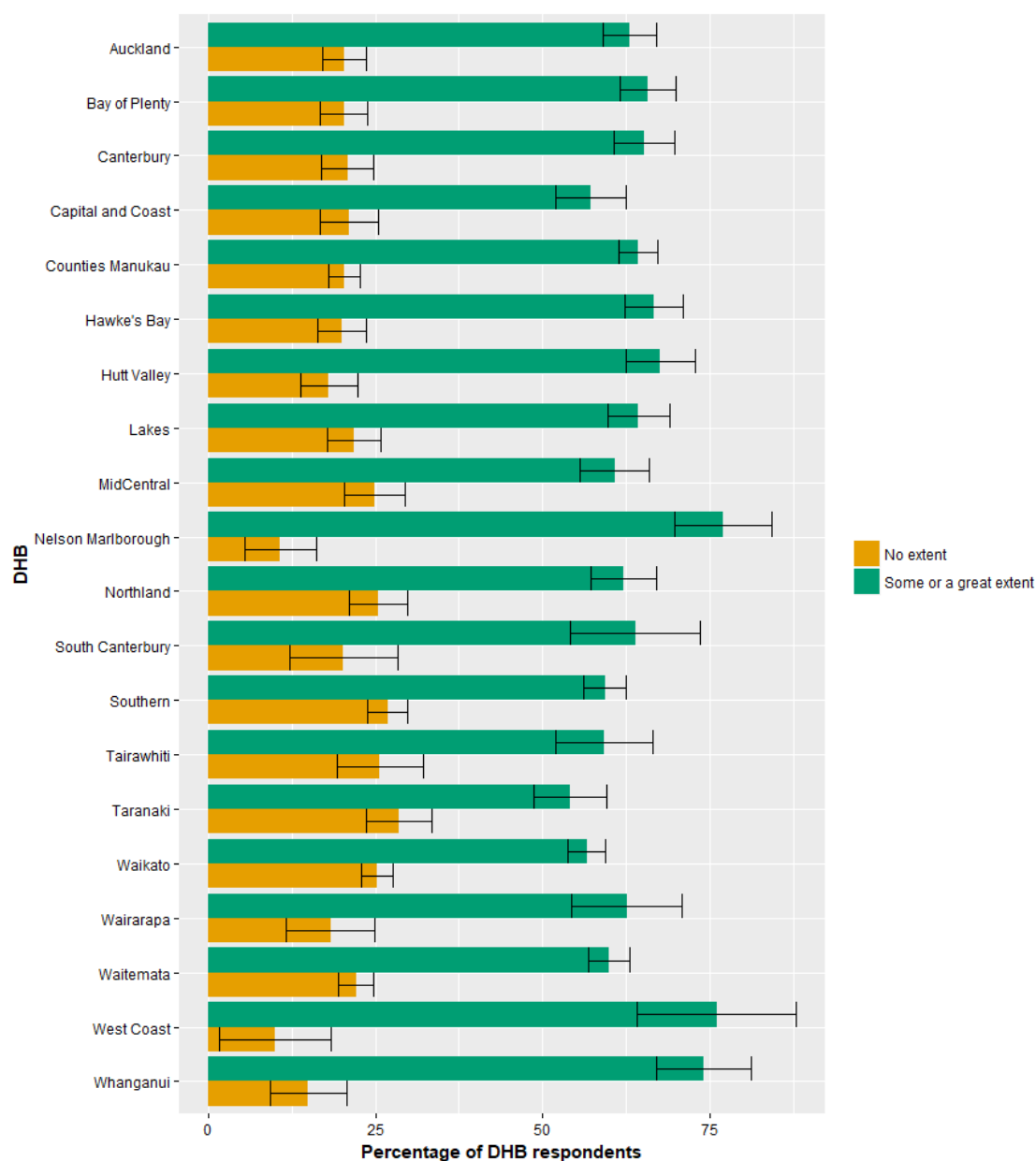


Overall, **5551 (67.5%**; 2012=75**%)** respondents felt they had been involved in working with other DHB staff, both clinical and managerial, to change the system where it would benefit patients. The mean across DHBs was **64% (SD: 6.1%)**. Agreement ranged from **54.1% (Taranaki)** to **76.9% (Nelson Marlborough)**.

**8221 (91.7%)** Respondents answered this question.

## 3.6 To what extent are health professionals in your DHB involved in a partnership with management with shared decision making, responsibility and accountability?
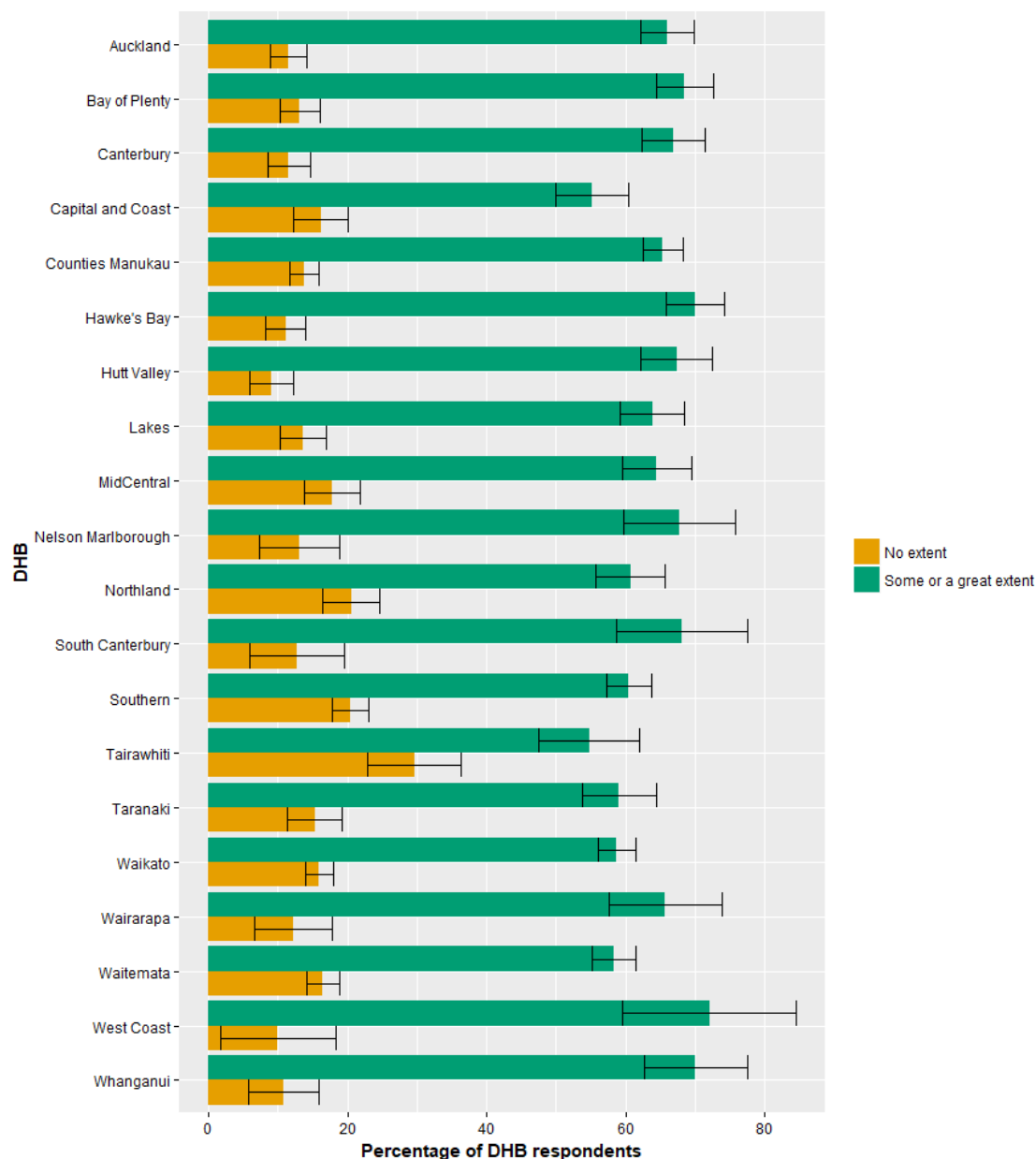


Overall, **5632 (68.6%**; 2012=71%**)** respondents felt that health professionals in their DHB were involved involved in a partnership with management with shared decision making, responsibility and accountability. The mean across DHBs was **64.1% (SD: 5.1%)**. Agreement ranged from **54.7% (Tairawhiti)** to **72% (West Coast)**.

**8206 (91.6%)** Respondents answered this question.

3.6a To what extent are health professionals in your DHB involved in a partnership with management with shared decision making, responsibility and accountability? ([2012 and 2017 compared](#))
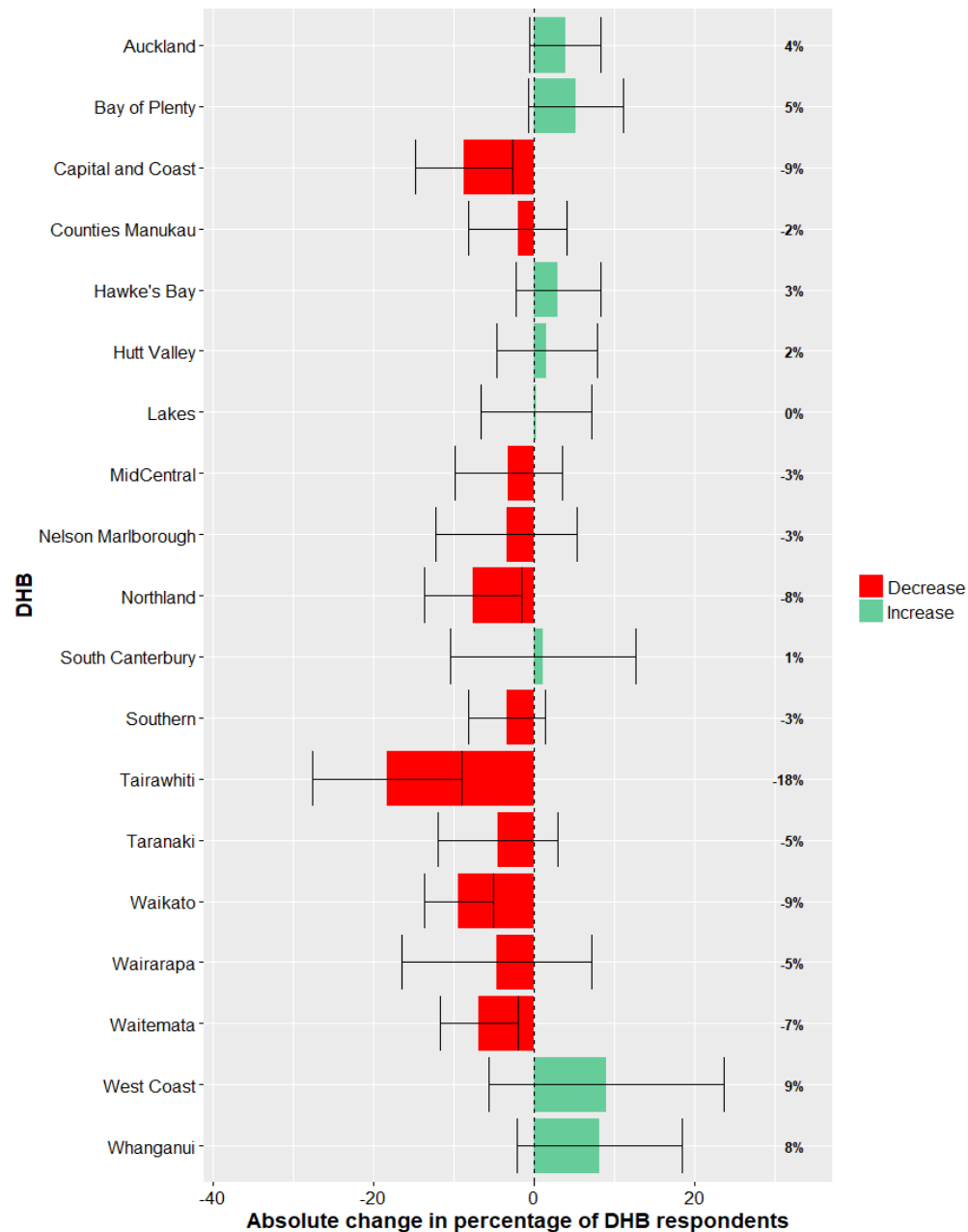


**71.3%** of respondents in 2012 reported that health professionals in their DHB were involved in a partnership with management with shared decision making, responsibility and accountability to some or a great extent compared to **68.4%** of respondents in 2017 (an absolute decrease of **2.9%**). The mean for DHBs decreased (**71.6%** vs **69.5%**). The mean difference in the percentage of respondents giving a 'some or great extent' response to this question across DHBs was **-2.1%** (**SD: 6.7%**). **West Coast** had the greatest increase by 2017 (**9.1%**) and **Tairawhiti** had the greatest decrease (**-18.3%**).

## 3.7 To what extent are health professionals in your DHB involved as full active participants in the design of organisational processes?
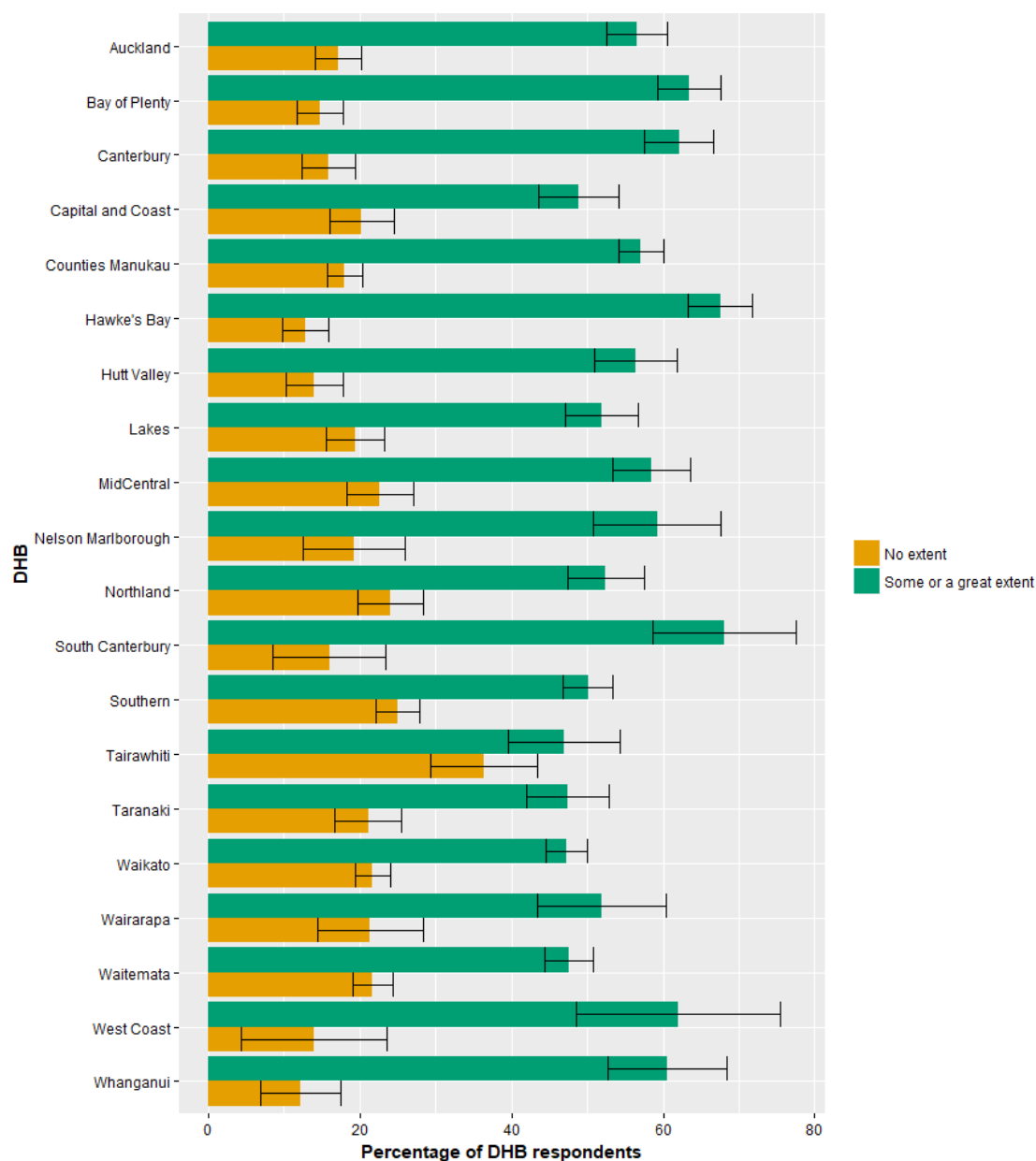


Overall, **4840 (59.5%;** 2012=61%**)** respondents felt that health professionals in their DHB were involved as full active participants in the design of organisational processes. The mean across DHBs was **55.8% (SD: 6.8%)**. Agreement ranged from **46.9% (Tairawhiti)** to **68.1% (South Canterbury)**.

**8136 (90.8%)** Respondents answered this question.

3.7a To what extent are health professionals in your DHB involved as full active participants in the design of organisational processes? (2012 and 2017 compared)
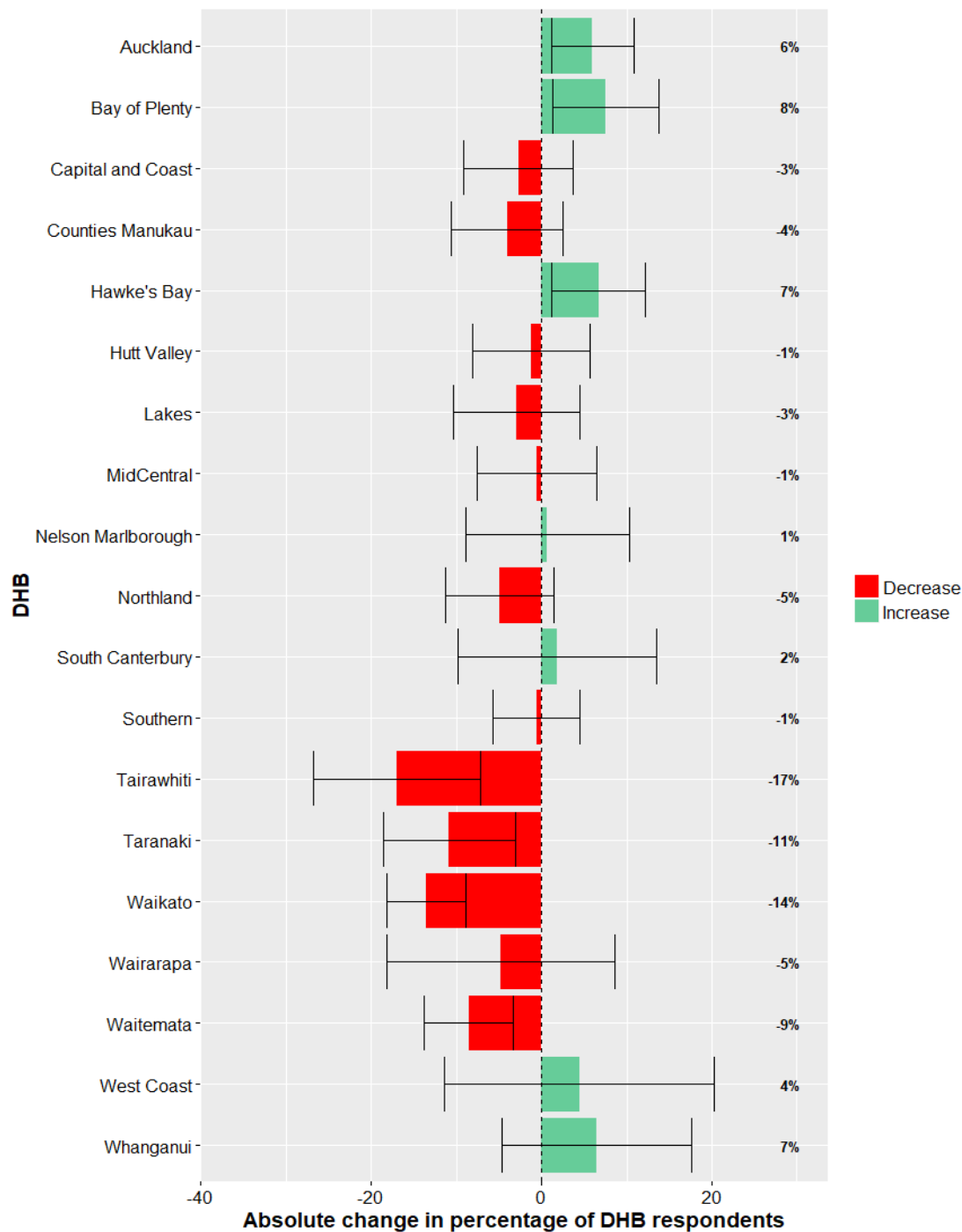


**61.5%** of respondents in 2012 reported that health professionals in their DHB were involved as full active participants in the design of organisational processes to some or a great extent compared to **59%** of respondents in 2017 (an absolute decrease of **2.4%**). The mean for DHBs decreased (**62.8%** vs **60.8%**). The mean difference in the percentage of respondents giving a 'some or great extent' response to this question across DHBs was **-2%** (**SD: 7%**). **Bay of Plenty** had the greatest increase by 2017 (**7.5%**) and **Tairawhiti** had the greatest decrease (**-17%**).

## 3.8 To what extent has your DHB sought to give responsibility to your team for clinical service decision making in your clinical areas?
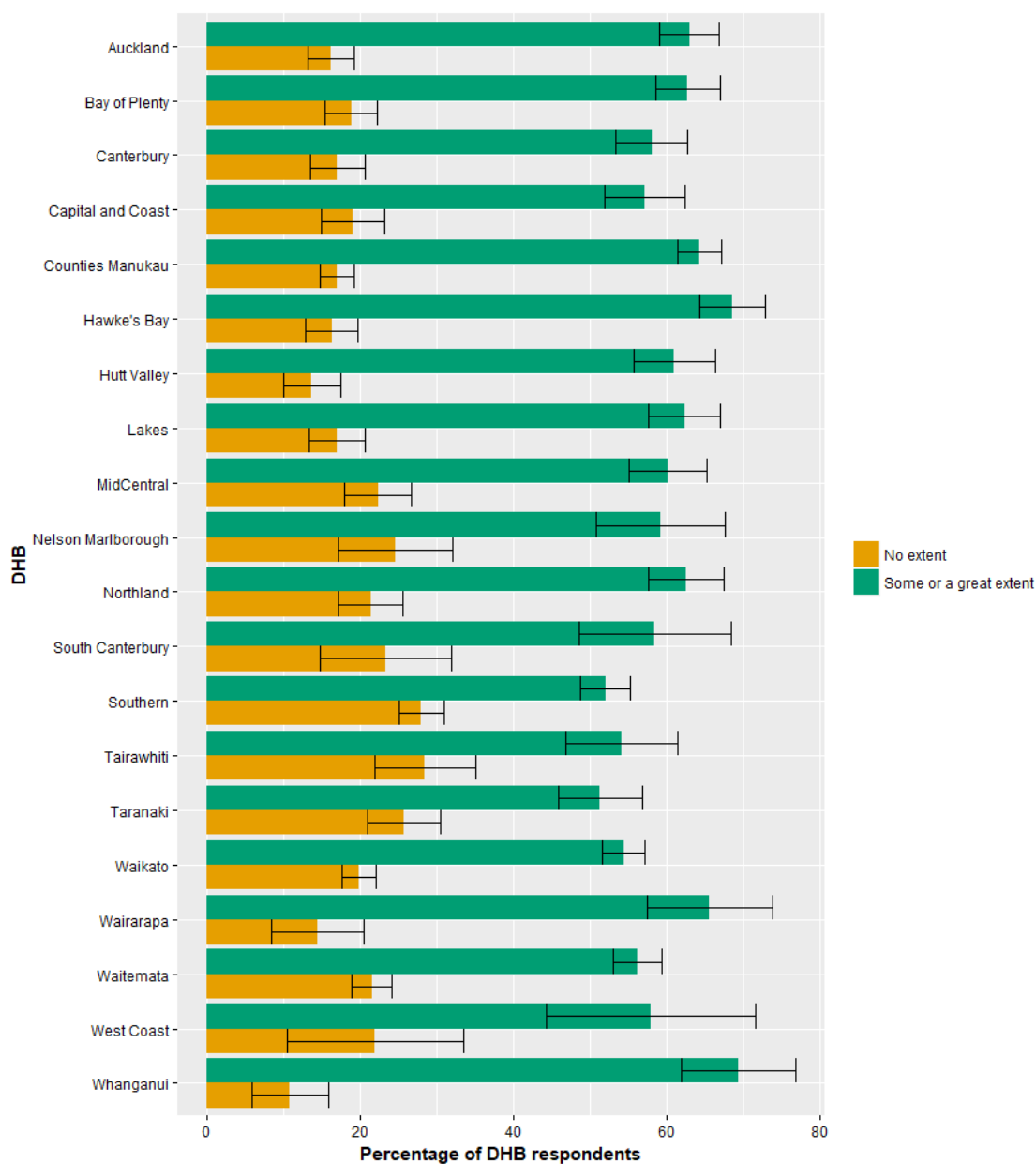


Overall, **5302 (64.9%**; 2012=69%**)** respondents felt that their DHB had sought to give responsibility to their team for clinical service decision making in their clinical areas. The mean across DHBs was **60% (SD: 5%)**. Agreement ranged from **51.4% (Taranaki)** to **69.4% (Whanganui)**.

**8171 (91.2%)** Respondents answered this question.

3.8a To what extent has your DHB sought to give responsibility to your team for clinical service decision making in your clinical areas? (2012 and 2017 compared)
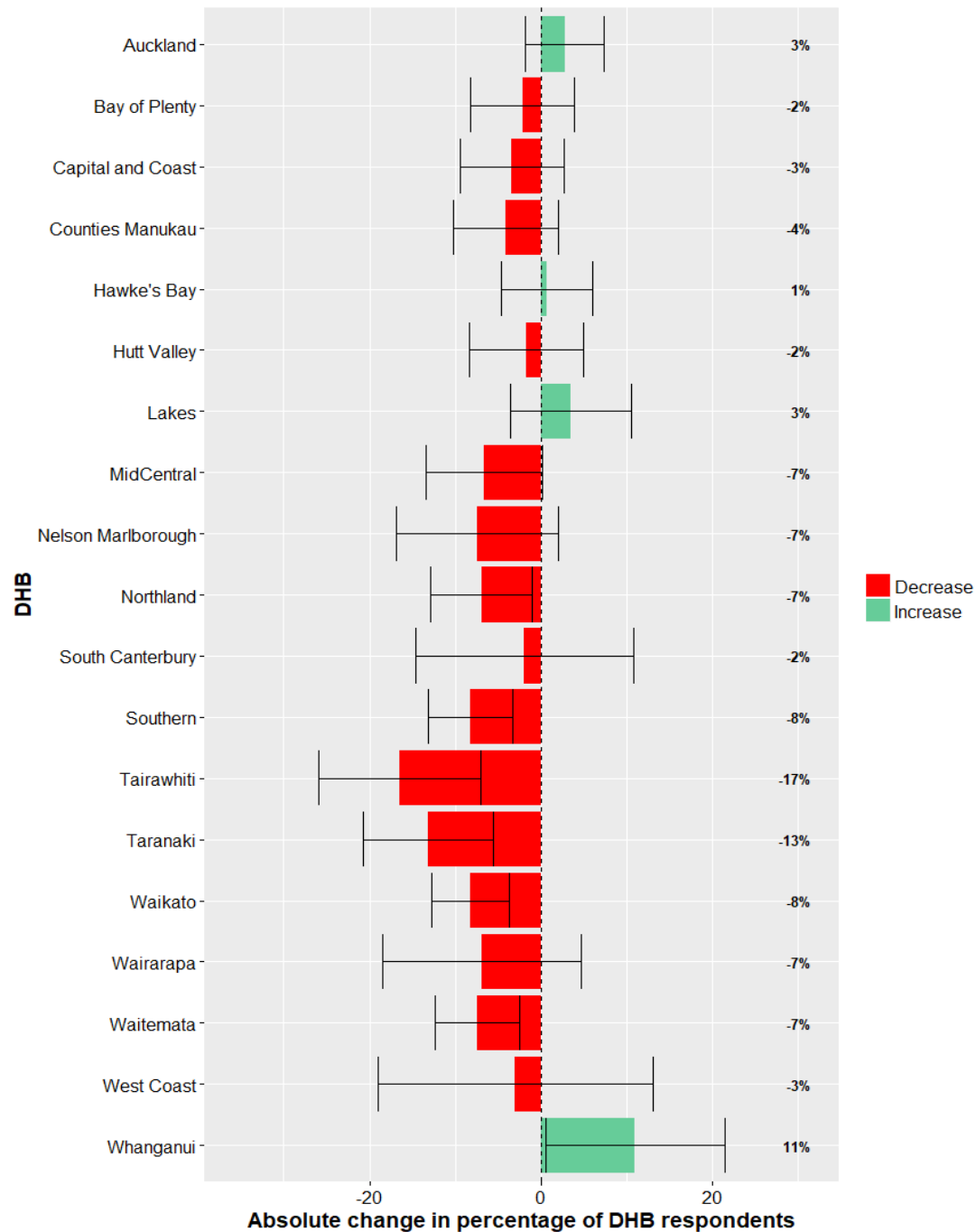


**69.5%** of respondents in 2012 reported that their DHB had sought to give responsibility to their team for clinical service decision making in their clinical areas to some or a great extent compared to **64.9%** of respondents in 2017 (an absolute decrease of **4.5%**). The mean for DHBs decreased (**69.9%** vs **65.7%**). The mean difference in the percentage of respondents giving a 'some or great extent' response to this question across DHBs was **-4.2%** (**SD: 6.2%**). **Whanganui** had the greatest increase by 2017 (**11%**) and **Tairawhiti** had the greatest decrease (**-16.5%**).

## 3.9 To what extent does your DHB provide sufficient support for you to engage in clinical leadership activities?
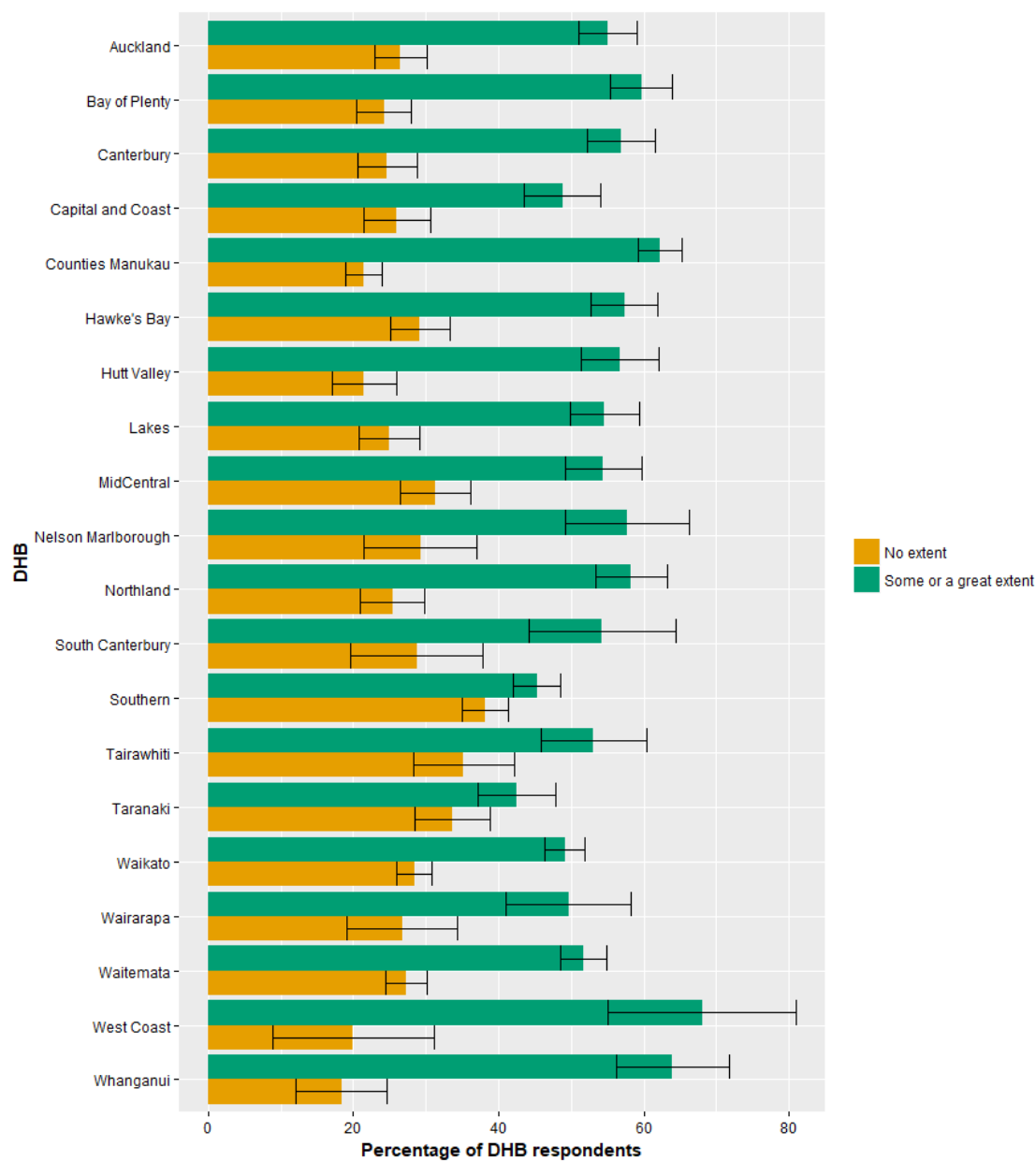


Overall, **4821 (58.7%**; 2012=36**%)** respondents felt that their DHB provided sufficient support for them to engage in clinical leadership activities. The mean across DHBs was **55% (SD: 6.2%)**. Agreement ranged from **42.5% (Taranaki)** to **68% (West Coast)**.

**8212 (91.6%)** Respondents answered this question.

## 3.10 To what extent does your clinical service share patient outcome data with the community it serves?
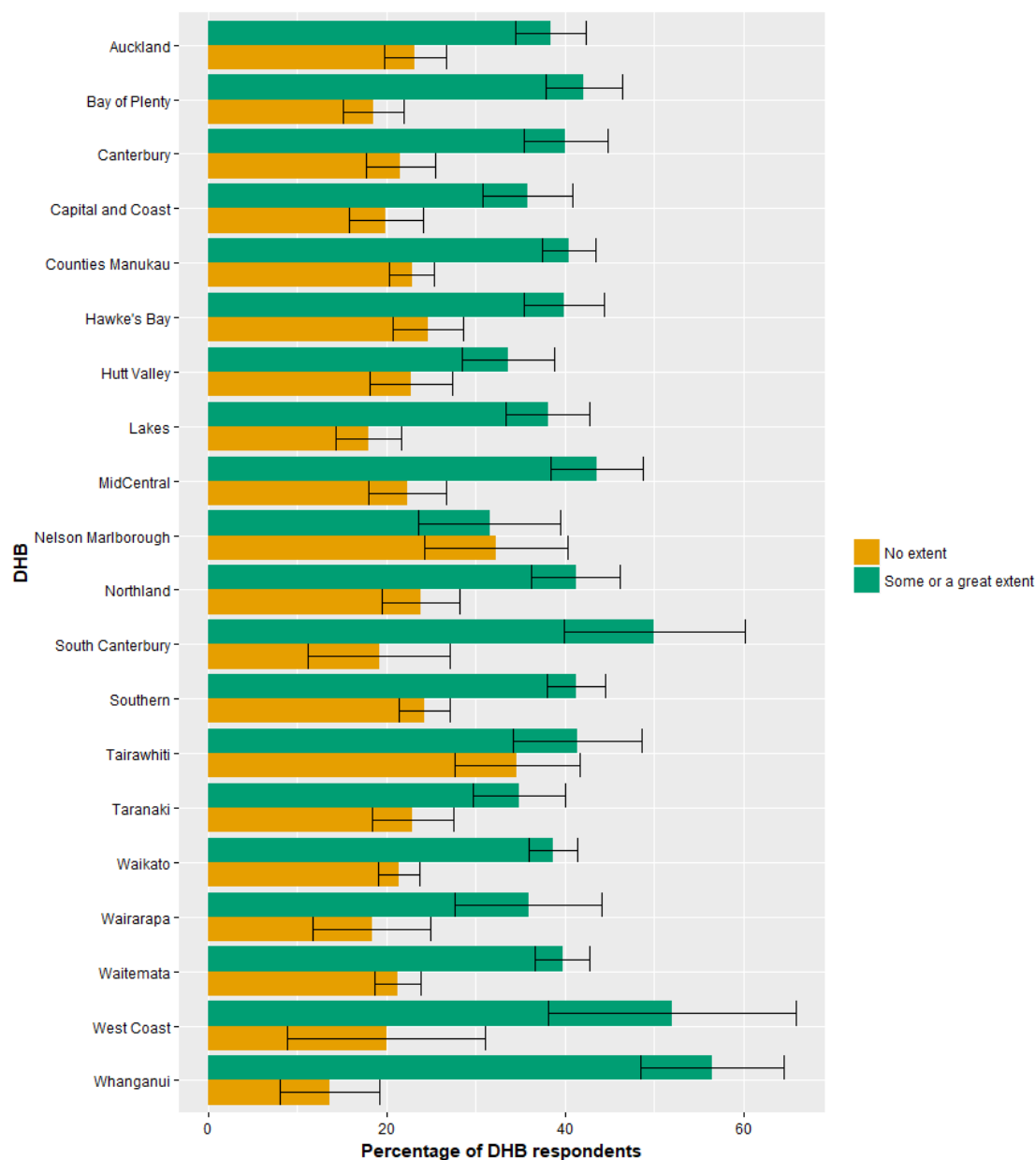


Overall, **3565 (44.9%**; 2012=not asked**)** respondents felt that their clinical service shared patient outcome data with the community it serves. The mean across DHBs was **40.7% (SD: 6.1%)**. Agreement ranged from **31.5% (Nelson Marlborough)** to **56.5% (Whanganui)**.

**7932 (88.5%)** Respondents answered this question.

## 3.11 To what extent does your DHB share patient outcome data with the community it serves?
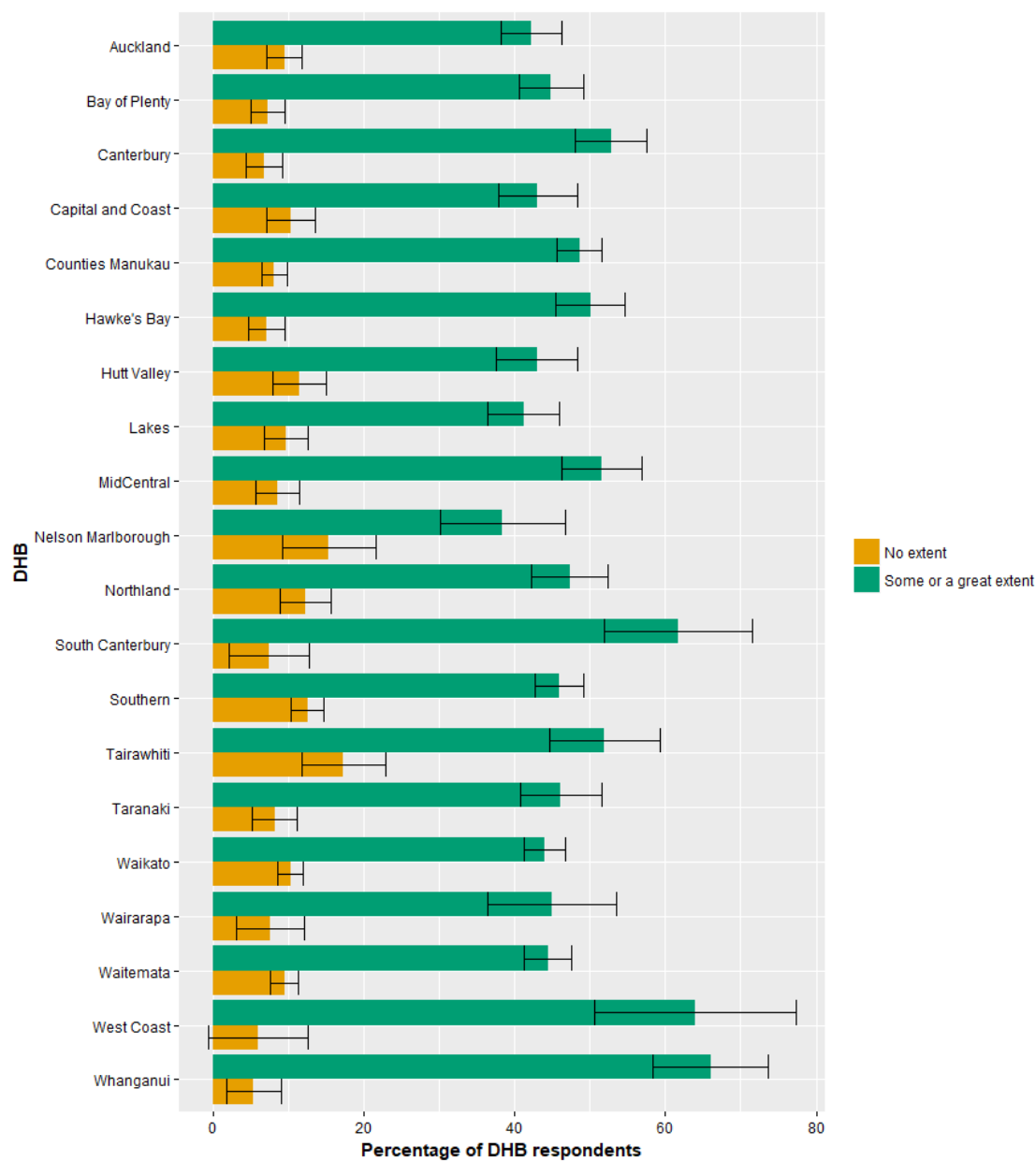


Overall, **4169 (52.6%;** 2012=not asked**)** respondents felt that their DHB shared patient outcome data with the community it serves. The mean across DHBs was **48.6% (SD: 7.6%)**. Agreement ranged from **38.5% (Nelson Marlborough)** to **66% (Whanganui)**.

**7927 (88.4%)** Respondents answered this question.

## 3.12 This DHB explicitly defines health professional roles in advancing patient safety in job descriptions and orientation, and in requiring continuing professional education.
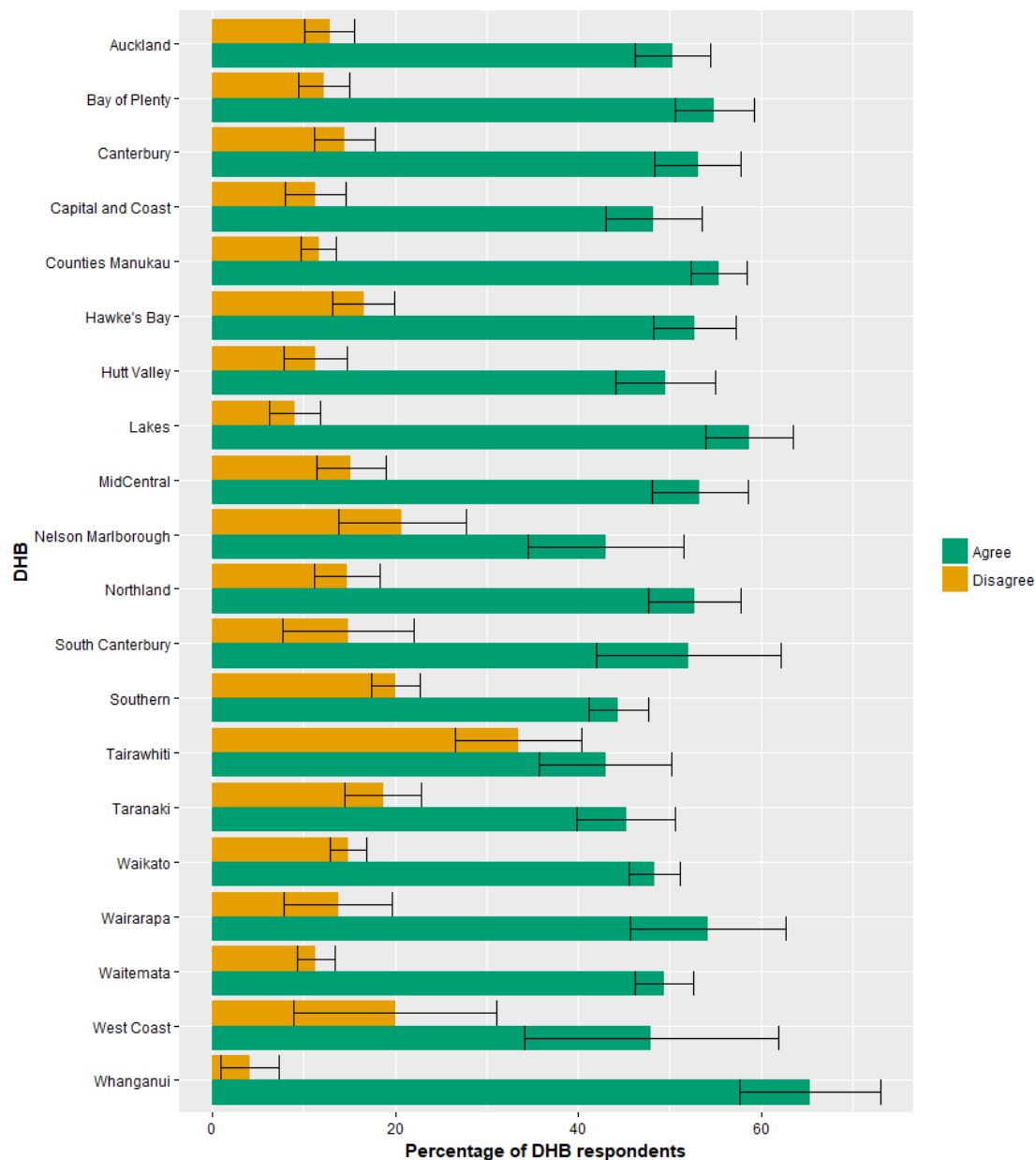


Overall, **4556 (57.5%;** 2012=not asked**)** respondents felt that their DHB explicitly defines health professional roles in advancing patient safety in job descriptions and orientation, and in requiring continuing professional education. The mean across DHBs was **51.1% (SD: 5.4%)**. Agreement ranged from **43% (Tairawhiti)** to **65.3% (Whanganui)**.

**7929 (88.5%)** Respondents answered this question.

## 3.13 Health professionals in this DHB work together as a well-coordinated team.
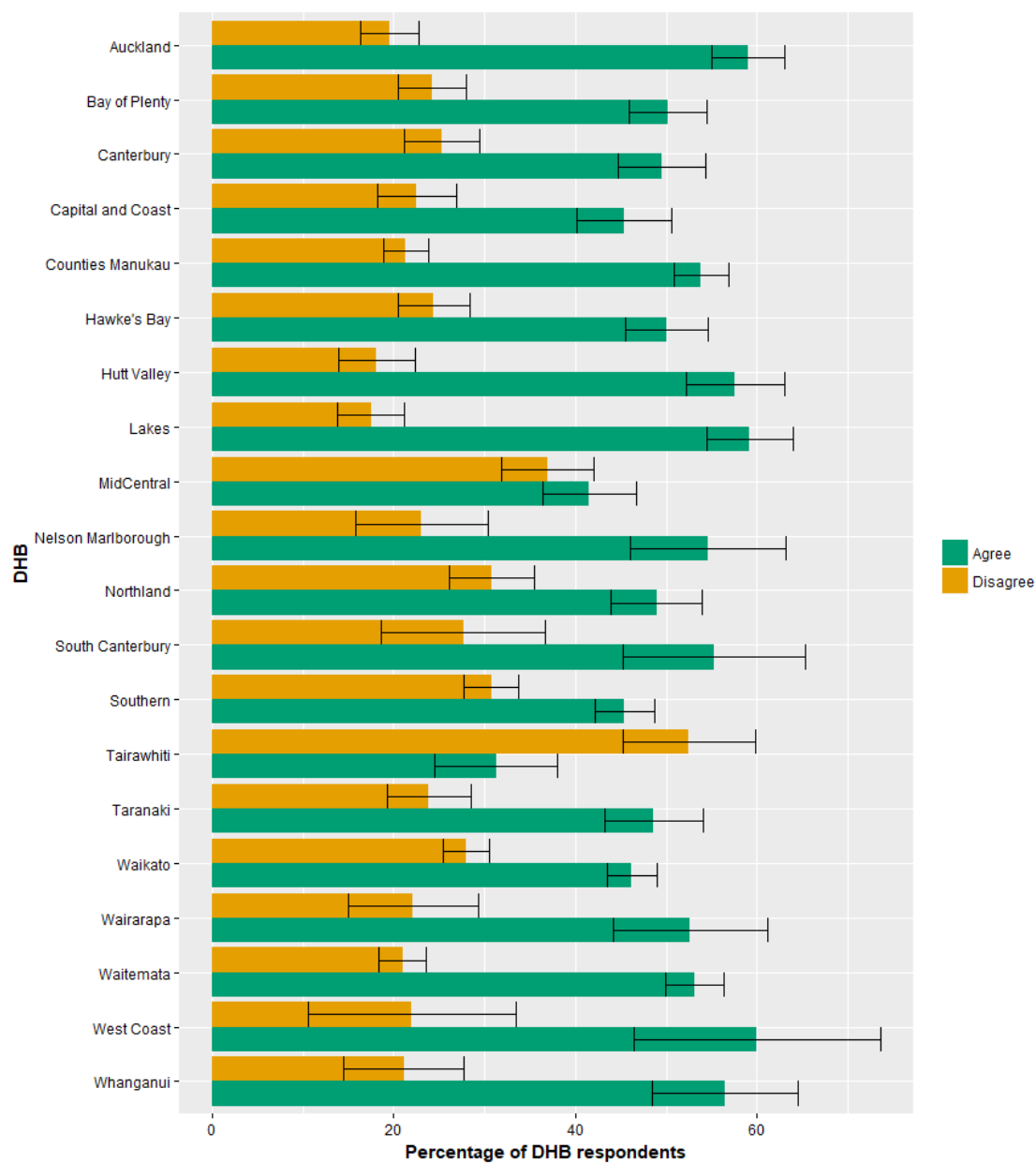


Overall, **4519 (57.4%;** 2012=57%**)** respondents agree that health professionals in their DHB work together as a well-coordinated team. The mean across DHBs was **51% (SD: 6.9%)**. Agreement ranged from **31.3% (Tairawhiti)** to **60% (West Coast)**.
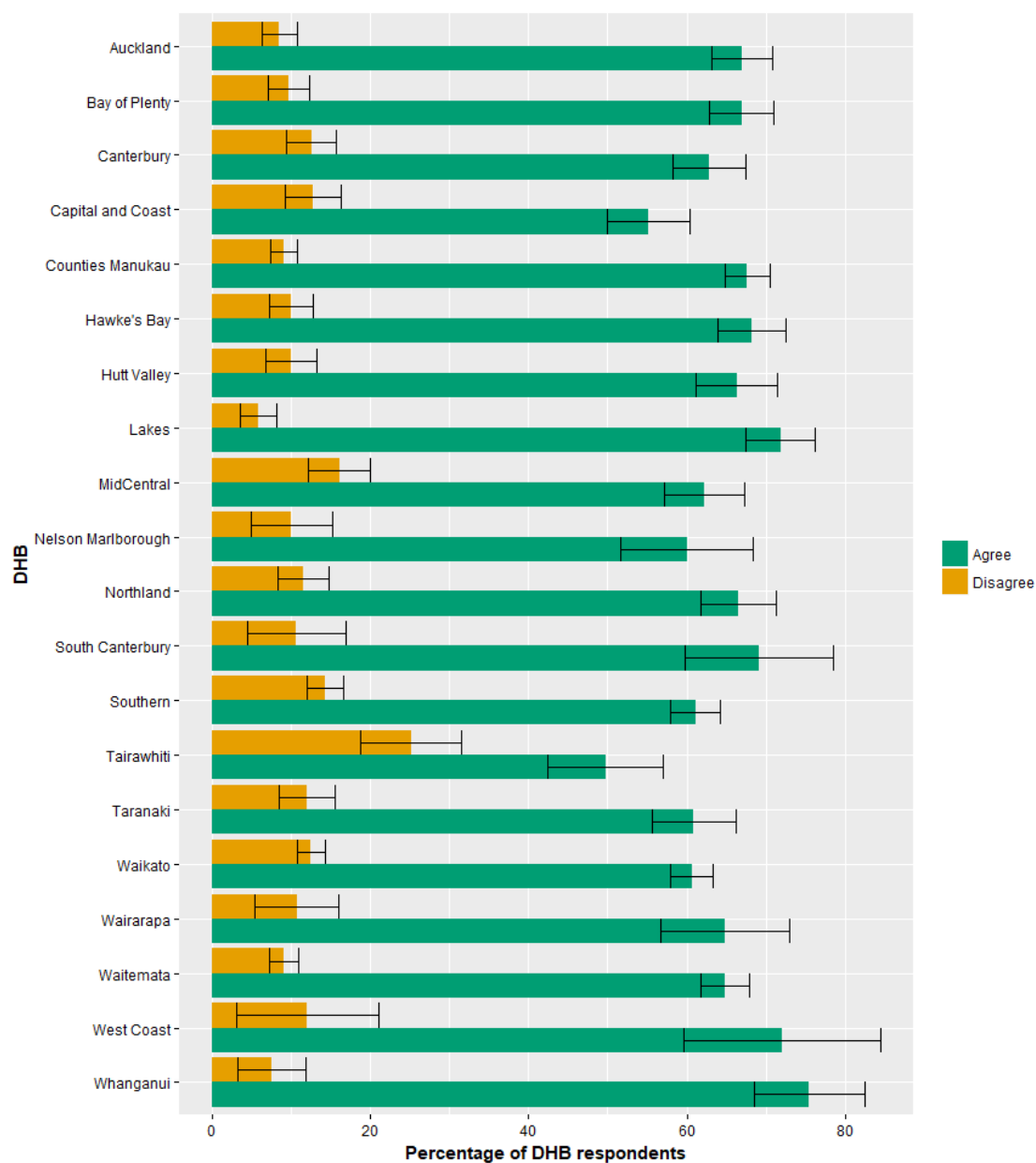
**7871 (87.8%)** Respondents answered this question.

3.13a Health professionals in this DHB work together as a well-coordinated team (2012 and 2017 compared).
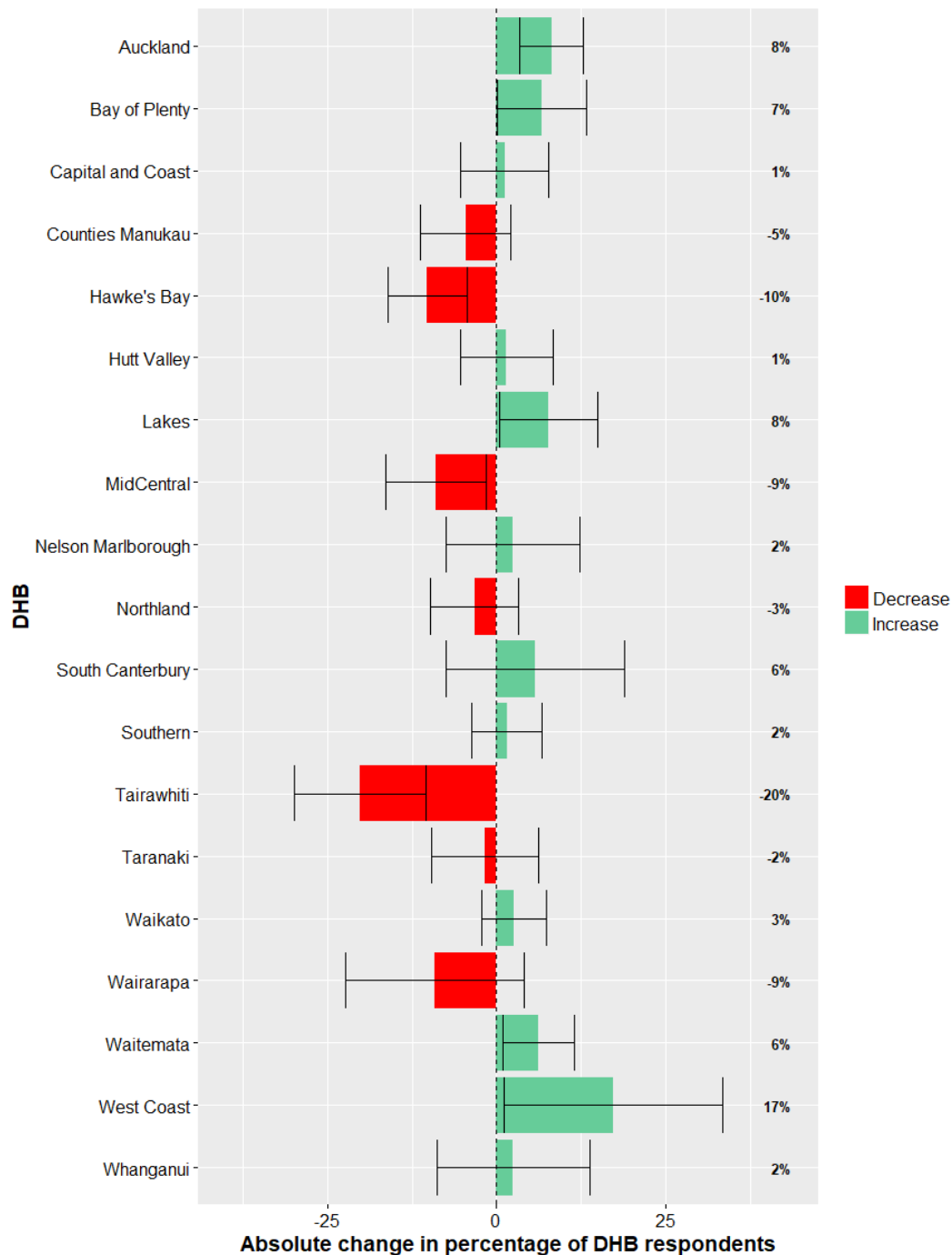


**57.1%** of respondents in 2012 agreed slightly or strongly with the statement that health professionals in their DHB work together as a well-coordinated team compared to **57.4%** of respondents in 2017 (an absolute increase of **0.3%**). The mean for DHBs increased (**57.3%** vs **57.6%**). The mean difference in the percentage of respondents agreeing to this statement across DHBs was **0.3%** (**SD: 8.4%**). **West Coast** had the greatest increase by 2017 (**17.2%**) and **Tairawhiti** had the greatest decrease (**-20.2%**).

## 3.14 Health professionals in this DHB involve patients and families in efforts to improve patient care.



Overall, **5760 (73.2%;** 2012=70%**)** respondents agree that health professionals in their DHB involve patients and families in efforts to improve patient care. The mean across DHBs was **64.7% (SD: 5.9%)**. Agreement ranged from **49.7% (Tairawhiti)** to **75.5% (Whanganui)**.

**7874 (87.9%)** Respondents answered this question.

3.14a Health professionals in this DHB involve patients and families in efforts to improve patient care (2012 and 2017 compared).
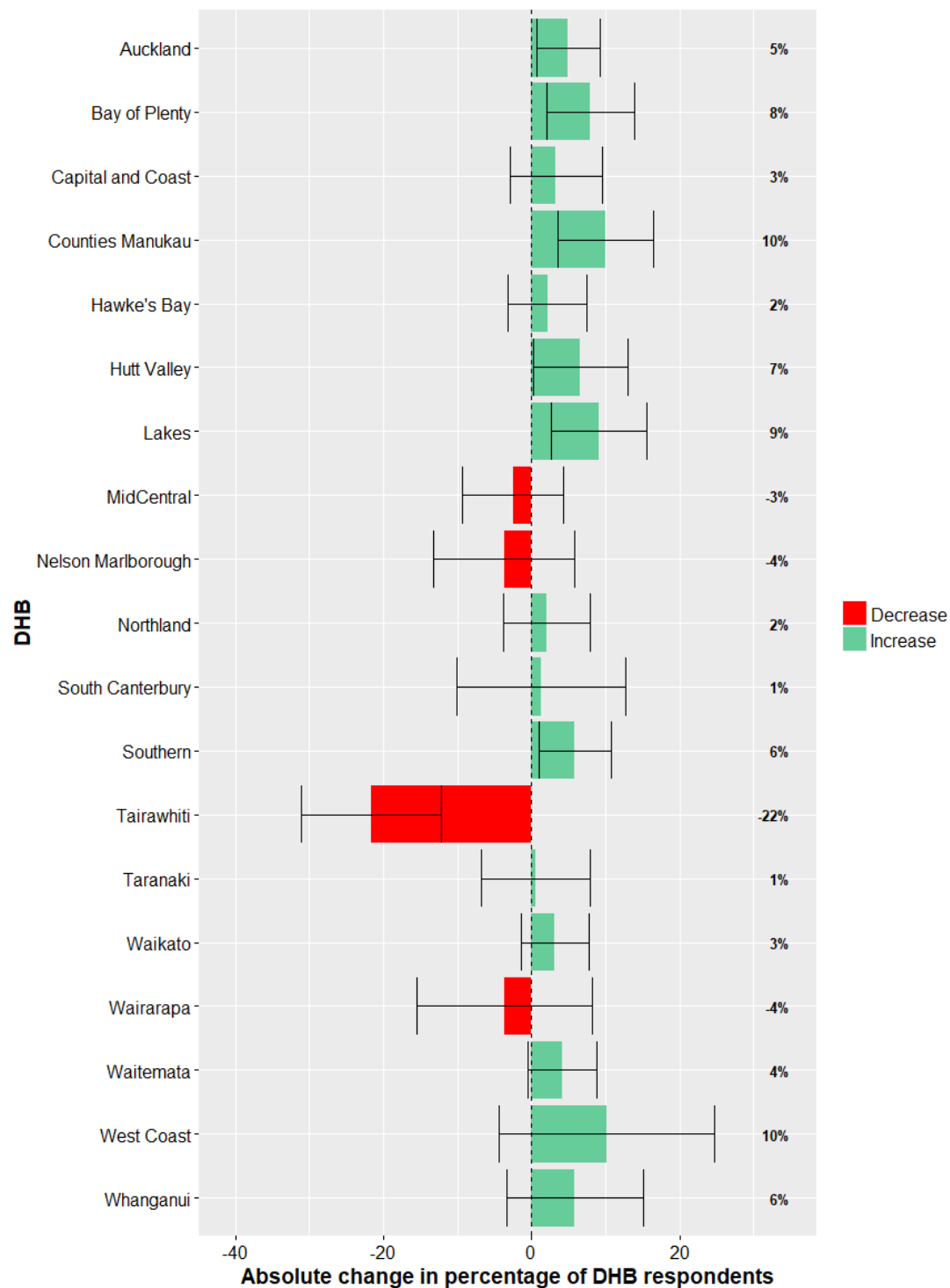


**69.5%** of respondents in 2012 agreed slightly or strongly with the statement that health professionals in their DHB involve patients and families in efforts to improve patient care compared to **73.1%** of respondents in 2017 (an absolute increase of **3.6%**). The mean for DHBs increased (**70.5%** vs **72.9%**). The mean difference in the percentage of respondents agreeing to this statement across DHBs was **2.4%** (**SD: 7.2%**). **West Coast** had the greatest increase by 2017 (**10.2%**) and **Tairawhiti** had the greatest decrease (**-21.6%**).
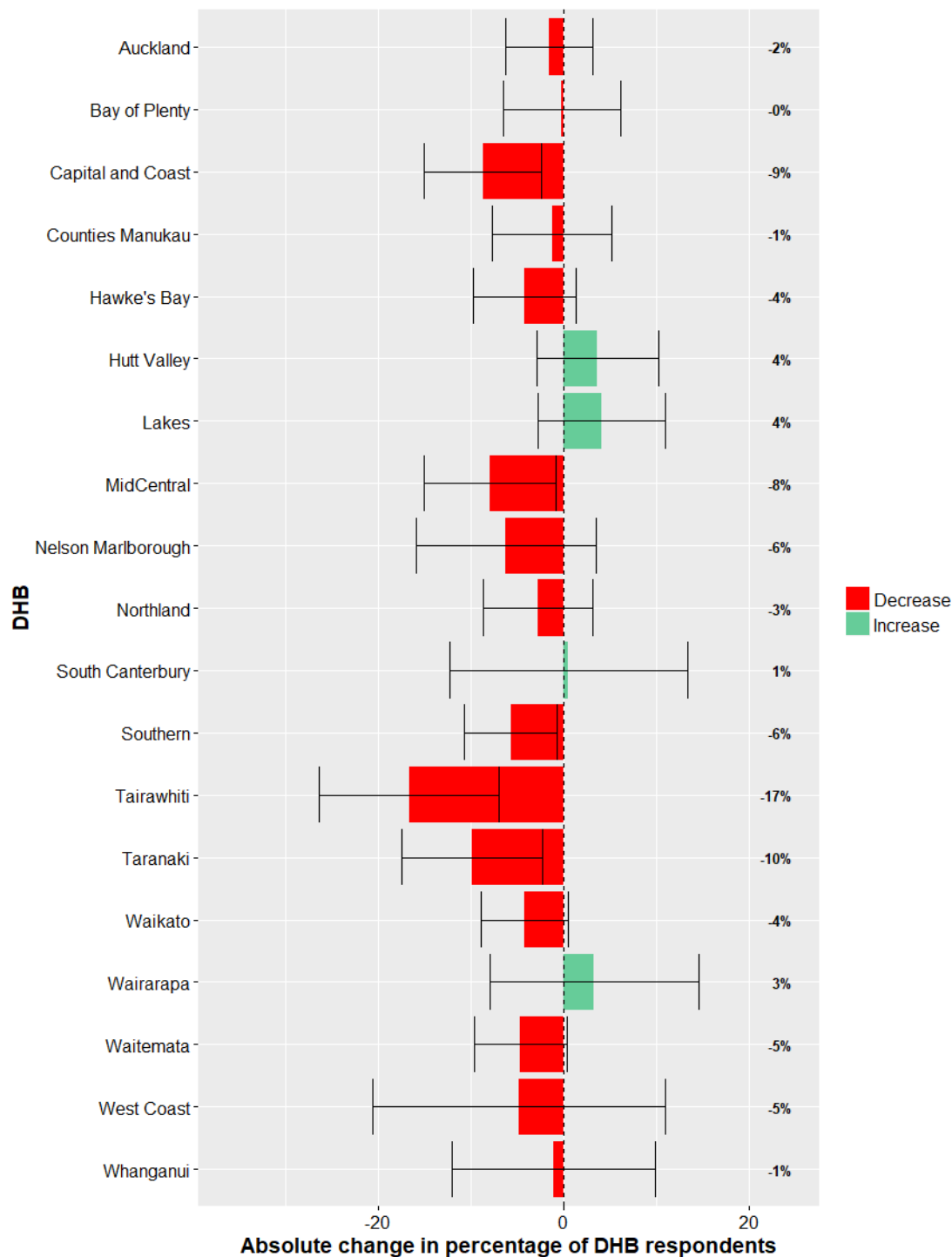
## 3.15 In this clinical area, it is easy to speak up if I perceive a problem with patient care.
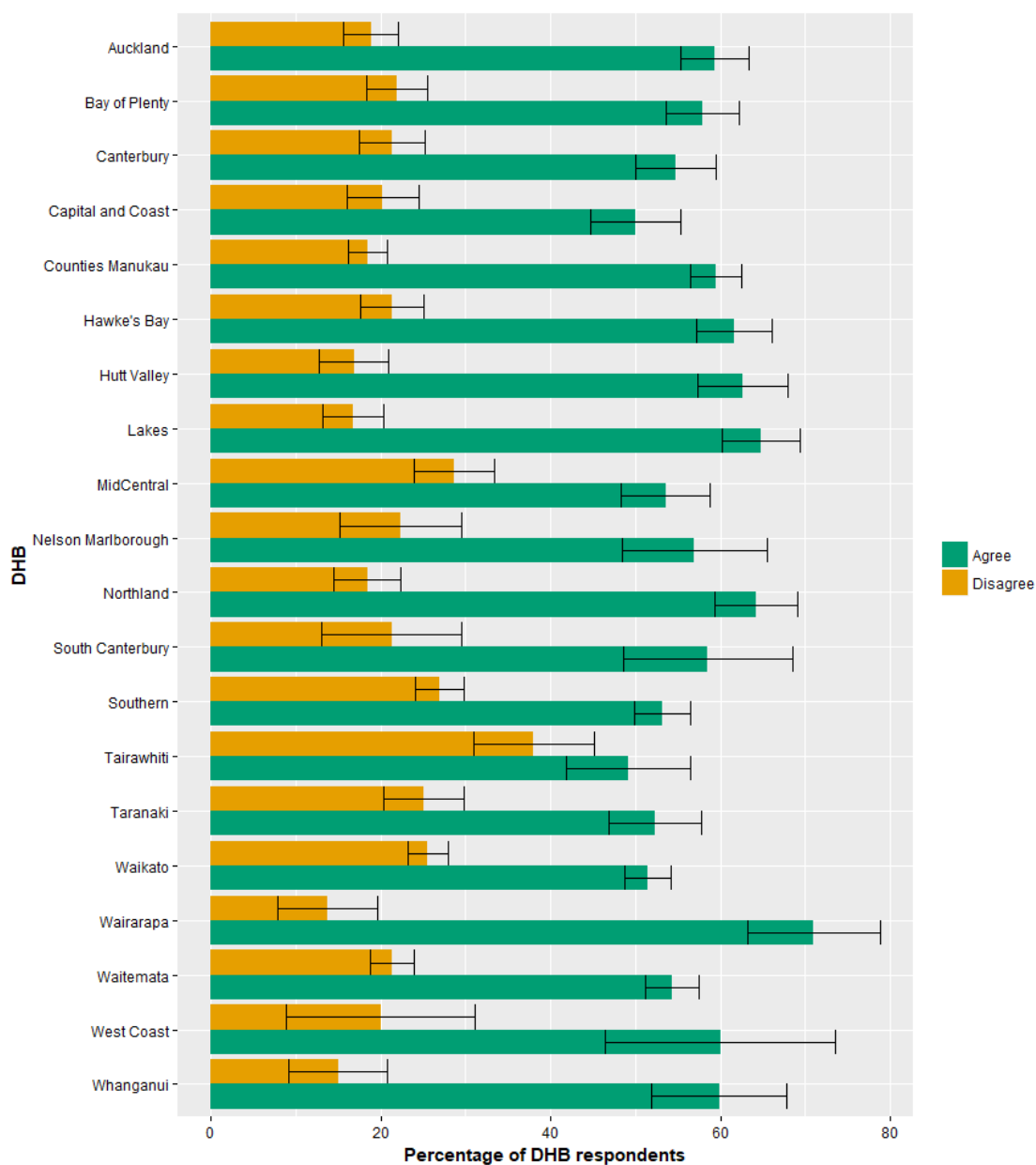


Overall, **5072 (64.5%;** 2012=69%**)** respondents agree that, in their clinical area, it is easy to speak up if they perceive a problem with patient care. The mean across DHBs was **57.7% (SD: 5.5%)**. Agreement ranged from **49.2% (Tairawhiti)** to **71% (Wairarapa)**.

**7869 (87.8%)** Respondents answered this question.

3.15a In this clinical area, it is easy to speak up if I perceive a problem with patient care (2012 and 2017 compared).



**68.7%** of respondents in 2012 agreed slightly or strongly with the statement that, in their clinical area, it is easy to speak up if they perceive a problem with patient care in their DHB compared to **64.5%** of respondents in 2017 (an absolute decrease of **4.3%**). The mean for DHBs decreased (**68.8%** vs **65.2%**). The mean difference in the percentage of respondents agreeing to this statement across DHBs was **-3.6% (SD: 5.1%)**. **Lakes** had the greatest increase by 2017 (**4.1%**) and **Tairawhiti** had the greatest decrease (**-16.7%**).

# 4 Questions by Profession

## 4.1 Clinical leadership is described as 'a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients'. How familiar are you with this concept?
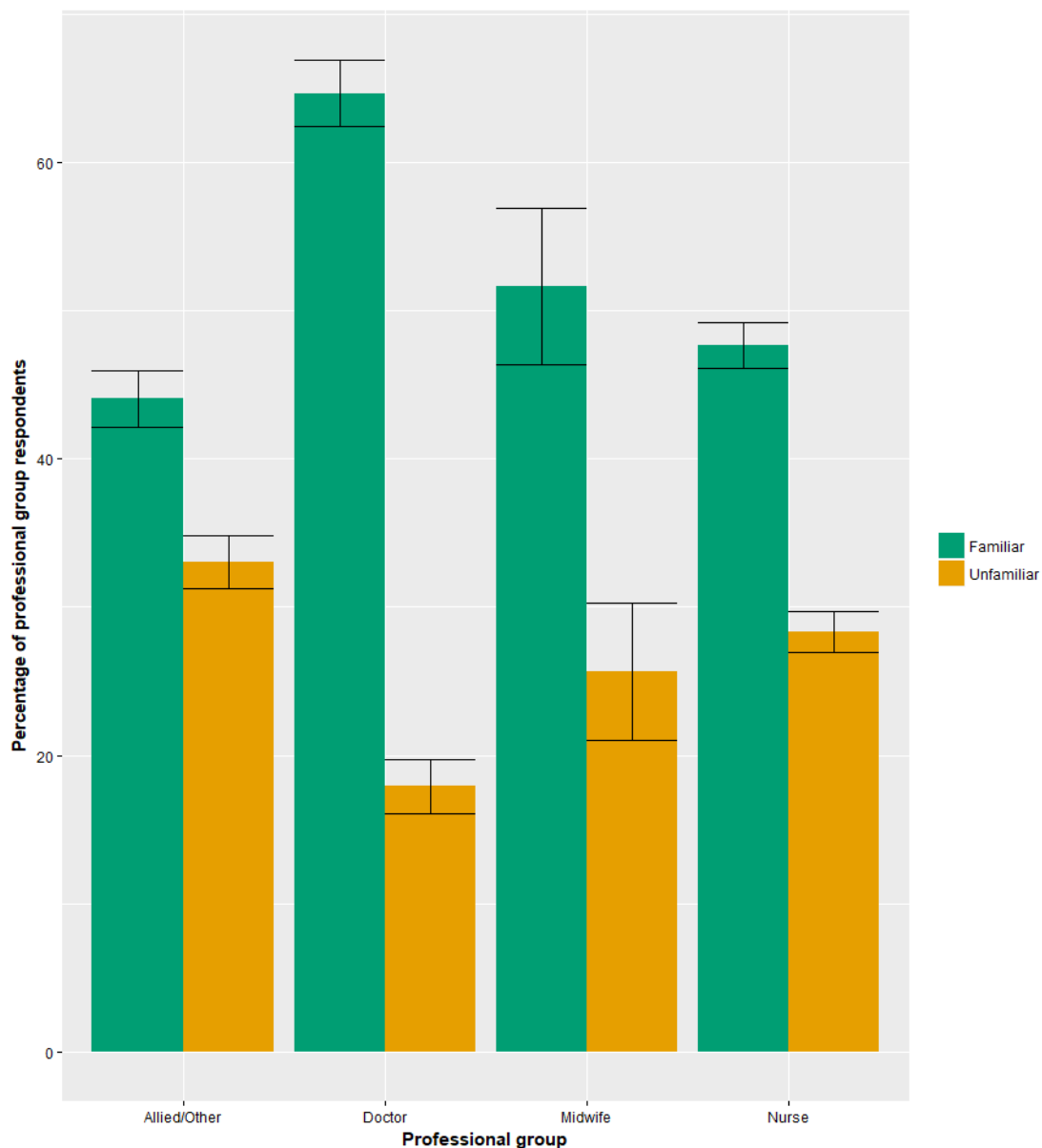


Most respondents were familiar with the concept of clinical leadership. Familiarity was highest in **Doctor (64.6%)** and lowest in **Allied/Other (44%)**. In 2012, doctors were also the highest.

## 4.2 To what extent do you believe that your DHB has worked to enable strong clinical leadership and decision making throughout the organisation?
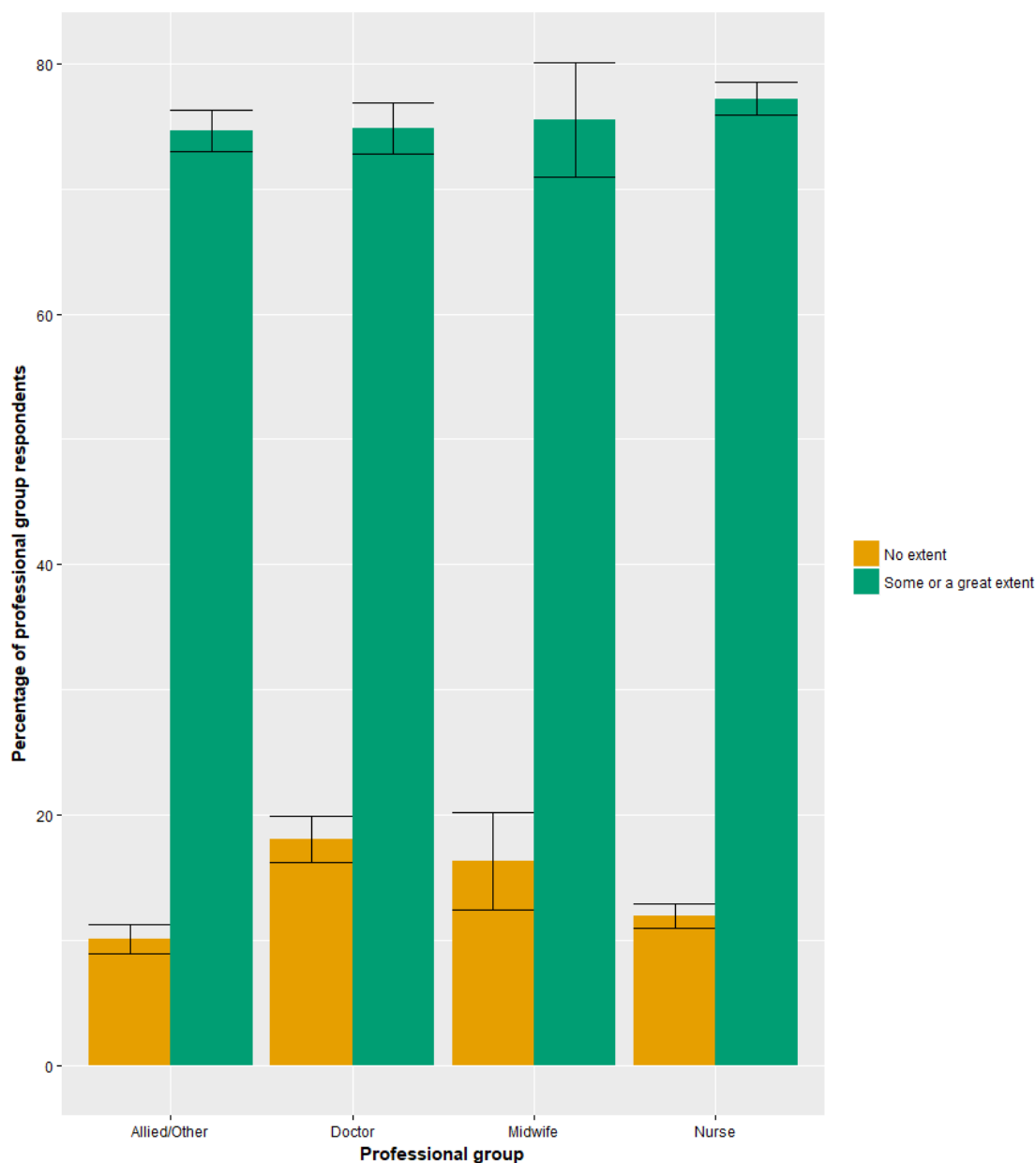


The vast majority of respondents believed that their DHB has worked to enable strong clinical leadership and decision making throughout the organisation. This was highest in **Nurse (77.2%)** and lowest in **Allied/Other (74.6%)**. In 2012, nurses were slightly higher.

## 4.3 To your knowledge, does your DHB have an established governance structure that ensures a partnership between health professionals and management?
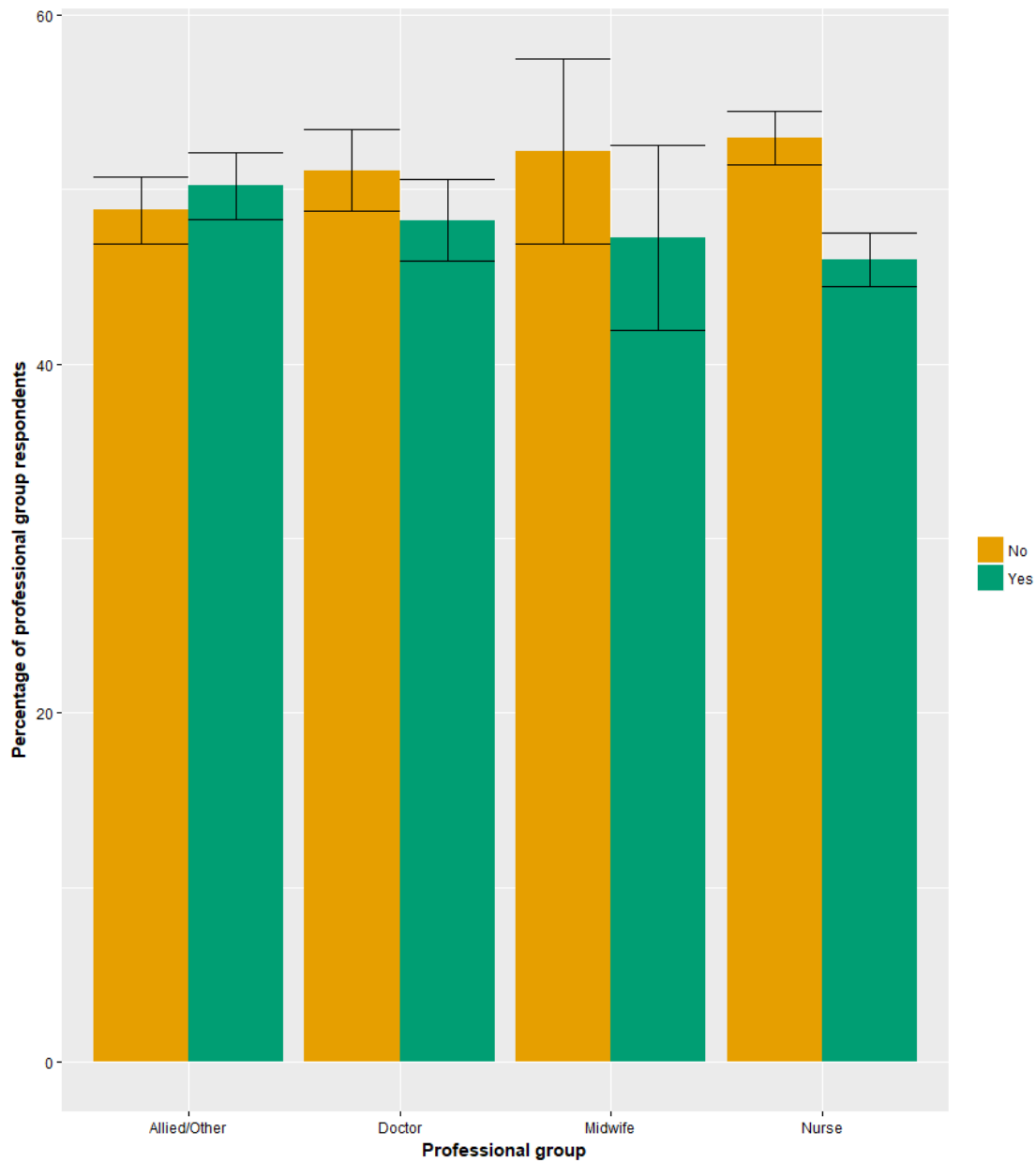


Just under half of respondents thought that their DHB had an established governance structure that ensured a partnership between health professionals and management. This was highest in **Allied/Other (50.2%)** and lowest in **Nurse (46%)**. In 2012, doctors and allied professionals were the highest.

## 4.4 To what extent has management within your DHB sought to foster and support the development of clinical leadership?
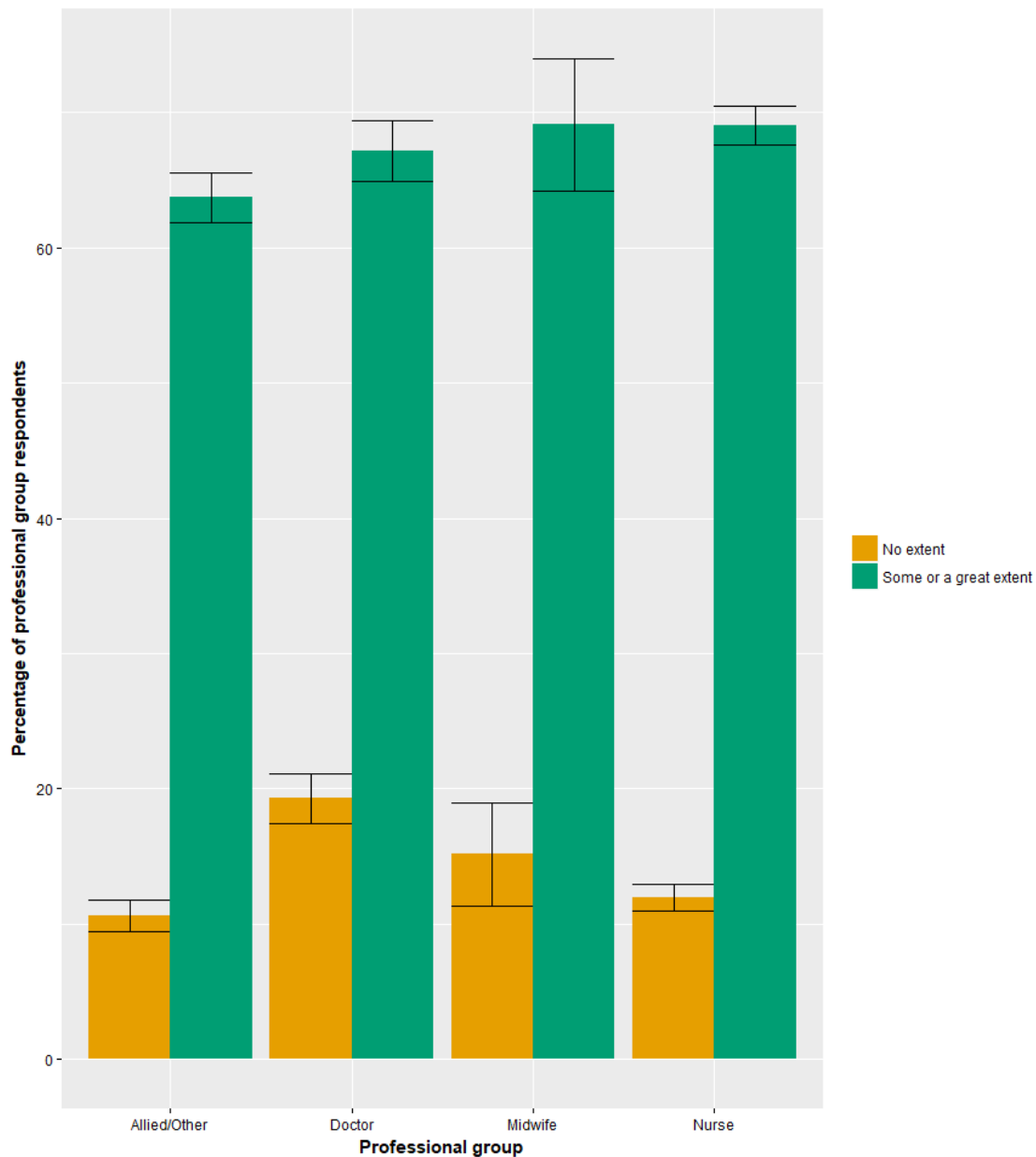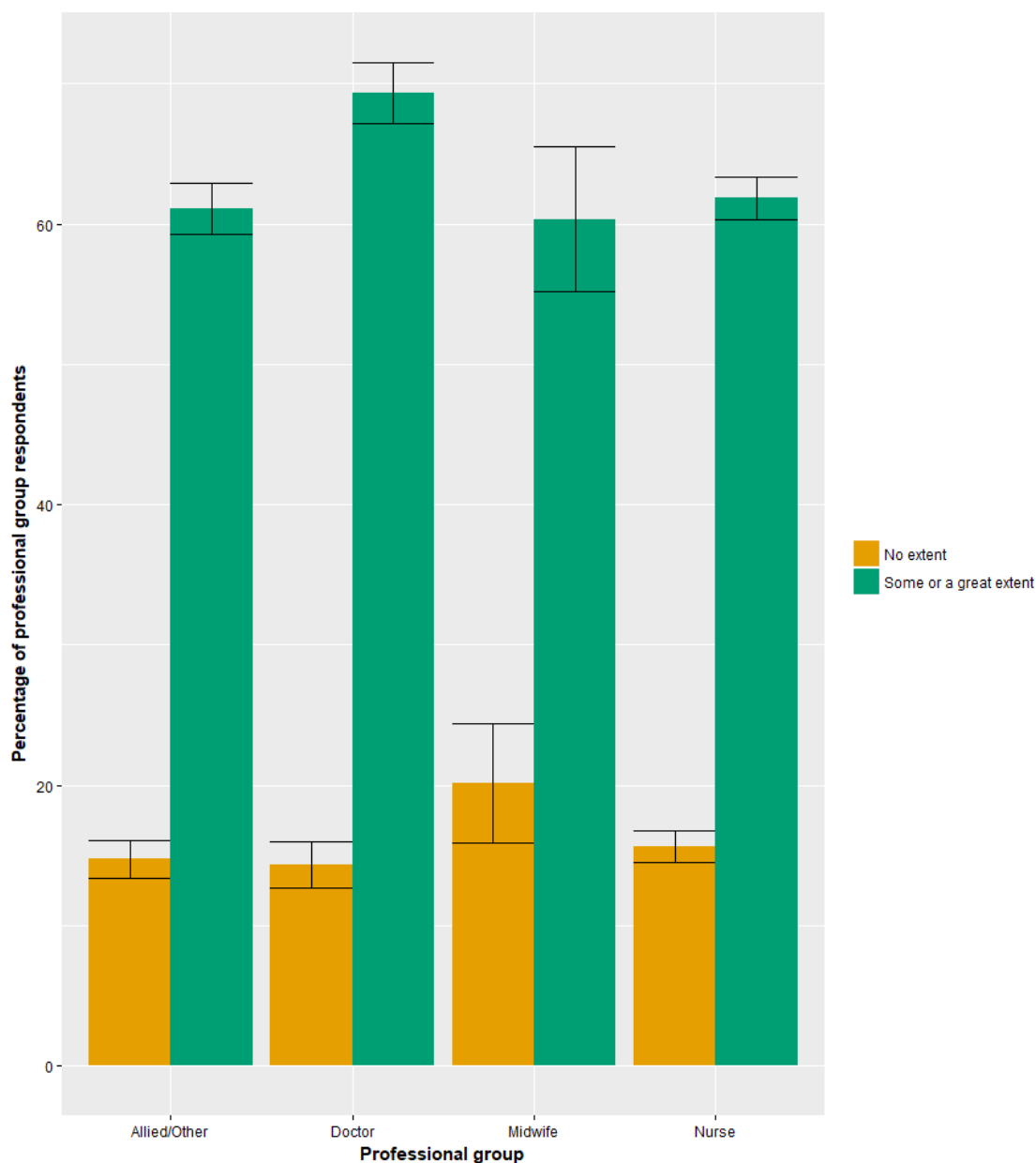


Over half of respondents agreed that management within their DHB sought to foster and support the development of clinical leadership. This was highest in **Midwife (69.1%)** and lowest in **Allied/Other (63.7%)**. In 2012, allied professionals were also the lowest.

## 4.5 To what extent have you been involved in working with other DHB staff, both clinical and managerial, to change the system where it would benefit patients?
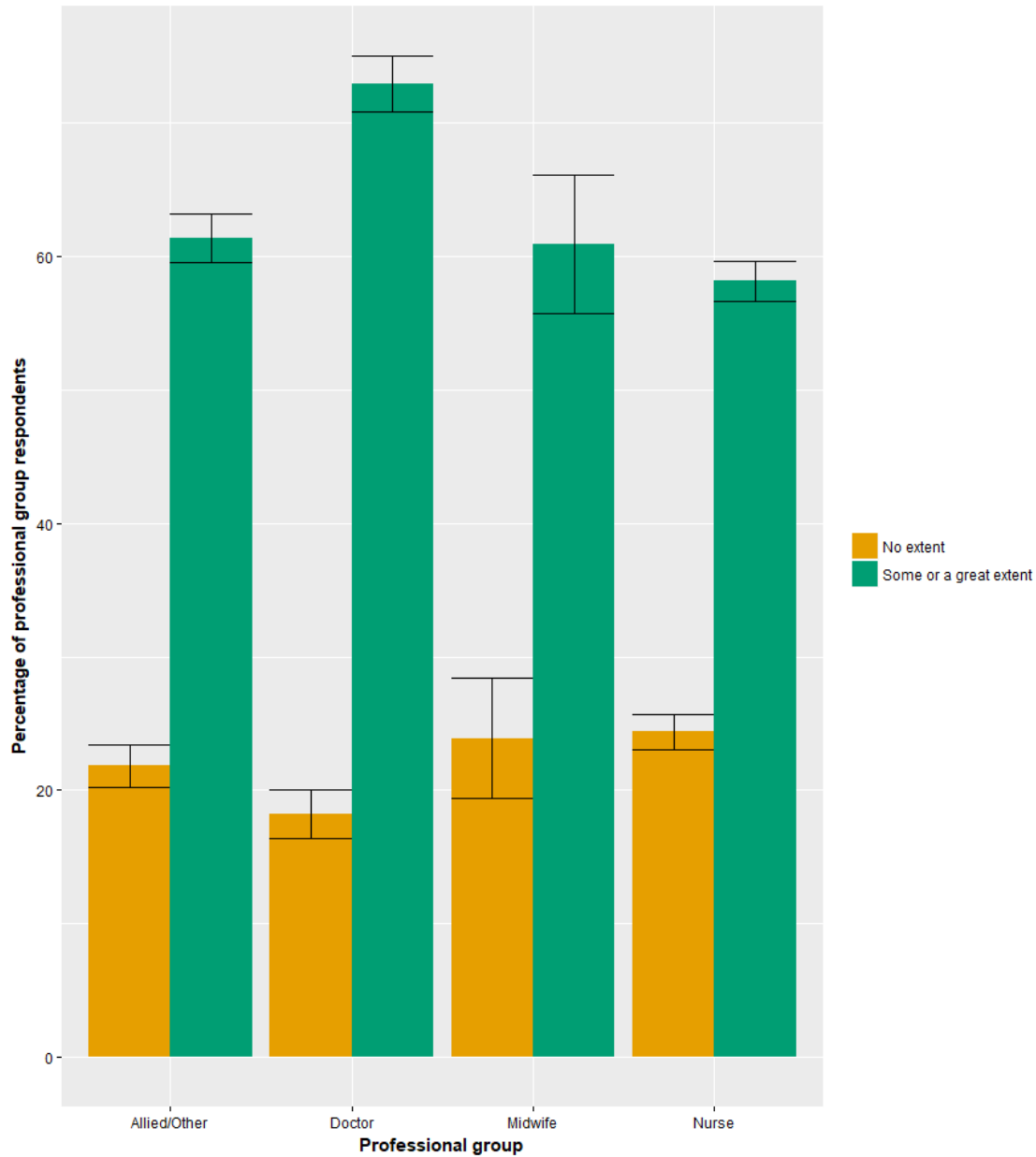


The majority of respondents reported that they were involved in working with other DHB staff, both clinical and managerial, to change the system where it would benefit patients. This was highest in **Doctor (73%)** and lowest in **Nurse (58.2%)**. In 2012, doctors were also the highest.

## 4.6 To what extent are health professionals in your DHB involved in a partnership with management with shared decision making, responsibility and accountability?
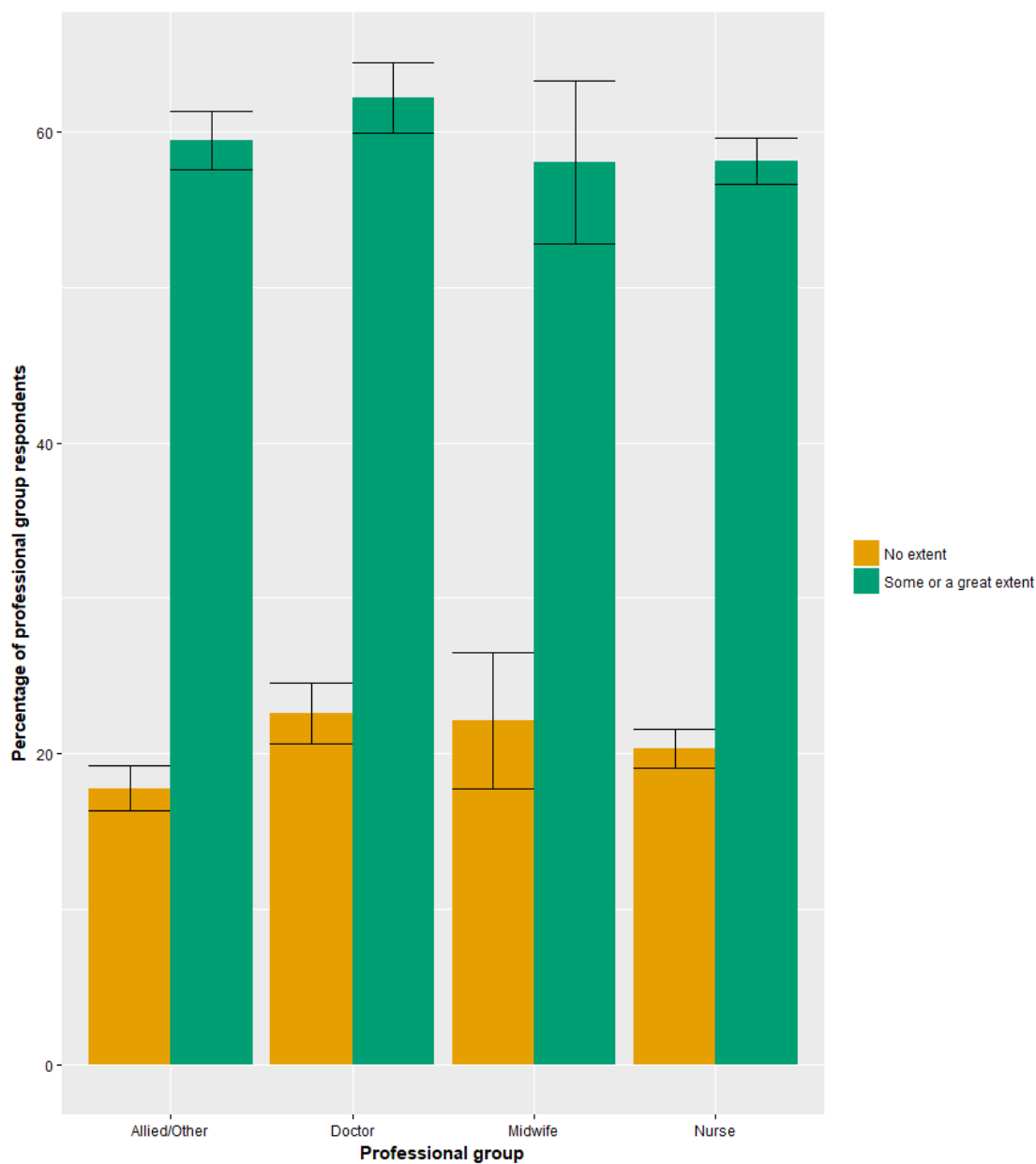


Around half of respondents reported that health professionals in their DHB were involved in a partnership with management with shared decision making, responsibility and accountability. This was highest in **Doctor (69.3%)** and lowest in **Midwife (60.3%)**. In 2012, doctors were also the highest.

## 4.7 To what extent are health professionals in your DHB involved as full active participants in the design of organisational processes?
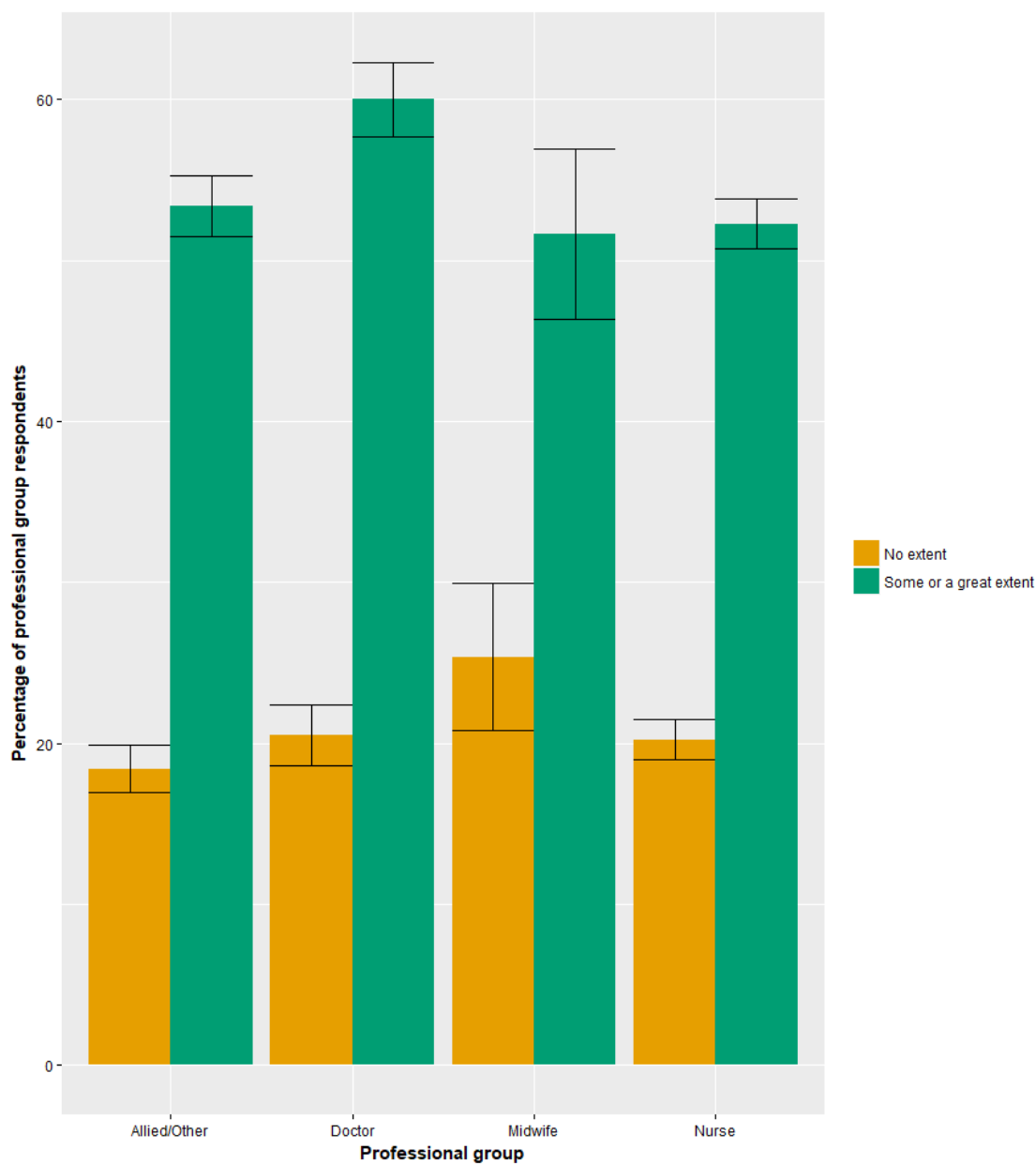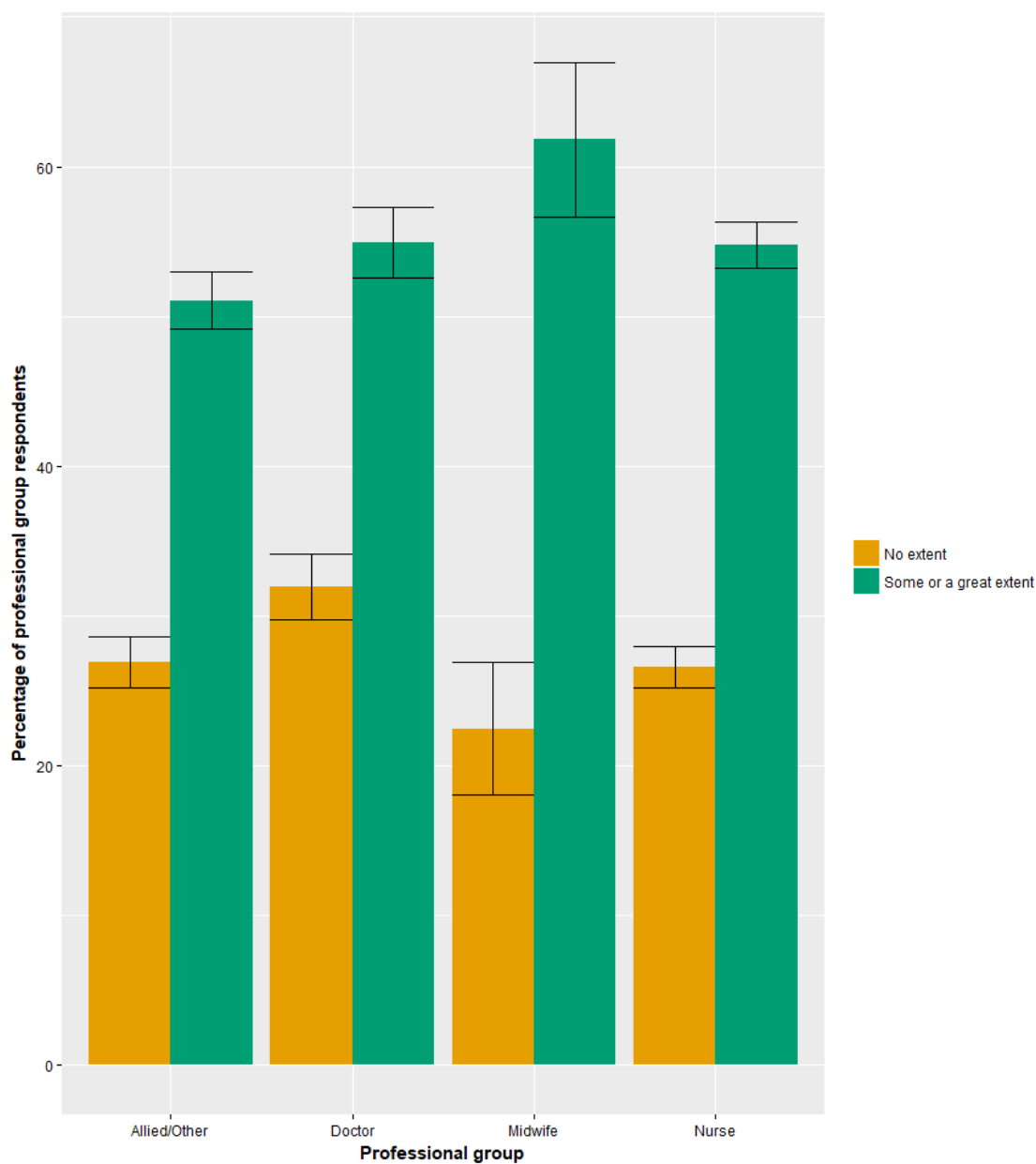


Just over half of respondents reported that health professionals in their DHB were involved as full active participants in the design of organisational processes. This was highest in **Doctor (60%)** and lowest in **Midwife (51.6%)**. In 2012, midwives were also the lowest.

## 4.8 To what extent has your DHB sought to give responsibility to your team for clinical service decision making in your clinical areas?
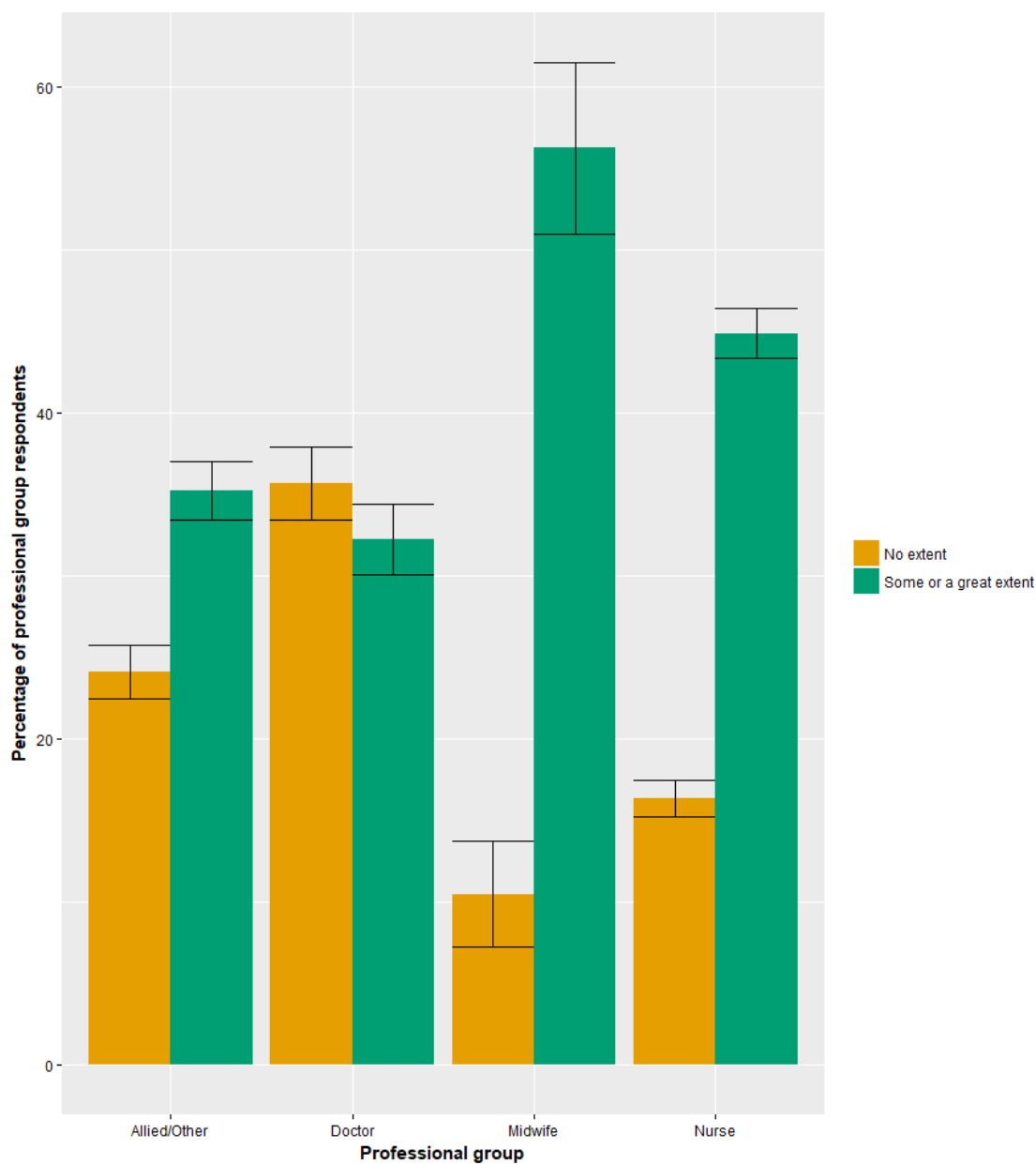


Just over half of respondents reported that their DHB had sought to give responsibility to their team for clinical service decision making in their clinical areas. This was highest in **Doctor (62.2%)** and lowest in **Midwife (58%)**. In 2012, nurses were the highest.

## 4.9 To what extent does your DHB provide sufficient support for you to engage in clinical leadership activities?



Just over half of respondents felt that their DHB provided sufficient support for them to engage in clinical leadership activities. This was highest in **Midwife (61.8%)** and lowest in **Allied/Other (51%)**. In 2012, doctors were slightly more likely than the others to report insufficient support.

## 4.10 To what extent does your clinical service share patient outcome data with the community it serves?



Comparatively few respondents reported that their clinical service shared patient outcome data with the community it served. This was highest in **Midwife (56.3%)** and lowest in **Doctor (32.3%)**. This question was not included in 2012.

## 4.11 To what extent does your DHB share patient outcome data with the community it serves?
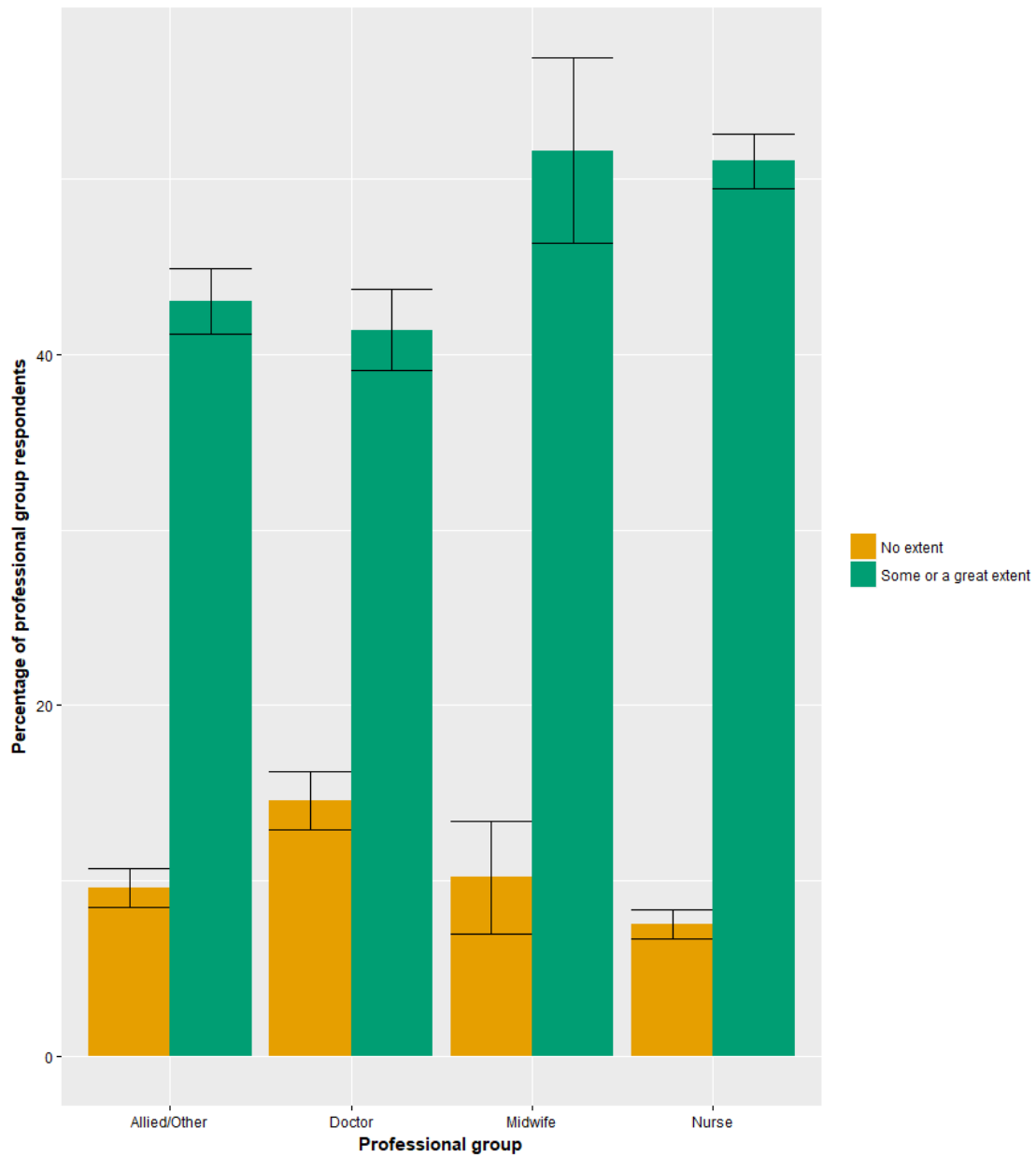


Around half of respondents reported that their DHB shared patient outcome data with the community it served. This was highest in **Midwife (51.6%)** and lowest in **Doctor (41.4%)**. This question was not included in 2012.

## 4.12 This DHB explicitly defines health professional roles in advancing patient safety in job descriptions and orientation, and in requiring continuing professional education.
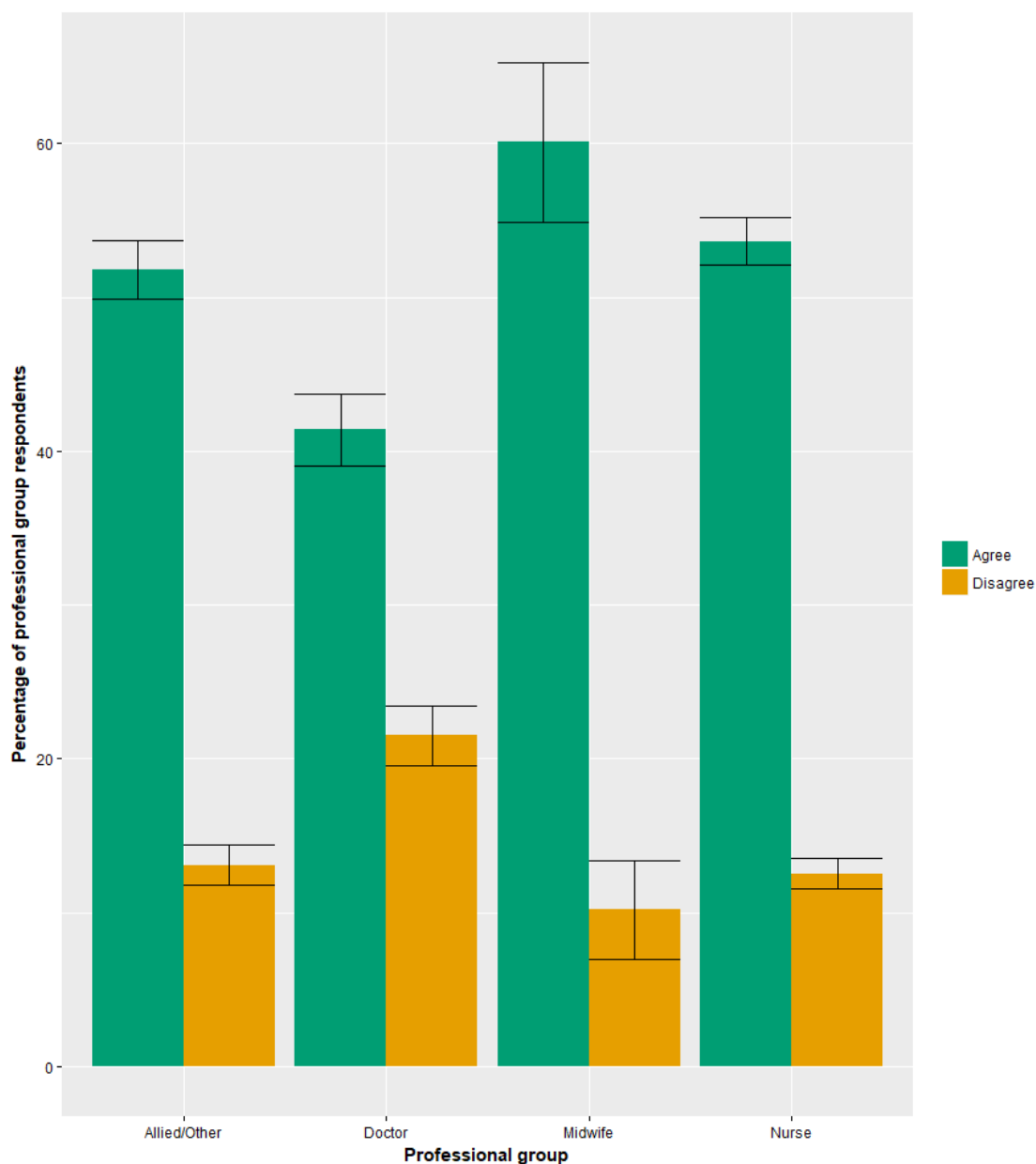


Just over half of respondents agreed that their DHB explicitly defined health professional roles in advancing patient safety in job descriptions and orientation, and in requiring continuing professional education. This was highest in **Midwife (60.1%)** and lowest in **Doctor (41.4%)**. This question was not included in 2012.

## 4.13 Health professionals in this DHB work together as a well-coordinated team.
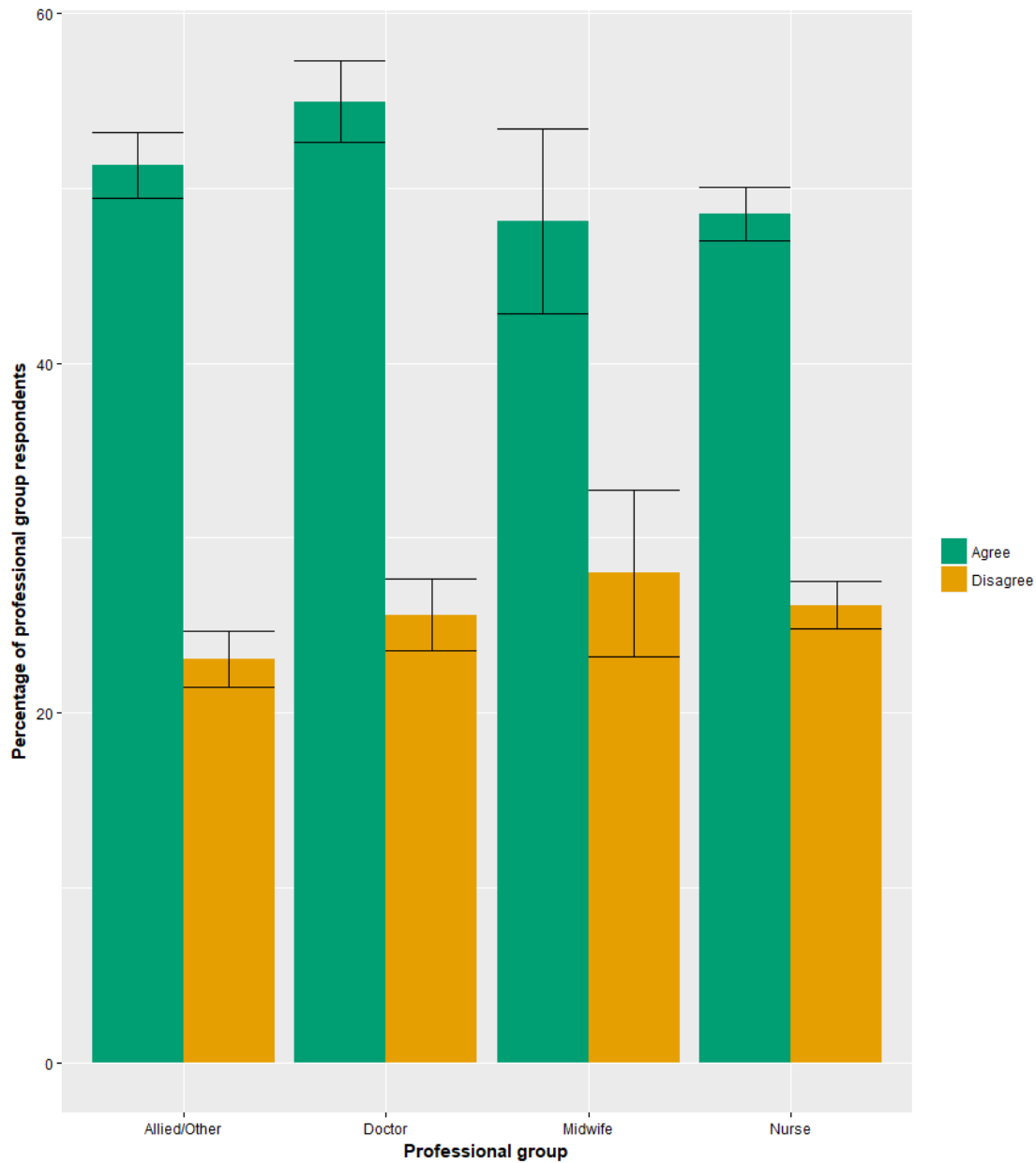


Just over half of respondents agreed that health professionals in their DHB work together as a well-coordinated team. This was highest in **Doctor (54.9%)** and lowest in **Midwife (48.1%)**. In 2012, midwives were the highest scoring group; the other three groups were the same.

## 4.14 Health professionals in this DHB involve patients and families in efforts to improve patient care.
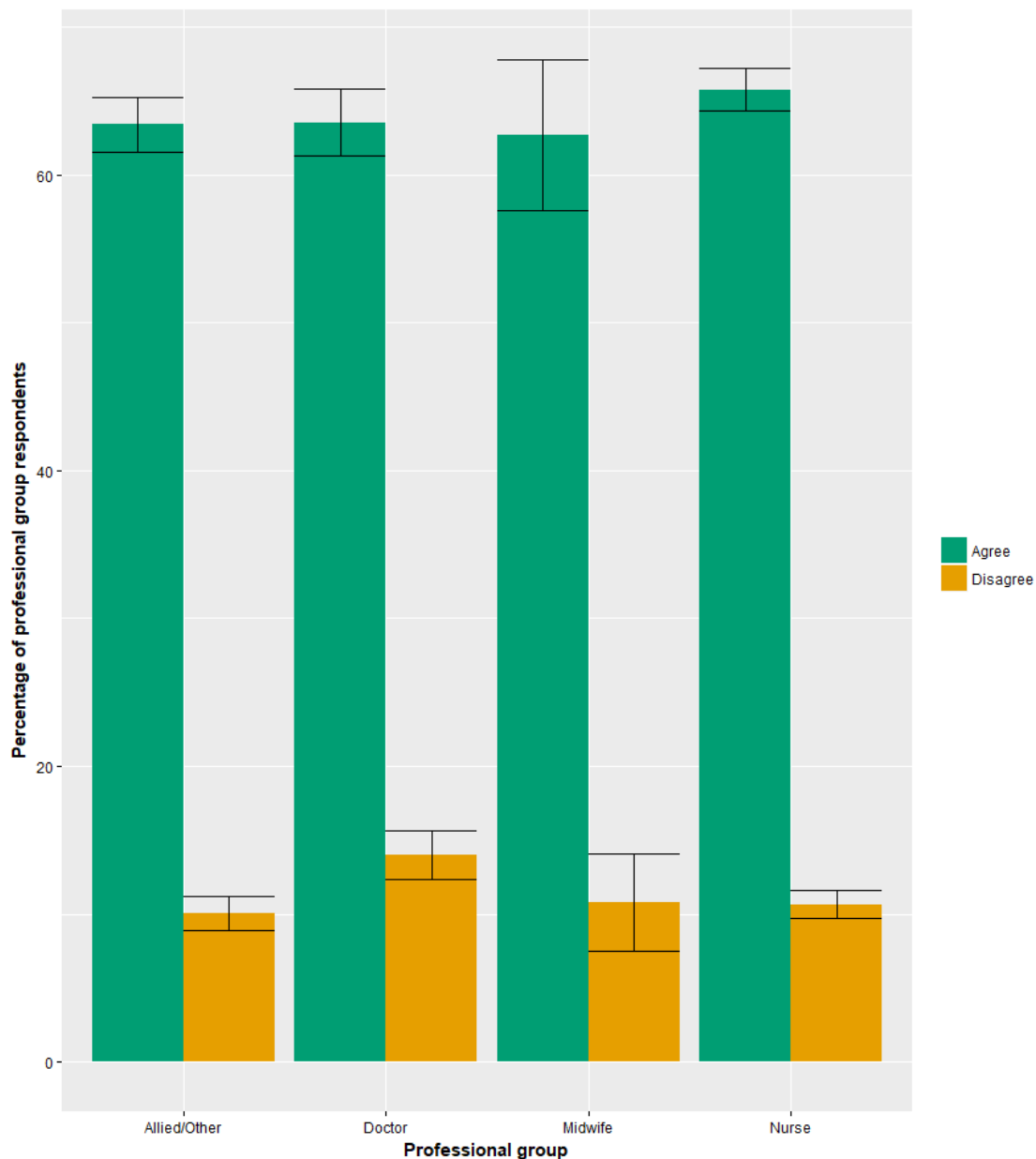


The majority of respondents agreed that health professionals in their DHB involved patients and families in efforts to improve patient care. This was highest in **Nurse (65.8%)** and lowest in **Midwife (62.7%)**. In 2012, nurses were the highest scoring group, with midwives second.

## 4.15 In this clinical area, it is easy to speak up if I perceive a problem with patient care.
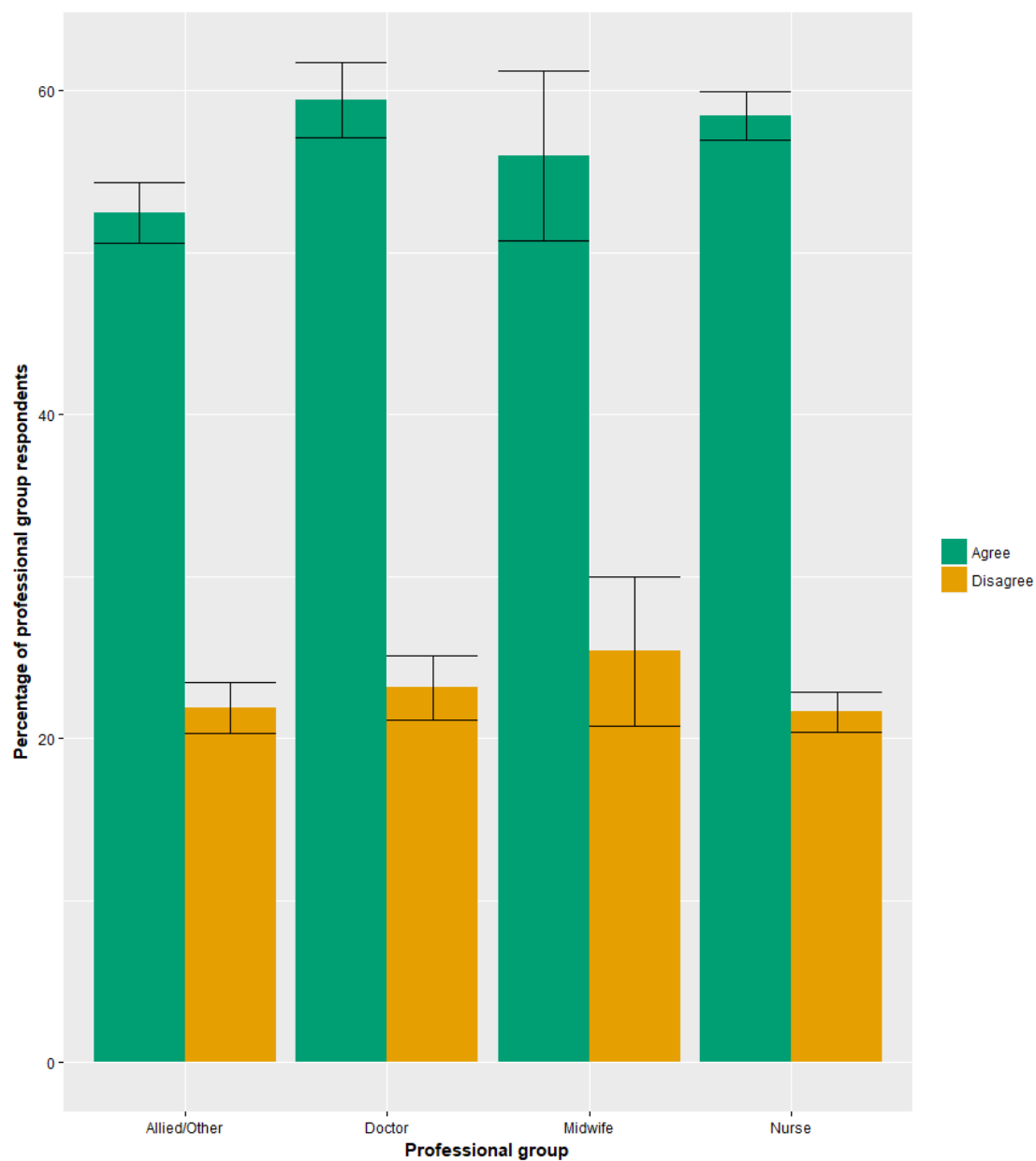


Just over half of respondents agreed that, in their clinical area, it was easy to speak up if they perceived a problem with patient care. This was highest in **Doctor (59.4%)** and lowest in **Allied/Other (52.4%)**. In 2012, nurses were the highest scoring group.

## Written comments from respondents

A total of 2497 written comments were received from the 8963 respondents (therefore, from 27.8% of respondents), amounting to over 180 pages of text. Analyses indicate over 95% of written comments were critical, with no difference by DHB, although many critical comments came from respondents whose answers to the main survey questions were more positive than their comments would imply. It is possible that respondents with negative or critical comments were more motivated to express their views. Below are representative quotes, both critical and supportive of clinical governance and quality activities in DHBs.

Critical comments

'Although the structures are in place clinical leadership is often compromised by the competing demands of clinical work and the time imperative of ongoing change. Major decisions are still made by a few service leaders with middle level managers and clinicians often required to demonstrate 'leadership' by implementing changes that they don't completely understand or agree with. There is a lack of senior clinicians to provide clinical guidance and supervision to less experienced clinicians who are frequently put in clinical situations beyond their skill levels.'

'It would be good if junior staff were involved more. Seems than often co-ordination between clinical and managerial staff occurs at a senior level, with little involvement or suggestions sought from more junior staff who, in reality, are more involved with the day to day aspects of patient care and safety. Another issues that prevents engagement with clinical leadership is time constraints - perhaps people would engage more if specified time was set aside for this?'

'Leadership by clinicians is not valued in my DHB and management follow their own agenda, rather than those that matter to clinicians and patients. When safety issues are raised immediate action is rarely taken, definitive responses are extremely slow and root causes rarely addressed. This should be the other way round with clinicians leading and management supporting clinical priorities.'

'There is a top-down style of leadership in my DHB. Too many ill thought out changes have been made despite sound objections raised by clinical staff. As a result, staff are disillusioned and morale is very low.'

'Sometimes I feel that we would do better for patient care if there was a means to feedback ideas for quality improvement/ways to save money/improve staff morale to senior management.'

'Leadership is generally poor. Robust decision making is not the norm. We tend to jump from one crisis to another without taking stock. The concept of Clinical Governance is unknown to most clinicians. Middle level managers are unsupported in decision making by their senior managers, who tend not to want to appear unpopular.'

<u>Supportive comments</u>

'The emphasis on creating a culture among staff that encourages communication and proactive ideas and behaviors is a strength in this DHB that I have not had elsewhere.'

'[this DHB] has engaged clinicians in leadership to a large extent. The constraints are mostly those imposed by the Government and are mostly related to funding.'

'I feel this DHB has made great moves in the last 10 years to involve the community it serves in improving service delivery and offers staff endless opportunity for education and participation in clinical leadership.'


## Discussion

*Key findings*

This study provides an update on progress with developing clinical governance, and on health professional perceptions of aspects of the quality and safety environment in New Zealand DHBs. The study brings an important cross-sector comparative dimension, due to its national coverage and inclusion of all 20 DHBs. It also allows for gauging progress over time, given the prior 2012 study which provided baseline data.

Perhaps, most notably, limited progress has been made since 2012. In 2017, slightly more familiarity with the concept of clinical leadership was found than in 2012 (table 3.1a). There was a marginal decrease in extent to which respondents believed their DHB was working to enable strong clinical leadership and decision making (tables 3.2a). There was a slight improvement in the extent to which respondents perceived DHBs had sought to foster and support clinical leadership (3.4a), and a considerable decline in staff reporting being involved in working with others in their DHB to change the system where it would benefit patients (tables 3.5; comparative table was not generated due to slight wording differences between 2012 and 2017 survey). There was a slight drop in perceptions of working in partnership with management, with shared decision making, responsibility and accountability (table 3.6a).[3] The decline was also reflected in other key questions. Notably, however, there appeared to be a substantial improvement in respondents reporting that their DHB had provided sufficient support to engage in clinical leadership activities, from 36% in 2012 to almost 59% in 2017 (table 3.9; comparative table was not generated due to slight wording differences between 2012 and 2017 survey). This is despite an often very constrained funding environment in the DHB sector.

As noted, only four of the Clinical Governance Development Index (CGDI) questions from the 2012 survey were repeated in the 2017 survey. Of these, the overall mean positive responses for DHBs decreased slightly between 2012 and 2017 for three of the four questions. Additionally, for each of these three questions, most of the DHBs showed a decrease between 2012 and 2017 (eleven DHBs for '*To what extent are health professionals*

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[3] The questions relating to tables 3.6 and 3.9 were worded slightly differently in 2012 and 2017. The data, therefore, need to be taken at face value and comparative tables have not been generated.

*in your DHB involved in a partnership with management with shared decision making, responsibility and accountability?'* through to fifteen DHBs for '*To what extent are health professionals in your DHB involved in a partnership with management with shared decision making, responsibility and accountability?'*). If the remainder of the CGDI questions were included, we would expect that the overall CGDI scores for DHBs would have decreased slightly in 2017. However, the magnitude of decreases is largely very small, and it is likely that they represent the influence of sampling variation and differing respondent mix across the two surveys rather than meaningful change in clinical governance practices.

On the three new questions developed for this 2017 study, a solid minority of respondents believed their clinical service shared patient outcome data with the community (table 3.10), while a slight majority believed that their DHB did so (table 3.11). The reasons for the differences in response to these two questions remain unclear and warrant further investigation. One possible explanation is that respondents perceive that outcome data are included in DHB publications such as annual reports and quality accounts. It could be useful to investigate the mechanisms through which outcome data are reported by clinical services and by DHBs. Only a limited majority of respondents believed their DHB included patient safety in job descriptions and continuing professional education requirements (table 3.12).

Responses to the three questions on elements of the patient safety climate were mixed. There was no change in perceptions of team work (tables 3.13a); some improvement in perceptions of involving patients and families in improvement efforts was found (tables 3.14a); and there was a drop in belief that it is easy to speak up when patient care lapses are perceived (tables 3.15a). This last finding is perhaps of particular concern, given the importance attached to building a safety culture in which speaking up is encouraged.[24]

Why some DHBs appear to have improved on some questions and others not remains an important question. Tairawhiti, for example, was amongst the better performing DHBs in 2012 but since appears to have declined somewhat on almost every comparable question. Further investigation into this could be useful. A handful of DHBs appear to have consistently improved performance across several questions since 2012, including Auckland, Bay of Plenty, Hawkes Bay, West Coast and Whanganui although, again, there are variations in performance across questions, while other DHBs improved on individual questions.

*Limitations*

The research presented in this report has various limitations. First, the survey method that underpins the analyses is often subject to critique. Survey methods are widely used, yet fixed-response questions are always open to individual respondent interpretations. Individual survey questions also only probe the specific areas they are targeted at. To complement the fixed-answer questions, an open-ended comments box was also included in the survey to allow for respondents to offer their own thoughts. This provided rich data, some of which were presented in this report. Similar data from the earlier 2012 study were reported on in a published journal article.[12]

Second, the survey response rate would ideally have been considerably higher. To offset response rate concerns, the data set is large and broadly representative of the health

professional workforce which boosts confidence in the data. Follow-up emails were sent in the attempt to raise response rates and some DHBs invested additional effort into boosting their staff participation. Some DHBs made note of the fact that they had conducted their own recent staff surveys on subjects such as safety culture and organisational engagement. For this reason, they felt staff could be feeling 'surveyed out', in turn, affecting the response rate. Given the complicated nature of the survey across 20 DHBs, each with different internal structures, and several professional groups, the response rate could be considered quite reasonable and certainly on a par with response rates in other complex fields of public health and health services research.[25-27]

Third, the survey method delivers only quantitative data (noting that open comments were collected in this survey as well). While important for gauging perceptions, and establishing a baseline against which to compare future studies, it could be useful to further investigate several of the issues highlighted by the analysis in this report – for example, why perceptions of respondents in some DHBs appears to have declined. This would perhaps best be done through qualitative methods, such as interviewing and focus group discussions, that permit in-depth exploration of viewpoints and experiences. The 2012 study did include in-depth case studies of clinical governance and leadership activities in 19 DHBs, which identified a series of key themes.[5,8]

Fourth, the data presented in this report are 'raw' comparisons. That is, they don't take into account the different mix of respondents from the two different surveys in 2012 and 2017. So, for example, if doctors responded differently from nurses (and they do), and the 2017 survey had more doctors in it than the 2012 survey, then any difference in a DHB across the years could be simply due to the different proportion of doctors in the DHB. Further analyses to look into this are planned.

## Conclusion

Going into the 2010s, there was a strong focus on clinical governance and leadership in the New Zealand health sector. The 2012 study detected considerable momentum at the DHB level. The focus amongst national agencies at that point, however, was in an embryonic state, albeit strongly supportive. Other than the recommendations of the Ministerial Task Group on Clinical Leadership and a ministerial statement,[2,6] there was no national policy or guidance for clinical governance development. Nor was there a framework for driving performance in this area. The DHBs, also, were varied in terms of their understanding of clinical governance and leadership and development of mechanisms and materials to support this.[8] The findings of the 2017 study described in this report could be a reflection of this situation.

Yet the principles of clinical governance remain as important as ever. HQSC's 2017 advice for the sector confirms this and encapsulates a series of key factors that providers should focus on. [21] HQSC's approach has precedents elsewhere. For example, Ireland's Health Service Executive (a central agency with oversight of public hospitals and health care) has had a concerted approach to clinical governance development, within a broader policy context of quality improvement and patient safety, dating back to at least the early-2010s. A

series of policy documents and practical advice for those involved in developing and implementing clinical governance at the service delivery level and in governance roles have been issued.[28-32] This has included advice for health boards as well as managers and health professionals. To be fair, Ireland's health system is organised in a way that provides a much stronger capacity than New Zealand to drive policy developments from the centre; in other words, to gain the participation of public hospitals and health services in national initiatives. Research suggests that Ireland's more centralised approach and mandate to drive policy initiatives could be more effective and worth replicating in New Zealand.[14]

If clinical governance in New Zealand is to advance, there is arguably a demand for a more supportive environment for this. This means encouragement and support from across the sector, with advice and guidance from the centre as well as clear commitment and support from the DHBs. Of course, health professionals also have a responsibility for enabling and developing clinical governance.[1,33] As the stewards of patient safety, in their role as front line service providers, they have an obligation on behalf of every patient and the broader system within which they deliver care to step up and work with others, including other professionals and managers, and engage in improvement activities.

Progress generally requires setting up measures for holding individuals and the system to account. In this regard, studies such as this one are critical to measuring development as well as highlighting areas where work is needed. HQSC is to be commended for focusing on this aspect. It would be useful for this focus to broaden to involve other central agencies.

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