Clinical Governance Assessment Project: Final Report on a National Health Professional Survey and Site Visits to 19 New Zealand DHBs

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RG and SH
Dunedin
22 November 2012

1. Introduction

1.1. Overview

The Clinical Governance Assessment Project (CGAP) was jointly commissioned by the National Health Board, Health Quality and Safety Commission and the DHBs through DHBSS. The research work for the project was led by the Centre for Health Systems, University of Otago, and so is both an assessment of the present situation with clinical governance in DHBs as well as an independent study designed to promote discussion and debate. The project represented a partnership arrangement in that various activities associated with the research were undertaken by the DHBs themselves, in collaboration with the Centre for Health Systems, with facilitation and support from DHBSS.

The research detailed in this report was conducted from April-November 2012 with considerable preparation beforehand. The CGAP involved one of the largest and most complex workforce surveys conducted in the New Zealand health sector, coupled with site visits and interviews with key personnel at 19 of the 20 DHBs[i]. The final component of the project was a 'wrap-up' meeting on 6 December 2012 at which this report was delivered and the project findings discussed, with a focus on cross-sector learning and the clinical governance developmental process.

The CGAP followed on from earlier work led by the Centre for Health Systems which sought to gauge the implementation of the 2009 *In Good Hands* report of the Ministerial Task Group on Clinical Leadership. That project involved a survey of ASMS members (mostly public hospital medical specialists, but also public hospital dentists and some public health physicians employed in public health services) and compared DHB performances via the Clinical Governance Development Index. In contrast, the focus of the CGAP was the entire health professional workforce, including all doctors, nurses, midwives and allied health professionals employed by DHBs. Again, these professionals are mostly public hospital employees. The intent was to gather quantitative data via a follow-up to the ASMS survey and, through the individual DHB case studies, learn how DHBs have approached and facilitated the development of clinical governance and leadership.

This report presents the findings from the CGAP. It is structured as follows. First, it overviews 'clinical governance' and places New Zealand's activities in an international context. Second, it provides a brief background to the earlier survey and introduces the present project. Third, the project methods are detailed. The bulk of this report is in the fourth and fifth sections which present the findings of the survey followed by the case studies. Last, the discussion section outlines implications of the research and a series of points for further consideration.

Key points of note include:

- There is good reason to be proud of and to celebrate progress with clinical governance development in New Zealand's DHBs. Especially so, given the nascent nature of activities in many DHBs and complexity of clinical governance which requires a pan-organisational approach, often a range of objectives and projects, and building of partnerships and new methods of working between all components of the workforce at all levels. The

[i] Canterbury DHB did not participate due to the demands of the earthquake recovery process.

survey data show very positive results, albeit with variations. The DHB case studies revealed solid and, in many cases, extremely impressive commitment and growth, along with a range of highly-innovative approaches to building clinical governance and leadership;

- A survey response rate of 25 percent. Respondent characteristics were broadly representative of the registered health professional workforce. Response rates varied between the DHBs from 7.5 to 49 percent (section 3.1);
- Some 3500 written comments were received from survey respondents. A snapshot is provided in this report (section 4.4). Further analysis of these is planned for 2013;
- The survey data portray positive development around several issues (section 4). A healthy proportion of respondents see:
  - Themselves as 'involved in a partnership with management, with shared decision making, responsibility and accountability';
  - That their DHB has worked to 'enable strong clinical leadership'; and to 'foster and support development of clinical leadership';
  - That quality and safety are goals of both clinical service and clinical resourcing and support (managerial/financial) initiatives in their DHB;
  - That their DHB had 'sought to give responsibility' to their team for 'clinical service decisions in their service area';
- A separate report contains more detailed analysis of three quality and safety survey questions[ii]. In brief:
  - Fifty-seven percent of respondents believe health professionals in their DHB work together in well-coordinated teams;
  - Seventy percent of respondents agree that health professionals involve patients and families in efforts to improve patient care;
  - Sixty-nine percent of respondents agree that it is easy to speak up when they see problems with patient care;
- The survey data suggest it could be useful to put more effort into:
  - Explaining what is meant by 'clinical leadership' and, in this regard, requested of clinicians;
  - Providing information to staff about the 'governance structures that ensure a partnership between health professionals and management';
  - Providing support for professionals to engage in clinical leadership activities;
- Comparison of CGAP data from SMO respondents with data from the earlier ASMS SMO survey suggests solid progress on clinical governance almost without exception. According to this analysis, some DHBs have demonstrated considerable and very positive improvement in a short space of time (section 4.1.15);
- Proportional odds mixed modelling of responses (section 4.3) to each of the survey questions reveals that females, younger or older respondents and those with longer service in the New Zealand health sector have higher or lower odds of responding positively to various questions. These findings have various implications;

[ii] Clinical Governance Assessment Project: Analysis of Three Quality and Safety Questions in a National Survey of New Zealand Health Professionals. Centre for Health Systems, University of Otago, Dunedin. 2012.

- The 19 DHB case studies revealed concentrated activity without exception but, again, to varying degrees. Many DHBs have made bold steps in terms of implementing structures to facilitate and advance clinical governance and leadership. There is considerable potential to learn from the often unique approaches taken by different DHBs. Readers of this report should be aware that clinical governance development is a recent focus for many DHBs, so the assessment is of initial progress. Several themes around DHB leadership, Senior Medical Officer engagement, opportunities for cross-sector learning, the role of clinical boards, training, and connecting clinical governance and quality improvement, emerged from the site visits (section 5);
- The discussion (section 6) highlights areas that warrant further consideration:
  - 'Clinical Governance' demands tighter definition. This should be a national project so that DHBs and health professionals receive consistent information. Tools to assist with clinical governance development and assessment could be linked to this;
  - There is a strong case for an arrangement to facilitate essential cross-sector fertilisation of information around clinical governance and leadership development, so that the multitude of excellent examples of clinical governance can be more widely shared;
  - Dedicated training for clinical governance and leadership is needed and should be tied to the specific requirements of clinical governance as well as to training in the tools of quality improvement;
  - How to get health professionals, especially doctors, engaged in clinical governance and leadership, as well as how to achieve a balance between the various professional groups (doctors, nurses, midwives, allied professionals) demands attention. Professional training institutes, including tertiary institutes and professional colleges, have a crucial role to play. How to better support 'clinical leaders', often in part-time posts, and to engender the participation of colleagues often on part-time contracts, also requires further discussion.

1.1.1. What is clinical governance?

The concept of clinical governance has been applied in a range of countries and health systems. While there is a deep history of clinical governance in many countries, including New Zealand, its contemporary resurgence was initially in the UK in part in response to management-clinical divides in the running of NHS hospitals and health services.[1–3] These divides had emerged as a result of the structures for and focus of management and related systems on improved performance and installation of generic managers to drive this.[4,5] In New Zealand's health system, 'managerialism', as it is sometimes called, was promoted from around the late-1980s and an explicit underpinning of policy developments in the 1990s.[6,7] One consequence was that managerialism often resulted in a disengaged health professional workforce.[8]

Clinical governance can also be seen as a response to patient safety and health professional regulatory concerns revealed through cases such as the Shipman and Bristol Hospital Inquiries in the UK,[9,10] the Gisborne Cervical Screening Inquiry in New Zealand and various reports of the Health and Disability Commissioner,[11,12] and the multitude of studies that show hospitalisation can result in unintended harm to patients.[13–17] These, in turn, have driven disquiet about professional accountability, standards, regulation, training and behaviour.[12,18–20]

Clinical governance has been defined in various ways in the literature.[3,21–24] The classic Scally and Donaldson definition suggests:

> 'Clinical governance is a system through which [health] organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.'[25]

What this and other definitions accessible in the published research literature seem to have in common is the idea that medical and other professionals have a responsibility to step up and change the systems and processes of care that they contribute to in order to improve patient safety and quality. Alongside this is the assumption that clinicians will also be given, and willingly take on, responsibility for resource allocation and associated decision making – perhaps in full or in partnership with management.

It may not be unreasonable to suggest that 'clinical governance' is an indistinct concept that could have multiple meanings to different players in the health system.[26] To some, it may be about bringing clinicians back into leadership and breaking down management-clinical divisions. In this sense, it is about building partnerships between the two and incorporating clinicians into the senior management team, as well as facilitating the development and support of clinical leaders throughout the health care organisation. It is also about rejuvenating clinical involvement in and, in turn, faith in leadership. To others, it may be about professionals leading improvements to services. This is as they are most closely involved in their design and delivery and have the best knowledge of where weaknesses lie, have the most control over resource use (as they control clinical work and the processes of patient treatment) and knowledge of where resources should be most appropriately allocated, and which initiatives are likely to provide best value and improve health care delivery and outcomes.[27] Clinical governance is also about professionals working more closely with one another, monitoring and regulating their activities with a focus on clinical service and system improvement.

Drawing from the literature and the policies of various countries, in practical terms, one might expect to see health professionals leading the way in quality improvement efforts, ensuring that clinical and organisational practices are evidence-based, and working to build team-based and systematised services delivery processes. If quality improvement is an aim, clinical governance might be seen as providing essential organisational fuel for this. The downstream effects of this are likely to include improvements in patient experiences and patient safety, in clinical performance and workforce satisfaction, reductions in hospital readmissions, more efficient and appropriately located services and, ultimately, financial performance improvements (although the evidence around the financial question is debated).[28–31]

At the heart of clinical governance is the idea that doctors, nurses and other health professionals are best placed to encourage performance improvement amongst peers and should be involved in leadership. An emerging literature provides support for this. A 2010 multi-country study by the McKinsey consultancy in collaboration with London School of Economics showed that clinically led hospitals were more likely to have standard processes in place and better quality of care.[32] They argued also that doctors had a skill mix that suggested they were well placed to assume service line management duties – being responsible for both budgetary and service leadership – and that hospitals seeking high performance should look to create structures that devolve such powers to medical leaders of clinical directorates and departments. A 2011 study of US hospitals added further weight to the argument, again showing a superior performance on financial and quality measures in clinically-led institutions.[33] Then there are clinically-dominated organisations such as the Pennsylvania-based Geisinger Health System which has worked to systematise services. For example, in pursuing best-practice, its clinical staff agreed to 40 critical steps in the process of coronary artery bypass graft surgery. Results show significant improvements in performance across a range of cost and quality measures.[29]

In summary, and for the purposes of this report, three core concepts sit behind 'clinical governance'. That:

- The focus of clinical governance is the system for organising and delivering care, with an aim of involving health professionals (clinicians) in leading and improving this;
- Leadership by clinicians is pivotal to clinical governance, including clinicians stepping into leadership positions as well as leading by example and leading change;
- Robust clinical governance requires a clinical workforce who are engaged and committed to service improvement in their organisation and to better patient care.

1.1.2. Clinical Governance in New Zealand

Clinical governance and leadership have been central health policy planks since the delivery of the 2009 *In Good Hands* report of the Ministerial Task Group on Clinical Leadership. *In Good Hands* drew on a wide range of international theory and practice of clinical governance and leadership, including the UK NHS Leadership Qualities Framework. It sought to bring a balance to the considerable efforts across the DHBs, especially their hospitals, into developing corporate governance structures and systems for reporting corporate outcomes.[34] To do so, clinical governance was required. Following Scally and Donaldson, this was defined as 'the system' in which leadership, 'by clinicians and others', was a core component. The challenge, said the report, was to create distributed leadership at service delivery, hospital and national levels with clinicians at the centre to 'transform clinical governance into an everyday reality at every level of the system, to ensure the whole system is *in good hands*' (italics added).[34] Specific recommendations included that:

- DHBs and their governing Boards create governance structures that ensure 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.

In Good Hands also noted a need for national reporting on clinical outcomes and effectiveness and development of a framework for this.

On release of *In Good Hands*, the Minister of Health announced that DHBs would be expected to implement its recommendations, saying:

> 'The Government is serious about re-engaging doctors and nurses in the running of front line health services and we expect DHBs to act on this report... We have instructed DHBs to foster effective clinical leadership and we will work with the Boards to make this happen... This is not about massive structural upheaval, it is about ***operating differently*** to develop and support strong clinical leadership and governance throughout the health system'.[35]

Since then, DHBs have invested considerable effort into developing structures for clinical governance, supporting clinical leadership and building a more engaged health professional workforce.

1.1.3. Assessing Clinical Governance and Leadership

In 2010, the Centre for Health Systems initiated a project aimed to provide an initial assessment of clinical governance development. This involved several steps, explained in more detail elsewhere.[36] First, the public hospital specialists union, the Association of Salaried Medical Specialists (ASMS), was approached and agreed to partner on a survey of its members. The published literature revealed limited pre-existing survey instruments focused on clinical governance development. Some studies used qualitative methods;[4,37] one featured a conceptual framework which had not been used in practice and, it was felt, was rather convoluted;[23] and some studies focused on medical workforce engagement.[38,39] As the aim was to assess specialist perceptions of DHB progress in implementing *In Good Hands*, and to do so via a concise survey, a new instrument focused on key areas that *In Good Hands* specified was designed. The end result was a fixed-response 11-item survey with an additional eight background questions and a comments box. Respondents were asked to rate familiarity with clinical governance concepts and policy, and, through a series of questions, the extent to which their DHB was working to develop and support clinical governance and leadership and partner with clinicians in this. The survey went through an extensive peer-review and piloting process with resulting adjustments and met the standards of content validity.[40]

Through June 2010, the survey was posted to all ASMS members in paper form, with two follow-up mail outs to non-respondents. Those who had still not responded were then invited by email to participate in a web-based version of the survey. The final response rate was 52%. The Clinical Governance Development Index (CGDI) was then developed and gave each DHB a score out of 100, based on weighted responses to seven related survey items.[36] The CGDI was, however, based on perceptions of one workforce group and did not incorporate those of other professionals nor of DHB leadership. It also did not pick up on important process issues or the lessons that might be shared between DHBs on their journeys to developing clinical governance and leadership.

An aim of the present assessment was therefore to include all health professionals in a follow-up survey and also to gather in-depth information from each DHB – in essence, to provide an opportunity for it to 'tell its story' in terms of how it had approached implementing the government's clinical governance policy.

2. Methods

As noted, the CGAP involved a health professional workforce survey and individual DHB case studies. These are further explained below.

2.1. The 2012 health professional survey

Following an extensive consultation process involving all DHBs, professional staff unions (e.g. ASMS, NZNO), professional group leaders (e.g. national CMO, DON, GMHR groups), and national agencies (NHB, MOH, HQSC), the survey was redesigned. Minor adjustments were made to some questions, some were removed, and some new questions added including three on aspects of the quality and safety of care and questions probing the extent to which health professionals were pursuing opportunities to become involved in governance and leadership activities. The end result is a more balanced survey tool, in that it canvassess health professionals' perspectives on the extent to which DHBs are working to promote clinical governance as well as to which health professionals themselves are seeking to and able to become involved in governance and leadership activities. The survey is attached in Appendix A. The survey was in a web-based format only[i], with invites to participate by email containing a direct link to the survey website which was designed and managed by the Centre for Health Systems.

2.1.1. Survey data collection process

The survey was one of the largest ever undertaken of the New Zealand health professional workforce. Several steps and processes were involved in conducting the survey, with all communications standard across the 19 participating DHBs:

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 Centre for Health Systems 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

[i] Some DHBs requested a limited number of paper copies of the survey for staff they felt may not have access to computers or may be difficult to reach by email. Completed surveys were returned to the Centre for Health Systems.

3. In all, some 41030 health professionals were invited to participate across the 19 participating DHBs;
4. On 15 May 2012, each DHB sent an email invite to their professional staff list containing the link to the survey website. The staff list generation and email invites were largely managed by the GM of HR in each DHB, with national coordination by DHB Shared Services;
5. Three follow up emails were sent at weekly intervals after the launch date and the survey closed on 22 June 2012;
6. DHB Shared Services assisted with coordinating reminder notices to all DHBs, which DHBs themselves forwarded on to staff;
7. Centre for Health Systems monitored response rates and provided weekly feed back to the DHBs;
8. All analyses were the responsibility of the Centre for Health Systems.

2.1.2. Case studies

Coupled with the survey was a case study of each DHB's approach and experiences with clinical governance development. This involved the DHB producing a self-review for which a standard template was developed (see Appendix B). In this, DHBs outlined their strategy for clinical governance, their 'three most important initiatives' and positives and negatives of these, and plans for next steps. Each DHB also hosted a one-day site visit to conduct interviews with key individuals involved in clinical governance and leadership development. This was approached as a listening exercise, with DHBs encouraged to 'tell their story'. A standard set of instructions was provided regarding who might be included in the interview schedule. Interviewees variously included the CEO, Chief Medical Officer, Director of Nursing and Midwifery, Director of Allied Health along with directors of clinical units/departments, groups of medical, nursing and allied health professionals, and others as appropriate, with considerable differences in the structure of each DHB's interview list. Some had a small number of interviewees; others an extensive list. Some DHBs arranged interviewees in groups. The site visits took place between July-Nov 2012. Across the 19 DHBs, some 165 people participated in interviews. Drawing on the self-review and interviews, a brief summary for each DHB was produced. The combined findings are presented and discussed in this report.

2.1.3. Quantitative analyses

The quantitative analyses of the CGAP survey items were broken into several parts.

1. A summary of the pattern of responses for each survey item. These were explored further by examining variation in responses by individual DHB and professional group;
2. Aggregated summary measures of survey item responses in the form of mean ranking across items and the Clinical Governance Development Index (CGDI); and
3. Statistical models to elucidate which groups of respondents were more likely to provide positive responses to the survey items.

Summary of survey item responses

Items in the CGAP survey were generally constructed so that the responses represented levels of agreement to or support of the item statements. To simplify the presentation of these analyses, the responses to most survey items have been dichotomised into those supportive of the item statement (e.g. 'some or a great extent', 'slightly or strongly agree') and those not supportive of the item statement (e.g. 'no extent' or 'slightly or strongly disagree'). Neutral categories (e.g. 'don't know', 'neither familiar nor unfamiliar', 'neither disagree nor agree') have not been presented. The results of these analyses are presented as percentages. Because of the removal of neutral categories, the percentages presented will not always add to 100%.

Responses to survey items have been analysed by individual DHB and professional group. Table 2.1 shows the occupations included in each professional group.

95% Confidence intervals have been included to provide an indication of the precision of the estimates obtained in the survey. The confidence intervals appear as black lines when graphed. Because of the large sample size, the confidence intervals tend to be narrow and therefore appear as a single line. Note that the confidence intervals are only included for analyses comparing DHBs. Other analyses which combine respondents from different DHBs (for example, analyses by professional group) introduce statistical clustering, which artificially narrows the confidence intervals unless accounted for. In these cases the confidence intervals are not included on the graphs, but are presented where appropriate in the text.

Rankings and the CGDI

One method of assessing overall DHB performance across the survey items is to calculate the mean survey item ranking of each DHB. Ranking for a survey item was determined by the percentage of responses supporting that item statement (see 2.1.3), with the DHB with the highest percentage being ranked first and so on. The mean of these rankings for a DHB across survey items 3 to 17 was then calculated.

The CGDI was developed and used previously in the ASMS study, and has been described in the literature.[36] It uses a set of seven questions to measure key aspects of the development of clinical governance within an organisation, yielding an overall percentage score. This score by itself is meaningless – it is impossible to currently say that a CGDI score of 75% is good or merely average. Rather, the CGDI is a comparative measure, and provides a useful tool to compare DHBs or, more usefully, the same DHB over time.

Unfortunately, one question used in the original CGDI was not included in the CGAP survey. An abbreviated six-item version, the $CGDI_6$, was therefore developed for this survey.

The $CGDI_6$ ranges from 0 to a maximum of 11. For convenience, it is reported here as a percentage. The Box on page 16 lists the items included in the $CGDI_6$, along with a description of how responses are scored. Note that only respondents with complete data for the $CGDI_6$ items (i.e. no missing data) are included in the analyses.

Table 2.1.: Occupations included in each professional group.

Professional Group	Included Occupations
Doctor	• SMO • RMO
Nurse	• Designated Senior Nurse • Registered Nurse • Enrolled Nurse
Midwife	• Senior Midwife • Registered Midwife
Allied/Other	• Other (please write the area in box) • Allied health professional (please write the area in box)

Box: Items and their scoring in the $CGDI_6$.

- To your knowledge, has your DHB established governance structures that ensure a partnership between health professionals and management?
  - No = 0
  - Yes = 1
  - (Don't know is treated as missing data)
- To what extent are health professionals in your DHB involved in a partnership with management with shared decision making, responsibility and accountability?
  - No extent = 0
  - Some extent = 1
  - A great extent = 2
- To what extent are health professionals in your DHB involved as full active participants in the design of organisational processes?
  - No extent = 0
  - Some extent = 1
  - A great extent = 2
- To what extent do you believe that quality and safety is a goal of every clinical initiative in your DHB?
  - No extent = 0
  - Some extent = 1
  - A great extent = 2
- To what extent do you believe that quality and safety is a goal of every clinical resourcing or support initiative in your DHB?
  - No extent = 0
  - Some extent = 1
  - A great extent = 2
- To what extent has your DHB sought to give responsibility to your team for clinical service decision making in your clinical areas?
  - No extent = 0
  - Some extent = 1
  - A great extent = 2

Statistical models of survey response

To aid in clarifying how different demographic groups in the survey sample responded to survey questions, a statistical modelling technique called *Proportional Odds Mixed Modelling (POMM)* was used. This is a technique used when the outcome being examined consists of categories with some natural ordering, but no fixed 'distance' between them. The use of POMMs allowed examining whether certain groups were more likely to give responses to survey items at the supportive or positive end of the response ranges provided. This likelihood was quantified using odds ratios. Odds ratios are a comparative measure, and indicate how many times as likely an outcome is in one group compared to another, all other things being kept constant. For example, if females were found to have an odds ratio of three for providing a supportive response to an item statement than males, this would mean that females were three times as likely to provide a supportive response to that item statement than males, *all things being equal*. An odds ratio of 0.50 would indicate that females were half as likely to provide a supportive response to the item statement than males, *all things being equal*.

There are two further advantages to using POMMs in the context of this survey:

- Respondents from the same DHB are likely to give more similar responses than respondents from different DHBs. POMMs are able to adjust for these possible similarities in response from staff within a DHB. Respondent DHB was used as a clustering factor to achieve this adjustment.
- Some of the demographic variables are closely related. For example, many of the female respondents were also nurses. This means that if gender was looked at in isolation, any relationship discovered between being female and the outcome might be in part due to the proportionately high number of nurses in that group. POMMs allow multiple demographic variables to be analysed in a single model. This statistically adjusts for situations where one of the variables in the model (such as professional group) might be affecting the relationship between another variable (such as gender) and the outcome. The resulting odds ratios from these models are free from the influence of other variables included in the model.

The group being compared to in the models is identified by being labelled the *reference* group in the tables reporting the results from the models.

3. Respondents

3.1. Response Rates by DHB

The overall response rate was 25%, with 10303 DHB staff responding. Workforce estimates supplied by the DHBs themselves were used to calculate these response rates. Figure 3.1 shows the response rate for each DHB. There were substantial differences in the response rates for DHB; only 7% of the staff from Counties Manukau responded to the survey, compared with 49% of the staff from Tairawhiti.

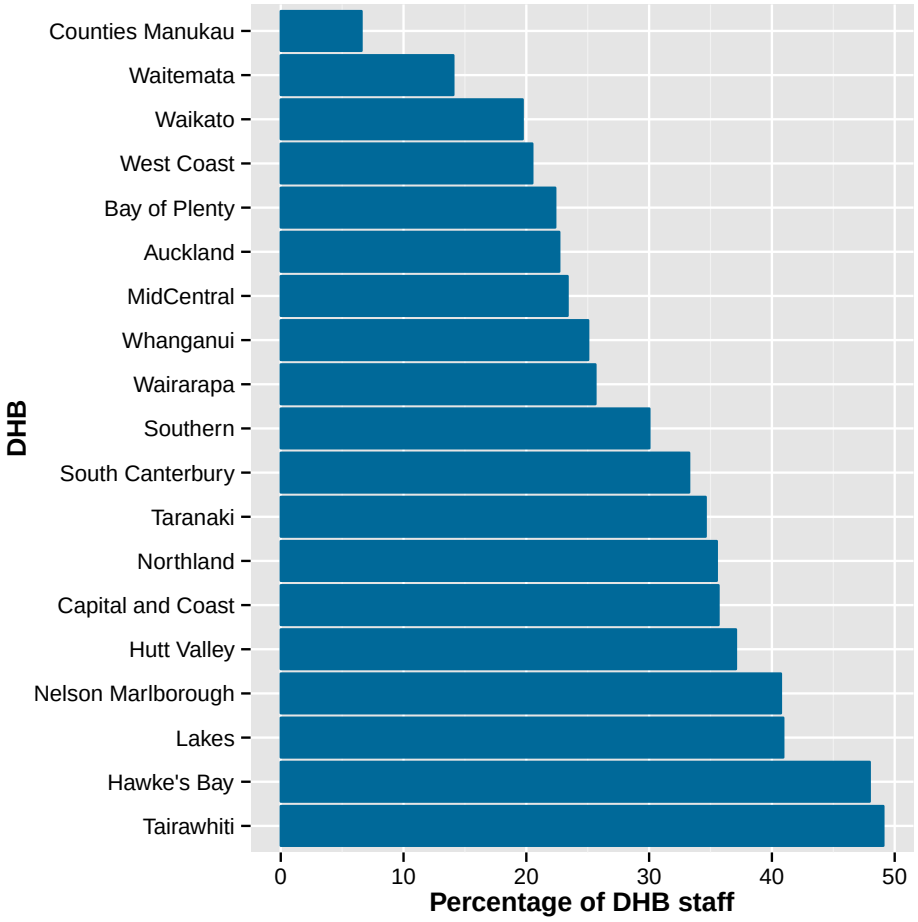

Figure 3.1.: Response rates by DHB.

3.2. Response rates by professional group

Response rates by professional grouping were calculated using the workforce data supplied by DHB Shared Services[i] (Figure 3.2). A greater proportion of Allied Health Professional/Other staff responded than for any other, while Nurses had the lowest response rate. In terms of absolute numbers, Nurses provided the largest number of survey responses (44%), while Midwives provided the least (3%).

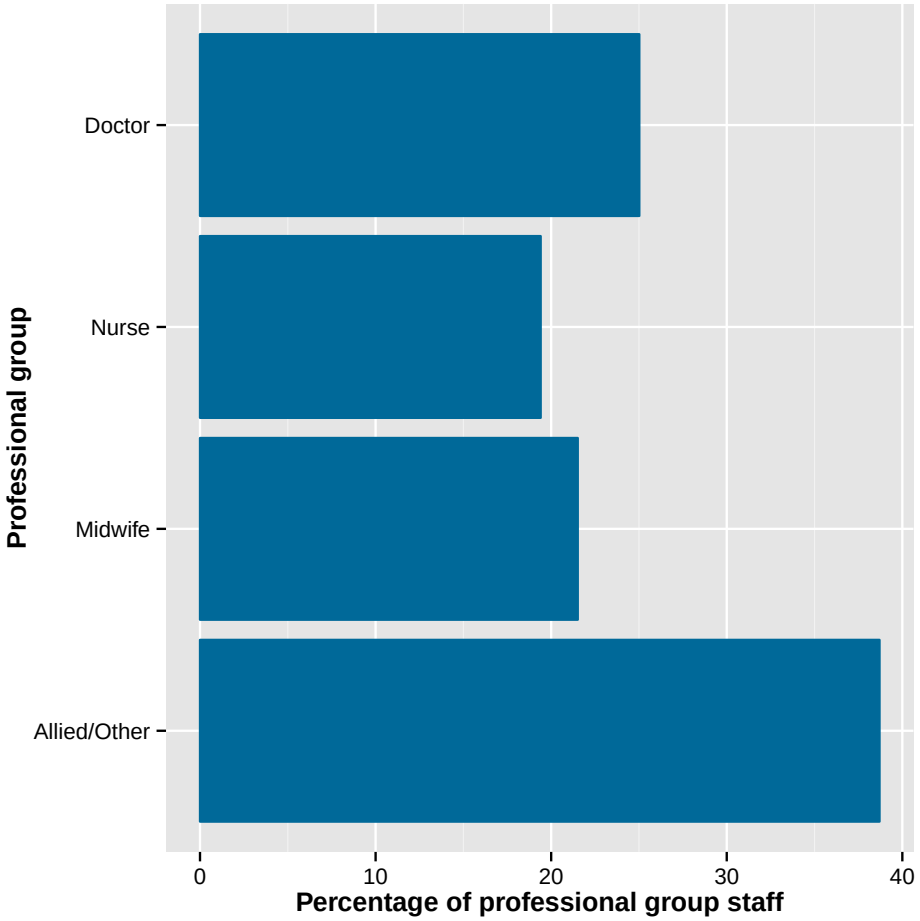

Figure 3.2.: Percentage of each professional group who responded to the survey.

[i] Amanda Newton, 19/07/2012

3.3. Comparison of participants with DHB workforce

The demographic information supplied by the participants was compared with DHB workforce data supplied by DHB Shared Services[ii] to assess the representativeness of the survey sample. Demographics which were directly comparable are shown in Table 3.1 below.

Some of the demographic information was not coded using the same categories that DHB Shared Services uses. These demographics are summarised in Table 3.2.

The survey sample was a good representation of the DHB workforce mix for gender and age group. There were some discrepancies with professional group and length of service, however, with nurses under-represented in the survey (despite providing the most survey responses of any occupation) and people who have worked longer in the DHB workforce over-represented.

3.4. Validity of the survey findings

While the survey response rate was not as high as would be optimal for a general survey, it is around the level which could be expected when surveying a worker population with the internet equivalent of a postal questionnaire. The survey captured a good mix of the workforce, with either a reasonable proportion or a large number of each worker demographic surveyed. This is reflected in the narrow 95% confidence intervals[iii] which indicate a high level of precision. The good coverage of the different demographic groups gives confidence that the range of responses across these groups has been captured.[41]

[ii] Amanda Newton, 19/07/2012

[iii] 95% confidence intervals are an indicator of the precision with which the survey estimates the population value. For example, if 76% of survey respondents reported being familiar with the concept of Clinical Leadership and this had a 95% confidence interval of 74% – 78%, we would be 95% confident (i.e. expect it to occur 95 times in a 100) that the percentage of the total workforce who were familiar with the concept of Clinical Leadership would fall between 74% and 78%.

Table 3.1.: Comparison of survey respondent characteristics with the DHB workforce as a whole (directly comparable demographics only).

	Survey Repondents (%)	DHB Workforce (%)
Gender		
Male	22%	20%
Female	78%	80%
Professional group		
Doctor	19%	18%
Nurse	44%	56%
Midwife	3%	4%
Allied Health Professional/Other	34%	22%

Table 3.2.: Comparison of survey respondent characteristics with the DHB workforce as a whole (differently coded demographics only).

Survey Coding	Survey Repondents (%)	DHB Workforce Coding	DHB Workforce (%)
Age Group			
20-29	9%	<25	6%
30-39	19%	25-34	23%
40-49	31%	35-44	25%
50-59	31%	45-54	27%
60 and over	10%	55-64	16%
		65 or over	3%
Length of Service			
<5 years	20%	<5 years	53%
5-15 years	37%	5-14 years	32%
More than 15 years	43%	15 and over years	15%

4. Analysis of Survey Responses

Note that question 7 is not included in these analyses, since it is a comment box.

4.1. Individual DHBs

4.1.1. Question 3

> *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, 47% (95% CI: 46% – 48%) of respondents were familiar or very familiar with the concept of Clinical Leadership, while 31% (95% CI: 30% – 32%) were unfamiliar or very unfamiliar with the concept. Figure 4.1 shows responses to this question by DHB. Familiarity with the concept of Clinical Leadership ranged from 43% (Taranaki) to 58% (Wairarapa).

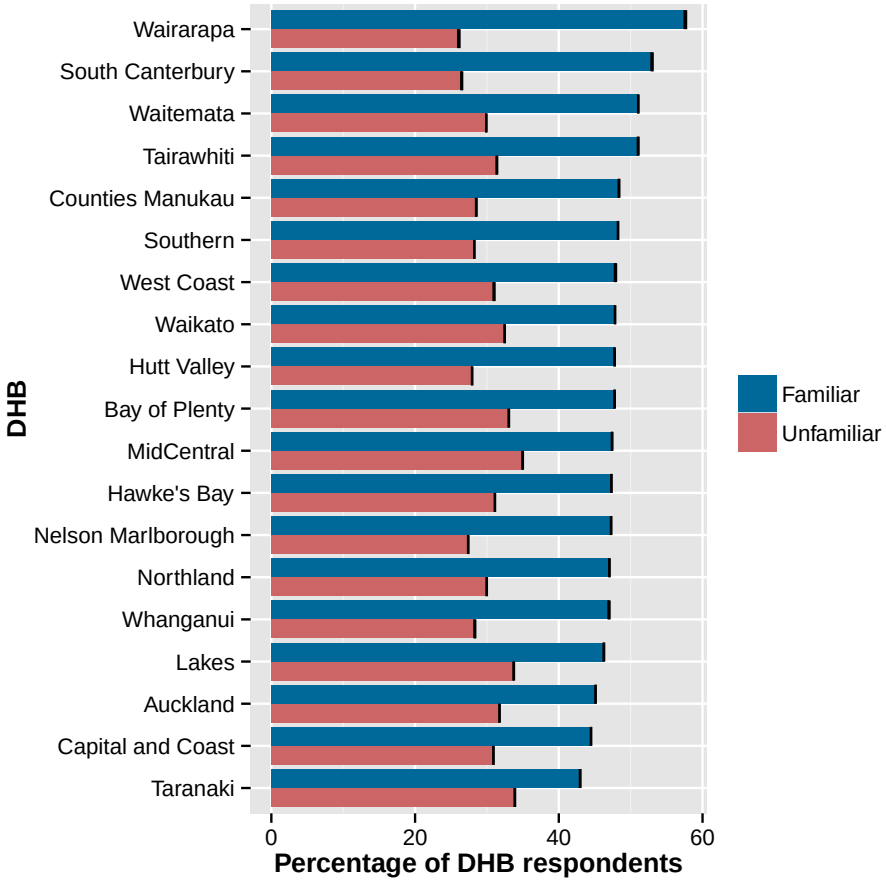

Figure 4.1.: Question 3 by DHB.

4.1.2. Question 4

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

Overall, 78% (95% CI: 77% – 78%) of respondents believed their DHB has worked to enable strong Clinical Leadership throughout the organisation to some or a great extent. Only 11% (95% CI: 10% – 11%) felt this was not the case. Figure 4.2 presents the percentage of each DHB's workforce who believed their DHB has worked to enable strong Clinical Leadership throughout the organisation to some or a great extent. This percentage ranged from 68% (West Coast) to 84% (South Canterbury).

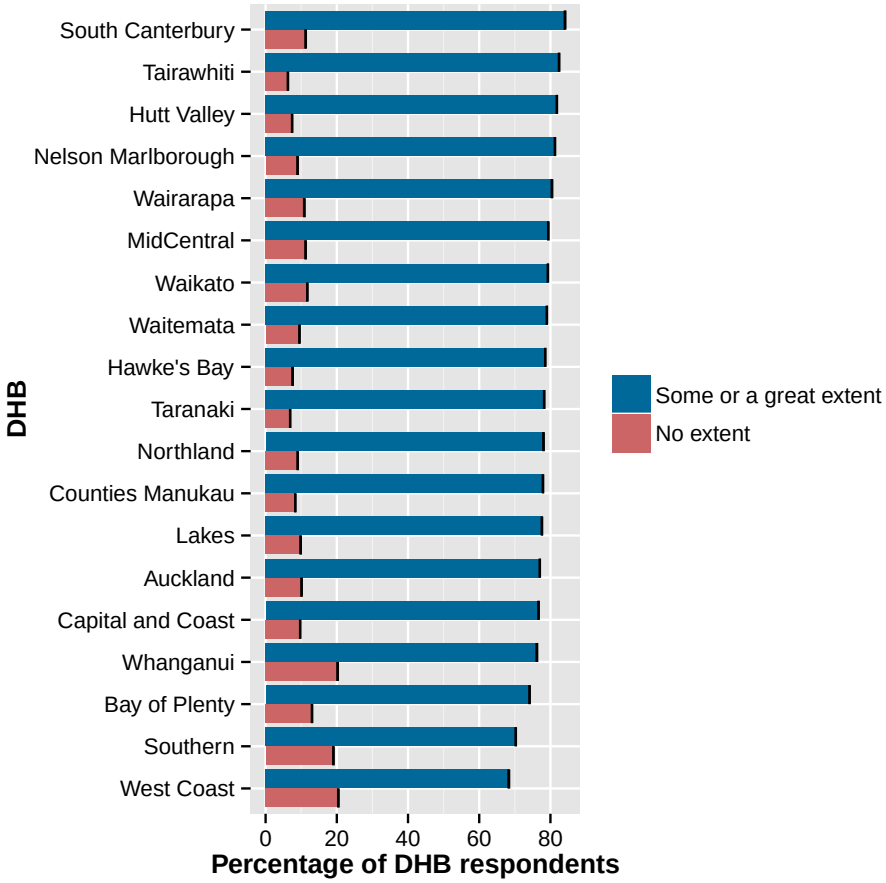

Figure 4.2.: Question 4 by DHB.

4.1.3. Question 5

To your knowledge, has your DHB established governance structures that ensure a partnership between health professionals and management?

45% (95% CI: 44% – 46%) of respondents reported that, to their knowledge, their DHB had established governance structures to ensure health professional/management partnerships, while 20% (95% CI: 20% – 21%) thought that their DHB had not. The results broken down by DHB (Figure 4.3) show substantial variation across DHBs, from 33% (Southern) to 62% (South Canterbury). Only 5 of the DHBs had more than 50% of respondents recording that, to their knowledge, their DHB had established governance structures to ensure health professional/management partnerships.

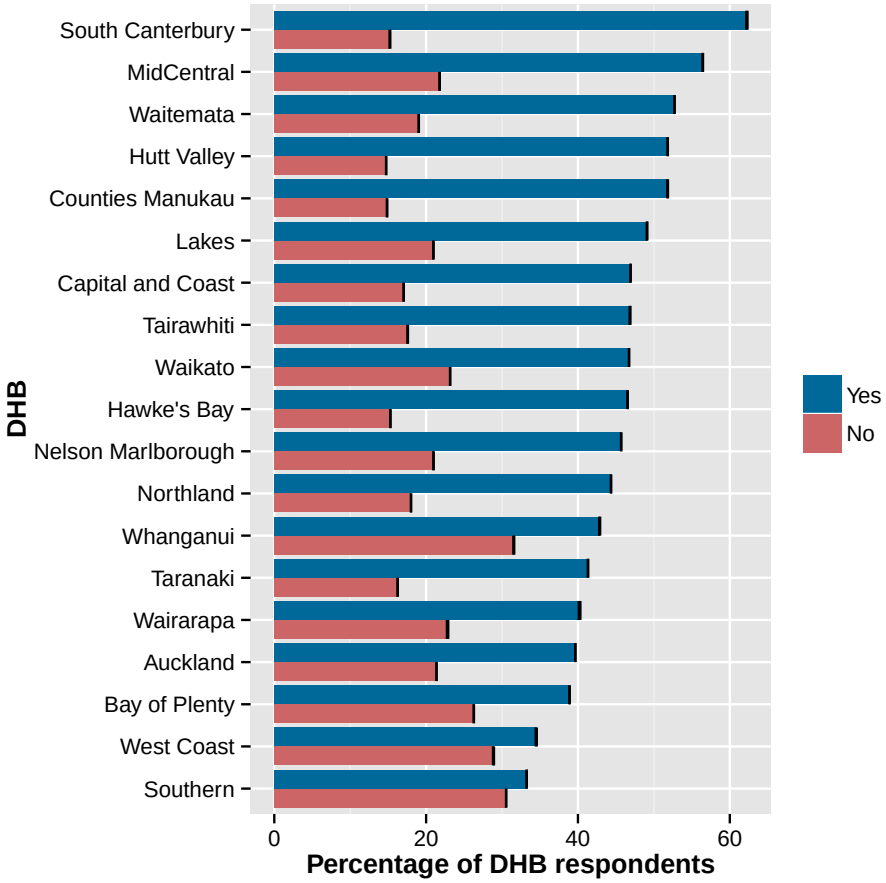

Figure 4.3.: Question 5 by DHB.

4.1.4. Question 6

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

Overall, 63% (95% CI: 62% – 64%) of respondents felt that their DHB had sought to foster and support the development of Clinical Leadership to some or a great extent. Only 12% (95% CI: 12% – 13%) of respondents felt that their DHB had not sought to do this. The percentage of respondents who felt that their DHB had sought to foster and support the development of Clinical Leadership to some or a great extent ranged from 56% (West Coast) to 75% (South Canterbury) (Figure 4.4).

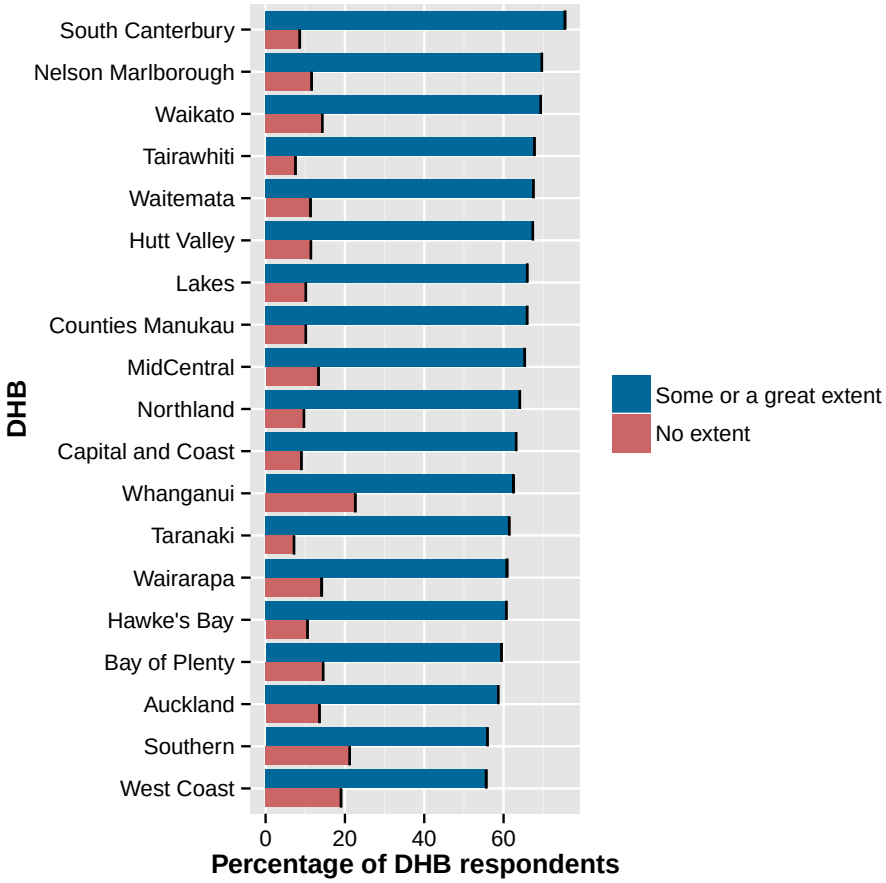

Figure 4.4.: Question 6 by DHB.

4.1.5. Question 8

To what extent have you sought to take up opportunities to work with other DHB staff, both clinical and managerial, to change the system where it would benefit patients?

A high percentage of respondents (75%, 95% CI: 74% – 76%) reported seeking to take up opportunities to some or a great extent to work with other DHB staff to change the system where it would benefit patients, while 14% (95% CI: 14% – 15%) reported not seeking to take up these opportunities. The percentages were high across all DHBs, ranging from 71% (Southern) to 85% (Wairarapa) (Figure 4.5).

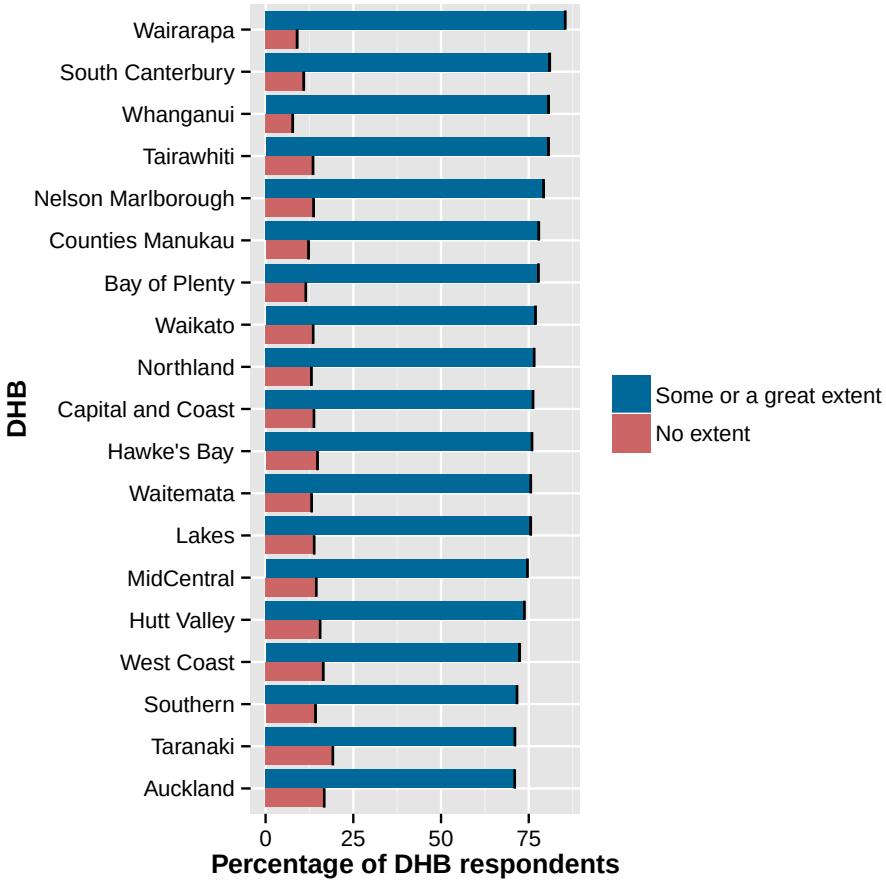

Figure 4.5.: Question 8 by DHB.

4.1.6. Question 9

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

According to 71% (95% CI: 70% – 72%) of respondents, health professionals in their DHB are involved with management in shared decision making, responsibility and accountability to some or a great extent. Only 12% (95% CI: 11% – 12%) felt this was not the case. DHBs ranged between 66% (West Coast) to 78% (Wairarapa) (Figure 4.6).

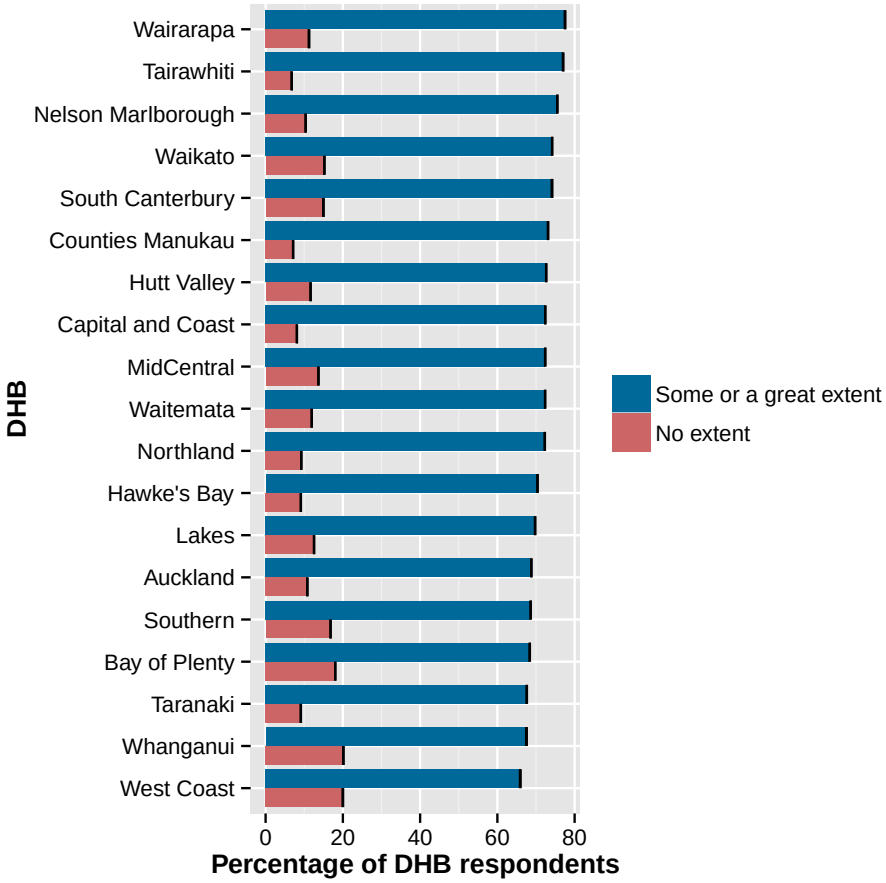

Figure 4.6.: Question 9 by DHB.

4.1.7. Question 10

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

61% (95% CI: 60% – 62%) of respondents reported that health professionals in their DHB are involved to some or a great extent as full participants in the design of organisational processes, with 17% (95% CI: 16% – 18%) reporting that health professionals were not involved. There was a high level of variation between DHBs, with the proportion of respondents from DHBs responding positively ranging from 55% (Southern) through to 73% (South Canterbury) (Figure 4.7).

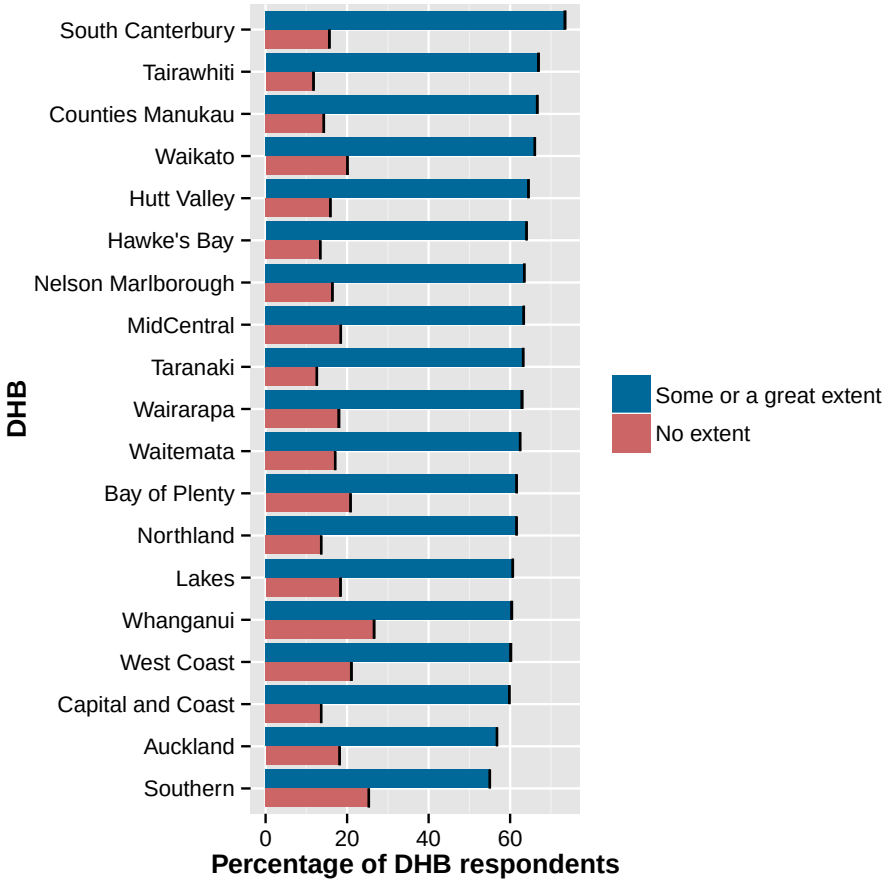

Figure 4.7.: Question 10 by DHB.

4.1.8. Question 11

To what extent do you believe that quality and safety is a goal of every clinical initiative in your DHB?

Virtually all (90% (95% CI: 89% – 91%)) of respondents believed that quality and safety was a goal of every clinical initiative in their DHB to some or a great extent. Only 5% (95% CI: 5% – 5%) believed that quality and safety were not a goal of every clinical initiative in their DHB.

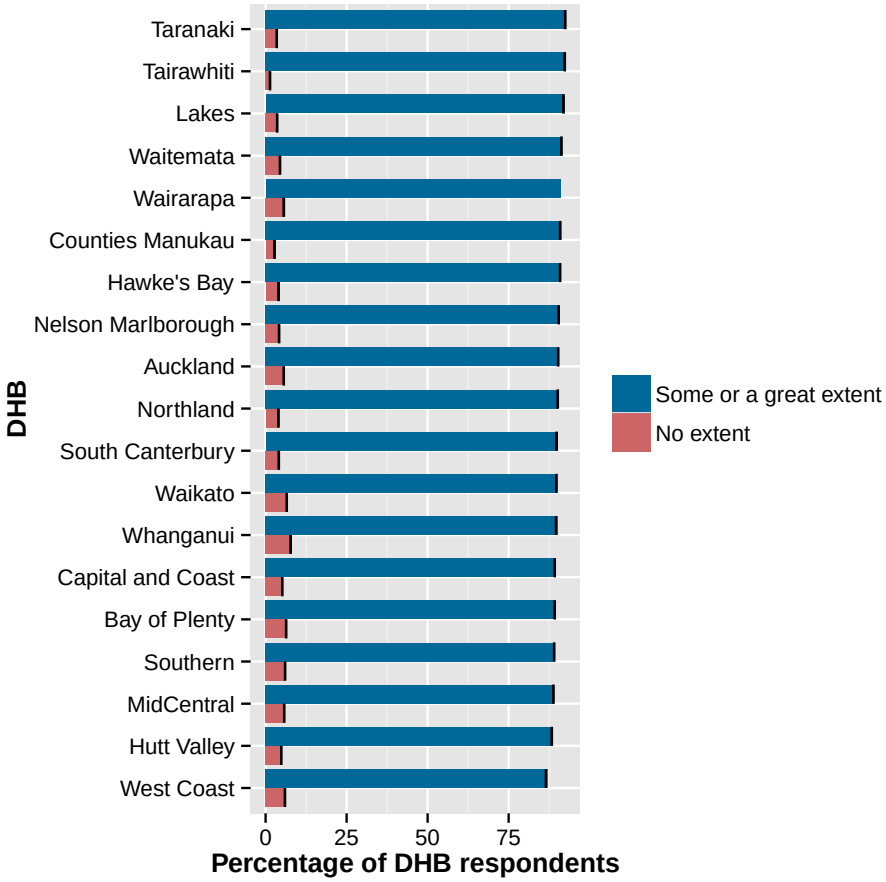

Figure 4.8.: Question 11 by DHB.

4.1.9. Question 12

To what extent do you believe that quality and safety is a goal of every clinical resourcing or support initiative in your DHB?

The vast majority (83% (95% CI: 82% – 83%)) of respondents believed that quality and safety was a goal of every clinical resourcing or support initiative in their DHB to some or a great extent. Only 8% (95% CI: 7% – 8%) believed that quality and safety were not a goal of every clinical resourcing or support initiative in their DHB. This was very consistently high across DHBs, although there was some variation (80% (Southern) to 88% (Wairarapa)) (Figure 4.9).

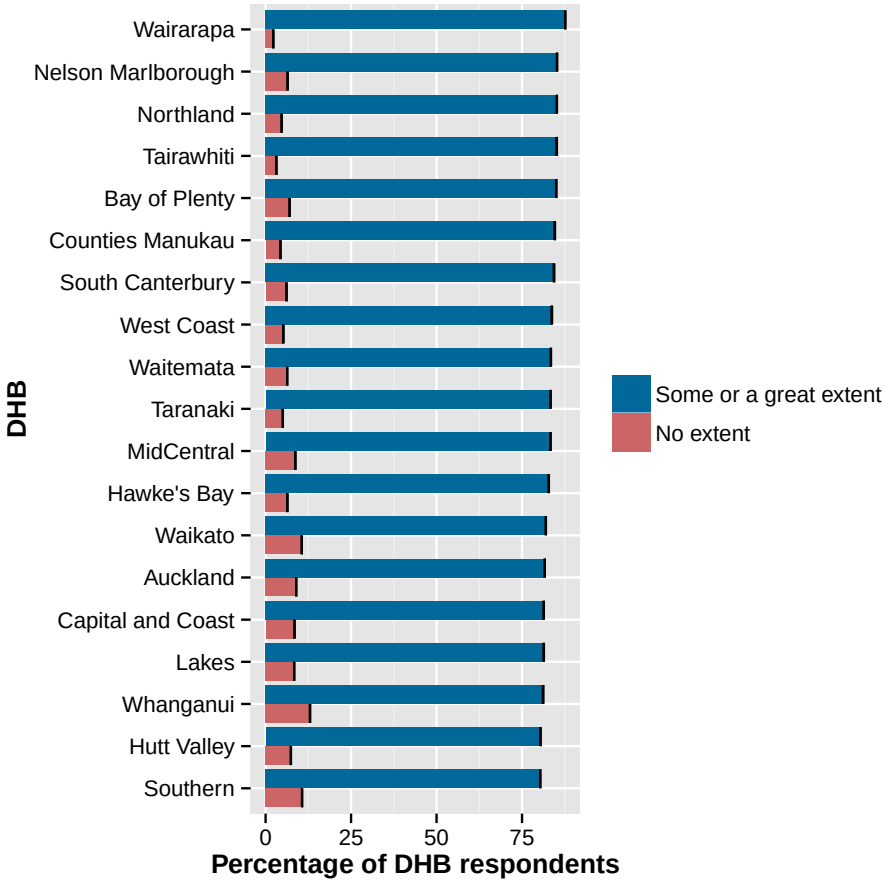

Figure 4.9.: Question 12 by DHB.

4.1.10. Question 13

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

The majority (69% (95% CI: 69% – 70%)) of respondents believed that their DHB had sought to give responsibility to their team for clinical service decision making in their clinical area to some or a great extent. However, 18% (95% CI: 17% – 18%) believed that their DHB had not sought to do this. There was variation across DHBs (63% (West Coast) to 80% (Wairarapa)) (Figure 4.10).

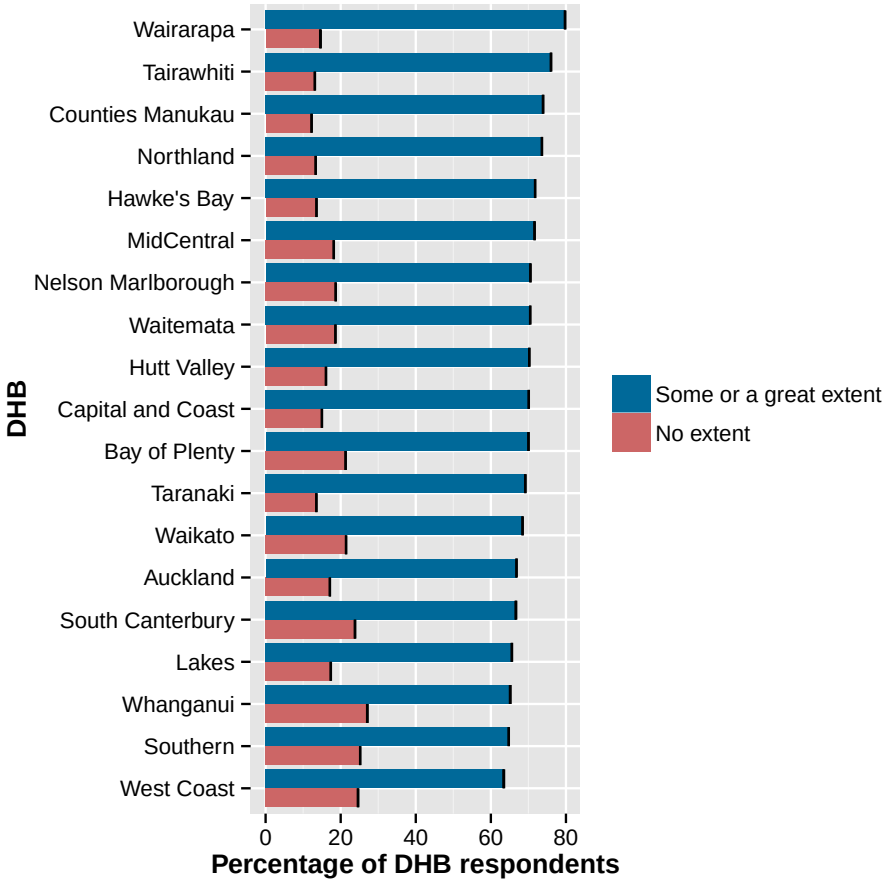

Figure 4.10.: Question 13 by DHB.

4.1.11. Question 14

Do you feel that your DHB provides sufficient support for you to engage in clinical leadership activities?

Very few respondents (36% (95% CI: 35% – 37%)) felt that their DHB provided sufficient support for them to engage in Clinical Leadership activities, with the majority (64% (95% CI: 63% – 65%)) answering 'No' to this question. There was substantial variation between DHBs, from 27% (Southern) to 44% (Hutt Valley). None of the DHBs obtained a positive response level over 50%, and none had a negative response level less than 50% (Figure 4.11).

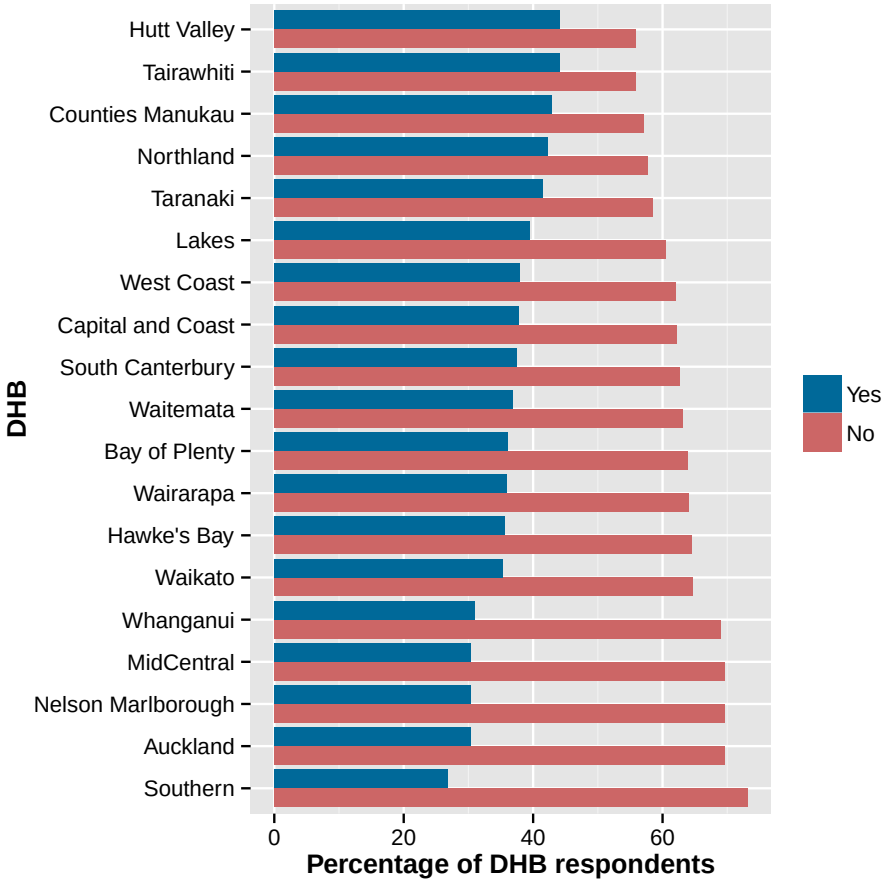

Figure 4.11.: Question 14 by DHB.

4.1.12. Question 15

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

Just over half of the respondents (57% (95% CI: 56% – 58%)) agreed with the statement that health professionals in their DHB work together as a well-coordinated team, with around a quarter (27% (95% CI: 26% – 28%)) disagreeing with the statement. Again, there was substantial variation across DHBs, ranging from 47% (West Coast) to 70% (Wairarapa). The level of negative responses largely mirrored this pattern across DHBs (Figure 4.12).

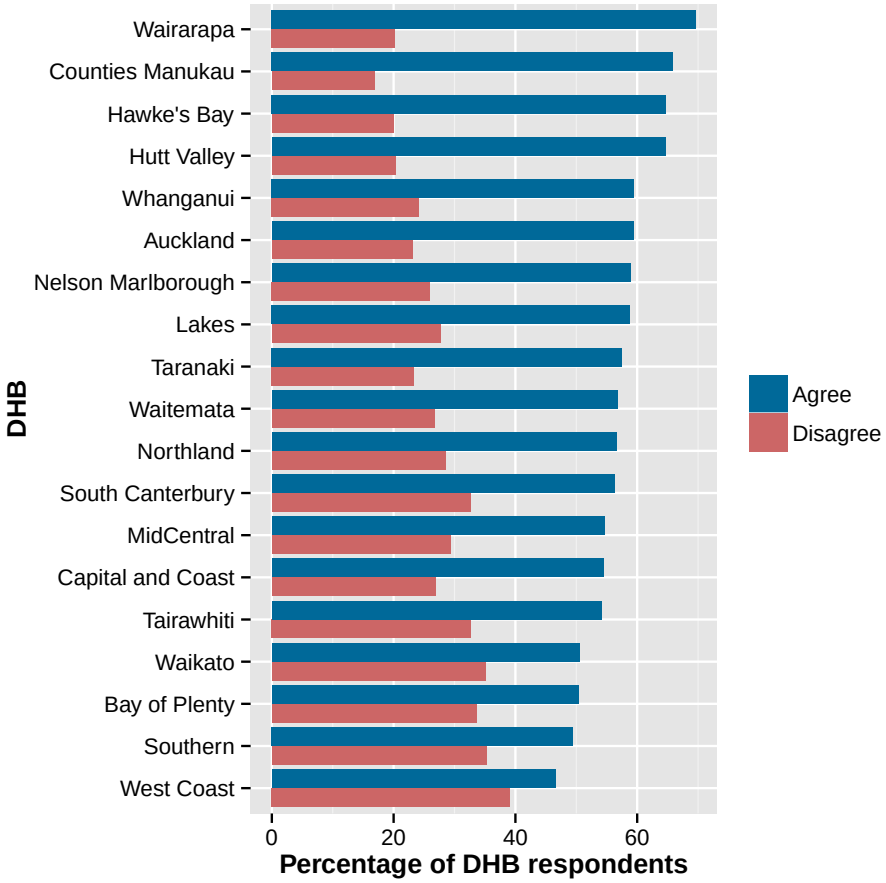

Figure 4.12.: Question 15 by DHB.

4.1.13. Question 16

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

Most of the respondents (70% (95% CI: 69% – 70%)) agreed with the statement that health professionals in this DHB involve patients and families in efforts to improve patient care, with 13% (95% CI: 12% – 14%) disagreeing with the statement. There was some variation across DHBs (from 63% (Southern) to 78% (Wairarapa)) (Figure 4.13).

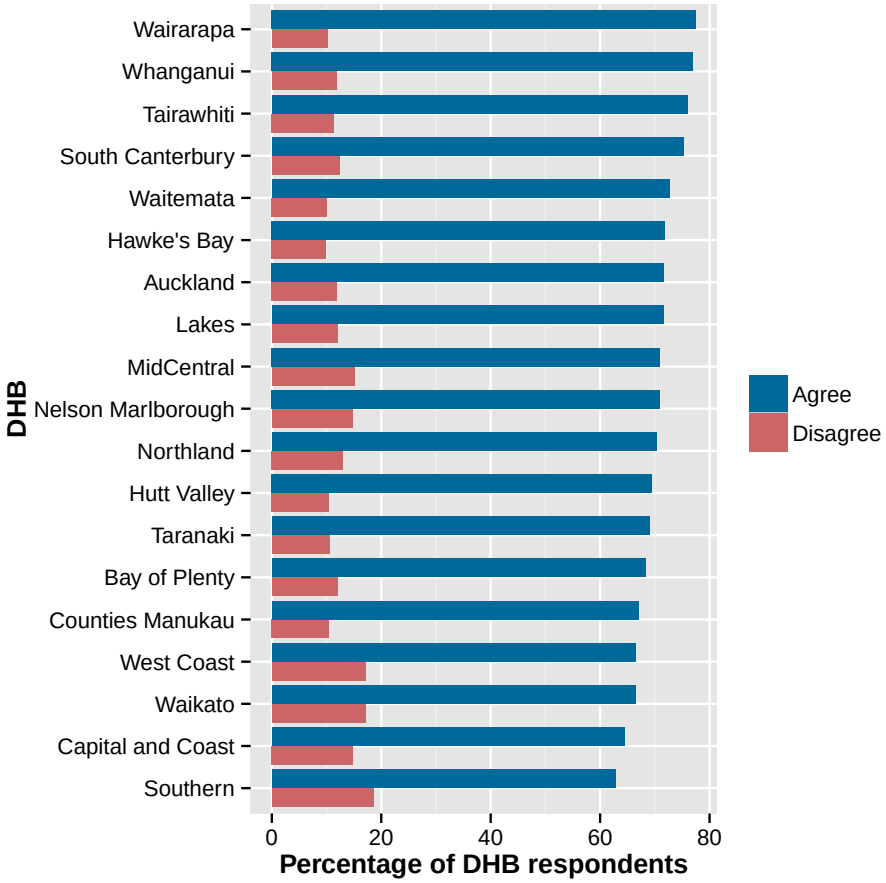

Figure 4.13.: Question 16 by DHB.

4.1.14. Question 17

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

Most of the respondents (69% (95% CI: 68% – 70%)) agreed with the statement that, in their clinical area, it is easy to speak up if they perceive a problem with patient care. However, 20% (95% CI: 19% – 21%) disagreed with the statement. The highest scoring DHB was Wairarapa (78%), with the lowest being Waikato (63%) (Figure 4.14).

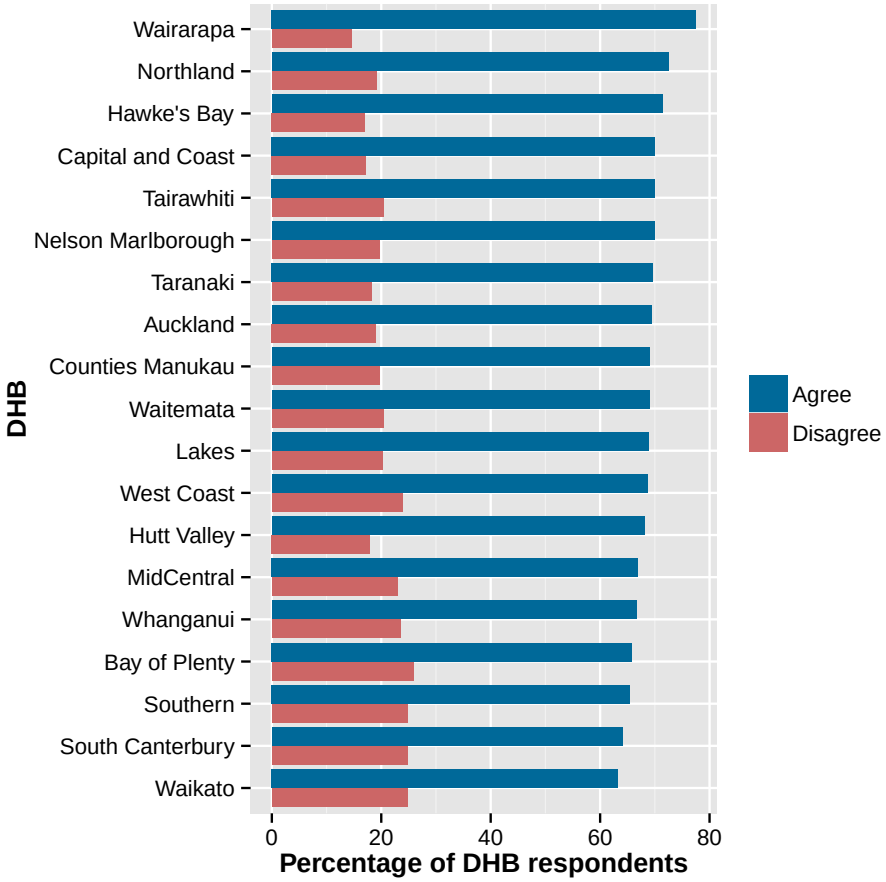

Figure 4.14.: Question 17 by DHB.

4.1.15. Mean DHB ranking and the Clinical Governance Development Index in the CGAP survey

The mean $CGDI_6$ score for the DHBs was 57%. Data from respondents with any missing responses (or 'Don't know' responses) in the items which made up the $CGDI_6$ scores were removed. This left 4988 records (48%).

The correlation between the $CGDI_6$ scores and the mean ranking for each DHB on CGAP survey items 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16 and 17[i] was -0.81 (95% confidence interval: -0.92 – -0.56, p = 0.0000). The negative correlation indicates that as $CGDI_6$ score increased, mean ranking (as a number) decreased. In other words, DHBs with a higher $CGDI_6$ score tended to have a better mean ranking on CGAP survey items than DHBs with a lower $CGDI_6$ score. The relationship between mean ranking and $CGDI_6$ score is shown in Table 4.1.

Table 4.1.: Mean ranking and $CGDI_6$ score for each DHB in the CGAP survey.

DHB	Mean ranking	Median ranking	Lowest ranking	Highest ranking	$CGDI_6$ score
Tairawhiti	4	4	15	2	61%
Wairarapa	5	1	15	1	62%
Counties Manukau	6	6	15	2	65%
South Canterbury	6	4	18	1	60%
Nelson Marlborough	7	7	17	2	56%
Waitemata	8	8	12	3	58%
Hawke's Bay	9	10	15	3	61%
Hutt Valley	9	8	18	1	59%
Northland	9	10	14	2	61%
MidCentral	10	10	17	2	55%
Waikato	10	10	19	3	54%
Lakes	11	12	16	3	55%
Taranaki	11	11	19	1	61%
Capital and Coast	12	12	18	4	58%
Whanganui	13	15	18	2	52%
Bay of Plenty	13	14	17	5	53%
Auckland	14	14	19	6	54%
West Coast	15	17	19	7	53%
Southern	17	18	19	6	49%

Comparison of the CGDI in the CGAP and Association of Salaried Medical Specialists (ASMS) survey

Comparison of DHB CGDI scores between the previous survey of ASMS members[36] and the current CGAP survey is not straightforward. As discussed above, CGAP used a unique version of the CGDI. Furthermore, the ASMS survey only included SMOs, whereas CGAP included members from all clinical groups in the health workforce. So that comparisons could be made, the $CGDI_6$ was calculated for each DHB[ii]. The $CGDI_6$ was then re-calculated for each DHB with CGAP data, but only including SMOs. After applying these exclusions, there were 1487 respondents from the ASMS survey used in this comparison and 1313 from the CGAP survey dataset. The results of this comparison are presented in Table 4.2.

[i] These were the quantitative items in the survey which did not deal with respondent demographics.
[ii] Except Canterbury, which was excluded because it did not take part in the CGAP survey.

Table 4.2.: Comparison of $CGDI_6$ scores for the CGAP and ASMS surveys. Note that the numbers have been rounded, which may make the difference not appear to equal the difference between the CGAP and ASMS $CGDI_6$ scores.

DHB	CGAP	ASMS Survey	Difference
West Coast	36%	41%	-5
Bay of Plenty	41%	38%	2
Southern	42%	42%	0
MidCentral	47%	43%	4
Wairarapa	49%	39%	10
Waikato	52%	46%	5
Hutt Valley	52%	49%	3
Nelson Marlborough	53%	41%	12
Auckland	53%	49%	4
Northland	55%	46%	9
Tairawhiti	56%	55%	1
Capital and Coast	57%	54%	2
Lakes	58%	49%	9
Whanganui	58%	40%	18
Waitemata	58%	47%	11
Hawke's Bay	61%	44%	17
Taranaki	64%	47%	17
South Canterbury	64%	44%	20
Counties Manukau	65%	52%	13
Mean	54%	46%	8

4.2. Professional Groups

Please note that a formal statistical analysis of the relationship between professional group and survey item response which adjusts for intra-DHB correlation and confounding by other demographic variables[iii] is given in section 4.3.

4.2.1. Question 3

> *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?*

Doctors more commonly reported being familiar with the concept of clinical leadership than the other professional groups, which showed similar levels of familiarity with the concept (Figure 4.15).

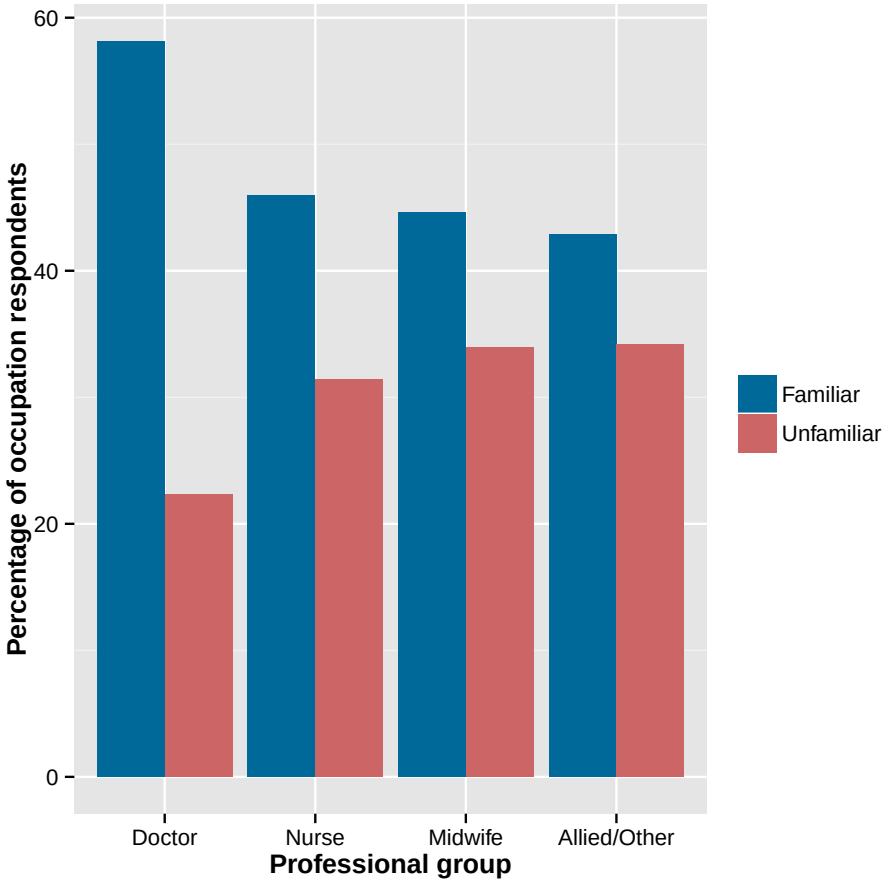

Figure 4.15.: Question 3 by Professional Group.

[iii] See section 2.1.3 for further detail.

4.2.2. Question 4

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

Reported belief that their DHB has worked to enable strong clinical leadership and decision making throughout the organisation did not vary substantially by professional group, although nurses did report this slightly more often than other groups (Figure 4.16).

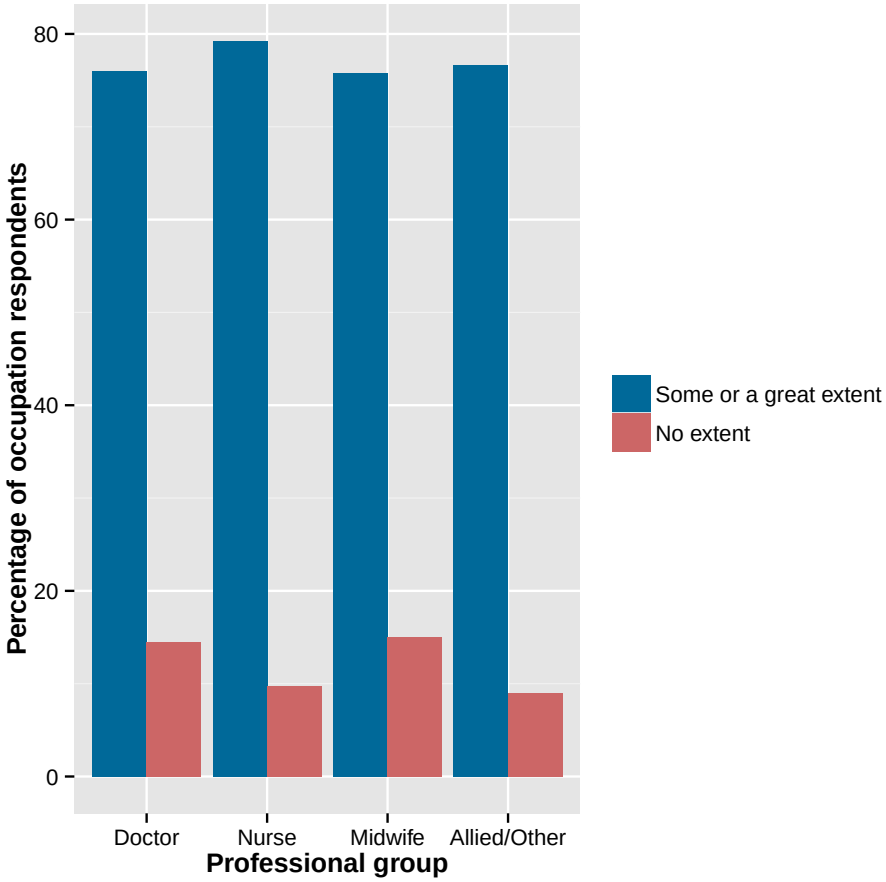

Figure 4.16.: Question 4 by Professional Group.

4.2.3. Question 5

To your knowledge, has your DHB established governance structures that ensure a partnership between health professionals and management?

The was some small variation in the percentage of respondents from each professional group reporting that their DHB had established governance structures that ensure a partnership between health professionals and management, with doctors and allied/other staff more likely to report this as being the case. Interestingly, midwives were more likely to report this not being the case, despite not having the lowest positive response percentage (Figure 4.17).

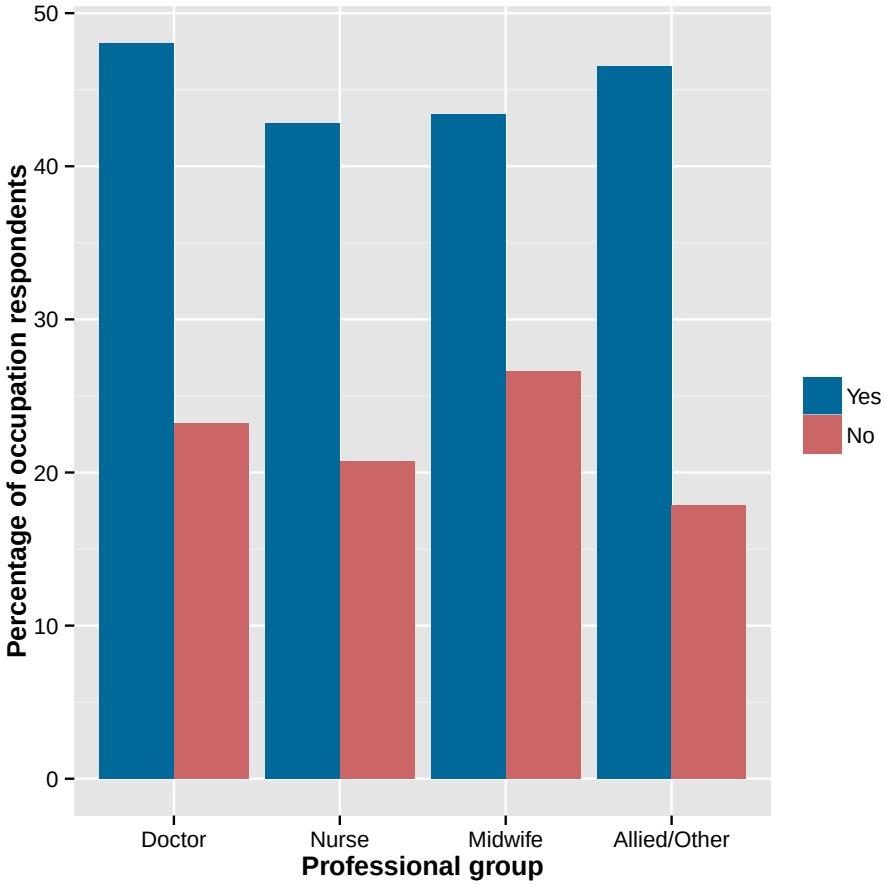

Figure 4.17.: Question 5 by Professional Group.

4.2.4. Question 6

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

There were only minor differences between professional groups in their responses to this item, with allied/other staff less likely to think that their DHB management has sought to foster and support the development of clinical leadership (Figure 4.18).

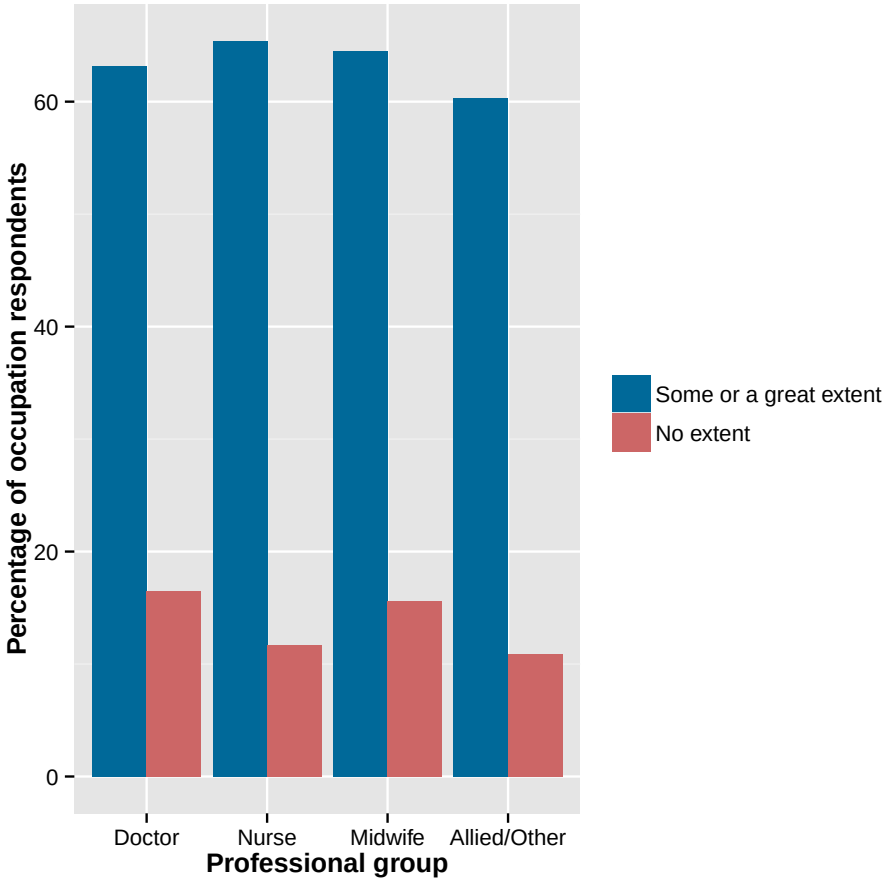

Figure 4.18.: Question 6 by Professional Group.

4.2.5. Question 8

To what extent have you sought to take up opportunities to work with other DHB staff, both clinical and managerial, to change the system where it would benefit patients?

Doctors were slightly more likely to report seeking to take up opportunities to work with other DHB staff, both clinical and managerial, to change the system where it would benefit patients, with negligable differences between the other professional groups (Figure 4.19).

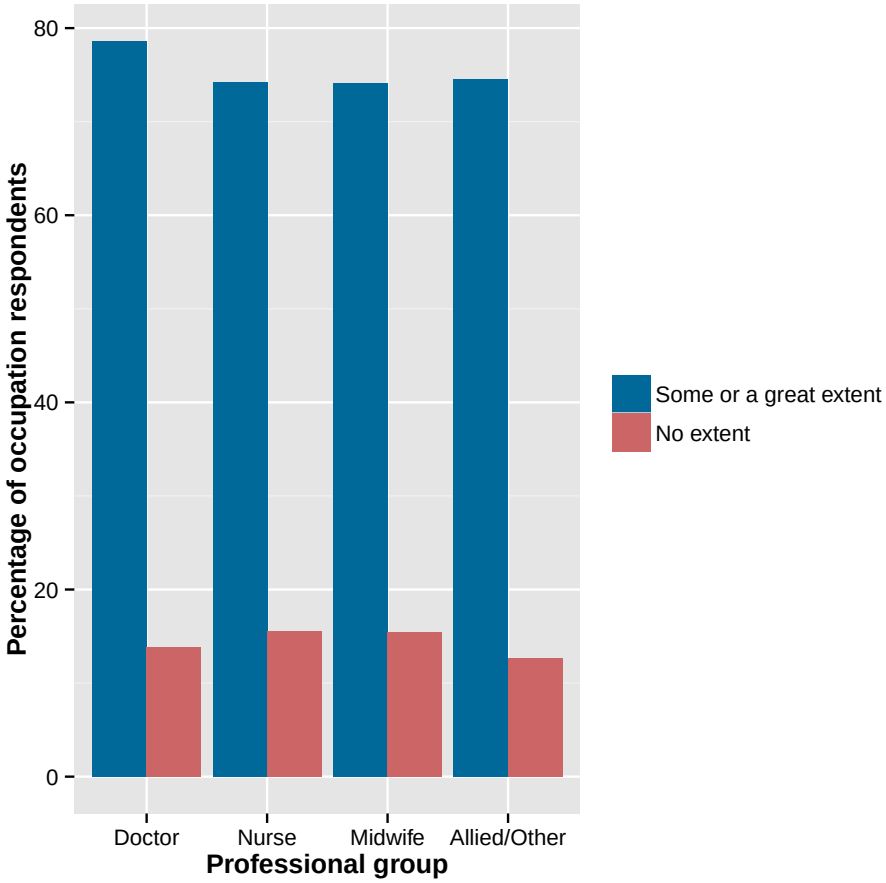

Figure 4.19.: Question 8 by Professional Group.

4.2.6. Question 9

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

There was a very small level of variation between the professional groups, with doctors slightly more likely to report that health professionals in their DHB are involved in a partnership with management with shared decision making, responsibility and accountability than midwives and allied/other staff (Figure 4.20).

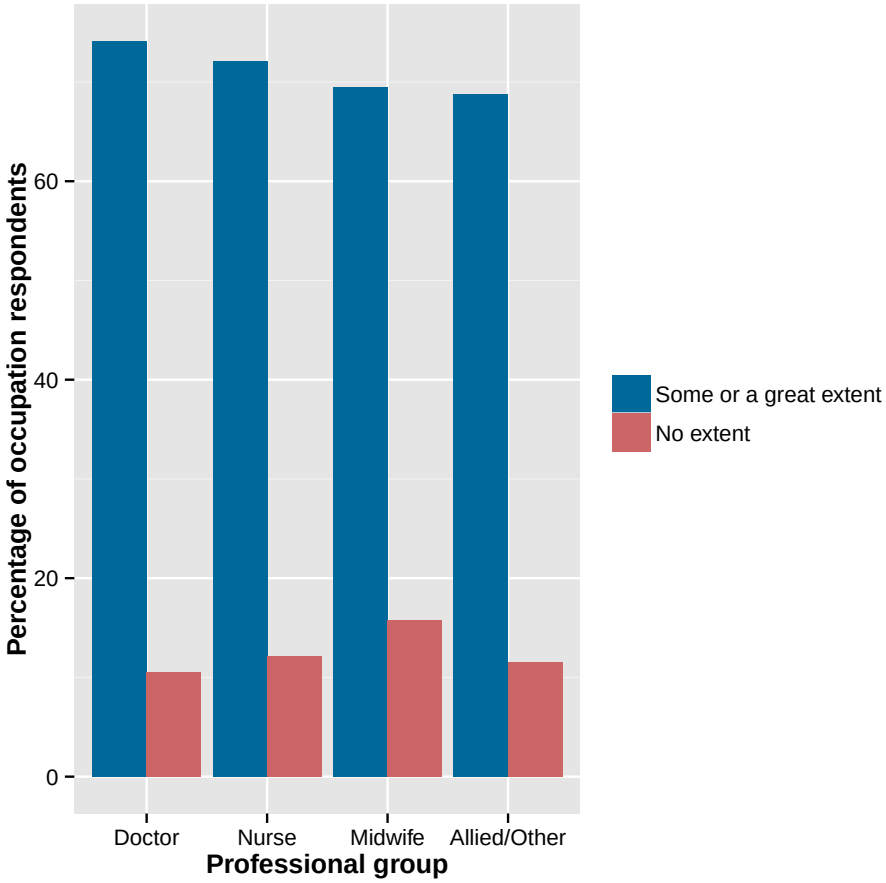

Figure 4.20.: Question 9 by Professional Group.

4.2.7. Question 10

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

Midwives were less likely to report feeling that health professionals in their DHB were involved as full active participants in the design of organisational processes than the other professional groups (Figure 4.21).

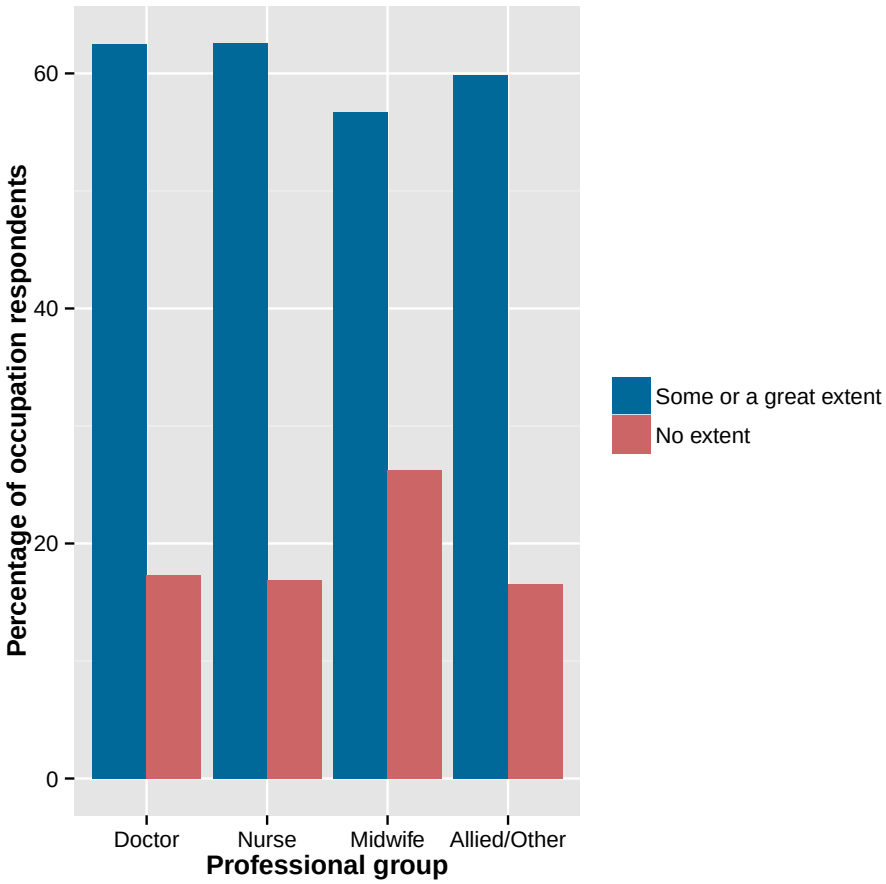

Figure 4.21.: Question 10 by Professional Group.

4.2.8. Question 11

To what extent do you believe that quality and safety is a goal of every clinical initiative in your DHB?

Doctors were slightly less likely to report that quality and safety is a goal of every clinical initiative in their DHB compared to other professional groups, particularly nurses (Figure 4.22).

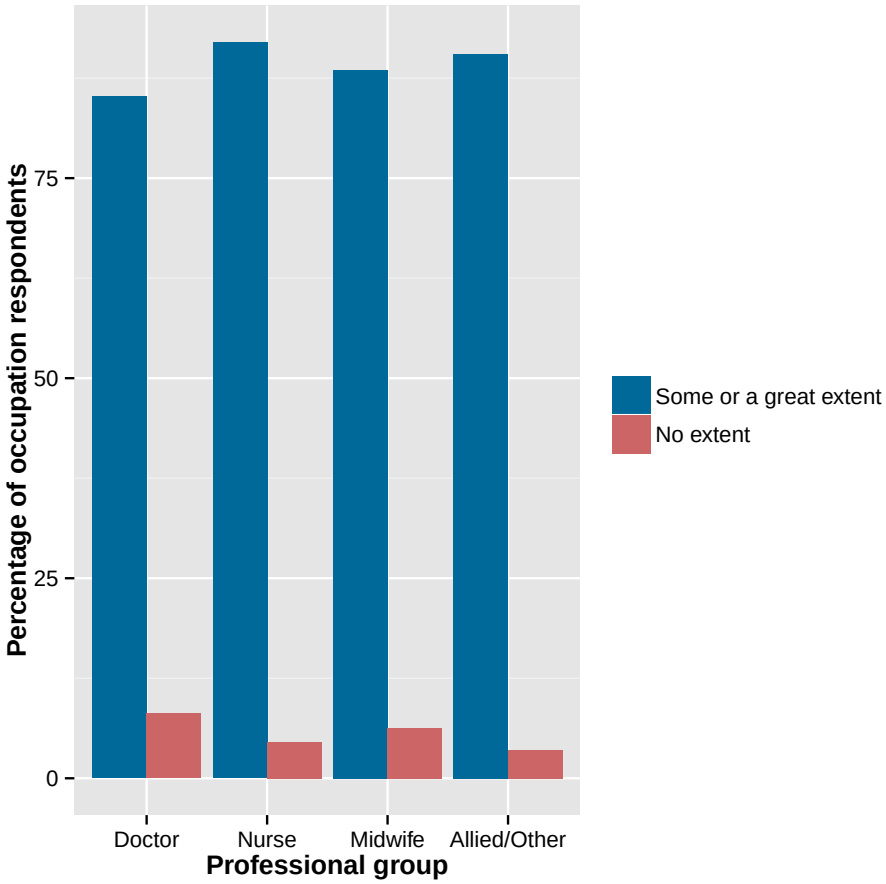

Figure 4.22.: Question 11 by Professional Group.

4.2.9. Question 12

To what extent do you believe that quality and safety is a goal of every clinical resourcing or support initiative in your DHB?

Nurses were more likely, and doctors less, to report that they believed quality and safety is a goal of every clinical resourcing or support initiative in their DHB (Figure 4.23).

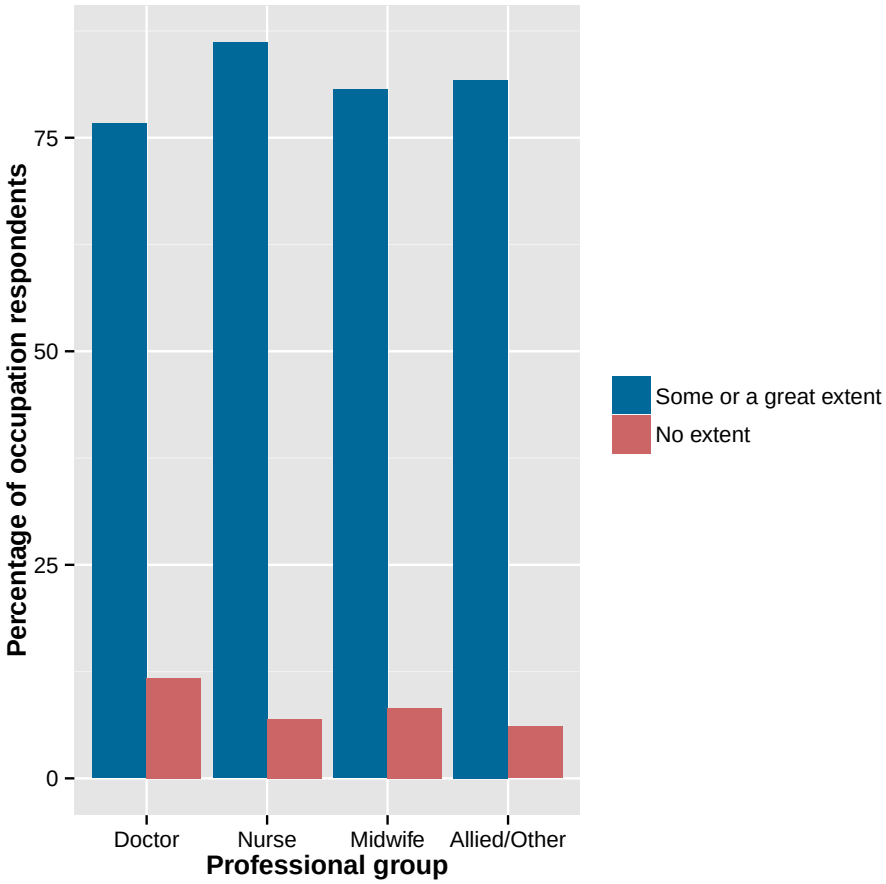

Figure 4.23.: Question 12 by Professional Group.

4.2.10. Question 13

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

Nurses were slightly more likely to report that their DHB sought to give responsibility to their team for clinical service decision in their clinical area compared to the other professional groups (Figure 4.24).

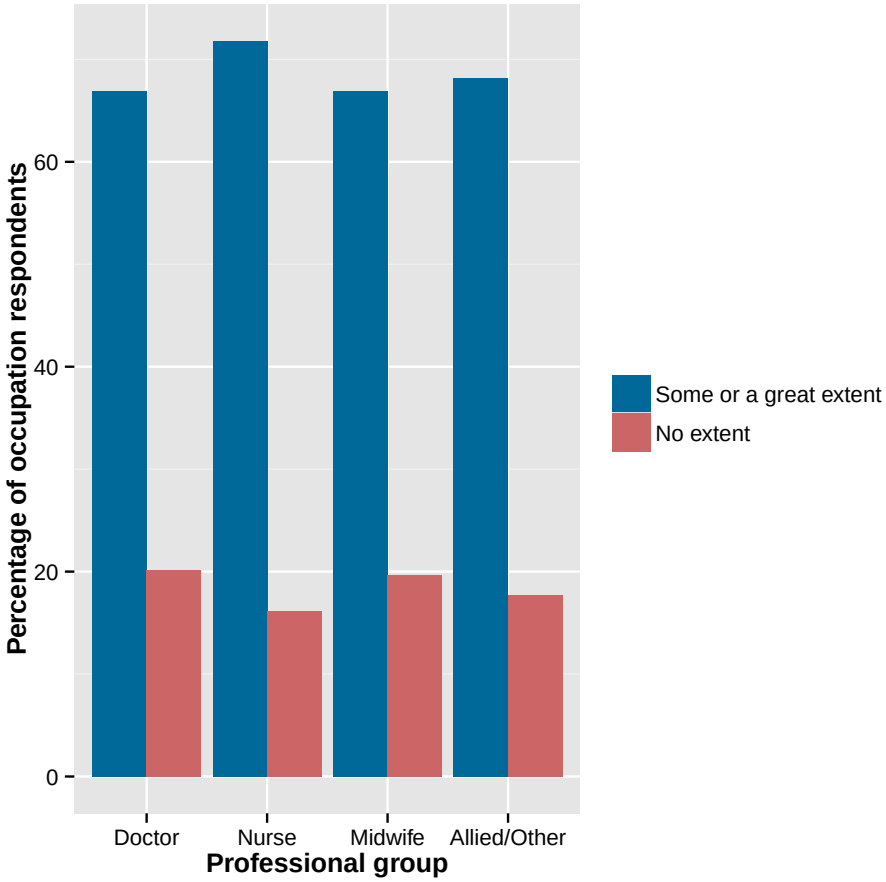

Figure 4.24.: Question 13 by Professional Group.

4.2.11. Question 14

Do you feel that your DHB provides sufficient support for you to engage in clinical leadership activities?

All of the professional groups largely felt that their DHB did not provide sufficient support for them to engage in clinical leadership activities, with doctors reporting this slightly more than the other professional groups (Figure 4.25).

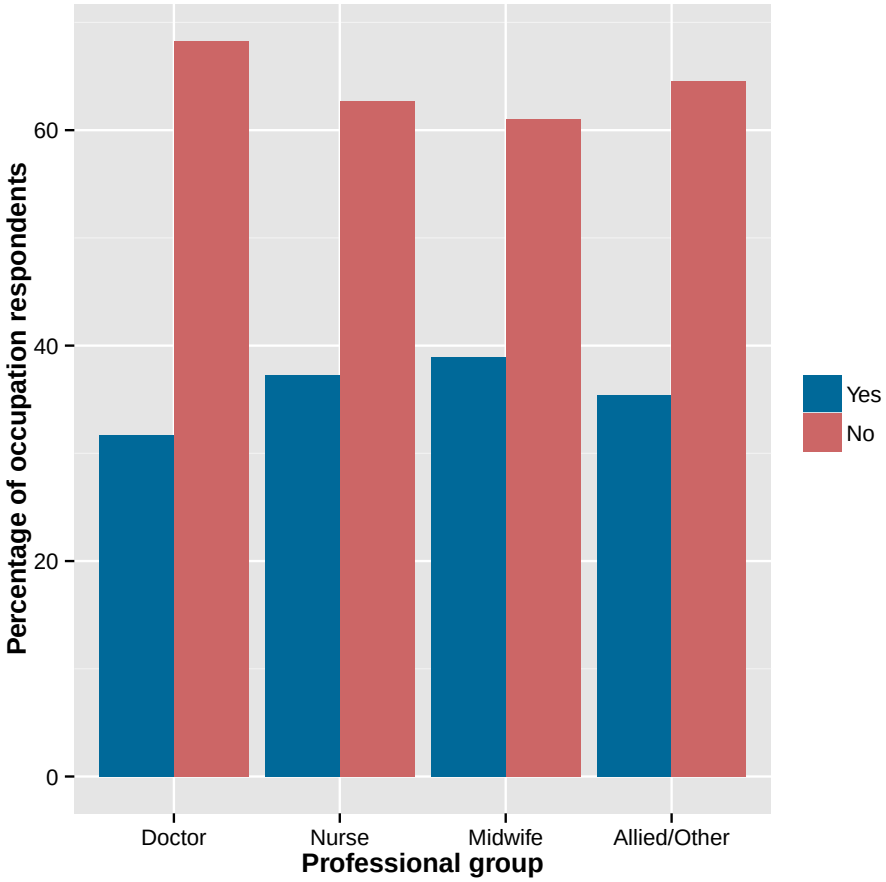

Figure 4.25.: Question 14 by Professional Group.

4.2.12. Question 15

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

There was little variation between professional groups for this item, although midwives were slightly more likely to report that health professionals in their DHB worked together as a well-coordinated team (Figure 4.26).

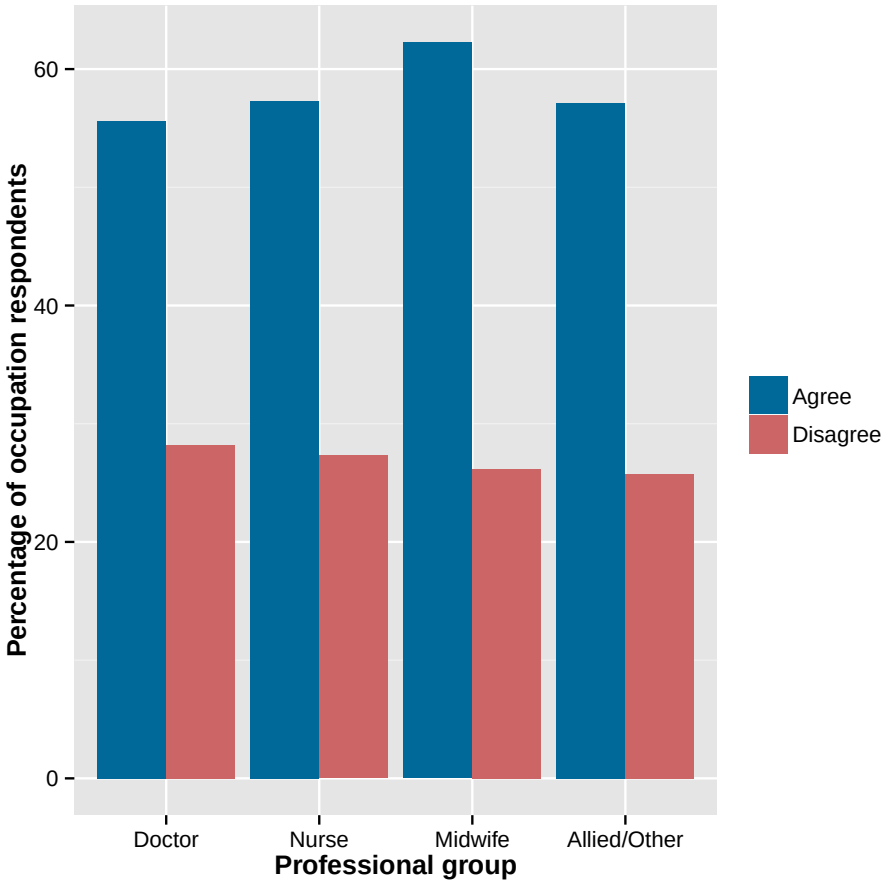

Figure 4.26.: Question 15 by Professional Group.

4.2.13. Question 16

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

Doctors and, to a lesser extent, allied/other staff, were less likely than nurses to report that health professionals in their DHB involve patients and families in efforts to improve patient care (Figure 4.27).

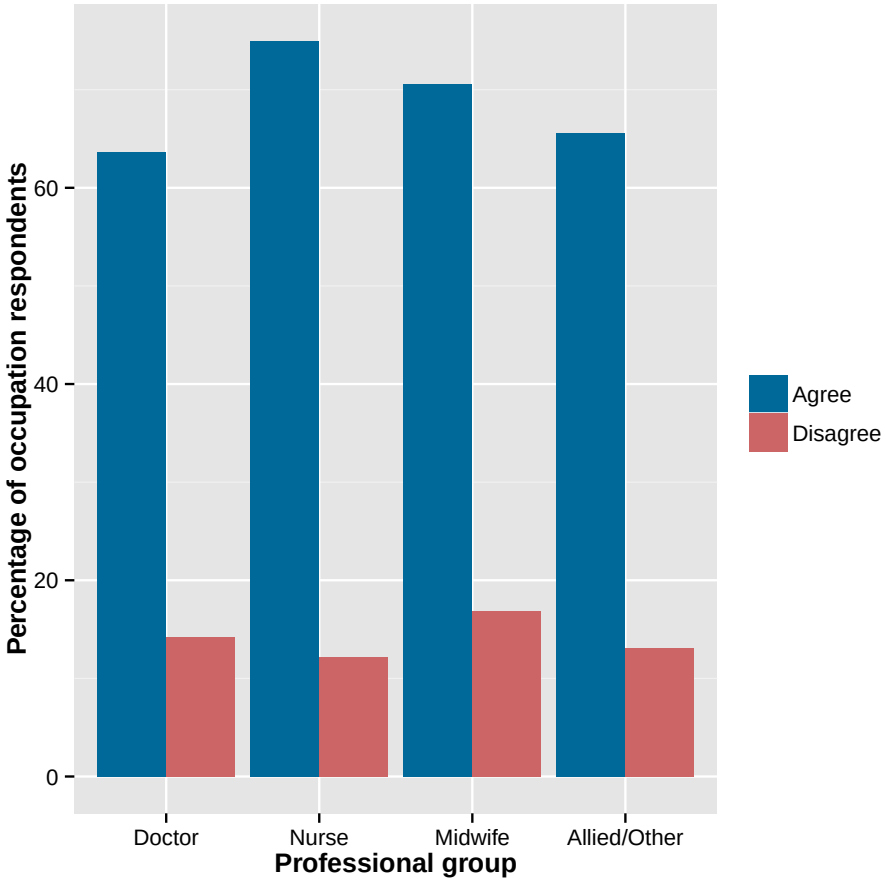

Figure 4.27.: Question 16 by Professional Group.

4.2.14. Question 17

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

Nurses reported that, in this clinical area, it is easy to speak up if they perceive a problem with patient care in their DHB more often than the other professional groups, particularly allied/other staff (Figure 4.28).

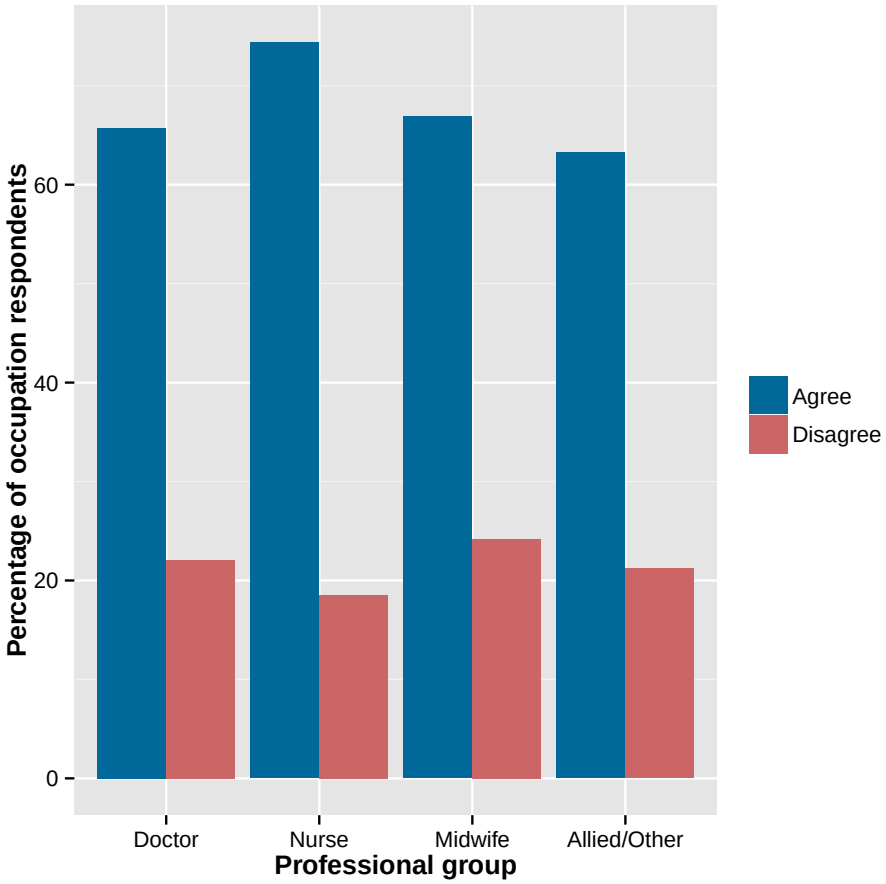

Figure 4.28.: Question 17 by Professional Group.

4.3. Predictors of response to individual questions

4.3.1. Question 3

> *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?*

There are a number of interesting results presented in Table 4.3:

- Female respondents were less likely to report high levels of familiarity with the concept of clinical leadership compared to male respondents;
- Nurses, midwives and allied/other staff were less likely to report high levels of familiarity with the concept of clinical leadership compared to doctors;
- Likelihood of reporting high levels of familiarity with the concept of clinical leadership appeared to increase with age and years of experience.

Table 4.3.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and familiarity with the concept of clinical leadership.

	Odds ratio	**95% CI**	***p* =**
Gender			
Male	reference		
Female	0.86	0.78–0.95	0.0024
Age			
20–29	reference		
30–39	1.24	1.06–1.44	0.0061
40–49	1.40	1.21–1.63	0.0000
50–59	1.57	1.34–1.84	0.0000
60 and over	1.42	1.17–1.71	0.0003
Years of experience			
Under 5 years	reference		
5–15 years	1.10	0.99–1.23	0.0856
More than 15 years	1.25	1.11–1.42	0.0003
Professional group			
Doctor	reference		
Nurse	0.60	0.54–0.67	0.0000
Midwife	0.54	0.43–0.69	0.0000
Allied/Other	0.58	0.52–0.65	0.0000

4.3.2. Question 4

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

The key results presented in Table 4.4 are:

- Likelihood of reporting belief that their DHB had worked to enable strong clinical leadership and decision making throughout the organisation to a great extent appeared to increase with age;
- Compared to doctors, nurses and allied/other staff were more likely to report believing that their DHB had worked to a great extent to enable strong clinical leadership and decision making throughout the organisation.

Table 4.4.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and reported extent that their DHB has worked to enable strong clinical leadership and decision making throughout the organisation.

	Odds ratio	**95% CI**	***p* =**
Gender			
Male	reference		
Female	1.02	0.90–1.17	0.7528
Age			
20–29	reference		
30–39	0.92	0.74–1.13	0.4135
40–49	1.07	0.87–1.31	0.5452
50–59	1.29	1.04–1.60	0.0230
60 and over	1.49	1.15–1.92	0.0023
Years of experience			
Under 5 years	reference		
5–15 years	0.85	0.73–0.98	0.0296
More than 15 years	1.03	0.87–1.22	0.7165
Professional group			
Doctor	reference		
Nurse	1.27	1.09–1.47	0.0020
Midwife	0.83	0.62–1.11	0.2116
Allied/Other	1.41	1.21–1.64	0.0000

4.3.3. Question 5

To your knowledge, has your DHB established governance structures that ensure a partnership between health professionals and management?

The key results presented in Table 4.5 are:

- Female respondents were more likely to report that their DHB had established governance structures that ensure a partnership between health professionals and management than male respondents;
- The likelihood of reporting this increased with age but not years of experience;
- Compared to doctors, nurses and midwives were less likely to report that their DHB had established governance structures that ensure a partnership between health professionals and management.

Table 4.5.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and whether the respondent reported that their DHB had established governance structures that ensure a partnership between health professionals and management.

	Odds ratio	95% CI	p =
Gender			
Male	reference		
Female	1.28	1.11–1.48	0.0007
Age			
20–29	reference		
30–39	1.17	0.92–1.50	0.2087
40–49	1.47	1.15–1.87	0.0020
50–59	1.75	1.36–2.25	0.0000
60 and over	1.87	1.38–2.53	0.0000
Years of experience			
Under 5 years	reference		
5–15 years	0.92	0.77–1.09	0.3230
More than 15 years	1.13	0.94–1.37	0.2006
Professional group			
Doctor	reference		
Nurse	0.83	0.71–0.98	0.0314
Midwife	0.60	0.44–0.83	0.0019
Allied/Other	1.07	0.91–1.27	0.4080

4.3.4. Question 6

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

The main points of interest from the results presented in Table 4.6 are:

- The likelihood of reporting that management within their DHB had sought to foster and support the development of clinical leadership increased with respondent age but not years of experience;
- Compared to doctors, nurses and allied/other staff were more likely to report that management within their DHB had sought to foster and support the development of clinical leadership.

Table 4.6.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and reporting that management within the respondent's DHB had sought to foster and support the development of clinical leadership.

	Odds ratio	**95% CI**	***p* =**
Gender			
Male	reference		
Female	1.01	0.88–1.15	0.9339
Age			
20–29	reference		
30–39	1.04	0.83–1.30	0.7352
40–49	1.25	1.00–1.56	0.0472
50–59	1.52	1.21–1.92	0.0003
60 and over	1.59	1.22–2.08	0.0007
Years of experience			
Under 5 years	reference		
5–15 years	0.95	0.81–1.12	0.5590
More than 15 years	1.16	0.98–1.38	0.0916
Professional group			
Doctor	reference		
Nurse	1.27	1.10–1.48	0.0017
Midwife	0.93	0.69–1.26	0.6585
Allied/Other	1.37	1.18–1.60	0.0001

4.3.5. Question 8

To what extent have you sought to take up opportunities to work with other DHB staff, both clinical and managerial, to change the system where it would benefit patients?

Summarising the results presented in Table 4.7:

- Female respondents were less likely to report that they sought to a great extent to take up opportunities to work with other DHB staff, both clinical and managerial, to change the system where it would benefit patients compared to male respondents;
- The likelihood of reporting this increased with respondent age and years of experience, although this increase disappeared for the 60 and over age group;
- Compared to doctors, nurses were less likely to report that they sought to a great extent to take up opportunities to work with other DHB staff, both clinical and managerial, to change the system where it would benefit patients. The other professional groups were not statistically significantly different from doctors in this likelihood.

Table 4.7.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and likelihood of reporting that they sought to a great extent to take up opportunities to work with other DHB staff, both clinical and managerial, to change the system where it would benefit patients.

	Odds ratio	95% CI	*p* =
Gender			
Male	reference		
Female	0.77	0.68–0.86	0.0000
Age			
20–29	reference		
30–39	1.39	1.16–1.68	0.0004
40–49	1.80	1.50–2.16	0.0000
50–59	1.65	1.36–1.99	0.0000
60 and over	1.19	0.95–1.49	0.1285
Years of experience			
Under 5 years	reference		
5–15 years	1.27	1.12–1.45	0.0003
More than 15 years	1.59	1.38–1.84	0.0000
Professional group			
Doctor	reference		
Nurse	0.81	0.71–0.92	0.0014
Midwife	0.81	0.62–1.05	0.1113
Allied/Other	1.00	0.88–1.14	0.9778

4.3.6. Question 9

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

The results presented in Table 4.8 show a slightly different picture to the previous analyses:

- No increase in likelihood is observed with increasing age;
- Compared to respondents who had under five years of experience, respondents with 5-15 years of experience were less likely to report that health professionals in their DHB were involved to a great extent in a partnership with management with shared decision making, responsibility and accountability. Respondents 60 and over were not statistically significantly different from respondents with under five years of experience;
- Only midwives were statistically significantly different in their likelihood to doctors, being less likely to report that health professionals in their DHB were involved to a great extent in a partnership with management with shared decision making, responsibility and accountability.

Table 4.8.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and likelihood of reporting that health professionals in the respondent's DHB were involved to a great extent in a partnership with management with shared decision making, responsibility and accountability.

	Odds ratio	95% CI	p =
Gender			
Male	reference		
Female	1.06	0.93–1.21	0.4083
Age			
20–29	reference		
30–39	0.95	0.77–1.19	0.6803
40–49	1.00	0.80–1.23	0.9660
50–59	1.14	0.91–1.42	0.2652
60 and over	1.16	0.89–1.52	0.2685
Years of experience			
Under 5 years	reference		
5–15 years	0.78	0.67–0.91	0.0016
More than 15 years	0.96	0.81–1.14	0.6458
Professional group			
Doctor	reference		
Nurse	0.93	0.79–1.08	0.3169
Midwife	0.64	0.48–0.87	0.0044
Allied/Other	0.96	0.82–1.12	0.5811

4.3.7. Question 10

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

Results for this model are presented in Table 4.9. Of note:

- The typical increase in likelihood with age is observed here;
- Compared to respondents who had under five years of experience, respondents with 5-15 years of experience were less likely to report that health professionals in their DHB were involved as full active participants in the design of organisational processes. Respondents 15 and over were not statistically significantly different from respondents with under five years of experience;
- Only midwives were statistically significantly different in their likelihood to doctors, being less likely to report that health professionals in their DHB were involved to a great extent as full active participants in the design of organisational processes.

Table 4.9.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and likelihood of reporting that health professionals in the respondent's DHB were involved as full active participants in the design of organisational processes.

	Odds ratio	95% CI	*p* =
Gender			
Male	reference		
Female	1.07	0.94–1.22	0.3358
Age			
20–29	reference		
30–39	1.12	0.90–1.39	0.3034
40–49	1.14	0.92–1.41	0.2290
50–59	1.31	1.05–1.64	0.0174
60 and over	1.49	1.15–1.94	0.0030
Years of experience			
Under 5 years	reference		
5–15 years	0.83	0.71–0.97	0.0177
More than 15 years	0.89	0.75–1.05	0.1679
Professional group			
Doctor	reference		
Nurse	1.00	0.86–1.16	0.9841
Midwife	0.58	0.43–0.77	0.0002
Allied/Other	0.99	0.85–1.15	0.9018

4.3.8. Question 11

To what extent do you believe that quality and safety is a goal of every clinical initiative in your DHB?

Results for this model are presented in Table 4.10. Of note:

- Female respondents are slightly more likely to report that they believe that quality and safety is a goal of every clinical initiative in their DHB to a great extent compared to male respondents;
- There was no statistically significant age effect, with only the sixty and over age group having an increased likelihood compared to the 20-29 age group. Respondents with five or more years of experience had a decreased likelihood compared to respondents with under five years experience;
- Compared to doctors, all of the other professional groups were more likely to report that they believe that quality and safety is a goal of every clinical initiative in their DHB to a great extent.

Table 4.10.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and likelihood of reporting that they believe that quality and safety is a goal of every clinical initiative in their DHB to a great extent.

	Odds ratio	95% CI	p =
Gender			
Male	reference		
Female	1.14	1.02–1.28	0.0242
Age			
20–29	reference		
30–39	0.85	0.71–1.01	0.0686
40–49	0.91	0.76–1.09	0.2994
50–59	1.14	0.95–1.37	0.1745
60 and over	1.30	1.04–1.61	0.0191
Years of experience			
Under 5 years	reference		
5–15 years	0.79	0.70–0.90	0.0003
More than 15 years	0.81	0.70–0.93	0.0034
Professional group			
Doctor	reference		
Nurse	1.61	1.42–1.84	0.0000
Midwife	1.43	1.10–1.85	0.0078
Allied/Other	1.57	1.38–1.79	0.0000

4.3.9. Question 12

To what extent do you believe that quality and safety is a goal of every clinical resourcing or support initiative in your DHB?

Results for this model are presented in Table 4.11. Of note:

- There was an increase in likelihood with age. However, more years of experience was associated with a decreased likelihood of a respondent reporting that they believe that quality and safety is a goal of every clinical resourcing or support initiative in their DHB to a great extent;
- Compared to doctors, all of the other professional groups (particularly nurses) were more likely to report that they believe that quality and safety is a goal of every clinical resourcing or support initiative in their DHB to a great extent.

Table 4.11.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and respondents reporting that they believe that quality and safety is a goal of every clinical resourcing or support initiative in their DHB to a great extent.

	Odds ratio	**95% CI**	***p* =**
Gender			
Male	reference		
Female	1.11	0.98–1.26	0.0867
Age			
20–29	reference		
30–39	0.90	0.74–1.09	0.2960
40–49	1.04	0.86–1.26	0.6713
50–59	1.35	1.11–1.64	0.0031
60 and over	1.78	1.41–2.25	0.0000
Years of experience			
Under 5 years	reference		
5–15 years	0.72	0.63–0.82	0.0000
More than 15 years	0.65	0.56–0.75	0.0000
Professional group			
Doctor	reference		
Nurse	2.11	1.83–2.43	0.0000
Midwife	1.74	1.32–2.31	0.0001
Allied/Other	1.84	1.60–2.12	0.0000

4.3.10. Question 13

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

Results for this model are presented in Table 4.12. Of note:

- The only statistically significant findings were that, compared to doctors, nurses and allied/other staff were slightly more likely to report that their DHB sought to give responsibility to their team for clinical service decision making in their clinical area to a greater extent.

Table 4.12.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and likelihood of respondents reporting that their DHB sought to give responsibility to their team for clinical service decision making in their clinical area to a greater extent.

	Odds ratio	**95% CI**	***p* =**
Gender			
Male	reference		
Female	1.02	0.91–1.15	0.7106
Age			
20–29	reference		
30–39	1.04	0.86–1.26	0.6508
40–49	0.97	0.80–1.16	0.7181
50–59	1.09	0.90–1.32	0.3833
60 and over	1.06	0.84–1.33	0.6392
Years of experience			
Under 5 years	reference		
5–15 years	0.86	0.75–0.98	0.0272
More than 15 years	0.88	0.76–1.02	0.0917
Professional group			
Doctor	reference		
Nurse	1.19	1.04–1.36	0.0118
Midwife	1.07	0.81–1.40	0.6402
Allied/Other	1.17	1.02–1.34	0.0258

4.3.11. Question 14

Do you feel that your DHB provides sufficient support for you to engage in clinical leadership activities?

Results for this model are presented in Table 4.13. Of note:

- Compared to doctors, nurses and allied/other staff were slightly more likely to report that they felt their DHB provided sufficient support for them to engage in clinical leadership activities to a greater extent;
- By contrast, respondents with 5-15 years of experience were slightly less likely than those with under five years experience.

Table 4.13.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and likelihood of respondents reporting that they felt their DHB provided sufficient support for them to engage in clinical leadership activities to a greater extent.

	Odds ratio	**95% CI**	***p* =**
Gender			
Male	reference		
Female	1.03	0.92–1.16	0.6001
Age			
20–29	reference		
30–39	1.00	0.83–1.20	0.9618
40–49	1.07	0.90–1.29	0.4361
50–59	1.11	0.91–1.34	0.3018
60 and over	1.02	0.81–1.28	0.8719
Years of experience			
Under 5 years	reference		
5–15 years	0.81	0.71–0.93	0.0019
More than 15 years	0.95	0.83–1.10	0.5221
Professional group			
Doctor	reference		
Nurse	1.27	1.11–1.46	0.0005
Midwife	1.41	1.08–1.83	0.0121
Allied/Other	1.15	1.01–1.32	0.0422

4.3.12. Question 15

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

Results for this model are presented in Table 4.14. Of note:

- Female respondents were slightly more likely to agree more strongly that health professionals in their DHB work together as a well-coordinated team compared to male respondents;
- This likelihood was much lower for all the age groups compared to the 20-29 age group. Likewise, respondents with five years or more of experience were also much less likely to agree more strongly that health professionals in their DHB work together as a well-coordinated team;
- There was no statistically significant difference between the professional groups.

Table 4.14.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and likelihood of a respondent agreeing more strongly that health professionals in their DHB work together as a well-coordinated team.

	Odds ratio	95% CI	p =
Gender			
Male	reference		
Female	1.12	1.01–1.24	0.0265
Age			
20–29	reference		
30–39	0.64	0.55–0.75	0.0000
40–49	0.59	0.51–0.69	0.0000
50–59	0.61	0.52–0.72	0.0000
60 and over	0.71	0.59–0.86	0.0005
Years of experience			
Under 5 years	reference		
5–15 years	0.76	0.68–0.85	0.0000
More than 15 years	0.85	0.76–0.97	0.0126
Professional group			
Doctor	reference		
Nurse	1.07	0.95–1.20	0.2561
Midwife	1.09	0.87–1.37	0.4512
Allied/Other	1.01	0.90–1.13	0.9035

4.3.13. Question 16

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

Results for this model are presented in Table 4.15. Of note:

- Female respondents were more likely to agree more strongly that health professionals in their DHB involve patients and families in efforts to improve patient care compared to male respondents;
- This likelihood was much lower for all the age groups compared to the 20-29 age group. Likewise, respondents with five years or more of experience were also much less likely to agree more strongly that health professionals in their DHB involve patients and families in efforts to improve patient care;
- There was no statistically significant difference between the professional groups.

Table 4.15.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and likelihood of respondents agreeing more strongly that health professionals in their DHB involve patients and families in efforts to improve patient care.

	Odds ratio	95% CI	*p* =
Gender			
Male	reference		
Female	1.20	1.08–1.33	0.0004
Age			
20–29	reference		
30–39	0.69	0.59–0.80	0.0000
40–49	0.61	0.53–0.72	0.0000
50–59	0.71	0.60–0.84	0.0000
60 and over	0.84	0.69–1.01	0.0697
Years of experience			
Under 5 years	reference		
5–15 years	0.79	0.70–0.88	0.0000
More than 15 years	0.75	0.66–0.85	0.0000
Professional group			
Doctor	reference		
Nurse	1.48	1.31–1.66	0.0000
Midwife	1.07	0.85–1.36	0.5560
Allied/Other	0.99	0.89–1.12	0.9235

4.3.14. Question 17

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

Results for this model are presented in Table 4.16. Of note:

- The only statistically significant age effect was for the 50-59 age group, who were 20% more likely to agree more strongly to the statement 'In this clinical area, it is easy to speak up if I perceive a problem with patient care' compared with the reference group of 20-29;
- Only nurses had elevated odds of agreeing more strongly with the statement compared to doctors. However, allied/other staff had reduced odds compared to doctors.

Table 4.16.: Results of the proportional odds mixed model for relationship between gender, age and years of experience and likelihood to agree more strongly to the statement 'In this clinical area, it is easy to speak up if I perceive a problem with patient care'.

	Odds ratio	**95% CI**	***p* =**
Gender			
Male	reference		
Female	1.10	1.00–1.22	0.0538
Age			
20–29	reference		
30–39	1.02	0.88–1.19	0.7925
40–49	1.10	0.94–1.28	0.2235
50–59	1.21	1.04–1.42	0.0170
60 and over	1.18	0.97–1.43	0.0927
Years of experience			
Under 5 years	reference		
5–15 years	0.98	0.87–1.09	0.6836
More than 15 years	1.12	0.99–1.26	0.0811
Professional group			
Doctor	reference		
Nurse	1.30	1.16–1.45	0.0000
Midwife	0.92	0.72–1.16	0.4578
Allied/Other	0.86	0.77–0.96	0.0089

4.4. Respondents' written comments

Some 3500 written comments were submitted by survey respondents in the open comments box. Analysis of these is planned for 2013, and is a substantial undertaking. This section provides a selection of examples of survey comments from respondents in one DHB:

> Clinical leadership skills are mainly acquired through experience, being thrown in at the deep end and role modelling. It would be great to see DHBs supporting more development of senior clinicians who are taking on managerial and clinical leadership roles.
>
> I think the leadership training courses are a good idea. Those who are interested in them and undergo the upskilling should be empowered to re-shape the organization and improve procedures. Not happening yet, but may be on the horizon.
>
> I have been fortunate to be in a clinical leadership role at this DHB and have been given lots of opportunity to develop my leadership skills and to participate in clinical governance within the organisation. Once you are in one of these roles the opportunities are immense, whether we do it at all levels of the organisation and offer opportunities as part of succession planning might be a different question
>
> I think that Registrars in general are unprepared for the transition to making decisions beyond their immediate patients, and this extends to clinical leadership. It remains a blind spot in our training. I believe that being involved earlier would give some registrars a sense of responsibility beyond that of immediate service requirements
>
> There is no formal leadership training offered to RACP trainees. It is discussed in learning objectives but there is no time allocated for learning formal leadership skills. I doubt the DHB would be able to cover our shifts to do this. I believe the DHB management has no real interest in fostering clinical leadership. Clinical input is for sign off of not for development of initiatives
>
> Working in radiology we are relied on a lot as a service for a large number of patients in the hospital. I have noticed, particularly in the emergency department, if we wish to communicate a concern about patient care levels to other staff, for example doctors, nurses, etc, our comments are more often than not met with disinterest or even annoyance/anger. This is very concerning – but I'm not sure what can do done about this attitude? I feel that health professionals in their own group e.g. radiology, nursing, etc seem to stick up for each other, support each other, communicate to each other and work well as a group. But communication and team work between two groups, for example radiology as one group, and nursing as another group, does not always work very well
>
> The pathways for clinical leadership are well developed for medical staff but not for Allied Health staff. For instance, in mental health, very few psychologists are able to act as clinical leads, even in services where there is a strong emphasis on psychological therapies. I consider this a great weakness. I do believe, however, that the medical clinical staff are closely involved in clinical leadership initiatives
>
> Would welcome more opportunity to be involved in clinical governance. Often feels like our input is not valued or 'shot down'

As clinical lead for gynaecology I have little protected time in my roster for managerial duties. I have no secretarial support and no dedicated risk co- ordinator. I have lots of ideas to improve our governance and risk management but nobody to help me with it. We need a gynae risk team that can review complications and a data management system to facilitate this. This requires time, structure and most importantly additional funding. Please help!!

Lip service is paid to clinical-management partnership but the questions of practising clinicians go unanswered. Many so-called clinicians in senior positions have lost contact with real clinical practice on the ground and are more concerned with pleasing executive management than providing best care

The greatest impediment to clinicians being involved in Leadership and Clinical Governance is not the willingness of the organisation, but the ability of clinical staff to commit sufficient time. Most are extremely busy, and these activities are deemed of lower priority or are confined to after hours

DHB has a management culture which is dismissive of clinicians' perspectives & focussed on corporate perspectives rather than the provision of truly appropriate care. It is risk averse to the extent that clinical care is skewed to protect corporate reputation rather than encouraging clinical excellence. Critical thinking is strongly discouraged, feedback systems do not allow true reflection on real situations. Obedience is valued, conformity is rewarded. Clinicians neither trust or respect managers. Decisions are often arbitrary & made without consultation.

Clinical leadership should not be confused with a right of length of service to the DHB. Clinical leaders should be identified early and trained, leadership training needs to be available for all staff. We all need the confidence to lead / support / teach if required

Clinical leadership is seen as medical leadership the role of the health professionals is not recognised. While there is a clinical governance structure in place it is vertical through the directorates there is no horizontal connection between the different services.

Significant changes have been made in [this DHB] to enhance opportunities for clinical leadership and an increasing focus on enhancing relationships with patients & family is emerging.

I'm impressed with the focus on developing leaders which I'm under the impression has been a driven from the top down (CEO) There appears to be an effort to allow clinicians to have a say in improving services.

I feel like Allied Health professionals are actually really good at this and we work across the organisation so we have a good idea of how things could improve, but often the opinion of AH professionals is not valued or appreciated as much as the opinion of doctors. Also, I feel like finances are the driver behind most decisions at the moment and initiatives are driven top down, rather than getting clinicians engaged in finding creative solutions to improving the quality of care AND saving money

5. DHB Case studies

5.1. Themes from the case studies

This section considers findings from across the 19 DHB case studies. It is structured in accordance with the key themes that emerged through the self-reviews and site visit interviews. Two initial points are worthy of note and underscore the discussions that follow. First, there is considerable diversity across the DHB sector relating to their size and location as well as fundamental differences in how the DHBs are structured and function. Therefore, certain themes are more relevant to some DHBs than others. Second, there was considerable variation in the information provided in DHB self-reviews and in availability of interviewees during site visits with obvious implications for the depth of understanding of each DHB's experiences.

5.1.1. Theme 1: Define 'Clinical Governance' and Tell Staff About It

Interviewees in several DHBs asked what was meant by clinical governance (reflecting the differing perspectives from the literature raised in section 3 above). Suggestions were that:

- While DHBs were expected to develop structures and processes for clinical governance, exactly what this should look like and what the aims of this were lacked clarity;
- For some, this lack of clarity may have been due to expectations that stem from professional training focused on specific clinical tasks and cases where evidence and best practice are usually clear and widely disseminated;
- Clinical governance and leadership are management and organisational issues, albeit issues which interface and have significant implications for clinical practice and performance, and therefore may require a different set of conceptual tools than those provided in professional, especially medical, training;
- It would be useful for the government to provide more specific information and guidelines for what clinical governance and leadership should look like, what structures should be put in place, how a DHB might measure its clinical governance performance (should it be some combination of culture change, improved clinical and financial performance?), what its relevance to professionals is and what professionals should expect by way of process and outcomes.

Interviewees also noted that frontline professionals may find confusion with the term, suggesting that if you asked nurses on wards if they know what clinical governance is they may draw a blank. Yet they would quickly tell you that they had actively looked for opportunities to improve patient services and the systems of care in the hospital, and worked with other professionals and leaders to do so.

5.1.2. Theme 2: 19 Different Approaches to Building Clinical Governance

All 19 DHBs are strongly committed to developing and supporting clinical governance and leadership, despite the concerns about conceptual clarity. However, as indicated above, each

DHB has taken its own unique approach to this. While there are some commonalities in approaches, no two DHBs are directly comparable. There are positives and negatives to this. On the upside, there are considerable opportunities for cross-sectoral learning from what has worked well based on the range of experiences (and experiments) with structures. As discussed below, every DHB has a unique lesson that all others could usefully look to. The downside of the diversity is that there is an enormous amount of effort going into developing parallel policies, structures and approaches with most DHBs working in isolation; there is limited, if any, sharing of information around clinical governance policies, structural approaches for this, or experiences. This is unfortunate as there are many highly innovative approaches as well as challenges that much more discussion of, and dissemination of information around, would be enormously beneficial to the sector.

To be fair, the diversity is not unique to clinical governance development. Indeed, the Ministerial Review Group report and many commentators have made note of this, suggesting the number of DHBs is not optimal for a small country, for cross-sectoral information sharing, or for promoting national approaches to policy and organisational issues.[42] It should be acknowledged that it is early days with clinical governance development. While some DHBs had moved to facilitate clinical leadership and clinical involvement in management well before *In Good Hands* was prepared, for many the journey has only commenced since the Minister's announcement in 2009. An aim for the DHBs and national agencies should be to consider how to draw lessons from across the DHBs so that parallel reinvention is minimised and development of structures, initiatives and processes that work well are maximised.

Some DHB structures and initiatives specifically aimed at facilitating clinical governance and leadership worthy of note include:

- Creation of a 24-member Executive Leadership Team. DHB ELTs mostly include the CEO, CMO, DON, DAH, GMHR, and so forth with perhaps 6-12 members in total. The 24-member ELT is intended to function like a cabinet or senate, bringing together key management and clinical leaders on a regular basis and flattening the organisational structure. It includes the leadership teams of the clinical directorates (service groups), which also feature a GP and have fully devolved budgetary and planning responsibility. This means there are GPs involved in leading DHB clinical directorates, in partnership with an SMO and a service manager, as well as on the ELT in roles that are more than representative. The two PHO CEOs in the DHB region are also members of the ELT. The result has been what was described as sometimes unwieldy discussions in ELT meetings but a substantial amount of consultation and communication that had previously not occurred as well as planning involving the whole spectrum of care – from primary care through to hospital services – because representatives of the different locations of care were brought together in the new structure.

- Development of a Clinical Council that reports directly to the DHB Board and has some delegated authorities. This Council is co-chaired by the CMO Hospital and CMO Primary Care, with these two posts unique to the DHB. Council has wide-ranging professional membership and includes the ELT, two GP representatives, the DON Hospital and DON Primary Care and others. It has a half day meeting once monthly and quarterly longer planning meetings. Council aims and expectations are spelled out in a guiding document (essentially to provide a clinically-led forum for building a clinically-led DHB and to show clinical staff by example that the DHB is serious about clinical leadership and multi-disciplinary team work), and members are expected to perform - not passively attend meetings - and actively support and promote the work of Council across the DHB. DHB Planning and Funding has membership on the Council to ensure activities with planning and clinical governance are aligned. In practice, this means Council provides an assessment of clinical impact of any planning and funding proposal. Plans for a new

Mental Health facility were rejected by Council until a model of care had been produced. This had significant implications for the design of the new facility. Council also looks at evidence of best practice to ensure that funding supports only clinical practices that are aligned with this. To continue building on the foundations laid by development of the CMO Primary Care role, the DHB has created a GM Integrated Care focused on clinical partnerships between primary care and hospital clinicians.

- Creation of a Clinical Leadership Council designed to span all primary and secondary care activities and coordinate the work of other clinical governance committees in the DHB region. Membership is from the spectrum of care and service providers, including consumer representatives as well as NGOs who contract with the DHB for the reason that these providers are often not involved in discussions around quality improvement and patient journeys. This Council is in addition to hospital and PHO clinical boards which could gradually be incorporated within the Council. There were some suggestions that the Council could eventually challenge the place of the DHB Board.
- Building an Executive Leadership Team that is clinically-dominated (e.g. 10 out of 15 members in one DHB; all but one member in another). One DHB requires that these clinical leaders remain clinically active. This means the DON, for instance, does a regular ward shift – including night shift. While demanding, these leaders said it provided a level of legitimacy and support amongst professional staff that otherwise would be more difficult to achieve; it also kept leaders in close contact with 'life on the wards' and the issues that mattered to staff.
- Developing material for staff that spells out the background to and rationale for clinical governance and leadership and shows how and why certain structures are being put in place, the activities being invested in, what staff can expect to see and, in turn, is expected of them.
- Building of partnership management models throughout the DHB and provider arm, with various approaches to this (as discussed below).
- Development of initiatives that demand clinical involvement such as one DHB's Clinical Practice Committee designed to review new technologies and clinical innovations and make recommendations to the DHB over which should be funded.
- Implementation of the Canterbury Pathways initiative in some DHBs and a strong focus on pathway development in others. This has stimulated discussions amongst clinicians from across the service spectrum and focused discussions on best practice as well as best site of care.
- Inclusion of an RMO on the clinical board to provide representation and also introduce the RMO workforce to clinical governance and leadership issues and engage them with the leadership structure.

5.1.3. Theme 3: Developing Clinical Governance is Multi-faceted and Takes Time

Flowing on from the previous two themes, clinical governance appears not to be something that emerges from simply creating a structure. Interviewees in many DHBs suggested it requires a multi-faceted approach, a readiness to learn from experience and adapt as demanded, and some situational factors that may often be beyond the capacity of an individual DHB to do much about – at least in the short-term. Organisational structure seems to be

important as it provides crucial signals to both management and health professionals. Structural change, particularly in the provider arm, has been a key method by which DHBs have expressed their commitment to clinical governance.

In practice, this has largely meant creation of new leadership roles, committees and management systems that require working partnerships in order to function and for clinicians to get involved. Stated intent also seems to be important, as many interviewees noted. Job descriptions can provide important indications of what is required of clinical leaders, especially when stepping into new positions, as can terms of reference for clinical boards, as noted below. Also important is outlining the rationale and aims of clinical governance and organisational structures as the signals sent to frontline professionals and their leaders can be a key determinant of their buy-in. Formal communications along with a less formal focus on building of relationships are therefore equally important. Some DHBs have been fortunate in having professionals eager to get involved in clinical governance activities and, in the process, enthuse professional colleagues. Other DHBs have experienced considerable difficulty in this regard, pinning hopes, for instance, on a new staff member with interests in the area or on investment in training and providing tools for understanding the importance of professional leadership and systems approaches to health service improvement.

Every DHB interviewee emphasised that development of clinical governance is a process not an outcome and takes considerable time and effort. Those DHBs that seemed to have more developed processes and a positive self-perception of their activities continued to adjust their structures and procedures. All said that they were only at the beginning of their journey and needed to be constantly vigilant, prepared to listen and to reflect. Of course, it needs to be acknowledged that DHBs and their provider arms are highly complex organisations that might be described as 'professional bureaucracies', in which professionals have a high degree of autonomy and control over their areas of specialty.[43] Hospitals and health systems (DHBs) might also be described as 'complex adaptive systems',[44] meaning they are composed of many independent parts each of which is critical to the whole but focused for the most part on its own activities and contributions. Achieving change in this context requires attention to the interactions between, and coordination of, the different parts and building a focus on the 'whole of system'. To quote one medical professional leader in a new clinical director role, this makes clinical governance development particularly challenging: 'it is about clinical leadership to lead a ship.'

5.1.4. Theme 4: Leadership from the Top is Crucial

The DHB Board, CEO and the senior leadership team have a pivotal role communicating their vision for clinical governance and leadership and being accessible to clinical staff if partnership is a goal – between both leadership and clinicians as well as between different professional groups. Interviewees suggested leaders should be actively involved in listening to health professionals, learning about professionals' work and what is important to them and about the barriers to engaging in clinical leadership and quality improvement. In short, they should be fully engaged with them. Leaders need to demonstrate their intent to partner with health professionals and especially professional leaders. Many interviewees in several DHBs also emphasised the importance of relationships; that a significant amount of time and effort had gone into developing relationships between, for example, the ELT and clinicians. This includes vertical relationships, from the CMO or DON down through their professional hierarchies as well as horizontal relationships between professional groups which is a foundation for promoting teamwork. It was also suggested that, for clinical governance to function well, no one clinical group should dominate as such: the role of the leadership should be to steer and support the ongoing conversations across the different parts and groups within the DHB. In short, and in keeping with recent studies, they should be seeking to build a 'compact' or

common framework that represents the rules of partnership and engagement and provides a focus for the organisation.[45,46]

In order to do this, some DHBs have put in place structures to reduce barriers particularly between the CEO and leaders of clinical directorates (service groups) and made clinical leadership an explicit priority through structural changes and key leadership appointments. Examples include disestablishment of COO and equivalent posts – effectively the removal of the funder-provider split – so that the line of communication between the CEO and ELT, especially CMO, DON, DAH, Planning and Funding, and clinically-led service directorates is direct. This had increased the workloads of the CEO and ELT but improved the collaborative spirit and, most importantly, improved communications, breathed life into the management-clinical partnership and built a sense of common purpose. Some CEOs have regular standing meetings with clinical service group leadership teams and have created specific forums to meet with hospital department heads to focus on issues related to clinical governance and leadership. Many CEOs have worked hard to turn around cultures of disengagement with systems for governance and leadership, especially amongst senior medical staff. Building a culture, many recognise, takes time and effort and some DHBs have circumstances more conducive to building robust clinical leadership than others.

Many interviewees, from senior leadership through to service managers and health professionals, highlighted the important role of the DHB Board. Some suggested their Board was fully committed to clinical governance, and a driver of many initiatives to facilitate this. Interviewees in other DHBs implied that their Board had some way to go if clinical governance was to be realised, suggesting the Board was predominantly focused on financial performance and that the Board members did not have an appreciation of clinical governance and leadership activities or of the 'bigger picture' of quality improvement. Underpinning this was the need for the Board to deliver on budget, in keeping with clear messages from central government that this was a fundamental focus. This, interviewees said, made for a difficult relationship and constrained the capacity to grow clinical governance.

5.1.5. Theme 5: Partnership Models are in Place

Every DHB has worked to build partnerships that permeate the leadership and organisational structure, again with differences in approach and extent. Interviewees in several DHBs frequently referred to 'relationships' as underpinning everything they do; they had invested considerable effort into building these and solid relationships both through the hierarchy and between professionals were a core organisational goal. Stable and accessible leadership had assisted with this as it helped build trust. A partnership structure was seen to be the mechanism for promoting and formalising strong relationships. Some examples of partnership arrangements include:

- The CEO and senior leadership team agreeing to work as a partnership, thereby setting the example for the rest of the organisation's leadership teams which are also structured and expected to function as partnerships. In practice, at the CEO level, this means one of the team takes the lead on an issue or function (e.g. DON for nursing; CMO for medical and quality improvement) while consulting with the others and incorporating feedback as appropriate.
- Use of a 'partnership agreement' (or 'position statement outlining core accountabilities' between operational and clinical leaders). This is a formal document developed in a DHB that has a 'dyad' leadership structure with a medical director and operations director leading each of its clinical services directorates. The agreement includes a series of leadership, quality and financial parameters that operational and clinical leaders work through together and agree who will take lead responsibility and accountability

for, while continuing to work as a partnership. Interviewees regularly referred to the partnership agreement, saying it was particularly useful for focusing the partnership and helped define and focus the working relationship while formalising the concept of partnership.

- The 'dyad' structure, noted above, which tended to represent a medically-led arrangement with a clinical director (an SMO) working in partnership with a service manager. Interviewees in such DHBs made various observations of the medically-led dyad: that it was designed to reassure the SMO workforce; that it provided an important signal to SMOs that their leadership role was crucial; but also that nursing and allied professionals had been left out. In some cases it was noted that nursing was already well organised, with leadership roles defined, plenty of competition for leadership positions, and a leadership career structure in place.
- The 'triumvirate' structure, common in several DHBs, with, at clinical directorate level, a medical director, nurse director and service manager working together in partnership.
- The 'diamond' or 'quad' structure with the first leadership tier composed of the CMO, DON&M, DAH and COO working in close partnership. The four-point model, with the three core professional groupings working alongside a service manager, is reflected in the clinical directorates.

5.1.6. Theme 6: Clinical Boards Can Play an Important Role

Most DHBs have developed a 'clinical board' (CB) of some nature[i]. In some cases, the CB is designed to build on a pre-existing arrangement, such as bringing together clinical governance activities from different parts of the DHB and primary care sector or is simply a committee that has evolved over time with increased relevance and renewed focus in the present context. For some DHBs, the CB is a new feature[ii]. For this reason, it is something of a work in progress. Yet the CB also appeared to interviewees to be a particularly important forum for bringing people together and providing a common focus, or had the potential for this.

In general, the CB involves members of the ELT and health professional leaders along with other stakeholders such as the PHO, GPs and, in some cases, consumer representatives. A small number of CBs also have front-line staff representatives elected from within the professional groups – medical, nursing and allied health. The CB in several DHBs is seen as the most critical forum for facilitating clinical governance. The aims of CBs tend to include:

- Develop inter-professional and sectoral relationships;
- Build new methods of working (including developing partnerships between management and clinicians and between professional groups);
- Provide clinical oversight of the DHB;
- Focus on issues deemed relevant. These can range from quality improvement and patient safety, through to resource allocation and prioritisation, and service and facility redesign; and
- Coordinate the activities of and receive reports from various quality and risk committees.

[i] Also called a Clinical Council or Clinical Governance Board/Committee or a similar term, depending on the DHB.
[ii] One DHB's inaugural CB meeting was on the day of the project site visit in September 2012.

The terms of reference for CBs, level of authority, methods of operation and focus differ considerably by DHB.

In some, the CB is seen as critical to building clinical governance and getting clinicians involved in governance and leadership. For example, some DHBs have specific terms of reference, developed and adjusted following feedback, making it clear that the CB is designed to facilitate clinical governance and framed within the Scally and Donaldson definitions and *In Good Hands* statement. The CB has been given delegated authority by the DHB Board and reports to it through the CEO who is a CB member. The CMO is chair and members understand that they are there to get involved. Members in one such CB spoken to said their workloads had increased somewhat but that they could see considerable value in the activities of the CB, especially as they had been charged with responsibilities of clinical oversight of the DHB. Having authority to make decisions and recommendations and a direct report to the DHB Board added weight to this.

Given the incipient nature of many CBs, it is perhaps unreasonable to be too judgemental about their performance. However, interviewees in different DHBs raised various issues that it would be useful to consider for the continued development of CBs:

- In some cases, the focus of the CB was not clear and seemed to lack rationale and profile. DHBs that have a specific strategy, such as use of IHI's Triple Aim[47] as an undergirding goal, or specific terms of reference framed with clinical governance definitions and statements, appeared to have CBs that were more focused.
- Some CBs did not meet frequently enough leading to charges that, if there was not enough business or it was not deemed important enough to meet more regularly, they probably should be disbanded or refocused and relaunched.
- One CB was a relatively open staff forum. While this was considered to be positive in terms of inclusiveness, it made it difficult to focus on specific issues and not just turn into a broad discussion of clinical staff concerns.
- Some CBs risked becoming vessels for management to communicate initiatives to clinical staff. There had been initial excitement at the prospect of a CB to facilitate clinical governance and involvement; the sometimes one-way nature of communication had meant key clinical leaders and followers were becoming sceptical and disengaged.
- Some CBs lacked a voice within the DHB, with limited authority, which was frustrating to members.
- Some interviewees suggested the CB was 'bogged down' in scrutinising and coordinating the activities of various sub-committees meaning it was difficult to find time to focus on strategic issues.
- Some CBs and especially their chairs noted that there was limited administrative support for their activities, meaning much of the routine preparatory and follow-up work had to be done by the chair and various members. At least one DHB had a specialist board secretary to support the CB and had done this to ensure the CB had sufficient support. Members noted that the expertise of this person and high-level of support made a crucial difference, with the secretary disburdening busy clinical staff and able to both coordinate CB activities and ensure many decisions were implemented.

5.1.7. Theme 7: Getting The Senior Medical Officer Workforce Involved

A common theme across almost all DHBs was the challenge of achieving an engaged SMO workforce. Interviewees widely acknowledged that medical workforce engagement is critical

to effective systems for clinical governance and leadership. While other professional groups are important, it was routinely suggested doctors have an especial position and level of influence over clinical processes and service organisation (echoing the literature on this). Yet getting SMOs engaged in clinical governance appeared to be one of the most fundamental challenges for almost all DHBs. This is a key reason why several DHBs had put in place 'medically dominated' clinical leadership structures: to show that they were serious about getting SMOs involved in governance and leadership; and also to appoint some key SMOs who, hopefully, would be able to encourage others to follow suit.

Some DHBs appeared to be in a better position than others as they had a 'critical number' of SMOs prepared to get involved in leadership and take on new Clinical Director and other roles. In one DHB, a crucial CD appointment had resulted in what was described as a 'transformation of cynicism'. The SMO in question was influential and had previously been particularly vocal in critiquing DHB leadership. When the new clinical governance structure was launched, including CD roles, the SMO was approached to take on the role as 'this would be an opportunity to get involved and change the things you have been critical of.' The SMO was now making a significant contribution to running the DHB, especially around resource allocation, and drawing SMO colleagues along in the process (however, when spoken with, the SMO did note a lack of time to dedicate to leadership activities along with inadequate administrative and other support services was hampering efforts).

For many DHBs, especially some smaller provincial ones, SMO involvement remains a significant barrier to progress. Several reasons for this were stated, often by SMOs who had taken on leadership positions:

- SMOs often see involvement in clinical governance and leadership as 'management' and therefore taking time away from their first priority and what they were trained for which is clinical work. This is exacerbated by the ever-present pressure that SMOs face to deliver required patient services;
- That management, and areas such as health system and quality improvement, are viewed by medical professionals as 'less valuable' than clinical work. For those moving into leadership posts, this can sometimes mean something of a demotion in terms of the esteem with which they are held amongst SMO peers;
- SMOs who move into leadership roles can have difficulty with SMO colleagues in a culture that is traditionally 'us (SMOs) and them (management)'. In this regard, several SMOs in various DHBs who had worked in other countries noted that the New Zealand SMO culture, and as a consequence the institutional arrangements[iii] underpinning DHB management systems, were rather 'traditional'. Turning this around into a partnership model, which is an aim of clinical governance policy, was a tremendous challenge which requires building trust that was eroded through managerially-driven reforms at the height of the 1990s as well as at other times;
- Coupled with the previous point, many CDs noted challenges in getting SMO colleagues involved in clinical governance and quality improvement activities. In some cases, it was suggested there was limited accountability for activities undertaken in the proportion of protected time built into an SMO's contract which is intended to be used for CME and other improvement activities. Some suggested that CDs and Heads of Departments should be arranging to have every SMO undertake quality improvement activities in their protected time and document this. In other words, make involvement in governance and improvement activities a key professional and employment responsibility.

[iii] Institutional arrangements include the rules and norms of behaviour. They are usually unwritten but shape relationships and organisational culture and determine 'how we do things around here'.

- SMOs in leadership posts often find limited support from within the SMO ranks, especially in some of the smaller DHBs. In several DHBs, Clinical Director appointees were the only applicants and, sometimes, reluctantly put their hand up as 'someone had to do the job'. Similarly, it is not uncommon for a DHB to have one or more CD posts vacant simply as no SMO is prepared to take on the role. There is a generic and widespread issue across many DHBs of a 'lack of competition' for clinical leadership posts.
- The root of the problem could be the lack of a career path for clinical leaders, with a lack of training in governance, leadership and quality improvement – from the early years in medical school through to advanced clinical training programmes. Leadership and management tends to be an 'add-on' or something that only those who enter the RACMA (Royal Australasian College of Medical Administrators) programme gain training and qualifications in.
- SMOs in CD posts often find, with a limited time allocation (often around 0.2-0.5 FTE) to the role, that it is extremely difficult to perform the leadership duties required. Much of the time is spent in meetings dealing with administrative matters and trying to sort out issues that SMO leadership is required for. This provides limited scope for working on other challenges such as quality improvement, team building or service reconfiguration. Many SMO leaders interviewed said they had little or no administrative support so wrote their own meeting minutes and correspondence post-meetings, further exacerbating the pressures on time. If they needed intelligence/research into an issue they usually had to do this themselves. On top of the CD roles, they maintained a busy role in clinical practice. SMO CDs in some DHBs appeared to have greater challenges than in others, especially with time and collegial support. There would appear to be significant opportunities for collective learning across DHBs around how best to organise, manage and support the fractional CD role and promote the importance of these roles to the broader SMO workforce. There is also a demand to consider what a reasonable time allocation to CD and equivalent posts is, given variation across DHBs, along with how to increase the time made available for these posts.
- Getting doctors to attend meetings is always challenging, especially if they don't believe an aim of the meeting in question is to 'make a decision'. Meetings which are perceived to be 'talkfests' will have poor attendance. Therefore, if SMO attendance is desired they should receive advance information on why the meeting is required and what key decisions will be taken.
- The fractional appointments were also cited as a point of contention in some DHBs as other professional group leaders are often in fulltime posts.
- One of the most cited challenges was the public/private mix of specialty practice in New Zealand. Several SMO leaders argued that the parttime basis on which many SMOs were employed made it a challenge to get them engaged in much beyond their clinics and clinical duties. It was difficult to know when SMOs were around and to know their timetables, to arrange meetings to discuss clinical governance issues or to get them interested in improving the public hospital system. Nursing and allied professional interviewees in several DHBs expressed similar concerns. For some DHBs, the public/private mix was seen as important for increasing income and therefore making clinical work in New Zealand more attractive in an international market. Yet the public/private mix also has the capacity to undermine the development and spirit of clinical governance.

Various suggestions for how to improve SMO involvement were raised, including:

- Develop better incentives. While financial incentives are not necessarily feasible nor acceptable in the New Zealand DHB environment, others could be considered. Providing CME points for involvement in a CB, for example, or for quality improvement and other clinical leadership activities.
- Include involvement in clinical governance and leadership as a contractual obligation or work out how to get SMOs to dedicate 10% of their protected time to improvement.
- Incorporate governance, leadership and quality improvement into all under-graduate and specialty training programmes.
- Create DHB-wide awards that champion and celebrate clinical and SMO leaders and provide examples of what leadership and governance activities look like.
- Improve support services for clinical leaders so their skills and time are optimised.
- Promote clinical leadership as a 'higher calling' with capacity to improve health outcomes for multiple patients simultaneously.

5.1.8. Theme 8: Terminology Across the Sector is Not Consistent

While many DHBs have implemented comparable clinical governance structures, there are some terminological differences that create confusion. Most DHBs, for example, have developed organisational structures that include 'service directorates'. These have tended to be called Clinical Directorates led by a combination of Clinical Directors and other leaders in some sort of partnership arrangement, under which sits a series of departments. DHBs have variously also used the terms Clinical Unit, Clinical Care Group, and Medical Directorate to describe what are elsewhere called Clinical Directorates. The DHB that uses Medical Directorate has titled its clinical departments Clinical Directorates. Most DHBs also have a Clinical Board. As noted above, titles for this vary by DHB.

5.1.9. Theme 9: Training for Clinical Governance and Leadership

Most DHBs have developed clinical governance structures and leadership roles with the availability of training to support the developmental process limited. Some DHBs and regions have had a greater level of training available than others. The Midlands Leadership Training Programme, available to staff from the five DHBs in the region, was cited as having been useful especially for bringing people from across the region together although only small numbers of staff from some DHBs were sometimes involved. The Northern region similarly has some regional training opportunities. The South Island region is developing its own leadership training hub, driven by an alliance between Canterbury DHB and South Island tertiary institutions, but this is still in planning. Many interviewees noted they were awaiting announcements from Health Workforce NZ around the Institute for Health Care Leadership and one or two DHBs are looking to develop their own leadership institutes/initiatives. One of these has the potential to transform into a national training institute; another could be a model for leadership training for small and remote DHBs. Most interviewees lamented the lack of specific training focused on governance and leadership or, where it was available, the limited number of places.

The response to this situation has been investment in a wide variety of external and internal training. Some DHBs have invested in IHI training offered through Ko Awatea at Counties Manukau DHB and consider the IHI Triple Aim framework and leadership and improvement approaches core to their strategy. Indeed, the Ko Awatea model is an example worthy of

emulation. It has brought together regional training activities and provided a focus for promoting and supporting quality improvement efforts and, in this way, provided a stimulus for clinical leadership in the Counties Manukau DHB. One other DHB indicated it was creating a 'mini-Ko Awatea' which could become a centre for leadership in smaller DHBs. The MidCentral DHB has put over 100 health professionals through its own regional 'Transformational Leadership Programme', which was initiated by a PHO and therefore brings together professionals from the spectrum of care. Some DHBs are working with NHS Innovation and Improvement specialists. Larger DHBs obviously have more resource for in-house support and training and one or two are working with a well known foreign academic on an improvement strategy designed to align with its clinical governance approach that could ultimately result in a complete reconfiguration of how its clinical services are structured.

In keeping with the overarching theme of inter-DHB communication, there would appear to be considerable opportunity for sharing approaches to and relative merits of the various training approaches. Other specific comments about training included:

- SMOs taking on new leadership roles are leaders, demonstrated by the fact they have taken on the roles, and already doing leadership. Therefore, training for these roles is not necessarily needed in generic 'leadership' but in specific management areas such as HR, finance and planning that clinical directors and other leaders typically engage with on a daily basis.
- Training for doctors is an area that has particular demand. There needs to be an initiative focused on junior doctors and RMOs as they are difficult to get involved in clinical governance. Like SMOs, they have demanding schedules but face additional pressures of meeting learning and examination standards in their clinical training. Leadership and quality improvement should be incorporated into their training as core competencies and are presently not considered as important to junior doctors and RMOs as is their basic clinical training.
- Training for doctors needs to recognise the 'me' worldview of much of medical and, especially, specialty practice which is oriented toward 'my patients, my service, my reputation…'. Leadership requires thinking and operating within an 'us' paradigm: 'us' as people and services who need to be worked with, led and managed with the medical leader 'one of us'.
- Professional training schools, especially the medical schools, have a critical role to play. They should be turning out doctors, nurses and allied professionals to whom clinical governance, leadership and quality improvement are natural capacities that they have been taught and applied in their practical training. They should be learning how to work as members of multi-disciplinary clinical teams and that they have a professional responsibility to engage with system improvement. Competencies in system improvement, team and inter-disciplinary work and quality improvement should be central to the entire clinical training process. There is also a demand that the career path in governance and leadership for different professional groups is clearly identified and core competencies and qualifications outlined.

5.1.10. Theme 10: Allied Health Challenges and Contribution

A common challenge across DHBs is integration of allied health (AH) into the clinical governance organisational fabric. The issues for many DHBs stem from two factors. First, the diversity of AH encompasses multiple professional groups, from occupational therapy, physiotherapy and rehabilitation services through to pharmacy and also scientific and technical services. This creates representational and leadership challenges with many groups being

too small to either warrant a dedicated leader or lacking someone prepared to take on a leadership role. Thus, in several DHBs the core leadership functions for some professional groups are performed by the Director of AH in partnership with service managers. Second, AH has been something of an add-on in the clinical governance structures of many DHBs – in some cases a quite recent addition – or is represented in the senior leadership team via a combined Director of Nursing, Midwifery and Allied Health meaning there is no dedicated seat at the DHB leadership table.

Many AH interviewees suggested that they were lower in the 'pecking order' than nursing and medicine and found this frustrating. The two aforementioned factors possibly contribute to these perceptions. However, AH interviewees, especially front-line professionals in those DHBs who arranged interviews with them, and often their leaders, noted the important role they played and potential to add value in the present environment. They noted important initiatives, such as physiotherapist-led first assessments of patients referred by GPs who might otherwise wait considerably longer to be seen by an SMO. They also noted their role in working with patients with multiple morbidity, chronic disease and conditions related to ageing in improving their health and providing services that would help disburden hospital-based specialists.

For AH leaders there is a demand to consider how to raise the profile of AH across the DHB sector. There is a need, some interviewees suggested, for AH to 'sell itself'. This probably requires some strategic thinking amongst AH leaders but also the DHB sector more generally, including how to:

- Establish an AH identity
- Illustrate the contribution AH makes and how it can contribute into the future.
- Get the various AH professional groups to work more closely together, especially in terms of forging an identity, but also groups such as pharmacy and physiotherapy and their respective professional bodies recognising the links between them and promoting these.

5.1.11. Theme 11: Frontline Staff Engagement

No DHB could confidently state that it has a frontline health care delivery professional workforce (e.g. nurses, allied professionals, and doctors) that are fully aware of and engaged with clinical governance and leadership. Indeed, the survey data show that significant numbers of staff are not aware of core concepts and have not taken opportunities to get involved in service and system improvement, perhaps through lack of time or interest. Many interviewees across the DHBs indicated that they felt the development and understanding of clinical governance had not yet permeated their front line (or lower level departmental/ward) structures. There were pockets of activity, driven by an individual or group in a particular area, but many staff remained complacent: they wanted to simply do their shift on the ward and go home. There was a general view amongst interviewees that this would gradually change as the impact of leaders, initiatives and structures grew and, as noted above, the survey data show improvements in SMO perceptions between 2010 and 2012. Providing training as well as outlining basic expectations to staff that they have a responsibility to get involved in improvement activities and teamwork were also seen as critical.

5.1.12. Theme 12: Connecting Clinical Governance and the Focus on Improvement

In addition to focusing on developing clinical governance structures, the DHBs have also been focused on quality, patient safety and system improvement to differing degrees. Each DHB

has a structure for supporting quality and safety activities with a dedicated manager and, in some larger DHBs, often a number of staff and perhaps even an 'improvement' unit as well. The quality and improvement services tend to cover a spectrum of activities, from patient complaints and risk management through to providing support for clinicians looking for assistance with their quality improvement efforts and developing quality and safety strategy.

The location of quality in each DHB differs. In many, the office sits within the provider arm and therefore reports to the COO or CMO. In some, quality falls under the DON leading to allegations that quality is a 'nursing issue' and to difficulties achieving traction with medical staff. Some have positioned quality at the ELT level which enhances visibility as well as the capacity to oversee and drive quality and safety from a higher level within the DHB. Arguably, this is the level at which quality should sit in every DHB. As demonstrated elsewhere, significant gains – including financial – can follow from a concerted approach to quality improvement and its adoption as core strategy;[28,30] the DHB Board and ELT obviously need to fully embrace, live and breathe this. On the downside, investments in quality improvement can be considerable and interviewees suggested, in the DHB environment, difficult due to ongoing demands live within budget.

Some DHBs have made quality their number one strategy and are fully engaged in using quality as a focus for clinical governance activities. There appears to be ample opportunity for all DHBs to do the same. In this, DHB Boards and leaders have a pivotal role to play.[48]

There are numerous examples in DHBs of initiatives that help focus and provide a framework for combining clinical governance and quality improvement. These include:

- Creation of a General Manager, Clinical Governance, who has a place on the ELT and also has responsibility for quality and safety for the DHB.
- Development of a 'balanced scorecard' or 'dashboard' that can be used by the DHB Board, ELT and clinical staff to measure performance over time. DHBs using or developing a scorecard have tended to link this to areas of strategic importance: some may be government targets; others which management and clinicians have agreed would help focus the improvement of clinical services and may include productivity and financial information, clinical performance and safety, and patient satisfaction. Once again, the scorecards in use tend to be DHB-specific and some include data that compares performance with similar hospitals. Yet the basic concept and design principle has relevance to all DHBs and there is ample opportunity for cross-sector sharing of approaches.
- Productive Ward, Releasing Time to Care and other provider arm projects, driven by health professionals, that focus staff on reducing waste and providing more time for patient care. DHB and regional initiatives such as the Northern Region's First Do No Harm campaign and individual use of mottos such as 'The Patient Always Comes First.'
- Use of information technology to highlight clinical service organisation and process issues, noted elsewhere to have an impact on productivity and quality if well designed and clinically-led.[49,50] In the DHBs, such use includes: deployment of the Caplan system which provides 12 minute updates on bed availability and demand across the entire hospital and in tandem with this, in one DHB, an 'integrated operations centre' intended to provide a 'whole of system' focus for day to day service and staff planning; use of Riskman, which provides a systematic approach to reporting of clinical and service delivery risks, patient complaints and patient safety incidents, with centralised data collection and follow-up functions; and gradual deployment of e-referral systems, shared electronic records, and e-medication management systems. While there is clear potential for gain from health IT, this is an area where DHBs and clinical leaders would also benefit from wider sharing of experiences and coordination of activities. As the US

Institute of Medicine recently asserted, there is a clear role for both government and 'Providers Inc' (the DHBs) working closely together.[50] This is to ensure that any purchased systems deliver on expectation and meet specific standards if high quality care and safe systems are an aim, but also to drive improvements in vendor performance which is an area where New Zealand has had a troubled history.[51,52]

6. Discussion

There is no doubt that DHBs, without exeption, are fully committed to developing clinical governance. Most DHBs have moved, in a short timeframe, from governance and organisational systems that featured few clinical leaders to undertake significant changes aimed at implementing principles outlined in *In Good Hands*. The commitment to this in many cases has been impressive with some highly innovative approaches to organisation and to promoting clinical leadership, along with a will to learn from experience and make adaptations as required.

A key finding of the CGAP is the variation across the DHBs in terms of how they have approached clinical governance. In keeping with this, some committed to clinical governance much earlier than others – preceding *In Good Hands* – and some appear to have a more concerted strategy and approach. Leadership and some local circumstances seems to have played an important role in this.

The CGAP drew data from different sources including a major workforce survey, DHB self-reviews and DHB site visits to conduct interviews. The 'mixed method' approach is often advocated for probing complex settings and issues[53–55] and has the benefit of generating both quantitative and qualitative data. The survey data portray a relatively positive picture with reasonable levels of recognition of clinical governance concepts, of activities DHBs have undertaken to promote and improve clinical governance and of respondent commitment to getting involved in clinical governance activities.

The responses to some questions are obviously more positive than to others, and some DHBs' overall responses more encouraging than others. DHBs may, for example, need to put more effort into explaining what is meant by 'clinical leadership' and, for this, expected of clinicians (question 3); and into providing information to staff about the 'governance structures that ensure a partnership' (question 5), although, to balance this, a healthy proportion of respondents see themselves as 'involved in a partnership with management, with shared decision making, responsibility and accountability' (question 9). DHBs and the government may also need to consider the implications of question 14, with only 36% of respondents feeling they had sufficient support to engage in clinical leadership activities. DHBs may take heart from the fact that a high proportion of respondents perceive their DHB has worked to 'enable strong clinical leadership' (question 4); and to 'foster and support development of clinical leadership' (question 6). High numbers of respondents see quality and safety as goals of both clinical (question 11) and resourcing or support (financial/managerial) (question 12) initiatives, and a solid majority indicate that their DHB had 'sought to give responsibility' to their team for 'clinical service decisions in their service area' (question 13).

More detailed analysis of the three quality and safety questions is contained in a separate report[i]. In sum, the baseline data are promising but also show room for improvement. More attention to promoting team work is demanded (question 15), especially in the present context of increasing chronic disease and multi-morbidity, and particularly for those DHBs where less than a majority agreed with the question. The picture is more positive regarding responses to questions 16 and 17. Question 16 canvassed the issue of family and consumer involvement in care improvement, now a government objective for DHBs, finding 70% agreeing they worked to do so. Question 17 found similarly high levels (69%) agreeing it was easy

[i] Clinical Governance Assessment Project: Analysis of Three Quality and Safety Questions in a National Survey of New Zealand Health Professionals. Centre for Health Systems, University of Otago, Dunedin. 2012.

to voice concerns about problems with patient care in their DHB. However, there is a valid argument that these percentages should be much higher and this also poses a challenge for DHBs.

Looking at variation, a cluster of DHBs scored consistently toward the top end on several of the survey questions while another cluster was nearer the bottom. It is difficult to state with any certainty why as there were both positive and negative comments written on surveys from both clusters of DHBs. Similarly, site visit interviews with DHBs from both clusters elicited a range of perspectives on the approach to and performances with clinical governance. Suffice to say that a variety of comments and perspectives are probably to be expected in any study where there is a large population working in a complex organisational environment undergoing change.

The questions where it was possible to draw comparisons with the previous ASMS member survey are perhaps the only way to presently gauge progress with clinical governance development – at least quantitatively. The analyses in this report indicate solid progress which should buoy policy makers and DHBs given the short time between the two surveys. For the other professional groups, the 2012 survey provides useful baseline data against which future studies may be compared.

The survey was one of the largest (perhaps the largest) ever undertaken of New Zealand's health professional workforce. We are not aware of any other such survey conducted in recent times. Given its magnitude, there were a number of associated challenges worth noting.

First, there will always be questions about the response rates – both by DHB and professional grouping. Yet, as discussed, the sheer number of respondents provides a level of confidence in the data that would not be possible with a smaller catchment of potential respondents. The relative comparability with the composition of the wider health professional workforce helps boost confidence in the data. The DHBs that achieved higher response rates put additional effort into encouraging staff participation. How to replicate these efforts across all DHBs in a future survey is an important consideration.

Second, using electronic means to conduct surveys has several advantages including reductions in cost and paper use and ease of data collection. There are also disadvantages including getting to staff who rarely check their official DHB email addresses or have limited access to workplace computers.[56]

Third, ensuring a consistent approach across DHBs was a challenge. As noted, standardised material for DHBs to use was distributed but, in several cases, we learned that key staff did not know about the survey. As noted, some DHBs also developed their own material and approach to encouraging staff participation.

Fourth, there is a general perception that health professionals in DHBs have been 'surveyed out' posing an additional challenge for engendering participation and raising response rates. Some DHBs had run their own surveys around the same time so the CGAP survey could have been seen as 'yet another one' by staff invited to participate.

Fifth, the survey generated some 3500 written responses in the comments box. These are potentially a very useful resource but analysis of such a large volume of comments is a major project in its own right that we will look to undertake in 2013. We were only able to provide a snapshot of responses in this report.

The 19 DHB case studies produced a similarly high volume of information but, again, with various limitations. The principal limit was the restricted availability of information, time and access to interviewees in some DHBs meaning it was difficult to gain a comprehensive understanding of their approach and experiences. This was partly a function of some DHBs providing limited information and interviewees. It was also due to the number of DHBs to be case studied. The upside of the latter is that the project was able to gather information on activities in each DHB which would be a much more involved undertaking with a more

in-depth approach. For the purposes of this report, the 19 DHB cases were largely treated as an opportunity from which to draw collective insights and lessons. Hence, the presentation of key themes that affected each DHB in some way or offered areas that DHBs might consider for improvement. Drawing from these themes, a series of issues warrant consideration:

- 'Clinical governance' needs tighter definition, with expectations clearly outlined and a communications strategy for this developed. Ideally, this should be a national project so that DHBs receive consistent information that can be communicated to staff. The place to start is probably the Scally and Donaldson definition cited earlier in this report and in *In Good Hands*. This has been used explicitly by some DHBs with the aim of providing a focus for staff, along with associated descriptive material that outlines intent and expectations. A national definition would offer scope to link with performance indicators, again standardised, designed to provide focus for clinicians and their DHB employers, and able to be tracked over time. Such performance indicators do not need to be developed and used as targets. Rather, they could be developed as tools to help focus managers and clinicians on the organisational and procedural issues that facilitate or hinder robust clinical governance.
- It would be very beneficial for the DHBs to share more information with one another about clinical governance development approaches and experiences, given the variability across the sector and early developmental stage which most DHBs are at. A national clinical governance clearing house could be considered. The simple process of travelling around DHBs allowed for some basic connections to be made between staff in DHBs grappling with issues in a vacuum with staff in other DHBs that had an effective approach or similar experience and ability to help out. There is a strong case for an arrangement, which would not require much resource, to help essential cross-fertilisation of information.
- As well as sharing lessons on structural approaches to facilitating clinical governance (the 'hardware'), broader discussion of some of the 'software' would be beneficial. Again, a clearing house could help with this. Job descriptions, partnership agreements, how to promote teamwork, how to design balanced scorecards, and other initiatives to promote clinical governance should be shared more widely.
- There is an obvious need for dedicated training for clinical governance and leadership. Exploratory work in this area has previously been commissioned by Health Workforce NZ and, as noted, some DHBs also have initiatives under way. Further discussion of the merits of various approaches would be useful, especially whether a national solution should be pursued or whether the local and regional initiatives should be comparable. These discussions should include key professional workforce group representatives so that training packages are tied to the specific requirements of clinical governance and leadership, as well as to training in quality improvement.
- There is an urgent demand for discussion around how to get health professionals, especially doctors, engaged in clinical governance and leadership, as well as how to achieve balance between the various professional groups (doctors, nurses, midwives and allied health).
  - A 'compact' that brings together and provides a focus for the different professional groups and DHB leaders, linked to the definition of and rationale for clinical governance and quality improvement, should be an aim of every DHB and its governing Board.
  - Training is obviously part of the solution to professional engagement but such training needs to commence from the outset. As noted, tertiary institutions and

professional colleges have a critical role to play in teaching students that health professionals are only as good as the systems in which they work. Professionals have an obligation to ensure these are high quality: safe, equitable, efficient, accessible and patient centred. It is no longer acceptable for professionals to treat their patients without concern for improving the system through which those patients travel.[20,57]

- The part-time nature of many senior doctors' employment creates barriers to full engagement with DHBs and commitment to improving the public health care system. Solutions to this requires further analysis and debate.
- How to provide better administrative and other support for clinical leaders, especially SMOs in leadership posts, should be on the agenda of both central government and the DHBs.

6.1. The final word

This report represents an investigation into what may be considered the present status of clinical governance in New Zealand's DHBs. Through a mix of survey and interview data – the latter conducted as a 'listening exercise' – the CGAP has provided a snapshot of professional perceptions at a point in time, while also reflecting a wide range of viewpoints across 19 DHBs around the structures for, challenges with and progress of clinical governance development. The CGAP has created a template for future clinical governance assessment, given the limited tools previously available for this. Most importantly, the data and discussions in this report have highlighted areas policy makers, national agencies, DHB leaders and health professionals might focus on in their efforts to advance upon already admirable progress in developing clinical governance and leadership.

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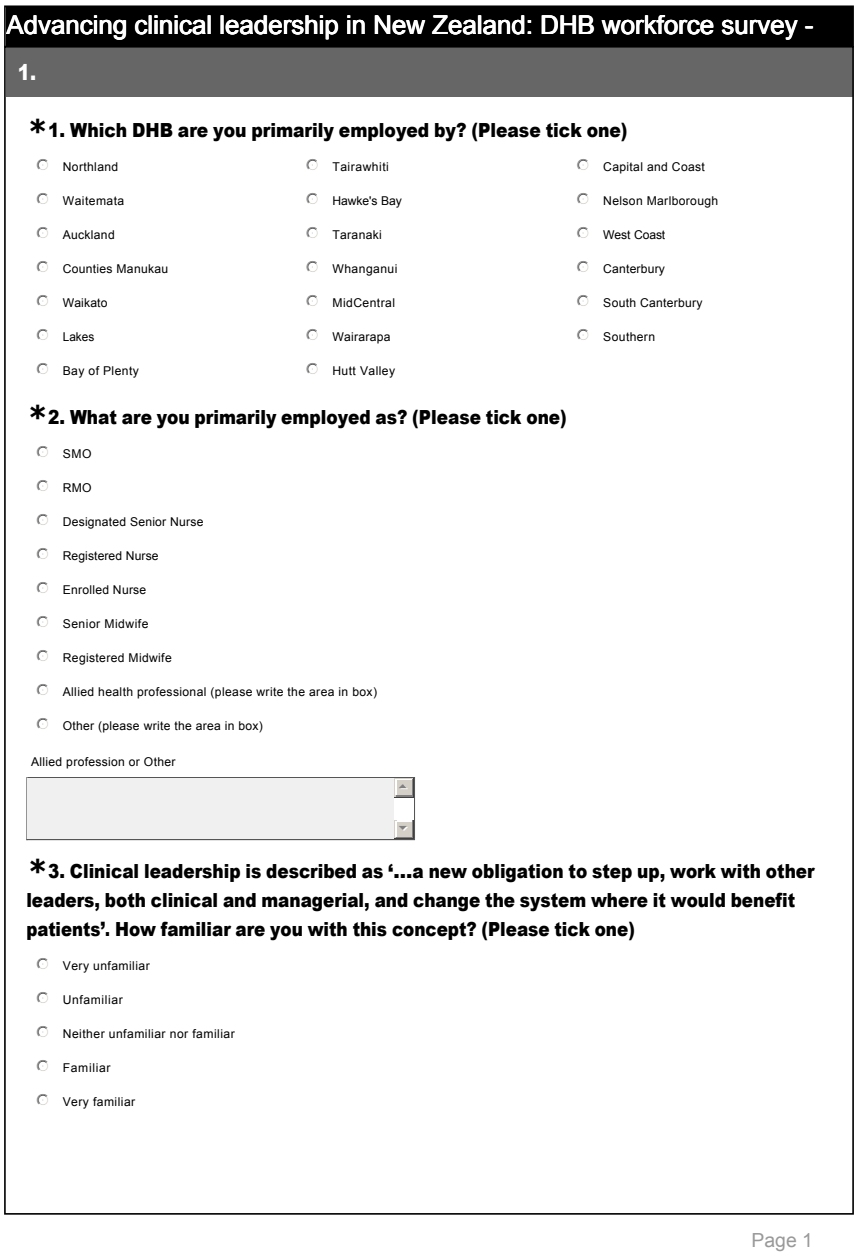
A. Copy of the full survey



Advancing clinical leadership in New Zealand: DHB workforce survey -

1.

***1. Which DHB are you primarily employed by? (Please tick one)**

- Northland
- Waitemata
- Auckland
- Counties Manukau
- Waikato
- Lakes
- Bay of Plenty
- Tairawhiti
- Hawke's Bay
- Taranaki
- Whanganui
- MidCentral
- Wairarapa
- Hutt Valley
- Capital and Coast
- Nelson Marlborough
- West Coast
- Canterbury
- South Canterbury
- Southern

***2. What are you primarily employed as? (Please tick one)**

- SMO
- RMO
- Designated Senior Nurse
- Registered Nurse
- Enrolled Nurse
- Senior Midwife
- Registered Midwife
- Allied health professional (please write the area in box)
- Other (please write the area in box)

Allied profession or Other

***3. 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? (Please tick one)**

- Very unfamiliar
- Unfamiliar
- Neither unfamiliar nor familiar
- Familiar
- Very familiar

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***4. To what extent do you believe that your DHB has worked to enable strong clinical leadership and decision making throughout the organisation? (Please tick one)**

- ○ No extent
- ○ Some extent
- ○ A great extent
- ○ Don't know

***5. To your knowledge, has your DHB established governance structures that ensure a partnership between health professionals and management? (Please tick one)**

- ○ No
- ○ Yes
- ○ Don't know

***6. To what extent has management within your DHB sought to foster and support the development of clinical leadership? (Please tick one)**

- ○ No extent
- ○ Some extent
- ○ A great extent
- ○ Don't know

7. Please give examples of any specific leadership development programmes that your DHB has provided:

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2.

***8. To what extent have you sought to take up opportunities to work with other DHB staff, both clinical and managerial, to change the system where it would benefit patients? (Please tick one)**

- No extent
- Some extent
- A great extent
- There have been no opportunities

***9. To what extent are health professionals in your DHB involved in a partnership with management with shared decision making, responsibility and accountability? (Please tick one)**

- No extent
- Some extent
- A great extent
- Don't know

***10. To what extent are health professionals in your DHB involved as full active participants in the design of organisational processes? (Please tick one)**

- No extent
- Some extent
- A great extent
- Don't know

***11. To what extent do you believe that quality and safety is a goal of every clinical initiative in your DHB? (Please tick one)**

- No extent
- Some extent
- A great extent
- Don't know

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***12. To what extent do you believe that quality and safety is a goal of every clinical resourcing or support initiative in your DHB? (Please tick one)**

- No extent
- Some extent
- A great extent
- Don't know

***13. To what extent has your DHB sought to give responsibility to your team for clinical service decision making in your clinical areas? (Please tick one)**

- No extent
- Some extent
- A great extent
- Don't know

***14. Do you feel that your DHB provides sufficient support for you to engage in clinical leadership activities?**

- No
- Yes

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3.

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

- Disagree strongly
- Disagree slightly
- Neither disagree nor agree
- Agree slightly
- Agree strongly

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

- Disagree strongly
- Disagree slightly
- Neither disagree nor agree
- Agree slightly
- Agree strongly

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

- Disagree strongly
- Disagree slightly
- Neither disagree nor agree
- Agree slightly
- Agree strongly

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***18. Are you (please tick one)**

- Male
- Female

***19. What is your age group? (Please tick one)**

- 20-29
- 30-39
- 40-49
- 50-59
- 60 or over

***20. How many years have you worked in the New Zealand public health care system? (Please tick one)**

- Under 5 years
- 5-15 years
- More than 15 years

21. We are interested in any further thoughts, especially on strengths and weaknesses in your DHB with regard to clinical leadership. Please feel free to add any comments in the box below.

B. DHB self-review template

Clinical Governance case study self-review template

The case study component of the University of Otago assessment of clinical governance and engagement consists of a self-review and DHB site visit. The case study seeks to build on work undertaken by DHBs for Q4 2011 reporting to the Ministry of Health on 'DHB Clinical Leadership' based on the principles outlined in *In Good Hands*.

In the spirit of DHBs learning from one another about strategies for facilitating and promoting clinical governance and improving quality and patient safety, and reflecting on your own experiences, please provide a candid assessment of your activities to date. Your report will be viewed only by the University of Otago team and the project Steering Group[i]. Information from your report and the site visit will be fed back to the DHB and may be used in production of the final project report which will be anonymised. Please keep your self-review brief.

1. DHB Name:

   _____

2. Who is primarily responsible for overseeing and facilitating clinical governance and leadership activities? (this could be either an individual or a group)

   _____

3. Does your DHB have an explicit strategy or set of goals for clinical governance (Y/N)

   If yes, please append a copy and provide a short summary of your strategy

[i] Members include: Jim Green, CEO, Tairawhiti DHB (Chair); Karen Orsborn, General Manager, HQSC; Helen Pocknall, Director of Nursing and Midwifery, Wairarapa DHB; Allan McGilvray, GM HR, Canterbury DHB; Mary Anne Gill, Communications Director, Waikato DHB; Ruth Hamilton, DHBSS; Stella Ward, Executive Director, Allied Health, Canterbury DHB and West Coast DHB; Kenneth Clark, CMO, Midcentral DHB; Jan Adams, COO, Waikato DHB; Robin Gauld, University of Otago.

Describing your clinical governance development activities:

Clinical governance has been described 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 by creating an environment in which clinical excellence will flourish. Clinical governance is the system. Leadership, by clinicians and others, is a component of that system'*[ii].

In keeping with this description, we are interested in specific initiatives aimed at facilitating clinical governance. In the table below, briefly describe the 'top three' initiatives you have developed (or, if you prefer, provide a written narrative instead but use the points in the table as a guide). Please tell us:

- what the initiatives aim to achieve (e.g. improving quality and patient safety);
- how initiatives were developed and implemented;
- any structures developed to support them;
- and how successful you feel the initiatives have been so far.

Please reflect on relative success to date, what has worked well, barriers or challenges encountered, lessons learned, planned actions and anything else you would like to report.

	Clinical governance and leadership initiatives	Progress achieved	What's worked well	What's not worked/ barriers/ lessons	Planned actions
1.					
2.					
3.					

Please also outline any additional initiatives currently under development (insert below):

Other comments:

We are interested in any other comments you may have about your clinical governance activities and the general strategy of your DHB around clinical governance and leadership and patient safety. We are also interested in what you see as the primary advantages and disadvantages of clinical governance as an organisational goal (insert below).

[ii] Adaptation cited in *In Good Hands* from: G. Scally and L.J. Donaldson. Clinical governance and the drive for quality improvement in the new NHS in England. BM, 317(7150):61–65, 1998.

Preparation for the site visit:

Finally, outline any other points that you feel would be useful for us to discuss at the site visit, or for DHBs to collectively reflect upon as part of the ongoing process of developing clinical governance and engagement and improving patient safety. At the site visit, we will be interested in exploring developments since the Q4 2011 Ministry report, so please be prepared to discuss this.

Please return your report by Friday 6 July to the email address below, where any questions should also be addressed:

robin.gauld@otago.ac.nz
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