# Annex 2

## Terms of Reference:

## Clinical Leadership and Quality

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## Improving performance through enhanced clinical leadership, and improved quality

## 1 Enhancing clinical leadership

*"I often refer to clinical leadership as 'the sword in the stone'; a powerful force for good if you can just get it out of the stone and wield it!!*

*Doctors love taking authority and are seldom prepared to take responsibility for performance and almost never for productivity and metrics which bring together performance and cost.*

*When they do it is magic! Couple it with innovation and change management and you have everything your heart desires."*

Mark Goldman, Clinical Lead, NHS National Leadership Council and CEO Heart of England NHS Foundation Trust

Enhanced clinical leadership is fundamental to enabling New Zealand's public health sector to address the important challenges described in the main body of this report and to assure New Zealanders of a quality and sustainable health care service in the future.

The past is peppered with reforms, designed along varying philosophical lines, and implemented by various government agencies. These reforms have generally been top-down and have had mixed levels of success. None, however, have been led by clinicians, even though the resulting changes have often had significant effects on clinical practice.

This was particularly the case during the 1990s, when reforms were occurring against the background of the need for a substantial reduction in public expenditure.

Health managers have also been asked to implement reforms without the mandate or co-operation of the clinicians who would be key to making them successful.

This scenario has led to some residual distrust amongst clinicians and, in some cases, relationships with management which can be tense.

However, there are a wide range of vibrant clinical-management partnerships up and down the country where shared passion and a common vision, built on mutually respectful working relationships, are resulting in genuine clinical service development and improvement.

Nevertheless, silos remain in health care and dismantling these is an important step in building sustainable services for the future. Silos exist between community and hospital services, between clinicians and managers, and along both professional and specialty lines.

Patients now present with increasingly complex conditions, often complicated by several co-morbidities. Patients also spend the vast majority of their lives in the community, touching primary care services to a variable extent, but more specialist services only rarely. Silos do not support the best, holistic approach to their care.

The MRG has been particularly encouraged to encounter the same recurring theme with many different health care services. What is clearly uppermost in clinicians' minds is providing a quality service to their patients. We are confident therefore that there are clinicians ready to deal with barriers to providing contemporary health care by breaking down existing silos, building relationships and pathways for more efficient patient care, and using the available resources to their very best for the common good.

New Zealand simply cannot afford the costs that come from having a fractured, dislocated and unresponsive health sector.

At some point there will be a tension between reducing cost and improving service, but as the main report points out, our current circumstances leave scope to improve service without having to increase cost e.g. through quality initiatives. In this sense, the MRG shares the assumption that lies at the heart of the IHI Triple Aim Initiative i.e. that "...new designs can and must be developed to **simultaneously** accomplish three critical objectives, or what we call the "Triple Aim":

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care."[1]

The emphasis on "simultaneously" is ours but it is absolutely fundamental to the Triple Aim concept – the "Holy Grail" of health care.

Focusing on the stewardship of resources to deliver the best value, quality, holistic services that are centred on patients, may well provide the platform for clinicians and management to embrace a new culture.

The Ministerial Group has heard from a number of groups about various factors that can limit clinicians' willingness to demonstrate clinical leadership attributes at whatever level. These include:

- Busy professional lives, where there is scepticism about the relative returns of spending time on leadership compared with treating patients,
- Incentives for accepting any sort of leadership role are weak, and peer support may even suffer,
- A lack of recognised and respected career paths supported by quality leadership and management skills and underdeveloped development and performance appraisals,
- The attitudes taken towards those clinicians who reduce clinical practice in order to contribute in a leadership role can range from a lack of peer recognition to outright peer disdain, and

[1] http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm accessed 9 July 2009.

- A Lack of clarity about the roles, accountabilities, responsibilities and expectations for clinicians taking up leadership roles, often coupled with the idea that leadership qualities and management skills are somehow inherent in clinical staff or 'simply common sense'. These factors can lead to clinicians accepting roles with little understanding of the day to day realities or of how to initiate and lead change with the best chance of success.

Attitudes, beliefs and perceptions play a large part in these barriers. Advocacy in a leadership role brings with it responsibility for making the change practicable, which in turn implies realistic proposals for implementation including timeframes, collegial support, consideration of any wider impact, the necessary resources and how the change might be achieved. Nowadays leadership may also mean prioritisation decisions have to be made between what can be done differently and what must be deferred in order to afford new developments. Decisions of this sort are frequently difficult and sometimes painful, but the leadership team needs colleagues who have had the opportunity to contribute and to hear the debate, to then understand the reasons for the decision and to be willing to live graciously with the consequences.

There are many examples of successful leadership partnerships around the country, but this needs to be more systematic and widespread throughout the health service.

### 1.1 CULTURAL CHANGE

The MRG heard from many that those who take on clinical leadership roles are seen by their colleagues as having "joined the dark side". While this is far from new,[2] if clinical leadership is to mean anything, then clinicians must be willing to reach some reconciliation of this tension and to support and work alongside clinical leaders and their management partners to share both decision-making and responsibility for the consequences.

Fundamentally, this requires a deep cultural change, which needs to be led by building appreciation of, and enthusiasm for, the opportunities.

This cultural change should start with the way in which we present clinical leadership – the language used and stories that are told. We must point to successful examples from the past, celebrate successful clinical-managerial partnerships of the present, and describe the future where leaders have the tools to work across professional, geographical and political boundaries and jointly support improving the nation's health.

*The MRG recommends that:*

*(a) The NHB should develop a cultural change programme aimed at enhancing:*

*(i) Recognition of and support for health care leaders, including via an annual leadership award programme celebrating and showcasing outstanding health care leaders from all parts of the sector, and*

*(ii) The ability of clinicians and managers to form productive partnerships, both within the hospital sector and across sectors.*

[2] Ham C. (2003). 'Improving the Performance of Health Services: The Role of Clinical Leadership'. ***Lancet*** 361(9373):1978-80.

Clarity about responsibilities, aims and expectations are important for any role, but especially for clinicians working in partnerships. There is real value in fitting the role to the specific organisation because although many responsibilities will be similar (e.g. clinical governance, professional leadership and providing clinical advice to the board), others will be localised, simply because of size and organisational structural differences.

*The MRG recommends that:*

*(a) DHBs should ensure that formal position descriptions are agreed, including annual performance expectations and leadership performance development plans for each formal clinical leadership role, from departmental to executive level in every organisation.*

Little consideration has been given to support for those wishing to return to clinical practice after a term in a leadership role. It is important, however, that clinicians have the confidence that sessions and support will be available for refreshing clinical skills after a time 'off-service'.

*The MRG recommends that:*

*(a) DHBs should ensure that clinicians taking on full-time leadership roles are assured on appointment of formal support for return to clinical practice at the conclusion of the appointment.*

The MRG has heard concerns about pay differentials e.g. where clinicians have stepped back from clinical practice for a period. In many organisations, clinical leaders have received a small salary allowance or a nominal sessional payment. However, this has come with no time allocation, implying an expectation that the responsibilities can be fitted in around the clinician's other responsibilities. This message does not suggest the role is valued or important. Formal allocation of working weekday sessional time for leadership responsibilities with back-filling support for clinical practice responsibilities sends the right message of equal value.

*The MRG recommends that:*

*(a) DHBs should ensure that formal clinical leadership roles are recognised by the allocation of sessional time during the working week to fulfill their duties.*

### 1.2 LEADERSHIP

For leadership to be effective there needs to be a culture of team work in which team members act professionally and accept and support collectively made decisions.

Those in the front-line have the most experience and understanding of the needs of the patient and must be able to influence leaders' thinking about the direction of services and of the organisation as a whole. Clinicians do however have to be aware of what can be changed and what cannot within the constraints affecting the organisation at the time.

Development programmes in clinical leadership need to have a deliberate focus on shared leadership learning and development within the local environment. The MRG heard about several such successful initiatives,[3] but noted that as these had been developed for a local environment, it was important they were not expected to function as 'off-the-shelf' answers for others.

Leadership development will require appreciation of the operational environment in some depth, as well as personal skills and competencies and a knowledge of available tools.

The report of the Ministerial Task Group on Clinical Leadership *In Good Hands* has highlighted, various frameworks for leadership skills and abilities exist, which all to a greater or lesser extent reflect personal leadership qualities as categorised by CanMEDS. The professional education and development curricula of some of the medical colleges include explicit and detailed attention to professional qualities,[4] and will undoubtedly serve future generations of senior staff well. Leadership qualities and skills are important however throughout a professional's career from undergraduate through to retirement in all health-related professions. There is scope to further develop and streamline these elements of education and training across the full length of a professional life.

*The MRG recommends that:*

*(a) The Minister should seek advice on how best to encourage universities to:*

*(i) Further embed and develop the academic status of the discipline of clinical leadership, supporting research in multi-disciplinary models and further formalising academic achievement in this area, including via the establishment of relevant Chairs, and*

*(ii) Ensure undergraduate courses in all health disciplines to include formal attention to leadership development appropriate to each year of the curriculum, both in theory and in practice.*

However, while these are all important leadership qualities to be nurtured and developed, there is also a knowledge base, including appreciation of particular techniques and tools (e.g. in change management, evidence analysis and quality improvement measures and tools) that are not yet widely taught as part of professional undergraduate or postgraduate education.

Some of the requisite knowledge base can be taught through formalised programmes, and academic recognition of such will be important in raising the profession's recognition of and respect for those in leadership roles.

This would enhance the status of clinical leadership and management beside the more traditionally-based academic streams, support clinicians to plan, assess and monitor their own learning and development in leadership, and offer some objective measures towards selection for formal leadership appointments.

[3] For example, Xcelr8 Programme in Canterbury DHB, Midland Leadership Programme, CMDHB Institute of Leadership.

[4] See for example, RACP Professional Qualities Curriculum, ANZCA Professional Attributes Module, RACS Standards and Protocols for Surgical Competence.

At the same time, however, the MRG recognises that adults learn best when able to integrate their own rich experience and existing knowledge with new learning. Adults are typically problem-oriented and practical and look for the relevance of any learning to current needs.[5] Formalised multi-disciplinary leadership programmes should therefore include more personalised, self-directed learning opportunities, involving guided individual reflection and evaluation. This aspect of leadership development should continue beyond any formalised academic course through appropriate networks (similar perhaps to the national CMOs' network) and regionally-based action learning groups.

Finally, recognising the innate characteristics of health care organisations described above, some understanding of the dynamics behind leadership teams and their life-cycles is important, both to prepare and protect individuals and ensure that as any cycle plays out, any risks of misunderstanding are mitigated.

*The MRG recommends that:*

*(a) DHBs should ensure that new appointments to clinical leadership positions receive a personalised assessment of leadership development needs, together with support and training to anticipate and understand environmental factors and their consequences and the opportunity for multi-disciplinary leadership skills development and mentoring,*

*(b) DHBs should ensure that a package of resources focusing on leadership skills and qualities is available to support clinicians in leadership positions as part of professional development programmes, to ensure leaders have the tools to work across contemporary boundaries to collaborate to achieve the best outcomes,*

*(c) DHBs should consider including a formal requirement for three to six months within a suitable mentoring partnership for all new appointments to leadership positions and all promotions. The mentoring partnership should be defined by formalised expectations of both partners and specified outcomes, and education and training made available to those new to offering mentoring support to new leaders, and*

*(d) DHBs should ensure that potential future leaders showing early promise are offered opportunities to develop their skills and competencies through involvement in performance improvement initiatives.*

[5] Knowles M. (1978). *The Adult Learner – A Neglected Species*. Gulf Publishing Co: Houston, USA.

## 2 Initiatives to increase elective services and reduce patient waiting times, improve access to timely primary and hospital services and improve productivity and quality of services for patients

Clinical leadership is not an end in itself. To mean anything, clinical leadership must result in more relevant and better quality, design, affordability, and delivery of services.

Increasing elective services encompasses both elective surgery, diagnostics and access to non-interventional specialist advice.

Increasing primary care access to appropriate diagnostics has been shown to improve the quality and appropriateness of referrals. Recent pilots have achieved some success in this area and should be further developed, publicised and evaluated, recognising that local differences in availability of resources may mean tailoring solutions locally

Except in large centres where dedicated elective facilities and duplicated resources exist, elective and emergency surgical service provision in public hospitals is inextricably linked, simply because the same resources – both human and physical – provide both. Intensive or urgent post-operative support is required for some elective cases and increasingly elective work requires more comprehensive clinical backup (both pre- and post-operatively) as the population ages and the co-morbidities associated with smoking and obesity supervene.

Only clinicians can fully appreciate this tension between elective and emergency services since it is competing clinical priorities that must be balanced. Similarly, clinicians are key to reviewing the appropriate locations for service provision across the breadth of the health system to enable better role delineation and ensure the right services are being delivered in the right place. This will include moving appropriate services back into the community, relieving pressure on hospital services and supporting primary care by increasing access for advice and assessments amongst other things.

*The MRG recommends that:*

*(a) Planning within DHBs to meet the Government's elective surgery targets should be led by clinicians from both the primary and hospital sectors in partnership with managers to ensure appropriate allocation of clinical priorities between and within specialties as well as capability between locations, and ensure suitable clinical provision is in place. In the occasional case where agreement cannot be reached within the specified timeframe, the matter will be elevated to the NHB for decision, and*

*(b) DHBs should review local primary care access to appropriate diagnostics to ensure the right access is made available in a planned and evaluated way, ensuring that all service demands are fairly and transparently prioritised.*

For many communities, increasing elective services is essentially about ensuring maximum use of current capacity. This will necessitate clinical leadership to develop new, more efficient, models of care. Recognising that workforce pressures across the sector mean new scopes of practice and novel clinical roles are inevitable, clinical leaders must now accept the challenge to trial existing models tailored to local needs, and /or design and develop a locally responsive and appropriate workforce that builds on the unique characteristics of existing professional disciplines and increases capability in their support.

*The MRG recommends that:*

*(a) Clinical leaders should be supported to trial, develop, and lead the implementation of new scopes of practice and supporting workforce models.*

The Ministerial Group has been told that, despite being clinically led, the work on prioritisation tools has not been comprehensively understood in primary, nor universally applied, in hospital services. Yet better appreciation of these tools may help primary care refer suitable cases and hospital services ensure their resources are equitably targeted to those most in need.

*The MRG recommends that:*

*(a) A national campaign (led from the highest level) be undertaken by the Ministry to explain and promote agreed national prioritisation tools.*

The MRG understands that present elective service provision does not meet existing clinical need. This is true for most, if not all, countries worldwide whatever their economic situation. However somewhat unusually internationally, New Zealand has for a long time been open with the public and explained when specialist interventional needs cannot be met within existing capacity. This does however increase the responsibilities of primary care practitioners, who must support those patients who do not meet local access criteria. This is a further opportunity for closer hospital/primary linkages in developing good supportive information and care pathways for these patients in primary care. Initiatives already exist in this area, but should now be accelerated.

*The MRG recommends that:*

*(a) Further work should be undertaken by the Ministry to promote examples of good practice in supporting primary care to manage unmet needs and to ensure implementation nationally.*

### 2.1 PRODUCTIVITY

Those responsible for monitoring the effectiveness of health sector funding must have reliable and comparable productivity data. Clinicians recognise that it is legitimate for the Government and the community to want assurances on the effectiveness of public health investment and that this requires measurement. As always, different measures are useful for different purposes. The community will be concerned to receive more and better health services for the capital, staffing and other resources that its taxes support. Clinicians will be concerned to deliver the right type of service for their patients and need good comparable performance data at the appropriate level. Recognising the need for meaningful indicators of this sort, the NHS has recently published a suite of more than 200 new indicators – a key outcome from the UK report *High Quality Care for All* by Lord Darzi.

Productivity measurement at system level will inevitably be imprecise so the credibility of the measure, to the public and to clinicians alike, can be enhanced if the data is compiled and produced by an independent organisation that is primarily concerned with the accuracy, reliability and comparability of the measures they produce and has real expertise in the field.

*The MRG recommends that:*

*(a) The NHB should ensure that:*

*(i) Productivity measures should be developed for use at system and hospital level. These should be developed by a credible, expert, and independent source, and*

*(ii) Clinical level productivity measures should be developed at an appropriate level with strong clinical input.*

## 3 Ways to establish clinical networks and leadership programmes to support these goals

### 3.1 CLINICAL NETWORKS

Clinical networks are a way of "enabling traditional professional and organisational boundaries to be crossed within an environment of professional generosity, to improve patient care."[6]

Within New Zealand, the MRG has found several models of clinical networks. These range from informal networks of like-minded clinicians drawn to collaborate by a common concern (of which the National Renal Advisory Board (NRAB) is a good example), to regional networks, such as those implemented through the NZ Cancer Control Strategy Action Plan, and the Ministry-mandated national model, such as the proposed national cardiothoracic surgical network. To date, however, networks have far from reached their full potential, and have tended to be focused on conditions or clinical specialties. We think that clinical networks offer one of the more powerful means of achieving meaningful understanding and integration between community and hospital services and are keen to see this potential realised.

Clinical networks offer a different approach to addressing long-standing problems in health care, such as the separation between primary and hospital care, local ownership of standards and practice quality, professional boundaries and the involvement of consumers.

[6] Metropolitan Health and Aged Care Services Division, Victorian Government Department of Human Services. (2008). ***Clinical Networks: A Framework for Victoria***.

We have had the opportunity to consider both mandated and organic models in New Zealand, and have been particularly impressed with the commitment, passion and frank enjoyment that exist alongside specific achievements where a network has evolved naturally. The NRAB, for example, produces detailed standards and audits all centres against these, providing valuable information for clinicians' own use in improving their services. We noted too that networks that coalesce naturally – or at least have the ability to develop along semi-autonomous lines – appear to align much better with delivering a quality health service, a finding supported by the literature.[7]

*The MRG recommends that:*

*(a) Irrespective of their origin, clinical networks should:*

*(i) Have clear terms of reference and reporting arrangements,*

*(ii) Be led by clinicians with appropriate qualifications and a record of achievement in management – appointments to leadership positions should be for a fixed term and holders should maintain some clinical role,*

*(iii) Normally include representatives from across the breadth of health care and include an expectation of a holistic approach to recommendations,*

*(iv) Include regular measurement and reporting of outcomes and outputs in their terms of reference as well as assessment for impact in the local environment,*

*(v) Have a clear plan of how their quality and process outcomes will be given effect,*

*(vi) Expect to disband once they have fulfilled their objectives, and*

*(b) Dedicated project support should be available for those networks fulfilling the requirements above and with clear quality and process outcome targets, and*

*(c) Clinical leaders, particularly of those formal national networks established by the Ministry or NHB to meet programmed tasks and defined timeframes, should have a recognised allocation of time for the role and their employer reimbursed to enable back-filling of the position.*

[7] Braithwaite J, Runciman WB, Merry AF. (2009). Towards Safer, Better Healthcare: Harnessing the Natural Properties of Complex Sociotechnical Systems. *Quality and Safety in Health Care* 18: 37-41.

## 4 Establishing and fostering greater clinical leadership in primary care, and across primary and hospital care within DHBs

Led at first by general practice, clinical leadership and effective clinician-management working relationships began to develop in primary health care with the emergence of IPAs during the 1993 reforms. Trust and confidence between clinicians and managers evolved naturally as they worked to establish their new organisations and then create innovative models of care e.g. programmes to manage avoidable hospital admissions in primary care, as in the Pegasus Health Group model, practice nurse and doctor participation in sexual health models by ProCare Health and numerous other examples.

These clinician-manager partnerships became the norm in primary care, extending beyond IPAs into other organisations. The conflict that is seen in some hospital care institutions, between clinicians and managers, has largely been avoided in primary care.

These sound and effective relationships have, to a great extent, transferred to PHOs in the environment of the 2003 reforms and continue today.

For the future, problems may arise with the changing nature of the primary care workforce. Internationally, primary care professionals, young nurses and doctors, are less inclined to make longer term commitments to work choices and may lack the enthusiasm for leadership roles. Leadership training is likely to become part of succession planning in primary care organisations. University and other courses may become part of professional development and continuing nursing, medical and allied health education.

Management roles almost certainly will require the same attention.

These favourable developments have been assisted by the evolution of groupings within organisations. Most IPAs and other organised primary care groups required their members to meet regularly, often once per month, to learn of and participate in new professional activities, such as developing prescribing guidelines, sharing information about best practice clinical activities for doctors and nurses, and so on. Similarly, the representatives of the organisations themselves started to meet together, both on an ad hoc basis and in formally arranged meetings and conferences.

These arrangements effectively became clinical networks and remain an important feature of the primary sector. The dissemination of knowledge and limited distribution of programmes of care that has been seen has occurred through these networks. The steady, rather than rapid, uptake of new programmes is as much a function of the work load and pressure that primary health care workers function under as any other factor, but the networks have been critical to success.

Evolution to, or incorporation with, hospital networks has not been widespread. There have been some successful arrangements, mostly in developing integrated care projects, like cardiovascular disease screening, chronic obstructive respiratory disease management and dyspepsia management.

Regrettably, in spite of examples like those quoted above, these developments within primary care have not extended in an integrated and widespread fashion across the primary-hospital interface. This issue will be addressed in the next section.

## 5 Establishing and fostering greater clinical leadership in primary care and across primary and hospital care within DHBs – primary and hospital integration

Predictably, our enquiries and review of literature found that no jurisdiction has discovered, from a population perspective, the ideal model for integrating primary and hospital services. This is despite significant investment by most of the major OECD countries aimed at strengthening primary care services. There are many outstanding examples where a part or parts of a system are working well. However no-one has entirely achieved it and New Zealand is no exception. Further, many of the international examples of primary/secondary integration, such as Kaiser Permanente in the US, are not suited to the New Zealand context in their entirety because of population distribution, funding arrangements and general cultural differences.

On that basis, the MRG has taken a pragmatic and considered approach to proposing the way forward. In doing so, we accept as a basic principle that an effective comprehensive primary care system is essential for the future sustainability of the New Zealand public health system. Underpinning the principle is an acknowledgment that effective primary care can improve population health outcomes and has the potential to moderate the future rate of spending increase in New Zealand through early intervention and better management of long-term health problems.[8]

New Zealand's commitment to the expansion of the role of primary care has evolved over the past 15 years, building on the foundation of general practice. The Primary Health Care Strategy (PHCS) remains a key part of the policy framework for the Government. However, major concerns have been raised over the performance of the sector and a recent OECD report on the state of the New Zealand public health system reinforces this concern in an economic climate of restraint. In particular, Primary Health Organisations (PHOs) have failed, for a variety of reasons, to deliver to their full potential. The evolutionary path that New Zealand has chosen has resulted in wide variation in the size, capability and composition of primary care networks. As an example, 30% of the population is enrolled with four PHOs while another 12% is enrolled with 41 of the 82 PHOs currently in existence.

The MRG strongly supports the view that more can be done to shift resources from overhead structures to front-line services. It is noted that some smaller PHOs, whose members are usually Access-Funded Practices, possess some of the qualities mandated by the PHCS, such as good community connection and delivering services to high needs patients. Unlike their larger PHO counterparts, however, they are deficient in analysis capability, public health initiatives and the provision to take on devolved hospital services.[9] Our recommendations aim to build on the positive examples and, at the same time, incentivise the better use of resources.

[8] Treasury, The. (2008). ***How Can Primary Care Contribute Better to Health System Sustainability***? Treasury: Wellington, NZ.

[9] Cumming J et al. (2005). ***Evaluation of the Implementation and Immediate Outcomes of the Primary Health Care Strategy***.

Getting the focus right is critical for the next phase of primary care development. Primary care is a complex web of interwoven relationships that typically include: GPs and their practice staff, community services such as district nursing, local pharmacies, private physiotherapists, community organisations, child health services, maternity services, home care providers, dentists, advisory services and many others. Striking the right balance between what needs to be done and how it is going to be done is vital in the circumstances. A 'principle-based' approach allows the flexibility for 'bottom up' change to be aligned to very clear accountabilities for results.

The conclusion of the OECD "...that new models of care have generally failed to take hold" is a challenge to PHOs to lift their performance. We cannot continue to do what we've always done. Creating the right atmosphere for change will be difficult but is essential. It is acknowledged that, in some cases, there will be a need to work through a history of mistrust and unresolved tensions. On the other hand, there are many fine examples of new models of care that have been developed through a mixture of' formal' or 'informal' networks of clinicians and managers working together and we can draw on these as beacons to the way forward. It will be a matter of 'horses for courses'.

### 5.1 GUIDING PRINCIPLES FOR INTEGRATION

Developing integrated models of care across a wide range of entities with different ownership and funding arrangements is the challenge for PHOs and DHBs. DHBs, under current legislation, are accountable at the local level for achievement of results. However it will be critical that DHBs form powerful partnerships with PHOs for leading and delivering the design and implementation of new models of care. To achieve this, DHBs will need to work toward the delegation of a mix of devolved funding and service delivery arrangements. The MRG believes the following principles provide guidance to service development and integration in New Zealand's public health system:

- **Patient centred care**: Patients are central to delivery of health care that includes self-management,
- **Workforce**: The effectiveness and capacity of the health workforce is maximised through multi-disciplinary team work,
- **Integrating specialist services**: Specialist services see one of their primary roles as supporting primary care teams and view these teams as key customers, while assisting them to manage their patients within the community,
- **Integrated clinical networks**: These networks include clinicians, managers and consumers and are chaired by acknowledged clinical leaders to provide a basis for service analysis and redesigning models of care,
- **Information**: Relevant individual patient information is available to all providers involved in the patient's care and that consolidated information is used collectively to understand the whole system to: improve the health status of the district; measure and reduce inequalities; improve patient pathways; improve quality and safety; and for service analysis and re-design,

- **Planning**: PHOs and the DHB work collaboratively, in conjunction with community stakeholder participation, to develop integrated service plans that align PHOs with DHB boundaries, either singly or collectively, and
- **Funding and contracting**: Funding and contracting supports good clinical practice and the integration of service plans that remove incentives to cost shift and transfers patient care and responsibility so the right care is delivered in the right place at the right time.

*The MRG recommends that:*

*(a) PHOs should be assessed for their level of preparedness including governance and management capability and support infrastructure, clinical engagement, 'community' engagement, and then offered delegated budgets with accountability for, and take some financial risk around, delivering quality and financial outcomes,*

*(b) Where practicable and desired by stakeholders, co-location of PHO primary care services, hospital and related NGO services should be considered. This may include the development of Integrated Family Health Centres, virtual connections between existing entities or other configurations involving all components of primary care delivery, in a patient-centric manner. Such concepts would constitute primary care clinics made up of GPs, nurses, allied health professional and hospital specialists,*

*(c) DHBs will need to ensure that it is clear what their funding arms are responsible for and what responsibilities and risks have been delegated to PHOs as part of any delegated funding and risk sharing arrangement e.g. in order to avoid overlap or competition between funders, and*

*(d) DHB funding of PHOs should be less prescriptive about tying funding to a certain workforce mix and instead put a greater focus on the outcome they are looking for and allow primary providers to choose the best mix of the skills of GPs, nurses, and nurse practitioners in meeting that outcome. PHOs should make more of the opportunities they already have to consider workforce mix, new scopes of practice and using specialists as part of the primary health care team.*

These recommendations should lead to:

- More engagement across the primary and hospital sectors, building higher levels of trust and greater recognition of the need to work effectively together to improve the health of individuals and populations, based on clinical and managerial partnerships, and
- A greater shared interest in IT infrastructure, with integrated models of care providing the basis for the development of protocols for the sharing of patient information and improving the health of individuals and populations.

## 6 The acceleration of national quality and safety improvement programmes

Quality can be defined in several ways. An often quoted definition suggests quality is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."(Institute of Medicine)

Most New Zealanders receive good care most of the time from the public health system. However, over the last few years we have heard quite a bit about the safety aspects of quality in health care – the near misses and the few instances when things go seriously wrong – known as serious and sentinel events. Like other high-risk industries, we recognise that health care is delivered by human beings so some element of human error is unavoidable. We also know that most of the time when things go wrong, the safety-net systems that prevent such events have failed, usually due to one or more previously unknown gaps. Considerable effort is therefore going into ways of anticipating what could go wrong, diagnosing what has gone wrong, and establishing systems and procedures to prevent this happening in future.

Safety and quality movements in health in the UK, the US, Australia, Scotland and Denmark all started with a similar emphasis on patient safety, addressing potentially avoidable patient death and harm. The Bristol and Shipman enquiries in the UK, which were triggered by certain individuals' clinical practice, demonstrated gaps in the safety systems that should have identified them quickly and prevented further harm. They also showed concerns over the safety of care can arise in both hospital and primary care. In New Zealand, the Cartwright and Gisborne enquiries had similar themes.

Undoubtedly, these high profile cases affected public perceptions, as well as professional assumptions, about health care. As past BMJ editor Richard Smith said about the Bristol case, "judgment was passed... [which] will probably prove much more important to the future of health care in Britain than the reforms… Reorganisations of the NHS come round with monotonous regularity, but changes on the wards and in surgeries are slow and often unrelated to the passing political rhetoric. In contrast, the Bristol case is a once in a lifetime drama that has held the attention of doctors and patients in a way that a White Paper can never hope to match".[10]

Following increased attention to patient safety, the next question arises: how do we know we are doing the best for our patients or could we improve? Interestingly, while the overall quality of care is often assumed to be uniformly excellent, reality may be different. Writing in *The New Yorker* magazine several years ago, Harvard Associate Professor of Surgery Atul Gawande pointed out that most medical practice can be considered to fall within a bell curve of outcomes: a few teams have relatively poor outcomes, a few have outstandingly good results, and "a great undistinguished middle."[11] Applied to the simple hernia operation, Gawande said the chances of recurrence ranged from one in ten to under one in 500, though most surgeons would have a recurrence rate of around one in 20. Clearly moving more of the large middle group towards the best achievers would do more to improve the quality of care on average than concentrating exclusively on the few poorest performers.

[10] Smith R. (1998). 'The Bristol Case'. ***BMJ*** (316): 1917-18 (June).
[11] Gawande A. (2004). 'The Bell Curve'. ***The New Yorker.***

Recognition of the bell curve phenomenon has contributed to a changing focus internationally away from concentrating heavily on safety towards looking at how more teams can achieve the best outcomes. So, for example, NHS Quality Improvement Scotland (NHS QIS) is currently changing its role from coordinating patient safety programmes to an emphasis on improving the quality of health care. As change of this sort involves both a culture where quality is integral to everything a practitioner does, all day, every day, and where practitioners know their own results and can constantly strive for improvement, it can only be led and spread by clinicians – it cannot be mandated. Systems supporting reliable data collection and analysis however are important to enable clinicians to monitor their work.

Improved quality and safety have benefits not only for the individual patient concerned, but potentially also for the population, by avoiding the need for some resources to be used to treat the consequences of errors.

Although improved quality of health care delivery, reduced waste and expenditure and therefore cost savings seem axiomatic, much of the published research for this association is based on estimates of cost based on retrospective case note reviews attributing saved bed-day costs to avoidance of error. For example, using retrospective data, Brown estimated adverse events could cost New Zealand $870 million, of which $570 million was due to potentially preventable events.[12] However, very few papers have been published demonstrating actual prospective cash savings to the bottom line as a result of quality improvements - the 'dark green dollars' of the IHI's latest White Paper[13] – although this might receive more attention with the increasing worldwide recognition of an urgent need to contain health care spending.

Nevertheless, the need to improve quality in the health sector is widely accepted and many countries now have a separate national organisation whose function it is to offer a range of quality improvement initiatives, provide implementation advice and support, benchmarking and gathering data on what works and why. Such bodies typically run collaborative and learning workshops aimed at helping clinicians and managers to make improvements and publish national reports of quality and safety indicators. They also play a key role in developing new standards and guidelines for quality improvements.

To date in New Zealand these functions have been undertaken by various groups, the most prominent of which is the ministerial Quality Improvement Committee (QIC). QIC has been very successful in raising the profile of health care safety and quality, and has worked hard to stimulate a groundswell enthusiasm for the quality agenda.

For example, QIC has, for the last two years, led the publication of the national report on hospital serious and sentinel events and has championed the following national quality improvement programmes:

- Safe medication management,
- Infection prevention and control,
- Review of mortality review committees,
- Standardised national investigation and reporting of serious and sentinel adverse events, and
- Promote the concepts of patient-centeredness and efficiency through the Optimising The Patient Journey (OPJ) Programme.

[12]Brown et al. (2002). ***Journal of Health.*** Sero Res Policy (7): Suppl 1 July.

[13]Mantin LA, Neumann CW, Mountford J, Bisognan OM and Nolan TW. (2009). ***Increasing Efficiency and Enhancing Value in Health Care***: IHI Innovation Series White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement.

These initiatives by QIC, which reflect similar international initiatives, have gone a long way towards starting New Zealand on the quality improvement path followed by other international jurisdictions. These existing initiatives should become business as usual for DHBs, who should assume the funding for them as the existing QIC budget is worked through. QIC has also initiated discussion with primary care and private hospital providers to be part of a whole of sector quality improvement initiative.

The time is now right to create a national quality entity that can pick up the successes of QIC and build these into a uniquely New Zealand quality movement that will, in turn, contribute to the worldwide movement.

*The MRG recommends that:*

*(a) An independent national quality entity should now be established to replace QIC with responsibility for helping providers across the whole sector improve patient safety and service quality.*

It is important that the new entity is independent of any organisation that has funding, regulatory and performance monitoring functions, to ensure freedom to learn, build and develop. This is consistent with other countries such as the NHS QIS which is a special independent health board, and the Danish Institute for Quality and Accreditation in Healthcare (IKAS).

### 6.1 PROGRAMMES

New Zealand should collaborate formally with one or more of the already established international programmes to build its own programmes, recognising that overseas programmes cannot simply be imported and implemented. There is also real benefit in broadening the quality focus beyond hospitals and DHBs to include the rest of the sector. For example, IPAC and RNZCGP are sponsoring a Quality Information for General Practice (QI4GP) Programme which will invest in clinical technology, information and processes, including an improved Practice Management System for the GP, that should help deliver safer and better quality primary care more equitability and efficiently. The programme also aims to reduce unnecessary hospitalisations and improve performance measurement. With respect to the latter, there is real scope to use the improvements in the GP Practice Management System to address the serious weaknesses that currently undermine the effectiveness of the $30 million the Government sets aside each year to fund incentives paid out under the PHO Performance Programme (PPP).[14] After discussions with the PPP governance group, the MRG concluded that Government would be better off scaling back payments due under the PPP for a period and use the resulting savings to help accelerate introduction of QI4GP.[15]

Quality as a culture needs to be seeded and nurtured in all health care thinking and practice, from clinicians to managers, support staff and patients. New Zealand is on its own unique health care journey, and however attractive it may seem to lift resources and programmes from elsewhere, success will only come as our own learning develops, informed by how our health system works. This is the same pathway all other jurisdictions have followed and we should not be tempted to short-cut the foundations if we want the change to last.

[14] For example, feedback to us from the General Practice Leaders Forum who reported a high level of dissatisfaction with the programme and cited a number of problems, from a lack of GP engagement that was associated with high number of GPs reporting that their clinical behaviour and patient care was not influenced by the programme through to concerns about data accuracy.

[15] In particular, the upgrading of GP's Practice Management Systems in a way that will strengthen the incentive impact of the PPP. Given how confident the QI4GP sponsors are in the ability of the project to help in reducing unnecessary hospital admissions, some of these savings could be recycled in the form of a commercial loan to GPs for upgrading their patient management systems, with the loan written off as targets for reducing these admissions are met.

Fundamentally making quality sustainable and core business requires national, organisational, clinical and management leadership. The style of leadership needs to be one that inspires, persuades, guides, and supports to ensure that quality initiatives are adopted, taught, expected and normalised in every part of the system.

The national quality entity will need to exercise this style of leadership when engaging with clinical, operational and organisation leaders to determine what they see as priority areas for improvement. Imposing or mandating a top-down national programme may provide the form of progress and compliance, but not the essence, of changing the hearts and minds of those at the front-line who will be needed for a sustainable quality improvement culture.

Quality solutions need to be tailored to define the target problem, the means of measurement, assessment of progress, establishment of baselines and reporting of improvements within well-defined timeframes. This means an environment and cultural approach, based on knowledge of concepts, ideas, models, tools and measures, drawn from the best in the world and used in uniquely local solutions. Outcome improvements should be compared against local, regional, national and international benchmarks and success celebrated to demonstrate, inspire and motivate others to follow and find their own success. Collaborative learning workshops (including the use of technology such as web-enabled seminars) to facilitate sharing and feedback amongst health professionals will be necessary. The culture of this organisation must be one of guiding, facilitating, supporting and making it easy for organisations of all kinds as well as individuals to participate.

*The MRG recommends that the national quality entity should:*

*(a) Establish formal linkages with one or more similar international bodies, but must concentrate on seeding and growing a local safety and quality culture, providing state of the art tools, skills and support and building New Zealand capability,*

*(b) Develop the next phase of a national quality and safety programme that addresses patient safety and continuous quality improvement, and*

*(c) Scale back the current PHO Performance Programme for a period and the resulting saving should be used to help accelerate the introduction of QI4GP.*

### 6.2 GOVERNANCE AND SUPPORT

The governing body of this independent national quality entity should be appointed by and report to the Minister. This governance board should be strongly supported by a clinical advisory group including representation from the primary, hospital, aged care, disability, public and private sectors. Consumer advice is also important and must be linked into both governance and work programmes.

This entity would assume the responsibility for the ongoing maintenance of the current national quality improvement initiatives as each of these move from being individual projects to business as usual within DHBs. The seed funding required for this entity should be modest and should reflect how other national quality entities were established and have been resourced.

This entity should build cost-effective and meaningful ways of collecting, sharing and benchmarking information and may be able to learn from similar bodies.

*The MRG recommends that the national quality entity should:*

*(a) Be governed by an appointed board and report to the Minister. Clinical appointments on this board must be drawn from the breadth of health care providers.*

### 6.3 FUNDING AND EVALUATING SAVINGS

Funding for this national entity will need to start with a top slice funding from Government and over time will move to a mix of ongoing government funding and subscription from membership and fees from running its quality programme.

The importance of being able to demonstrate the transferability of real cash savings from improved safety and quality is getting greater importance. Research into measuring and evaluating real cash savings from improved safety and quality should be sponsored by this national quality entity.

*The MRG recommends that the national quality entity should:*

*(a) Expect to become partially self-funding by the end of its third year of operation through the development of resources, teaching and learning opportunities and other supports for workforce development and education, and*

*(b) Support prospective research and rigorous evaluation to demonstrate the transferability of real cash savings from improved safety and quality.*