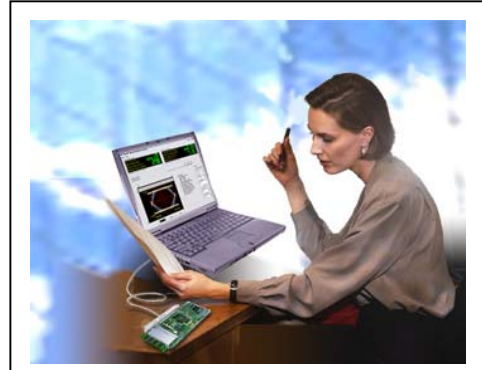


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# **Report on a study tour of the Clinical Governance Support Team of the English National Health System**



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*A report by Ms Maureen Robinson, Dr Ian O'Rourke and  
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## 0 BACKGROUND

### 0.1 Introduction

This report provides a briefing on the clinical governance and patient safety activities of the National Health System (NHS) in England. It emerges from a study tour conducted in September and October, 2003 of the Clinical Governance Support Team (CGST) in Leicester, the National Patient Safety Agency (NPSA) in London, the Commission for Health Improvement (CHI) in London and NHS Trusts in Derby, Bournemouth and Torquay. Participants on the tour were: Ms Maureen Robinson, Director, Quality and Clinical Policy Branch, NSW Health; Dr Ian O'Rourke Chief Executive Officer, Institute for Clinical Excellence (ICE); and A/Professor Jeffrey Braithwaite, Director, Centre for Clinical Governance Research, University of NSW.

The study tour followed an invitation from Professor Aidan Halligan and Mr Ron Cullen of the NHS who had visited the NSW and Victorian health systems in mid-June, 2003. The study program was developed for us by the CGST following our request to investigate the following programs and how they operate.

1. The Clinical Governance Development Program (CGDP)
2. The Board Development Program (BDP)
3. The Team Resource Management and Patient Safety Program (TRM & PSP)
4. The Knowledge Management and Information Services Strategy (KMISS)
5. The Performance Development Program (PDP).

In addition the study tour team met with representatives of CHI and NPSA. We thus provide two additional sections in the report:

6. The CHI clinical governance review and star rating processes
7. The incident management monitoring process of the NPSA.

We focused on how each of these programs is organised from a policy perspective and the way each delivers operationally. Our key aims were to determine how these programs work in practice, what the success factors and barriers to success are, and what the opportunities are for the NSW health system to integrate some of the better ideas or adapt the programs for our use. A study tour of this type is not a one-way process. We also shared information with those we met about the NSW health system and the work of NSW Health, ICE and the Centre for Clinical Governance Research in promoting clinical governance. This was well received, and the platform for a mutually beneficial series of exchanges has been laid.

## 0.2 The problem

Around the world health systems have become concerned about and increasingly recognise the need to improve the quality of care provided to consumers including the safety, effectiveness, appropriateness, access, efficiency, and acceptability of that care.<sup>1</sup> Health systems over the last two decades have been striving to ensure safety, improve quality and involve clinicians, consumers, policymakers and managers in these processes.<sup>2,3,4,5</sup> Clinical governance has emerged as a means by which this can be achieved.

For the NHS clinical governance is defined by Scally and Donaldson in the UK in 1998 as follows:<sup>6</sup> *“A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”*

The NSW Health Department’s submission to the Independent Pricing and Regulatory Tribunal (IPART) report<sup>7</sup> of August 2003 argued it is:<sup>8</sup> *“a set of ideas to encourage stakeholders to take responsibility for the health system overall, and for the safety of patients and the quality of care.”* A simpler definition embraced by ICE is:<sup>9</sup> *“A framework which ensures the highest possible safety and quality of clinical care.”*

We see clinical governance largely as a set of mechanisms to encourage people to work in teams to improve their workplace processes and performance. It represents an opportunity to emphasise systematically the importance of a range of ideas drawn from disciplines such as clinical practice improvement, organisational behaviour, management and quality and safety and use these in enhancing clinical and managerial processes.

## 0.3 An overview of our observations

The NSW health system has implemented a wide range of strategies centred on clinical governance. We judge it is doing well relative to peer health systems in other States and Territories and other developed countries. Nevertheless there is value in learning from other approaches and methods.

The NHS’s particular strengths in clinical governance centre on the way in which the Modernisation Agency (the part of the NHS responsible for reforming the NHS) has made available expertise and resources to clinical governance in a strategic way. It has provided high quality clinical governance education and support programs to teams; organised the programs in a clear and professional manner; and developed expertise in health services performance review. The NHS has made significant progress in facilitating consumer involvement and improving organisational accountability.

The NSW health system has comparative strengths to support clinical governance through its information systems design and capacity, a robust quality framework and a stable and effective area health services structure. NSW Health has made significant progress in recent years in patient safety initiatives, education and training in safety and quality and involving clinicians and consumers in health care processes.

Although there are similarities the context and emphasis in the NHS and NSW differs. However, both systems have strengths and have made progress in policy and performance in recent years on a range of fronts, and each has developed policy and operational capability to facilitate the success of clinical governance initiatives.

Overall, the NHS's initiatives in clinical governance represent a major attempt to transform the culture of an entire health system. The NHS is reputed to be the world's largest employer.<sup>i</sup> This is an open and admirable attempt to encourage bottom-up cultural change via clinical teams. Clinical governance education, dissemination of materials and CHI ratings of Trusts (health services) are made public. The bottom-up process is complemented by top-down strategies such as introducing clinical guidelines and pathways through the National Institute for Clinical Excellence (NICE), inspection processes through CHI and patient safety programs through NPSA. Time will tell, but the levels of investment, commitment and expertise being provided by the British Government to clinical governance all suggest that benefits will be realised. Nevertheless, the history of changing large organisations and complex human systems also suggests it is very difficult to do this successfully.

In what follows we provide details about each of the NHS programs we investigated in the study tour and make observations about how well they are working at the systems and clinical team levels. We also analyse the relevance and applicability of these programs for the NSW health system.

#### **0.4 An evaluation approach**

Although we did not conduct a formal evaluation of the NHS clinical governance initiatives during our tour we nevertheless were broadly informed by evaluation principles and processes as we studied the NHS's programs. We were interested during the tour to weigh the work of the NHS against its own objectives for clinical governance. We were guided by Fink's approach,<sup>10</sup> the United Kingdom's Evaluation Society's work<sup>11</sup> and the Centre for Clinical Governance Research's evaluation methods.<sup>12</sup> We structure our report on each program under these headings: overview; key observations; current initiatives in NSW; and opportunities for the NSW health system.

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<sup>i</sup> With the possible exceptions of the People's Republic of China's military and the Indian Railway system.

## 0.5 Recommendations

Current plans are in train for the NSW health system to develop its clinical governance capability over time. Five specific recommendations emerged from the study tour to support this direction.

1. Three specific programs should be funded and developed over time:
  - Clinical governance training and support program. This program will provide education and support in clinical governance to teams throughout the NSW health sector.
  - Board and organisational performance development program. This program will provide education and support to Boards in their strategic, operational, performance and leadership responsibilities for their Area Health Service, along with organisational development. This program would combine components of the Board Development Program (Section 2) and the Performance Development Team Program (Section 5) discussed later in this report.
  - Coach and facilitator development program. This program will develop a cohort of coaches and facilitators on a train-the-trainer basis to act as catalysts, educators and support persons to clinical teams to promote change.
2. Running parallel to these education and support programs but separate from them, an inspection system needs to be designed and instituted. This system would identify where clinical or organisational performance was deficient against standards, and recommend appropriate remedial action.
3. A plan should be developed for knowledge management and ideas dissemination centred on clinical governance. The NSW health system's capacity as a learning organisation can be improved if there are clear processes for sharing information, knowledge and experiences from others about successes and failures over time.
4. Partnership links with the NHS should be developed further. Using comparative international experience as a benchmark is invariably useful. Both the NSW and NHS health systems can gain from such a program. This may take the form of regular exchanges and placements in order to share ideas and documentation on policies, procedures, structures, education initiatives and practices.
5. Suitable evaluation processes need to be established during the early stages of planning for the education and support programs and the inspection system. It is vital to build in evaluation standards and indicators into the planning stages of each of these initiatives.

## 1 THE CLINICAL GOVERNANCE DEVELOPMENT PROGRAM (CGDP)

### 1.1 Overview

The Clinical Governance Development Program (CGDP) is essentially a training and development strategy targeted at clinical teams throughout the NHS. It seeks to provide clinical teams with the skills, knowledge, methods and approaches necessary for them to lead and achieve improvements in clinical care. Some 900 teams have been trained to date.

Teams are taught to use the Review, Agree, Implement and Demonstrate (RAID) model as a way of analysing and improving their services. This model shows teams at the outset how to **review** the care they offer. This involves a diagnostic assessment of services and how they are delivered. Teams use various tools, for example, customer focus groups, surveys of patients and other stakeholders, staff workshops, policy and literature review to determine priorities for action designed to improve clinical care.

The **agree** phase involves teams in prioritising actions following the review process, and negotiating a shared approach to improvement. Teams need to secure internal agreement and engage with external groups including their health service's management team in order to determine priorities and future actions.

The next phase is the **implementation** phase. This involves determining the specific change strategies required to address each of the above priorities and implementing those strategies.

The final phase in this cycle of activity is the **demonstration** phase. Here, the team has responsibility for continually measuring the gains that have been made and sustaining the improvements over time.

In terms of the program's structure and operations, teams volunteer to enter the program. There is a lot of interest and competition from teams throughout the NHS to participate. There is currently a twelve-month waiting list to join the program. A new course starts every two-three weeks. Each program is conducted over nine months and consists of five learning days conducted away from the work place at a modern, well furnished, central education facility in Leicester. Appendix 1 contains an outline of the curriculum for each of the five learning days.

Each course consists of eight to twelve teams and each team comprises around four to six participants. Some people must compulsorily attend in order for the team to be enrolled in the course, eg a consultant doctor must be on each team.

The course is provided by a Faculty of some eight people who have expertise in various disciplines including change management, team development, services improvement, clinical improvement and quality methods. Teams are supported in the field by program managers who provide technical, logistical and emotional support and help keep teams motivated and on track. Each program manager is responsible for a range of NHS Trusts and has responsibility for up to 45 teams at any point in time.

## 1.2 Key observations

We met with a range of staff involved in this program. These include the acting director of the Clinical Governance Support Team, other senior NHS staff at director level, faculty members responsible for the education program, program managers with day-to-day responsibility for teams in the field, and participant team members. We conducted field-work and met with teams at South Derby City Hospital (termination of pregnancy team) and Derbyshire Royal Infirmary (radiology procedures consent team). Overall, reports were favourable about the educational value of the program, how it was operating after several years' experience with it, and the experience of teams in the field with the RAID model. There was a recognition by participants that there need to be sensible strategies put in place for ongoing improvement of the program.

The NHS has clearly made a large investment in clinical governance and is serious about providing high-level education of teams, skills development and ongoing support such that each team has a good chance of being successful at creating change and making service improvements. It is equally clear that the NHS has assembled skilled policy makers, educators and program leaders to run this program. The indicators suggest this is a successful initiative although the return on investment is hard to determine and in any case will not be realised for some time. This, of course, is the case with all longer-term transformation strategies. Moreover, there has been no systematic, comprehensive evaluation of all aspects of the program to date and it appears that this was not planned at the inception of the program. However, the United Kingdom's National Audit Office did review the CGDP recently and was complimentary about its organisation, structure, delivery and effect.<sup>13</sup>

## 1.3 Current initiatives in NSW

There is a broad, overarching framework promoting clinical governance in NSW. This has not been matched by other States and Territories. The main training and development mechanisms in clinical governance in NSW are the Clinical Practice Improvement Program provided by Northern Centre for Health Improvement, the Safety Improvement Program taught by NSW Health and ICE staff and the Human Factors Training Program run by ErrorMed. Each of these programs is sponsored by and partially funded by ICE, and supported in various ways by NSW Health.

Many of the initiatives of the Quality Unit in the Quality and Clinical Policy Branch of NSW Health are designed to support clinical governance development, for example, the three clinical risk management programs for Neurosurgeons, Rural GPs and Obstetricians. Research and evaluation expertise for various clinical governance programs has been provided by the Centre for Clinical Governance Research at UNSW to both ICE and NSW Health. Overall, we have invested in clinical governance in NSW through these various strategies and now recognise the need to move to the next stage of activities.

## 1.4 Opportunities for the NSW health system

There are several opportunities for the NSW health system which are envisaged in current plans and arise from the study team's assessment of the CGDP. The CGDP as a comprehensive education strategy has not been instituted in an organised, systematic way in Australia. Although we need to contextualise the way this program works for NSW, the structured way it operates is a useful mechanism for bringing NSW initiatives in clinical governance together into an improved framework. There is a recognisable need in NSW to implement in a more effective way *The Clinician's Toolkit for Improving Patient Care*.<sup>14</sup> A program modelled on the CGDP would provide a suitable mechanism for achieving that.

This program is concerned with organisational development centred on a bottom-up model involving clinical teams in their own service improvement and development. This extends our existing approach in NSW of training individuals in clinical practice improvement methods and has been in the planning stage, with ICE, NSW Health and the Centre for Clinical Governance Research having developed an earlier briefing paper canvassing this concept.<sup>15</sup> Our visit suggests we should realise this aim and move to train and develop clinical staff in teams. We also need to invest in supporting teams across time as they make progress. This might involve establishing a cohort of team support program managers who would work with teams in the field, facilitate progress and keep them motivated and on track.

One important lesson is that CGST did not plan for evaluation of their program from the time of its establishment. We should learn from this and ensure that we establish an evaluation framework early in the process. In addition CGST is working toward setting up a program of research to underpin the activities. We should mirror this in NSW. There needs to be a well-conceptualised action research program running alongside the NSW health system initiatives in clinical governance so that progress is analysed and knowledge of what works and what doesn't is captured and disseminated.

## 2 THE BOARD DEVELOPMENT PROGRAM (BDP)

### 2.1 Overview

The Board Development Program (BDP) is concerned to support clinical governance at the strategic level. Boards of NHS Trusts have a duty of quality over the long term, and are expected to support clinical governance activities as a major response toward improvement of patient safety and quality.<sup>16</sup> Recently the discourse in the NHS has shifted from clinical governance to integrated governance,<sup>17</sup> by which is meant that Board governance is important at the corporate, strategic level of the system and this needs to be linked to the clinical governance initiatives at the team level.

In the past, NHS Boards have tended to concentrate on financial matters, often at the expense of quality and safety, which have traditionally been a clinical concern. Many Board members have not been trained in strategy, policy formulation, or evaluation and review of Trust performance and some do not have strong skills in leading complex organisations. The BDP group within the CGST aims to enhance Boards by supporting their efforts and training them in these responsibilities. It also aims to challenge Boards to be able to demonstrate that they are facilitating effective leadership, clinical and managerial processes, people development, policy and strategy formulation, and resource and partnership management within the Trust for which they are responsible.

The BDP group uses a staged process conducted over a nine-month cycle involving Preparation, Diagnosis, Development and Implementation phases. **Preparation** involves the BDP team meeting with the Trust's Chief Executive and Board Chair and examining data on the organisation's performance, analysing Board papers and the minutes of board meetings. The BDP team then makes a **diagnosis** – via a diagnostic review centred on evaluating Board performance. This process includes the conduct of two workshops with Board members, the first to work on Board member roles and responsibilities and second to think through how the Board does and should function. At these workshops the BDP Faculty administers a self-assessment questionnaire on organisational improvement and seeks input from the Trust's various stakeholder groups about what needs to be done to improve Board performance. Feedback on the results is provided. Next the BDP team designs a Board **development** program, tailored to each Board's specific problems, and an organisation-wide strategic development plan. Finally there is **implementation** – the changes are instituted and a monitoring process invoked.

This program involves approximately 15 face to face contact days with the Clinical Governance Support Team. The CGST acts in a facilitation and education role to the Board during their development program.

## 2.2 Key observations

Most Boards in the Australian and English health sectors in both the public or private sectors are not developed in this way. Board roles and the competencies of Board members vary. The BDP seems to promote a useful approach to Board development and makes a contribution toward strengthening Board influence. It is the other side of the coin from the clinical governance initiatives at clinical team level. Receiving systematic support in this format is reportedly proving to be valuable for many NHS Boards.

The BDP was established after the CGDP was in train for some time and is at an earlier stage of development than some of the other CGST initiatives. We did not have the opportunity because of time pressures to discuss with Boards their reaction to the program and to assess its value from that perspective.

It should be recognised that NHS Trust Boards, unlike their counterpart NSW health Boards, consist of both executive and non-executive members. If deployed in NSW, the program might involve both Board members and members of the Area Health Service executive staff.

## 2.3 Current initiatives in NSW

Board development tends to be less systematic in NSW than that organised by the BDP. There is an annual process of review but not a process of Board development or an assessment of their roles. There has been an attempt by a limited number of Boards in NSW to provide some education to Board members in clinical governance. This has been provided by the Director of the Quality and Clinical Policy Branch as part of the annual Board training process organised by the Chief Executive Officer of some Area Health Services. Such measures have at this point largely resulted in awareness-raising rather than large-scale skills or knowledge enhancements.

## 2.4 Opportunities for the NSW health system

We could usefully take a leaf from the BDP book and design a Board support and development process for NSW Health Boards. NSW Health Boards tend, like their NHS counterparts, to emphasise budget rather than clinical matters. It would be valuable to see NSW Boards developed in their strategic, higher level responsibilities. It is a strong idea to ask Boards to demonstrate their achievements and progress in clinical governance, quality and safety. Boards can influence the strategic direction and priorities of an organisation. How and how effectively they do this are core competencies for Boards and Board members.

We believe that such a program could be effective in the NSW health system. The logistics of providing it here would be easier than doing so in the NHS. The NHS has approximately 600 Trust Boards, all of which will be eventually included in the BDP. In the NSW health system, there are 20 Area Health Service Boards.

### **3 THE TEAM RESOURCE MANAGEMENT AND PATIENT SAFETY PROGRAM (TRM & PSP)**

#### **3.1 Overview**

The Team Resource Management and Patient Safety Program (TRM & PSP) concentrates on developing health care professionals within NHS Trusts as team coaches and support persons. It involves teaching participants about such things as teams dynamics, communication and conflict resolution, dealing with difficult people, running effective meetings and project management. It provides participants with training in the use of improvement tools such as brainstorming, cause and effect diagrams, nominal group techniques, running focus groups, and developing affinity diagrams.

When trained, coaches work with individual clinicians and managers within the health system and coach teams other than their own<sup>ii</sup> in their efforts to improve care. They work as coaches for approximately half of their working week. The program has trained a select group to be coaches to the Trust coaches under a train-the-trainer model. A summary of the course curriculum is provided at Appendix 2.

#### **3.2 Key observations**

These initiatives are complementary to the CGDP and act to strengthen safety and team performance. We met with several members of the CGST about this program, observed several sessions of the team coaching program in action and visited two Trusts within which team coaches were working.

We note that this program could usefully be re-titled. It seeks more to provide a resource to teams that are attempting quality improvement in general than to improve patient safety itself. Ms Robinson had the opportunity to meet the CEO, the Director of Clinical Services, three coaches and the Director of Diabetic services in the Royal Bournemouth and Christchurch Hospitals NHS Trust and three doctors (a paediatrician, a surgeon and an ophthalmologist) at the Torbay Hospital Trust all of whom have been trained as coaches, and are using their team coaching skills with teams in the Trust. Favourable comments were received from the staff interviewed about the effect of the program on both their institutions and their individual practices. We judge that this program provides high quality education and a strong support capability.

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<sup>ii</sup> Under this program a team coach is considered to be a person who works with a team that is not his or her own clinical team and a team facilitator is considered to be a person who is trained to facilitate improvement within his or her own team.

### 3.3 Current initiatives in NSW

Although there has been a realisation that there is a need for the development of teams and team coaches in recent years neither NSW Health nor ICE have yet introduced such a program. Little research has been undertaken to determine whether there are other providers of similar programs in Australia or NSW, who may either supply such a program to the NSW health system or assist in the development and delivery of such a program.

### 3.4 Opportunities for the NSW health system

This program provides a significant opportunity for the NSW health system. Over the past decade new roles have been created in the health sector in response to important initiatives or improvement trends. Staff in these roles have continued beyond the life of the initiatives and have in many instances metamorphosed into other roles or simply become less relevant. Some Area Health Services have better coaching and facilitation capabilities than others. There has been a suggestion by Quality and Clinical Policy Branch for Area Health Services to cluster these staff together into a clinical practice improvement or a clinical governance unit and redefine the roles to sharpen the focus on providing support to teams. This has been implemented in a limited way in some Areas, but further work is needed in skills development. This program, if implemented in NSW, would contribute significantly to this effort.

The large number of quality managers, clinical pathways coordinators, accreditation coordinators, data managers and other key staff in the NSW health system could benefit individually from being trained as coaches and provide capacity in the health system for facilitating improvement. The Patient Safety Managers who have recently been employed in each Area Health Service could also benefit and provide skills diffusion to various teams if given appropriate training.

Conducting team and individual coaching in the circumstances under which behaviour can be encouraged to change is a valuable strategy. The team and individual coaching program seemed well designed and taught and we could learn from it. Establishing a service that can be assembled relatively quickly, with capacity to deal with troubled teams on notification by a Chief Executive, is also worthwhile considering.

It would not be our intention to implement the program with the same design features as those in the NHS's program. We suggest including more human factors content and training on system redesign. We believe that the other clinical governance programs we have analysed in this report would benefit from the presence of trained coaches in the organisations in which the programs are being conducted.

## **4 THE KNOWLEDGE MANAGEMENT AND INFORMATION SERVICES STRATEGY (KMISS)**

### **4.1 Overview**

The Knowledge Management and Information Services Strategy (KMISS) tries to capture knowledge and lessons learnt from the experience of teams in the field in order to disseminate these to other teams across the system. Several strategies underpin this program's activities. One is to provide tools by which documentation such as case studies, 'eureka' moments in service improvements, reports and published papers are made available for dissemination via an intranet system, postings to websites, e-mail diffusion and circulation of hard copies to target audiences.

A component of this strategy is to capture the core competencies, skills, interests and expertise of various people within the Clinical Governance Support Team and other core personnel. These are publicised so that as people do their work they can access those experts and build a network of skills on any particular project. In addition, information remains posted about people who have left the Clinical Governance Support Team following their secondment so that they can be consulted at a later date on issues in which they have expertise. This is an attempt to overcome the well-known problem of loss of corporate knowledge when people leave an organisation or move to another role or organisation.

Another component of the program is to look at ways to engender culture change around knowledge management – for example, by incorporating responsibility for knowledge management into duty statements and encouraging it to be one of the core activities of personnel. A third strategy is to promote improved processes by which knowledge is shared, such as by establishing communities of practice and clinical and managerial networks. As an example, the Clinical Governance Support Team seconds people from within the NHS and also from other industries into CGST programs with the objective of disseminating those people's experience and knowledge when they go back to their Trust after their period of secondment.

### **4.2 Key observations**

It is a sound idea to share ideas and knowledge about successes and failures throughout a health system. The NHS has made a considerable investment in this endeavour, compared to investments in earlier eras. It is doubtful whether there has been substantial penetration in knowledge management at this stage across the NHS, and staff of KMISS are aware of this.

It is always difficult for a range of reasons to share even the best ideas such that they are widely taken up and instituted at local levels.<sup>18,19</sup> Nevertheless, we judge that there is considerable progress with this initiative and the preconditions for an effective knowledge management process have been established.

One problem is that there has been no evaluation of the knowledge management strategy. This would be highly desirable. Another issue is that research groups outside the NHS are now being invited to participate in the knowledge management activities and to comment on how best to research and evaluate the various clinical governance programs. The CGST intends to access Department of Health research funding to provide resources to this process.

### **4.3 Current initiatives in NSW**

In NSW we have given some thought to establishing knowledge management processes but we do not have a culture of explicitly capturing and disseminating knowledge. For that reason, we will be starting from an earlier point than the NHS if we want to pursue seriously a knowledge management strategy.

Nevertheless, there are some initiatives around knowledge management diffusion that have been sponsored across the New South Wales health system. For instance, firstly, the IT infrastructure capability necessary to establish the underpinnings of a knowledge management strategy is in place – including websites, intranets and e-mail capability. Secondly, the Department has over a long period of years, as has ICE more recently, worked with research bodies to try to create an evidence-based decision-making culture. In addition, both the Department and ICE have sponsored evaluations of programs where it has been deemed appropriate to do so, although this activity has been sporadic. Thirdly, there is *ad hoc* sharing of ideas between ICE, NSW Health and Area Health Services. Fourthly, recent initiatives such as the breakthrough collaboratives and the GMTT strategy have established networks of clinicians and managers and enabled work teams with common interests to collaborate. Fifthly, the Baxter Awards have helped create an emphasis on knowledge sharing.

### **4.4 Opportunities for the NSW health system**

Few organisations in health or elsewhere manage knowledge well. A system-wide strategy such as the clinical governance knowledge management initiatives contemplated here requires a great deal of attention to ensure that there is a diffusion of good ideas and successes. It is also important to share lessons about failures as teams encounter them.

If we were to organise to leverage our learning in this way, this would give us a platform for a knowledge management process. The crucial missing ingredients are that we need to develop a clear plan and process for knowledge management especially around clinical governance, and we need to make investments in this area.

Thus, there are opportunities for the NSW health system to improve its knowledge management capability in clinical governance and also in other areas. For this to be successful we will need to make progress on a number of fronts. We will need to recognise that knowledge management should be a high priority and that effective diffusion of knowledge across not only clinical teams but across Area Health Services, management teams and policy-making groups is useful. Learning from our experiences in health care so we understand our successes and failures is a valuable pursuit if it leads to better ways of working.

Getting the right people in place to enable us to disseminate information and create a sound knowledge management strategy is important. We think that it is wise not to be so hung up on the technology but to disseminate clear evidence and ideas and set up strong processes across the NSW health system so that people engage with and embrace new ideas, ways of working and ways of thinking.

## 5 THE PERFORMANCE DEVELOPMENT TEAM PROGRAM (PDTP)

### 5.1 Overview

The Performance Development Team Program (PDTP) was originally developed in response to the star rating system. The star rating system is an initiative designed to assign Trusts to one of four categories. Trusts receive three, two, one or nil stars. These results (a 'league table') are widely published. The star rating system is described in more detail in the next section of this report, on the CHI.

The CGST identified the need to provide intense development and support to a Trust that had received a nil star rating. When the first Trusts were awarded nil star ratings, typically morale plummeted. There was a need not only to tackle the root of the problem – that you are a poorly performing organisation across a number of clinical governance indicators – but also the effect of announcing the rating itself was damaging. So considerable support was envisaged to nil star-rated Trusts.

It is now compulsory for nil star-rated Trusts to participate in the PDT. Staff of the program work with the whole organisation using a modified RAID process in order to develop the capacity to improve clinical governance performance.

There are five phases in the process usually lasting up to twelve months. The **first phase**: the initial engagement, in which the PDT conducts a semi-structured diagnostic process to examine data and consult stakeholders. At this point a client manager from CGST is appointed to the organisation and stays in the Trust for the duration of the process. The **second phase**: in which the diagnostic data and stakeholder views are fed back to senior staff in the organisation and the priorities for action are identified and agreed upon. The **third phase**: contract establishment, in which the CGST and the organisation agree on a contracted plan of action and roles and responsibilities of the parties involved. The PDT has a range of strategies and methods on which it can draw, and modifies these for local conditions. These include team coaching, leadership development, use of external consultants and experts within CGDP. The **fourth phase**: implementation of the action plan, in which the agreed actions are undertaken. The **fifth phase**: demonstration of improvement, in which sustained change is demonstrated and measurement of progress continued. It is anticipated that nil star organisations will then have the capacity to progress through the star rating system, thereby publicly demonstrating their improvement.

### 5.2 Key observations

It is a sensible initiative to identify poorly performing organisations and then provide a mechanism for facilitating their improvement. The support provided to such organisations is a key factor in their continuous improvement.

We would need to give consideration to how such an approach could meet the needs of NSW. We did not meet with any organisation which was involved in the PDTP, ie time did not permit us to go into the field to see organisations *in situ*.

### **5.3 Current initiatives in NSW**

There is at present no program in Australia designed specifically for performance development in poorly performing or dysfunctional organisations. Nor is there a robust system for identifying such organisations. It could be suggested that the NSW health system is of sufficient standard and quality that there is no need for either of these processes. However, with increased consumer awareness and expectations and a desire for greater accountability for the quality of care that is provided to patients, there is also a growing need to commit resources to such processes.

Within the Australian health care system there are several longstanding accreditation systems. These encourage continual improvement in organisational and clinical performance across time. These are voluntary, collegiate process without the teeth of the star rating system. Accreditation programs have not been set up as assistance programs and do not have the mandate of rating organisations in a clear way and then compulsorily tackling the problems of those organisations.

### **5.4 Opportunities for the NSW health system**

While a program of this type has merit it is not clear the extent to which NSW would embrace this approach. Some stakeholder groups will be nervous about, or perhaps will oppose, public ratings of organisational and clinical performance. It is clear that if organisations are identified as relatively poor performers by some other means (eg, Campbelltown and Camden Hospitals) then having a process with features similar to PDTP provides a capability to tackle the issue. We now have a better understanding of what such a program might look like, and need to think through its use in the NSW health system.

## 6 THE COMMISSION FOR HEALTH IMPROVEMENT'S CLINICAL GOVERNANCE REVIEW AND STAR RATING PROCESS

### 6.1 Overview

CHI was established in 1999 to be an independent performance management body. CHI has statutory powers, is responsible to the government but independent of government. It is now responsible for undertaking clinical governance reviews in health care Trusts and more recently for allocating a star rating to each Trust. When CHI was first established it attempted to undertake both an inspectorial role and a facilitatory role in system improvement. It was realised that these two functions were incompatible and so the facilitation role was undertaken by the Clinical Governance Support Team and the inspectorial role was maintained by CHI.

A clinical governance review consists of four phases. Phase one involves a twelve-week data capture process. Phase two comprises a team visit and data analysis. The report is written in phase three. Typically phases two and three take a total of seventeen weeks. Phase four consists of an ongoing action and implementation process. Trusts are normally selected for review on a random basis but can be fast tracked if there is a specific concern or need identified.

Each review provides a numerical rating between i and iv on seven categories. These are:

- Patient, carer and consumer involvement
- Risk management
- Clinical audit
- Staffing and staff management
- Education and training
- Clinical effectiveness
- Using information.

The Star rating process is in its third year of operation. It was initially introduced to provide the public with a numerical rating for acute Trusts in the NHS but has now been extended to include all Trusts.

Star ratings are calculated by combining performance in a number of areas of organisational and clinical performance. These include some high level key targets eg in relation to access and waiting times, a wider set of performance indicators eg patient experience, clinical outcomes, cleanliness of facilities, budget control and human resource management and, where reports have been published by CHI, progress in implementing clinical governance. Targets and other performance indicators are different for different types of Trusts. Each Trust will have approximately 7-8 high level targets.

Organisations gain or lose stars depending on their performance in these reviews. Some review categories and ratings carry more weight than others. For example, if a Trust receives a level i rating on any of the seven CHI components it will automatically lose one star. If a Trust receives 5 or more level i ratings on its CHI review it is immediately nil star-rated.

Following the enactment of legislation which is currently before Parliament, CHI will be amalgamated with an associated body to become the Commission for Health Audit and Inspection (CHAI). It is expected that CHAI will then take on a defined inspectorial role rather than a service review role.

## **6.2 Key observations**

The study team had the opportunity to meet with a representative from CHI to discuss the clinical review process and with various Trust clinicians and managers from various levels across several organisations including a Trust CEO. There is recognition that inspection of health services is a fundamental component of clinical governance and that this inspection role must be separate from any performance improvement activity.

There is also recognition however, that the system of inspection that currently exists in the UK could be improved. In its present form it creates perverse incentives. For example, the importance of the four hour ED trolley wait target that is measured in a single week across the country has created the incentive for Trusts to ensure achievement of targets by using measures such as cancelling elective surgery lists, employing extra medical staff and postponing meetings.

There is a belief amongst some NHS personnel that the star rating system is inaccurate, overly subjective and perhaps unjust. Yet there is little doubt that the CHI system has pressured organisations to focus on clinical governance. However, it has also forced organisations to focus on other issues that some CEOs and other health care staff perceive are more politically-oriented than services-oriented.

## **6.3 Current initiatives in NSW**

The NSW health system has a number of mechanisms in place for assessing the quality of care. These include various health service accreditation processes and performance agreements between Area Health Services and the Director-General. There is also a limited set of targets that have been established for hospitals which include day surgery rates, day of surgery admission rates and ED triage times. In addition, there are inspection processes that take place for specific components of services eg laboratories. We have yet to establish a mechanism for combining the various data sets to provide an overall perspective on the performance of a particular organisation, or the health system as a whole.

There is no thorough review strategy in the NSW health system that assesses organisations against clinical governance standards. There has been high level policy development in recent years in NSW for the achievement of effective clinical governance. The implementation of these policies has not however been policed or systematically evaluated. In the more distant past there was little recognition of the importance of such processes as the focus has primarily been on budgetary performance. Quality (including clinical governance) and budget must be seen as equal partners in health if effective reform is to be encouraged.<sup>20</sup>

The Australian accreditation process is more mature and sophisticated than the CHI star rating process, and produces a wider range of information. It has not been given the mandate to operate in the same manner as this agency.

#### **6.4 Opportunities for the NSW health system**

Robinson et al in a recent paper provided to the IPART review team<sup>21</sup> recommended the establishment of more rigorous approaches to performance management and review and to achieving strong accountability for the quality of care provided to consumers of NSW health services. A sound inspection process will form a fundamental component of such a strategy. It should be recognised that any such organisational performance review process will be multi-dimensional. No one process can provide all the information required to assess accurately performance across an entire organisation.

An opportunity exists for NSW to lead other States and Territories in this process. The components of such a system could be:

- Performance target results eg access indicators, ED triage times, and the recently identified dashboard of indicators
- Data summarised from the Health Care Complaints Commission
- Accreditation survey results
- Clinical indicator results provided by organisations
- An as yet undeveloped inspection process of clinical governance against standards
- An organisational safety and clinical governance climate survey.

A clinical governance review process could be developed in one of a number of ways. It should be the responsibility of the Department of Health to establish the standards for clinical governance against which all organisations will be inspected. The Department could then go to tender to engage an independent organisation to develop the criteria for inspection against the standards and to conduct the inspections of health services in NSW.

Alternatively, the Performance Management or Audit Branch of NSW Health could be resourced and have their role enhanced to undertake these inspections. Quality and Clinical Policy Branch has a role to play in the identification and development of the clinical governance standards. We are of the clear view that there is no role for either the Institute for Clinical Excellence or Quality and Clinical Policy Branch in the inspection process. This is consistent with the recommendations made by IPART.

There should also be a clear understanding that any information gathered by ICE or the Quality and Clinical Policy Branch for the purposes of clinical governance or quality improvement should not be used for performance management purposes. Both the governments of the United States of America<sup>22</sup> and Denmark<sup>23</sup> have recently passed legislation protecting such data from being used in this manner. We do not see organisations or clinicians engaging in improvement processes if there is a risk that disclosure of sensitive information for the purpose of improvement is used for performance management purposes. The two processes should be separate and be seen to be separate.

## 7 THE NATIONAL PATIENT SAFETY AGENCY

### 7.1 Overview

NPSA was established in 2001 as a Special Health Authority specifically to develop and implement a system in the NHS for managing health care incidents. Approximately 120 people are employed by the organisation.

To date the NPSA has among other activities, piloted an IT system for incident reporting, commenced some training in root cause analysis (RCA) across the NHS, set up a solutions directorate and began the development of a new incident classification and reporting system.

### 7.2 Key observations

The study team had the opportunity to meet with four senior staff from the NPSA to discuss their philosophy on incident management and the process they have developed to do so. We formed the opinion that this is an early stage development in incident management in comparison with those in place in the Australian health system and other health systems. It appears that the NPSA is concentrating on developing multiple media resources and products to assist Trusts to implement an incident management system. Further work will be needed to influence the development of a just culture within which effective incident management can take place.

In the NHS a climate exists such that clinicians involved in serious incidents are candidates for suspension or prosecution. One hospital we visited reported that on one of their wards there is a system for numerically rating an incident that has been reported. When a nurse or doctor reaches a certain number of points he or she is suspended. An incident that relates to paediatric care rates higher than any other incident. The threshold can be reached with one incident. One nurse has been suspended for nine months. In another case a doctor who inadvertently injected the wrong drug into a patient's spine was convicted and gaoled for manslaughter.

There appears to be a cultural requirement in the UK for poorly performing health care organisations to be held publicly accountable for that performance. We believe that this is an understandable reaction to the public inquiries that have uncovered poorly performing organisations and individuals, eg the Bristol Royal Infirmary Inquiry,<sup>24</sup> the Shipman Inquiry<sup>25</sup> and the Alder Hay Inquiry.<sup>26</sup>

The adverse consequence is that a blame culture has to some extent become institutionalised. It seems there is a poorly differentiated distinction being made in the NHS between criminal and deliberate unsafe and harmful behaviour on the one hand and normal human error that will always occur in health care on the other. The culture and fear of “another Dr Shipman” are forcing the development of systems that are geared more towards identification and management of criminal or willful behaviour rather than towards the mitigation of the effects of normal error. There are clear challenges for the NPSA to manage safety within the context of such a culture.

It is the opinion of the study team that the NPSA benefited from hearing about the patient safety initiatives in NSW, specifically the Safety Improvement Program. We will provide further information to NPSA staff over time.

### **7.3 Current initiatives in NSW**

NSW is presently implementing a comprehensive incident management process across the State. It is not necessary to elaborate on this in this report. This program commenced in early 2002 and is progressing well. There is a need for further development of capacity over time for system redesign and knowledge management in this program both at ICE and in the Quality Branch.

The Safety Improvement Program is being judged by many people in the NSW health system to be an effective initiative. It should be allowed to develop significantly over time if the full benefit of the program is to be realised across the health system.

### **7.4 Opportunities for the NSW health system**

There are no specific opportunities for NSW transferable from our visit to the NPSA. There are benefits in considering further the initiatives of the Veterans Administration in the United States of America in incident management and patient safety. These suggestions are addressed in a separate report.

## 8 APPENDIXES

### APPENDIX 1: CLINICAL GOVERNANCE DEVELOPMENT PROGRAM

#### CURRICULUM OVERVIEW

##### DAY 1

##### Introductions

The Review Process – including:

- Error chain analysis
- Risk management systems that currently exist
- Patient affiliates
- Culture – and how to influence it
- Some complexity theory
- gaining input from sponsors, service users and people with whom the team interacts
- 1/1 interviewing
- drivers for change
- tools and techniques for involving/listening to customers
- Baseline measurement development

##### DAY 2

- Feedback
- Tools and techniques for achieving patient involvement
- Communication strategy
- Workshop facilitation Skills
- Basic change concepts (eg WIFM, force field analysis, risk matrices)
- Additional session on culture/core values and resolving differences
- Presenting the findings and undertaking a roadshow

A large amount of time is allocated to working together as a team

<b>DAY 3</b>	<p>The Agreement process including:</p> <ul style="list-style-type: none"><li>- Establishing priorities and developing the agreement on these</li><li>- Project management</li><li>- CPI method</li><li>- Process mapping</li><li>- Measurement – balanced score cards, quality and quantity</li></ul> <p>Most teams have completed the Review process by Day 3</p> <p>Teams given a guideline for preparing a Review document</p>
<b>DAY 4</b>	<ul style="list-style-type: none"><li>- Leadership</li><li>- Managing transition - “William Bridges” work</li><li>- Preparing a business case</li><li>- Review document completed</li></ul>
<b>DAY 5</b>	<ul style="list-style-type: none"><li>- Exploring CQI in more depth</li><li>- Sustainability mechanisms</li><li>- How audit fits into CQI f/w and appraisal and education</li><li>- <b>Implementation and Demonstration phases</b></li></ul> <p>CGST supports participating teams in their area</p> <p>Sometimes long way down track, beyond the training period</p>

**APPENDIX 2: TEAM RESOURCE MANAGEMENT PROGRAM CURRICULUM OVERVIEW**

<p><b>The methods</b></p>	<ol style="list-style-type: none"> <li>1. Universal improvement</li> <li>2. Background to the ideas</li> <li>3. Elements of the project-by-project approach</li> <li>4. Steering Group method</li> <li>5. Planning method</li> <li>6. Improvement method</li> <li>7. Problem solving method</li> <li>8. Network method</li> <li>9. Piloting your proposals</li> <li>10. Implementing your proposals</li> </ol>
<p><b>Tools and Techniques</b></p>	<ol style="list-style-type: none"> <li>11. Tools for planning and organising             <ul style="list-style-type: none"> <li>– Brainstorming</li> <li>– Clustering-by-these</li> <li>– Must-could-should</li> <li>– TPN analysis – total-partial-not</li> <li>– Chronological clustering</li> <li>– GANTT charts</li> </ul> </li> <li>12. Tools for analysis             <ul style="list-style-type: none"> <li>– Ishikawa diagram</li> <li>– Kano model</li> <li>– Measles diagram</li> <li>– Movement maps</li> <li>– Deployment flowcharts</li> </ul> </li> </ol>

	<ul style="list-style-type: none"><li>13. Tools for evaluation and decision making<ul style="list-style-type: none"><li>– Prioritisation techniques</li></ul></li><li>14. Techniques for group work</li><li>15. Effective meetings</li></ul>
<b>Using data</b>	<ul style="list-style-type: none"><li>16. Introduction to data</li><li>17. Data collection, display and analysis</li><li>18. Tools for data display and analysis</li><li>19. Questions to ask when presented with data</li><li>20. Costing and budgeting</li></ul>
<b>Working with Groups</b>	<ul style="list-style-type: none"><li>21. Observing groups in action</li><li>22. Understanding groups</li><li>23. Making interventions</li><li>24. Resistance to change</li></ul>
<b>Miscellaneous</b>	<ul style="list-style-type: none"><li>25. Tips for facilitators</li><li>26. Further reading and information</li></ul>

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## REFERENCES

- 1 NSW Health. *The framework for managing the quality of health services in New South Wales*. Sydney: NSW Health Department, 1999.
- 2 Barraclough BH. Safety and quality in Australian healthcare: making progress. *Medical Journal of Australia* 2001; 174 (12): 616-7.
- 3 Braithwaite J, Finnegan T, Graham B, Degeling PJ, Hindle D, Westbrook M. How important are safety and quality for clinician-managers? Qualitative evidence from triangulated studies. *Clinical Governance: an International Journal* 2004; 9: in press.
- 4 Smallwood R. Safety and quality in healthcare: what can England and Australia learn from each other? *Clinical Medicine* 2003; 3 (1): 68-73.
- 5 Mawji Z, Stillman P, Laskowski R, Lawrence S, Karoly E, Capuano TA, Sussman E. First do no harm: integrating patient safety and quality improvement. *Joint Commission Journal on Quality Improvement* 2002; 28 (7): 373-86.
- 6 Scally G, Donaldson LJ. Looking forward: clinical governance and the drive for quality improvement in the new NHS in England. *British Medical Journal* 1998; 317 (7150): 61-5.
- 7 Independent Pricing and Regulatory Tribunal. *NSW Health: focusing on patient care*. Sydney: NSW Government, IPART Report, 2003.
- 8 Robinson ME, Stewart GJ, McCaughan BC, Braithwaite J, Tridgell P. *Clinical governance in the NSW health system*. Sydney: NSW Health, Submission to IPART, 2003.
- 9 O'Rourke I, Robinson ME, Braithwaite J. *Proposal for the enhancement of the clinical governance development and training program*. Sydney: ICE, Submission to the ICE Board, 2003.
- 10 Fink A. *Evaluation fundamentals: guiding health programs, research, and policy*. New York: Sage, 1993.
- 11 United Kingdom Evaluation Society (UKES). Glossary of evaluation terms [[http://www.evaluation.org.uk/ukes\\_new/Pub\\_library/Glossary.htm](http://www.evaluation.org.uk/ukes_new/Pub_library/Glossary.htm), last accessed 23 September 2003]
- 12 Braithwaite J, Hu W, Sorensen R, Patterson R, Meyerkort S, Salkeld G, Zhang K, Mallock N, Iedema R, Betbeder-Matibet L. *Evaluation of the Clinical Practice Improvement Training Program*. Sydney: Centre for Clinical Governance, NSW and Institute for Clinical Excellence NSW, 2002.
- 13 National Audit Office. *Achieving improvements through clinical governance – a progress report on implementation by NHS Trusts*. London: National Audit Office, 2003.
- 14 NSW Health. *The clinician's toolkit for improving patient care*. Sydney: NSW Health, 2001.
- 15 O'Rourke I, Robinson ME, Braithwaite J. *Proposal for the enhancement of the clinical governance development and training program*. Sydney: ICE, Submission to the ICE Board, 2003.
- 16 National Health Service. *Governing the NHS – a guide for NHS Boards*. Leicester: NHS Clinical Governance Support Team, 2003.
- 17 National Health Service. *Integrated governance*. NHS Clinical Governance Support Team, 2003 [in preparation].

- 18 Rogers EM. *Diffusion of Innovations* (5<sup>th</sup> ed). New York: Free Press, 2003.
- 19 Van de Ven AH, Polley DE, Garud R, Venkatamaran S. *The Innovation Journey*. New York: Free Press, 1999.
- 20 NSW Health. *The framework for managing the quality of health services in New South Wales*. Sydney: NSW Health Department, 1999.
- 21 Robinson ME, Stewart GJ, McCaughan BC, Braithwaite J, Tridgell P. *Clinical governance in the NSW health system*. Sydney: NSW Health, Submission to IPART, 2003.
- 22 Senate and House of Representatives of the United States of America. *Patient safety and quality improvement Act*. Washington, DC: [Currently before Congress], 2003.
- 23 Minister for the Interior and Health, Denmark. *Act on patient safety in the Danish health care system*. Göthenberg, Denmark: Act No 429 of the Parliament of Denmark, 2003.
- 24 Kennedy I. *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 –1995*. London: Command Paper: CM 5207: <http://www.bristol-inquiry.org.uk/index.htm>, last accessed 18 October 2003.
- 25 Smith J. *The Shipman Inquiry [Three reports: Report one: death disguised; Report two: the police investigation of March 1998; Report three: death certification and the investigation of deaths by coroners]*. London: <http://www.the-shipman-inquiry.org.uk/home.asp>, last accessed 18 October 2003.
- 26 Redfern M, Keeling J, Powell E. *The Report of The Royal Liverpool Children's Inquiry*. London: HMSO, 2001: <http://www.rlcinquiry.org.uk/>, last accessed 18 October 2003.