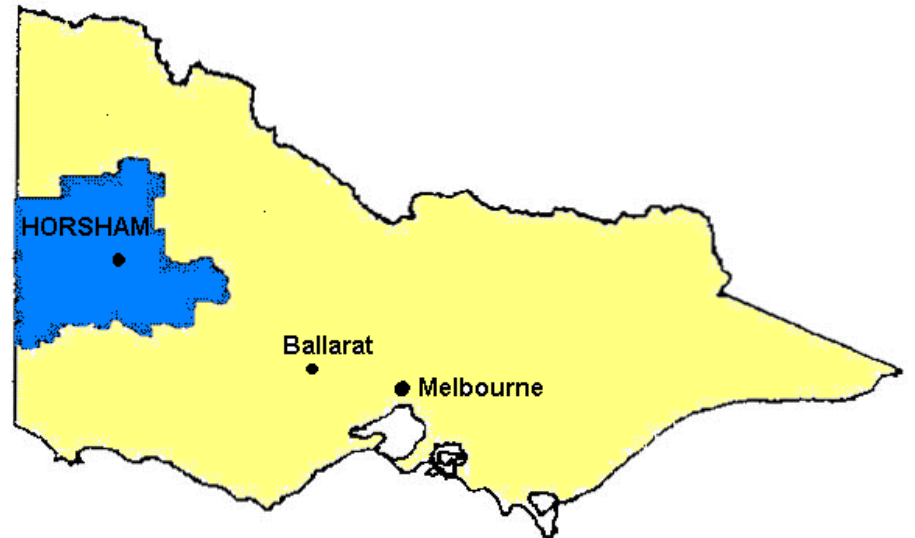
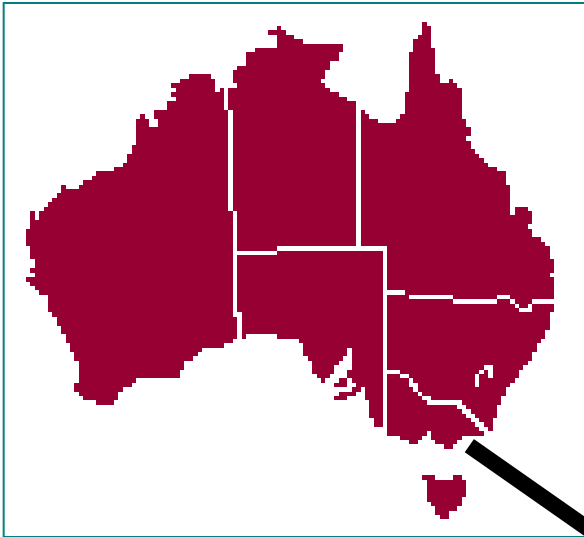


The Role of Boards of Management in Clinical Governance

Professor Alan Wolff

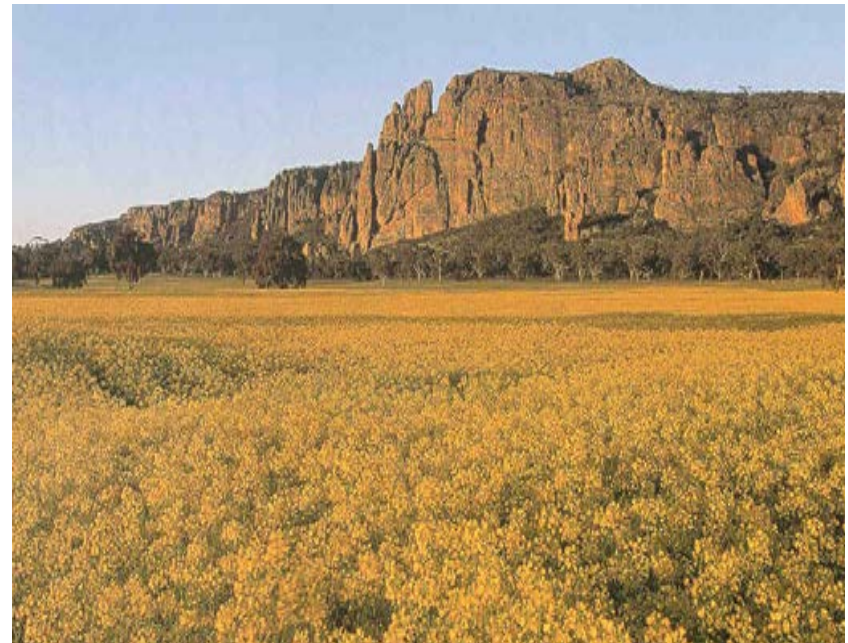
Wimmera Health Care Group

October 2015



Horsham, Victoria, Australia

- North Western Victoria
- Cropping & sheep farming
- Nearest tertiary referral centre 200 kms
- Melbourne - 300 kms
- 55,000 area population

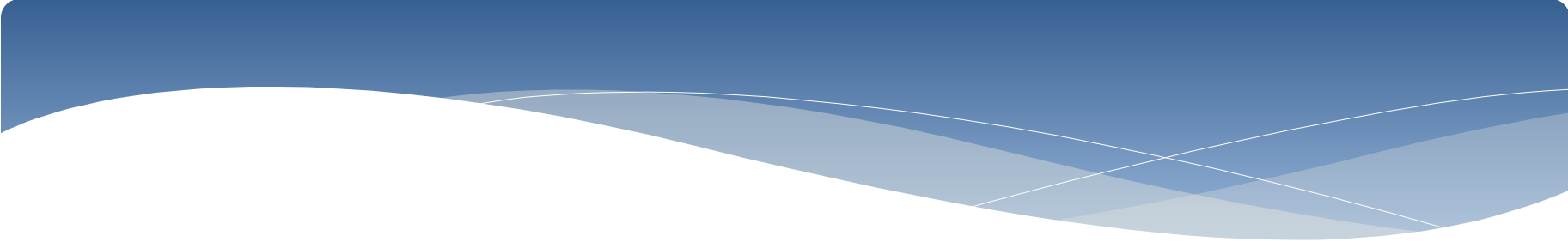




Clinical Governance

What is it?





“Doing the right thing, at the right time, by the right person – the application of the best evidence to a patient’s problem, in the way the patient wishes, by an appropriately trained and resourced individual or team... working within an organisation that is accountable for the actions of its staff, values its staff (appraises and develops them), minimises risk and learns from good practice and indeed mistakes”

Gray C. What is clinical governance? BMJ Career Focus 2005; 330:
254-261

CLINICAL GOVERNANCE



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graph TD; A[CLINICAL GOVERNANCE] --> B[Quality]; A --> C[Safety]; B --> D[Quality Improvement]; C --> E[Risk Management]
```

The diagram illustrates the structure of Clinical Governance. At the top level is 'CLINICAL GOVERNANCE'. This branches into two main areas: 'Quality' and 'Safety'. 'Quality' further leads to 'Quality Improvement', and 'Safety' leads to 'Risk Management'. All text is in a bold, blue, sans-serif font within rectangular boxes.

Quality

Safety

Quality Improvement

Risk Management

WIMMERA BASE HOSPITAL

EMERGENCY

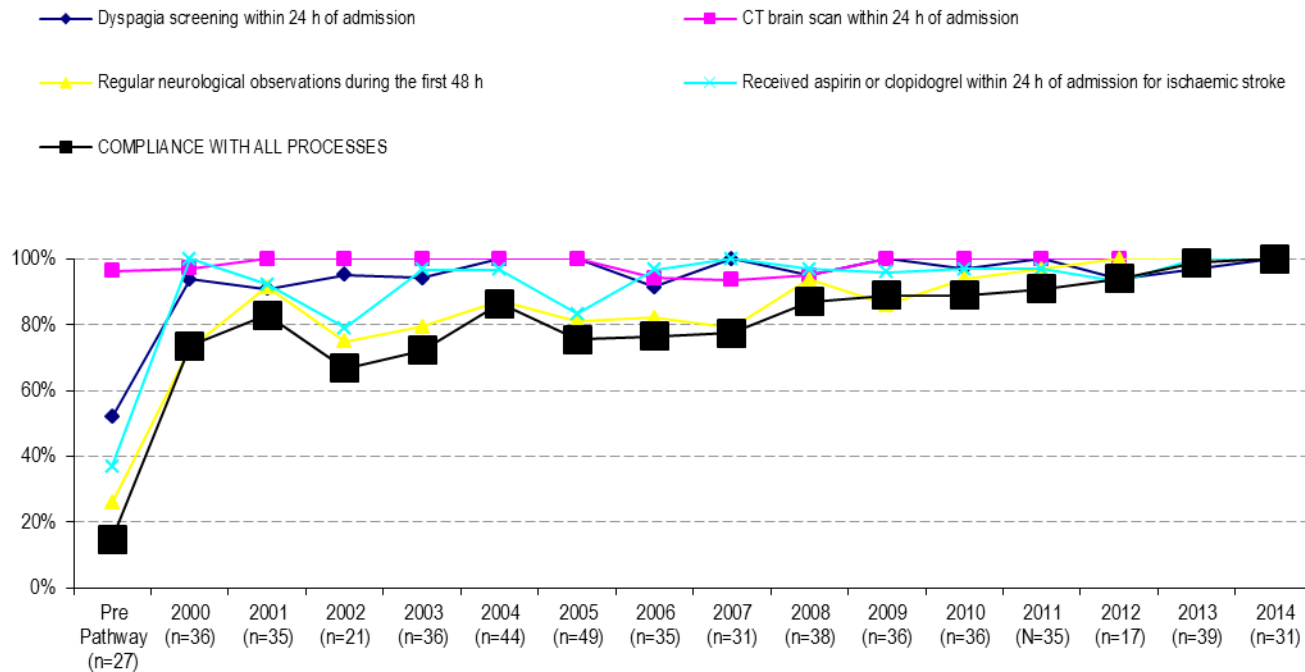


Quality Improvement

= getting it right more often

Stroke Pathway Audit

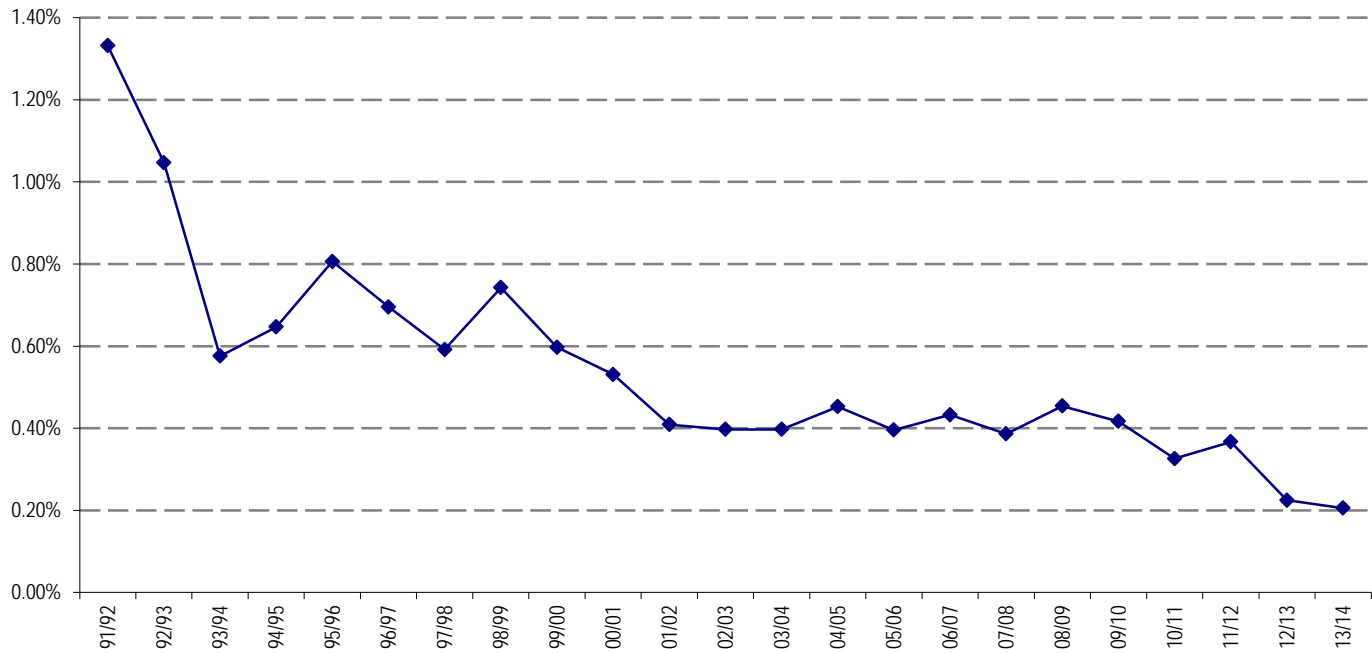
Timeline of proportion of patients with stroke who received key interventions before and after introduction of the clinical pathway



Risk Management

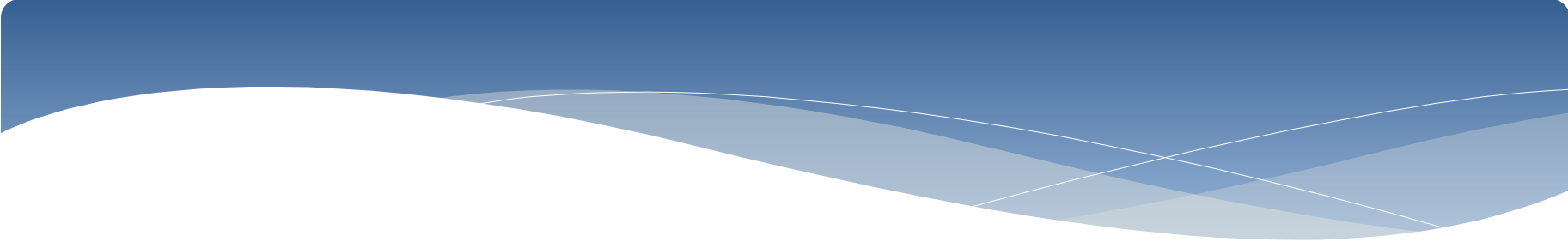
= getting it wrong less often

Inpatient Adverse Event Rate (% Separations)

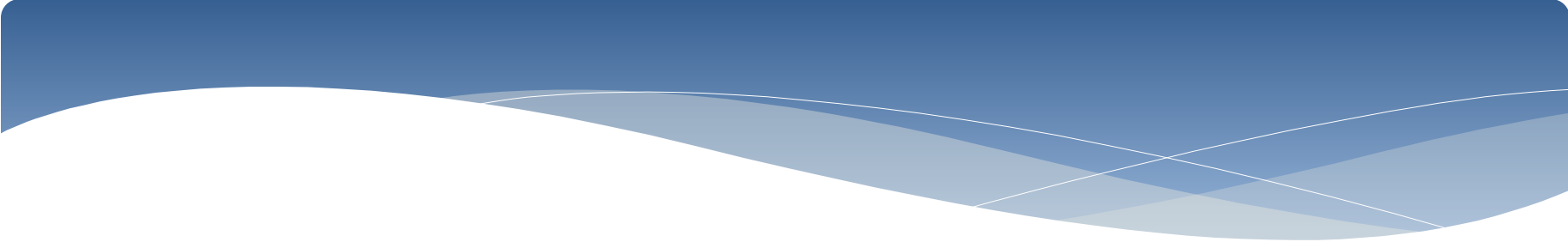


Core Components of Clinical Governance

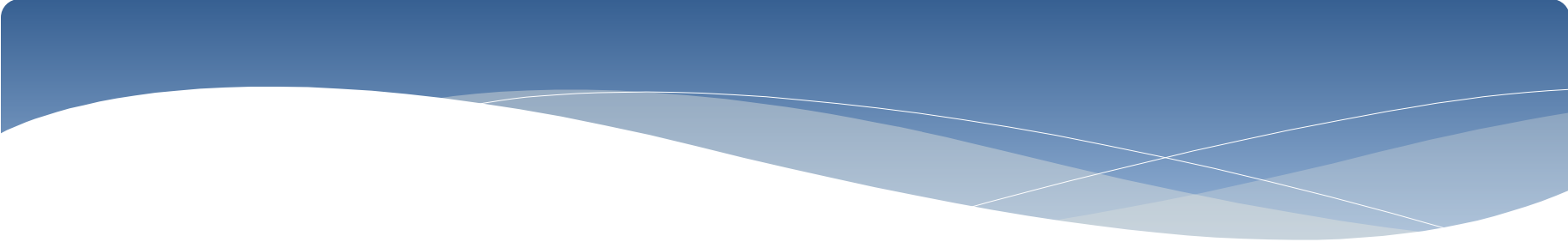
- Credentialing and privileging
- Risk management
- Clinical audit
- Evidence based medicine
- Professional development
- Consumer involvement
- Organisation factors (eg. resources, support, communication)



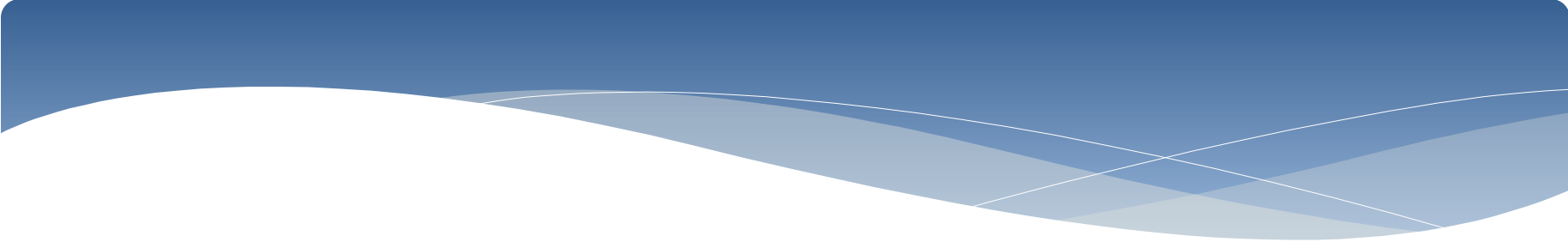
*Health service boards are
responsible for the quality & safety of
the care their service provides to
patients*



“Board members may be confused or intimidated by the clinical area of quality and safety, and consequently may devote much more time to their areas of comfort such as finance.” (Carlow, 2010)



There is emerging evidence that health
service boards can impact on the quality
& safety of the patient care



A postal survey of 445 US not for profit hospitals found an association between better processes of care and mortality in managing patients with cardiac failure, myocardial infarction, and pneumonia, and boards having:

- a standing board quality committee*
- spending a significant time discussing quality issues at most board meetings*
- regularly reviewing their hospital's quality performance using dashboards or balanced scorecards*
- reporting the hospital's quality and safety performance to the public*
- requiring new clinical programs and services to meet quality-related performance criteria*
- and the board and medical staff are as involved as management in setting the agenda for the board's discussion on quality*

The Role of Boards in Clinical Governance

- Obtain expertise
- Formulate strategy
- Ensure a robust framework
- Monitor performance
- Take appropriate action
- Shape culture
- Evaluate performance

The Role of Boards in Clinical Governance

1. Have knowledge, skills and experience in health care & quality and safety
 - Core competency
 - Education
2. Formulate strategy and participate in the development, implementation and achievement of the clinical quality and safety plan

The Role of Boards in Clinical Governance

3. Ensure a robust framework is in place that ensures high quality and safe care:
 - Quality and safety is the Board's highest priority
 - Structures, systems, processes, policies and procedures supporting clinical quality and safety are robust, reliable, transparent and regularly reviewed (e.g. committee structure, risk management, reporting, monitoring, accountability)
 - Adequate resources are allocated
 - A comprehensive annual quality & safety plan is developed and implemented

The Role of Boards in Clinical Governance

4. Regularly monitor performance and validate data
 - Effective monitoring systems have been developed and implemented
 - Quantitative data – accurate and timely reports of an appropriate, balanced and comprehensive set of high level, key performance measures (assessed against appropriate standards)
 - Qualitative data – patients, staff
 - Progress made towards objectives of clinical quality and safety plan

The Role of Boards in Clinical Governance

5. Action

- All board decisions are made after considering and recording their potential effect on clinical quality and safety
- Ensure the improvement loop is closed when suboptimal or unsafe care has occurred

The Role of Boards in Clinical Governance

6. Shape a healthy culture by establishing, modelling and promoting values
 - High visibility in the health service
 - Place emphasis on quality and safety (first item on agenda & 20% of board meeting time)
 - Visibly engage with staff, patients and local community
 - Maintaining effective relationships with senior leadership and medical staff leadership
 - Supporting innovation
 - Disseminate clinical quality and safety program objectives and results widely
 - Recognise, acknowledge and celebrate when staff provide high quality and safety

The Role of Boards in Clinical Governance

7. Regularly evaluate the board's clinical governance performance
 - Internal – self evaluation
 - External – utilising regulators, the public and clinical quality and safety experts

Wimmera Medical Centre



An Action Plan to Achieve Best Practice in Clinical Governance

ACTION PLAN

1.

Clinical quality and safety is a key and prominent component of the health service's vision, mission, values and strategic plan.

2.

There is clinical quality and safety
subcommittee of the board.

3.

The health service has a clinical quality & safety plan that describes:

- how clinical quality & safety is structured;
- the measurements that will be made;
- how the board will directly engage with patients, relatives, clinical staff, key partners, and the public;
- the composition & frequency of the clinical quality and safety report;

3

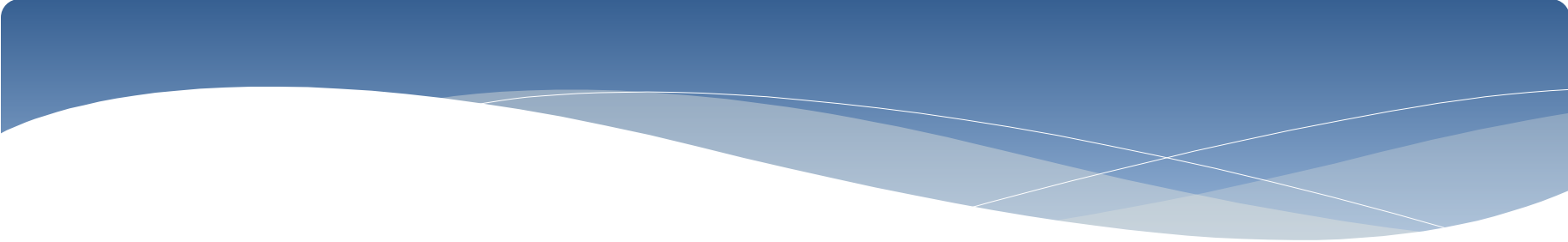
The health service has a clinical quality & safety plan that describes *(continued)*:

- how data will be audited;
- how results will be disseminated throughout the health service;
- the resources allocated;
- the board & staff clinical quality and safety education program and is:
 - consistent with national & state requirements & best practice in clinical quality and safety; and
 - reviewed annually.

4.

Board members have appropriate knowledge in clinical quality and safety

- Quality and safety is a key board member competency
- One or more board members are doctors.
- Information about clinical quality and safety is part of the board member orientation program.
- There is an ongoing clinical quality and safety education program for board members.



A study of Californian hospitals, found the absence of doctors on boards was associated with a 1.5-5% decrease in quality of care measures in patients treated for heart attack, heart failure, pneumonia or surgery infection prevention (Baker & Krishan, 2014)

5.

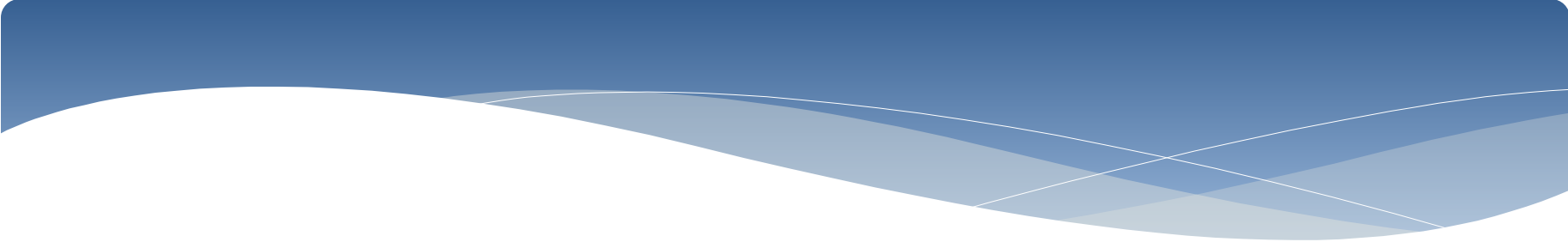
Board meetings:

- Discuss clinical quality and safety as the first item on the agenda of each board meeting;
- Commence with a patient discussing their experience in health service
- Discuss the impact of all board decisions on clinical quality and safety;

5.

Board meetings(*continued*):

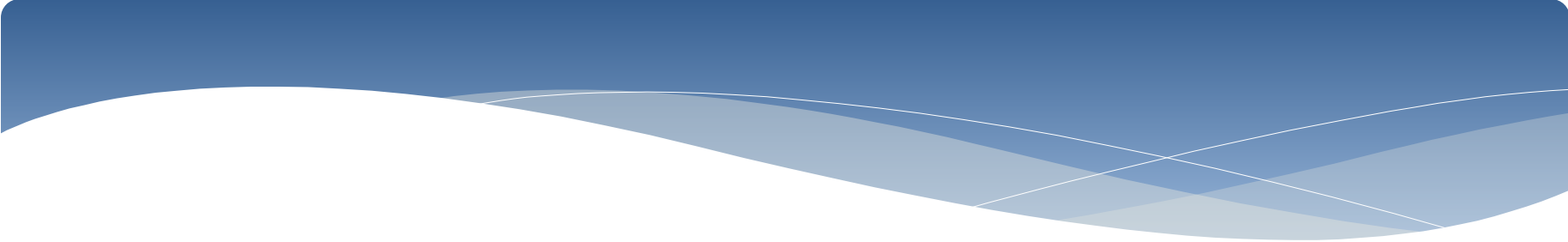
- Spend more than 20% of the meeting discussing clinical quality and safety; and
- End with members reflecting on how the meeting has improved clinical quality and safety in the health service



“When [board members] hear stories of the patients whose lives have been affected by quality and safety events, boards will drive for improvement with a much greater sense of urgency and commitment.” (Reinertsen, Bisognano & Pugh, 2008)

6.

Clinical quality and safety discussions at board meetings have resulted in actions that have measurably improved the quality and safety of patient care.



“the concern of some board members [is] that they are drowning in data yet thirsty for meaningful information.”

(Bismark, 2013)



Designing safe care systems

7

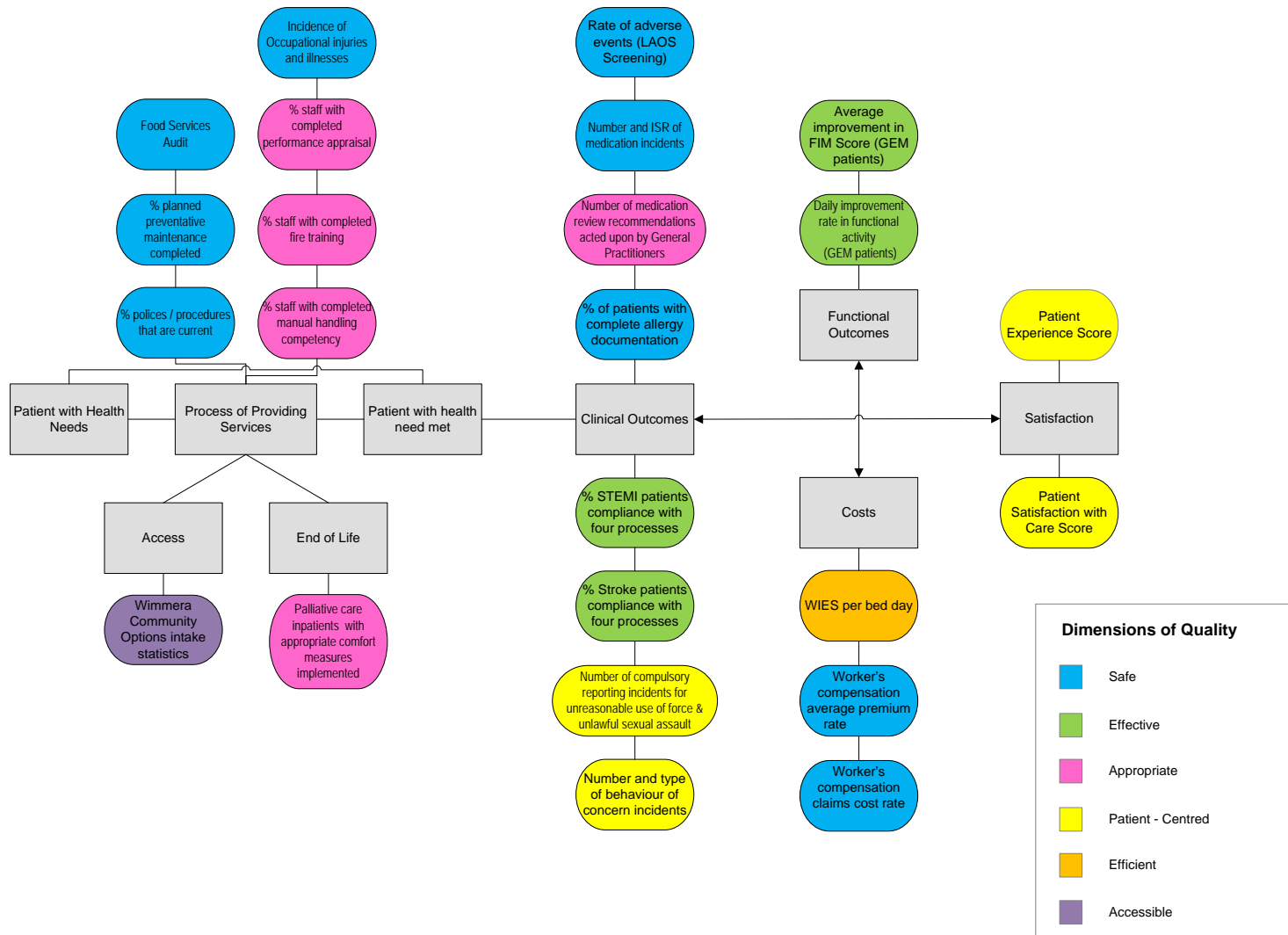
Board reports include:

- high level system-wide measurements
- clinical audits
- a summary of adverse patient events
- reports to insurers of clinical incidents
- a risk register of current and potential extreme and high risks
- patient complaints

7.

Board reports include *(continued)*:

- legal claims
- patient satisfaction/experience data
- accreditation and other external ratings or assessments
- safety culture data



KEY FOR KPI'S		
<u>Tolerance Level</u>	<u>Range</u>	<u>Audit Frequency</u> (Unless timeframe is set by other requirements)
	Greater than 20% of target OR Outside 95% Confidence Levels OR 2 Standard Deviations	Audit monthly
	Between 5 - 20% of target	Audit quarterly
	Within 5% of target	Audit 6 monthly, if remains within 5% of target for 2 consecutive audits then reduce to annually.
Movement Guide		
↓↑	Green arrow (positive result)	
↓↑	Red arrow (negative result)	
→	Blue arrow (no change in results)	

Agenda Item No * 9.1.4	Key Performance Indicator <u>Clinical Pathways Indicators</u> (Copy Attached)	Result	Target	Movement since last report	Tolerance Level
Reported by: Mrs Taylor	STEMI patients commenced on the pathway receiving all key discharge medications (Antiplatelets; Statins; Beta Blockers; ACE Inhibitors).	100%	100%	→	
	Stroke patients commenced on the pathway receiving ALL four processes of care: (Dysphagia screening within 24hrs; CT brain scan within 24hrs; regular neurological observations during first 48hrs; Aspirin or Clopidogrel within 24hrs for ischemic stroke patients)	100%	100%	↑	
Improvements since last report		Planned Actions			
<ul style="list-style-type: none"> ➤ Ongoing monitoring of the number of patients with ST Elevation Acute Myocardial Infarction and Stroke to determine proportion who receive key interventions. ➤ Audit results circulated to staff and used for training purposes ➤ Review of ST Elevation Acute Myocardial Infarction Clinical Pathway ➤ Review of the Stroke Clinical Pathway 		<ul style="list-style-type: none"> ➤ Update of ST Elevation Acute Myocardial Infarction Clinical Pathway ➤ Update of the Stroke Clinical Pathway ➤ Appointment of Victorian Stroke Telemedicine (VST) site coordinator to implement stroke telemedicine and to assist in quality improvement activities for stroke care 			
Board Response:					
For Information					

Clinical Pathway Indicators (October 2015)

AGENDA ITEM NO 9.1.4

Indicator 1: % STEMI patients compliance with 4 process indicators

Indicator 2: % Stroke patients compliance with 4 process indicators

Responsibility: Clinical Pathways Co-ordinator

Description: The Wimmera Health Care Group Clinical Pathways Policy states that each Clinical Pathway must be reviewed at a minimum of 3 years or earlier as necessary in order to:

- ensure pathways are based on current evidence based practice
- monitor variance and take action as appropriate
- provide benchmark data for comparison on practice patterns.

Indicator 1: The proportion of patients with STEMI (ST Elevation Myocardial Infarction) who received all key discharge medications (Antiplatelets; Statins; Beta Blockers; ACE Inhibitors).

Indicator 2: The proportion of patients with stroke who received all key processes of care (Dysphagia screening within 24hrs; CT brain scan within 24hrs; regular neurological observations during first 48hrs; Aspirin or Clopidogrel within 24hrs for ischemic stroke patients).

Why monitor this KPI: Process indicators are a sensitive measure of the quality of patient care. In many clinical conditions achieving the best outcome requires completion of all processes of care individually demonstrated to improve patient outcome. An "all or none measurement" of compliance with all key process indicators provides greater precision in measuring the quality of care being provided and improvements in care being made.

The STEMI Pathway has been implemented at Wimmera Health Care Group since 2001. Measuring four key processes achieved individually and as a 'bundle of care' ensures we are providing quality care leading to improved patient outcomes.

The Stroke Pathway has been implemented at Wimmera Health Care Group since 2000. Measuring four key processes achieved individually and as a 'bundle of care' ensures we are providing quality care leading to improved patient outcomes.

Frequency of Monitoring: annually

Related Accreditation Standard:

National Safety and Quality Health Service Standards (NSQHSS)

- Standard 1.2.2 Action is taken to improve the safety and quality of patient care
- Standard 1.5.2 Action is taken to minimise risks to patient safety and quality of care
- Standard 1.6.2 Action is taken to maximise patient quality of care
- Standard 1.7.1 Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce
- Standard 1.7.2 The use of agreed clinical guidelines by the workforce is monitored

Method:

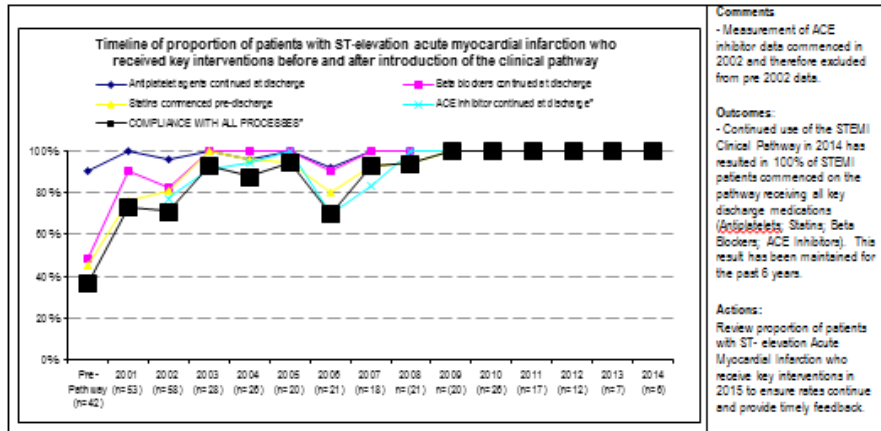
Indicator 1: Retrospective audit of Wimmera Health Care Group patients admitted and coded as a STEMI admission (F41A-F60C) and placed on the STEMI Pathway.

Indicator 2: Retrospective audit of Wimmera Health Care Group patients admitted and coded as a stroke admission (B70A-B70D) and placed on the Stroke Pathway.

Item	Key Performance Indicator (April - June 2015)	Result	Target	Movement since last report	Tolerance Level
	STEMI patients commenced on the pathway receiving all key discharge medications (Antiplatelets; Statins; Beta Blockers; ACE inhibitors).	100%	100%	→	
	Stroke patients commenced on the pathway receiving ALL four processes of care: (Dysphagia screening within 24hrs; CT brain scan within 24hrs; regular neurological observations during first 48hrs; Aspirin or Clopidogrel within 24hrs for ischemic stroke patients)	100%	100%	↑	
Improvements since last report		Planned Actions			
<ul style="list-style-type: none"> • Ongoing monitoring of the number of patients with ST Elevation Acute Myocardial Infarction and Stroke to determine proportion who receive key interventions. • Audit results circulated to staff and used for training purposes • Review of ST Elevation Acute Myocardial Infarction Clinical Pathway • Review of the Stroke Clinical Pathway 		<ul style="list-style-type: none"> • Update of ST Elevation Acute Myocardial Infarction Clinical Pathway • Update of the Stroke Clinical Pathway • Appointment of Victorian Stroke Telemedicine (VST) site coordinator to implement stroke telemedicine and to assist in quality improvement activities for stroke care 			
Response:					
For information					

Results of Audit

Indicator 1

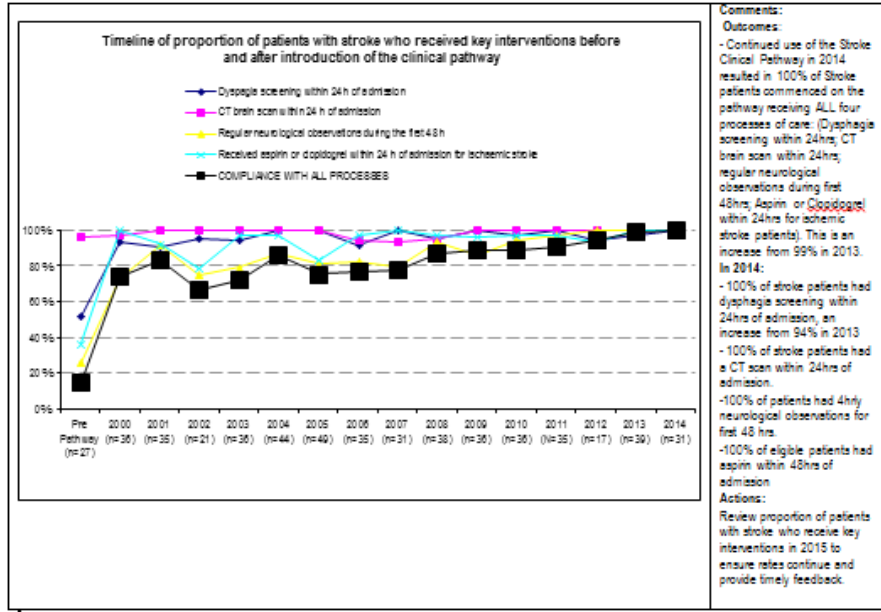


Comments:
- Measurement of ACE inhibitor data commenced in 2002 and therefore excluded from pre 2002 data.

Outcomes:
- Continued use of the STEMI Clinical Pathway in 2014 has resulted in 100% of STEMI patients commenced on the pathway receiving all key discharge medications (Antiplatelets; Statins; Beta Blockers; ACE Inhibitors). This result has been maintained for the past 6 years.

Actions:
Review proportion of patients with ST-elevation Acute Myocardial Infarction who receive key interventions in 2015 to ensure rates continue and provide timely feedback.

Indicator 2



Comments:

Outcomes:
- Continued use of the Stroke Clinical Pathway in 2014 resulted in 100% of Stroke patients commenced on the pathway receiving ALL four processes of care: (Dysphagia screening within 24hrs; CT brain scan within 24hrs; regular neurological observations during first 48hrs; Aspirin or Clopidogrel within 24hrs for ischemic stroke patients). This is an increase from 99% in 2013. In 2014:
- 100% of stroke patients had dysphagia screening within 24hrs of admission, an increase from 94% in 2013
- 100% of stroke patients had a CT scan within 24hrs of admission
- 100% of patients had 4hrly neurological observations for first 48 hrs
- 100% of eligible patients had aspirin within 48hrs of admission

Actions:
Review proportion of patients with stroke who receive key interventions in 2015 to ensure rates continue and provide timely feedback.



8.

The board, independently of executives or clinical staff, set at least one goal annually to measurably improve quality or reduce harm in a specific area.

9.

Actions decided at previous meetings in response to reports are placed on an action list which is reviewed as a standing agenda item at each meeting.

10.

There is an annual audit of the quality of data about clinical quality and safety reported to the board.

11.

The objectives and results of the clinical quality and safety program are disseminated to all staff.

12.

The chief executive is held accountable for clinical quality and safety in the health service.

13.

Adequate resources are allocated to enable the health service to undertake appropriate clinical quality and safety activities.

14.

Regular education and training about clinical quality and safety is provided to all staff commencing at orientation.

15.

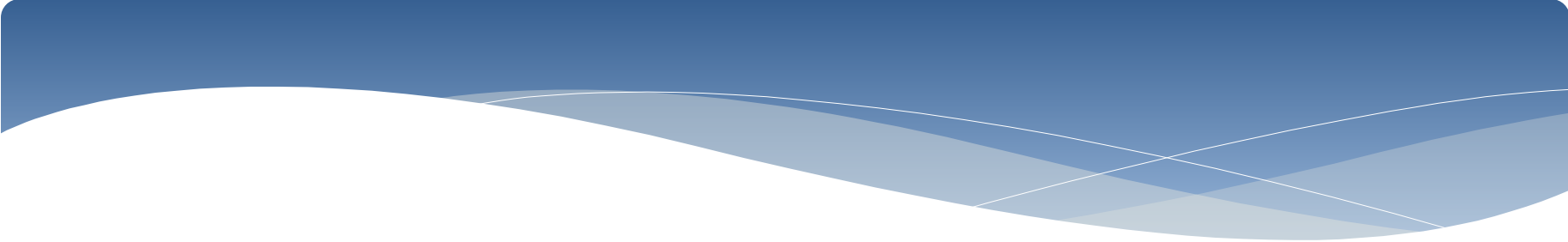
The knowledge, skills, attitude and engagement of staff in clinical quality and safety is regularly assessed.

16.

High quality and safe care provided by staff is encouraged, acknowledged and celebrated.

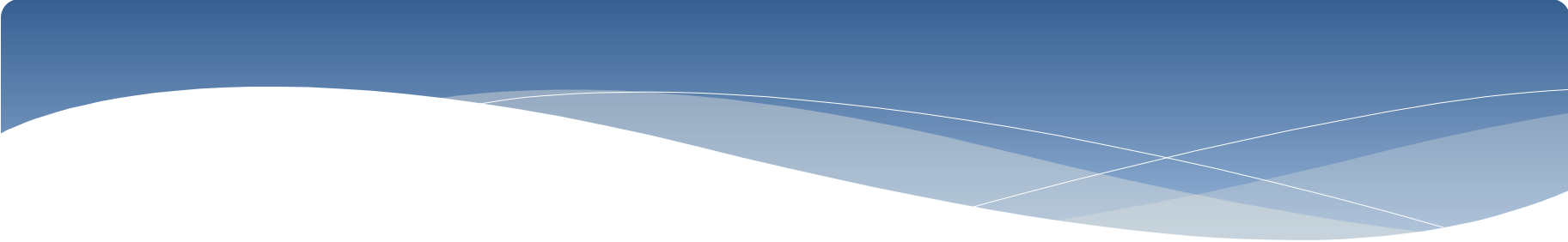
17.

Board members walk around the Health Care Group with senior clinical staff each month to talk with patients and staff about their experiences and discuss these interactions at each Board meeting



“...boards should demonstrate through their actions that they value staff and pay attention to staff health and wellbeing” “organisations with engaged staff deliver better patient experience, fewer errors, lower infection and mortality rates, stronger financial management, higher staff morale and motivation and less absenteeism and stress.”

(The King's Fund, 2012)



“The serious failure of the [Mid Staffordshire Trust] Board was in part attributed to its failure to listen sufficiently to its patients and staff or to ensure the correction of deficiencies brought to the Trust’s attention.” (Muhlebach, 2013)

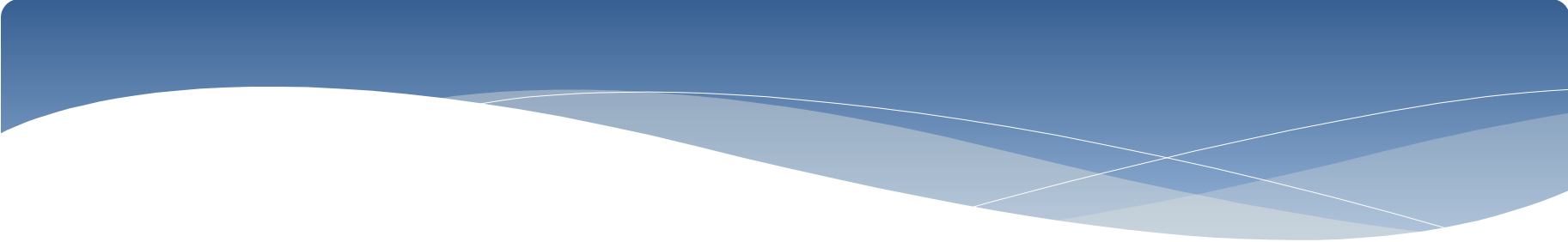


18.

The board undertakes an annual self-evaluation of its clinical governance performance.

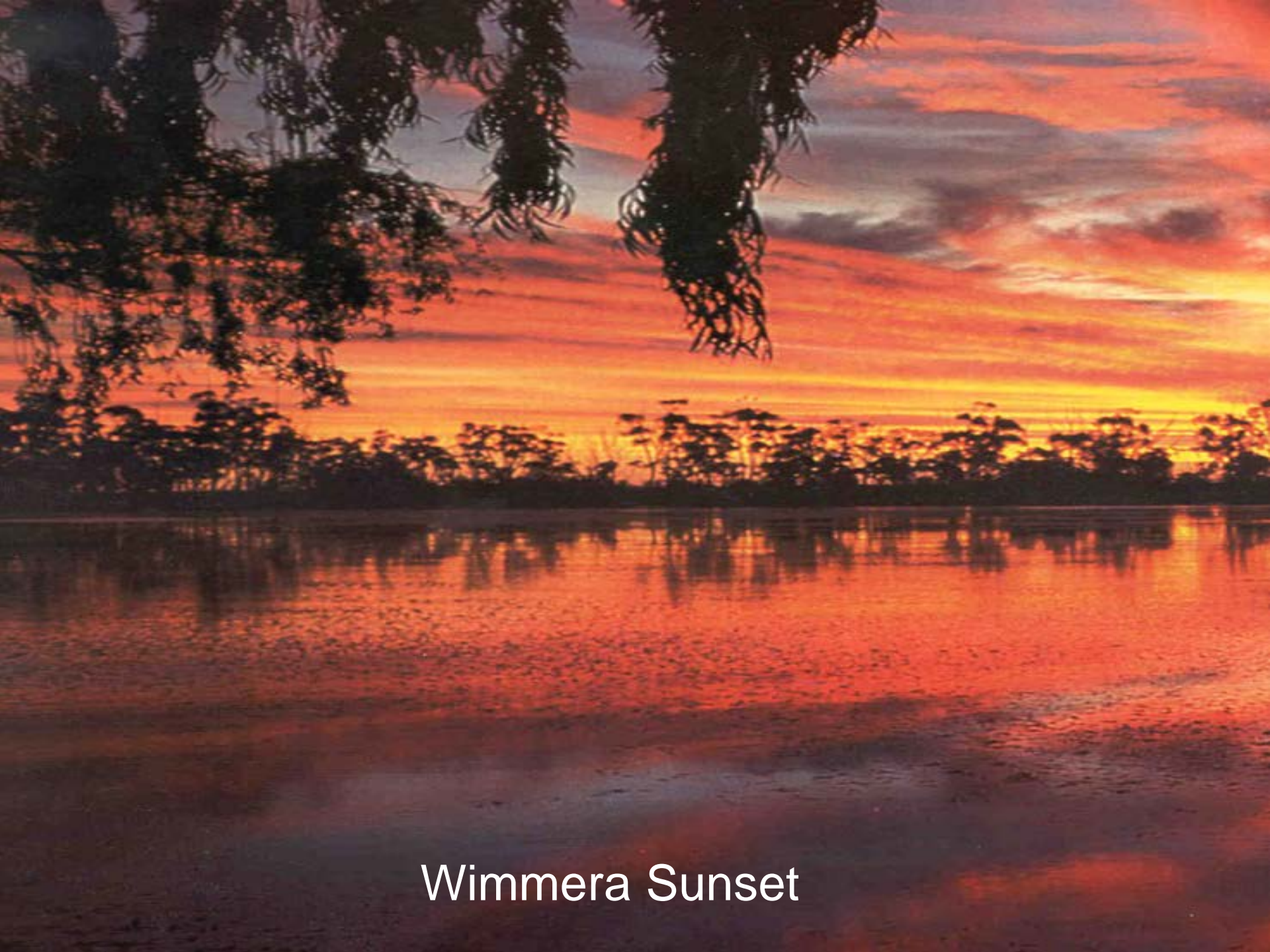
19.

The board seeks regular external review of clinical quality and safety in the health service and its clinical governance processes and performance.



“What the board pays attention to gets the attention of management. And what management is paying attention to tends to be noticed throughout the organisation.”

(Reinertsen, 2007)



Wimmera Sunset