

CLINICAL GOVERNANCE

A Guide for Primary Health Organisations

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Introduction

Clinical governance can help Primary Health Organisations (PHOs) foster teamwork, support individual clinical and non-clinical staff, meet the requirements of the PHO Performance Management Programme and most importantly improve health outcomes for their enrolled populations.

The concept of clinical governance is not new, although the terminology may be. Most Independent Practitioner Associations (IPAs) engaged in various forms of clinical governance activity and the infrastructure they developed to support this activity has provided the building blocks for most of the larger PHOs that have superseded them. This infrastructure has included management and clinical staff, information systems, clinical guidelines, peer discussion groups, continuing medical education (CME), continuing nursing education (CNE) and personalised feedback on clinical performance.

However, as PHOs take on wider responsibilities for their enrolled populations, there is a need to redefine clinical governance in the context of the Primary Health Care Strategy and the upcoming PHO Performance Management Programme.

While the Health Practitioners Competence Assurance Act (HPCAA) places the responsibility for maintaining individual competency of clinicians on the clinicians themselves and their governing bodies, there is no guarantee clinicians are meeting the expectations of PHOs, or conversely, whether PHOs are meeting the expectations of clinicians. From a broader PHO perspective, an effective clinical governance structure will ensure PHOs maintain high standards of clinical care and their quality of service is continually improved across the entire organisation.

“To be effective, clinical governance should reach every level of a healthcare organisation. It requires structures and processes that integrate financial control, service performance and clinical quality in ways that will engage clinicians and generate service improvements¹.”

Note:

For the purposes of this guide, the term “clinician” refers to general practitioners, nurse practitioners, primary care nurses and any other health professionals providing face to face primary care to their PHO’s enrolled population.

¹ Degeling P, Maxwell S, Iedema R, Hunter D. Making clinical governance work. BMJ 2004;329:679-681

Defining Clinical Governance

Early United Kingdom discussions struggled with a definition for clinical governance. Initial guidance on the duty of NHS trusts set out mandatory components of clinical governance and some of the structures that must be in place. Clinical governance can be defined as:

“A framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish².”

Unlike the NHS with its prescriptive clinical governance models, PHOs will be expected to develop their own models of clinical governance based on what best suits their communities of interest while meeting the requirements of the PHO Performance Management Programme. These include the added responsibilities of financial accountability and a requirement to operate within the limits of finite resources - important factors missing from early NHS models.

Despite these differences, a lot can be learned from the United Kingdom experiences. (See Appendix 3 - Recommended Reading)

Why We Need Clinical Governance

Having a vision of *“continuously improving the quality of their services”* is not sufficient in itself - the real challenge for PHOs is to gain a common understanding of what that vision means for individuals within the PHO, and what is required to make the vision a reality.

The aim of this guide is to introduce PHOs to the processes behind the concept of clinical governance, so when they develop their model for improvement they can address the following questions with confidence:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What change can we make that will result in improvement?

² Scally G, Donaldson L. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998;317:61-65 (4 July)

Suggested Elements of Clinical Governance

Because the clinical team is at the core of clinical work, engaging with clinicians during the development and implementation of clinical governance plans will need to be an essential ingredient for success³. It has been shown that the key elements of clinical governance suggested below will only be successfully implemented if the following recommendations are adhered to:

- Clinicians remain central to making decisions in the best interests of individual patients within available resources
- Clinical governance should address all elements, rather than focusing on selected elements such as risk, safety or quality
- Proceedings and discussions around clinical governance are conducted in an open and transparent manner¹

Failure to adhere to these recommendations or not taking account of the detailed composition of a clinician's work could result in clinicians disengaging from the whole process¹.

Literature reviews and expert opinion have identified 6 elements of clinical governance PHOs will need to address when designing their own model. These are:

1. Clinical effectiveness
2. Quality assurance
3. Provider education and development
4. Clinical audit → continuing quality improvement (CQI)
5. Risk management
6. Research and development

1. Clinical effectiveness

Clinical effectiveness is a measure of the extent to which a particular intervention works. The measure on its own is useful, but is enhanced by considering whether the intervention is appropriate and whether it represents value for money.⁴

PHOs will need to consider some of the qualitative aspects of care especially the broader definition which includes issues such as continuity of care, care which is sensitive to the personal needs of the patient and care which is based on an holistic analysis of individual patient's needs rather than the effectiveness of any single intervention⁴. This may be of particular importance for PHOs with a significant percentage of Māori or Pacific People enrollees or a community of interest based on a mix of culture and ethnicity.

³ Edwards N. Commentary: Model could work. BMJ 2004;329:681-682

⁴ Starey N. What is clinical governance? www.evidence-based-medicine.co.uk

2. Quality assurance

Quality assurance refers to initiatives designed to assure minimum standards of (existing) care and the mechanisms created to identify and deal with those whose performance does not meet these standards⁵. It encompasses both provider education and clinical audit. If a PHO is to develop effective quality assurance processes, the performance monitoring aspect of clinical audit needs to be developed in a manner which does not disengage clinicians. PHOs will need to foster a “no blame learning environment” - the concept of “what went wrong and what can we learn from this?” rather than “who went wrong?”

Poor performance and poor practice can too often thrive behind closed doors. Processes which are open to public scrutiny, while respecting individual patient and clinician confidentiality, and which can be justified openly, are an essential part of quality assurance.

3. Provider education and development

In the modern health service, it is no longer acceptable for any clinician to abstain from continuing education after qualification - too much of what is learnt during training becomes outdated too quickly.⁴

General practitioners currently participate in a variety of CME activities provided by their own professional bodies, the industry and their peers. They are also recipients of the bpac^{nz} “Responsible Use of Pharmaceuticals” campaign which provides feedback to practitioners on their individual prescribing behaviour, and encourages behavioural change through advocating evidence based best practice. A similar programme focusing on appropriate use of laboratory tests by GPs commenced in July 2005.

Practice nurses participate in a variety of CNE activities provided by their own professional bodies, the industry, their peers and in conjunction with GP programmes.

A number of PHOs also utilise the services of clinical facilitators - these facilitators come from a variety of occupational backgrounds, most being pharmacists with additional post-graduate qualifications, but others have been GPs, nurses, laboratory technicians or former pharmaceutical industry representatives.

The challenge for the PHO is to adopt a multidisciplinary approach to provider education and development which encompasses the requirements of the PHO Performance Management Programme, the services currently being provided to the PHO by bpac^{nz} through the pharmaceutical and laboratory campaigns, and the individual requirements of their clinicians.

⁵ Campbell S, Sheaff R, Sibbald B, Marshall M, Pickard S, Gask L, Halliwell S, Rogers A, Roland M. Implementing Clinical Governance in English primary care groups/trusts: reconciling quality improvement and quality assurance. *Qual Saf Health Care* 2002; 11:9-14

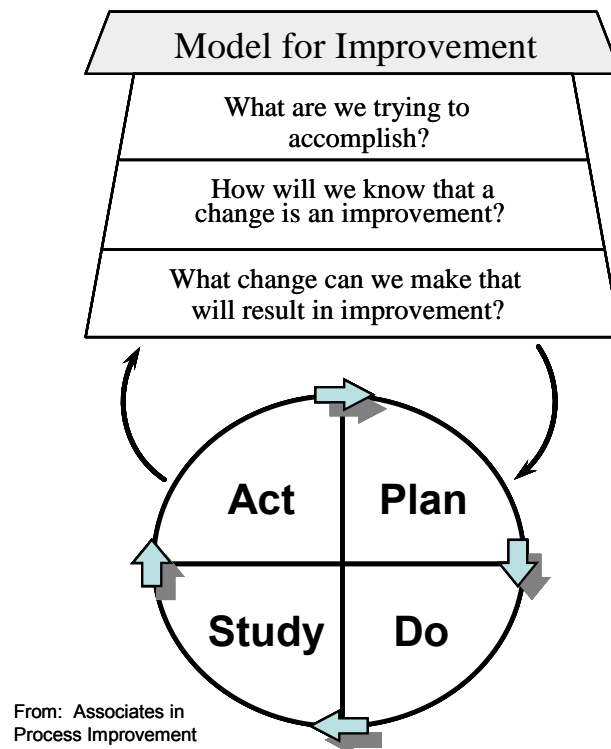
4. Clinical Audit → CQI

Clinical audit comprises the following:

- the review of clinical performance
- the refining of clinical practice as a result
- the measurement of performance against agreed standards or targets

It is a cyclical process resulting in a graduated improvement in the quality of clinical care⁴ - often referred to as “Continuing Quality Improvement” (CQI).

Clinical audit is not new for individual clinicians - most already participate in clinical audit activity through their professional bodies, or can use off-the-shelf audit programmes such as the bpac^{nz} clinical audit tools provided as part of the “Responsible Use of Pharmaceuticals” campaigns. The challenge for PHOs will be to utilise clinical audit tools which measure performance of the entire primary health care team at a practice level.



- **Plan:** Objective - to test a proposed change
Predictions - will assumptions/test be correct?
Plan - write down sequence of activities to achieve the desired change/goal
- **Do:** Carry out the plan
Record confirming and nonconforming observations
- **Study:** Compare data to predictions
Summarise what was learned
Update the team's theory(s)
What is our degree of belief in our theory(s)?
- **Act:** Are we ready to implement the change?
What examples should we test on the next cycle?

5. Risk Management

Providing primary care to an enrolled population carries an element of risk to patients, clinicians and the PHO. These risks all need to be minimised as part of any quality assurance programme

Risks to patients can be minimised by compliance with the Health Practitioners Competence Assurance Act (HPCAA), Occupational Safety and Health (OSH), MedSafe recommendations, individual and organisational indemnity insurance and recommendations provided by the Health and Disability Commissioner. In addition, patient risks can be minimised by ensuring that systems are regularly reviewed and questioned. PHOs can learn from others mistakes and patients' complaints through a process of "significant event auditing" which a number of PHOs have already adopted, or carried over from the IPA environment.

Risks to clinicians can be minimised by ensuring clinicians are immunised against infectious diseases, operate in a safe working environment using best practice recommendations at all times, and are encouraged to participate in quality assurance programmes in a "learning environment". One of the major sources of complaints about clinicians is a failure to adequately communicate. This could be clinician ⇔ patient, clinician ⇔ clinician, clinician ⇔ laboratory, clinician ⇔ pharmacy, etc. Effective communication systems will minimise these risks.

Risks to the PHO can be minimised by ensuring high quality employment practice (including locum procedures and reviews of individual and team performance), compliance with the Privacy Act, well publicised information on rights of consumers, policies on cultural safety and robust enrolment procedures. These standards should be extended to any organisation or individual contracted to provide services to the PHO's population.

6. Research and Development

Good professional practice has always sought to change in the light of new evidence from research. The time lag between recognising potential benefits and introducing change can be shortened by PHOs using and implementing research.

PHOs need to know the treatment or practices they initiate are of benefit to their population. Any initiatives should utilise techniques such as

- critical appraisal of the literature
- sound project management
- development of guidelines and protocols
- implementation strategies

These need to be followed up with the development of a robust evaluation process incorporating baseline data and objective measurement of outcomes. PHOs may consider contracting externally with organisations or individuals who specialise in provision of this support.

Implementing Clinical Governance

There has been much discussion both in the United Kingdom and here in New Zealand about how best to implement clinical governance in the primary health care environment. The UK model has been very prescriptive in terms of lines of accountability and defined structures for NHS trusts to work to, but has come in for a lot of criticism because of this. It is often referred to as the “top down” approach and has been blamed for alienating or even disengaging clinicians from the whole process of clinical governance.

By contrast, the New Zealand IPAs that emerged from the early ‘90s developed their own versions of clinical governance driven largely by the desire of clinicians to set their own minimum standards while adopting a continuing quality improvement (CQI) process as negotiated with the funding organisations of the day. This is referred to as the “bottom up” approach, and while it has found much favour with clinicians who were happy to buy in to the process, it has not always resulted in consistent standards or models of clinical governance across the sector.

The PHO Performance Management Programme has defined clinical, financial and process indicators, so PHOs already know what will be expected by their DHBs in terms of standards and expectations around their performance in all areas of activity. Achieving a balance between what PHO management expects of its clinicians and how this can be reconciled with clinical judgment will require goodwill, understanding and leadership from both management and clinicians. A good medium to facilitate this balance is through the establishment of a clinical governance committee.

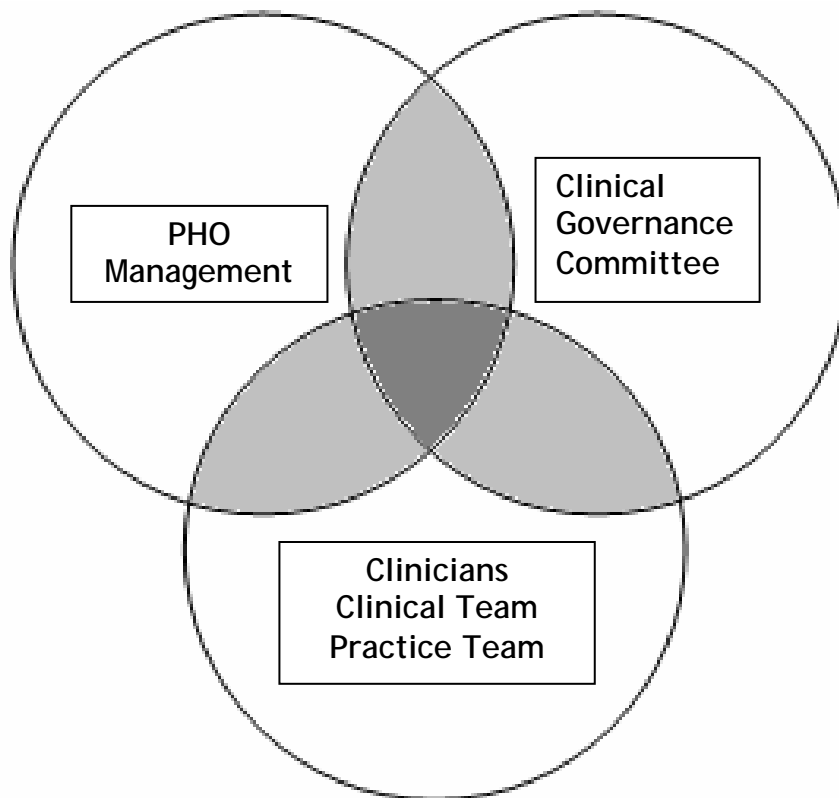
Clinical Governance Committee

The role of a clinical governance committee (CGC) should be to ensure the elements of clinical governance referred to earlier form the basis of activity within the PHO. Everyone within the PHO needs to be aware of their roles and responsibilities if this is to happen. However, this does not mean all communication within the PHO needs to be channeled through the CGC - that would be quite impractical and unnecessary.

Each PHO will need to determine the degree of involvement of their CGC in decision making at a board level. This could range from the CGC giving informal advice to the board through to the CGC making binding decisions for specific activities where the board felt the best advice or expertise should come from the CGC.

The relationships between management, the CGC and clinicians are not straightforward. In the following diagram (Figure 1), the lighter shading demonstrates the potential for tension between any 2 groups, while the darker shading shows the potential for a degree of tension amongst all 3 groups. However, the darker shading also identifies a key liaison opportunity for the clinical facilitator role within the PHO.

Figure 1



Clinical Governance Committee - Membership

PHOs will need to determine the membership of their CGCs in order to ensure they get the best outcomes for their enrolled population. The mix will vary from one PHO to another and will depend on a number of variables including communities of interest, services provided and size of the enrolled population. A suggested skill mix is:

- PHO management
- Clinicians (GP, Nurse)
- Non-clinical (health promoter, smoking cessation provider, other)
- Practice management
- Clinical facilitator
- Community/iwi

Referred Services Management & the PHO Performance Plan

Referred Services Management (RSM) is the term used to describe appropriate utilisation of pharmaceuticals and laboratory tests by clinicians, and forms a major component of a PHO's Performance Plan (See Appendix 1). All PHOs need to develop a PHO Performance Plan acceptable to their DHB before they can participate in the PHO Performance Management Programme, and once in the programme, a number of clinical and financial indicators will relate directly to RSM. (See Appendix 2)

Developing a PHO Performance Plan will require strong leadership from both clinicians and PHO management and the CGC will be central to this process. The PHO will receive support from:

- The PHO Performance Management Programme through centrally generated quarterly reports
- bpac^{nz} through their contracts with PHARMAC and DHBNZ for pharmaceutical and laboratory utilisation and education campaigns
- The services of a clinical facilitator to aid with RSM and the broader delivery of the plan.

The bpac^{nz} Service

The current contract with PHARMAC for “The Responsible Use of Pharmaceuticals” campaign provides support to clinicians, PHOs and DHBs through provision of the following:

- Quarterly educational programmes for clinicians in specific therapeutic areas including a summary of the latest evidence to support best practice (POEMs - Patient Oriented Evidence that Matters)
- Quarterly prescribing reports (subject to available data) at an individual level for GPs in the therapeutic areas as above including peer comparisons within their PHO, their DHB and nationally
- Annual prescribing reports at an individual level for GPs including comparisons as above
- Regular summaries of latest evidence of interest to primary care clinicians through e.t.c. (Evidence that Counts), Bandolier
- Case studies
- Clinical audit resources for practices
- Primary care nurse supplements to POEMs
- Quarterly and annual aggregated data reports for PHOs and DHBs, including comparisons with PHOs with similar demographics
- The bpac^{nz} website: www.bpac.org.nz
- Clinical governance implementation support

The new contract with DHBNZ for a “Laboratory Test Utilisation Review and Education Service” provides clinicians, PHOs and DHBs with a similar range of

reports and support material to that of the pharmaceutical campaign. The service began on 1 July 2005

The Role of the Clinical Facilitator

A requirement of the PHO Performance Plan will be to engage the services of a clinical facilitator. The clinical facilitator will require the skills, knowledge and experience to act as a conduit between PHO management, the CGC and clinicians and will require good working relationships with all 3 groups.

Some of the tasks of the clinical facilitator specific to RSM include:

- One-on-one discussions with clinicians (especially outliers) around their individual prescribing and laboratory test ordering
- Reinforcement of key messages of each education campaign through individual or peer discussion groups with clinicians
- Interpretation and dissemination of bpac^{nz} data for PHO management, the CGC and individual clinicians
- Use quarterly reports from PHO Performance Management Programme to develop and implement strategies for the PHO to ensure relevant clinical performance indicator (CPI) targets are successfully achieved
- Progress reports to the CGC including identification of potential problems which may prevent the PHO meeting its objectives
- Planning and coordination of local RSM/CPI activities in conjunction with other PHOs and the local DHBs

While larger PHOs will have the capacity to employ their own clinical facilitator, medium and smaller PHOs may struggle with funding such a position. Options for these PHOs to consider include:

- Contracting of the clinical facilitator role to an external organisation
- Working together with other PHOs to develop a shared services platform for provision of facilitation and other services.

The clinical facilitator will have access to individual pharmaceutical and laboratory utilisation data which will need to be treated in a sensitive manner and only used for the purposes for which it was intended.

Managing the Economic Impact of Clinical Decisions

Because health resources are finite, managing the economic impact of clinical decisions may ultimately become the biggest challenge and the greatest source of tension within the PHO. Health interventions need to be evidence-based, patient-centred, context-sensitive and cost-effective. They will usually be multi-faceted and multi-disciplinary. (See Appendix 4)

Who are the decision-makers?

Clinical judgment and decision making cannot be considered in isolation - it comes with financial responsibility. Whether it is the individual clinician, the clinical team or a systematic approach which dictates a clinical decision or course of action, it will have an economic impact.

Management does not have direct control over clinical decisions but there is a responsibility for clinical teams to be aware of the economic impact of their decisions. The PHO should have support mechanisms in place to help the decision-making process and ensure that members of the team are appropriately informed.

Where does responsibility lie?

While clinicians remain the decision makers, the PHO board has a responsibility to ensure there is an appropriate organisational and cultural environment within the PHO to allow clinicians to act with confidence. This environment needs to be supported with significant financial and human resources

“Effective practice governance requires significant financial and human resources. The UK’s Primary Care Groups (PCGs), for example, have faced many governance hurdles as time and human resources remain critical restraints. According to a recent UK survey, 41% of those responsible for practice governance did not have a budget to support its implementation and 35% said they had little or no fiscal support (Campbell 2001). The prospects for success are limited in this type of fiscal environment.”⁶

DHBs also have a responsibility to ensure their expectations of a cost-effective primary health care service are not compromised by a failure to adequately resource PHOs for implementation of effective clinical governance.

⁶ Ensuring Excellence: Renewing BC’s Primary Care System. September 2002:26
www.bcma.org

Appendix 1

PHO Performance Plan



PHO Performance Management

Guide to the PHO Performance Plan – Template

Introduction:

Completion of a PHO Performance Plan (below) is a prerequisite to participating in the PHO Performance Management Programme. This document provides guidance for PHOs completing a Performance Plan around some of the sections required.

PHO Performance Management Plan – Template

Name of PHO	
Address	
Phone number	
Names of PHO Contacts for this plan	
Name of your local DHB	
Name of your DHB Contracts Manager	
Phone number	
Contract number and PHO Payee Number	
Date of Plan	
Date for commencement in first performance period	

SECTION A

Meeting Prerequisites (*Agreed with DHB Contract Manager*)

1. Ethnicity is recorded on 85% of your patient register	Yes/No
2. Processes are in place to ensure your DHB is regularly updated with practitioner information is sufficient data (i.e. 12 months) is already provided to enable baseline reporting	Yes/No
3. Processes are in place to ensure all reporting requirements contained in your contract with the DHB are met is sufficient data already provided to enable baseline reporting (i.e. the latest quarter of Service Utilisation Reporting and Immunisation Reporting data). In addition, you are complying with the fees agreement as per your contract with the DHB.	Yes/No
4. You have signed the current nationally agreed PHO service agreement with your DHB	Yes/No

SECTION B

1. **Clinical Governance Arrangements**
2. **Implementing the PHO Performance Management Programme**
3. **IT Support Systems**
4. **Contractual Arrangements with Member Practitioners**
5. **The PHO Policy for use of performance payments**
6. **Additional arrangements with your DHB**

SECTION A

Meeting Prerequisites

1. Ethnicity is recorded on 85% of your patient register

Identifying the ethnicity of your population will assist in accurately determining your benchmark budget for pharmaceutical and laboratory expenditure (there is a weighting for ethnicity). It will also help you to target your high need population for progress on clinical indicators. Improvement in clinical indicators for high need populations will attract more weighting towards financial reward than for the rest of your population.

2. Processes are in place to ensure your DHB is regularly updated with practitioner information and there is sufficient data already provided to enable baseline reporting.

To accurately measure your performance against the indicators it is important that we can identify which practitioners belong to your PHO. This is in accordance with your PHO Service Agreement. We require the last 12 months of data to be provided for this pre-requisite.

3. Processes are in place to ensure all reporting requirements contained in your contract with the DHB are met and there is sufficient data already provided to enable baseline reporting.

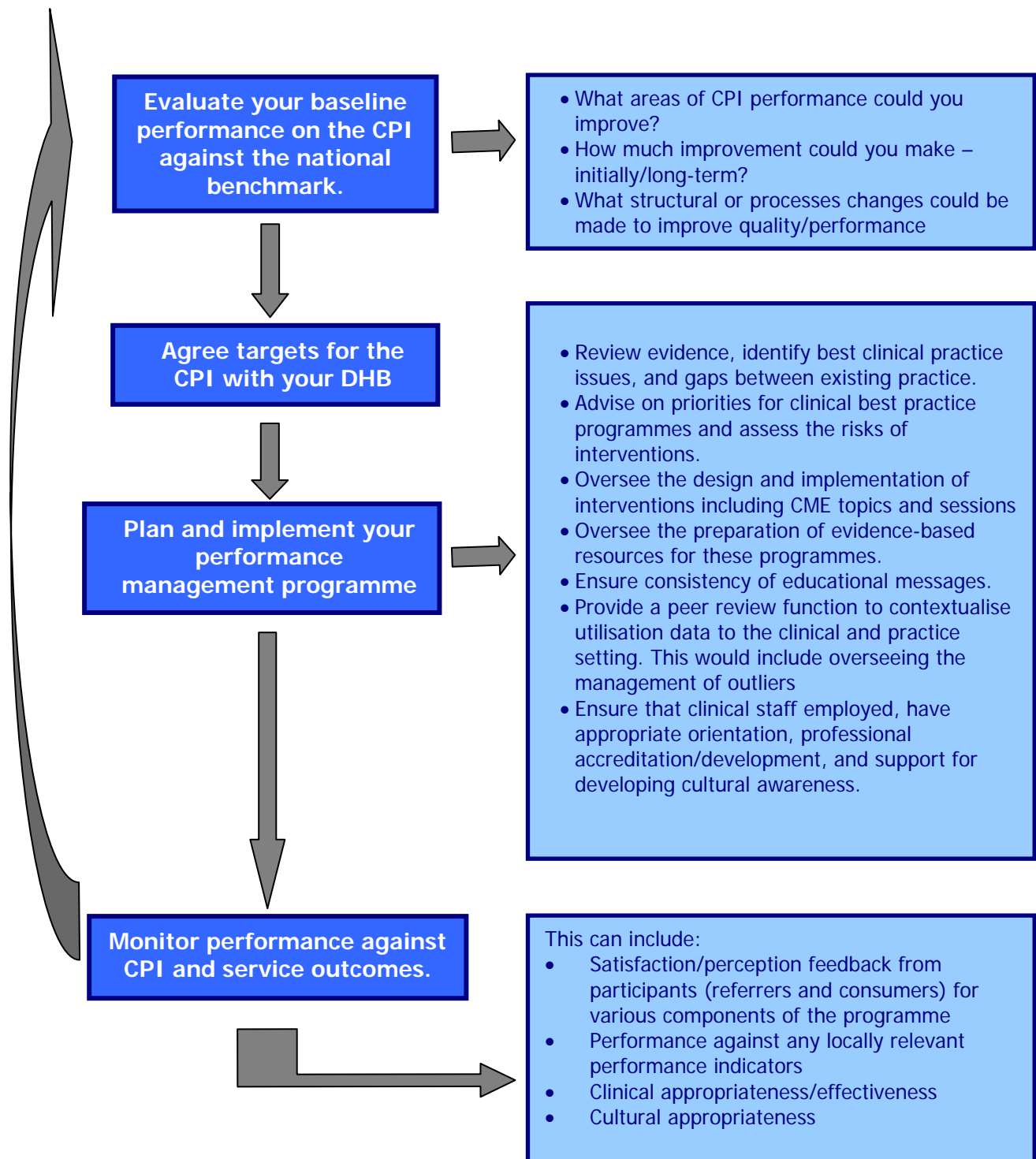
This is an existing requirement of your PHO contract and ensures areas of your PHO's performance are being adequately addressed. These reports include full Service Utilisation Reporting and Annual Reports. The Service Utilisation Reporting which also contains the Immunisation Reporting is required for the most recent quarter.

4. You have signed the current nationally agreed PHO service agreement with your DHB

SECTION B

1. Clinical Governance Arrangements

This section is to describe the broadly based infrastructure you will use to ensure clinical governance of your Performance Management Plan. The diagram below illustrates what will be required to implement the Programme for your PHO. It illustrates the continuous quality improvement (CQI) process you will require through a clinical governance framework.



The PHO may already have in place the clinical governance infrastructure required to implement the performance framework or will need to develop one.

The cornerstone of this clinical governance is a clinical oversight function performed by a Clinical Reference/Advisory group.

Clinical Reference/Advisory Group

This function may be set up as a separate sub-committee of the PHO Board or incorporated within a Clinical Governance Committee (or equivalent) of the PHO. The function may in fact be performed by a number of committees, sub-committees, or clinical leaders (e.g. consumer input may be the function of a community advisory board or the PHO board). Whatever the configuration, there needs to be a clear hierarchy of decision-making and accountability. As well as overseeing the CQI process, the group will also coordinate links with other organisations and ensure appropriate community/Maori/PI involvement.

For the effective ongoing implementation of the PHO performance framework locally it is important that a variety of health professionals are involved in the clinical governance structure. This could include Practice Nurses, Pathologists, Pharmacists, Midwives, and Specialist Physicians.

For any Clinical Reference/Advisory committees it is important to establish clear terms of reference. These would include the composition and review of the committee, objectives, accountability, reporting, and decision-making rules.

2. Implementing the PHO Performance Management Programme

This section is for the PHO to document how it plans to implement the Programme locally. It is expected that each PHO will have the following functions (either in house or outsourced) as core components of their organisational approach to the Programme:

1. Access detailed information and analysis on utilisation patterns and performance against indicators
2. Clinical Facilitator visits to practitioners and/or peer review groups to discuss diagnostic and treatment patterns, disease management strategies, and best practice
3. Implementation of national guidelines and formulation of local guidelines
4. Personalised feedback to members on their population need and utilisation patterns
5. Bulletins to member practitioners on best practice
6. Incentives to encourage member participation in clinical governance activities

While it will be most effective undertaking all six of these activities, the precise mix and emphasis of the interventions will be determined locally by the PHO. If the PHO chooses to use a different approach to the activities listed above, they will require the support of the DHB.

PHOs will be supported at a national level through:

- A National Advisory Group comprising sector representatives experienced in this area. This group would be responsible for giving guidance on areas of national focus and providing oversight and support on educational materials that will be available at a local level.
- 'Headline' utilisation analysis and feedback, quarterly reports on indicator performance, best practice bulletins, education materials, and assistance to PHOs provided by national agencies.

Function	Considerations
<p>1. Access to detailed information and analysis on utilisation patterns and performance against indicators</p> <p>2. Facilitator visits to practitioners and/or peer review groups to discuss diagnostic and treatment patterns, disease management strategies, and best practice</p>	<p>As above this information will be provided at a national level.</p> <ul style="list-style-type: none"> • How will this information be analysed at the PHO level? • Will the PHO want to do any of its own local data extraction and analysis? • Can you do this in-house or do you have an outsourcing arrangement? <p><u>Clinical Facilitator Visits</u> These resources would be managed by the PHO but not necessarily be PHO employees. It is expected that each PHO would have access to clinical facilitation for both laboratory and pharmaceutical education. In addition, you may choose to use facilitators as change agents for assisting with implementing changes to improve performance against other indicators.</p> <ul style="list-style-type: none"> • Who will you use? <ul style="list-style-type: none"> ○ PHO employees? ○ Clinical Facilitators contracted from other PHOs, DHBs, or other agencies? ○ Contracted local pharmacists (with clinical expertise)/pathologists? ○ Peers to visit? • What will be the frequency/schedule of visits? • How will you target visits? <ul style="list-style-type: none"> ○ Outliers? ○ The bulk in the middle? ○ Clinicians with a significant population of high-needs patients?
<p>3. Implementation of national guidelines and formulation of local guidelines</p>	<p><u>Peer Review Groups</u> Peer review groups are important forums for formulating local diagnostic and treatment guidelines; discussing utilisation behavior; incidents and disease management techniques; and sharing educational resources. They are also useful for gaining practitioner support and understanding of system changes required to improve performance.</p> <ul style="list-style-type: none"> ○ How will these be organised and structured? <p>This is a function that will need to be carried out at all levels of the Health sector - nationally through the NZ Guidelines Group, at a district level by DHBs, and locally by PHOs.</p> <ul style="list-style-type: none"> • How will you implement guidelines locally? • How will you identify areas that require the creation of local guidelines? • What process will you use to create these guidelines?

4. Personalised feedback to members on their population need and utilisation patterns

Personalised feedback to members on their pharmaceutical and laboratory utilisation and population need will be produced at a national level.

- How will you distribute feedback to ensure it is coordinated with your CME and peer review sessions?
- Will feedback be presented individually or in a group for discussion?
- How will you analyse feedback reports to target education initiatives to individuals (e.g. outliers in certain areas)?
- How will you coordinate facilitator visits around feedback reports to assist in interpreting and provide supporting academic detailing?
- Will the PHO want to do any of it's own local data extraction and analysis to produce feedback reports? Can you do this in-house or do you have an outsourcing arrangement?
- How else will you reinforce the educational messages in bulletins?

5. Bulletins to member practitioners on best practice

Pharmaceutical and laboratory bulletins will be produced at a national level with distribution through PHOs.

- How will you distribute bulletins to ensure they are coordinated with your CME and peer review sessions?
- Will you produce your own bulletins – what will be the process?
- How will you reinforce the educational messages in bulletins?

6. Incentives to encourage member participation in clinical governance activities

- Will you be incentivising participation in clinical governance activities? This could include providing financial recompense for additional work required to undertake these activities or sponsorship for attending educational activities.

What does a PHO need to plan and document around these activities?

The PHO will need to determine with its DHB the mix of activities it plans to undertake. For each of these activities it will need to consider and document how they will be implemented, including:

- Time frames (initiation, milestones)
- Resource requirements and workloads
- Engaging practitioner participation
- Cultural and structural changes required
- Policies and processes (e.g. to management of outliers, coordination of the programme)
- Critical success factors/barriers

3. Contractual Arrangements with Member Practitioners

To effectively implement the PHO performance framework you will need to be able to access, interpret, and feedback individual practitioner utilisation data for pharmaceutical and laboratory test data. For individuals in your PHO to be able to do this you will require a signed consent from each of your practitioners.

4. IT Support Systems

PHOs will receive regular reports on progress against indicators and targets, which, initially, will be derived from national information sources (e.g., the laboratory and pharmaceutical 'warehouses' and the National Screening Unit databases). In the future they will be derived directly from PMS systems.

PHOs will be supported at the National level in the development of improved information systems and analysis.

This section serves for the PHO to consider and document any IT support or data analysis issues you may have in implementing or maintaining the programme and how these issues will be managed.

5. The PHO Policy for the use of Performance Payments

The final part of this section is to document your plans for using performance payments you receive.

PHOs will have flexibility in their use of performance payments. As recommended by the Advisory group, funds could be used in:

- Extending health programmes or introducing new ones
- Extending or introducing quality initiatives
- Investing in CQI infrastructure
- Increasing the incomes of practitioners where needed to recruit/retain them
- Funding professional development, including communication skills.

It is anticipated that the payments will be made at a PHO level and that any subsequent payments to practice or practitioners (for example, for peer group participation) would be set by the PHO with oversight through this plan and the PHO annual report.

Appendix 2

PHO Performance Management Programme Phase 1 indicators

2006	Clinical Indicators
1	Influenza immunisations in the elderly
2	Cervical smear recorded in last 3 years
3	Breast screening recorded in last 2 years
4	Children fully vaccinated by 2nd birthday
5	Inhaled corticosteroids - average daily dose
6	Ratio of Metformin to Sulphonylurea prescriptions
7	Investigation of thyroid dysfunction (TSH vs. FT4)
8	Ratio of ESR to CRP test ordering

2006	Process Indicators
1	% of valid NHI on patient registers (transitional indicator)
2	Access for high need enrollees (ongoing indicator)
3	Achievement of performance plan objectives

2006	Financial Indicators
1	Pharmaceutical expenditure relative to benchmark
2	Laboratory expenditure relative to benchmark

Appendix 3

Recommended Reading

The following articles are recommended reading:

Making clinical governance work

Pieter J Degeling, Sharyn Maxwell, Rick Iedema, David J Hunter
BMJ Volume 329 18 September 2004 www.bmj.com

Clinical governance and the drive for quality improvement in the new NHS in England.

G Scally, L Donaldson.
BMJ Volume 317 4 July 1998 www.bmj.com Free

Commentary: Model could work

Nigel Edwards
BMJ Volume 329 18 September 2004 www.bmj.com

What is clinical Governance?

Nigel Starey
www.evidence-based-medicine.co.uk Free

New Zealand's independent practitioner associations: a working model of clinical governance in primary care?

Laurence Malcolm and Nicholas Mays
BMJ Volume 319 20 November 1999 www.bmj.com Free

Prescribing how NHS trusts "do" quality: a recipe for committees but little action?

P M Whitty
Quality and Safety in Health Care 2004 www.qshc.com

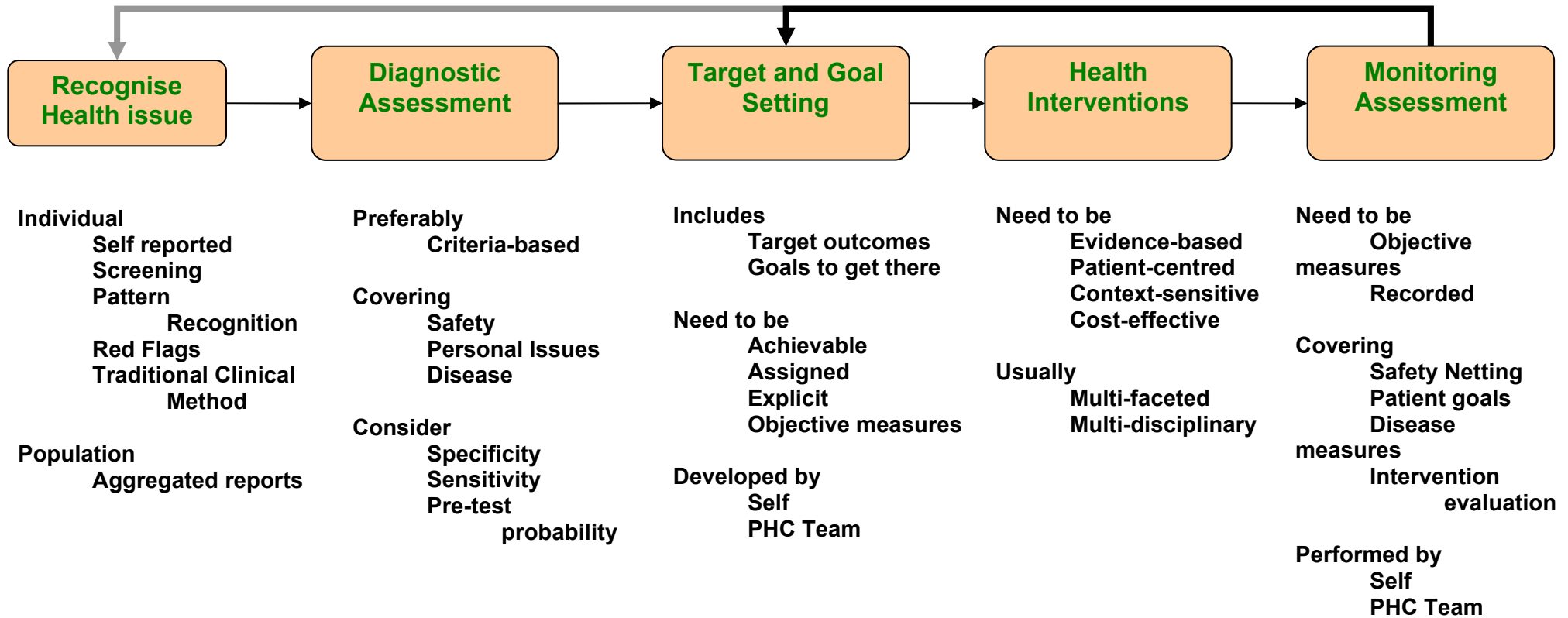
Implementing clinical governance in English primary care groups/trusts: reconciling quality improvement and quality assurance.

S M Campbell, R Sheaff, B Sibbald, M N Marshall, S Pickard, L Gask, S Halliwell, A Rogers, and M O Roland.
Qual Saf Health Care 2002;11:9-14 www.qshc.com Free

Appendix 4

Enhanced Primary Health Care

Enhanced Primary Health Care



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