A QUALITY & SAFETY GUIDE FOR DISTRICT HEALTH BOARDS

GOVERNING
FOR
QUALITY

About this guide

This guide will help district health boards (DHBs) put quality and safety at the centre of governance and drive improvement in their organisations. While the guide has been written with DHBs in mind, the principles and guidance are relevant and can be applied to all health care providers.

It includes:

- an outline of the role of boards as agents for quality and safety improvement
- the seven essential steps boards can take to improve the quality and safety of health care services:
  1. Lead and set clear goals
  2. Gather information and seek out patient stories
  3. Establish system-wide measures and monitor them
  4. Put a high quality and safety culture in place
  5. Ensure the right mix of people and encourage discussion
  6. Commit to ongoing learning at all levels
  7. Define roles and establish clear accountability at all levels
- a checklist to guide boards and assess progress. ●

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Foreword

If we are serious about improving the quality of health and disability services and reducing avoidable or preventable harm to patients, boards must engage in this imperative – it is the board that sets the priorities for a DHB and culture begins at the top.

An increasing body of evidence points to board leadership as a critical element for better, safer health care. Bader and O'Malley have made the point that boards 'can choose to be either active leaders or passive overseers in this process'.[1]

Leadership in this context requires a commitment to act, but it also requires an understanding of the issues. There is quite a lot to understanding the fundamentals of quality and safety in health care, much as there is to understanding the fundamentals of board responsibilities in respect of governance and finances. Many board members are already knowledgeble in all these areas, but for many more, education and training will be required – and for all who take on the responsibility of directorship, ongoing education is important.

The Health Quality & Safety Commission is responsible for driving improvement in the quality and safety of New Zealand's health and disability services. Our objectives have been captured in the New Zealand Triple Aim:

- Improving quality, safety and experience of care.
- Improving health and equity for all populations.
- Gaining best value from public health care resources.

Achieving these objectives requires, first, that we do the right things and, second, that we do these things right first time.

Ensuring the quality of health care is inextricably linked to ensuring the financial health of DHBs. It is vital to ensure we do the right things. The health outcomes of a population are determined by many other factors as well as health care services. Continuing to increase the funding invested directly in health care can only be achieved at the cost of other essential social requirements, such as housing, employment and education. Health care is not just about increasing production, in the sense of more procedures and consultations. If patients in New Zealand are to receive effective care that meets their needs, we cannot waste money on treatments not supported by reasonable evidence. Nor can we waste money on the costs of avoidable or preventable patient harm.

Variation in accessed health care is recognised as a problem internationally. The discrepancies in outcomes between different population groups in New Zealand is evidence that we have not yet met the needs of all New Zealanders – although progress is being made.

Governing for quality has a critical role to play in furthering these goals and getting the best possible results out of available resources – for all our populations.

There is a great deal of impressive improvement work already underway across New Zealand DHBs, and many examples of good governance. However, if we want to have truly world class services, the pursuit of excellence must continue. I hope *Governing for quality* will be a catalyst for further discussion and action in this regard. I encourage board members to use this resource to help drive quality improvement even further – and to provide feedback on its value, and on ways to improve future editions of this publication.

Professor Alan Merry ONZM FRSNZ
Chair, Health Quality & Safety Commission

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1   Bader B, O'Malley S. 2006. Great Boards. *7 things your board can do to improve quality and patient safety*. Bader and Associates Governance Consultants. 6(1). URL: www.greatboards.org (accessed November 2015).

Introduction – the role of governance in improving quality and safety

Improving quality and safety is fundamental to the DHB's governance role.

It is the board, with the senior leadership team, which sets the organisation's strategic quality direction and goals for improvement. It is the board and senior leaders that model desired attitudes and values that drive quality improvement. Their approach to governance will reflect the compassionate, patient-centred, high-quality care they expect of others.

That's why boards are so instrumental in setting and championing a culture within their organisations that puts the quality and safety of consumer care at the heart of everything they do.

The board, along with senior leaders, needs to put effective governance structures in place so teams can adapt to constantly changing health care environments.

The board environment should be safe, where honest and unfiltered discussion on patient safety and quality issues is encouraged.

Board members are responsible for putting in place systems that involve patients and families/whānau in quality-of-care discussions – listening to the consumer voice. This is also essential for ensuring equitable outcomes for all.

It is the role of the board and senior leaders to set clear expectations of staff and communicate compellingly about quality and safety. The aim is to create the right environment for organisational learning.

The board needs to drive a culture where education and training are valued and readily available to all staff. Such a culture will help to create an environment where all staff have the knowledge, skills and behaviours appropriate to their role. And board members themselves need to ensure they understand quality and safety issues to fulfill their responsibilities. This guide has been developed to improve understanding and encourage discussion about these issues. If you would like a two-hour workshop on quality and safety issues at your DHB, please contact the Health Quality & Safety Commission. ●

Boards *do* affect quality

A growing body of international research into health organisations shows boards can make an enormous contribution to improving quality and patient safety. Effective governance and oversight by well-informed and skilled board members lies at the heart of improving quality and patient safety in health organisations.

In particular, evidence highlights the importance of strong and committed leadership. It is the board's role to make better quality of care their organisation's top priority, and to set clear and measurable goals for improvement.

An effective board supports and expects a culture that continually strives to improve the quality and safety of care provided, and values experience, diversity and respect.

International studies recommend that boards need to allocate adequate meeting time to quality and safety issues.[2]

All board members should be able to answer these questions about quality and safety:

- How safe is your organisation?
- Is your organisation treating patients and families/whānau with respect and compassion?
- Is your organisation responsive to the cultural needs of all your patients, families/whānau and communities?
- Is patient safety improving year by year?
- Does your organisation collect robust data to measure quality and patient safety?
- Does your organisation achieve equitable outcomes for all patients, families/whānau and communities?
- Does your board report publicly against its quality and safety aims?
- How does your organisation compare with other similar organisations?

The answer to these questions requires an ongoing engagement with quality and safety issues, and a determination on the part of board members to keep these issues top of mind. ●

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2   Institute for Healthcare Improvement. 2008. *Governance Leadership 'Boards on Board' How-To Guide*. 5 Million Lives Campaign. Getting Started Kit. Cambridge, MA: Institute for Healthcare Improvement. URL: www.ihi.org (accessed November 2015).

What the research tells us

Around the world, research is being conducted into the impact of board decision-making on patient safety. Evidence shows better outcomes are achieved in organisations where the focus on quality issues is paramount.

Recent research[3] involving nearly 4000 New Zealand health professionals established there is already an encouraging foundation on which to build a more robust quality and safety culture.

Key findings included:

- 77 percent agreed or strongly agreed health professionals in their DHB involved patients, families and whānau in efforts to improve family care
- 71 percent agreed or strongly agreed in their clinical area it was easy to speak up if they perceived a problem with patient care
- 71 percent agreed or strongly agreed there were people and processes in place to identify, analyse and act upon all adverse events to prevent future occurrences
- 74 percent agreed or strongly agreed their organisation had zero tolerance for patient harm anywhere in the organisation.

Overall the results of the survey provide a positive view of the existing quality and safety culture within DHBs. However, people saw room for improvement in the systems, structures and work processes across departments, work groups and with outside providers. A third of those surveyed agreed or strongly agreed 'there was little coordination of quality improvement efforts across departments and work groups'.[4]

The need for greater inspiration and leadership in these areas was also identified. Less than half of those surveyed agreed the organisation inspired them to do the best job they could every day. And nearly 60 percent of those surveyed thought there was further room for improvement in the quality of patient care.[5]

There is a challenge here for DHBs to advance quality and safety through their leadership, planning and system-level coordination.

Another three-year study[6] of New Zealand organisations highlighted that collective learning and continuous improvement are the central elements of an adaptive, resilient, high-performing organisation. The study describes organisational learning as 'a powerful and sophisticated competency' to help organisations 'adapt, survive and thrive in turbulent environments'. In this study, the specific characteristics of an adaptive organisation are identified as:

- an openness to learning, feedback and ongoing improvement
- an environment that encourages problem-solving, rather than handing out blame
- a safe culture where it is okay to admit mistakes and jointly learn from them
- an ability to pause and reflect as individuals and as a group
- an ability to listen to others and consider alternative options
- a willingness to explore untested new ideas.

3   Martin G, Mason D, Lovelock K, et al. 2015. *Health professionals' perceptions of quality survey. A report for the Health Quality & Safety Commission*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/General-PR-files-images/Perceptions-of-quality-survey-Oct-2015.pdf (accessed November 2015).

4   *Ibid*.

5   *Ibid*.

6   Nilakant V, Walker B. 2015. *Building Adaptive Resilience, high-performing today, agile tomorrow, thriving in the future. Key findings from the Building Resilient Infrastructure Organisations Project*. Christchurch: University of Canterbury.

Other international research also demonstrates a strong correlation between high-performing health care organisations and boards that are actively engaged with quality assurance measures and issues. One US study showed 91 percent of high-performing health care organisations had boards that regularly reviewed quality data and information.[7]

Research also shows, however, that quality and patient safety is an area boards often neglect.

A study of over 5000 health care organisations in the USA described the state of health care governance as 'highly variable'.[8] Another survey of 1000 board chairs in US hospitals found 'fewer than half of the boards rated quality of care as one of their two top priorities, and only a minority reported receiving training in quality'.[9]

A national survey of health trust boards in the UK reached a similar conclusion. It found boards of governors were generally 'well-meaning but largely ineffective in helping to promote and deliver safer healthcare within their organisations'.[10] This was mainly due to a lack of awareness and understanding of the vital role of board members in assuring quality.

An Australian study[11] confirmed boards *are* key agents for change and reform in any health system. It identified the need for boards to elevate their vision beyond day-to-day processes, and give the organisation its direction, 'the purposes and values that define its actions'. The key message in this study was that board members were responsible for 'big-picture', strategic thinking that directly impacts on quality and patient safety. ●

7   Jha A, Epstein A. 2010. Hospital Governance and the quality of care. *Health Affairs* 29(1). URL: http://content.healthaffairs.org/content/29/1/182.full.html (accessed November 2015).

8   Institute for Healthcare Improvement 2008, *op. cit.*

9   Jha et al 2010, *op. cit.*

10   Mannion R, Freeman T, Millar R, et al. 2015. Effective board governance of safe care: A theoretically underpinned, cross-sectioned examination on the breadth and depth of relationships through local case studies and national surveys. *Health Services and Delivery Research* no 4.4. URL: http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0020/144821/FLS-10-1007-02.pdf.

11   Duckett S, Beaumont M, Bell G, et al. 2015. *Leading Change In Primary Care: Boards Of Primary Health Networks Can Help Improve The Australian Health Care System*. URL: http://ahha.asn.au/sites/default/files/docs/policy-issue/leading_change_in_primary_care.pdf (accessed November 2015).

The need to challenge outmoded views of governance

One of the main barriers to improving quality and safety is a narrow, outmoded view of governance. Too often boards are seen as only being responsible for an organisation's financial health and reputation.

As a consequence, little attention is given to establishing an organisational culture that will drive ongoing improvements in quality and patient safety.

Research in the USA has shown quality issues often receive significantly less attention at board level than financial issues. Ninety-three percent of US hospital boards put financial performance on the agenda at every board level compared with only 63 percent putting quality performance issues on the agenda at every board meeting.[12] Another telling statistic was that at low-performing hospitals, nearly half the boards did not regularly review quality measures.

Another barrier that can arise at board level is the perceived tension between financial considerations and quality improvement, as if a trade-off is required between the two. Enhancing quality does not necessarily cost more – in fact improved processes and workflows may use fewer resources and can reduce costs over the long term.

A study[13] of the link between quality improvement and health care financial performance, involving 1784 community hospitals in the USA, found quality programmes were a consistent predictor of positive financial performance. 'The longer a hospital's involved with QI (quality improvement), the higher the cash flow and the lower the cost per case.'[14]

'… [M]any of the arguments against quality improvement have been based on the premise that such programmes are expensive and divert scarce resources… This has proved not to be the case.' [15]

DHBs that effectively implement quality improvement programmes can expect to improve their financial performance. An integral part of quality improvement is therefore getting the chief financial officers of health organisations to view their role as chief quality enabler, rather than simply budget-keeper.

Board members will also be aware of the high costs of neglecting quality and safety. Examples include under-investment in regional/national electronic systems and adverse event review/investigation processes. An organisation's reputation is easily damaged by a serious failure in patient safety.

Just how damaging it can be, and the enormous costs involved, is vividly outlined in the Francis Report,[16] which many in the health sector will be familiar with. This report highlighted a whole-system failure at the Mid-Staffordshire NHS Foundation Trust. Its central message was that improving quality and safety requires the safety of the patient to be at the centre of service delivery, the first concern of professionals and the shared responsibility of all. ●

12   Jha et al 2010, *op. cit.*

13   Alexander JA, Weiner BJ, Griffith J. 2006. Quality Improvement and hospital financial performance. *Journal of Organizational Behavior* 27 (7): 1003–29.

14   *Ibid.*

15   *Ibid.*

16   www.nhsemployers.org/your-workforce/need-to-know/the-francis-inquiry

Modern view of governance

The modern view of governance is that boards have a significant responsibility to make better quality of care their organisation's first concern. This responsibility cannot just be delegated to medical staff and executive leadership – it is the boards' responsibility to ensure these delegations are acted on effectively. Ensuring patient care is safe and harm-free is at the very core of a board's legal and fiduciary responsibility.

In practice, taking responsibility for improving patient quality care means boards will:

- spend an adequate amount of board time on quality issues
- hold the chief executive accountable for quality and safety goals, and see the chief executive as the person who has the greatest impact on quality
- base the chief executive's remuneration on quality and safety performance
- participate in the development of explicit quality criteria to guide clinical staff
- review patient and family/whānau satisfaction scores annually
- set the agenda for quality
- involve clinical staff in discussions around quality, with clinical staff taking the lead.[17]

A core role of the board is to improve how quality systems function. To achieve this, boards need to actively pursue change, innovation and reform. A board is not there to maintain the status quo. It has to think and act creatively.

A board must articulate its vision of change and strike the right balance between stability and innovation. The active pursuit of change is an evolutionary process that involves board members seeing themselves as enablers. They must have a clear vision and use all means at their disposal to achieve safer care.

Research highlights[18] a number of things all boards can do to improve quality and reduce avoidable or preventable harm. These are outlined in the next section. ●

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17   Institute for Healthcare Improvement 2008, *op. cit*.

18   *Ibid.*

What boards can do – the seven essentials

1. Lead and set clear goals

It is vital an organisation is unified around a clear mission, vision and strategy to improve quality and patient safety. This involves the board setting a clear direction and monitoring performance. The board's commitment to improving quality must be unwavering and visible to all who work in the organisation.

This vision must be communicated repeatedly to all stakeholders. Boards and chief executives will drive the right leadership culture and nurture people with the skills to lead the changes they desire.

Board members will demonstrate an energy and appetite for improvement. Studies have shown lack of will and commitment on the part of the board is a common cause of quality improvements stalling. A highly engaged board 'will be the source of will for the entire organisation'.[19]

Boards can set specific goals to reduce harm each year and make a public commitment to measurable quality improvement.

2. Gather information and seek out patient stories

Boards will review progress toward safer care as part of considering every agenda item at every board meeting. It is also important they put a 'human face' on harm data by hearing stories of patients and families/whānau who have experienced harm. Such story-telling is a powerful way of provoking fresh conversations and helps to guarantee a patient-centred approach at board discussions.

Boards will also receive detailed information from various sources to help establish patterns of harm. One idea is to report back to the board on a significant patient injury in the health care organisation. This will involve sharing the stories of the patient, family/whānau and staff involved. The aim is to illuminate the nature and source of hazards in a complex health care system.

Other potential sources of valuable information include:
- surveys of patient and family/whānau experience
- surveys of staff attitudes and perceptions towards organisational safety culture.

3. Establish system-wide measures and monitor them

Boards need to identify organisation-wide measures of patient safety, update the measures continually and make them transparent to the entire organisation and stakeholders.

A board must make sure it is getting the right information on quality of care and the reports it receives contain data that can help board members track quality improvement at the system level. These measures will also include benchmarks against comparable organisations as a way to monitor progress. An example is the rate of medical harm per 100 admissions or per 1000 patient days.

Boards should be educated to understand data in a range of formats. It is also recommended boards present their organisation's key safety data in an easily understood 'dashboard' format. Simple, visual displays are an important aspect of providing a high-level overview of performance against selected quality and safety indicators. Dashboards should be designed to include those areas that impact on quality and safety in an organisation.

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19   *Ibid.*

Boards will also consider establishing a quality and safety sub-committee, chaired by a board member, which analyse quality and safety issues in greater depth than is possible at a board meeting. This is common practice when dealing with financial issues.

4. Put a high quality and safety culture in place

Boards will commit to establishing and maintaining an environment that is respectful, fair and just for all who experience pain and loss as a result of avoidable or preventable harm – patients, families/whānau and frontline staff.

Boards need to drive a culture of high quality and safety characterised by:

- respect
- transparent and open communication
- a commitment to full disclosure
- apology and support where needed
- resolution for patients and families/whānau where harm has occurred.

Boards will demonstrate the courage and commitment to confront these issues, and model expected attitudes and behaviours to the rest of the organisation. They will encourage staff members to proactively manage risk and maximise clinical safety.

In seeking a culture change, experience shows organisations should concentrate on identifying existing pockets of good practice that other groups can emulate. If people are doing good work, it's important for organisations to understand how they got there, and how staff leaders and clinicians worked together to achieve the results.

It is best to focus on delivering positive messages about change rather than negative ones. Every organisation will have examples of great culture and exceptional performance. The challenge is to replicate them. Usually it is not a matter of people not wanting to change, but not knowing how.

It is also important to celebrate learning and achievement, when quality milestones are achieved.

5. Ensure the right mix of people and encourage discussion

To tackle quality and safety issues, boards need a diverse range of skills and experience. Traditionally, for their appointed members, boards have tended to include people with a narrow band of skills, ie, people with technical, professional or financial expertise.

A more modern view is that there needs to be a broad mix of board members including those who can think 'outside the square', challenge the status quo and come up with imaginative solutions. Research shows[20] including 'mavericks' who think and behave differently from others will help efforts to achieve change.

Boards members need to be capable of ranging across multiple areas and appointments to the board should reflect this. The overall aim is to create an environment which encourages robust analysis and debate.

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20 Massie S. 2015. *Talent management. Developing leadership not just leaders*. London: The King's Fund. URL: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/talent-management-leadership-in-action-jun-2015.pdf?utm_source=The+King%27s+Fund+newsletters&utm_medium=email&utm_campaign=5770588_HMP+2015-06-05&dm_i=21A8,3FOM4,FLXAAH,CALXO,1 (accessed November 2015).

An observational study[21] of four health boards in England revealed great variation in board members' level of engagement with patient safety. It described wide variation in how board debate was steered and influenced by chief executives and board chairs. The most effective discussions happened when there was reasoned and respectful questioning of management, and discussion was framed within the narrative of improving patient and family/whānau experience. This allowed improvements to be explored dispassionately in relation to culture change, rather than being seen as a personal challenge.

6. Commit to ongoing learning at all levels

A board needs to develop its own capabilities to engage effectively with quality and patient safety issues and work out the best strategies to drive continuous improvement. Boards need the skills and knowledge to lead effectively in this area.

On a practical level, board members will have the competence to:
- review quality and safety plans and reports
- evaluate their effectiveness
- consider recommendations for improvement.

Board competencies go to the heart of an organisation's health and safety culture. A recent study[22] found the competencies of board members 'appear to be linked to staff feeling safe to raise concerns about patient safety issues and also their confidence that their organisation would address their concerns'.

Keeping staff engaged and motivated is also crucial to an organisation's ability to provide high-quality care. Through senior management, the board will set an expectation for levels of education and training for all staff. It is easy to over-estimate the ability of frontline staff to improve without the right assistance. Some health care organisations develop their own programmes to build the specific skills staff require to deliver improvements.

A broader view of staff competencies is also required. In the safety and harm context, communication, consultation and relationship-development skills are as important as technical knowledge.

Leadership development is also vital to create an innovative culture. People with talent need to be nurtured so there is confident and empowered leadership at every level.

Boards will place a premium on accessing fresh ideas about improving clinical best practice. They must actively seek out new ideas that are superior to the status quo. The aim is for quality improvement to become part of business as usual.

7. Define roles and establish clear accountability at all levels

The roles of boards and senior leaders in the area of safety and quality are complementary.

A board sets the strategic leadership and direction. It drives an organisation's safety and quality culture. Senior leaders implement the strategic direction, manage operations, report on safety and quality, and implement a high quality and safety culture throughout the organisation.

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21   Freeman T, Millar R, Mannion R, et al. 2015. Enacting corporate governance of healthcare safety and quality: a dramaturgy of hospital boards in England. *Sociology of Health and Illness* 38(2): 233–51.

22   Mannion et al 2015, *op. cit.*

As the diagram below illustrates, this relationship is two-way and dynamic.

Board's roles

Setting direction

Ensuring accountability

Shaping organisational high quality and safety culture

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Senior leaders' roles

Implementing strategic direction

Managing operations

Reporting on safety and quality

Implementing the organisation's high quality and safety culture

More specifically, boards will set clear quality improvement targets for the executive team, and link improved performance in quality and safety to remuneration. Organisational managers will ensure quality and safety figure prominently in performance reviews and are part of day-to-day discussions.

It is the board's responsibility to ensure action is taken to address and remedy poor performance. ●

Assess your progress – a high quality and safety checklist for boards

Here are some questions to help your board assess the robustness of its quality and safety processes and identify areas for improvement. Working through this checklist will help your board identify gaps and initiate discussion.

Please note a separate tool, *Improving quality and safety in the New Zealand health system: A framework for building capability*, is being developed and will be made available to all DHBs.

✅ Supporting a culture of care and compassion

1. *Supporting a culture of care and compassion will be the single most important factor in driving high quality and safety across health services.*

➡️ What is the process for staff to raise concerns about high quality and safety? How do you ensure they can do this in a safe environment?

➡️ What processes or systems are in place to enable referrers (eg, GPs) or other providers to provide input?

➡️ How do you collect, monitor and analyse patient and family/whānau experience data? How do you use this data when making strategic and/or operational decisions?

➡️ How do you ensure everyone in your organisation takes responsibility for high quality and safety in their role?

➡️ How is high quality and safety reflected in the strategic vision of your organisation?

➡️ How do you recognise the importance of care quality in your staff appraisal systems? What are your procedures for managing poor quality care?

➡️ How do you ensure your staff are aware of and adhere to high quality standards and strategies in the health system?

✅ Promoting board responsibility for high quality and safety

2. *Quality and safety in a DHB is ultimately the responsibility of the board, and will be central to the strategic vision of the organisation. In addition to this, every staff member will be aware of their responsibility in ensuring high quality and safety, whatever their role.*

➡️ What quality and safety information is provided to the board? What else does your board do to assure itself all patients and families/whānau are receiving quality care within your responsible population?

➡️ What priority does the board give to high quality and safety? How is this reflected in the board's work and in the education and training provided to board members?

➡️ How do you address high quality and safety issues with your contracted providers? Whose responsibility is it in your organisation?

➡️ What information do you collect or receive to monitor quality and safety within your contracted providers?

✅ Communicating with and listening to patients and families/whānau

3. *Communicating with patients involves listening to them, and providing them and their families/whānau with the right information to be active participants in their own care. Communication will be respectful, understandable and caring. Patients should be able to answer several key questions to determine the quality of care they are receiving.*

4. *Listening to patients and families/whānau helps alert organisations to issues and sensitive events as well as enabling them to make improvements in the care of their patients.*

- What communication standards do you have to govern staff communication with patients and families/whānau?

- How do you encourage patients and families/whānau to give feedback (including complaints)? What proportion of your discharged patients and their families/whānau has provided feedback to you in the last year?

- How do you ensure patients and families/whānau are aware of the Code of Rights and of the role of the Health and Disability Commissioner if they do not feel they receive the appropriate standard of care?

- What is the role of the patient in their care while they are admitted? What information is given to the patients and their families/whānau to enable them to be active participants in their own care, during their time in hospital and post-discharge? How is this information given?

- How do you enable patients and families/whānau to participate in quality improvement in your organisation, and how do you share the results with them?

- How do you close the 'quality loop' and ensure lessons learnt are applied?

☑ Effective information and monitoring systems

5. *Each organisation needs to collect data and build a comprehensive picture about quality and safety in the organisation, to enable issues and sensitive events to be identified before they escalate.*

6. *Data such as the standardised mortality ratio and clinical quality indicators, if analysed effectively, contribute to a robust data set to drive quality and safety.*

7. *The public reporting of key quality and safety data also ensures patients and families/whānau are informed about the quality of care in their DHB.*

- How do you collect, monitor and analyse patient experience data? How do you use this data when making strategic and/or operational decisions?

- How do you collect, monitor and analyse staff experience data? How do you use this data when making strategic and/or operational decisions?

- What is your early warning data set, to enable you to identify and monitor risks and pick up issues before they escalate?

- How do you collect, monitor and analyse data on adverse events?

- How do you collect, monitor and analyse data on mortality?

- Where is the information shared and discussed, and resulting actions agreed? How is progress against agreed actions measured and monitored?

- How do you ensure appropriate action is taken and is working?

☑ Maintenance of high professional standards and confidence

8. *High quality and safety in the health system is also maintained through law and regulation. This includes auditing services, credentialing of clinicians and a range of standards staff working in the health sector are required to meet.*

- How do you ensure recommendations from the Health and Disability Commissioner are put into practice? Whose responsibility is it to ensure this happens?

- How do you ensure your credentialing processes are robust? How often are senior clinical staff credentialed?

- How do you ensure issues raised in HealthCert and other audits are addressed? Whose responsibility is it to ensure this happens?

☑ Strengthening clinical governance and clinical leadership

9. *Clinicians are not only responsible for the provision of high quality patient care; their leadership is also important at all levels of the system. Clinical participation in the management and governance of DHB services is essential in creating the culture needed for high quality and safety.*

→ What clinical governance processes and structures do you have?

→ How are clinicians represented at the board and executive leadership level?

→ How does your board identify potential clinical leaders and what development processes do you have in place for them?

→ What clinical audit processes do you have?

→ How do you address deficiencies in practice and service, and how do you ensure your organisation learns from any issues that arise?

→ How do you ensure the 'quality loop' is closed and lessons learnt are applied? ●

References and recommended reading

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