Governance strategies

Elements of Governance

Discussion Paper

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Introduction

This paper explores the governance component of the Griffith Area Palliative Care Service (GAPS) and the subsequent Rural Palliative Care Program. Good governance means developing the capacity and capability of the governing body to be effective. The level of involvement of stakeholders' participation at a governance level has a direct impact on outcomes and sustainability. Good governance will also ensure the projects aim(s) and goals remain clear.

This paper details a number of models of governance, various governance principles are highlighted and practical examples are provided by other participants of the rural palliative care program (RPCP) and stakeholders within the palliative care sector. Implementation is discussed and considerations suggested.

Background

It is well accepted that leadership and models for palliative care practice are largely those of the well-resourced centres. It is also widely appreciated that people living in rural and remote areas of Australia are disadvantaged with respect to the provision of palliative care. Strategies that increase the palliative care capacity of health care workers in non-urban communities need to be developed and implemented. Rural GPs have always had a central role in the management of their dying patients. In light of the increasing incidence of cancer, an ageing population and improving societal acceptance of palliative care, this is likely to be increasingly so in the future.

Collaboration

There are extremely complex issues in palliative care service delivery for which no single agency can be responsible. Delivering effective and seamless services for clients – particularly those with complex needs – across a range of care settings requires agencies to work together, respecting each others priorities, and understanding each others roles and responsibilities. NSW Health (2006) suggests we need to collaborate when:

- clients or communities have complex needs that cannot be met by a single policy, program or service
- other agencies (e.g. State, Commonwealth, Local Government, non-government or private sector agencies) affect your services or clients
- your policies, programs or services have a "flow-on" effect to others.

This is certainly the case for palliative care service provision in rural Australia. Collaboration is a requirement to improved outcomes. The challenge is to secure the place of palliative care as an integral part of health care across Australia, routinely available within local communities to those people who need it, when they need it. Care and support for people who are dying and their families should be built not only into health care services, but into the fabric of communities and their support networks. Care built around the principles of palliative care[i1] needs to be available to anyone who is dying, whatever the cause of death.

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Working collaboratively with partner organisations will assist with:

- developing and implementing a shared strategy / service model to better meet the needs of the community
- developing and implementing more effective solutions to solve issues or problems that involve other government or non-government agencies
- developing more innovative, effective or efficient ways to provide palliative care services and use all of the available resources.

Governance structures

The term governance refers to the act of governing, or the authority to rule and control. Governance has become an everyday term and in doing so taken on various meanings. Literature outlines numerous different levels or types of governance including: corporate, agency, organisational, strategic and clinical.

Clinical governance

Around the world, health systems have become increasingly concerned about the need to improve the quality of care provided to consumers. This includes the areas of:

- safety
- effectiveness
- appropriateness
- access
- efficiency
- acceptability of that care[2].

Barraclough (2001) and Smallwood (2003) suggest that health systems over the last two decades have been striving to ensure safety, improve quality and involve Clinicians, consumers, policy makers and managers in these important processes. Clinical governance has emerged as a means by which this can be achieved.

Clinical governance is a framework through which organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish[3] A framework which ensures the highest possible safety and quality of care[4]

Robinson, O'Rourke and Braithwaite (2003) state "we see clinical governance largely as a set of mechanisms to encourage people to work in teams to improve their workplace processes

[2] NSW Health. The framework for managing the quality of health services in New South Wales; NSW Health Department, 1999.

[3] Scally G, Donaldson LJ. Looking forward; clinical governance and the drive for quality improvement in the new NHS in England. British medical journal 1998; 317 (7150);61;5.

[4] O'Rouke I, Robinson ME, Braithwaite J. proposal for the enhancement of the clinical governance development and training program. Sydney; ICE, submission to the ICE board, 2003

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and performance. It represents an opportunity to emphasise systematically the importance of a range of ideas drawn from disciplines such as clinical practice improvement, organisational behaviour, management and quality and safety and use these in enhancing clinical and managerial processes[3]."

Core governance principles

There is no single model of good governance[5]. Work carried out by the Organisation for Economic Co-operation and Development (OECD) in both OECD and non OECD countries has identified some elements that underpin good governance, thereby ensuring the basis for an effective corporate governance framework. These common elements are:

- the rights of shareholders and key ownership issues
- the equitable treatment of shareholders
- the role of stakeholders in corporate governance
- disclosure and transparency
- the responsibilities of the board.

The United Kingdom's office for public management suggests six core governance principles:

- focusing on the organisations purpose and on outcomes for citizens and users
- performing effectively in clearly defined functions and roles
- promoting values that underpin good governance and upholding these through behaviour
- taking informed, transparent decisions within a framework of controls
- developing the capacity of the governance team to be effective
- engaging stakeholders and making accountability real.

These broad principles have been accepted across the Rural Palliative Care Program (RPCP) projects when developing their governance structures. The main function of these groups has been:

- setting strategic directions to ensure community needs are met
- achieving strategic directions and operational goals
- ensuring financial viability
- monitoring and improving quality
- setting performance goals and monitoring
- utilising relevant standards /government policy frameworks / priorities
- risk management both clinical and non clinical
- management accountability and performance management systems
- a clear vision and focus of the future
- role delineation and evidence based practice
- development of strategic partnerships.

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[5] OECD principles of corporate governance, OECD, 2004. 13.

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Examples

The governance arrangements for the RPCP include three domains:

- care/clinical governance
- scientific governance
- organisational governance.

These core governance domains should ensure that:

- clients and their families are treated appropriately
- the full range of project resources are employed to best effect
- appropriate accountabilities are rendered
- the project is able to answer the key policy questions about effectiveness, efficiency and generalisability for which it is being undertaken[6].

An example of good governance within the rural palliative care sector can be drawn from GAPS, the service from which the Rural Palliative Care Program was developed.

The GAPS board of governance aims to provide:

1. Organisational governance

- Monitoring and analysing the projects progressive activity and budget performance.
- Considering proposals for extraordinary expenditure beyond the specified scope of the project using the projects funds.
- Considering the inclusion of exceptional assets to the project from community benefactors.
- Reviewing the projects policies and procedures and recommending amendments as appropriate.
- Liaising and consulting with key community stakeholders.
- Information dissemination to the general public.

2. Methodological or 'scientific' governance

- Assessing progress with the projects key performance indicators (KPIs).
- Evaluating the outcomes of the project.
- Investigating options for publication and public presentation of the projects evaluation and measured outcomes.
- Making further recommendations to fund holders and interested parties based on the evaluation and outcomes of the project.

[6] Murrumbidgee Division of General Practice (2000). *Translating the National Palliative Care Strategy into a model of care that works for rural Australia – a pilot study.* Submission to the Department of Health and Ageing.

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3. Clinical governance

- Ongoing analysis of identified variances in clinical practice from that specified within the scope of the project.

The governance committee comprises each of the major stakeholders and has been established with an independent chair. This committee is closely involved in the detail of the project and makes decisions on policy and resource use, receiving monthly reports from the project manager.

Change management

Leigh et al (2004) argue that with quality clinical care, the change agenda needs to involve people and systems beyond local clinical teams. The argument follows that true commitment to change and quality improvement needs to permeate across the organisational and professional systems that contribute directly or indirectly to clinical practice. It follows that the development of a new service model will rationally seek to form an executive body with terms of reference to oversee performance, monitor quality and ensure fiscal accountability. This approach is consistent with the argument put forward by Leigh et al (2004) that while clinicians can each effectively work on change within their immediate areas, they also need an avenue to address organisational issues beyond their control but affecting their practice. Ideally it is structures that span traditional organisational boundaries, which provide clinicians with forums to present these issues for resolution.

This in reality meant that two forums were required for success, a clinical advisory group made up of practitioners reporting back to the overarching governance group on issues that they collectively feel need to be highlighted. Clinical working groups could then be constructed to explore and report on highlighted issues.

The Centre for Health Service Development in a 2001 external evaluation found that:

> The governance committee is selected and well placed to ensure that the project remains on track. It gives careful attention to the areas of financial and clinical responsibility and to the quality of project reports and monitoring. This ensures that feedback to the community is maintained and that the project can be seen to act properly in addressing its task In conjunction a clinical working party has been responsible for developing the various clinical guidelines, strategies and protocols upon which the project is based.

Hatton et al suggest that in Griffith:

> For the first time, multiple state and Commonwealth-funded providers, private agencies, pastoral care and consumer advocates have come together to resolve problems collaboratively. While it is not possible to conclude from this work in progress that all issues have already been resolved, it is clear that the project has developed and implemented several sustainable structures and processes with demonstrable links to both mainstream health care services, and to consumer and community interests. This includes an innovative system for joint inter-agency and community governance, which does not impede the routine operational management of participant agencies, yet ensures the objectives of

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the conjoint service are properly administered. Agency partnerships, collaboration, role delineation and networking are critical to ensure an effective service is provided. Minimising duplication and streamlining communication processes are essential elements for busy practitioners

Models of governance within RPCP

The following examples of good governance from within the RPCP highlight the participants within the governance groups. The variation is not unexpected and reflects the difference in service providers across the country.

Southern Queensland Rural Division of General Practice (SQRDGP)

SQRDGP employed a fulltime program coordinator with research and project experience. She has clinical experience although is no longer registered as a nurse. The coordinator's role therefore has no clinical input responsibility and is strategic only. It is further worth emphasising that the program coordinator role is not perceived as a nursing position. A further part time project worker has been employed to assist in the consent process, a registered general nurse with good palliative care experience, her role is to interface with the clinical component of the project and she is also heavily involved in the role out of the model to other areas within the region.

An advisory committee was established and meets on a regular basis. The committee has broad base representation:

- Medical Director – Public Hospital
- Blue Care, Palliative Care Nurse in Community
- St Luke's
- DON, Private Hospital
- Community Health
- DON, Cherbourg Hospital (Indigenous Representative)
- Local MP – Independent
- Member of the Minister's staff
- general practitioner.

Feeding into this group is a clinical committee that currently meets once a week and includes representatives from the following:

- Blue Care - Palliative Care Nurse
- Branch Manager - St Luke's
- Director of Nursing - South Burnett Community Private Hospital
- South Burnett Health Service District – Community Health (when available).

According to SQRDGP, the governance and management of this project is efficient and effective with the committees being very active in seeking out problems and identifying solutions.

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South East New South Wales Division of General Practice (SENSWDGP)

SENSWDGP has had three different project coordinators over the life of the project. Each has had success in implementing the core components. Whilst this change has added a level of complexity good governance has not allowed a negative impact to occur.

A program advisory group was established comprising:

- South East NSW Division of General Practice
- three general practitioners representing each area
- Senior Nurse Manager, Moruya Hospital
- Senior Nurse Manager, Bateman's Bay Hospital
- Chief Pharmacist Moruya and Bateman's bay Hospitals
- Nurse Manager, Eurobodalla Community
- Narooma Pharmacy
- Palliative Care Volunteer
- Pastoral Care Worker
- CEO, Katungal Medical Centre
- South Coast Home Nursing Service
- Senior Nurse Manager, Bateman's Bay
- Bateman's Bay Community Health
- Care Manager, Maranatha Lodge
- SAHS Aboriginal Hospital Liaison Officer
- Clinical Nurse Consultant, Oncology Clinic Moruya Hospital.

In addition, minutes are circulated to the following group to ensure effective communication:

- Manager Aged and Extended Care SAHS
- Nurse Manager Bateman's Bay Hospital
- Eurobodalla Nursing Service
- CNC Oncology SAHS
- ER Nursing Service
- Director of Nursing Edgewood Park Residential Aged Care Facility
- Illawarra Retirement Trust
- CEO, Banksia Village
- Manager Crown Gardens.

SENSWDGP have reported that this group is currently chaired, enthusiastically and effectively by a general practitioner and that further sub committees have been formed to investigated specific issues, such as education.

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The SENSWDGP Project Coordinator has stated that:

> “The advisory group has been a key to the success of this project. A group of stakeholders was recruited who had a passionate interest in supporting the development of palliative care services in this area. The GP involvement (chairperson is a GP) has allowed this service to have a GP champion within the GP fraternity advocating development. The other two GPs were from the two other major townships in the shire, creating good coverage of GP representation on the advisory panel.

Furthermore:

> “The advisory group has been very dedicated and has met every month during this time period. They had been essential to the success of the program as they represent every relevant service and are very supportive.”

The SENSWDGP have been active in seeking alternative funding and have successfully attracted funding from the local palliative care program funding (round three) which will be used to enhance the bereavement care provided within the area.

Adelaide Hills Division of General Practice (AHDGP)

The AHDGP has employed a project coordinator who has a clinical nursing background in oncology and palliative care in both Australia and the United Kingdom. They have also employed a part-time GP consultant to interface with the current medical practitioners.

The governance committee initially was scheduled to meet every two months however due to the level of complexity of these types of projects the meeting were rescheduled for every six weeks.

This group was instrumental in initiating an Adelaide Hills Palliative Care ‘think tank’ to look strategically at local needs and how to take this forward. They also wanted to highlight as a project outcome, the issue of local palliative care funding and the impact on local service provision.

Membership of the group comprises:

- EO Adelaide Hills Division of General Practice
- GP Advisor to Project (AHDGP)
- Palliative Care Project officer (AHDGP)
- CNC Palliative Care, Adelaide Hills Community Nursing Service
- EO /DON, Mt Barker Hospital
- DON, Hahndorf Nursing Home
- Community Representative
- CNC, Stirling Private Hospital
- EO Adelaide Hills Community Health Service.

According to AHDGP, the governance meetings for this project are currently occurring every six weeks. Changes in health service management have proved to be problematic and commitment to the project by partner organisations has fluctuated. Attendance at this meeting though has remained high and the main issues remain on the agenda.

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Implementation

Eagar, Garrett and Lin (2001[7]) suggest that the process of implementation is about effecting behavioural change and is therefore an activity of change management. They further highlight the planner's role in securing the implementation of plans is complex. It includes being the problem solver and analyst, educator and activator to name just a few roles. It is therefore of paramount importance that the project coordinators are equipped with the relevant skills and attributes to successfully undertake the roles required to implement complex multifaceted initiatives with potentially many partner organisations. The ability of the coordinator or other driving force has a direct effect on project outcomes. It is therefore imperative to ensure that this position is appropriately resourced in relation to grading for recruitment purposes.

Implementation considerations are outlined below:

- identify options to meet the needs of the client or community
- assess each option against the intended results for clients, the implications for agencies, and the fit to government or cluster objectives
- analyse the risks and benefits of each option
- agree on a preferred approach
- test this approach against current practice, policies and procedures and with senior staff in the organisation if there is a deviation from usual practice proposed
- consider how to involve clients and other stakeholders
- ensure all decision makers have appropriate levels of authority
- determine whether a written inter-agency agreement is required
- clarify the purpose of the initiative
- clarify the roles and responsibilities of agencies
- specify resource commitments
- outline governance arrangements, review & conflict resolution processes etc.
- specify a number of performance measures to show the results of collaboration
- identify shared training to support the approach
- address system changes to support the initiative eg. planning, policy, it, funding, reporting
- establish a project business plan with milestones, timelines, and expected results
- develop a communication strategy to involve both internal and external stakeholders.

It is worth noting in relation to perform measures that Evans et al (2005) suggests that doctors have traditionally been reluctant to adopt clinical pathways or decision support tools to supplement memory and record clinical information and results. However, these can help standardise clinical care and reduce human error by ensuring that uniform, evidence based practices are adopted. These strategies also provide the basis of affective clinical governance.

[7] *Eagar, Garrett and Lin (2001) Health Planning Australian perspectives*

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Evaluation

The biggest impact that clinical governance makes is to change people's attitudes and thinking about their organisation and how it functions. Hospitals will become learning organisations, where constructive criticism, cooperative development and inter-professional respect allow successes to be celebrated and mistakes are not considered blameworthy but opportunities for improvement (the West Australian Council for Safety and Quality in Health Care).

The commission for Health improvements (CHI) has been undertaking Clinical governance reviews in England since 1999. Each review investigates seven specific categories:

- patient , carer and consumer involvement
- risk management
- clinical audit
- staffing and staff management
- education and training
- clinical effectiveness
- using information.

There is currently no established mechanism for combining various data sets of a particular health system as a whole for assessing quality of care or clinical governance standards and therefore benchmarking is problematic.

Tip

Regularly monitor results of collaboration for clients and communities. Use your results to learn, improve and modify your approach, and to celebrate success.

Conclusion

Good governance means developing the capacity and capability of the governing body to be effective. The level of involvement of stakeholders participation at a governance level has a direct impact on outcomes and sustainability. Good governance is also responsible for ensuring the projects aim and goals remain clear. It has been noted by the external evaluators that there is a contrast between those projects that have paid a lot of attention to partnerships, role delineation and networking and those that have paid less attention to these issues. This is further emphasised by the projects that have obtained further/alternative funding and have increased their levels of sustainability.

The governing body is required to clearly focus on the group/organisations purpose and on the outcomes for the community and clients/ users.

Not only does there need to be clearly defined functions and roles but a mechanism to ensure these are carried out effectively. This may require ongoing input to develop the capacity of

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the governance team. Evaluating performance as individuals and as a group requires quality feedback and strategic evaluation.

In summary there needs to be excellent team work; with everyone working together towards a common goal. This includes:

Purposeful meetings

Purposeful meetings are the foundation of good teamwork, regular meetings at all levels are required to share information and discuss problems.

Relationships

Good relationships are vital to effective functioning. Unity is another expression of relationships and relates to a feeling of belonging within the function of the group. Commitment, motivation and dedication of staff arise directly out of this unity and common vision.

Communication

Sharing of information between multiple groups and stakeholders.

Foundation framework and values

The framework in which the team operates is often an historic tradition, there needs to be an approach to problem solving which is proactive and determined, underpinned by a structure and systems which facilitate this.

Good governance can be the key to the development of a team with a unified vision of giving patients priority, respecting each other as well as patients, and working in and with the community to achieve optimal care.

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Endnotes

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[i] The World Health Organisation defines palliative care as including the following principles:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative Care Australia. Standards for providing quality palliative care for all Australians. May 2005 p10