Independent review of governance arrangements at Royal Darwin Hospital

Conducted by

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Australian Council on Healthcare Standards

A REVIEW FOR THE NORTHERN TERRITORY GOVERNMENT
COMMISSIONED BY THE HON DR CHRIS BURNS MLA,
THEN MINISTER FOR HEALTH
DELIVERED TO THE HON MR KONSTANTINE VATSKALIS MLA,
MINISTER FOR HEALTH

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1.0 Executive summary

1.0

Introduction

Royal Darwin Hospital (RDH) in recent times has been the subject of a great deal of attention, and not inconsiderable criticism, about the quality of its care and the safety of its patients, and the way it is governed. The media, politicians, the Coroner, the Health and Community Services Complaints Commissioner and other stakeholders have expressed and documented concerns. The hospital's reputation has suffered, and morale has been adversely affected. As a consequence, the then Minister for Health, the Hon Dr Chris Burns MLA, commissioned an independent review of the governance arrangements at RDH in November 2008, asking Mr Brian Johnston, Chief Executive of the Australian Council on Healthcare Standards to help develop Terms of Reference and identify a review team.

The review was conducted by Ms Kaye Hogan, Dr Taffy Jones and Professor Jeffrey Braithwaite between November 2008 and February 2009, addressing the Terms of Reference, with the specific aim "to make recommendations on any matter relating to governance at the RDH including the current policy framework, practices supporting clinical governance and the structural relationships between corporate and clinical governance within the hospital and between the hospital and the DHF".

Background to the review

The reviewers were independent of the Minister's office, the Department of Health and Families (DHF) and RDH. They applied several frameworks to RDH: a model of good corporate governance from Langlands and colleagues (2004), a model of effective clinical governance from Braithwaite and Travaglia (2008) and an organisational change model from Bolman and Deal (2003). These models suggest that RDH has some ground to cover in achieving satisfactory standards of corporate and clinical governance, and they provide a set of yardsticks against which RDH Board members, executives, managers and clinicians can measure progress.

Methods

In order to be comprehensive, the review team gathered data from four sources. We analysed selected academic and policy literature, reviewed DHF and RDH organisational documentation, interviewed a cross-section of 105 stakeholders including 93 individuals and 12 groups, and assessed seven public submissions made by interested parties.

Findings and recommendations

Twenty-six findings and corresponding recommendations form the core of this report. The review argues that there need to be clearly delineated roles and accountabilities for governance between DHF and RDH, particularly in terms of responsibilities for strategic and operational performance of RDH. Governance of RDH should be predominantly a responsibility of the Board and executive group. DHF's responsibility is for funding, health systems policy and overall direction. The allocation of funding needs to be based on casemix measures or a more explicit, transparent rationale. There should be a documented service agreement and performance measures between DHF and RDH, and clarification and agreement about delegations, committee structures, decision-making processes, responses to media issues and clinical service planning.

Within RDH, effective coordination of recommendations from this review and other reviews and reports is needed. Roles and responsibilities of the Board and executive team are in need of clarification. Internal decision-making requires attention, and policies and practices including those for human resource management, complaints and recruitment of staff should be improved, streamlined and widely adopted.

In regard to clinical governance, systems and initiatives designed to address quality of care, patient safety and clinical risk must be put in place. This calls for mechanisms to promote greater involvement of patients in their care and decisions, and to tackle clinical performance, clinical communication, patient handovers, staff workloads and skill mix, nursing retention and recruitment, junior medical officers' (JMOs') recruitment and management, the use of data to reinforce clinical decisions and support for decisions with ethical challenges.

Ultimately, corporate and clinical governance will be served by those with responsibilities for RDH realising improved service objectives and patient outcomes, strengthening and building on existing values, improving the policy framework and addressing resource allocation issues more rigorously and transparently than in the past. Ministerial and DHF support is needed for these to be achieved, and also to improve organisational competence, decision-making processes, and develop both managerial effectiveness and clinical-managerial relationships. Clinical quality improvement and managerial quality improvement systems require revamping.

Concluding remarks

A concerted effort from many people will be necessary to build momentum and capacity, and put RDH on the front foot once again. A three year timeline over the period 2009-2011 is stipulated for the implementation of the review's recommendations. Monitoring and evaluation processes to ensure effective implementation are specified.

2.0 Terms of reference

2.0

Terms of reference from the Minister

Background

This independent review of governance arrangements at Royal Darwin Hospital (RDH) (henceforth, the review) was requested by the Minister for Health for the Northern Territory, Dr Chris Burns MLA, following recent public comment on governance practices at RDH, including the recent findings of the Coroner in relation to the death of Mrs Margaret Winter in December 2006.[1] The Chief Executive of the Australian Council on Healthcare Standards (ACHS), Mr Brian Johnston, agreed to develop terms of reference and identify an expert team to conduct the governance review in liaison with the Department of Health and Families (DHF). Ms Kaye Hogan, team leader, Dr Taffy Jones and Professor Jeffrey Braithwaite were appointed as the independent reviewers. The review was conducted between November 2008 and February 2009.

The ACHS Organisation Wide Accreditation Survey of the hospital, originally scheduled for December, was brought forward at the request of the Minister. Five expert surveyors carried out an in-depth review against the ACHS standards and criteria from 3-7 November 2008. That report was considered by the independent review team, along with the Coroner's report and other supporting documentation.

The review is regarded as essential for the assurance of public accountability within the Northern Territory health care system and as an effective quality assurance strategy. Its focus is on assuring that governance in the hospital and between DHF and the hospital is of current best practice to ensure high quality outcomes for patients requiring RDH's services.

Purpose

The review's purpose is to make recommendations on any matter relating to governance at the RDH including the current policy framework, practices supporting clinical governance and the structural relationships between corporate and clinical governance within the hospital and between the hospital and the DHF.

Method

The review was asked to consider structures and processes including:

1. Service objectives and values
2. Policy framework
3. Resource allocation methodologies; levels of authority and delegation; and independent verification
4. Organisational capacities, capabilities and structures
5. Decision-making processes
6. The effectiveness of management at all levels including the effectiveness of the relationships between managers and those being managed
7. Hospital wide audit and quality improvement processes and outcomes
8. Quality improvement processes in place in management.

Contemporary definitions of clinical governance describe it as a shared responsibility involving both clinical and corporate functions. Therefore, the review also considered relevant aspects of the Department's functions in relation to the governance of RDH.

Consultation process

The review considered significant internal organisational documents and external reports including the Department of Health and Families Annual Report 2007-2008,[2] the ACHS Organisation Wide Survey,[3] the Hospital Management Boards Act 1980, as amended,[4] the Coroner's report D0208/2006 [Inquest into the death of Margaret Winter],[1] the Coroner's report D0038/2005 [Inquest into the death of Sandra McRae],[5] and the opening Coroner's address into the death of Georgia Rae Tilmouth.[6] A selection of other internal and external documents related to governance, clinical governance, organisational structure, policies and processes was also considered, for which references are provided below. Reviewers were asked to consult widely, and in response initiated a wide-ranging interview process including with the following individuals and groups.

- **Minister**
- **Chief Executive (CE)**
- **Key departmental staff**
- **General Manager (GM) and executive staff, RDH**
- **RDH Board members**
- **Australian Medical Association (AMA), Northern Territory Incorporated**
- **Australian Nurses Federation (ANF), Northern Territory Branch**
- **Other relevant individuals and groups identified by the Minister.**

A full listing of consultation sessions is provided (Appendix A). In addition the review was asked to invite public submissions. An advertisement was placed in the *Northern Territory News* on 13 December 2008, and 10, 17 and 21 January 2009. The advertisement asked for "written contributions from interested people who would like to comment on any aspect of the governance arrangements at RDH." It indicated that "... Submissions, no longer than 1,000 words, should ... address the Review's Terms of Reference ... ".

Accountability

The primary point of responsibility for the duration of most of the review period was to the then Minister for Health, the Hon Dr Chris Burns, MLA. As a result of Ministerial changes in the NT, the final report was discussed with and delivered to the new Minister for Health, the Hon Mr Konstantine Vatskalis, MLA. Dr David Ashbridge, Chief Executive of the Department of Health and Families was kept advised of progress.

The review team members were not available for comments to the media. All communication was the responsibility of the Minister and the CE, DHF.

3.0 Background to the review

3.0

The independent reviewers' approach and conceptual models underpinning the review

It is important for reviewers to be transparent about any pre-conceptions they might hold and the models and definitions they have in mind, or seek to operationalise, in conducting their work. This is no mere academic exercise. The reviewers are keen to be both open in their reporting, to be transparent about how the review was conducted, and to document the conceptual models that were brought to bear in conducting it.

The reviewers' approach

The reviewers were independent of ACHS, the Minister's office, the DFS and RDH. They are experienced in health systems assessments and are committed to health systems reform and improvement, both in terms of policy and practice. A summary of their *curricula vitae* is provided (Appendix B).

How the review was conducted

Participants interviewed by the reviewers were invited to be open and frank. They were advised that while no comment would be attributed to any specific individual or group, aggregated views and non-attributed comments would be used. Questions were tailored to the knowledge and expertise of participants. Broad issues of the challenges RDH faced with governance and clinical governance, and the measures that could be taken to address these, were canvassed. In most cases wide-ranging discussions ensued. The review was supported logistically and administratively by staff in ACHS, DHF and RDH (Appendix C).

Conceptual models: governance

The most useful governance model for the purpose of the review was that developed by Langlands and colleagues[7] for the *Independent Commission on Good Governance in Public Services* in the United Kingdom. The model proposes a standard comprising six elements of good governance. It enabled the reviewers to structure overarching questions about governance of RDH and its relationship with DHF (Table 1).

Table 1: A conceptual model for good governance applied to RDH

Criteria for good governance	Application to RDH
Good governance means focusing on the organisation's purpose and on outcomes for citizens and service users	• Is RDH's purpose clear? • Are services of high quality? • Are taxpayers receiving value for money?
Good governance means performing effectively in clearly defined functions and roles	• Are RDH's functions clear? • Are the Board's and executives' roles and responsibilities clear? • Are relationships effective? • Is organisational performance satisfactory?
Good governance means promoting the values for the whole organisation and demonstrating the values of good governance through behaviour	• Are the organisational values known and publicised? • Are they put into practice? • Do individual Board members and executives behave in ways that uphold and exemplify good governance?
Good governance means taking informed, transparent decisions and managing risk	• Is organisational decision-making transparent and effective? • Is good quality information used to manage quality of care and risk? • Are risk management strategies and systems effective?
Good governance means developing the capacity and capability of the governing body to be effective	• Do Board members and executives have the requisite skills, knowledge and experience to perform well? • Are there processes in place to develop capacity to govern effectively?
Good governance means engaging stakeholders and making accountability real	• Are institutional stakeholders effectively engaged? • Are formal and informal accountability arrangements effective? • Is there a planned and organised approach to accountability with the public? • Is there a planned and organised approach to accountability with staff?

Source: Adapted from Langlands et al (2004)

Conceptual models: clinical governance

The most relevant clinical governance model for the purpose of the review was that developed by Braithwaite and Travaglia from extensive literature reviews, published in a recent edition of *Australian Health Review*.[8] This model proposes that effective clinical governance rests on four pillars. This paper, too, enabled the reviewers to structure appropriate questions (Table 2).

Table 2: A conceptual model for effective clinical governance applied to RDH

Criteria for effective clinical governance	Application to RDH
Advocating for positive attitudes and values about safety and quality	• Is RDH actively engaged in promoting accountability for patient care and continuous improvement? • Are there processes in place for dealing with qualified privilege, continuous improvement, clinical education and ethical approaches to the delivery of care?
Planning and organising structures for safety and quality	• Are RDH's processes and strategies effective in managing performance, managing risk, reporting and managing critical incidents, credentialing medical and other practitioners, applying standards and participating in accreditation processes?
Organising and using data and evidence	• Is there an ethos and approach which encourages the use and sharing of information and data? • Is there encouragement of clinical effectiveness, evidence based practices and clinical audit? • Are clinical indicators used effectively?
Sponsoring a patient focus	• Are consumers encouraged to participate in decisions affecting their care? • Is there an organisational and clinical focus on patient safety and quality of care? • Is there evidence of support for informed consent? • Is there evidence of support for open disclosure? • Are complaints handled effectively?

Source: Adapted from Braithwaite and Travaglia (2008)

Conceptual models: organisational change

Review team members were keen to identify a change strategy for RDH staff to support improvements in governance. This is important to stipulate at the outset, to help frame the recommendations of the review. Reviewers started from the premise that no matter how accomplished RDH might be there will always be opportunities for improvement, and having a defined plan for organisational change was an important consideration for the RDH Board, executives and staff who will be required to implement the recommendations. After assessing relevant change models, the review settled on a framework modified from Bolman and Deal[9] (Table 3), the last element having been added by the review team.

Table 3: A model for change and improvement for RDH

Elements in the change model	Application to RDH
Structural considerations	• How can RDH use its existing structure better?[i] • Is RDH decision-making streamlined? • Are roles, responsibilities and reporting arrangements within the RDH organisational structure defined, widely accepted and understood?
Cultural considerations	• What are the predominant attitudes and values, and behaviours and practices, that characterise RDH? • Are beliefs and attitudes positively-oriented toward sustainable improvement? • Are behaviours and practices aligned with organisational needs and goals? • Are there effective communication and consultation opportunities?

[i] Note the review team members are not advocating a restructure of RDH. The evidence suggests that too much effort is spent tweaking health care structures for no identifiable gain. The review team's assessment of the research evidence is that restructuring is an over-used strategy for health systems reform and should not be contemplated as an option for RDH.

Political considerations	• Politics are inherent in all organisations, especially those with high levels of community ownership, strong stakeholder involvement and relatively autonomous staff. Do RDH staff recognize the power and influence structures? Are they used wisely? • Are there opportunities for positive, negotiated political outcomes? • Are politics exercised constructively or destructively? • How do relationships manifest? Is the political climate bullying, supporting, combatative, collaborative or consultative? In what proportions?
Human resource considerations	• Is the environment for staff open and transparent, or closed and opaque? • Is there an emphasis on teamwork and inter-professional practice? • Are recruitment, selection and performance management processes effective? • Are there effective training and development opportunities? • Do encouragement processes [eg, rewards, praise, motivation] work well?
Planning and resource change	• Are there adequate strategic and clinical service plans? • How is clinical service planning undertaken? What is the strategic planning process? • Is planning based on needs analyses and mapped to services? • How are resources secured? Are the mechanisms effective? • How are resources allocated? Is the process fair, open and effective? • How are resources used? Are there effective mechanisms to monitor and improve resource use?
Source: Adapted from Bolman and Deal (2003)	

Concluding remarks

Team members found it useful to frame their review activities in the context of these conceptual models. Internal and external stakeholders responsible for RDH's governance may find these models helpful in their endeavours in improving governance arrangements over time, and in giving effect to our recommendations.

4.0 Method

4.0

Review team methods

Data gathering modes

In accordance with its terms of reference and by agreement with the Minister, the review team gathered information from four sources:

- **External documentation** particularly reports, inquiries, and scholarly literature.
- **Organisational documentation** including internal reports, policy and procedure documents, organisational charts and associated information.
- **Interviews** with individuals and groups including those stakeholder groups specified in the terms of reference, in accordance with the attached schedule (Appendix A).
- **Public submissions** invited by the review team by public advertisement.

Analysis of data

The data were analysed using the following methods:

- **External documentation** was assembled through electronic search engines, and also based on reviewers' knowledge of the literature, read by the team and reflected in questions posed and as a framework for the review (section 3.0).
- **Organisational documentation** was reviewed by each team member and a synthesis of the main conclusions discussed for inclusion in this report.
- **Interviews** were shared by team members; some key stakeholders were interviewed by the whole team, and other individuals and groups were interviewed separately, matched to the individual team member's expertise. These were documented and written into the findings and recommendations
- **Public submissions** were reviewed separately by team members and synthesised via team discussion. They were subjected to a content analysis technique using Leximancer version 3.0, a content analysis software package, to derive key themes. These were synthesised and summarised (Appendix D), and taken into account in the findings and recommendations.

5.0 Findings and recommendations

5.0

Preface to the specific findings and recommendations

RDH's profile

RDH is a publicly funded 343 bed principal acute care and tertiary referral hospital in the NT and the National Critical Care and Trauma Centre servicing the region.[ii 3 10] In 2008 it provided 47,280 inpatient, 56,342 emergency department and 94,384 outpatient services, and had 1,693 full time equivalent staff.[10] Its mission is to provide culturally appropriate client-centred care in an environment which values and supports staff, and its vision is to be recognised locally, nationally and internationally as a centre of excellence providing quality health services.

RDH primarily services the Darwin urban and Darwin rural areas, covering an expanse of some 127,000^2 kms with a population estimate in 2003 of 121,403.[10] The population has been growing quite rapidly in recent years and now totals some 150,000, as have admissions to RDH, putting pressure on the hospital's services. Consultancy services are provided to a larger area where needed, expanding to the whole of the Top End, and to the region where necessary. Depending on the season and tourism patterns, there are fluctuations in numbers of visitors, tourists and seasonal workers, affecting patient loads and staffing resources and turnover, particularly amongst nursing groups. Some 28% of the population identify as Aboriginal, but indigenous patients constitute over half of all separations and utilise over half of RDH's resources.[10]

There are significant health problems facing the population RDH serves. The health status of indigenous populations is lower than that for other groups. Life expectancy is 15-20 years lower than for non-indigenous populations. The burden of disease including those of lifestyle and poverty are considerable. The NT has the highest rates of alcoholism, domestic violence, renal failure, diabetes and cardiac disease in Australia, and the rate of rheumatic heart disease is the world's highest.

[ii] Descriptive data about RDH in this section were taken from a range of sources including the most recent ACHS pre-survey assessment.

The independent review's focus and overarching findings

RDH's services are provided under the auspices of the DHF and it is a member of the Acute Care Services Network of five public hospitals comprising Royal Darwin, Alice Springs, Nhulunbuy (Gove), Katherine and Tennant Creek Hospitals. The independent review's charter according to its Terms of Reference was not the DHF or the Network but the governance arrangements at RDH. Hence, these other institutions are mentioned in passing, not for lack of interest but for focus.

In broad terms the review found that internal organisational documentation provided about the governance and clinical governance of RDH was accessible, informative and useful. It was of value in us understanding the structures and processes of RDH.

People attending our interviews and discussions were courteous and helpful. They appeared to want improvements to the corporate and clinical governance of RDH, and saw the review as an opportunity to achieve this. On the other hand, staff reported that there was an RDH culture of not listening, and blaming others, which permeated parts of the organisation. This was more evident when major issues were being dealt with, such as Coroner's cases, or when there was pressure induced from multiple reviews and inquiries, as is occurring now. We hope this represents a low point, and that the recommendations of this review can help with the process of improvement and self-sufficiency.

Seven public submissions were received. They covered the provision of information and information systems to underpin effective decision-making, the possibility of bringing in no fault liability based on the New Zealand experience, electronic record-keeping, relating staffing levels to clinical need and specific issues of corporate and clinical governance within RDH, particularly culture and culture change, relationships and communication. These were of value in informing the review of a range of concerns of the community and key interested parties.

The review had regard to recent inquiries into health systems in Australia[11-19] and elsewhere.[20] The key messages are that good governance of public hospitals is a team effort requiring partnerships between governments, communities, policymakers, managers and clinicians;[20] excessive centralisation and top-down approaches rarely achieve their aims;[21] restructuring is often a recipe for confusion and frequently impedes progress; empowering local managers and clinicians is pivotal; and involving the community is paramount.

We divide our findings and recommendations into three areas: governance issues as they relate to DHF and RDH; governance issues of RDH; and clinical governance issues within RDH. These act as a template for reporting our findings and recommendations, as shown below.

The review noted that there are many skilled, caring and committed staff at RDH. Supporting these staff in providing safe, quality patient care, underpinned by effective and efficient corporate governance within RDH, and between DHF and RDH, is a priority.

It seemed to us that RDH was stretched for space and was very busy, and it appeared that it was under-funded for the work being done. We could not determine this definitively because there did not seem to be the requisite casemix adjusted data or relevant performance information benchmarked to the performance of other comparable hospitals. There may be savings to be made which could be re-invested in patient care, but lack of financial and other information meant we could not make judgements about this.[iii] This problem has implications for governance. Even if executives and unit managers want to be accountable, it will be challenging to do so effectively because of the lack of information, data bases and systems.

We believe DHF should implement some form of casemix related funding so that the workload and case complexity of the hospital is recognised and appropriately funded. If this is not supported on political, policy or administrative grounds, then it will be important for workload and funding to be benchmarked with similar hospitals, eg The Canberra Hospital in the ACT, or John Hunter Hospital in Newcastle, NSW.

The most pressing governance issue is one of patient safety, as indicated by the Coroner in the case of Mrs Margaret Winter.[1] The review team is of the very strong view that clinical resourcing to provide safe patient care must be the highest priority.

Overall, we found both corporate and clinical governance within RDH need to be strengthened. We note that RDH is not standing still, and a range of people we interviewed recognised the scope of work needed to improve. There was evidence that the essential structures and personnel were in place or they were about to be. Nevertheless, a concerted effort is required to create good governance and clinical governance models and then sustain them. Further capacity-building and inter-professional teamwork is needed to make improvements and realise potential. We explain why, and what to do about this, below, through the presentation of twenty-six findings and recommendations.

[iii] Professor Guy Maddern, in his 2005 review suggested that there were efficiencies to be made in operating theatres; and we have no doubt there are others.

Governance issues as they relate to DHF & RDH

Overall statement

Responsibilities for the performance of RDH are split between those of the Minister's office, officers of DHF, and the Board, executives, managers and clinical personnel at RDH. This is similar across jurisdictions running publicly funded health systems. There is no perfect solution to getting roles completely clarified and the balance of responsibilities and accountabilities right. In every jurisdiction these are often in a state of flux. However, we found examples of uncertain and confused responsibilities and unclear accountabilities characterising the relationships between DHF and RDH. Resources are provided by DHF, which has policy and strategic oversight of the hospital, but where its responsibilities end and the Board's and hospital executives' responsibilities for operational and clinical performance starts was not clear, either to us or those we interviewed.

It seemed to the review that responsibilities were often taken depending on the personalities of the office holder rather than as a result of prior work to clarify responsibilities. If senior DHF office-holders are strong, active personalities with an interest in detail then this seems to lead to what is seen by RDH managers and clinicians as micro-management of issues from above, for example.

While there are multiple organisational layers to handle decisions, a range of committee structures and much internal policy documentation, there is felt to be poor communication and many gaps between DHF and RDH. There are therefore opportunities to improve communication, clarify roles and responsibilities and ensure that relationships are less subject to the vagaries of personalities. Services need to be built on needs, systems and processes, not individual idiosyncrasies.

There has been progress made in other jurisdictions such that the relationships between departments of health and hospitals are clearer, better defined and enjoy more effective communication regimes than we observed in the NT in the case of RDH. DHF and RDH could learn from the experience for example of Victoria in this regard, which allocates responsibilities more clearly than we witnessed in NT.

Particular issues between DHF and RDH include a lack of agreement about how funding is allocated and for what purposes, and who is responsible for strategic and operational performance of RDH. RDH staff seek improved levels of communication between DHF and RDH, and senior managerial and clinical staff want much clearer delegations and authority, and more autonomy to run the hospital effectively. The review team believes that more effective governance will ensue if the roles and responsibilities for RDH between DHF and RDH are regularised.

Findings and recommendations

Finding 1. The division of responsibilities and accountabilities for strategy and operational performance of RDH is not clear between DHF, RDH, the RDH Board and executive group. There are legislative requirements for the Board, discussed below. Effective governance is not evident at RDH at present, and should be promoted in the light of the Langlands model[7] summarised in Table 1 with our application to RDH. There is a case for DHF to become temporarily more involved in RDH's detailed operational performance if finances are out of control, but this should be the exception not the rule.

Recommendation 1. Clarify the roles of DHF, the RDH Board and executive, and communicate these widely, in order to promote effective governance of RDH. The Board should be responsible for governance of RDH, the executive team for its execution, and DHF for funding, health systems policy and overall direction. DHF involvement in operational performance should normally be via performance monitoring based on established indicators following negotiation and agreement.

Finding 2. While DHF Divisions have both policy and overarching health service delivery responsibilities, there are cross-overs and points of confusion with the Board and executives of RDH in terms of strategy and operational performance.

Recommendation 2. Publicise an open statement clarifying DHF staff accountabilities for RDH, confirming their responsibilities for strategic performance, DHF and RDH goals and key performance indicators (KPIs).

Finding 3. Delegations are well publicised but do not seem to be uniformly accepted. There are levels of micro-management of RDH by DHF and others in government.

Recommendation 3. Delegate appropriate authority to RDH, and negotiate a service agreement including a suite of agreed annual performance targets that the Board and executives are to meet, and allow them to manage these.

Finding 4. The committee structure between RDH and DHF is complex, and often ineffective in contributing to performance and providing feedback to stakeholders, including government. Some committees do not meet, and others do not discharge their decision-making and communication functions effectively.

Recommendation 4. Clarify and streamline the committee structure between DHF and RDH, with the aims of improving role delineation, communication, accountabilities and responsibilities.

Finding 5. The existing arrangements between DHF and RDH often act as bureaucratic layers through which it is reported to be hard to secure decisions and approvals.

Recommendation 5. RDH executives should act as enablers of and advocates for hospital services, and be empowered to handle all operational aspects of hospital performance.

Finding 6. Bureaucratic and political arms of government in all jurisdictions are required to respond to media events and become involved in minor matters or issues of the moment, or emphasise some issues at the expense of others. NT is no exception. The problem arises when this interferes with effective governance, as sometimes happens in the case of RDH. It was apparent to the review that sections of staff are demoralised by recent media reports and are concerned that the consistent portrayal of RDH as providing poor standards of care impacts on the hospital's reputation, the confidence of patients and the community, and the capacity to recruit new staff.

[By way of comment, the review team argues that much media-driven short-termism needs to be responded to, but not to the detriment of good governance and operational performance, as the ongoing issues of quality of care and safety of patients should be the main focus. By and large, as we indicate above, DHF should be responsible for the strategic performance of RDH and the RDH Board and executives should be responsible for its operational performance. Each should be held to account by government for their respective roles, contributions and performance, and should respond to the media accordingly.

The media has to be educated about the need for more balanced assessment of the problems, as it tends to simplify unduly most health care issues. Media reporting, often presented in emotive and crisis-inducing terms, takes staff away from managing the system or caring for patients. This provokes health system responses to superficial matters at the expense of key, deep-seated issues which executives should be addressing. These take time, with which the media has little patience. So the cycle continues. Most health care stakeholders need a better understanding of the media, how it works, the influence it has and the knee-jerk reactions it stimulates. Less distortion of issues, and more concerted effort on real problems, are needed.]

Recommendation 6. RDH should work consistently through the General Manager and other designated staff to improve relationships with the local media and their understanding of hospital and related issues.

Finding 7. There has been inadequate needs analysis of patients served by RDH completed so far as we could tell, and few good examples of costed clinical services plans. At the heart of such plans should be comprehensive consideration of current services and future needs, and how these can be met. The planning process should produce documented understandings of RDH's present needs and future requirements, and enable DHF and RDH to create stable and mutually agreed roles and responsibilities for RDH's services. It should be linked to RDH's strategic planning processes. The plans should also be related to the allocation of space and the use of and alterations to the physical facilities in the future.

Recommendation 7. In conjunction with DHF and other key stakeholders and under the supervision of the Board, RDH should prepare a five year strategic plan and clinical services plan. This should be costed, be adjusted for casemix and should include clear process and outcome indicators, and form the basis of RDH performance measures. It should also transparently link clinical activity to resource allocation, and form the basis of space allocations and alterations.

Governance issues within RDH

Overall statement

Staff of RDH generally want their own entity to manage and work in, and to regain the public's confidence in RDH. A number of staff are keen to be given responsibility for RDH's performance and management of its services, but many observe there is micro-management of sometimes minor issues from the political and bureaucratic arms of government, often stimulated by media pressure or special interest lobbying. While this is what happens in democracies in Westminster systems, it is nevertheless the case that governments giving undue weight to special pleading or engaging in excessive micro-management of issues can undermine the responsibility structures needed for organisations to perform effectively and be held to account.

The review team members agree that an effective governance model for RDH is for the Board and executives to be given clear authority to manage RDH's services on a daily basis and be responsible for delivering the agreed model of care with pre-determined, negotiated standards and performance levels. This will require a concerted effort by Board members, executives, managers and staff. They will need to be willing and able to provide effective leadership and management, to strengthen corporate and clinical governance, and make required improvements in systems, processes and strategies to provide care of a high standard.

Findings and recommendations

Finding 8. The recommendations of this review will require significant coordination. Moreover, in addition to this review of governance arrangements there are numerous other reviews taking place within or about the management of, and care delivered at, RDH. To ensure effective coordination of these, a task force of executives, managers and clinicians, with adequate patient representation, under the auspices of the RDH Board ought to be established, to consider and give effect to these recommendations. The task force should include in its remit recommendations of the Coroner in recent cases [eg, Margaret Winter,[1] Sandra McRae[5] and Georgia Rae Tilmouth[6]] and those of the Health and Community Services Complaints Commissioner (HCSCC) who has expressed concern over recent matters which have been brought to her attention. The task force should be supported by an independent individual or team with a charter to provide change management expertise and help create the momentum for change and assist with the implementation of recommendations.

Recommendation 8. Establish a task force of senior executives and clinicians under the direction of the Board, with representatives of other main stakeholder groups including patients, with the support of a change management expert or team, to process recommendations emanating from this and other reviews at RDH.

Finding 9. Within RDH, the Board's and executive members' roles and responsibilities have not been sufficiently differentiated and elucidated. Doing so should aim to alleviate accountability issues, and smooth approvals processes.

Recommendation 9. Clarify the roles and responsibilities of the Board and Board members. The Board should act in accordance with its functions as specified in the Hospital Management Boards Act 1980, as amended. RDH executive members' roles should be clarified and documented, including those of the General Manager, Deputy General Manager, Director of Medical Services, Executive Director of Nursing Services, Executive Officer and Co-Chairs of the Divisions of Surgery and Critical Care, Medicine and Maternal and Child Health. [iv]

[iv] The Hospital Management Boards Act 1980, as amended, indicates that the Board's functions are, *inter alia*, at section 22. Functions, part (1), to "(a) give directions and offer advice ... to the Manager of the hospital with respect to any matter relating to the operation of the hospital; (b) to fix and supervise the standards of service provided by or through the hospital; (c) to advise and make recommendations to the Minister on any matter relating to the operation of the hospital, including the needs of the hospital in relation to its future development; (d) to co-ordinate the use of resources in the hospital". Later, at part (2) of section 22, the act says "For the avoidance of doubt, it is declared that the powers of direction of a Board do not include powers to give directions for or in relation to – (a) the recruitment, management and discipline of staff; or (b) the financial management of the hospital."

The review examined a sample of the minutes of the Board's meetings and discussed the Board's role with key stakeholders. This raised a range of issues. One is that members of the Board had poor attendance at meetings, with several Board members present at only one-third of the meetings. Another is that the Board did not seem to be addressing the strategic responsibilities demanded by the Act in the extracts noted above, drawn from section 22. Instead the Board seemed to defer to the DHF on the one hand and the executives of the hospital on the other for the direction of the hospital and to fix and supervise standards of service. Another is that some vital planning and policy issues seemed not to be discussed by the Board, nor responsibility taken to ensure that they were in place. For instance, there was no evidence that any of the parties responsible for the governance of the hospital had developed a clinical service plan, which would be deemed essential to express the needs of the hospital in respect of its current levels of service provision and future development.

Finding 10. The RDH governance committees (the Executive Governance Group and enlarged Hospital Governance Group) do not appear always to provide effective feedback of decisions. Minutes of meetings and action points are apparently not always recorded or widely circulated. It is perceived in some quarters these groups act as another layer of bureaucracy that staff are obliged to navigate through rather than providing leadership in improving clinical care and acting as advocates for hospital services. Submissions and requests with supporting business cases are needed if resources are to be committed. When submitted to the relevant governance group, and in other cases where decisions are sought, there should be clear feedback on the outcome including if more work is required. Where cases are rejected, the reasons why should be clearly communicated.

Recommendation 10. Review the terms of reference of the RDH governance groups to include all aspects of governance, providing leadership to the hospital, and processes for shared decisions, including requests for resources and decisions beyond the remit of any one individual exercising his or her leadership role. The roles of the Medical Advisory Committee (MAC) and Nursing and Midwifery Council (NMC) in supporting patient care and advocating a clinical perspective need to be acknowledged and strengthened. They can provide valuable clinical input into decision-making processes.

Finding 11. There were few indications of an open process for setting priorities for new services and associated requests. Priority lists for staffing and equipment were not accessible by review team members, for example.

Recommendation 11. Review the process of priority-setting for new services, equipment and staff. There should be adequate debate about the priorities for staffing and equipment with lists prioritised according to patient need. Requests should be linked to, and incorporated into, RDH's strategic plan and clinical service plan. The RDH Governance Group should be responsible for determining staffing and equipment priorities and keeping these under review.

Finding 12. Human resource management practices, while comprehensively documented including via accessible policies and procedures, fall short of the ideal. Review team members were told of instances of bullying, of senior medical staff behaving in an unprofessional manner in the presence of nursing or junior medical staff, of staff, including senior managerial staff, denigrating or blaming others, of slow or no response to complaints about competency issues, of appointments without advertising, of failures to follow clear process in recruitment, selection and appointments, and of unnecessary delays in appointing candidates. It appeared to us that the centralised service model, particularly for recruitment, needs to be more responsive. It is noted that service level agreements for centralised services such as HR are not in place. Good policy and procedures are not being followed. The review team noted that key positions such as the Director of Medical Services, Executive Director of Nursing Services and Director of Allied Health posts have been left vacant for lengthy periods. Every effort must be made to ensure that such key positions are filled as expeditiously as possible in future.

Recommendation 12. Develop a plan for the implementation of good human resource management practices that are already well known both in principle and via DHF and RDH policy documentation. This includes promoting a just culture,[v, 22 23] zero tolerance for abuse or bullying, reinforcing processes for conflict resolution, the promotion of organisation-wide respect and trust, expediting procedures for handling competency or disciplinary matters and streamlining and then following recruitment processes.

Finding 13. Nursing staff expressed concern that RDH has experienced a period of more than two years without a permanent appointment to the Executive Director of Nursing position. There is a perception by nursing staff that the position is not valued. It is urgent that this position be filled on a permanent basis to provide stable professional leadership for RDH nurses and in promoting practice improvements to enhance patient care.

Recommendation 13. The key position of Executive Director of Nursing must be filled without further delay, and systems and strategies introduced to ensure that timely appointments are made to all key positions in future. Once appointed, the Board and executives should provide strong support to the incumbent's efforts to make improvements.

[v] There is a large and growing literature on promoting a just culture. A good starting point is Reason's seminal paper in 2000 in the British Medical Journal [http://www.bmj.com/cgi/content/extract/320/7237/768] and Marx's 2000 book.

Finding 14. RDH has also been without a Director, Allied Health for a lengthy period of time and at the time of the review recruitment was in progress. Both this and the Executive Director Nursing positions should provide valuable contributions to governance, particularly in advancing multi-disciplinary approaches to patient care. Views were also expressed about the potential to provide improved allied health services by streamlining the existing services throughout the hospital to achieve improvements such as common standards and increased weekend cover, particularly in support of improved discharge practices.

Recommendation 14. The key position of Director, Allied Health must be filled without further delay, and systems and strategies introduced to ensure that timely appointments are made to all key positions in future. Once appointed, the Board and executives should provide strong support to the incumbent's efforts to make improvements.

Finding 15. There are multiple mechanisms for handling complaints and ministerial correspondence. Complaints appear to come from various sources to a number of different areas, including DHF, with ineffective coordination of effort. This seems to be a reactive system, and recording and managing complaints is not working well, and reporting is not timely. Various existing models and those from other jurisdictions can be reviewed with profit. For example, there has been work in the Division of Surgery and Critical Care to develop a flow chart and pathway of complaints. Efforts should be coordinated such that sufficient time is given to staff at lower levels to respond. Staff development sessions on the management of complaints and ministerial correspondence would be useful.

Recommendation 15. Develop a system for tracking and trending complaints and identify resources to support improved complaints management.

Finding 16. There are disincentives for potential staff to work at RDH. These include high workloads, remuneration levels compared with other jurisdictions, heat and humidity, housing affordability including rental levels and work for partners that is difficult to secure. With regard to attracting and retaining medical staff, participation in clinical outreach services is highly regarded and is viewed as an attraction. However, this is not given the priority by RDH that medical staff believe it should have. Nursing recruitment is equally affected by the above factors. Amongst the many recommendations of the recent study[24] of mobility and midwives in the Northern Territory the report advocates one system of recruitment to the Northern Territory. This approach may alleviate the movement of nurses and related accommodation issues. However there is a need for RDH to develop and implement a workforce strategy to retain and recruit nurses as a priority, particularly to address the high levels of overtime worked by nurses to meet the constant workload demands and reduce the use of agency nurses as achieved in other jurisdictions including Victoria and Alice Springs.

Recommendation 16. Develop a staffing strategy that addresses those issues that can be resolved, and make a concerted effort to market the benefits of working at RDH. These are considerable; few places offer the challenges and rewarding work that RDH offers.

Finding 17. The Divisions of Surgery and Critical Care, Medicine and Maternal and Child Health have the potential to make substantial improvements in the clinical care and financial performance of units in their respective areas of responsibility. To do so they will need effective business and financial support, support for clinicians to develop managerial skills and improved information and data resources to underpin decision-making.

Recommendation 17. Future business support positions within RDH Divisions should be upgraded to the status of business managers. Managerial, administrative, logistical and IT support provided to Divisions should be identified, specified and resourced. The contractual arrangements and appointments of co-directors need to be finalised such that delays are avoided in appointments, the terms of appointments are specified and succession planning is clear. Co-directors and support staff of the Divisions will work better together if they are physically collocated.

Clinical governance issues within RDH

Overall statement

Quality of care and patient safety are of paramount importance. A model for managing these effectively in the Australian context has been advocated in recent work.[8] Table 2 provides a summary, and some key questions for RDH. While every individual must play a part in effective clinical governance to ensure high levels of quality of care and patient safety, particular responsibility in addition to that of the Board and executive rests with the co-chairs of RDH Divisions and heads of clinical and support units.

The review team found that although there were high levels of commitment from staff, there was scope for improvements in systems and initiatives to address quality of care issues, improve patient safety and manage clinical risk. Clinicians and managers at RDH repeatedly said that improvements in patient care should emanate from this review. As a way of providing additional assistance, we make available in Appendix E some suggestions for clinical units to support improvements in quality and safety.

Findings and recommendations

Finding 18. The mechanisms for involving patients in clinical decision-making are not well developed and vary across services. Patient satisfaction surveys do not seem to be conducted, or only on an irregular basis. This is unusual as many large hospitals participate in such activities today. Opening up the hospital to the public (eg, community open days) might help. Each Division should develop and circulate an action plan incorporating ways to create greater involvement of patients in their care and key decisions.

Recommendation 18. Patients should have greater input into standards of care, safety and quality. Patient satisfaction surveys should be planned and systematically conducted, with results fed into organisational decision-making and quality improvement strategies.

Finding 19. Clinical audit, quality improvement and patient safety issues, and supporting clinical policies, are not always given priority either at divisional or departmental levels. Clinical audit and peer review do not appear to be sufficiently robust, and need to be. Quality management procedures, the risk register and incident reporting system are in the early stages of development. For example, the AIMS system is not effectively used, particularly by medical staff, and data emanating from it is not utilised to flag and manage potential problems. We note that the incident reporting system is under review. Root cause analyses (RCAs) are conducted but there is little evidence of action on recommendations or the effectiveness of actions taken. Attendance at clinical review meetings should be a priority. Clinical data are increasingly available at RDH via the Quality Risk Management Unit. The development and application of clinical protocols is important, particularly for high volume cases. Credentialing and defining the scope of practice for new staff is undertaken but there seems to be no regular review of existing staff. Nursing indicators need to be expanded beyond falls and pressure ulcers in line with contemporary practice and regularly reviewed.

Recommendation 19. Comprehensive initiatives are required to address matters of audit, quality and patient safety, and to develop policies to support clinical practice. There needs to be a strong focus of Divisional co-directors on clinical performance of staff and clinical review carried out in all units.[vi,1 11 12 21 25] Every inpatient should be clinically reviewed, and every unit should produce data about performance and outcomes (eg, length of stay, complication data, AIMS data) and use these to explain, correct or modify clinical behaviour and improve care.[vii 26]

[vi] For a recent example of the repercussions of the failure to address this is found at http://www.ombudsman.vic.gov.au/www/html/7-home-page.asp [the Victorian Ombudsman's report of an investigation into issues at Bayside Health concerning Dr Thomas Kossman]. For more information on the effects of having poor clinical processes and what to do about this see the Bundaberg Inquiry (the Davies inquiry into Dr Jayant Patel, and report on what should happen to reform the Queensland health system [the Forster report]). For advice on translating these kinds of recommendations for the benefit of running a more effective clinical unit see Hindle, Braithwaite and Iedema (2005), summarised in Appendix E.

[vii] As recommended in Professor Guy Maddern's 2005 review of operating theatres.

Finding 20. Clinical communication is a major issue, as is clinical leadership in some quarters. Work is underway at RDH to address some specific instances of poor clinical communication. This should be given priority as the current situation is not sustainable and is certainly not in the best interests of optimal patient care. Instances discussed with the review by way of illustration include planning for services without consulting appropriate administrative and clinical staff (eg, radiotherapy), ICU staff not appropriately consulting with surgical staff about patient decisions and ignoring post-operative surgical instructions, surgical staff not always responding rapidly to ICU staff, clinical handovers in surgery not done on a daily basis, obstetricians not meeting regularly and when held these meetings not being given priority, inadequate communication between disciplines and departments including the acceptance of transfers from other hospitals when nursing workloads are high and resources inadequate and few multi-disciplinary meetings. Nursing could also benefit from reviewing other modes of patient handover, eg bedside handovers which provide an opportunity for patients to be directly involved in their care. Clinical leadership generally needs to be addressed and supported, perhaps starting with surgery and obstetrics and gynaecology.

Recommendation 20. There should be compulsory formal handover of surgical patients at a set time with identified attendees seven days a week. This principle should be adopted as standard throughout RDH. Multi-disciplinary meetings between relevant medical and other staff should be encouraged for both administrative purposes and for review of patients' management. A multi-disciplinary approach to management and review of patients should be required and facilitated. Engendering a climate of trust, respect and mutual support should be a priority. Developing and supporting clinical leaders needs further attention.

Finding 21. It appeared that the unavailability of support services such as ward clerks and allied heath staff at peak workload times, and the requirement for nurses to relieve patient care assistants for meal breaks, directly impacts on the most effective use of nursing skills. There is widespread concern amongst nursing staff in relation to skill mix and workload issues. The review team recognises the importance of these issues and that this is a critical matter in relation to good clinical governance because of the direct consequences on the quality of care and safety of patients, and also because of the effect on nursing morale and retention rates.[24] The reviewers are aware that nursing workload levels are the subject of a separate review being conducted by Professor Christine Duffield of University of Technology, Sydney, and that her report has yet to be received by the Minister.

Recommendation 21. Review nursing skill mix, supporting services and workload issues in conjunction with the Duffield review's recommendations.

Finding 22. Junior medical staff are key to an effective hospital. The review was advised that there was no centrally consolidated place for junior medical officer (JMO) recruitment and management; JMO allocation and rostering systems were deficient, and lacked flexibility to cope with absences; feedback mechanisms regarding JMO performance were piecemeal; education was not emphasised, and opportunities for attending education were limited because of heavy workloads; the pathway to access counselling, employee assistance or support structures was not clear; and cultural awareness programs for JMOs coming from other jurisdictions was poor.

Recommendation 22. Develop and implement a plan to modernise and improve JMO recruitment and management, allocation and rostering, performance feedback, education, support structures and access to cultural awareness education.

Finding 23. Medical resourcing appears to fall short of appropriate and safe levels in several areas. Particular areas of concern include very heavy clinical workloads, night shift RMO staffing levels, obstetrics registrar coverage, reliance on employment of international medical graduate (IMG) registrars and senior medical staff, most notably in surgery. While some improvements have been made there are issues of medical organisation that need to be addressed including supervision of junior staff, bedside teaching and ward rounds that appear to be neither coordinated nor effective. RDH is at risk of losing its intern accreditation from the Australian Medical Council (AMC).

Recommendation 23. If future avoidable deaths and Coroner's cases are to be minimised and intern accreditation is to be maintained, resourcing of adequate numbers of registrars and other junior medical staff in all Divisions, and proper supervision of these staff, must be a priority including the provision of adequate medical coverage of the hospital at night.

Finding 24. Workload data and other hospital data are not made widely available. These have implications for staffing levels, patient safety, and future resource allocation decisions. A sign of a maturing organisation is healthy, professional discussions about issues such as workload and patient safety.

Recommendation 24. Workload and other important data should be made available widely, subject to suitable confidentiality requirements being met.

Finding 25. Clinical and managerial staff face difficult ethical decisions from time to time, but there is no clinical ethics committee.

Recommendation 25. Establish a clinical ethics committee or provide designated support for those making decisions of a challenging ethical nature within RDH.

Finding 26. A range of operational initiatives reportedly require the attention of senior staff. These include bed management, particularly discharge planning; patient transport, which it was argued could be more efficient; increased patient education in community settings, as many patients do not travel to RDH for scheduled appointments; the allocation of ward clerks; allied health support in emergency department; levels of interpreter services to meet peak workloads; levels of accommodation to cope with high staff turnover; the policy of nursing staff remaining in residence for one year only; the future of rehabilitation services; monitoring the competency of agency staff; further attention to practice and policy development in nursing; and appointing nurse practitioners in relevant areas. Although these are operational rather than governance issues they are included here to illustrate some of the areas where poor governance has resulted in operational frustrations.

Recommendation 26. The executive group should determine the priority of these issues of operational concern identified to the review.

6.0 Discussion

6.0

Introduction

Having presented our findings and recommendations, we turn to a discussion of their implications. The Discussion section takes up the Terms of Reference, and deals with the overall purpose of the review including eight key aspects of RDH's structures and processes highlighted by the Minister as requiring the attention of the review team. It complements our presentation of the findings and recommendations in section 5.0.

Service objectives and values [related findings and recommendations: #1-5; #7; #23]

While RDH's organisational structure appeared appropriate for its purpose, and RDH has a long-standing role as Darwin's key provider of acute and associated services, the review team believe that more work could be done to specify and clarify organisational-wide service objectives, as well as at divisional and unit level. We suggested above that links between DHF and RDH could be expressed in terms of a documented service agreement clearly related to casemix-based or rationally-derived, benchmarked and negotiated funding levels. Once established and fine-tuned, this in turn could lead to the development of detailed service agreements and understandings at divisional and unit levels. Within RDH, divisions and units need to be clearer about what service levels are expected from them in exchange for the resources they receive. We do not doubt that developmental work had been done in this area by DHF and RDH staff. However, the detailed analysis and specification of service objectives related to funding did not appear to us to have been given sufficient priority and hence was not sufficiently advanced. Developing a clinical service plan (finding and recommendation #7) is a key success factor.

So far as values are concerned, as we indicate in our findings and recommendations, the morale of RDH is low, the hospital's reputation has been damaged and remains under threat, the Coroner and Health and Community Services Complaints Commissioner have adversely reported on aspects of RDH's services, recent budget over-runs had taken their toll, RDH is under the media glare and is often subject to micro-management from above and there are multiple internal and external reviews taking place. This would test the resolve and values of any organisation, even a robust

one. General values of importance in such an environment are ones that emphasise teamwork, a collaborative, inter-professional approach, transparency and openness (vertically, between managers and clinicians, and horizontally, across groups and organisational units), having shared goals, and encouraging success. People in leadership roles should play a significant role in nurturing such values. In regard to values relating to the governance of RDH, Table 1 presents those from Langlands et al[7] that the review team argues are key elements in RDH's long-term success.

Policy framework [related findings and recommendations: #12; #15-16; #18; #22; #24]

The findings and recommendations also point to challenges for RDH's policy framework. While there are documented policies and procedures in place, some of which are developed and promulgated by DHF and some by RDH, adherence to them is variable and their application inconsistent. Some policies and procedures are not as up-to-date as they could be, and others have not been well communicated. We have made findings and advanced recommendation on some of these, such as those on human resource management practices (finding and recommendation #12) and others relating to complaints management (#15), staffing (#16), patient input (#18), nursing skill mix and workload issues (#21), JMO processes (#22) and sharing data (#24). In addition, we have suggested the roles and responsibilities for RDH's policy and performance be clarified and communicated (see also findings and recommendations #1-5). So while the policy framework is relatively intact, and was endorsed by the RDH clinical governance group in November, 2008, its implementation is variable, and needs to be strengthened and tightened.

Resource allocation methodologies; levels of authority and delegation; and independent verification [related findings and recommendations: #1-4; #23]

We have argued that resource allocation methodologies need development, and require a casemix-based approach or a more rational and explicit basis (see our overall comments prefacing the finding and recommendations). There are efficiencies that can be made, but specifying the details of these was not the focus of our review. We note that a review conducted by Professor Guy Maddern of University of Adelaide in 2005[26] made recommendations to encourage more efficient and effective operating theatres, for example.

We have also advanced the view that the Board, executive and unit managers need to be more clearly responsible for, and have suitable delegated authority for, RDH's performance, clinical service development and long-term organisational and clinical outcomes (see findings and recommendations #1-4).

Organisational capacities, capabilities and structures [related findings and recommendations: #9-10; #13-14; #17]

Our belief is that the new organisational structure, properly staffed and resourced, with a well-functioning Board and executive, will be able to make considerable ground in setting up the conditions for RDH's success.RDH has great potential and does many things well, but falls short on others, as our findings and recommendations make clear. The organisational capacities and capabilities of RDH need development and resourcing over time. This will require support from the Minister and DHF.

Decision-making processes [related findings and recommendations: #6; #8; #11; #19-22]

There was evidence that executive and clinical staff realised that organisational and clinical decision-making could be improved, and we have identified in our findings and made corresponding recommendations on many issues that, if implemented well, will constitute improvement in the way decisions are made and the quality of decision-making. This, too, will likely be a longer term endeavour. Improving the way executive and managerial decisions are made (see findings and recommendations #8 and #11, for example) and clinical decisions are made (see findings and recommendations #19-22) is an improvement journey that requires concerted effort. Bearing in mind confidentiality, to the extent possible, all decisions should be open, transparent and publicly defensible. Decision-making in regard to the recommendations of this report, and other reviews presently underway, require attention. We discuss this below, in section 7.0.

The effectiveness of management at all levels including the effectiveness of the relationships between managers and those being managed

[related findings and recommendations: #12-17; #20]

Management-staff relationships in virtually all modern organisations and institutions, public and private, are taxing and hard to get right. Workforces are changing, employee expectations rising, and the social, economic and legislative demands on managers increasing. RDH has particularly acute additional difficulties including its remote location, challenging patient populations, regional responsibilities, recent budgetary over-runs and reputation-sapping reports such as those from the NT Coroner on the quality of its care and the weaknesses in its systems. RDH managers require support from internal and external stakeholder groups particularly the Minister and his office and the DHF. Developmental opportunities for managers should be identified through annual performance review activities, and pursued. Management-staff relationships can be strengthened over time, as findings and recommendations #12-17, and #20, suggest.

Hospital wide audit and quality improvement processes and outcomes [related findings and recommendations: #19; #25]

Table 2 presents attributes that recent research shows are important for effective clinical governance. We have summarised these in terms of key application questions for RDH. In addition, findings and recommendations #19 and #25 are central to a better approach to audit and quality improvement.

Quality improvement processes in place in management [related findings and recommendations: #1-5; #8-9; #26]

Almost 60 years ago (in fact, in 1950) Deming[27] took even earlier work from Shewhart[28] and codified them in 14 points which can be synthesised further, into four key goals: avoid organisational silos and build relationships between divisions and units; develop managers and leaders to do this; inculcate a continuous improvement philosophy (in health, this means in both the business and clinical aspects of care); and train and develop people to create an ethos of improvement and self-improvement. There was evidence of some progress at RDH along these lines, but further development is warranted. Most of our recommendations, in effect, relate to these points.

7.0 Conclusion

7.0

Concluding remarks

We have documented a range of findings and tendered corresponding recommendations designed to improve corporate and clinical governance at RDH. To conclude our review, we make some final remarks.

There are many willing, competent and skilled staff at RDH. Almost everyone in our judgement wants to commit to, and strive for, improvement. There are structures, policies and procedures in place, and a new policy framework, recently endorsed by senior RDH staff. Reviews are underway to help sharpen the focus of executives, managers and staff on what needs to be done. There are suggestions for enhancement emanating from this review, not only from our findings and recommendations, but also from models we have provided to strengthen corporate governance (see Table 1) and clinical governance (see Table 2). We have presented an example of a change model (see Table 3) which we believe can be usefully applied and provided a summary of what should be done in clinical units to promote improvement (see Table 6, Appendix E).

Most of the failings at RDH are inherently about a lack of follow through, and of poor implementation of new and existing ideas, policies, systems, models of care and procedures. Organisations which are constantly on the back foot, under severe criticism, and are subject to multiple reviews, must regain the initiative and move into a cycle of improvement rather than defensiveness. A clear, useful starting point in creating positive momentum is to embrace these findings and adopt the recommendations, thereby implementing change and improvement to corporate and clinical governance processes. This involves the Board, executives, managers and clinicians with the strong support of the Minister and DHF.

We conclude by indicating that we believe nothing we have suggested is beyond the capabilities, with support, of the RDH Board, executives, managers and clinicians. It will not be easy to do all the things we have stipulated. People need support to perform well, and ongoing training, education and development. Recommendations from multiple other reviews, the Health and Community Services Complaints Commissioner's recommendations and Coroner's recommendations have been provided recently, or are in the process of being reported. They constitute a blueprint for change, and a very challenging range of issues to address.

Timelines and implementation

An implementation plan is needed. As a first step we suggest some timelines for tackling and implementing our recommendations (Figure 1), but there needs to be a more detailed plan for tackling recommendations from other review initiatives.

Figure 1: Suggested timelines for the implementation of recommendations

Recommendation	Quarters											
	2009				2010				2011			
	1	2	3	4	1	2	3	4	1	2	3	4
Governance issues between DHF and RDH												
Recommendation 1: clarify roles, responsibilities	♦	♦										
Recommendation 2: confirm DHF accountabilities	♦	♦										
Recommendation 3: settle delegations and targets	♦	♦										
Recommendation 4: streamline committee structures	♦	♦	♦									
Recommendation 5: reiterate RDH accountabilities	♦	♦										
Recommendation 6: improve media relationships	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Recommendation 7: prepare clinical service plan	♦	♦	♦	♦	♦							
Corporate governance issues within RDH												
Recommendation 8: establish implementation task force	♦											
Recommendation 9: clarify RDH roles, responsibilities	♦	♦	♦									
Recommendation 10: streamline governance groups	♦	♦	♦									
Recommendation 11: review priority setting processes			♦	♦	♦							
Recommendation 12: improve human resource practices	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Recommendation 13: recruit, support EDNS appointee	♦	♦										
Recommendation 14: recruit, support DAH appointee	♦	♦										
Recommendation 15: enhance complaints management			♦	♦								
Recommendation 16: develop, implement staffing strategy	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Recommendation 17: support Divisional structure			♦	♦	♦	♦	♦					
Clinical governance issues within RDH												
Recommendation 18: systematise patient input			♦	♦	♦	♦	♦					
Recommendation 19: address quality and safety systems	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Recommendation 20: clinical communication, leadership		♦	♦	♦	♦	♦	♦					
Recommendation 21: nursing workload and skill mix		♦	♦	♦	♦	♦	♦					
Recommendation 22: modernise JMO processes		♦	♦	♦	♦	♦	♦					
Recommendation 23: prioritise clinical resourcing		♦	♦	♦	♦	♦	♦					
Recommendation 24: publicise relevant data	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦		
Recommendation 25: establish clinical ethics committee		♦	♦									
Recommendation 26: tackle reported operational issues		♦	♦	♦	♦	♦	♦					

Those assigned the responsibility for implementation should prioritise these recommendations. It seems to us that recommendation 8, and then recommendations 1, 2, 3, 7, 9 and 13, should be given priority.

Evaluation and monitoring program

Finally, there needs to be an evaluation process to complement the implementation strategy. It will be important for the RDH task force responsible for implementation of the recommendations, supported by the change management individual or team noted in finding and recommendation 8, to monitor progress and evaluate the extent to which the recommendations are given effect over time, and how. We strongly suggest the Board and executive group monitor and evaluate progress by having all recommendations as standing agenda items over the next 2-3 years. It needs to be made clear how these recommendations and those of other reviews are dealt with, whether recommendations are accepted or rejected, and implementation activities need to be tackled, and made transparent. A formal review at the end of that period should consider what progress has been made and what further recommendations and improvement initiatives to enhance governance arrangements are needed.

8.0 Appendices

8.0

Appendix A: List of individuals and groups consulted

Ms Frances Abbott	Mr John Franklin	Cecilia O'Brien
Acute Care Services Staff	Mr David Gawler	Dr Dan O'Neill
Dr David Ashbridge	Mr Steve Gutheridge	Dr Didier Palmer
Ms Carol Atkinson	Dr Krispin Hajowicz	Ms Penny Parker
Professor Lesley Barclay	Ms Robyn Harrison	Dr Rob Parker
Ms Sally Bates	Ms Marie Hughes	Ms Barbara Paterson
Dr Barbara Bauert	Dr Jane Hosking	Patient care assistants
Dr Paul Bauert	Dr Diane Howard	Mr Ian Pollock
Mr Peter Beirne	Dr Marcus Ilton	Dr Mike Purvis-Smith
Dr Peter Beaumont	Mr Gary Ingliss	Quality Risk Management Flow Team
Dr Samantha Bigg	Dr Carolyn Jamieson	Ms Christine Quirke
Bio-medical & maintenance staff	Mr Kosta Kalikajaros	Ms Margie Rajak
Board Members of RDH	Dr Nadarajah Kanga	Dr David Read
Dr Richard Bradbury	Dr Anne Kidman	Ms Carolyn Richards
Ms Maureen Britton	Dr Charles Kilburn	Dr Greg Rickard
Professor Di Brown	Ms Celia Kemps	Dr Alan Rueben
The Hon Chris Burn, MLA	Ms Denby Kitchener	Mr David Ryan
Mr Peter Campos	Ms Melanie Labrooy	Dr Vino Sathianathan
Ms Suzanne Cameron	Professor Michael Lowe	Dr Peter Satterthwaite
Dr David Chapman	Ms Kristine Luke	Ms Jenny Scott
Dr Henry Cho	Mr Michael Lynch	Ms Sally Seivers
Ms Carol Cieri	Ms Jane Mackintosh	Ms Marilyn Sneddon
Clinical Nurse Managers	Dr Matthias Maiwald	Dr Brian Spain
Ms Jenny Cleary	Mr Mac Mather	Dr Emma Spencer
Ms Colleen Cox	Mr Colin McDonald	Dr Di Stephens
Mr Kelvin Currie	Ms Louise McKinnon	Ms Sharon Sykes
Ms Carmel Croyden	Ms Kate McTaggart	Theatre Staff
Professor Christine Duffield	Medical Advisory Committee	Mr Kevin Thomas
Ms Jillian Edgar	Ms Renee Moore	Mr Rodney Thomson
Emergency Department staff	Dr Levi Morse	Mr John Treacy
Ms Jan Evans	Ms Chris Murray	Ms Sally Viney
Executive staff	Dr Len Notaras	Mr Roger Weckert
Ms Yvonne Falckh	Nursing and Midwifery Council	Dr Suranga Weerasoorya
Ms Chris Favell	Nursing Program Consultants	The Hon Gerry Wood MLA
Ms Michelle Foster	Nursing representatives	Dr Gina Wulf

Appendix B: Brief *curriculum vitae* of independent review team members

Professor Jeffrey Braithwaite, PhD is Foundation Director, UNSW Institute of Health Innovation, Director, Centre for Clinical Governance Research, and Professor, School of Public Health and Community Medicine, University of New South Wales, Australia. His research examines the changing nature of health systems, particularly the structure and culture of organisations, attracting funding of more than $33 million. He has published or presented over his career on more than 600 occasions, including publishing multiple times in the *British Medical Journal, The Lancet, Social Science & Medicine* and many other prestigious journals. Jeffrey has received numerous national and international teaching and research awards including a Vice-Chancellor's award for teaching from UNSW and three separate awards for research papers in 2007. His international work includes teaching, health systems reviews, presenting and research including in the United States of America, England, Scotland, Denmark, Canada, New Zealand, The People's Republic of China, Japan, Singapore, Hong Kong, East Timor, Laos and Papua New Guinea.

Kaye Hogan, AM is a health services executive and registered nurse who has a strong track record in improving the safety and quality of patient care and delivery systems. As a healthcare management consultant, who also works for the Australian Council on Healthcare Standards, she appraises clinical and corporate services against the appropriate standards in a variety of hospital and healthcare settings, making recommendations for improvement, and manages their implementation. She has held the position of Executive Director of Nursing Services in an ACT teaching hospital, managed the closure and amalgamation of hospital services across multiple sites as well as planned and managed major facilities upgrade programs. Kaye's corporate governance experience includes roles as a board member of the Australian Red Cross, the Australian Red Cross Blood Service, Canberra Hospitals and Royal College of Nursing, Australia. She holds current appointments on Ethics Committees of the Departments of Defence and Veterans Affairs.

Dr. Taffy Jones, AM is a medical doctor who has extensive experience in hospital governance and administration, and has undertaken consultancy work in a number of major Australian teaching hospitals. He has also done work in developing countries on improving standards of healthcare in general and clinical care in particular for the World Health Organisation and others. He has a wide ranging experience in continuous quality and performance improvement, risk management, standards of clinical practice, and all aspects of clinical governance. He has held the position of Director of Medical Services in major teaching hospitals in Victoria, and been President of the Royal Australasian College of Medical Administrators. He has also chaired a number of Committees and Boards in health and community services.

Appendix C: Acknowledgements

We would like to thank the then Minister for Health, the Hon Dr Chris Burns, MLA, for commissioning us to undertake this review on the advice of Mr Brian Johnston, the Chief Executive of the Australian Council on Healthcare Standards, both of whom were highly supportive of this assignment. Their support and guidance, and that of the present Minister for Health, the Hon Mr Konstantine Vatskalis, MLA is greatly appreciated.

Ms Susanne Heuberger at ACHS, Ms Penny Parker in the DHF and Mr Kevin Thomas and Ms Hollie Sekulich at RDH provided excellent administrative and logistical support. This made our task much easier.

We appreciate the support to the review given by many people in the Northern Territory. They variously provided information and advice, answered our questions, wrote a submission or gave us access to documentation. Everyone we met was unstinting in their support for the review and gracious in hosting us.

Ms Jo Travaglia of the Centre for Clinical Governance Research, University of New South Wales content analysed the public submissions. We thank her for making her expertise available to the review.

Appendix D: Content analysis of public submissions

Overview and results

Seven public submissions were received as at 29 January, 2009: from [1] an individual in a private capacity focusing on no-fault liability, [2] an information technology (IT) solutions company, [3] a company with an interest in records management, [4] a second individual in a private capacity concerned about the measurement and management of staffing levels, [5] the principals in a family health practice, [6] the Commissioner of the NT Health and Community Services Complaints Commission and [7] a private individual with an interest in health services management. Six of these submissions were reviewed using Leximancer 3.0, a software content analysis tool which facilitates the examination of core concepts and themes in textual documentation. One was handwritten and not able to be content analysed electronically. The concept map shows the picture of the concepts the submissions raised (Figure 2) and the major themes and key concepts in their contributions are presented in a ranked list (Tables 4 and 5).

Figure 2: Concept map of public submissions

Table 4: Major themes in public submissions

Themes (top ten)	Connectivity
Best	100%
TRIM	56%
legislation	32%
system	18%
areas	07%
staff	06%
FTE	05%
clinical	03%
implement	02%
organisation	02%

Table 5: Key concepts in public submissions

Proper nouns (top ten)	Count	Relevance
TRIM	16	59%
RDH	12	44%
HP	10	37%
Information Management	7	26%
FTE	7	26%
Discovery	6	22%
Department	5	19%
Northern Territory Government	5	19%
Governance	4	15%
Department of Health and Families	3	11%
General concepts (top ten)	**Count**	**Relevance**
best	27	100%
management	19	70%
governance	19	70%
information	18	67%
records	18	67%
business	18	67%
types	17	63%
system	17	63%
legislation	16	59%
time	16	59%

Analysis

A total of fourteen themes and 66 concepts were generated from the submissions. There were separate narratives and concerns in each of the submissions.

Best is the number one theme, and the number one concept. The commercial submissions were interested in arguing that the best information systems and effective record keeping underpinned good governance. Within this theme we see the strength of their narratives in *best records* (and management thereof), but equally that of other submissions in the conceptual clusters around *best governance,* and *best information.*

Best is linked to *governance* through *records. Best governance* is associated, from the perspective of the submissions, *with managing, compliant* and *standards. Best records* lead to *business, corporate, record, ensure,* (which leads to *organisation)* and ultimately *department* on one branch (and from there to *implement* and *practices),* and *record, policy* and *system* on the other. The concept of *system* links *best* with *RDH* and *department* along one line, and *patient* on the other.

There is a strong association between the *information* related concepts in the *best* theme and those of *TRIM* and *legislation.* The concept of *information* links *management* to *documents, electronic, TRIM* and *Northern Territory Government* (associated with *rules)* on one branch and *full, requirements* and *government* on the other. The *best* and *TRIM* themes are linked to *legislation* through *use* and *HP. HP* links *Department of Health* with *available, time, decision,* whole and *areas. Legislation* is linked in the submissions with *Governance* (through *Discovery*), *happy, following* and *staff.* The *staff* theme links to that of *FTE* through a series of concepts: *additional, staff, achieve, difficult, managers, manager, FTE, reduce* and from *manager* to *approved, chart, clinical* and FTE.

Summary

In essence, the commercial submissions raised the importance of effective systems to assist in sound decision-making and governance. One of the private citizen contributions suggested that the NZ system of no-fault liability would assist in disclosure and efficiency of administration of compensation and the other pressed the case for the improved management of staffing levels (full time equivalents (FTEs). The principals in the health practice, with demonstrable knowledge of RDH and other health services were concerned about a range of governance and service issues, including RDH's leadership and culture, communication, and lack of information-sharing. Both this, and the final submission, that from the Health and Community Complaints Commission, were concerned about the role of the Board, including issues of accountability and transparency of governance arrangements, and the quality and safety of services to patients.

Appendix E: What clinical units need to do to promote clinical governance

Review team members were keen to provide a change strategy at the clinical unit level, to support improvements in clinical governance. Hindle and colleagues[21] provided a set of attributes and definitions for clinical units in making a concerted effort to promote clinical governance and improve patient safety and quality of care on a continuous basis. For a discussion of this and its application see Braithwaite et al [http://www.med.unsw.edu.au/medweb.nsf/page/ClinGov_Monographs#2005][29] (Table 6).

Table 6: A summary of the attributes clinical units should aim for in promoting patient safety and improving quality of care applied to RDH

Attributes	Application to RDH's clinical units
Generating ideas about the quality of care and patient safety	• Everyone in clinical units should be encouraged to believe they have a responsibility to suggest improvements, openly as well as confidentially
Good communication	• Effective communication should prevail between junior and senior staff, and between clinicians in different professions
Shared management of information systems	• All information is patient information (not exclusively clinical information only for the benefit of some staff), and should be readily available for the entire care team, and accessible to patients
Shared responsibility and accountability	• All staff should take the initiative in fixing problems; blame is the last option for addressing mistakes
Continuous learning	• Processes should be subjected to informal, ongoing evaluation; finding and announcing mistakes, and asking for advice, should be recognised as signs of strength
Teamwork	• Good patient care requires the skills of many people; teamwork should be encouraged at every opportunity; team members should be regularly praised and rewarded for their work; patients should also be recognised as part of the team

Consumer involvement	• Steps to involve consumers in matters affecting their care should be taken at every opportunity; providing well-written materials to, and welcoming questions from, patients and their families should be routine behaviours
Effective meetings	• Meetings are excellent opportunities to share ideas, to build team spirit and to make collective decisions. To be effective, they need agreed rules for their conduct; an action orientation; and an ethos of inclusivity; and they benefit from routine evaluation as to their effectiveness
Promoting leadership	• All staff, at all levels in the organisation, should consider themselves responsible for showing leadership, and in practice exhibit leadership behaviours in appropriate circumstances

Source: Adapted from Hindle, Braithwaite and Iedema (2005); see also Braithwaite et al (2008)

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