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An Australian Government Initiative

Clinical Governance Guidance for Commissioned Services August 2024

Contents

1. Introduction

Clinical governance ensures accountability and transparency across all disciplines of health care, supporting staff to ensure patients and the community receive high standards of quality care and service provision, and quality improvements are continuously reviewed, monitored and implemented.

Good clinical governance ensures that the community and the health service organisation can be confident that systems are in place to deliver safe and high-quality care and continuously improve services.

The Gippsland PHN Clinical Governance Framework provides best practice guidance in clinical governance with strong emphasis on leadership, culture and improvement as being fundamental to high-quality, safe care and service. The framework identifies the five domains and systems required to develop and maintain a high performing organisation and service.

The Framework aligns closely with the Victorian Clinical Governance Framework[1] and the National Model Clinical Governance Framework[2].

This guidance document is designed to provide commissioned health service organisations practical guidance on the systems and processes needed for sound clinical governance and can be tailored and scaled to best suit health services circumstances and best meet the needs of their consumers.

1.2 Reference Documents

- National Model Clinical Governance Framework 2017, Australian Commission on Safety and Quality in Health Care, Sydney.
- Australian Commission on Safety and Quality in Health Care (ACSQHC) 2008, Australian Charter of Healthcare Rights, ACSQHC, Sydney.
- Delivering high-quality healthcare, Victorian Clinical Governance Framework (Safer Care Victoria) June 2017, Department of Health and Human Services, State of Victoria.
- Victorian Duty of Candour Framework: an implementation guide, October 2022, Safer Care Victoria, State of Victoria.
- Victorian Duty of Candour Guidelines, October 2022, Safer Care Victoria, State of Victoria.[3]

2. Definitions

Clinical Governance: the integrated systems, processes, leadership and culture of an organisation that are at the core of providing safe, effective, accountable and person-centred healthcare underpinned by continuous improvement.[4]

High Quality, Safe, Effective, Person-Centred Care: where avoidable harm during delivery of care is eliminated; where appropriate and integrated care is delivered in the right way at the right time, with the right outcomes, for each consumer; where people's values, beliefs and their specific contexts and situations guide the delivery of care and organisational planning and where the organisation or health service is

[1] Delivering high-quality healthcare, Victorian Clinical Governance Framework (Safer Care Victoria) June 2017, Department of Health and Human Services, State of Victoria
[2] National Model Clinical Governance Framework 2017, Australian Commission on Safety and Quality in Health Care, Sydney
[3] https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour
[4] Delivering high-quality healthcare, Victorian clinical governance framework, Safer Care Victoria, DHHS, June 2017

focused on building meaningful partnerships with consumers to enable and facilitate active and effective participation.[5]

A just culture: part of safety culture with the major features being:

- a systems-thinking mindset to adverse event review and improvement
- provision of a psychologically safe workplace where employees feel safe to report adverse events and near misses
- acknowledging and managing the innate cognitive biases that we all have as part of being human
- the concept of shared accountability between the organisation and an individual when adverse events occur.[6]

Statutory Duty of Candour (SDC): the statutory duty of candour set out in section 128ZC of the *Health Services Act 1988*, section 22I of the *Ambulance Services Act 1986* and section 345B of the *Mental Health Act 2014*. It is a legal obligation for Victorian health service entities to ensure that patients and their families or carers are apologised to and communicated with openly and honestly when a serious adverse patient safety event (SAPSE) has occurred. It builds on the Australian Open Disclosure Framework currently utilised for all cases of harm and near miss.

Clinical Incident: An event or circumstance that resulted, or could have resulted, in unintended and/or unnecessary harm to a person. An incident may be a near miss. Clinical incidents may also be associated with omissions where patients are not provided with a medical intervention from which they would have likely benefited.[7]

3. Scope

This guidance document applies to all Gippsland PHN clinical commissioned health service organisations.

4. Clinical Governance Principles

The following principles will guide effective clinical governance systems and are adopted from the Victorian Clinical Governance Framework (Safer Care Victoria)[8].

- **Excellent consumer experience**
  - Commitment to providing a positive consumer experience
- **Clear accountability and ownership**
  - Accountability and ownership displayed by all staff
  - Compliance with legislative and appropriate departmental policy requirements
- **Partnering with consumers**
  - Consumer engagement and input is actively sought and facilitated
- **Effective planning and resource allocation**

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[5] Delivering high-quality healthcare, Victorian clinical governance framework, Safer Care Victoria, DHHS, June 2017

[6] Safer Care Victoria (2022). Just Culture Guide: For health services. *SCV-Just-Culture-Guide-for-Health-Services.pdf (safercare.vic.gov.au)*. Victorian Department of Health, Melbourne.

[7] Australian Commission on Safety and Quality in Health Care (ACSQHC)

[8] Delivering high-quality healthcare, Victorian clinical governance framework, Safer Care Victoria, DHHS, June 2017

- Staff have access to regular training and educational resources to maintain skill set
- **Strong clinical engagement and leadership**
  - Ownership of care processes and outcomes is promoted and practised by all staff
  - Health service staff actively participate and contribute their expertise and experience
- **Empowered staff and consumers**
  - Organisational culture and systems are designed to facilitate the pursuit of safe care by all staff
  - Care delivery is centred on consumers
- **Proactively collecting and sharing critical information**
  - The status quo is challenged and additional information is sought when clarity is required
  - Robust data is effectively understood and informs decision making and improvement strategies
- **Openness, transparency and accuracy**
  - Health service reporting, reviews and decision making are underpinned by transparency and accuracy
- **Continuous improvement of care**
  - Rigorous measurement of performance and progress is benchmarked and used to manage risk and drive improvement in the quality of care

5. Clinical Governance Domains

The Gippsland PHN Clinical Governance Framework and associated policies and procedures are the system of safeguards that govern clinical practice within programs commissioned and/or delivered by Gippsland PHN. The Clinical Governance Framework responds to five domains of Clinical Governance and corresponding systems[9]; it is reflective of contemporary clinical practice codes, frameworks and standards. The five domains of the framework are:

- Leadership and culture
- Consumer directed care and partnership
- Clinical risk management
- Clinical effectiveness and appropriateness
- Effective workforce and staff education

Within the five domains, key systems and practices are required to support safe, effective, person-centred care for every consumer. The domains are interrelated and integrated into the organisations broader governance arrangements (for example clinical risk management is a component of broader risk management, leadership and culture is a component of the organisations purpose and culture governance framework).

Quality improvement is a foundation element of the clinical governance domains, systems and processes as depicted in Figure 1.

[9] Delivering high-quality healthcare, Victorian clinical governance framework, Safer Care Victoria, DHHS, June 2017

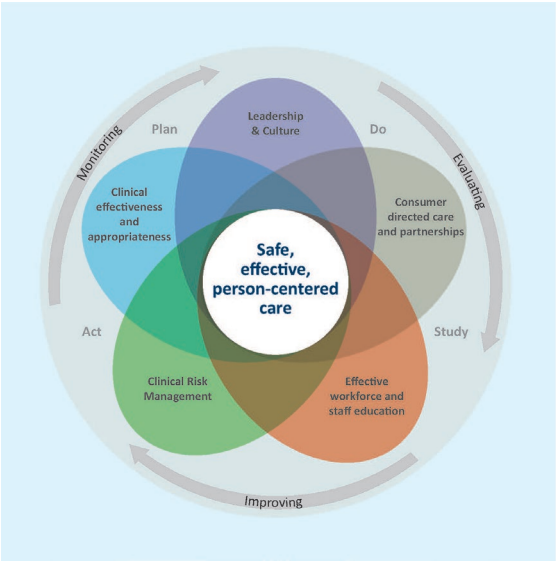

Figure 1: The interrelated five domains of clinical governance

6. The role of commissioned service providers

- All commissioned clinical services contracted by Gippsland PHN are required to have in place a Clinical Governance Framework that reflects Gippsland PHNs Clinical Governance Framework and to have effective structures, systems and processes to implement that framework.
- Service providers will be expected to participate in service reviews with Gippsland PHN and to provide regular reports on the quality and performance of their service to Gippsland PHN including evidence and examples of how structures, systems and processes support the Clinical Governance Framework.
- Service providers manage clinical risks and incidents in line with the Clinical Governance Framework and report to Gippsland PHN in accordance with their clinical service order agreement and in alignment with the agreement Terms and Conditions.

7. Clinical Incident reporting

7.1 Providers must:

- Adhere to relevant professional standards.
- Ensure processes exist for monitoring Consumer Experience including service quality evaluation and management of consumer complaints.
- Keep a register of significant clinical incidents and provide details to Gippsland PHN upon request including how clinical incidents are managed, resolved and contribute to organisational learning.
- Inform Gippsland PHN by phone or in writing within 24 hours of an incident, issue or complaint such as:
    - Any action or event in which the media is likely to have the potential to subject the organisation to high levels of public or media scrutiny; and
    - Any event notifiable under the providers Professional Indemnity Insurance.

- Any event or adverse clinical incident which may result in adverse publicity for the provider or for Gippsland PHN
- Serious adverse clinical events which will involve an internal review or Root Cause Analysis investigation by the provider
- Any notifiable event under the provider's insurance or an individual Health Professional's professional indemnity insurance
- Notification that the relevant National Board or other accrediting body has decided to investigate either the provider or a health professional employed by the provider
- Conditions, limitations or restrictions are imposed by the relevant National Board in relation to a Health Professional's practice
- Cancellation, or threat of cancellation, of accreditation status of the provider
- Cancellation of a health professional's registration by the relevant National Board or other accrediting body
- An adverse finding made against a provider or Health Professional by any registration, disciplinary, investigative or professional body;
- Provider or Health Professional is charged with or convicted of a breach of any Law that regulates the provision of health care or health insurance;

7.2 Adverse clinical Incidents must be reported via the Feedback reporting form.