Delivering high-quality healthcare

Victorian clinical governance framework

Safer Care Victoria

VICTORIA
State Government

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Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

Foreword

As the inaugural chief executive officer of Safer Care Victoria, I am delighted to release this updated framework to inform and guide good clinical governance, *Delivering high-quality healthcare*. This update has been written to better meet the needs of health services as we, together, seek to deliver the ambitious recommendations set out in the recently released *Targeting zero: the review of hospital safety and quality assurance in Victoria* (Duckett) report.

The refreshed framework has been developed with input from an expert group and informed by extensive sector feedback. I believe that it clearly articulates the Victorian Government's expectations regarding clinical governance. Our intent is that it also provides practical guidance on the systems and processes needed for delivering on our shared goal of outstanding healthcare for Victorians. Always.

All Victorians have the right to expect and receive consistently safe and high-quality healthcare. Effective clinical governance systems are fundamental to delivering on that expectation. Being effective means that clinical governance must be tailored and scaled to suit health services' circumstances and be regularly reviewed, evaluated and amended. Only in this way can we hope to drive continuous improvement to better patient outcomes and zero avoidable harm. Our purpose at Safer Care Victoria is to help enable all health services to deliver safe, high-quality care and experiences for their patients. I hope this framework assists in that purpose.

Of course, the framework is not an end in itself. I am pleased to let you know that significant other work is well underway to improve and enhance the way in which the government supports health services in providing safe, quality care. Safer Care Victoria will have a particular focus on strengthening patient experiences and partnerships and on enhancing and measuring clinician engagement. Healthcare begins with a patient–clinician encounter. Quality and safety also begins there.

I and our teams at Safer Care Victoria look forward to working closely with health service staff, the Department of Health and Human Services, the Victorian Agency for Health Information and consumers as we strive to achieve zero avoidable harm.

Victoria has a healthcare system that we can all take great pride in. I appreciate the effort and contribution that you make every day to ensuring Victorian health services are providing safe, quality care. I hope you find this framework helpful in your work.

Professor Euan Wallace AM
Chief Executive Officer
Safer Care Victoria

Contents

Delivering high-quality healthcare

Part 1: Overview – context, principles, expectations and roles

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

Context

Healthcare is inherently complex and high risk. High-quality healthcare requires continued commitment from all staff to the pursuit and maintenance of excellence. Whether that excellence is in an operating theatre or in a clinic or on a ward, whether it is clinical or in cleanliness, or timeliness or in food preparation, each and every component of healthcare counts. Just ask the patients. Fundamental to such excellence and to providing quality person-centred care are robust, integrated clinical governance systems. Safer Care Victoria requires all health services to have formal clinical governance structures and functions in place. We also require that those structures and functions are evaluated regularly for their effectiveness in driving continuous improvement. Boards hold this responsibility as a key aspect of their overall governance role and are, by law, directly accountable to the Victorian Minister for Health. However, effective clinical governance is everyone's business.

Clinical governance is not about compliance. High-performing health services achieve great outcomes by taking actions that go beyond compliance. These include (Ham et al. 2016):

- **a vision for the future** – clearly communicated, specific and quantifiable goals for improving care
- **consumer partnerships** – the consumer is at the centre of care and viewed as a critical partner in the design and delivery of healthcare
- **organisational culture** – a 'just' culture exists whereby health service staff are supported and their wellbeing prioritised
- **continual learning and improvement** – health service staff are provided with opportunities and encouragement to further their skill set and qualifications

“
To err is human, to cover up is unforgivable, and to fail to learn is inexcusable.
”

Sir Liam Donaldson
World Health Organization
Envoy for Patient Safety

- **clinical leadership** – strong, transparent, supportive and accessible leadership fosters a culture of learning, accountability and openness, with strong clinical engagement
- **teamwork** – staff are supported at all levels of the organisation by skilled management
- **quality improvement** – established methods and data are used to drive and design actions to improve safety and quality.

(The term 'consumer' includes patients, clients, residents, families, carers and communities.)

The content in this updated clinical governance framework reflects the current literature on high-performing health services and best practice in clinical governance. There is a renewed and strengthened emphasis on leadership, culture and improvement as being fundamental to high-quality care. The framework identifies the systems required to develop and maintain a high-performing organisation.

The systems are organised into five domains and underpinned by continuous monitoring and improvement:
- **leadership and culture**
- **consumer partnerships**
- **workforce**
- **risk management**
- **clinical practice.**

The framework has been designed so that health services can adapt and implement its components to best meet the needs of their consumers and organisation. It is important that governance systems do not remain static but that they are regularly reviewed and evaluated to meet local requirements and drive continued improvement. It is critical that every member of the organisation – board, management, clinical, administrative, ancillary – understands that they have a role in pursuing excellence.

For the purposes of this framework, high-quality care is defined as:
- **safe** – avoidable harm during delivery of care is eliminated
- **effective** – appropriate and integrated care is delivered in the right way at the right time, with the right outcomes, for each consumer
- **person-centred** – people's values, beliefs and their specific contexts and situations guide the delivery of care and organisational planning. The health service is focused on building meaningful partnerships with consumers to enable and facilitate active and effective participation.

> " Clinical governance and quality improvement requires a focus on evidence and data, not just trust. "
>
> CRANAplus 2013

The following principles should guide effective clinical governance systems.

> **"**
> Clinical governance is essentially an organisational concept aimed at ensuring that every health organisation creates the culture, the systems and the support mechanisms so that good clinical performance will be the norm and so that quality improvement will be part and parcel of routine clinical practice.
> **"**
>
> **Sir Liam Donaldson**
> speaking at the Conference on the Development of Surgical Competence on Clinical Performance and Priorities in the NHS, November 1999

Clinical governance principles

Excellent consumer experience	• Commitment to providing a positive consumer experience every time
Clear accountability and ownership	• Accountability and ownership displayed by all staff • Compliance with legislative and departmental policy requirements
Partnering with consumers	• Consumer engagement and input is actively sought and facilitated
Effective planning and resource allocation	• Staff have access to regular training and educational resources to maintain and enhance their required 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 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

Clinical governance roles and responsibilities

In order to achieve consistently safe and high-quality care, the following critical elements of the five domains apply to every employee within Victorian health services:

- commitment to partnering with consumers to facilitate effective engagement and participation
- ownership and accountability for the quality and safety of the care provided
- regular evaluation of performance to identify areas for improvement.

In addition to these responsibilities, every member of a health service (clinical and non-clinical alike; see Figure 1) has specific responsibilities regarding achieving and maintaining high-quality and safe care.

Figure 1: Clinical governance roles

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The **Victorian Government (Department of Health and Human Services, Safer Care Victoria and Victorian Agency for Health Information)** has a number of key clinical governance responsibilities including:

- setting expectations and requirements regarding health service accountability for quality and safety and continuous improvement
- ensuring health services have the necessary data to fulfil their responsibilities, including benchmarked and trend data
- providing leadership, support and direction to ensure safe, high-quality healthcare can be provided
- ensuring board members have the required skills and knowledge to fulfil their responsibilities
- proactively identifying and responding decisively to emerging clinical quality and safety trends
- effectively monitoring the implementation and performance of clinical governance systems, ensuring the early identification of risks and flags
- monitoring clinical governance implementation and performance by continually reviewing key quality and safety indicators.

Consumers are at the centre of clinical governance and should:

- participate in their own healthcare and treatment, and that of their family and carers, to their desired extent
- participate in system-wide quality and safety improvement
- partner with healthcare organisations in governance, planning and policy development to co-design and drive improvement in performance monitoring, measurement and evaluation
- advocate for patient safety to support the best possible treatment and outcomes for themselves and others
- provide feedback, ideas and personal experience to drive change.

Health service boards are accountable for the safety and quality of care provided by their service, with key responsibilities being:

- performing as a discrete entity accountable to the Victorian Minister for Health and ultimately being accountable for the quality and safety of the care provided by the organisation
- setting a clear vision, strategic direction and 'just' organisational culture that drives consistently high-quality care and facilitates effective employee and consumer engagement and participation
- staying engaged, visible and accessible to staff
- ensuring it has the necessary skill set, composition, knowledge and training to actively lead and pursue quality and excellence in healthcare
- understanding key risks and ensuring controls and mitigation strategies are in place to mitigate them
- monitoring and evaluating all aspects of the care provided through regular and rigorous reviews of benchmarked performance data and information
- ensuring robust clinical governance structures and systems across the health service effectively support and empower staff to provide high-quality care and are designed in collaboration with staff

- delegating responsibility for the implementation, monitoring and evaluation of clinical governance systems to the CEO and working in partnership with the CEO to realise the organisation's vision
- regularly seeking qualitative and quantitative information from the CEO, executive and clinicians about the status of the quality and safety of care processes and outcomes in all services.[1]

The **health service CEO** is responsible for:
- providing visible leadership and commitment in delivering and supporting the strategic direction set by the board
- creating a safe and open culture that empowers staff to speak up and raise concerns
- working in partnership with the board to ensure efficient allocation of resources that achieve public value and deliver on the organisation's vision for quality and safety
- equipping staff to fulfil their roles by providing role clarity at each level of the organisation along with the necessary knowledge, tools, resources and opportunities to engage and influence the organisation's core business
- elevating quality of care within the organisation, ensuring the voice of the consumer is at the centre of core business and that the organisation remains focused on continuous improvement
- fostering a 'just' culture of safety, fairness, transparency, learning and improvement in which staff are empowered and supported to understand and enact their roles and responsibilities
- delegating the implementation, review, measurement and evaluation of operational quality and safety performance to executive and clinical leaders
- regularly reporting to the board with internal and external data on clinical risks, care processes and outcomes, areas for improvement and progress towards excellence across all clinical services
- proactively seeking information from qualitative and quantitative sources, including the voice of the consumer and clinician, to paint a comprehensive picture of the quality of care and services
- adopting a 'no surprises' partnership approach with the board in the pursuit of excellence and welcoming questions that may help identify important issues or blind spots.

The health service **executive** has a clearly defined role in clinical governance including to:
- lead and support the health service to deliver the board's vision for safe, quality care, facilitating and ensuring effective staff and consumer involvement
- develop and support safety and quality leaders in their services and provide assurance to the CEO that staff at each level of the organisation are supported to actively pursue high-quality care for every consumer
- ensure robust and transparent reporting, analysis and discussion of the safety and quality of care occurs regularly and is informed by qualitative and quantitative data, committee structures and clinician engagement
- understand and monitor the areas of key risk and ensure escalation and response actions are taken where safety is compromised
- regularly evaluate clinical governance systems to ascertain their effectiveness.

[1] This information should be sought beyond the purposes of audit and accreditation.

Clinical leaders/managers within a health service are required to:

- understand the challenges and complexity of providing consistently high-quality care and support clinicians through a culture of safety, transparency, accountability, teamwork and collaboration
- provide a safe environment for both consumers and staff that supports and encourages productive partnerships between different clinical groups and between clinicians and consumers
- provide useful performance data and feedback to their clinicians and relevant committees and engage clinicians in identifying and taking appropriate action in response
- actively identify, monitor and manage areas of key risk and lead appropriate escalation and response where safety is compromised
- be skilled in staff management, foster productive and open cultures, and promote multidisciplinary teamwork
- ensure staff are clear about their roles and responsibilities, are supported with resources, standards, systems, knowledge and skills development, and hold them to account for the care they provide
- expect and drive action in response to managing risks and improving care.

All health service staff should:
- provide high-quality care in their services as a priority
- go beyond compliance to pursue excellence in care and services
- speak up and raise concerns and issues, promoting a culture of transparency
- share information and learnings regarding clinical safety
- regularly update their skills and knowledge to provide and support the best care and services possible
- actively monitor and improve the quality and safety of their care and services
- work with care standards and protocols
- contribute to a culture of safety, transparency, teamwork and collaboration.

Part 2: Domains and systems

Within the five domains, key systems and practices are required to support safe, effective, person-centred care for every consumer, every time.

The five domains of clinical governance are interrelated (see Figure 2) and should be integrated into the organisation's broader governance arrangements (for example, clinical risk management is a component of broader risk management).

It is expected that health services tailor and implement these components to support consumers and staff to work together to achieve high-quality care.

Figure 2: Clinical governance domains

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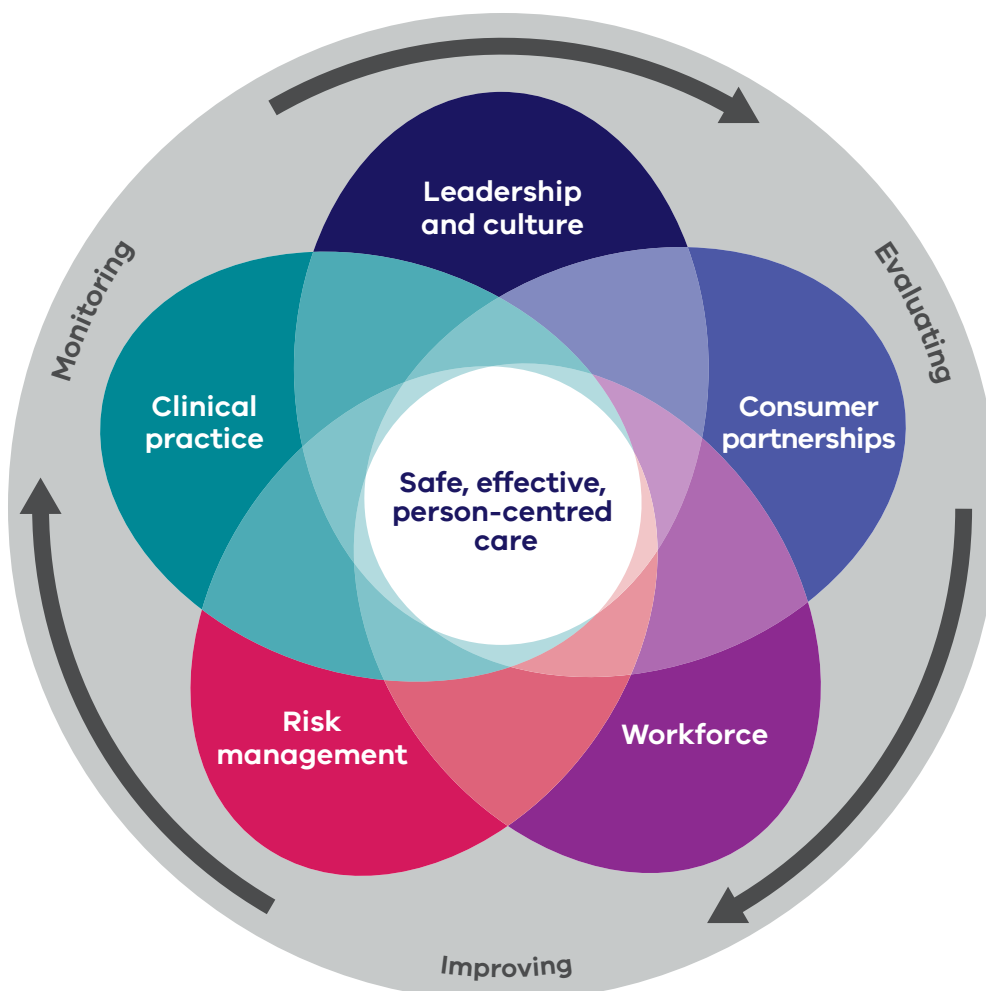
Leadership and culture

High-quality healthcare requires engaged clinicians and patients.

Visible, accountable and purposeful leadership at all levels of a service is required to cultivate an inclusive and just culture that will make engagement a reality. Engaged staff and consumers who actively participate in organisational strategy, planning and delivery are the origins of quality.

Culture doesn't just happen; it is purposeful. A strong organisational culture is required to support leaders and staff to create and maintain high-quality care. The culture should be one of fairness, respectfulness and transparency. It should be based on principles of natural justice, innovation, learning from errors and accountability for decisions and behaviours.

Creating and maintaining this culture and achieving this strategic goal requires effort, robust systems and productive working relationships between boards, CEOs, the executive, consumers, clinical leaders and all staff. These relationships support and challenge each group to achieve a shared vision for excellence in the safety and quality of care. Culture is organisation-wide, not craft group or workplace-specific.

Systems must be in place to ensure:

- a clear vision for improving the quality of care is developed and communicated
- there is organisational alignment in achieving strategic goals and priorities for providing high-quality care for every consumer in a way that is seamless and integrated
- there is a supportive, transparent culture, set and led by the board that assists all health service staff to provide high-quality care and continuously improve
- clear accountability is assigned for planning, monitoring and improving the quality of each clinical service
- the CEO, board and clinical leaders regularly discuss where the health service is positioned in relation to peer health services and seek external ideas and knowledge on how best to strive for high-quality care
- the board and executive visibly engage with and support consumers, clinicians, managers and staff in their roles
- appropriate governance structures, including committee and reporting structures, are in place to effectively monitor and improve clinical performance

Some signs of success

Staff survey response rates exceed 40 per cent

Staff report that a 'just' culture exists within the health service

There are high rates of agreement with safety culture questions in the People Matter survey

Leaders conduct regular walkarounds and ask staff and patients questions related to the safety, effectiveness and patient-centredness of the care being experienced and delivered

The board and executive lead and regularly discuss progress with a plan to achieve a set of strategic goals and priorities for safe, effective and person-centred care

There is consumer representation on board quality committees

- there is development and support at all levels of the organisation of leaders who promote and drive high-quality care
- staff skills and systems for achieving high-quality care and for managing change and improvement are developed across the organisation
- the organisation's safety culture is regularly measured to identify areas of success and issues for improvement, including staff understanding at all levels of their role in creating safe care
- there is regular and rigorous evaluation of the effectiveness of systems for developing and supporting positive organisational leadership and culture.

Consumer partnerships

Healthcare is all about the consumer. Consumer experience and participation (among patients, clients, residents, families, carers and community members) are crucial indicators of quality and safety. Effective consumer partnerships are essential for improving healthcare outcomes and driving continuous improvement. Lifting and responding to the consumer voice is at the origin of good clinical governance.

Empowering consumers to partner in care and decision making enables staff to better understand the individual consumer's specific needs, concerns and values. It supports staff in providing more appropriate treatment and care plans and leads to better clinical and patient outcomes. Consumer feedback, both positive and negative, is a valuable resource and should be encouraged in all aspects of the service. Complaints should be responded to in consultation with the consumer to reach suitable resolutions; outcomes should then be used to drive improvement.

Partnering with consumers is a cornerstone of healthcare delivery and the key contributor to achieving the organisation's strategic goals. Consumer partnerships should be promoted across the organisation in planning, policy development, guidelines, training and care delivery.

Systems should be in place to ensure:

- consumers and their needs are key organisational priorities
- consumers are actively invited to provide feedback on their experiences of care

Some signs of success

Being able to identify changes made in response to complaints or feedback from an active consumer advisory committee whose members are trained and supported

Consumer-led patient walkarounds

Positive patient survey feedback, particularly on questions relating to information and involvement

Shared understanding of established goals relating to patient outcomes

A clear consumer advisor governance framework is in place that supports open and effective reporting of advisor concerns to the executive and board

Consumer representatives on board quality committees feel they are making a useful and respected contribution to improving care

Consumers are encouraged and equipped to participate in organisational strategy and decision making for care improvement

- consumers are provided with the relevant skills and knowledge to participate fully in their care to the extent they wish
- consumers are provided with the opportunity, information and training to fully participate in organisational processes for planning, monitoring and improving services
- clear, open and respectful communication exists between consumers and staff at all levels of the health system
- services respond to the diverse needs of consumers and the community
- services learn from and act on the feedback on clinical care and service delivery as provided by consumers in order to make improvements
- the rights and responsibilities of consumers are respected and promoted to the community, consumers, carers, clinicians and other health service staff, as required by the Australian Charter of Healthcare Rights (ACSQHC 2008) (see also *The Australian Charter of Healthcare Rights in Victoria* brochure)
- consumer participation processes are monitored for their effectiveness in empowering consumers to fully partner in their care
- complaints are responded to compassionately, competently and in a timely fashion, with feedback provided to all parties about the action resulting from their input
- issues arising from complaints are analysed, reported and used to improve care and services
- the systems for empowering meaningful consumer participation are regularly and rigorously evaluated.

Workforce

Systems are required to support and protect a skilled, competent and proactive workforce. This requires comprehensive strategies and plans for recruiting, allocating, developing, engaging and retaining high-performing staff. These strategies will ensure the health service has the right people with the right skills at the right time to provide optimal care.

Providing a physically and psychologically safe workplace is fundamental to achieving a high-performing workforce and for addressing workplace bullying. Organisational planning and resource allocation must involve effective staff engagement.

Staff at all levels of the organisation require access to training and information about effective change and about improvement tools and methods. Staff should be supported to apply these tools and methods to review and improve their practice. Proactive human resources systems should support staff to develop and consolidate their skill base, work within their scope, provide supervision where required and manage performance.

Systems should be in place to ensure:

- planning, allocation and management of the workforce provides the appropriate personnel and skills to deliver high-quality care and to meet changing consumer needs
- the health workforce has the appropriate qualifications and experience to provide high-quality care and ongoing professional development to maintain and improve skills
- a safe and fair workplace based on a 'just' culture and mutual respect is provided, with systems in place to address issues with culture such as workplace bullying
- promotion and support of multidisciplinary teamwork is the basis of providing high-quality care
- clear communication of role expectations, responsibilities and standards of performance is provided to all staff, and employees are supported and held accountable for meeting these expectations
- mentoring and supervision is used to support, monitor and develop clinical staff
- training and tools are provided so staff can monitor and improve their own practice and organisational processes more broadly

Some signs of success

Staff engagement and satisfaction is measured and is a priority area of focus for the board

The training and development budget is fully utilised

Staff orientation and induction includes quality and safety issues

There are high levels of participation in employee performance reviews and professional development planning

There is a system for ensuring that critical clinical training requirements have been met

Resource planning and allocation provides for effective staff supervision and mentoring

Delivering high-quality healthcare

- innovation in workforce practice supports the development and maintenance of workforce excellence
- there is a just process for addressing individual performance that prioritises consumer safety
- a defined system for managing complaints or concerns about a clinician is in place and is regularly reviewed for its effectiveness
- the systems for developing and supporting the workforce are regularly and rigorously evaluated to ensure their effectiveness in supporting high-quality care.

Risk management

Minimising and safeguarding against clinical risk requires a structured approach to safety that is both proactive and reactive – prevention and repair. Consistently safe practice is built on staff awareness and knowledge. It is supported by robust systems that prioritise safety. Effective systems support staff to identify and respond appropriately when things go wrong.

Clinical risk management strategies and processes must be integrated with broader governance within the health service to rigorously identify, monitor, review and mitigate risk. Risk identification and treatment strategies must be frequently reviewed to ensure early identification of trends in risk across all clinical services. Where safety is compromised, leadership and risk systems must support staff to initiate appropriate and timely escalation, management and corrective action. It is essential that all issues related to risk are subsequently analysed in order to inform future practice and improve safety.

Systems should be in place to ensure:

- a planned, proactive, systematic and ongoing evidence-based approach to creating safety for consumers and staff is in place
- the organisational culture supports staff to pursue safe practice and to speak up for safety
- risk considerations and data inform goal and priority setting and the development of business and strategic plans
- clinical processes, equipment and technology are designed to minimise error and support clear, unambiguous communication between staff

- risks are proactively identified, monitored and managed through an effective register with clearly understood, integrated risk data
- known clinical risks are proactively addressed and all services are regularly scanned to identify risks as they emerge
- identification and reporting of clinical incidents is consistent with the requirements of the Victorian Health Incident Management System (VHIMS) and is tracked over time to monitor and identify safety issues
- clinical incidents are investigated to identify underlying systems issues and root causes, and this information is used to improve safety
- open disclosure processes are in line with the *Australian open disclosure framework* (ACSQHC 2013)
- the service complies and adheres with risk-related legislation and relevant Australian standards
- systems and datasets for developing and supporting clinical risk management are regularly and rigorously evaluated to ensure their effectiveness in supporting high-quality care.

Clinical practice

Good clinical practice requires systems that support clinicians to provide safe and appropriate care for each consumer with the best possible outcome, working within the clinical scope of the organisation.

Clinical practice should strive for patient-centred, cohesive, integrated care at all times along the care continuum. It should ensure a shared understanding of the care pathway and goals between clinicians and consumers.

Systems for clinical practice effectiveness should ensure clinicians have the required knowledge and skills, technology and equipment to provide the best care possible. Clinicians must also be supported and expected to regularly and rigorously review their practice, to embrace peer review and teamwork, and to contribute their knowledge and experience to improving care.

The safety, effectiveness and appropriateness of care should be regularly reviewed using appropriate measures and reporting mechanisms.

Clinical services actively participate in relevant clinical registries and clinical audit activities

Benchmarked and trended information about the clinical effectiveness of services is available to and used by clinicians and by the board

Publicly available data about performance on a range of outcome measures (such as pressure injuries and hospital-acquired bacteraemia) is displayed in the health service

Clinicians are working within their approved credentialling and scope of practice requirement

Research and evidence should form the basis of care provision, in tandem with appropriately credentialled, experienced and competent staff. Clinicians at all levels of the organisation should have access to training and information about effective change and improvement tools and methods, and be supported to apply them to review and improve their practice.

Variations in clinical quality and clinical practice will occur within the complexity of healthcare; these should be actively monitored and discussed in light of what is best for the consumer. As with clinical governance itself, clinical practice is not 'set and forget'. It must be closely monitored and regularly reviewed, evaluated and evolved in line with emerging evidence/technologies and changing consumer needs.

Systems should be in place to ensure:

- evidence-based clinical care is delivered within the clinical scope and capability of the health service
- evidence-based clinical care standards and protocols are clearly articulated, communicated and adhered to across the organisation
- clinicians regularly review and improve clinical care, preferably in a multidisciplinary manner
- credentialling, scope of practice and supervision processes support clinicians to work safely and effectively within their scope of practice
- active clinical partnerships are developed with consumers and include a shared understanding of the care plan
- consumers are transitioned across care settings and services smoothly
- clinicians participate in the design and review of clinical systems and processes, and support clinical innovation
- data on the safety, clinical effectiveness and person-centredness of care is collected, analysed and shared for the purposes of both accountability and improvement
- clinical care processes and outcomes are measured across all services
- clinicians regularly review their own performance

- clinicians lead activities to improve clinical practice, and these activities are planned, prioritised, supported by change and improvement science, and are sustainable
- clinical practice variation is closely monitored and regularly reviewed to ensure quality outcomes for high-risk, high-volume and high-cost services
- there is a 'just' process for addressing issues with individual clinician performance that prioritises consumer safety
- clinical quality improvement activities undergo external reviews
- new procedures and therapies are introduced in a way that ensures quality and safety issues have been identified
- clinical practice is regularly and rigorously evaluated to ensure its effectiveness in supporting high-quality care
- appropriate utilisation of healthcare is monitored and reviewed as a component of quality.

Critical clinical governance questions

- How do we know our care is safe and effective?
- How do we ensure the quality and safety of care?
- Do we know what the red flags are?
- How will we fix what we know isn't working?
- What needs to get done to improve the quality and safety of care?
- Do we have a 'just' culture to facilitate continuous improvement in quality and safety?
- What actions do we take as a group to ensure that intimidating and inappropriate behaviour is not tolerated?
- What actions do we take to ensure patients are empowered to meaningfully partner in their care and the organisational design of the service?
- Are we frequently evaluating the impact and extent of the patient voice?
- How effective are our organisational governance systems in supporting our safe, effective and person-centred goals for every consumer?
- What must we do to increase the effectiveness of our systems?
- Do all staff feel supported to create consistently safe, person-centred and effective care?
- What must we do to increase support for staff?
- Are our clinicians adequately skilled, engaged and empowered to provide safe, high-quality, person-centred clinical care?
- Are we achieving our purpose of providing a safe, person-centred and effective experience for every consumer? What must we do to make more progress on achieving our purpose?
- Where is the evidence that our patients are better off?
- Do we have a shared definition/understanding of success?

Symptoms of clinical governance failure

A number of common themes have emerged from reviews of healthcare organisations that have experienced high-profile failures in patient care:

- an institutional, isolated and inward-looking culture that is unsupportive of learning and that develops and cultivates a fear of speaking up
- a disengaged board, CEO and executive who are unwilling to hear bad news
- clinical leaders who are disconnected from the organisation's clinical governance processes and systems
- lack of clinical leadership, staff engagement and teamwork to support safe, high-quality care
- weak reporting format and content, particularly a lack of benchmarking and trend analysis, and a passive monitoring response
- a quality system based on compliance with standards with limited service and care improvement beyond the requirements of the standards
- a lack of robust review of clinical practice and an assumption that monitoring, performance management or intervention is 'someone else's responsibility'
- tolerance of substandard care – problems are long-standing and known by many stakeholders but not actively addressed
- a lack of consumer participation and input and limited interest in consumers and their families – decisions are made in the interests of the organisation and staff over the safety and quality of patient care.

Part 3: Additional information – references and acknowledgements

Additional information

The Victorian Government will provide supportive and adaptive leadership and set a clear vision of excellence for Victorian health services. In striving for continuous improvement and achieving the recommendations set out in the *Targeting zero: the review of hospital safety and quality assurance in Victoria* report, the government will implement new approaches to building and addressing clinical capability. This goal is underpinned by the commitment to delivering a person-centred healthcare system and improving quality and safety across Victoria.

The Department of Health and Human Services is intensifying its efforts as the system leader and manager and increasing the focus on leading and coordinating: health system design and planning; policy development and implementation; and funding design. The department will work with rural and regional health services to improve collaborative clinical governance arrangements. In addition, the strengthened oversight and engagement processes will enable the department to act quickly and decisively to address quality and safety risks and to facilitate more effective information sharing with and between health services.

Safer Care Victoria will lead quality and safety improvement across Victorian health services – public and private – by providing support via a range of new quality and safety programs and utilising the experiences of frontline clinicians through vitalised clinical networks and the establishment of the Victorian Clinical Council. Together with the department, Safer Care Victoria is developing tools, resources and clinical governance training programs for clinicians, board members and management to supplement this framework and to assist health services in its implementation. These will continue to be refreshed to ensure utility and relevance.

The Victorian Agency for Health Information is committed to expanding relevant quality and safety datasets available to health services and improving timeliness and accessibility. Standardised benchmarking reports will also be provided to health services to drive improvements to safety and quality and to better assess and improve clinical governance performance and processes.

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