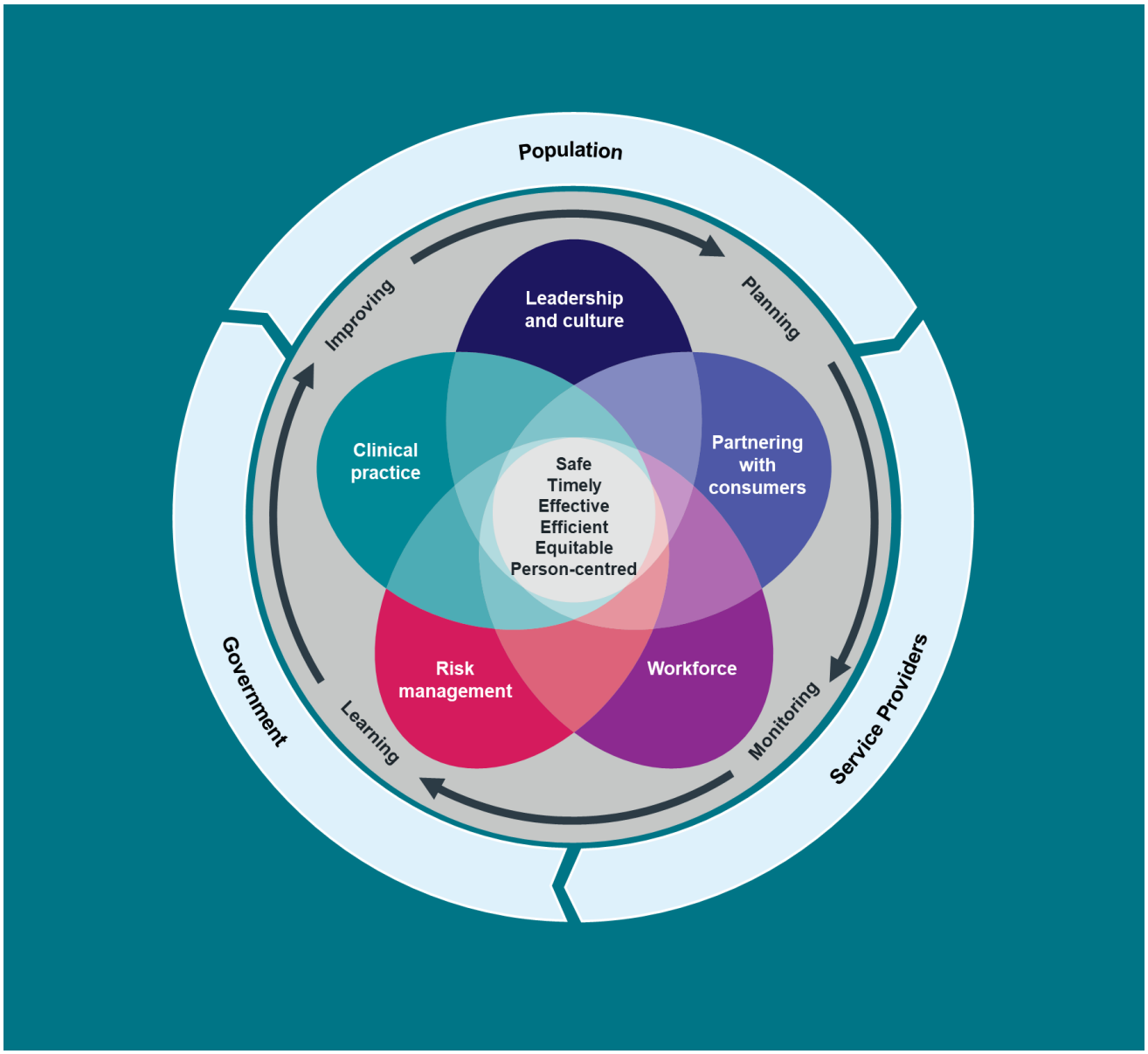

Delivering high-quality care

Victorian Clinical Governance Framework

August 2024

OFFICIAL

Safer Care Victoria

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Primum non nocere.

First, do no harm.

– Hippocrates

Foreword

As the Chief Executive Officer of Safer Care Victoria (SCV) and Victorian Chief Quality and Safety Officer, I am delighted to release the updated version of the Victorian Clinical Governance Framework (the framework). This framework provides best practice guidance for leadership of care providers on the essential clinical governance systems, structures, people, and organisational culture required to ensure the provision of high-quality care.

Since the release of the previous framework in 2017, there have been transformative changes across the health system, and, as the system evolves, it is imperative that clinical governance is kept front of mind to ensure high-quality care delivery. Changes to the system include the long-lasting impacts from the COVID-19 global pandemic which placed unprecedented pressure on the system resulting in accelerated expansion and innovation in digital and virtual care solutions. Victoria has also undergone significant regulatory and legislative changes, including the introduction of the Statutory Duty of Candour legislation to ensure consumers receive open and honest communication when things go seriously wrong, and the establishment of the Chief Quality and Safety Officer role to strengthen oversight of quality and safety across Victorian healthcare service providers.

This updated framework makes more explicit SCV's commitment to supporting employees and consumers across all care sectors, regardless of whether care is being delivered in a community or primary setting, public health service, private hospital, custodial setting, an ambulance, aged care residence, mental health facility or virtually, via digital health. While great strides have been made in governance practice across Victoria, we know that clinical governance and partnering with consumers remain challenging standards to implement. This framework delves deeper into the critical components of safety culture, principles for genuine partnering, and the importance of the quality and partnering mindsets required to achieve high-quality care delivery.

We appreciate the many effective clinical governance frameworks in existence, but it is important for our state to have a common language. It is envisaged this framework will support that common language to guide development of local clinical governance frameworks tailored to local needs.

Local clinical governance frameworks are successful when supported and valued by the people tasked with operationalising them. People are the most critical element to clinical governance success. Together with the broader SCV team, I look forward to partnering with you as we continuously strive to provide high-quality care for all Victorians.

Ms Louise McKinlay

Chief Executive Officer, Safer Care Victoria

Chief Quality and Safety Officer Victoria

Part 1: Overview

Clinical governance is the integrated systems, practices, and culture, underpinned by a cycle of continuous planning, monitoring, learning and improvement. Clinical governance is central to the provision of high-quality care. For the purposes of this framework, high-quality care is defined as safe, timely, effective, efficient, equitable, and person-centred care.

Many aspects of delivering care are inherently complex and high-risk. High-quality care requires continued commitment from the entire workforce to pursue and maintain excellence and actively reduce the incidence of avoidable harm. Whether that commitment occurs in an operating theatre, a primary or community care clinic, a hospital ward, a residential aged care facility, a custodial setting, an ambulance, or virtually, from the comfort of home, every component of care counts. The pursuit of excellence can only be achieved if consumers are included as partners in every stage of the process.

A word about the term 'consumer'

There are a variety of words to describe people who use and engage with the health sector. The term 'consumer' was selected for its broad definition and its consistency with the Australian Commission on Safety and Quality in Health Care. This framework uses the term 'consumer' to include people from all health sectors, including patients, residents, clients, families, supporters, those with lived and living experience, carers, advocates, representatives, volunteers and communities who may be past, current, or potential users of the healthcare system.

Safer Care Victoria (SCV) requires all health services to have formal clinical governance structures and functions in place. Boards hold this accountability as part of their governance role and are, by law, directly accountable to the Victorian Minister for Health. However, effective clinical governance is everyone's business.

Fundamental to achieving high-quality care are robust and integrated clinical governance systems that create a psychologically safe culture and promote learning and development. Clinical governance structures help care teams monitor safety outcomes, drive quality improvement, and prevent avoidable harm while delivering best-practice and evidence-based care.

Excellence in clinical governance is a mandatory priority and shared commitment as stipulated in the Department of Health Statement of Priorities between Victorian care providers and the Minister for Health. SCV strongly recommends care providers use this framework to develop local clinical governance arrangements, and that clinical governance outcomes are regularly evaluated to inform continuous improvement.

> 'Excellence in clinical governance aims for the best patient experience and care outcomes by assuring safe practice, leadership of safety, an engaged and capable workforce, and continuing to improve and innovate care.'
>
> Excerpt from the Department of Health 2023–2024 Statement of Priorities

Clinical governance includes adhering to local and national legislative and regulatory requirements, including accreditation to the Australian Commission on Safety and Quality in Healthcare (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards (or similar) and reflects the critical mindsets, values, and behaviours that prioritises and enables delivery of high-quality care. The Clinical Governance Standard (Standard 1) of the NSQHS Standards aims to ensure health service organisations have robust clinical governance systems in place. This standard sets out minimum requirements and does not specify how a health service organisation should develop or implement clinical governance systems. Each health service organisation must put in place strategies that consider its local circumstances. This framework builds on the foundation provided by national standards, providing additional guidance and detail on the signs of success and necessary organisational culture and mindset required to deliver high-quality care.

> '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

Defining high-quality care

Sound clinical governance aims to support the people delivering high-quality care. This latest version of the framework defines high- quality care as safe, timely, effective, efficient, equitable and person-centred care.[1]

- **Safe** – actively prevent avoidable harm.
- **Timely** – reduce wait times and other harmful delays in diagnosis and treatment and ensure employees have timely access to critical resources.
- **Effective** – deliver appropriate and connected care in the right way at the right time, with the right outcomes, for every consumer.
- **Efficient** – eliminate avoidable waste, including waste of time, equipment, supplies, ideas, and energy.
- **Equitable** – provide care that does not vary in quality because of individual characteristics such as gender, ethnicity, socioeconomic status, health literacy, ability, or geographic location.
- **Person-centred** – deliver personalised care and organisational planning that is guided by the consumer's values, beliefs and specific contexts and situations.

Figure 1 | Ways to achieve high-quality care

[1] Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.

Clinical governance in the Victorian health sector

The five domains of clinical governance are **leadership and culture**, **partnering with consumers**, **workforce**, **risk management**, and **clinical practice** (see Figure 2). Implementing the integrated systems, practices, and culture across these five domains is essential to provide high-quality care. The relationship between quality and safety is symbiotic and interconnected. The outcomes from the integrated systems, practices, and culture are enabled by a continuous cycle of planning, monitoring, learning, and improving (the enablers). This moves organisations beyond compliance, towards proactively preventing harm, and drives positive consumer and employee experience.

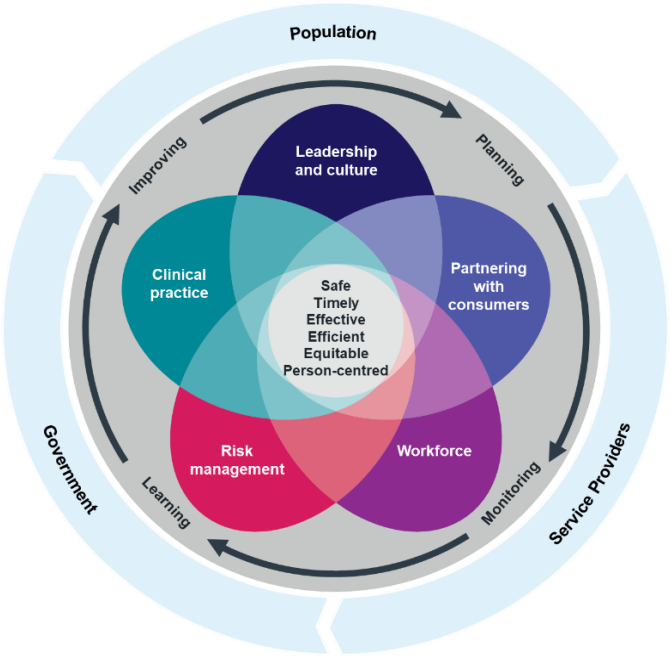


Figure 2 | Domains, enablers, and ecosystem of clinical governance in Victoria

Across all care settings, the five interconnecting domains of clinical governance and the cycle of continuous planning, monitoring, learning, and improving, sit within an ecosystem of:

- **Population** – the communities and individuals interacting with service providers
- **Service providers** – the organisations providing care services
- **Government –** the funders and regulators of service providers

Clinical governance systems, practices, and culture should be regularly evaluated to ensure they are fit for purpose to drive continuous improvement. It is critical that ***every*** member of the organisation has a clear and universally understood role in pursuing clinical governance excellence.

> 'To err is human, to cover up is unforgiveable, and to fail to learn is inexcusable.'
>
> —Sir Liam Donaldson

Clinical governance principles

The following principles guide effective clinical governance systems, processes, and culture. SCV does not mandate the language used to describe the domains, enablers, and ecosystems of clinical governance and service providers should use language that is meaningful to them and their stakeholders. What is most important is that the principles, domains, enablers, and ecosystems of clinical governance are applied in a way that is both true to this framework's intent and meaningful to the organisation.

Consumers consistently receive high-quality care	Organisations are committed to providing a positive consumer experience every time. Organisations monitor and evaluate consumer experience for the purpose of continuous learning and improvement.
Partnering with consumers	Consumer engagement and input is actively sought, facilitated, and used to drive system change to improve consumer experience and outcomes.
Strong engagement and leadership	Leaders cultivate safe and positive working environments for employees. Ownership of care processes and outcomes is promoted and practised by all employees. Employees actively participate and contribute their expertise and experience.
Valuing the experience and expertise of employees and consumers	Consumers are empowered to genuinely partner and contribute at all levels of the organisation with formal reporting avenues to executive and governing teams. Organisational culture and systems are designed to facilitate the pursuit of high-quality care by all. Care delivery is centred on and developed from consumer and workforce sentiment.
Clear accountability and ownership	All employees demonstrate accountability and ownership for their professional development. All employees are compliant with legislative and departmental policy requirements.
Effective planning and resource allocation	Employees have access to regular training and educational resources to maintain and enhance their required capability.
Openness, transparency, and accuracy	Health service reporting, reviews, and decision-making are underpinned by transparency and accuracy.
Proactively collecting and sharing critical information	Clinicians are provided with relevant performance data to drive improvement and enable individual learning and development. Diverse data is collected and shared with the board to inform decision-making and improvement strategies that reduce unwarranted variation.
Continuous improvement of care	Performance and progress are rigorously measured, benchmarked, and used to manage risk and drive improvement in each dimension of high-quality care. Clinical outcomes data is regularly reviewed to understand what is working well and where care could be enhanced so that this complete picture then informs quality improvement strategies. There is evidenced individual accountability for furthering learning and development and changing practice to improve care outcomes.

Part 2: The ideal clinical governance mindset

The framework provides a structure for understanding the key integrated systems, processes, and culture needed to achieve high-quality care. The application of the framework requires leaders to have a specific mindset. This mindset includes the ability to think and lead adaptively with a relentless focus on partnering with consumers and driving continuous quality improvement. The three elements of the ideal clinical governance mindset are presented below. These mindsets are discussed in relation to the improvement cycle.

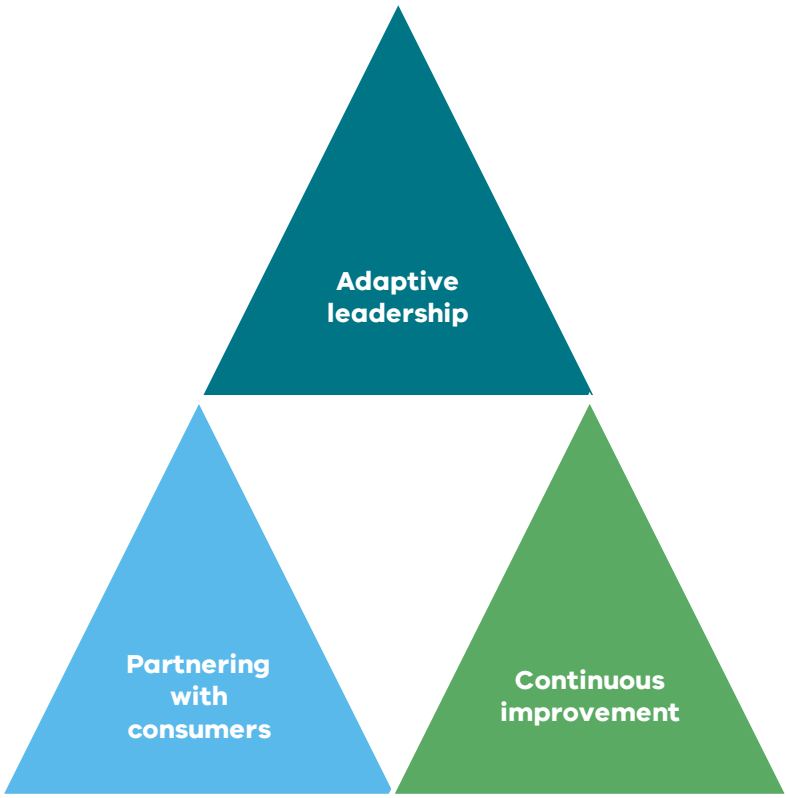


Figure 3 | The ideal clinical governance mindset

'The secret of change is to focus all of your energy, not on fighting the old, but on building the new.'

—Socrates

Adaptive leadership

Health services are complex adaptive systems, and providers are frequently required to respond to multifaceted, changing circumstances while striving to achieve high-quality care outcomes. The adaptive leadership approach is underpinned by the concepts of technical and adaptive challenges. Technical challenges are situations where the problem and solution can be clearly defined. They can be resolved through authoritative expertise and within the organisational structures, processes, and ways of operating. Conversely, adaptive challenges are complex, vague, systemic problems which lack a clearly defined or simple solution. When health service leaders apply adaptive leadership, they are better able to effectively manage ambiguity and complexity. Adaptive leaders mobilise people to address adaptive challenges.

The six aspects of the adaptive leadership mindset

1. Get on the balcony (obtain a high-level perspective)
2. Identify the adaptive challenge (assess and evaluate the situation)
3. Regulate distress (inspire and motivate change and monitor responses)
4. Maintain disciplined action (navigate conflicts as they arise)
5. Give the work back to employees (empower them to take a role in adaptive work)
6. Protect leadership voices from below (provide a platform for all voices to be heard)

Partnering with consumers

When health service leaders apply a partnering mindset, they prioritise working with people who use the care system to ensure that health information and care delivery meets consumers' needs. True partnerships with consumers exist when clinical governance leaders treat consumers with dignity and respect, when leaders share information with consumers, and when leaders support consumers' participation and collaboration. SCV details the domains of effective partnering in the 'Partnering in healthcare framework' (see link on page 43).

Continuous improvement

When leaders apply the continuous improvement mindset they embrace learning, always want to be better and do better, are comfortable with tests of change, and are not afraid to fail and try again. Key aspects of this mindset involve feeling psychologically safe and prioritising the psychological safety of others, curiosity, and an interest or proficiency in interpreting data and information.

> 'Every system is perfectly designed to get the results it gets'.
>
> —W. Edwards Deming

The improvement cycle

The improvement cycle of planning, monitoring, learning, and improving provides leaders with a process to adopt the ideal clinical governance mindset.

For each part of the improvement cycle, there are a series of questions to consider that support the ideal clinical governance mindset in action.

Plan	• Consider the change you want to make. • How will you know a change will make an improvement? • What do you need to explore or challenge in the system to understand the conditions that support or inhibit the proposed process or outcome? • What does 'getting on the balcony' show you from a high-level perspective? • Can you identify the adaptive challenges present in the improvement you wish to make? • Whose voices are and are not present, and how might that influence the adaptive challenges present in the improvement you wish to make? • Keep fear of failure at bay and remember the adage that 'trying and failing is better than never trying at all' because there is much to learn from making mistakes.
Monitor	• Is your data collection infrastructure in place to measure and monitor if the changes selected are resulting in improvement? • Aside from metrics, what else about the system are you monitoring to inspire change, regulate stressors, and observe responses? • Are you elevating the voices of those who may be less able to speak to the level of those who can, and ensuring the power dynamics are shared and equal? • How are you navigating conflicts while maintaining disciplined focus on both the change and the improvement goal?
Learn	• Be curious about what you find. • Manage emotions if the outcomes are not what you expected and seek to understand more about why. • What might you need to do or say to ensure those around you feel psychologically safe to speak about what could be learned? • Create agency and shared ownership of the learning by involving others in the analysis, interpretation, and discussion of the outcomes. • Empower others to undertake their role of using the learning for improvement.
Improve	• Try, and try again. Revise and redo, or scale and spread, depending on the outcome. • Get back on the balcony to look at the situation from a high-level perspective. Who is standing with you on the balcony? • What has this experience told you about improvement work and what will you take into the next cycle?

'A bad system will beat a good person every time'

– W. Edwards Deming

Part 3: Your clinical governance role

Clinical governance is everybody's business and requires a whole-of-organisation approach to achieve high-quality care. This section helps to break down specific clinical governance roles, functions, and behaviours.

Consumers

Genuine consumer engagement and partnership is critical to effective clinical governance practice, therefore, consumers who wish to have a role in high-quality care should be empowered to:

- Participate in their own care and treatment, and that of their family and those they care for, to their desired extent.
- Build health literacy, which means improving how consumers understand information about health and care; how they apply that information to their lives, use it to make decisions, and act on it.
- Become involved in internal and external facing consumer advisory committees or other consumer engagement groups to provide feedback, ideas, and personal experience to drive change at the individual and organisational and system level through formal channels to the executive and board (or equivalent)
- Participate in opportunities to design, develop, and test high-quality care improvements.
- Become partners with care organisations in governance, planning and policy development to co-design and drive improvement in performance monitoring, measurement, and evaluation.
- Be seen as legitimate sources of expertise and important advocates for high-quality care to support the best possible outcomes for self and others.

Boards

(or equivalent*)

Boards (or equivalent) are accountable for the delivery of high-quality care provided by their service, with key responsibilities including:

- Setting the organisational strategy, ensuring high-quality care is the central priority and that the strategy is effectively implemented.
- Establishing a clear organisational vision that encompasses a strong safety culture to enable the provision of consistently high-quality care.
- Overseeing the operationalisation of the Victorian Clinical Governance Framework within the organisation.
- Assuring that all clinicians employed at their health service, either as staff or as contractors, are credentialled and are working within their scope of practice.
- Empowering employees and consumers (at the individual, organisational and system level) to be effective and represented across the organisation and provide authentic opportunities for them to be heard.

	• Identifying and supporting key improvement initiatives that enhance care outcomes, ensuring these initiatives are adequately funded and are monitored and informed by diverse data and reporting. • Being accessible and visible to the entire organisation with clear and formal communication channels. • Ensuring active monitoring and oversight of employee and consumer experience data to drive improvements. • Being a distinct entity accountable to the Victorian Minister for Health, ensuring the provision of high-quality care. • Ensuring the organisation maintains connected partnerships with other organisations to provide high-quality care across settings and geographical distance. • Supporting the CEO and executive to fulfil their roles and responsibilities effectively. • Ensuring the board has the necessary skills, capability, and structure for effective leadership and oversight, and exhibits a commitment to their own individual and collective learning and development. • Identifying and mitigating key enterprise risks and implement appropriate controls, (such as commissioning deep dives into risk areas and outsourcing external expertise when necessary) recognising the boards' limitations and deficits. • Reviewing clinical performance data to monitor all aspects of care and ensure this is given the same weight and investment of time as reviewing financial metrics.
 **Chief executive officers (or equivalent*)**	**CEOs are responsible for delivery of high-quality care provided by their service, with key responsibilities including:** • Driving and sponsoring local application of the framework across their organisation to achieve consistently high-quality care. • Providing visible leadership and commitment in delivering and supporting the strategic direction set by the board. • Creating and fostering employee psychological safety, where employees are empowered to enact their responsibilities and speak up and raise concerns without fear of negative consequences. • Working in partnership with the board to ensure efficient allocation of resources that achieve public value and deliver on the organisation's vision for high-quality care. • Ensuring the voice of the consumer is at the centre of core business across the organisation. • Ensuring the organisation is outcomes focused and prioritises continuous improvement. • Operationalising connected partnerships with other organisations and with other care providers. • Creating formal and informal connections within the organisation to facilitate high-quality care provision. • Equipping employees to fulfil their roles by providing coaching, 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. • 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

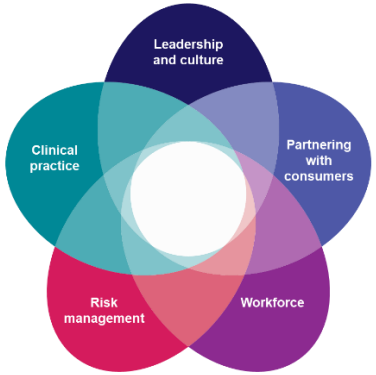
	• Proactively seeking information from qualitative and quantitative sources, including the voice of the consumer and clinician, to paint a comprehensive picture of the quality of care and services. • Adopting a 'no surprises' partnership approach with the board in the pursuit of excellence and welcoming questions that may help identify critical issues or blind spots. • Developing robust clinical governance structures collaboratively with employees at all levels to empower them in the delivery of high-quality care.
 **Senior leadership and management**	**Leaders and managers are required to:** • Create opportunities and conditions that enable consumers to build health literacy. • Lead your service with a focus on delivering high-quality care. • Actively model and set a strong safety culture that fosters commitment to improvement at the individual level and as an organisation. • Foster open and psychologically safe communication that enables a culture of multidisciplinary teamwork and effective employee management, ensuring clarity of roles and responsibilities, resource support, and accountability for the care provided. • Ensure all within the organisation are aware of their distinctive roles and responsibilities and empowered to fulfil them. • Facilitate and promote genuine partnerships with consumers at all levels. • Operationalise processes that support transparency, accountability, teamwork, and collaboration to enable the provision of high-quality care. • Lead and coach teams to engage in the formal and informal connections to facilitate high-quality care. • Create a safe and empowered environment for consumers and employees that supports and encourages productive partnerships and collaboration at the individual and organisational levels. • Provide employees with timely performance and improvement data and feedback, actively involving them in identifying and addressing issues, and ensuring appropriate action is taken. • Actively identify, prioritise, monitor, and manage key risk areas, leading escalation, and response efforts when safety is compromised. • Support employees who are impacted when quality and safety processes fail. • Assuring that all clinicians employed at their health service, either as staff or as contractors, are working within their scope of practice. • Work to ensure employees feel they are valuable and critical assets within the organisation.

 **Employees**	**Employees should:** • Understand and agree that providing high-quality care is their core business and go beyond compliance to pursue excellence in care and services. • Actively facilitate genuine and meaningful consumer partnerships. • Regularly update their skills and knowledge to provide and support the high-quality care and services whenever possible. • Work within care standards and protocols. • Participate in the formal and informal connections within the organisation to facilitate high-quality care provision. • Actively monitor and improve the delivery of high-quality care and services. • Share information and learnings regarding high-quality care. • Feel safe and valued to enable sharing of concerns, ideas, and initiatives, speak up and raise concerns and issues, promoting a culture of transparency and trust that their concerns have been heard and acted upon. • Model and contribute to safety culture, transparency, teamwork, and collaboration.
Victorian government (Department of Health and Safer Care Victoria)	**The Victorian government has the following key clinical governance responsibilities including:** • Setting expectations and requirements regarding health service accountability for high-quality care, partnering, and continuous improvement. • Facilitating and ensuring consumer partnerships and involvement are embedded across the care system at all levels. • Ensuring care services have the necessary data to fulfil their responsibilities, including benchmarked and trended data. • Providing stewardship, support, and direction to ensure high-quality care can be provided consistently across Victoria. • Ensuring board members have the required skills and knowledge to fulfil their roles and responsibilities. • Proactively identifying and responding decisively to emerging 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.

*Where an organisation does not have a board and CEO who is the ultimate decision-maker and holds the accountability for the organisation's performance, then these roles fall to the key decision-maker and accountable person or group at the organisation.

Part 4: Five clinical governance domains in application

Effective clinical governance is characterised by five domains to support the delivery of high-quality care for every consumer, every time. The five domains of clinical governance are interrelated and should be integrated into the organisation's broader governance arrangements. Clinical governance systems should not be viewed in isolation to financial and corporate governance systems.



Organisations, leaders, and individuals will know they are performing best practice clinical governance when they engage in the following activities.

Plan	Monitor	Learn	Improve
Identify the specific activities under the clinical governance domain that are consistent with best practice.	Identify the data you collect and track to understand how you are performing the planned activity over time.	Interrogate monitoring outcomes to understand complexities and context of the impact of planned activities, identifying strengths and improvement opportunities.	Suggest change activities required to address what is learned from interrogating monitoring outcomes, informing the next planning cycle.

Leadership and culture

Signs of success: Leadership and culture

Consumers and employees engage meaningfully with leaders	• The board and executive are visible and accessible to employees and model and lead with accountability and integrity. • Leaders regularly discuss progress with a plan to achieve a set of strategic goals for high-quality care. • Ownership of care processes and outcomes is promoted and practised by all employees. • Consumers and employees are empowered to actively participate and contribute their expertise and experience.
Consumers and employees feel empowered by leaders	• Organisational culture and systems are designed to facilitate the pursuit of high-quality care by all employees. • Care delivery is centred on consumers. • Employee survey response rates reflect a diverse and engaged representation. • There is genuine consumer representation on board quality committees and service improvement working groups.
Evidence of strong safety culture	• Employees report that a safety culture exists within the service (e.g. high rates of agreement with safety culture questions in the People Matter survey). • Open disclosure and Statutory Duty of Candour reporting processes are valued, supported, and well embedded at all levels. • Leaders are transparent and actively coach and facilitate improvement by sharing pertinent information, allocating adequate resources, encouraging reflection, and celebrating success.
Leaders are visible to consumers and employees	• Leaders are visible, conduct regular walkarounds, and ask consumers and employees questions about the degree of high-quality care being experienced and delivered. • Leaders use information learned during walkarounds to drive improvements.

To create a positive and safe environment in care settings, it is important to have effective leadership at all levels. This includes leaders who are visible, accountable, and focused on the organisation's purpose. Care quality is improved when employees and leaders work in an inclusive, safe culture, and where consumers and employees actively participate in planning and delivering services.

A strong organisational culture does not happen by chance, it must be deliberately cultivated. This means fostering an atmosphere of fairness, respect, and transparency, while emphasising the principles detailed within SCV's *Victorian Safety Culture Guide (2024)*. This guide builds on James Reason's safety culture model, which encompasses five interrelated subcultures –-Informed, Reporting, Just, Learning, Flexible –

underpinned by the principles of leadership support, psychological safety, employee wellbeing and employee engagement. When combined, these elements enable safety cultures to thrive and results in a culture where safety is prioritised, risks are managed, and continuous improvement is encouraged, leading to better care delivery and patient outcomes. To learn more about safety culture and how you can measure and monitor it within your organisation, refer to the *Victorian Safety Culture Guide* (linked on page 43).

How leadership and culture achieve high-quality care

Action	Plan	Monitor	Learn	Improve
High-quality care included in strategic plan	High-quality care is included as an aspiration in the strategic plan and is supported by the implementation of effective clinical governance systems.	Track and measure clinical governance initiatives as outlined in the organisation's strategic plan.	Using the continuous improvement mindset, seek to understand how to continuously improve high-quality care delivery in each clinical governance domain.	Board and executive review and revise their quality and safety agenda to ensure it represents best practice according to the framework.
Understand organisational clinical governance stability	Organisations proactively seek to understand their clinical governance stability through self-assessment.	• Administer the *SCV Clinical Governance Health Check self-assessment tool* for executives and boards. • Track *Clinical Governance Health Check* data over time.	Explore executive and board function and maturity in relation to key clinical governance concepts.	Identify improvement priorities to advance clinical governance functions in the pursuit of high-quality care delivery.
Consumers involved in strategic planning	Leaders purposefully involve consumers in high-quality care strategic planning committees to provide their perspectives.	• Track active participation and contributions of consumers in committee meetings. • Collect consumer feedback on the impact of their involvement in committees.	Review decisions ensuring they reflect the needs, expectations, and experiences of the community, and foster a consumer-centred approach that builds trust between the care organisation and its stakeholders.	Optimise consumer participation in high-quality care committees to inform strategic planning from the consumer perspective.
Leaders engage with employees on safety	Leaders engage actively with employees on issues of safety and culture by undertaking surveys and focus groups.	• Track the percentage of employee survey responses that express positive views on their experience of safety culture.	Leaders reflect on ways employees can be more actively involved in decision-making processes and feel like there is a	Surveys and focus groups are promoted and questions are designed to optimise authentic and honest engagement.

Action	Plan	Monitor	Learn	Improve
		• Track feedback trends from employee surveys and focus groups to gauge perception of leadership commitment.	culture of openness and involvement.	
Leaders create a schedule of engagement activities	Leaders create a schedule of activities to engage with consumers and employees.	• Track the frequency and quality of safety-related interactions during walkarounds or similar. • Collect feedback from consumers and employees on the impact of leadership engagement.	Identify leadership engagement activities that are most impactful for consumers and employees and seek to understand what it is about the activity that resonates.	Leaders test engagement activities that drive a culture where consumers and employees feel empowered to give feedback and improve where necessary.
Leaders employ targeted interventions to improve safety culture	Leaders employ targeted interventions based on diverse data sources, survey results and consumer input to improve safety culture metrics.	Track employee sentiment through several different instruments (e.g. People Matter Survey, local 'pulse-checks' and formal and informal feedback) to increase the proportion of employees who agree they feel confident in their safety and wellbeing.	Triangulate data to understand and identify areas of employee experience, safety, and wellbeing concern.	Co-design safety culture improvements with consumers and employees.
Leaders establish a structured reporting mechanism	Leaders establish a structured reporting mechanism for the board and executive to discuss progress on improvement priorities.	• Track improvement priorities. • Track action towards achieving improvement priorities. • Track board and executive feedback to those submitting reports on improvement priorities.	Explore reporting mechanisms for monitoring action towards improvement priority and assess the effectiveness of reporting on achieving organisational goals.	• Leaders celebrate successful action toward improvement priorities. • Board and executive adapt to better demonstrate how the organisational goals are steered towards high-quality care.

Partnering with consumers

Signs of success: Partnering with consumers

Consumers report excellent experience	• Boards monitor Victorian Healthcare Experience Survey (VHES) results overlaid with internal consumer experience data, complaints, and compliments, to understand the consumer experience. • Positive patient survey feedback, particularly on questions related to information and involvement. • Shared understanding of establishing goals related to care outcomes.
Consumer partnership is evident in organisation actions	• Consumer engagement and input is actively sought and genuinely valued, with ideally at least two or three consumers on a board. • Able to identify changes made in response to complaints or feedback from an active consumer advisory committee whose members are trained and supported. • The organisation monitors implementation and progress against the *Partnering in healthcare framework* and has an organisational strategy that supports open and transparent reporting to the board on consumer sentiment.
Consumer involvement in decision-making is evident at all levels	• Consumers are encouraged and equipped to participate in organisational strategy and decision-making for care improvement. • Formalised board reporting channels and structures that enable genuine consumer involvement. • Change is led or co-led by consumers. • Consumers on board sub-committees feel they are making a useful and respected contribution to improving care.

The core business of any service provider is the provision of high-quality care and therefore the consumer is at the centre. Consumer experience and participation are important indicators of care outcomes and preventable harm. Building effective partnerships with consumers is crucial for improving care outcomes and driving continuous improvement. Strong relationships with consumers should support both a better consumer experience and better outcomes.

Listening and responding to the consumer voice is fundamental to good clinical governance. Empowering consumers to participate in care and decision-making helps service providers at all levels understand the specific needs, concerns, and values of consumers. This leads to better treatment and care plans and improved patient outcomes and experience. Partnering with consumers to obtain feedback, both positive and negative, is valuable and should be encouraged. Complaints should be addressed collaboratively with consumers to find suitable resolutions, and outcomes should be used to drive improvement.

Partnering with consumers should be promoted throughout the organisation at all levels. Examples of organisation systems and processes where partnering is key include planning, policy development, guideline development, training design, and care delivery. Consumer voices help to identify issues that impact high-quality care and improve service design and delivery.

How partnering with consumers achieves high-quality care

Action	Plan	Monitor	Learn	Improve
Consumer feedback	Consumers are aware of how to provide feedback about the care they receive at a service.	The number of people completing feedback surveys and looking at complaints and compliments is monitored	Explore what matters most to consumers and what makes for a high-quality care experience.	Use insights from feedback to improve consumer experience.
Consumers participate in shared decision-making	Consumers receive information that is easy to understand and can share in decision-making about their care.	Feedback is actively sought from consumers about the information received and the usefulness of that information in making decisions about their care	Identify barriers and enablers to information sharing to facilitate informed decision-making and health literacy.	Use insights from feedback to improve consumer information provisions.
Culturally safe and inclusive care	The cultures, identities, beliefs, and choices of consumers are respected.	This may be measured through the addition of questions to consumer feedback surveys.	Identify organisational oversight regarding cultures, identities, beliefs, and choices through consumer feedback.	Address any oversight by building awareness to improve consumer experience of culturally safe care and organisational practices that provide inclusive care.
Appoint consumers to key positions	Consumers are appointed to positions on advisory groups, boards, and committees. Aim for three (minimum two) consumers in a group to avoid tokenistic inclusion.	Monitor the number of consumers on groups, boards, and committees.	Learn which groups, boards and committees in your organisation have consumer representation.	Explore how you can increase consumer participation on groups, boards and committees which currently do not have any.
Meaningful partnerships	Organisations partner meaningfully with consumers in governance, planning and policy development.	Assess where your current partnering is classified using the 'IAP2 Public Participation Spectrum' (e.g. classifications	Explore why your current partnership sits where it does.	Consider ways to move consumer partnership in your service beyond consulting and towards engaging and co-creation.

Action	Plan	Monitor	Learn	Improve
		of inform, consult, or co-design).		
Removal of barriers to participation	Organisations look for and remove barriers to consumer participation, including having accessible and inclusive ways to communicate.	Monitor demographics of consumers appointed to advisory groups to ensure diversity.	• Understand how consumers are recruited to and engage in advisory groups to ensure all communities are adequately represented. • Explore barriers and enablers to consumer participation in advisory groups, including time commitments, remuneration, family, and work commitments.	• Consider ways to improve consumer partnership to ensure representation of all communities who access the service. • Ensure consumers understand their role and feel supported to increase the likelihood of continued partnering.
Training and support for employees to optimise consumer participation and inclusion	Employees receive training and support to work with consumers, including how to foster an inclusive environment that encourages active participation and values the contributions of consumers in committees.	• Track the number of partnering training sessions offered. • Track uptake of partnering training by employees, including their demographics. • Collect feedback on partnering training, including capability uplift and skill application, from trainees. • Track consumer experience against uptake of partnering training.	Assess organisational partnering training opportunities to understand: • who is undertaking the training (which disciplines) • the impact of application in practice. • the impact on consumers' experience when correlated with training uptake.	• Improve access and quality of training and support for employees so they have the skills to partner with consumers effectively and understand the value of these partnerships. • Target underrepresented disciplines to undertaken partnering training.
Orientation, training, and support for consumers	Provide orientation, training, and support to enable meaningful contributions from consumers.	Collect experience, understanding, and skill acquisition feedback on the consumer training and mentoring program.	Work with consumers to identify the key orientation information, training, and support required to actively engage as a consumer.	• Provide consumers with training and mentorship to fulfil their role. • Address access to and quality of opportunities to support consumers to partner with

Action	Plan	Monitor	Learn	Improve
				employees and organisations in meaningful ways.
Remuneration	Organisations have a policy to remunerate consumers for their time and reasonable expenses.	• Track number of hours consumers are engaged where they are remunerated. • Track the number of hours that consumers are unremunerated.	Explore with consumers any barriers to participation in consumer advisory activities.	Regularly review the policy in partnership with consumers to eliminate financial barriers to participation in CAGs (e.g. cost of transport or childcare).
Establish a consumer representative register	Organisations establish a consumer representative register with frequent formal communication channels to the consumers representative group highlighting opportunities to engage in various projects.	• Track the breadth and number of consumers on the register. • Track the frequency of consumers self-nominating to partner on projects with service providers. • Track the frequency of consumers reporting their experience.	Explore the most effective channels of communication with consumers and consider the impact of social, clinical, literacy, language, and cultural diversity on consumer participation in consumer partnership activities.	Use insights from partnerships with consumers to improve overall experience for consumers, ensuring a focus on social, clinical, literacy and cultural diversity that reflects the community in which the service is located.
Consumers provide feedback	Consumers provide feedback, including complaints, to an advisory committee whose members are trained and supported.	Track the number of identified changes made as a direct result of consumer feedback.	Assess the impact of consumer feedback on improving overall consumer experience.	Identify and implement changes in response to the feedback.
Consumers participate in walkarounds	Consumers join executives on their regular leadership walkarounds and can provide open and honest feedback.	• Monitor the frequency and quality of safety-related interactions during walkarounds. • Monitor feedback from consumers on the impact of walkarounds.	• Identify quality and safety concerns from the consumer perspective. • Compare consumer feedback trends from leadership walkarounds to consumer	Use valuable insights into consumer experience and areas for quality and safety improvements to drive change.

Action	Plan	Monitor	Learn	Improve
			feedback trends collected via other methods.	
Monitor implementation and progress	Organisations monitor implementation and progress against the *Partnering in healthcare framework* and have an organisational strategy that supports open and transparent reporting to executive and boards on consumer sentiment.	Track consumer experience surveys, including: • frequency of feedback • closure of feedback loops to determine whether feedback is understood and acted upon.	Explore the barriers and enablers to consumers feeling comfortable and empowered to provide feedback and valuable insights to executive and boards.	• Action feedback from consumers to promote empowered sharing of consumer insights. • Respond to consumer sentiment to ensure consumers feel valued.
Foster inclusivity	Foster an inclusive environment in committees and working groups that encourages active participation and values the contributions of consumers.	Conduct surveys or interviews with consumers to gauge their perception of the value and impact of their contributions.	Identify the key conditions required to promote active consumer participation in committees and working groups.	Use insights to ensure consumers feel their input is valued and contributes meaningfully to care improvements.
Co-design for improvement	Co-design initiatives that educate consumers and empower them to actively participate in organisational strategy and decision-making for care improvement.	Track the number of consumer-led initiatives or contributions in organisational decision-making processes and assess their impact on care improvement.	Identify how consumers want to participate in co-design, acknowledging that there is not a 'one-size fits all' approach to co-design.	Use insights to improve how consumers are actively engaged in shaping care improvement strategies.
Strategic document to guide partnering	Organisations have a strategic document that outlines the local approach to partnering with consumers, which	The strategic document is endorsed by leadership and is communicated effectively to employees through position descriptions, orientation,	Compare the local strategic document against the SCV *Partnering in healthcare framework* to determine how local guidance can be strengthened.	Regularly review the document in partnership with consumers and members of the organisation to ensure it remains relevant and achieving its aim.

Action	Plan	Monitor	Learn	Improve
	was co-designed with consumers.	training, and other mechanisms.		
Consumer feedback surveys	Organisation-wide consumer feedback surveys are in place and there is a process for results to be reported through governance structures.	Feedback surveys are easily accessible and monitored to facilitate consumers completing them.	Consumer feedback is analysed and reported to the executive and board regularly.	This feedback informs improvement.
Board and executive support	Board and executive actively support partnering with consumers including dedicated roles on governance groups and committees that include remuneration for their contributions.	• Track feedback from consumers in governance groups and committees regarding experience of partnering with board and executive. Track uptake of consumer remuneration.	Explore feedback to understand the local enablers and barriers to active consumer engagement and consumer motivation to engage with executive and boards.	• Act on feedback to improve authentic partnership with board and executive. Develop a remuneration policy outlining how consumers are valued and compensated for their contributions.
Consumer advisory group	Organisations have a Consumer Advisory Group (CAG) (or similar) in their governance structure that is led or co-led by consumers with a direct line to executive and reporting to the board.	• Track frequency of group meetings. • Track group meeting purpose and outcomes. • Track CAG reporting to executive and boards. Seek consumer feedback from CAG on their experience within the organisational governance structure.	• Explore the impact CAGs have on organisational decision-making. Explore consumer feedback of CAG engagement to understand enablers and motivations to meaningful participation.	• Build consumer capability to lead or co-lead CAGs. • Establish direct access between CAGs and executive and boards. Executive and board decisions are influenced by CAG insights and reporting.

Workforce

Signs of success: Workforce

Workforce planning and resourcing meets organisational needs	• Every role has a clearly defined position description which outlines responsibilities and functions and is linked to individual performance monitoring. • Succession planning is proactive and occurs regularly for all key roles. • Workforce planning is effective and ensures the organisation is resourced appropriately with the right capability, and high-risk areas are clearly identified and monitored (e.g. percentage of new employees and agency/locum employees). • Employee orientation and induction includes explanation of local clinical governance systems, practices, and culture. • There is a system for ensuring critical clinical training requirements have been met. • Resource planning and allocation provides for effective and safe employees supervision and mentoring ratios.
Workforce reports excellent wellbeing and experience	• Employee wellbeing is prioritised, and wellbeing, job satisfaction, and employee engagement indicators are measured and monitored. • Employee engagement and satisfaction is measured and is a priority area of focus for board and management. • Employees are actively coached through improvement opportunities.
Workforce capability and performance are monitored to identify improvement opportunities	• Clinicians have a defined scope of practice built on their competency with measures to track scope of practice and detect outlier cases. • All employees have access to regular training and educational resources relevant to their role to maintain and enhance their required skill set and progression. • The training and development budget is fully utilised. • All employees have a performance agreement in place, a professional development plan and have participated in formal and informal employee performance reviews.

Systems are required to support and protect a skilled, competent, and engaged workforce. These include recruitment, credentialing, rostering, development, and retention of high-performing employees and leaders. These strategies ensure that service providers have the right people with the necessary skills at the appropriate times in appropriate settings to deliver high-quality care. Effective systems also work to ensure each role's core functions and responsibilities are universally understood.

Creating a physically and psychologically safe workplace is crucial for ensuring retention of high-performing employees. All employees should have access to capability development relevant to their role, including development of high-quality care, quality improvement, and partnering and co-design capability. Employees should be supported to apply this capability to review and enhance their individual practices and collective service provision. Robust organisational development systems enable employees to strengthen their skill sets, work within their scope, engage in quality improvement, provide supervision, and manage performance effectively. Effective workforce planning is essential to the provision of high-quality care and involves regular assessment to ensure known skill gaps are tracked, the percentage of new employees and agency or locum employees is known and mitigated against, and succession plans are in place.

How workforce achieves high-quality care

Action	Plan	Monitor	Learn	Improve
Employee development plans	Organisations create employee development plans, including associated budget and address staffing risks, training development gaps, and performance management.	• Track and monitor the progress of each plan along with employees' confidence and skills acquisition. • Track uptake of training budgets across the organisation.	• Identify and explore developmental areas to achieve capability uplift. • Understand the barriers and enablers to workforce participation in training and development.	• Review the plan for effectiveness and revise activities as appropriate. • Empower employees to proactively identify and plan their professional development goals. • Increase uptake of training and development budget.
Performance planning and review	Implement a structured and supportive performance planning and review process, including opportunities for professional development.	• Track percentage of employees participating in performance planning and review processes. • Track completion of professional development activities. • Monitor feedback relating to performance review	Explore barriers to active employee participation in performance planning, and achievement of professional development goals.	Use feedback to improve the performance review process and professional development planning so there is a culture of continuous improvement and career growth, leading to increased employee engagement and job satisfaction.

Action	Plan	Monitor	Learn	Improve
		process and professional development planning.		
Employee wellbeing	Organisations regularly measure employee wellbeing, engagement, and job satisfaction to establish mechanisms for continuous improvement.	Track changes to indicators of employee: • wellbeing • engagement • job satisfaction.	Overlay employee outcomes with consumer experience and outcome data to identify correlations.	Use insights to improved employee experience and in turn consumer experience and outcomes.
High-quality care learning and development	Incorporate high-quality care learning and development into employee orientation and induction programs.	Collect feedback from new employees on orientation programs.	Assess the comprehensiveness of high-quality care delivery content in orientation and other learning and development programs.	Use the feedback to improve orientation and learning and development to ensure new employees are well-informed and aligned with the organisation's commitment to high-quality care.
Monitor critical competency requirements	Establish a systematic approach to monitor and verify that all relevant employees meet critical clinical competency requirements.	Regularly audit and assess employee competency and training records to verify the completion of critical clinical training requirements.	• Identify when critical clinical competency requirements are unmet and seek to understand how this has occurred. • Identify trends of unmet clinical competency completion.	Use audit results to ensure there is high standard of clinical competence and compliance with essential training protocols.
Employee mentoring	Resource effective employee supervision and mentoring to build capability to deliver high-quality care.	Collect feedback from employees on the effectiveness of: • supervision and mentoring • mentee experience • mentor experience	Assess the adequacy of resources allocated to employee supervision and mentoring programs, including impact on the mentor and mentee from a capability uplift, time, and effort perspective.	• Adjust mentorship resources based on impact (e.g. increase or decrease allocated mentoring time or resources). • Use insights to improve mentoring programs to help ensure improved employee capability.
Defined position descriptions	Every role has a clearly defined position description, which is linked to individual performance monitoring.	• Audit employee knowledge of where to locate their position description.	Identify position descriptions that require updates, evolution, and a clearer definition to accurately	• Improve position descriptions to provide role clarity. • Cross-check position descriptions at annual

Action	Plan	Monitor	Learn	Improve
		• Audit performance reviews for alignment with position descriptions.	reflect the responsibilities of that role.	performance reviews to ensure they articulate the right capabilities to perform the required duties.
Workforce planning	Workforce planning encompasses budget considerations, professional development, and training, as well as workforce demand and capacity.	Monitor and assess: • Recruitment practices • Annual professional development planning • Employees retention rates • Workforce capability	Identify a balance of workforce capacity and capability investment with individual, local and organisational requirements.	Review the workforce planning function to ensure it has the right knowledge, skills, and resources to perform its role for the organisation.
Succession planning	Clear succession planning is in place across the organisation for all key roles, including identification of critical roles and positions, required capabilities, and clearly defined succession criteria.	Monitor and assess: • The number of board and executive roles (critical roles) that are filled internally. • The number of management and senior leader roles that are filled internally.	Understand key organisational roles that are at risk due to lack of succession planning and identify key stakeholders to invest in capability uplift for succession planning.	Ensure that: • regular performance evaluations include development goals. • feedback and performance evaluations identify areas of excellence and areas that need further development. • mentorship and collaboration are accessible to build capability.
Occupational violence and aggression response	Organisations have clearly defined occupational violence and aggression (OVA) response processes documented that are communicated to employees.	• Incidence of OVA is captured in organisational data. • Victorian Health Incident Management System (VHIMS, or equivalent system) data of 'code grey' and 'code black' responses are tracked, trended, and themed.	• Identify risk of OVA from trended data to better understand causation and high-risk scenarios. Explore impacts of OVA on employees, including correlation to personal leave, burn-out rates, and workforce turn-over.	• Develop risk mitigation activities to decrease OVA occurrence and improve OVA response including management of clinical aggression (MOCA) training. • Develop targeted improvements to support employee wellbeing, including physical and psychological safety specific to OVA (e.g. debriefing opportunities, access to Employee Assistance Programs).

Action	Plan	Monitor	Learn	Improve
		• Employee-reported violence and aggression incidents are tracked and trended.		

Risk management

Signs of success: Risk management

Meaningful data is routinely collected and monitored	• Care quality outcomes are monitored against external benchmarks. • Consumer perception of safety culture is monitored and informs improvement strategies. • Performance data regarding consumer and employee experience is reviewed conjointly to better understand perception of safety culture. • Trending analysis of data is conducted.
Risk monitoring is timely, transparent, and accurate	• Organisation reporting, reviews, and decision-making are underpinned by transparency and accuracy. • Statutory Duty of Candour reporting is conducted quarterly via the Victorian State Government Health Collect portal. • Documented review of risks and mitigation actions are reported to the board at least quarterly.
Risk identification is used to drive continuous learning and improvement.	• Consumers are actively engaged and participate in adverse patient safety event reviews. • Genuine commitment, as evidenced in practice, to comply with the intent and requirements under the Statutory Duty of Candour legislation, openly disclose and learn from errors. • Risk and improvement data is trended and analysed by the board and executive to make decisions about improvement efforts. • Key improvement initiatives are tracked, monitored, and supported by the board.
Risk registries are forward looking and preventative	• Emergency management plans and crisis plans are developed and in place. • Rigorous measurement of performance and progress is benchmarked and used to manage risk and drive improvement in the quality of care. • The board receives regular reports on workforce risks, ensures succession plans are in place and workforce pressures and gaps are identified.

Safeguarding against risk requires a structured approach that is both proactive and reactive – prevention and repair. The aim of sound risk management is to operate in complex, high-hazard situations for extended periods while avoiding adverse events. Successful organisations continually evolve their operations to maintain this high standard.

Organisations with sound risk management do five key things:

1. Employees and leaders do not ignore any mistakes or errors, no matter how small, because any deviation from the expected result can lead to an adverse event, serious or sentinel. Adverse events are addressed immediately and completely. Leaders understand the necessity of addressing any level of technical, human, or process error thoroughly and promptly. Ideally, even potential breakdowns in a process are identified and addressed proactively, and staff and leaders are focused on anticipating how and where things could fail, even if they have not.
2. Health services are complex, adaptive systems, and employees and leaders accept and embrace that complexity. When adverse patient safety events occur the service conducts root cause analysis or other appropriate review methods. Consumers are actively involved in investigations as they bring unique perspectives to this process. Employees and leaders continuously look at data, benchmarks, and other performance metrics, and to prevent oversimplification, they constantly seek information that challenges current beliefs as to why problems arise.
3. There is a shared understanding that true awareness of problems and solutions comes from the front line. Front line employees are closer to the work than executive leadership and boards, and they are better positioned to recognise the potential failings and identify opportunities for improvement.
4. Employees and leaders anticipate trouble spots and improvise when the unexpected occurs. This requires flexibility to identify errors that require correction while at the same time finding solutions in a dynamic environment. Employees and leaders are explicitly trained on how to manage unexpected events. The culture fosters cross-functional, multidisciplinary collaboration and flexibility to accommodate changes in conditions or resources. As multidisciplinary teams, they prepare in advance for emergencies and have clear means of communication and control.
5. Expertise, rather than authority, is valued. When situations are high-risk and circumstances change rapidly, front-line subject matter experts are essential for urgent situational assessment and response. To defer to expertise, leaders know who in the organisation has the relevant specialised knowledge. They also focus on creating experts and helping adept employees keep their skills sharp and current. Leaders also acknowledge that experts may not always be those with the clinical expertise, consumers, their families, carers, or any individual that has high contact with consumers (such as a support service employees member), may have the expertise required.

Organisations that do these five things are better able to fulfil their requirements of the Statutory Duty of Candour, which legislates that organisations provide an apology and engage in open and honest communication when consumers experience a serious adverse patient safety event.

Risk management and prevention for clinical governance should be integrated with organisational governance.

How risk management achieves high-quality care

Action	Plan	Monitor	Learn	Improve
Benchmarking	Organisations regularly compare the quality and safety outcomes against established benchmarks or industry standards.	Track the organisation's performance against external benchmarks and assess improvements over time.	Identify high-quality outcomes and clearly highlight areas of under-performance to then use safety insights to drive quality initiatives.	Employees and leadership use this information to devise improvement strategies that are appropriately owned, resourced, and tracked.
Analyse trends	Organisations implement a systematic process for analysing trends in relevant data sets, such as incident reports and consumer outcomes.	• Track frequency of undertaking trended analysis. • Track number of actionable improvements resulting from this analysis.	Compare trends from data analysis with other indicators of care outcomes and experience to assess accuracy of trends.	Use insights to improve the process so data sets accurately collect indicators which identify trends to proactively address emerging issues and continuously improve.
Risk recognition, mitigation, and reporting	Organisations establish a structured process for documenting, analysing, and reviewing risks, along with proposed mitigation actions, and regularly report this information to the board.	• Track and theme risks. • Track mitigation strategies. • Track frequency of risk theme. • Track frequency of risk reporting to the board. • Track successful implementation of mitigation actions.	Evaluate the thoroughness of documented risk and how the board uses risk registry reporting to guide decision-making.	Use evaluation results to improve the process so potential risks are identified and proactively addressed with mitigation strategies to prevent future incidents.
Incident reporting	Organisations manage and report to leadership regularly on incidents.	Track the time taken to report, review and manage risks and incidents.	Identify barriers and enablers to incident reporting, reviewing and mitigation of risk.	Strategies are put in place to ensure incidents are reported, reviewed, and managed in a timely manner.
Monitor safety culture	Organisations conduct regular assessments of consumer and employee sentiment to gauge	• Track safety culture, consumer outcomes, and experience metrics over time.	• Compare safety culture trends across diverse groups and levels of the organisation.	Strengthen safety culture to improve consumer and employees experience.

Action	Plan	Monitor	Learn	Improve
	the organisation's safety culture.	• Track implementation of these improvement strategies.	• Explore consumer outcome and experience data to identify strengths and improvement opportunities. • Triangulate safety culture and consumer outcome and experience data to determine correlations.	
Establish routine reporting pathway to board.	Organisations establish a reporting mechanism to update the board regularly on progress towards organisational goals related to high-quality care delivery.	• Monitor what data is routinely reported to the board. • Monitor how progress towards organisational goals is reported. • Track feedback from the board about reporting of progress towards organisational goals.	• Assess report comprehensiveness to understand alignment of actions with organisational goals. • Explore if boards have the right information reported to ensure progress towards goals.	• Use insights to ensure board is informed and involved with driving the organisation towards its care improvement goals. • Collaborate with board members to test alternative reporting mechanisms if current reporting is deemed inadequate.
Regular review of trended risk and improvement data.	Organisations facilitate regular reviews of trended risk and improvement data during board and executive meetings.	• Track use of trended data in board and executive decision making. • Track implementation of improvement initiatives over time.	• Boards identify organisational strengths and opportunities for improved risk mitigation using trended data. • Explore which data best informs the executive and board.	• Use this information to improve data-driven decision-making, leading to targeted and effective improvements. • Use meaningful data sets to drive improvement, ensuring a cohesiveness between safety and quality.
Apply corporate governance principles	Organisations apply broader corporate governance principles that include clinical, risk and financial governance to understand care delivery outcomes.	Care outcomes are monitored and triangulated against cost, consumer experience and risk.	Explore the impact and intersection of, clinical, risk, and financial governance on the delivery of high-quality care.	Optimise high-quality care outcomes by balancing corporate governance.

Action	Plan	Monitor	Learn	Improve
Clear and accessible Whistleblower policy.	Organisations have a clearly documented Whistleblower Policy that is well communicated and accessible to all employees.	• Track frequency of Whistleblower Policy activation. • Track Whistleblower Policy themes. • Track improvements from Whistleblower Policy activation.	• Identify barriers and enablers to activation of local Whistleblower Policy as activation is indicative of sound safety and reporting culture. • When an action is instigated, leaders respond in a manner indicative of their commitment to psychological safety, transparency, and accountability.	Promote local Whistleblower Policy activation outcomes to improve reporting culture, mitigate risk, and strengthen practices, processes, and systems to prevent incident recurrence.
Speaking up for safety	Organisations cultivate an environment in which speaking up for safety is encouraged and promoted.	• Track near-miss risk incident reporting. • Track Whistleblower Policy activation. • Track sentinel event reporting. • Track Statutory Duty of Candour compliance	Explore barriers and enablers of reporting incidents, (as well as near misses from multiple perspectives) including workforce capability to recognise and report.	Use these findings to strengthen safety and reporting culture.
Maintain workforce stability to foster high-quality care.	Organisations maintain workforce stability to optimise service delivery and mitigate risk.	Monitor: • percentage of agency/locum employees. • employee retention rates. • employee turnover rates. • employee feedback via exit interviews.	• Review how information is shared with decision-makers and seek to understand how it guides workforce planning. • Explore employee experience feedback to better understand retention.	• Invest in workforce by providing professional development opportunities. • Recognise and celebrate individual and local high-quality care delivery. • Leaders actively and meaningfully engage with the workforce to maintain motivation. • Clearly articulate workforce challenges and remedies.

Clinical practice

Signs of success: Clinical practice

Systems and processes assure consistently high-quality care	• Credentialing and scope of practice processes are transparent and regularly assessed for effectiveness. • Clinicians have clear position descriptions and defined scope of practice. • Cases treated by the organisation are appropriate for clinicians' skill and experience and the organisation's capability. • Employees are committed and supported to participate in activities such as Multidisciplinary Team (MDT) meetings and Mortality and Morbidity (M&M) meetings.
Critical information is proactively collected and shared to inform outcomes	• Clinical services actively participate in relevant clinical registries. • Clinical services actively participate in relevant clinical audit activities. • Information about the clinical effectiveness of services is provided to all levels and is benchmarked and trended within the organisation. • Clinicians are engaged in peer comparative performance meetings on outlier cases and receive coaching to improve their practice • Clinicians receive comparative reports on individual performance from their organisation to identify opportunities to improve care outcomes.
Continuous learning and improvement are enabled through effective planning and monitoring	• Safety insights are used to inform quality improvement initiatives to ensure a strategic and cohesive approach to high-quality care. • Robust and diverse qualitative and quantitative data informs decision-making and improvement strategies to support high-quality care. • Performance data showing high-quality care is displayed, shared, and celebrated, along with any associated improvement initiatives.
Clinicians are committed to the pursuit of excellence	• Outcomes from activities such as M&M meetings and MDT multi-disciplinary team meetings are recorded, shared, and tracked to measure impact. • Clinicians demonstrate a commitment and sense of accountability towards their own continued learning and improvement.

Delivering high-quality care requires motivated, accountable, and committed clinicians who feel supported by their leadership teams. They have systems that enable them to provide evidenced-based, best-care to each consumer, while staying within the organisation's clinical guidelines. These clinicians and systems must operate within a strong safety culture to be successful. Clinical practice should focus on high-quality care throughout the entire consumer journey, with clear communication and shared goals between clinicians and consumers.

Effective systems for clinical practice should ensure that clinicians have the necessary knowledge, skills, technology, and equipment to deliver high-quality evidence-based care. Variations in clinical quality and practice are likely within the complexity of care; these should be actively monitored and discussed, with a focus on the outcome, not the person, to ensure high-quality care for every consumer. Clinicians' input and time should be valued and supported, which will foster their engagement with regular review of their practice, participation in peer review, and contributions to continuous improvement. Clinicians should demonstrate commitment to and accountability for their individual development and learning, which in turn should be valued and acknowledged by leadership teams. Those electing not to engage may need mentoring and coaching to foster contribution. Care quality should be regularly evaluated using appropriate measures and reporting to inform opportunities for improvement.

As with clinical governance itself, clinical practice is not 'set and forget'. It must be closely monitored, regularly reviewed, and evaluated and should evolve in line with emerging evidence and technologies and changing consumer needs.

How clinical practice achieves high-quality care

Action	Plan	Monitor	Learn	Improve
Participation in relevant clinical registries	Organisations encourage and facilitate active participation of their relevant clinical services in all the aligned clinical registries and audit activities.	• Track the percentage of clinical services actively participating in registries and audits. • Track registries and audits participation types. • Monitor and benchmark the data being entered	• Assess the impact of participation in registries/audits. • Explore barriers and enablers to active registry and audit participation. • Analyse the benchmarked data to assess your organisations comparative performance.	• Use this information to understand pinch points and improve capacity to participate in clinical registries and audits. • Identify registries and audit activities that may improve clinical outcomes through active participation. • Use the data to identify areas of clinical practice to target for improvement.
Transparent benchmarking of	Organisations establish a system for regularly	• Evaluate the level of individual accountability	• Evaluate accessibility and use of benchmarked and trended	Improvement activities and decisions made by clinicians

Action	Plan	Monitor	Learn	Improve
clinical effectiveness data	collecting, benchmarking, and trending clinical effectiveness data, which is accessible to clinicians and the board.	by clinicians to learn and improve (e.g. via Performance Development Planning). • Evaluate employee experience data to understand the extent of safety culture across individual teams.	clinical effectiveness data by clinicians and the board in decision-making processes. • Explore the barriers and enablers to clinicians engaging in genuine learning opportunities, including assessing if clinicians are provided adequate time, information, and incentive to change practice. • Overlay quantitative and qualitative data to better understand causes for under-performance.	and the board are based on benchmarked and trended clinical effectiveness information.
Publicly available outcome measure data is provided.	Organisations implement a system for regularly updating and displaying publicly available data on outcome measures within the service.	• Track frequency and accuracy of updated publicly available data. • Track the impact of increased transparency on consumer and employee awareness of outcomes.	• Understand how frequently data should be updated to meet the needs of consumers and employees. • Explore what data helps consumers and employees understand quality of care at the service.	Continue to pursue transparency and accountability, while improving data access systems.
Credentialling and scope of practice	Organisations implement a comprehensive credentialing process and regularly review and update scope of practice requirements for clinicians.	Track the completion and compliance of clinicians with the credentialing process and assess adherence to approved scope of practice requirements through regular audits.	Identify and understand how clinicians are qualified and practicing within their approved credentials, to maintain a high standard of care.	Use these insights to identify any potential outliers and ensure capability opportunities are offered and accessible to clinicians to ensure continued professional growth and development to meet role requirements.

Action	Plan	Monitor	Learn	Improve
Promotion of multidisciplinary care models	Multidisciplinary Team (MDT) care models are actively supported at the organisational level (via systems, processes, and structures) and at the individual level to collaboratively pursue high-quality care.	Clinicians: • report effective MDTs and demonstrate a willingness to participate. • report time and information to allow for genuine learning and change to practice. Consumers: • report positive care experience and outcomes via patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs). Monitor outcomes including: • treatment outcomes • amount of consumer care coordination • amount of duplication • number of consumers recruited to clinical trials.	• Employees reflect on outcomes of their practice across multiple spheres (e.g. clinical outcomes, patient satisfaction, and efficiency). This is evidenced at the individual clinician level and at the team, unit, department discipline level resulting in changes that tangibly improve outcomes. • Explore the positive and negative outcomes on high-quality care when the multidisciplinary care models are optimised versus lacking.	• PREM and PROM data is used identify better delivery of MDT models of care and facilitate individual accountability and responsibility for improvement. • Targeted efforts are made to ensure MDTs are included in high-quality care delivery. • Participation and engagement at MDTs improve as clinicians learn the value and benefit to themselves and consumers.
Conduct robust morbidity and mortality meetings on a regular basis	Organisations hold robust and structured multidisciplinary M&Ms meetings that are well attended and valued by clinicians.	• Track frequency of multidisciplinary M&M meetings. • Track and theme morbidity and mortality outcomes. • Track and monitor actions from	• Explore local clinical practice, processes, and system outcomes resulting in morbidity and mortality. • Compare frequency of multidisciplinary M&M cases discussed against morbidity and mortality rates.	• Identify activities to minimise harm and optimises service delivery, including potential clinical practice changes. • Drive clinician accountability and responsibility for learning and improvement through actions from multidisciplinary M&M

Action	Plan	Monitor	Learn	Improve
		multidisciplinary M&M meetings. • Track clinician experience and practice change due to participation in multidisciplinary M&M meetings. • Monitor number of clinicians and disciplines attending multidisciplinary M&M meetings.	• Identify under-represented disciplines at meetings and explore reasons for under-representation.	meetings and continuous monitoring of M&M data. • Plan multidisciplinary M&M meetings that optimise active participation from all disciplines.
Ensure high-quality clinical handover at all points where transfer of care occurs	Organisations create conditions, through well-defined and communicated expectations, resources, process, and systems, that enable high-quality clinical handover at transfers of care (both internally and intersectoral).	• Track consumer-reported experience and care outcomes related to movement between care providers via PREMs and PROMs. • Track clinicians reporting access to the right information to enable provision of high-quality care.	Explore the organisational conditions that prevent best practice, high-quality clinical handover at transfers of care (both internally and intersectoral) from the consumer and clinician perspective.	Focus improvement efforts to address pinch points at transfer of care, including clear expectations for clinical handover that facilitates high-quality care.
High-quality discharge planning	Organisations create the conditions that facilitate high-quality discharge planning.	• Track preventable readmission rates. • Track 'failure to attend' and 'lost to follow-up' rates. • Track patient experience of integrated care and outcomes via PREMs and PROMs.	Explore barriers and enablers to best discharge processes, including technology, communication methods, and clinician and consumer characteristics.	• Strengthen processes at discharge, including communication between consumers and follow-up care providers to ensure high-quality care outcomes. • Strengthen consumer participation in discharge planning.

Action	Plan	Monitor	Learn	Improve
Monitoring performance and use of key clinical indicator and outcome data	Clinical performance and clinical outcome data is triangulated with clinician credentialing.	Monitor clinical outcomes including: • post-operative complication rates • unplanned return to theatre rates • unplanned readmission rates • average length of stay, by condition • transfer of care to alternative service provider (escalation or de-escalation) • unplanned admission to intensive care units • unexpected use of blood products • discharge destination.	Explore unexpected clinical outcomes and deviations to identify potential capability and/or clinical practice gaps.	Develop actions to address any deficits and seek to improve individual and craft group clinical practice to deliver high-quality care. Ensure clinicians are offered coaching, where appropriate, to improve their practice. Monitor, track, and report on progress to the organisations' leadership.

Glossary

Below is a list of terms and definitions commonly used in this document.

Term	Definition
Agency and locum employees	A person who is outsourced from an external organisation to temporarily fulfil the duties or function required.
Care	The word 'care' has been chosen as an inclusive term to describe all activity performed by the care setting provider in relation to an individual receiving care.
Care setting	A care setting encompasses a wide range of environments where specialised care is delivered to meet the unique needs of various populations. This includes aged care, digital and virtual health, public and private acute health, public and private sub-acute health, mental health, ambulance, primary and community care, custodial health, and future health settings.
Clinical	In this document, 'clinical' refers to the practical application of health professional knowledge and skills in any setting of care involving direct patient care or other related activities.
Clinical governance	Clinical governance refers to the integrated systems, processes, leadership, and culture that are at the core of providing safe, timely, effective, efficient, equitable and person-centred care underpinned by continuous improvement. This applies to all care settings.
Co-design	Co-design brings consumers and stakeholders together to design new products, systems, services, and policies.
Consumers/consumer representative	The term 'consumers' is inclusive and refers to patients, residents, clients, families, supporters, those with lived and living experience, carers, advocates, representatives, volunteers, and communities who may be past, current, or potential users of the service.[2]
Continuous improvement	Organisational process that engages all team members in planning and implementing ongoing improvement strategies and practices.
Employees	In this document, 'employees' is defined as all people engaged or employed by the organisation to fulfil specific roles and functions. This includes senior medical officers and visiting medical officers.
Health workforce	All people working in a health service organisation, including clinicians and any other employed or contracted locum, agency, student, volunteer, or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with, patients in the health service organisation.[3]
High-quality care	The elements of high-quality care are safe, timely, effective, efficient, equitable and person-centred.
Occupational health and safety	Involves complete physical, mental, and social well-being within a workplace.

[2] Adapted from *Partnering in healthcare: A framework for better care and outcomes*.

[3] Adapted from the *National Model Clinical Governance Framework*.

Term	Definition
Occupational violence and aggression	Any incident, irrespective of the intent or harm, where an employee is verbally, physically, or psychologically abused, harassed, or threatened by a patient, resident, or client, another employee or member of the public.[4]
Organisation	Service where care is delivered, including public and private hospital settings, aged care, mental health services, ambulance, and custodial health settings.
Partnering with consumers	The collaborative and inclusive relationship between health professionals, consumers, families, carers, and communities that enables better health outcomes and a more efficient and effective health system. It is based on how different people's knowledge and insights can come together through collaboration, inclusion, and engagement. It is not only an exchange of knowledge and information, but a process through which new knowledge and strategies are co-created for better outcomes and impact.
Patient reported experience measures (PREM)	Information collected from consumers about their experience of the care they received from service providers and the outcomes achieved. [5]
Patient reported outcome measures (PROM)	Information collected from patients which captures their perception of their own health through questionnaires. PROMs enable patients to report on their quality of life, daily functioning, symptoms, and other aspects of their health and well-being.[6]
Quality improvement	A systematic method used to achieve higher levels of performance in an organisation.
Safety culture	The product of individual and group values, attitudes, and behaviours that determine the commitment to and practice of organisational safety.
Statement of Priorities	All Victorian public healthcare services, including dental health services, Ambulance Victoria, and the Victorian Institute of Forensic Mental Health (Forensicare) agree to a Statement of Priorities (SoP). SoPs are annual accountability agreements between Victorian public healthcare services and the Minister for Health. They outline the key performance expectations, targets, and funding for the year as well as government service priorities. The department has a role as a systems manager to ensure SoPs are consistent with the strategic plans of public health services and are aligned to government policy directions and priorities. SoPs consist of four parts: • Part A provides an overview of the service profile, strategic priorities, and deliverables the health service will achieve in the year ahead. • Part B lists the key financial, access and service performance priorities and agreed targets. • Part C lists funding and associated activity. • Part D forms the service agreement between each health service and the State of Victoria for the purposes of the National Health Reform Agreement.

[4] Adapted from *WorkSafe Victoria, Occupational violence and aggression: Safety basics*.

[5] Adapted from *Australian Institute of Health and Welfare: Patient-reported experience and outcome measures*

[6] Adapted from *ACSQHC Patient reported outcome measures*

Term	Definition
	The mechanisms used by the department to monitor health service performance against the SoPs are outlined in the department's performance monitoring framework for Victorian health services.
Victorian State Government Health Collect portal	HealthCollect is a secure online system used by the department to collect data from and distribute information to health services. The HealthCollect portal uses a service and component-based architecture to support a wide range of data collections and applications.
Visiting Medical Officer (VMO)	Independent medical clinicians credentialed to admit and treat patients at specific organisations.
Walkarounds	Walkarounds are a commitment by the senior leadership (Boards and executive) of an organisation to meet and talk with staff working at the point of care, specifically focusing on issues affecting consumer and employee safety. They occur regularly, allow quick and effective follow up of safety issues, and enhance relationships and communication between senior leadership and point of care teams.

Useful resources

Resource link	Leadership and culture	Partnering with consumers	Workforce	Risk management	Clinical practice
ACQSHC: Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners			●		●
ACSQHC National Standards		●			
ACSQHC NSQHS Partnering with consumers standard		●			
ACSQHC Partnering with consumers: a guide for consumers		●			
ACQSHC Patient Reported Outcome Measures		●			
Australian Health Practitioner Regulation Agency) Whistleblower Policy			●		●
Health Legislation Amendment (Quality and Safety) Act 2022	●	●	●	●	●
IAP2 Spectrum of Public Participation		●			
SCV Adverse Patient Safety Events Policy		●		●	●

Resource link	Leadership and culture	Partnering with consumers	Workforce	Risk management	Clinical practice
SCV Credentialing and scope of practice for senior medical practitioners policy			●		
SCV Just Culture Guide	●		●	●	●
SCV Just Culture in adverse event reviews factsheet	●	●	●	●	●
SCV Leadership and Safety Culture factsheet	●		●	●	●
SCV Partnering in healthcare		●			
SCV Sentinel events and Statutory Duty of Candour	●	●	●	●	●
Victorian Agency for Health Information eHealth data interpretation videos	●			●	
Victorian Department of Health Occupational violence and aggression	●	●	●	●	●
Victorian Public Interest Disclosure Act 2012	●	●	●	●	●
Victorian Safety Culture Guide	●	●	●	●	●
Victorian Whistleblowers Protection Act 2001	●	●	●	●	●

References

Australian Commission on Safety and Quality in Health Care (2013) *Australian open disclosure framework*, ACSQHC, <https://www2.health.vic. gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management/open-disclosure/ open-disclosure-framework>.

Australian Commission on Safety and Quality in Health Care (2017) *National Model Clinical Governance Framework*, ACSQHC, <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-model-clinical-governance-framework>.

Australian Commission on Safety and Quality in Health Care (2020) *Australian Charter of Healthcare Rights (second edition),* ACSQHC <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-charter-healthcare-rights-second-edition-a4-accessible>

Australian Commission on Safety and Quality in Health Care (2021) *National Safety and Quality Health Service Standards (second edition)*, ASQHC <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition>

Australian Commission on Safety and Quality in Health Care (2023) *Partnering with consumers*, ACSQHC, <https://www.safetyandquality.gov.au/our-work/partnering-consumers>

Aven T (2022) A risk science perspective on discussion concerning Safety I, Safety II, and Safety III, *Reliability Engineering & System Safety,* 217 , doi: 10.1016/j.ress.2021.108077.

CRANAplus (2013) *Clinical governance guide for remote and isolated services in Australia*, CRANAplus website <https://crana.org.au/professional-support/clinical-governance-for-remote-and-isolated-health>

Gandhi T, Kaplan G S, Leape L, Berwick D M, Edgman-Levitan S, Edmondson A, Meyer G S, Michaels D, Morath J M, Vincent C, Wachter R (2018) Transforming concepts in patient safety: a progress report, *BMJ Quality and Safety, 27*(12):1019-1026. doi:10.1136/bmjqs-2017-007756.

Ham C, Berwick D, Dixon J (2016) Improving quality in the English NHS: a strategy for action, The Kings Fund, London.

Haslam SA, Jetten J, Maskor M, McMillan B, Bentley SV, Steffens NK, Johnston S (2022) Developing high-reliability organisations: A social identity model, *Safety Science,* 153, doi:10.1016/j.ssci.2022.105814.

Heifetz RA, Grashow A, Linsky M (2009) The practice of adaptive leadership: Tools and tactics for changing your organization and the world, Harvard Business Press.

Heifetz RA, Laurie DL (1997) *The work of leadership*. Harvard Business School Publishing.

Hollnagel E, Wears R L, Braithwaite J (2015) *From Safety-I to Safety-II: A White Paper*, National Library of Congress.

Institute of Medicine (US) Committee on Quality of Health Care in America (2001) *Crossing the Quality Chasm: A New Health System for the 21st Century*, National Academies Press, Washington DC.

Safer Care Victoria (2019) *Partnering in healthcare for better care and outcomes*, Safer Care Victoria, State Government of Victoria,<https://www.safercare.vic.gov.au/publications/partnering-in-healthcare>.

Sampath B, Rakover J, Baldoza K, Mate K, Lenoci-Edwards J, Barker P. (2021) Whole System Quality: A Unified Approach to Building Responsive, Resilient Health Care Systems, Institute for Healthcare Improvement <https://www.ihi.org/resources/white-papers/whole-system-quality>.

Sexton B, Helmreich R, Neilands T, Rowan K, Vella K, Boyden J, et al. (2016) The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research, *BMC Health Services Research, 6*(44):1–1, doi: 10.1186/1472-6963-6-44.

Van Laar D, Strevens C, Labib A, Mitchell C (2023) No harm in learning–A balanced High Reliability Organisation (HRO) approach in healthcare, *Journal of Social and Economic Statistics*. *12*(2). doi: 10.2478/jses-2023-0006.

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