

Clinical Governance

In Community Health

Board Of Management

Clinical Governance Reporting
Guidelines



1. Introduction

The role of the Board of Management in governance of a community health service involves the following main responsibilities:

- Overseeing/developing the strategic direction
- Financial Monitoring
- Guidance and Monitoring of the management of the service
- Managing risk through early identification and response
- Legislative compliance monitoring
- Accountability to members/stakeholders
- Monitoring and Leading clinical quality and safety

This document is concerned with the last of these responsibilities, the governance of the quality and safety of clinical services, or as it is more commonly referred to as clinical governance.

The purpose of this document is to provide general guidelines for CEO's and Board of Management (BoM) members to enable effective reporting on the safety and quality of clinical services in community health. The guidelines and checklist can be used in orienting new BoM members or for specific clinical governance training. The guidelines can be tailored to an individual organisation by adding an organisation specific BoM reporting overview to Appendix One. This document has been prepared with the assistance of members of the VHA Board of Management Clinical Governance working group, which is part of the DHS funded Clinical Governance in Community Health Project.

2. Clinical Governance

Clinical Governance has been defined as

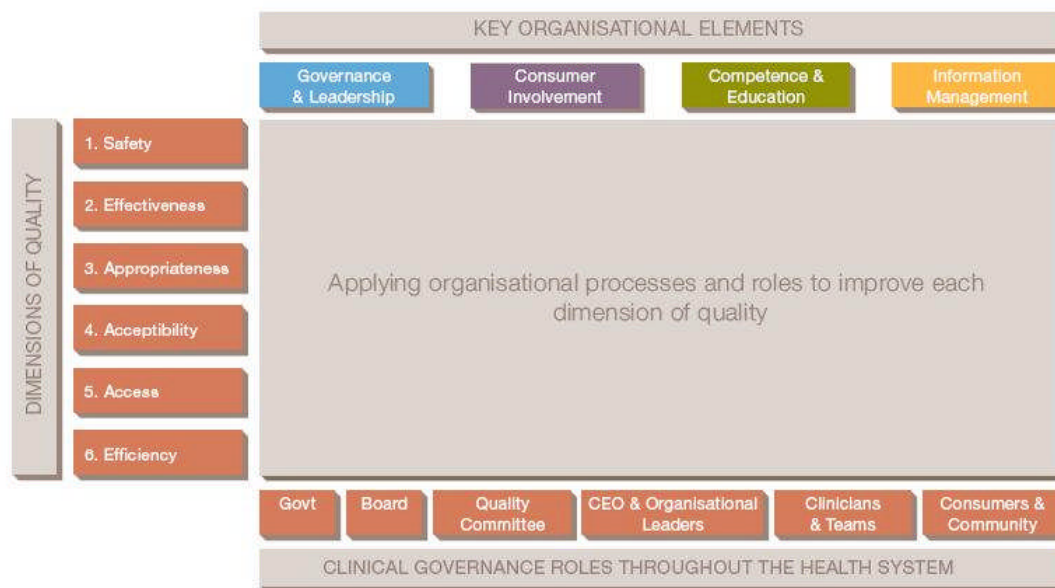
The systems by which the governing body, managers and clinicians share responsibility and are held accountable for patient or client care, minimising risks to consumers, and for continuously monitoring and improving the quality of clinical care.

(Australian Council on Healthcare Standards)

The effective governance of clinical services involves the participation of BoM, managers and staff in a range of activities to ensure the quality and safety of clinical services. In the community health context, clinical services can be seen as all those services that involve interaction with clients whether it be through intake, 1:1 consultations or group work in a variety of settings. Clinical governance requires that BoMs and managers assume the same responsibility for the safety and quality of clinical services as they do with strategic, financial and statutory obligations. The ultimate responsibility for clinical governance rests with the BoM.

The Victorian Quality Council (VQC) describes clinical governance activities in detail in the document 'Better Quality, Better Health Care' (VQC, 2005). The principles and theoretical framework for safety and quality presented in the VQC document form the basis for the approach described here to BoM reporting. The VQC framework describes the intersection between four critical organisational processes essential for quality improvement and each of the six dimensions of quality, as well as exploring related roles and responsibilities throughout the health system as seen below in figure 1.

Figure 1: Diagrammatic representation of Victorian Quality Council Safety and Quality Framework (2003)



For the purposes of this framework, the dimensions of quality are described as follows:

Safety of health care: A major objective of any health care system should be the safe progress of consumers through all parts of the system. Harm arising from care must be avoided and risk minimised in care delivery processes. This is achieved through:

- Accreditation audits (QICSA / HACCC / GP)
- Audits – eg. Infection control / Food Safety / Drug Storage
- Incident review
- Complaints review

Effectiveness of health care: Consumers of health services should be able to expect that the treatment they receive will produce measurable benefit. The effectiveness of health care relates to the extent to which a treatment, intervention or service achieves the desired outcome. Measures include:

- Evaluation of Clinical Indicators e.g. DHSV dental indicators
- Client complaint processes
- QIPPS reports

Appropriateness of care: It is essential that the interventions that are performed for the treatment of a particular condition are selected based on the likelihood that the intervention will produce the desired outcome for each patient. Essentially, the appropriateness of health care is about using evidence to do the right thing to the right patient, at the right time, avoiding over and under utilisation. Processes to ensure this include use of:

- Clinical pathways and guidelines
- Standardised assessment tools
- Client care plans
- Client record and clinical audits

Acceptability of care is the degree to which a service meets or exceeds the expectations of informed consumers. Opportunities must be provided for health consumers to participate collaboratively with health services and service providers in health service planning, delivery, monitoring and evaluation at all levels. Processes in place for achieving this dimension include:

- Strategic Planning (includes community and consumer consultation)

- Complaints monitoring
- Consumer participation e.g. client satisfaction surveys and focus groups
- Staff professional development

Access to services: Health Services should offer equitable access to health services for the population they serve on the basis of need, irrespective of geography, socio-economic group, ethnicity, age or sex. Processes in place to support access include:

- Standardise intake systems
- Service information
- Interpreter systems
- Outreach services
- Demand management systems
- Fee Policy
- Accessible buildings

Efficiency of service provision: Health services must ensure that resources are utilised to achieve value for money. Current processes addressing efficiency include:

- Service planning, reporting and evaluation frameworks
- Financial monitoring

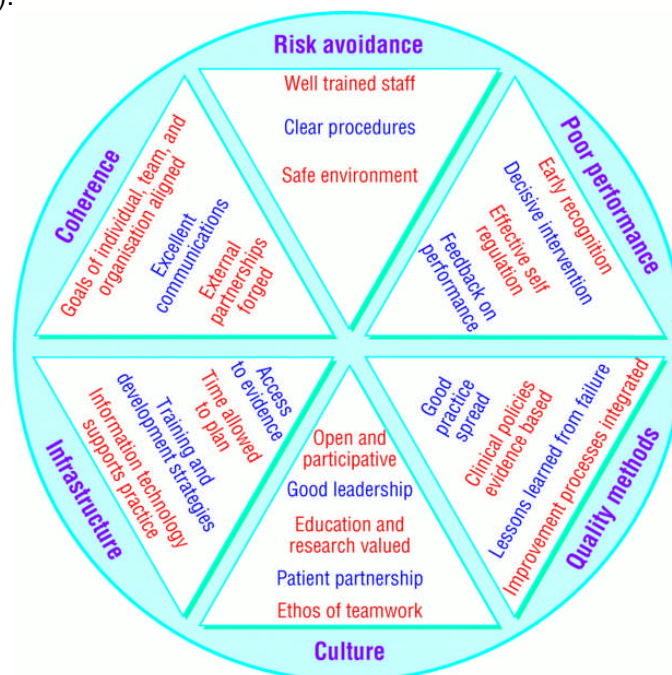
Clinical Governance is in effect a broad umbrella term for a range of activities that ensure the quality and safety of clinical services to clients.

These activities encompass and overlap with the areas of:



- Risk management
- Occupational health and safety
- Quality
- Strategic planning
- Staff development and supervision
- HR
- Information Management

The relationship between all these elements is represented in Figure 2 below by Scally and Donaldson (1998).



3. Board of Management Responsibility

The Victorian Quality Council's publication 'The Healthcare Board's Role in Clinical Governance' is a useful reference for understanding the role of the BoM (VQC, 2004). The document identifies four key principles from the literature to enable effective clinical governance:

- 2 **Just Culture** - Build a culture of trust and honesty where there is open discussion of error and where staff willingly report adverse events
- 3 **Foster Commitment** - Foster organisational commitment to continuous improvement through assigning clear responsibilities for clinical quality and safety to CEO's and managers
- 4 **Supportive Organisation Structures** - Establish rigorous monitoring and response systems
- 5 **Evaluate Performance** - Evaluate and respond to key aspects of organisational performance

These key principles and the actions required by the BoM to address each principle are elaborated on in this section.

3.1 Just Culture

Building a culture where open discussion of error is embedded in everyday practice is essential. The term 'silence kills' is pertinent to the health setting. If a culture of blame exists in a community health service then there is unlikely to be opportunities for staff to reflect and improve on clinical practice. Staff need to be able to confidently discuss concerns, near misses and mistakes in a just, open and supportive environment.

For the BoM this means that the focus on quality and safety of clinical services must be clearly articulated via the strategic plan and/or policies and procedures of the community health service. Specific policies and procedures can be introduced to support and formalise the discussion of clinical errors and risk e.g. clinical risk management policy and procedure (see policy and procedures online at www.vha.org.au in the project section) Formal structures can be put in place to ensure that clinical risk and error is routinely discussed through regular agenda items at team meetings, team planning, supervision and performance appraisals.

3.2 Foster Commitment

Organisation commitment to quality and safety is formalised through assigning responsibility for clinical governance. These responsibilities are documented in relevant terms of reference, positions descriptions and workplans. Commitment to quality and safety is further supported by appropriate orientation and training of all staff to ensure that safety and quality issues are seen to be the responsibility of all staff not just managers.

The BoM need to be satisfied that responsibilities for reporting on clinical quality and safety are clearly outlined in the community health service. This may involve modifying position descriptions (see Clinical Governance position description checklist at www.vha.org.au in the project section). The literature shows that the CEO's commitment to quality and safety influences the BoM's clinical governance performance.

3.3 Monitoring Systems

As all community health services have different structures for BoM subcommittees and internal quality and safety committees, the exact reporting structure to enable BoM governance of the quality and safety of clinical services can vary. Reporting, whether through quality, program or risk reports, must cover a comprehensive range of indicators to enable the BoM to be informed of the quality and safety of services. It is necessary that individuals and relevant committees are given clear responsibility by the BoM for reporting on quality and safety indicators and that an agreed reporting format to the BoM is developed.

The reporting to the BoM on the quality and safety of clinical services may be integrated into existing reports and structured in a number of formats such as reporting on indicators:

- Against specific monitoring, implementation and evaluation of clinical governance related policies and procedures
- Grouped according to strategic objectives
- Grouped according to key organisational areas e.g. HR, OHS, Programs and Services.

As with any report to the BoM there needs to be a distinction between detailed operational reporting required at a management level and the BoM overview required for effective governance. While effective clinical governance does not require the creation of additional reports, modification of more frequent, detailed quality and safety operational reporting at a management level is required to provide a BoM overview. Table One below provides an example of the different formats for organisational reporting and BoM reporting on two indicators relevant to clinical governance. The shaded area highlights the abbreviated version of the management report given to the BoM. Depending on the structure of your organisational reporting, these indicator reports to the BoM may form part of a program specific report, a quality committee report or a report against policy implementation

Indicator	Management report format	Audit Frequency	Responsibility for audit	Audit Results Reported to	BOM report format	BOM report frequency
Complaints	No. and type of complaints and response time	Annual	Quality Coordinator	Quality Committee	Summary of audit findings, trends and recommendations	Annual
File audits	No. of audited files meeting set requirements	Annual	Program Manager	Quality Committee	Summary of audit findings and recommendations	Annual

Table 1: Example of quality and safety indicator reporting at organisational and BoM level

The checklist provided in section 6 is a useful tool that lists suggested indicators for your service to use in reporting to the BoM on the quality and safety of services. The checklist can be used to determine if quality and safety indicators are currently reported on regularly in existing reports to the BoM and if additional indicator reporting needs to be included to allow effective clinical governance.

Ultimately the BoM needs to be assured that monitoring and evaluation of clinical quality and safety via audits and reports is occurring regularly and the results/trends are within or outside of acceptable limits or parameters.

3.4 Evaluate performance

This principle involves the active evaluation of the community health services response to quality and safety issues. The BoM can use a range of qualitative and quantitative methods to monitor performance. This may involve formal evaluation of the BOM clinical governance performance through accreditation or other external evaluation. The BoM may also be involved in benchmarking and comparing organisational performance to enable sharing of lessons learned in the community health sector and broader health sector. The checklist provided in Section 6 can be used as an audit tool of clinical governance.

4. References

G Scully and LJ Donaldson (1998) *Clinical Governance and the drive for quality improvement in the NHS in England*, BMJ, Volume 317.

Victorian Quality Council. (2003), Better Quality, Better Health Care, A Safety and Quality Improvement Framework for Victorian Health Services, Metropolitan Health and Aged Care Services Division, Department of Human Services: Melbourne.

Victorian Quality Council, (2004) The Healthcare Board's role in clinical governance , Metropolitan Health and Aged Care Services Division, Department of Human Services: Melbourne.

5. Resources and Links

A range of resources and links can be found at www.vha.org.au under the projects section and Clinical Governance Project.

6. BoM Clinical Governance Reporting Checklist

The checklist below provides suggestions for reporting to the BoM on the quality and safety of clinical services from which services can review and develop their own reporting structure and format. Organisations can use the checklist to review current reports to the BoM to determine if the BoM is receiving adequate information to inform the process of clinical governance. A comprehensive range of indicators has been provided that reflect the main activities that relate to the quality and safety of clinical services. Not all indicators will be relevant to all organisations or services. The reporting frequency presented in the checklist is only a minimum suggested frequency and organisations may require more frequent reporting.



BOARD OF MANAGEMENT CLINICAL GOVERNANCE REPORTING CHECKLIST

The table below provides suggestions for reporting to the Board of Management (BoM) on the quality and safety of clinical services using a key result area report structure (see Clinical Governance Guidelines section 3.3). The suggestions for reporting indicators and their reporting frequency are intended as a guide only to assist BoM to develop their own Clinical Governance Reporting system suitable for the specific requirements of their community health service.

How to Use the Checklist

- Using the checklist review current reports (quality and safety, risk, program etc) to the BoM to determine if the BoM receiving adequate information on the quality and safety of services
- Analyse the audit results and determine how any additional reporting on indicators needed for effective clinical governance will be structured in your agencies governance reporting framework
- Checklist can also be used as an audit tool on BoM Clinical Governance performance

INDICATOR	DESCRIPTION OF INDICATOR	SUGGESTED MINIMUM REPORTING FREQUENCY
Governance		
1. Accreditation Reports	Summary of Accreditation Report, recommendations and action plan/Quality Work Plan. May include QICSA, RACGP, HACC etc.	Every 3 years
2. Strategic Plan Report	Evaluation of progress of strategic plan	Annually
3. Business/Operational Plan	Evaluation of progress of annual business/operational plan	Annually
4. Risk Management Plan / Report	Identifies main risks for organisation, current controls and plans to minimise risk. Could be a stand alone report or be included in each program area report as part of a standardised BoM reporting approach	Annually or as required
5. Insurance Reports	Outlines current insurance coverage for organisation i.e. VMIA, motor vehicle, Workcover etc. Could be part of an annual Internal Audit of Corporate Services	Annually
6. Legislative Compliance Report	Outline of work undertaken during the year to ensure compliance with new and existing legislation ie audits / improvement projects / staff training etc. Could be part of a Corporate Services Report	Annually or as required
7. DHS Quality of Care Reports	Quality of care report provides opportunity for community health service to work with community and report annually on quality & safety of services	Annually
8. Quality Improvement Project Reports	Progress Evaluation of Quality projects. May include report against the Quality Workplan as required by accreditation bodies or other projects that have occurred	As timetabled



BOARD OF MANAGEMENT CLINICAL GOVERNANCE REPORTING CHECKLIST

INDICATOR	DESCRIPTION OF INDICATOR	SUGGESTED MINIMUM REPORTING FREQUENCY
Human Resources Management		
9. Professional Development Report	May include: <ul style="list-style-type: none"> ▪ Hrs/EFT/Program ▪ Key organisational training areas ▪ Mandatory training achieved e.g. CPR Might be part of a larger HR report	Annually
10. Recruitment and Retention Report	May include audit of systems: <ul style="list-style-type: none"> ▪ Recruitment processes i.e. Credentials checks / Police checks / Drivers License checks ▪ Scope of Practice reports ▪ Staff Turnover rates ▪ Sick Leave rates ▪ Exit reports Might be part of a larger HR report	Annually
11. Staff Satisfaction Survey	May include summary of findings, recommendations for improvements and projected timelines. Stand alone report or part of HR report	Every 3 years
12. Performance Appraisals	May include summary of <ul style="list-style-type: none"> • % of staff with completed performance appraisals • Recommendations for process improvement / changes to business processes / focus for professional development Might be part of a larger HR report	Annually
13. Professional Supervision Report	May include information regarding % staff receiving recommended regular individual or group supervision Might be part of a larger HR report	Annually
Client Services		
NB The clinical governance indicators presented in this section could be structured as part of a comprehensive individual service/program/discipline report to the BOM which also included information about service model improvements, Quality improvement projects, scope of practice issues		
14. Client Access Report	Outline of current client profile: <ul style="list-style-type: none"> ▪ Age / Postcode / COB / ATSI usage / age / gender / language / HCC holder ▪ Barriers to access etc.. ▪ Interpreter usage Might be done as a stand-alone report or incorporated into Service / Program reports	Every 3 years



BOARD OF MANAGEMENT CLINICAL GOVERNANCE REPORTING CHECKLIST

INDICATOR	DESCRIPTION OF INDICATOR	SUGGESTED MINIMUM REPORTING FREQUENCY
15. Demand Management Report	May include: <ul style="list-style-type: none"> ▪ Waiting lists ▪ Referral patterns Might be done as a stand-alone report or incorporated into Service / Program reports	Annually
16. Activity Reports	Include reports, where available, against performance targets	Quarterly
17. Integrated Health Promotion Report	Progress on integrated health promotion plan	Annually
18. Clinical Indicator Reports	Where available e.g. dental Might be done as a stand-alone report or incorporated into Service / Program reports	Annually or as required
19. Complaints and Compliment Reports	Collated report against issues using Health Services Commission classifications Resulting quality improvement activities / system change Reported over time i.e. comparative figures Stand alone report	Six monthly
20. Clinical Audit Reports	Summary of formal evaluation of clinical practice against clinical pathways/guidelines	As required
21. Medication Safety Audits – licence, registration	Summary of findings and recommendations followed by management response and action plan Might be done as a stand-alone report or incorporated into relevant Service / Program reports	Six monthly
22. External Reviews (eg. DHSV Record Audits)	Summary of findings and recommendations followed by management response and action plan Might be done as a stand-alone report or incorporated into relevant Service / Program reports	As occurs
23. Client Engagement & Participation Reports	May include: <ul style="list-style-type: none"> ▪ Collation of survey reports including PHCCOS ▪ Volunteer Report ▪ Results of any client / community focus groups ▪ Client participation in any planning initiatives ▪ Organisation Membership numbers ▪ Community events etc... Might be done as a stand-alone report or incorporated into relevant Service / Program reports	Annually
24. Co-located and subcontracted services report	Report of collocated services, complaints, issues, terms of lease agreements	At contract renegotiation



BOARD OF MANAGEMENT CLINICAL GOVERNANCE REPORTING CHECKLIST

INDICATOR	DESCRIPTION OF INDICATOR	SUGGESTED MINIMUM REPORTING FREQUENCY
25. Student Services (student no's, effect on client no.s)	Summary of student activity. Might be done as a stand-alone report or incorporated into Service / Program reports	Annually
Information Management		
26. Client Records Audits	Summary of findings and recommendations followed by management response and action plan	Annually
27. FOI Request Report	Copy of report forwarded to Health Services Commissioner May be part of a Corporate Services Report or a stand alone report	Annually
28. Policy & Procedure Update Report	Copy of index of policies & procedures plus timelines for updating and reviewing	Six monthly
Client Health and Safety		
29. Health & Safety Report	To include: <ul style="list-style-type: none"> ▪ Equipment maintenance report ▪ Workplace site inspection report May be part of a Corporate Services Report or a stand alone OHS report	Annually
30. Client Incident Reports	Incident report could include: <ol style="list-style-type: none"> a. CHS Category 1 incidents reported b. Summary of organisation incident findings, key issues, recommendations and action plan for improvement 	<ol style="list-style-type: none"> a. In month of occurrence b. Six monthly
31. Infection Control Report (incl. cleaning, sterilising etc.)	May include: <ul style="list-style-type: none"> ▪ Sterilising audit findings ▪ Cleaning audit findings ▪ Food Audit findings ▪ Improvement initiatives ▪ Any external audit findings Might be done as a stand-alone report or incorporated into relevant Service / Program reports	Annually



BOARD OF MANAGEMENT GOVERNANCE REPORTING

Appendix One

Insert your organisation's governance reporting framework here