

A New Framework for Clinical Governance in Queensland Health

Discussion Paper

Please provide any comments on the proposals in this paper by 19 May 2006.

Comments can be lodged on the web <http://www.health.qld.gov.au/clinicalgov> or mailed to:

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Queensland Health

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Background

1. This paper outlines a proposed new framework for clinical governance in Queensland Health.
2. The existing arrangements for clinical governance of Queensland Health services were the subject of trenchant criticism in the Forster Report. In particular, Forster recommended “comprehensive reformsto result in Queensland Health having a vastly improved clinical governance system in which the community can have confidence. It will include improved:
 - Recruitment and selection processes;
 - Credentialing privileges;
 - Incident monitoring reporting;
 - Involvement of clinicians in enhancing practice and comprehensive multi-disciplinary clinical audits”.
3. The Forster Review provided extensive recommendations about improving the clinical governance arrangements in Queensland. Similarly the Davies Report also drew attention to weaknesses in the existing Queensland Health processes.

The Queensland clinical governance approach

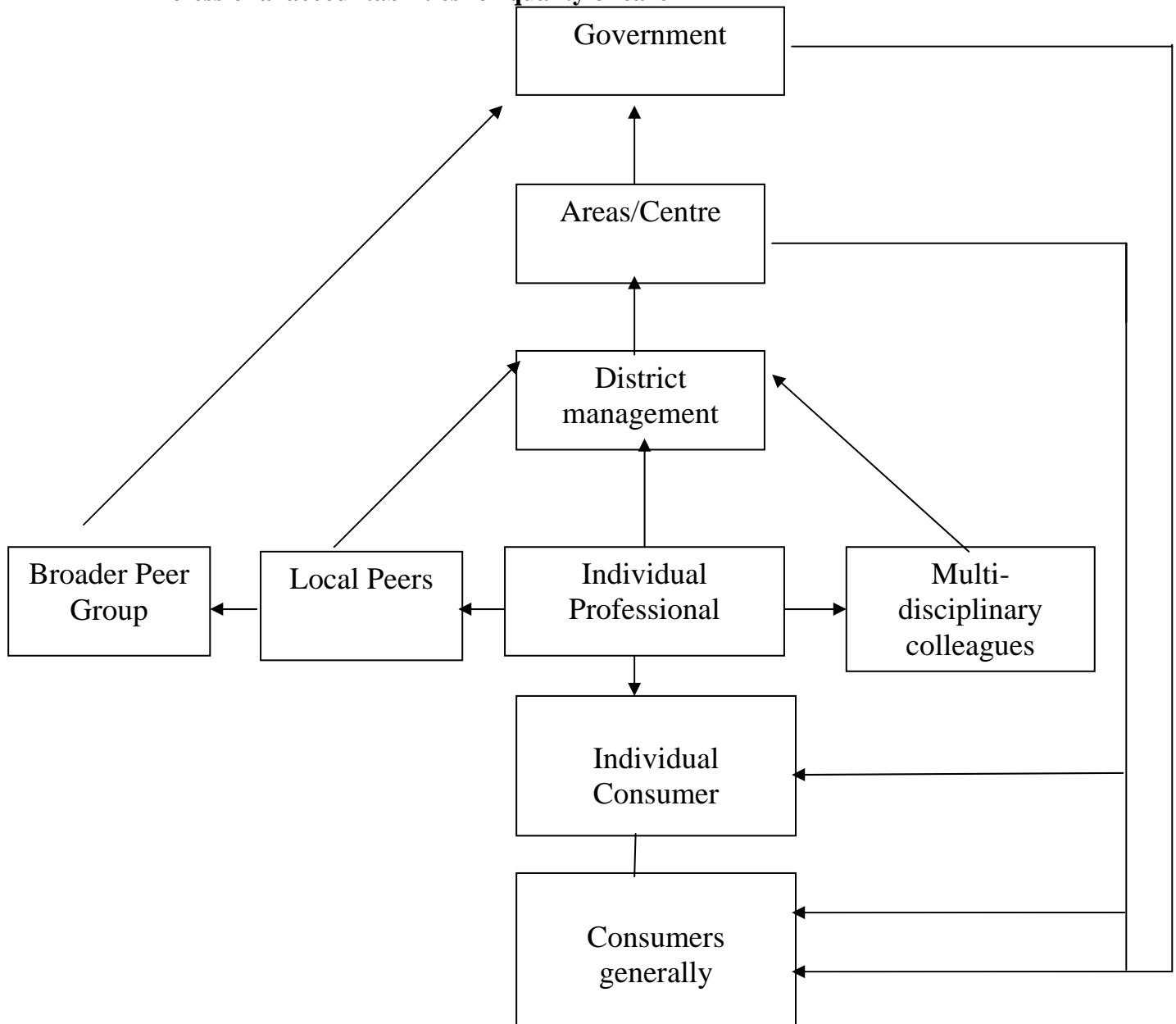
4. The Queensland Health clinical governance framework is the web of policies, processes and accountabilities which are directed at improving patient safety and the quality and effectiveness of Queensland Health services.
5. The following elements are fundamental to the Framework:
 - 5.1 Line management responsibility for patient safety and quality;
 - 5.2 Clinician and patient involvement;
 - 5.3 A just and open approach for managing adverse events;
 - 5.4 Responsibilities articulated for all levels of Queensland Health;
 - 5.5 Measurement of outcomes and performance;
 - 5.6 Transparency and accountability; and
 - 5.7 An emphasis on the need for Queensland Health to improve its performance in patient safety, quality and effectiveness.
6. The key functions to be performed as part of clinical governance are:
 - 6.1 Pro-active analysis of risks (taking into account environment and role) and identification of strategies, activities and organisational processes to eliminate or mitigate risks;
 - 6.2 Support (including training, advice) to staff and District Health Services to manage the processes of clinical governance;
 - 6.3 Monitoring of compliance including measurement of performance and reporting internally and externally
7. This discussion paper outlines the assignment of these clinical governance functions to each of the organisational levels of Queensland Health.

8. The Queensland Health Clinical Governance Framework is predicated on line management responsibility for clinical governance functions. This means that responsibility for clinical governance at the local level rests with local supervisors, in turn accountable to the District Manager, in turn accountable to the Area General Manager, in turn accountable to the Director General. There are specific accountabilities at each of these levels. Super-ordinate levels also have responsibility to measure and assess whether subordinate levels are fulfilling their responsibilities.

Accountability of clinicians

9. There are many formal and informal accountability relationships relating to the quality of care provided by clinicians. These are summarised in the following figure.

Professional accountabilities for quality of care



10. The individual clinical professional clearly has accountability to the patient or consumer.
11. However, the individual clinician also has accountability to the employer, Queensland Health, through the District management.
12. Employment accountability is supplemented by accountability of the clinician to professional peers through organised specialty or unit meetings in a hospital, for example.
13. The clinician is also accountable to a broader peer population through specialist societies and to the relevant professional registration body for his or her actions. In Queensland Health this may also occur through Clinical Networks.
14. Clinicians who work in multidisciplinary teams should also be accountable to the team.
15. Hospitals and District Health Services have an accountability relationship to a broader group of potential consumers through the District Health Council. This may involve the publication of comparative performance measures.
16. There is also accountability of government to consumers.

The role of the clinical service and the facility

17. The clinical unit, centre or service is the basic building block of all health services. It is the immediate level within which patients are treated, where the various disciplines in the hospital (medical, nursing and allied health personnel) come together to treat and care for patients. Clinical services should structure formal opportunities for multi-disciplinary audit and review processes as a means of ensuring that services are safe, effective and of high quality.
18. Facilities also have groupings of staff from the same profession. These groupings provide the setting for peer review and audit.
19. The formality of review practices in departments and services will vary across facilities. In larger hospitals, clinical teams will have organised clinical review programs, larger groups of medical staff will have formalised organisational structures which provide for the accountability of medical staff within that discipline.
20. Smaller facilities will still require formalised structures but they will be less elaborated.

The role of the District Health Service

21. Important as the team and facility level structures are, the critical *accountability* level within the Queensland Health organisational hierarchy is the District Health Service. The District Health Service is the fundamental reporting entity of

Queensland Health and District Health Service Managers (or Clinical CEOs) have clear formal accountabilities within the organisation.

22. All District Health Services will establish a District Quality and Safety Committee as the peak body advising the District Health Service Manager/Clinical Chief Executive Officer on all matters relating to clinical governance. It is recommended that these committees have at least one consumer member.
23. The critical task of District Health Services is to develop and implement a *clinical risk management plan*. This plan will outline how the core components of clinical governance are to be effected within the District Health Service.

A. The proposed framework relies heavily on District Health Services developing clinical risk management plans.

Do District Health Services have the skills and resources to do this?
Will there be a training need here?

Is there a need for enhanced information system support?

24. Implementation strategies and organisational structures will need to take account of community expectations and the role of facilities within the District Health service and will therefore vary from smaller to larger District Health Services.
25. Larger District Health Services and District Health Services which are engaged in more complex clinical activities can be expected to have more sophisticated structures of clinical governance to provide for the oversight of those activities.
26. District Health Services will be required to publish an annual report on the quality and safety of services within the District Health Service. The draft of this report must be provided to the relevant District Health Council. The Quality and Safety Report must include commentary on the set of clinical indicators specified by the Department.

The District Health Service clinical risk management plan

27. The District Health Service clinical risk management plan must:
 - 27.1. Address all elements of clinical risk relevant to the District Health Service's role and environment and the Clinical Service Capability Framework.
 - 27.2. Specifically include detail of how the functions listed below will be managed.
 - 27.3. Include a clear statement of responsibilities and accountabilities for managing risks.
 - 27.4. Provide opportunities for clinical staff and patients to engage in the clinical governance of the District Health Service.

B. The approach taken to the District Health Service Clinical Risk Management Plan specifies mandatory requirements but is generally permissive in how District Health Services meet these requirements.

Should the policy be more specific eg. about committee composition, clinical review processes?

Should a template for a Clinical Risk Management Plan and associated committee Terms of Reference be developed?

28. Smaller District Health Services may develop their clinical risk management plans jointly with other District Health Services and establish joint processes addressing the required components below.

Credentialing and privileging

29. Credentialing and privileging of staff involves:
- 29.1. Ensuring that all new medical staff (and other staff practising in extended roles or undertaking advanced procedures) are assessed in terms of their competence at the time of employment;
 - 29.2. Clearly specifying the range of procedures and/or patients for which the clinician will have admitting rights; and
 - 29.3. Reviewing and respecifying these elements on a regular basis.
30. Specification of privileges should be done in a way which allows monitoring (e.g. Diagnosis Related Groups, Service Related Groups, specific ICD10 AM procedures and/or diagnoses) and sufficiently refined to be demonstrably related to the specific credentials, experience and skills of the practitioner.
31. The Area Credentialing and Privileges Committee is accountable for ensuring that all relevant staff are appropriately credentialed and have privileges assigned.
32. A medical officer may not be granted privileges in a discipline unless a Fellow of the relevant College (or a person recognised as a specialist in the specialty) has been consulted.
33. Clinical staff must not commence work unless the credentialing and privilege process has been completed or a written interim determination has been made by the Executive Director of Medical Services under delegation from the Area Credentialing and Privileging Committee.
34. An interim determination, which must be reported to the next meeting of the Area Credentialing and Privileging Committee, can be for a period of no more than three months, with no extension possible.
35. Clinical staff should have their privileges reassessed on a regular basis, at least every three years.
36. Clinical staff must provide evidence of appropriately accredited professional development when seeking renewal of clinical privileges.

37. The credentialing and privileging process is to be undertaken within the context of the facility's designated role in accordance with the Clinical Service Capability Framework, and privileges should not be approved outside the facility's designated role.
38. The Executive Director of Medical Services of the District Health Service should monitor using quantitative data from the hospital morbidity system that medical staff are working within the privileges that they have been granted. This monitoring should occur at least annually.
39. There should be a parallel assessment and feedback process for all trainee medical staff at least annually.

Clinical review and audit

40. All clinical staff should participate in clinical review and audit activities.
41. Similarly, the work of all clinical staff should be subject to review and audit.
42. The clinical risk management plan must outline the processes whereby clinical review takes place within facilities. The District Health Service review process must include both opportunities for multi-professional review in addition to any single professional review process.
43. Review will take two main forms: proactive review of indicators (such as reported complications, adherence to agreed processes); and specific reviews of adverse events.
44. Audit should also be a regular part of District Health Service activity. There are a number of appropriate forms of audit and reviews of indicators (grand rounds, death and mortality reviews etc) and an individual within each clinical unit should be designated as responsible for organising such reviews. Where appropriate review presentations should be multi-disciplinary. The Clinical Risk Management Plan must specify the audit strategy for all clinical units of the District Health Service's facilities.
45. As a minimum, the audit program for a District Health Service must include review of all Severity Assessment Code 1 events (as defined in the Clinical Incident Implementation Standard) i.e. all defined sentinel events.
46. Adverse event review must take place in accordance with the Queensland Health Incident Management Policy and associated Implementation Standards.
47. The District Health Service clinical risk management plan must identify processes to be used to review clinical indicator data supplied to the District Health Service by the Quality Measurement and Strategy Unit, clinical networks and/or by the Australian Council on Healthcare Standards.
48. Reports on audits and reviews undertaken within the District Health Service will be provided to the District Safety and Quality Committee.

49. The Committee will monitor:
 - 49.1. Implementation of actions from reviews and audits;
 - 49.2. The extent of audit/review activity within each aspect of District Health Service activity;
 - 49.3. Coronial and medico-legal issues;
 - 49.4. Trends and patterns of adverse events and complaints.
50. The Committee will provide a quarterly report to the District Health Council on safety, quality and effectiveness issues including qualitative and quantitative information, actions to address issues identified, progress on implementation and outcomes.
51. The clinical risk management plan must also specify:
 - 51.1. Governance processes for infection control and medication safety;
 - 51.2. The names of committees (and terms of reference) for committees currently or proposed to be gazetted as Quality Assurance Committees under the Health Services Act 1991.

Education and research

52. Clinical staff should be actively engaged in ensuring that their practices are up-to-date. Where a clinical network has been established involving broad involvement in a specialty (or where a collaborative program has been developed) all relevant staff should aim to participate in such a process.
53. Staff should also be engaged in systematic ways of improving their skills and be able to demonstrate their activities in this regard. This may include use of the Skills Development Centre (see below) or seeking mentoring from an external colleague.
54. All District Health Services have responsibilities in the education of future generations of staff and structures should be in place to ensure that the education provided to these students is appropriate.
55. District Health Services should also ensure that there are systems in place to monitor the effectiveness of educational support for, and professional supervision and guidance of, International Medical Graduates.
56. Clinicians in larger hospitals also have a responsibility in research in part to ensure that staff of the unit remains abreast of developments in their specialty to ensure that the practices of the hospital represent contemporary world best practice.

<p>C. Is this the appropriate emphasis on education and research in clinical governance?</p>
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Consumer complaint management

57. The District Health Service Clinical Risk Management Plan will outline how the District will implement the Queensland Health Consumer Complaints Management Policy.
58. The District Health Service Manager will provide a monthly report to the District Health Council outlining de-identified qualitative and quantitative information on consumer complaints, actions to address issues identified through this process, progress on implementation and outcomes.

D. The Discussion Paper lists mandatory components of the clinical risk management plan as credentialing and privileging, clinical review and audit, education and research and consumer complaints management. Is this the right list of mandatory components?

Managing medical staff performance

59. In line with Queensland Health policy, medical staff must have an annual performance appraisal.
60. The appraisal process should include self-assessment by the medical practitioner of:
 - 60.1. Clinical indicator data collected by the staff member's clinical unit, provided by the Quality Measurement and Strategy Unit, relevant clinical networks, Queensland Cancer Control Analysis Team and/or by the Australian Council on Healthcare Standards;
 - 60.2. Where appropriate, publicly released material from the Queensland Audit of Surgical Mortality, the Queensland Paediatric Quality Council, the Queensland Maternal and Perinatal Quality Council and the Queensland committee to enquire into peri-operative deaths; and
 - 60.3. Where appropriate, coronial and medico-legal data.
61. Overtime, the performance assessment process should move to a 360 degree feedback process incorporating:
 - 61.1. assessment by colleagues and subordinates from within the same disciplines
 - 61.2. the views of colleagues in the clinical team from other disciplines, such as nursing; and
 - 61.3. Consideration of patient feedback over the reporting/reassessment period;
62. Clinicians will be able to request data about their own performance (where it is identifiable) from the Quality Measurement and Strategy Unit within the Reform and Development Division. These data will enable clinicians to track their own performance in terms of outcomes. Clinicians will need to develop a clear specification of the outcome measures to be tracked and the procedures or diagnoses to be evaluated.
63. A critical component of the District Health Service's role is managing medical staff performance; this entails both routine pro-active processes such as the

appraisal processes outlined above, as well as *ad hoc* processes for dealing with problems when they arise.

64. Responsibility for managing diminished performance of medical staff normally rests with the Executive Director of Medical Services and the District Manager, although in larger hospitals it is also a function of Division heads.
65. Area Clinical Governance Units will engage consultant medical expertise to provide advice and recommendations to District Health Service Managers and Executive Directors of Medical Services in the process of managing poor medical staff performance. However, the District Health Service Manager will remain the decision maker.
66. An Area clinical consultant will be available to assist District Health Services in identifying peers, with appropriate skill and training, who can provide advice and recommendations when concerns are raised about a clinician's performance.

E. Does the approach in the Discussion Paper reflect contemporary best practice in performance appraisal of medical staff?

Should there be greater uniformity across Queensland Health eg. by specifying the dimensions of appraisal such as using the CanMeds roles framework of the Royal College of Physicians and Surgeons of Canada?
Are there other approaches which should be adopted?

Is there a training requirement here?

Should the approach to medical staff performance appraisal be specified in the clinical risk management plan?

The role of the Area

67. Area General Managers have the responsibility of monitoring compliance and performance and supporting the District Health Service clinical governance functions.
68. Areas will establish Clinical Governance Units to assist the General Manager in the discharge of these functions.
69. The leadership of District Health Services sets the tone and culture for clinical governance within a District. It is therefore important the performance appraisal of District Managers undertaken by the Area General Managers, specifically addresses the performance of District Health Services in terms of clinical governance, patient safety and quality.
70. This performance appraisal should be informed by the District Health Service's annual quality report and the District Health Services formal response to performance indicator information provided by the Quality Measurement and

Strategy Unit, together with the responses by the District Health Service to identified improvement opportunities.

F. Is there a requirement to change the Position Descriptions of District Health Service Managers to emphasise their roles in patient safety & quality?

Support

71. Area Clinical Governance Units will provide support to District Health Service Managers and senior staff in District Health Services to assist District Health Service staff in their clinical governance roles. This support might include:
 - 71.1. Advice to District Health Service executives on the appropriate path (blame worthy, system investigations, individual performance review) to be followed in response to a clinical incident;
 - 71.2. Sources of data and performance indicators that might be used in monitoring activities of clinical units;
 - 71.3. Assistance in interpretation of data supplied by the Quality Measurement and Strategy Unit;
 - 71.4. Prompt external clinical review when concerns are expressed about clinician performance;
 - 71.5. Facilitating exchange of information amongst District Health Service staff on strategies to improve performance, clinical governance issues etc;
 - 71.6. Facilitating, for smaller District Health Services, joint clinical risk management plans and joint clinical governance processes;
 - 71.7. Developing Area-wide staff development and patient safety programs;
 - 71.8. Managing the process for seeking approval for gazettal of committees as Quality Assurance Committees under the Health Services Act 1991.

G. Are there other forms of support that should be provided?

72. Areas will establish Credentialing and Privileges Committees to have responsibility for credentialing all new appointees within the Area and to assign privileges to these appointees.
73. The Area Privileges Committees may function through District Health Service sub-committees.

Compliance and performance

74. A key role of the Areas will be to approve the District Health Service clinical risk management plan.
75. As part of this approval process, the Area General Manager must ensure that structures and processes have been developed for all of the core clinical governance activities required by Queensland Health policy.

76. Area Clinical Governance Units will review reports from external accreditation agencies such as the Australian Council of Health Care Standards (ACHS) and medical colleges and specifically consider any recommendations to District Health Services by such agencies which signal patient safety issues.
77. In the case of ACHS reports, the Area will monitor closely High Priority Recommendations and any situations where a facility does not achieve a grading of Moderate Achievement on a mandatory criterion.
78. Areas will also review progress of District Health Services in addressing issues identified in reports provided by the Quality Measurement and Strategy Unit.
79. Areas will refer initial notifications of incidents to District Health Services to be managed in accordance with the Queensland Health Incident Management Policy.
80. The Area Clinical Governance Units will develop processes for receiving and managing staff initiated complaints where the staff member believes that District processes have failed to produce satisfactory actions.
81. The Area Clinical Governance Units will develop processes to support, monitor and audit District consumer complaints management processes

H. Are there ways in which the proposed compliance framework could be strengthened to ensure that patient safety issues in facilities are detected quickly and addressed?

Accountability

82. Areas will report to the Patient Safety & Quality Board about:
 - 82.1. any critical issues affecting patient safety in any of the relevant District Health Services (monthly);
 - 82.2. action being taken by District Health Services in response to reports provided about performance on key clinical indicators (quarterly); and
 - 82.3. trends in and issues arising from consumer complaints (quarterly).

The role of the Corporate Office and other central units

Support

83. The Skills Development Centre in Brisbane and through its Affiliate Centres across the state will provide structured programs to assist staff to develop their skills (including communication skills) in a simulated environment. The Centre will accept referrals from District Health Services or self referrals. In the case of self referrals, this can be on a confidential basis.
84. Clinical networks will:
 - 84.1. Offer advice to District Health Services and Areas on appropriate metrics to be used in measuring performance of clinical units;
 - 84.2. Develop and implement state-wide safety initiatives;

- 84.3. Develop quality and safety benchmarking processes and involve District Health Service clinicians in the discussion and interpretation of benchmarking data;
 - 84.4. Provide advice on contemporary evidence-based care paths and protocols; and
 - 84.5. Undertake clinical audits.
85. The Clinical Practice Improvement Centre will be available for advice and practical support in the collection and analysis of clinical outcomes data that may be required for the assessment of team and individual clinician performance.
86. The Quality Measurement and Strategy Unit in the Reform and Development Division will provide:
- 86.1. Clinical indicator data to District Health Services on a monthly basis (lagged by eight weeks from the end of the month), together with quarterly and annual aggregations. For larger units, these monthly data will be presented in a way which highlights statistical differences;
 - 86.2. A quarterly Area Action Report highlighting clinical indicators where District Health Service performance is aberrant. The Unit will also provide a similar report to the Patient Safety and Quality Board;
 - 86.3. Quarterly and annual reports to clinical networks on key clinical indicators;
 - 86.4. Reports on individual clinician or clinical unit performance on request.
87. The Patient Safety Centre will provide a range of support and advisory functions to District Health Services, Areas and Executive Management Team:
- 87.1. At a District level:
 - 87.1.1. Deployment, training and support of a network of 37 Patient Safety Officers.
 - 87.1.2. Training package development and implementation in Root Cause Analysis, Human Error Awareness, for staff and students.
 - 87.1.3. Develop and maintain a state-wide clinical incident information system with district reporting capabilities.
 - 87.1.4. Advice and decision-support to leadership in responding to patient safety incidents and problems.
 - 87.2. At an Area/Network level:
 - 87.2.1. Reporting to support clinical governance activities including tracking sentinel events, corrective actions and outcomes;
 - 87.2.2. Ensure coordination of state-wide safety improvement activities.
 - 87.3. At a State level:
 - 87.3.1. Develop and implement State-wide Alerts and Advisories;
 - 87.3.2. Report on State-wide vulnerabilities and proposed corrective actions.

<p>I. Are there other forms of support which should be provided?</p>
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Compliance and performance

88. Oversight of the Queensland clinical governance framework will be vested in a reconstituted Patient Safety and Quality Board to advise the Director-General on all matters relating to patient safety, quality and effectiveness.
 89. The key functions of the Board are:
 - 89.1. To identify system-wide/ substantial organisational risks in relation to safety and quality and approve mitigation strategies. (Substantial organisational issues include these adverse events which are high mortality, high morbidity, high frequency and/or high cost);
 - 89.2. To promote improvement in effectiveness of health care;
 - 89.3. To assess Area Health Service responses to safety and quality issues.
 90. The Board will receive:
 - 90.1. Quarterly reports from Areas;
 - 90.2. Quarterly statistical reports on trends in key clinical indicators;
 - 90.3. Reports on development of patient safety, quality and effectiveness issues nationally, including any proposals from the Australian Commission on Safety and Quality in Healthcare or the Coroner;
- J. Is this the right composition and role for the peak clinical governance body in Queensland Health?
91. Consistent with the principle of emphasising line accountability, the Patient Safety and Quality Board will be reconstituted to consist of:
 - 91.1. The Director-General or nominee (chair);
 - 91.2. The Area General Managers;
 - 91.3. The Chief Health Officer;
 - 91.4. Three Queensland-based clinicians appointed by the Director-General:
 - 91.4.1. One following consultation with the Committee of Presidents of Medical Colleges;
 - 91.4.2. One following consultation with the Royal College of Nursing (Australia);
 - 91.4.3. One following consultation with the Health Professions Council of Australia;
 - 91.5. One person appointed by the Director-General following consultation with the Queensland Consumer Health Council;
 - 91.6. A clinical academic appointed by the Director-General following consultation with the Queensland Vice-Chancellors' Committee.
 92. Members of the Patient Safety and Quality Board (other than the Area General Managers and the Chief Health Officer) will be appointed for a three year term.
 93. The Patient Safety and Quality Board will provide an annual report on quality of care in Queensland hospitals.
 94. Initial notifications of incidents received in the corporate office and other central units will be referred to District Health Services to be managed in accordance with the Queensland Health Incident Management Policy.

95. Complaints about Area supervision of District management of incidents will normally be referred to the Health Quality and Complaints Commission.

Next steps

96. This paper sets out proposed approaches to governance to improving patient safety, quality and effectiveness of health care in Queensland Health facilities. Once the consultation period has been completed, the approaches contained in this paper will be revisited and definitive policies developed. These will be implemented via new Policy Statements, operating procedures and so on. These changes should be in place later this year.

Related Policies

- Clinical networks (see http://www.health.qld.gov.au/cpic/documents/Networks_Policy.pdf)
- Incident management (draft policy at http://qheps.health.qld.gov.au/psc/documents/im_policy_v2_07.pdf)
- Consumer Complaints Management (current policy, which is being revised, is at <http://www.health.qld.gov.au/complaints/documents/15184CMP&I.pdf>)
- Performance Appraisal (see http://www.health.qld.gov.au/industrial_relations/Masters/HSD/hsd_01_98.pdf)
- Integrated (HR/IR) Resource Manual (IRM) (see http://www.health.qld.gov.au/industrial_relations/irm_menu.asp)

K. The public will have a critical involvement in the Clinical Governance Framework through District Health Councils and public reporting.

Consumer complaints management is also an integral part of the framework. Does this give consumers an adequate voice in the new framework?

L. Are the overall information flows described in the document adequate to support good clinical governance? Are additional data collections required?