Quality and Safety Strategy
2019-2021
10. Quality and Safety Governance Committee Structure

10.1 Quality and Safety at a Regional Level

10.2 Quality and Safety at an Organisational Level

11. Obligations

11.1 Statutory obligations

11.1.1 Board Charter

11.1.2 Contractual obligations

11.1.3 Accreditation and Regulatory obligations

11.1.4 Attestation statement

12. Health Service Directive Obligations

13. Consultation

14. Approval governance pathway

14.1 Document author

14.2 Document custodian

14.3 Endorsing committee/position

14.4 Approving officer

15. Effective dates

16. Version control

17. Evaluation criteria

18. Appendix
1. **Introduction**

Torres and Cape Hospital and Health Service (TCHHS) is the most northerly of Queensland's Hospital and Health Services and covers over 158,000km² across 13 local government areas.

Our Vision is to provide high quality health care that delivers measurable improvements in the health of people in the communities of Torres Strait and Cape York.

Our Purpose is to:

- Honour the Aboriginal and Torres Strait Islander cultures
- Work in true partnership with communities and other organisations
- Be a leader in providing high quality, innovative and effective remote health services

TCHHS is one of Australia's largest providers of health services to Aboriginal and Torres Strait Island peoples, serving a population of 25,000, of which 63.7% identify as Aboriginal and/or Torres Strait Islander. The northern boundary is adjacent to Papua New Guinea.

2. **About the Strategy**

2.1 **Purpose**

This strategy is underpinned by the:

- **TCHHS Health Service Plan 2016 – 2026.**
- **TCHHS Strategic Plan 2015 -2019,** and the
- **TCHHS Operational Plan 2018-2019.**

The strategy sets out the health service's commitment to improving the quality of health care services provided to the people of Torres and Cape communities.

The principles of good governance (transparency, accountability, probity, patient centres, no blame culture) form the basis of our strategy. The strategy intends to develop and instil a culture of clinical excellence across our services, through the development, implementation, monitoring and evaluation of clinical governance programs built into the day to day work of staff, all within the legislative framework.

It is also imperative the health service meets its mandatory accreditation requirements against the National Safety and Quality Health Service Standards (NSQHS), and to Standard 1 in particular; Clinical Governance; which describes the clinical governance, and safety and quality systems are required to maintain and improve the reliability, safety and quality of health care, and improve health outcomes for patients.
2.2 Scope

This strategy applies to the governance of all clinical services and incorporates governance structure and processes, roles and responsibilities, continuous improvement, reporting criteria, safety, and quality and risk elements.

2.3 Applicable standards

The strategy seeks to meet the standards set by the following tools and documents:

- The Australian Commission on Safety and Quality in Healthcare (ACSQHC) standards
- The ACSQHC Australian Safety and Quality Clinical Governance Framework
- Department of Health – Service Agreement
- Clinical Services Capability Framework

3. The Platform

3.1 Operating model for clinical services

The Operating Model for the clinical services of the health service consists of an Executive Leadership Forum (ELF), overseeing two geographically aligned health service areas, managed by Executive General Managers.

Quality, Safety and Risk is a shared responsibility for all employees of the health service. To ensure effective clinical governance, specific roles have been established to support staff at all levels to provide quality and safety of care.

The Executive Director of Nursing and Midwifery has overall responsibility for the strategic direction and management of Quality and Safety within the health service.

3.2 Functions of the Quality, Safety and Risk Unit

The Quality, Safety and Risk Unit (QSRU) supports and strengthens clinical governance with the health service by providing expertise and assistance to each of the service groups and facilities. Services provided by the QSRU are supported by a range of specific strategies.

The Unit is currently organised into work streams, which are aligned to the core clinical governance and patient safety functions. Each work stream provides leadership, expert advice, guidance and oversight of activities to facilitate participation and collaboration in our planning
and decision-making processes. The Director of the Quality, Safety and Risk leads the QSRU and reports directly to the Executive Director, Nursing and Midwifery Services.

Teams include:

3.2.1. Patient safety team
- Patient experience and feedback
- Patient Safety – Incident Management
- Clinical Risk – mortality and morbidity
- Clinical Audit and Evaluation
- Clinical Activity and Performance
- Patient Safety Leadership and Education

3.2.2. Quality
- Clinical Audit Program
- Process improvement
- Quality Improvement
- Accreditation

3.2.3. Risk and compliance management
- Electronic risk management system support - RiskMan
- Management and monitoring of: Health service risks, and clinical and non-clinical incidents
- Roll out of RiskMan including education
- Compliance and Administration
- Reporting

3.2.4. Information privacy and confidentiality
- Preparation of documents for release under the various provisions for rights to information
- Liaison with Information Commissioner
- Annual reporting
3.2.5. Document management
- Procedural Documents Register
- Development and review of procedural documents
- Management of the TCHHS Policy Register

3.2.6. Infection prevention and control
- Education and training
- Surveillance
- Outbreak support

4. The Strategy

4.1 National model clinical governance framework.

‘Clinical Governance’ is defined as the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, governing body, executive, workforce, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures the community and health service organisations can be confident systems are in place to deliver safe and high-quality health care, and continuously improve services.¹

The National Clinical Governance Standard and the National Partnering with Consumers Standard together ensure the creation of clinical governance systems within the health service that:
- Are fully integrated within overall corporate governance systems
- Are underpinned by robust safety and quality management systems
- Maintain and improve the reliability, safety and quality of health care, and
- Improve health outcomes for patients.

4.2 Organisational governance relationships

The responsibility of the governing body (the Board) for clinical governance is an integrated element of its overall responsibility and accountability to govern the organisation (Figure 2). As a component of broader systems for corporate governance, clinical governance involves a complex set of leadership behaviours, policies, procedures, and monitoring and improvement mechanisms directed towards ensuring good clinical outcomes.
Figure 2: Corporate Governance Relationships

Under this model, it is important to recognise the following:

- Clinical governance is of equivalent importance to financial, risk and other business governance
- Decisions about other aspects of corporate governance can have a direct effect on the safety and quality of care, and decisions about clinical care can have a direct effect on other aspects of corporate governance, such as financial performance and risk management
- Governing bodies are ultimately responsible for good corporate (including clinical) governance
- Governing bodies cannot govern clinical services well without the deep engagement of skilled clinicians working at all levels of the organisation
- Clinicians, managers and members of governing bodies have individual and collective responsibilities for ensuring the safety and quality of clinical care; as well as being reflected in the NSQHS Standards, many of these responsibilities are specified in relevant professional codes of conduct.

Although it is ultimately the responsibility of the Board to set up a sound clinical governance system, and be accountable for outcomes and performance within this system, implementation involves contributions by individuals and teams at all levels of the health service. Well-designed systems shall be in place to deliver, monitor and account for the safety and quality of patient care.

The five components of the Safety and Quality (Clinical Governance) Framework are as follows:
• **Governance, leadership and culture** – integrated corporate and clinical governance systems are established, and used to improve the safety and quality of health care for patients

• **Patient safety and quality improvement** system - safety and quality systems are integrated with governance processes to actively manage and improve the safety and quality of health care for patients

• **Clinical performance and effectiveness** – the workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients

• **Safe environment for the delivery of care** – the environment promotes safe and high-quality health care for patients

• **Partnering with consumers** – systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation; elements of this component include:
  – clinical governance and quality improvement systems to support partnering with consumers
  – partnering with patients in their own care
  – health literacy, and
  – partnering with consumers in organisational design and governance.

It is important the strategy aims to instil a culture for clinical excellence and is based on three core principles for safe and high-quality care:

• Consumer centred

• Organised for quality

• Driven by information.

5. **The importance of culture in clinical governance**

Culture is important in clinical governance to ensure patients and consumers receive safe and high-quality care. Organisational culture is a complex and contested concept with many different definitions. Central to most of these definitions is:

...*culture consists of the values, beliefs and assumptions shared by occupational groups. These shared ways of thinking are then translated into common and repeated patterns of behaviour: patterns of behaviour in turn are maintained and reinforced by the rituals, ceremonies and rewards of everyday organisational life.*

---

Factors identified as being important for sustaining cultures to ensure safe and high-quality care include:

- Leaders articulating a vision for high-quality, compassionate and safe care, and acting on this vision throughout the organisation,
- Translating the vision into clear objectives for safety and quality at all levels of the organisation, and establishing measures to assess progress,
- Providing a supportive and positive working environment for the workforce,
- Ensuring members of the workforce are engaged in their work,
- Having an organisation that is transparent about performance, open to learning and continuously improving, and
- Supporting multidisciplinary teams to work together effectively.

The health service is committed to fostering a culture having:

- Strong strategic and cultural leadership of clinical services focusing on:
  - effective planning to enable development and improvement opportunities to be captured
  - cultural leadership that requires, and gives priority to, safety and quality, and supports continuous improvement
  - allocating resources to support the delivery of high quality care.
- Clear responsibilities for managing the safety and quality of care, and delegation of the necessary management authority for this purpose
- Reliable processes for ensuring that systems for delivery of care are designed and performing well, and clinicians are fully engaged in the design, monitoring and development of these systems
- Effective use of data and information to monitor and report on performance, through the health service organisation to the governing body
- Well-designed systems for identifying and managing clinical risk.

6. Roles and responsibilities

6.1 Patients / Consumers

Patients/consumers have the right to be confident that their care is based on current knowledge, and is delivered by highly skilled, competent staff who are supported by the organisation to maintain high standards of practice and health care delivery. Person centred care is delivered across the organisation focussing on placing the patient at the centre of everything we do,
looking after our people because they look after our patients and embedding family/carers in all aspects of care. Our patients should expect care to be delivered as close to home as possible.

6.2 Clinicians

Clinicians work within, and are supported by, well-designed clinical systems to deliver safe, high-quality clinical care. Clinicians are responsible for the safety and quality of their own professional practice, and professional codes of conduct include requirements that align with the Clinical Governance Framework.

6.3 Managers

Managers (including clinical managers) advise and inform the governing body, and operate the organisation within the strategic and policy parameters endorsed by the governing body. They are primarily responsible for ensuring that the systems that support the delivery of care are well designed and perform well.

6.4 Governing body

The governing body is ultimately responsible for ensuring the organisation is run well and delivers safe, high-quality care. It does this by establishing a strong safety culture through an effective clinical governance system, satisfying itself this system operates effectively, and ensuring there is an ongoing focus on quality improvement.
7. Clinical Governance Functions

7.1 Risk management

The TCHHS Enterprise Risk Management Framework applies to both clinical and non-clinical risks. Risk Management is a key activity which aims to provide consistency and improvement in the way we manage risk by integrating processes into existing systems and strategies for safety and quality. Risk profile analysis covers the identification, investigation, analysis and evaluation of clinical risks and the selection of the most appropriate approach to the correction, amelioration and reduction of identifiable risks. It supports innovation and opportunities to deliver the best possible health care and health outcomes for the community.

---

5 National Model Clinical Governance Framework, Australian Commission on Safety and Quality in Health Care.
7.2 National standards achievement - accreditation

National Standard achievement provides a mechanism to ensure minimum standards of safety and quality are met, and a quality improvement system is in place that allows health services to realise development goals. A systematic approach to quality improvement identifies those accountable for action in health service organisations, and focuses on risk, quality and patient safety to ensure that the necessary monitoring and actions are taken to improve services.

The 2017 review of the Australian Health Service Safety and Quality Accreditation Scheme of the accreditation process will see a focus on the following strategies to improve the accreditation process:

- Improve the veracity of health service organisation assessments
- Improve the effectiveness and expertise of the assessment team
- Assess the health service organisation's safety and quality data to better inform assessment processes
- Improve regulatory oversight
- Improve communication about the assessments and their outcomes
- Improve resources and support for health service organisations.

7.3 Clinical audit

The delivery of services is undertaken by developing systems and processes according to best practice standards to achieve the outcome of safe and efficient patient care. A suite of audits provides the health service staff with information to review both the processes within the systems, the systems themselves and importantly the system outcomes to determine the outcomes of safe patient care are being achieved. The Continuous Quality Improvement Activity Procedure guides the process of audit within the health service.
7.4 Patient safety and quality management

The Quality Safety and Risk Unit consists of a team of Patient Safety and Quality Managers who are responsible for the following.

- Coordinate the management, monitoring and analysis of clinical incidents and open disclosure across the organisation
- Provide staff education and training in patient safety and quality processes
- Coordinate information sharing about system and process gaps with partnering organisations who also provide clinical care within the same clinical environments
- Support the implementation of clinical auditing processes and primary health care system assessments.

They do this by:

- Providing feedback to frontline staff about the findings from clinical incident analysis
- Support the processes to implement organisational recommendations from SAC 1 events
- Network with state patient safety bodies to ensure state wide patient safety initiatives are fit for purpose for TCHHS.
- Facilitating and documenting system assessments for the Primary Health Care Centres
- Providing expert advice in quantitative and qualitative clinical data collection methods, and data interpretation.
- Implement and monitor clinical incident management processes in accordance with QLD Health legislation.
- Oversee the quality of data entered into the RiskMan clinical incident system to ensure accurate reporting.

The Patient Safety and Quality Managers are required to practice in accordance with the Hospital and Health Boards Act 2011. Organisational procedures describe how incident management is conducted within the health service. Procedures are updated when there are changes to management of clinical incidents.

7.5 Clinical review

Effectively run clinical audit and peer review processes, incorporating analysis of morbidity and mortality, and contributing to improved patient safety form a key element of an effective clinical governance system.

Participation in clinical review/clinical audit meetings is a ‘core’ activity for all clinicians. While it is recognised different services will have different requirements and aims in relation to clinical
review meetings, the main principles are that they should be a forum for discussion of deaths, as well as other clinical and adverse events.

If required, the use of external consultants will be utilised to undertake external reviews of very high clinical risk areas.

**Note**: ‘Clinical Review’ is also a term used in reference to Tier 3 clinical incident analysis.

### 7.6 Patient liaison services

This service provides the conduit for patient feedback to the health service. The [TCHHS Consumer Feedback Management (Compliments and Complaints) Procedure](#) provides direction for staff in the management of consumer feedback. This activity records, analyses and responds appropriately to all consumer feedback, including compliments and complaints, internally and externally. The issues, trends and analyses are reported to the TCHHS Quality and Safety Committee and the Board Quality and Safety Sub Committee.

### 7.7 Patient experience

Listening to patients, their families and carers, including them in provision and planning of their care and seeking their input in service development are central to good clinical governance. The patient experience shapes who we are and influences our actions and behaviours; it directs the decisions we make and frames how we engage with those who are in our care, and those for deliver the care.

### 8. Consumer / Community partnerships

Consumer/community partnerships are central to the delivery of safe, high-quality services. Involving consumers in informed decision making and informing them of escalation processes such as [Ryan's Rule](#), provides us with the important opportunity to review and improve clinical practices; identify and manage risks. Working with consumers and communities helps us identify community needs and priorities. Consumers will be actively engaged and supported to participate in all levels of governance within the health service. The [TCHHS Consumer Engagement Strategy](#) provides the principles upon which the organisation supports a proactive approach to consumer involvement and engagement in their care services.
9. Cultural capability

The TCHHS has a significant Aboriginal and Torres Strait Islander population as well as many people from a culturally and linguistically diverse background. The Aboriginal and Torres Strait Islander population experience a higher burden of disease which contributes significantly to service need and present us with a higher complexity of care needs and more co-morbidities for health care, compared to the non-indigenous population.

We aim to deliver person centred care for our multicultural and diverse individuals, families and communities by partnering in their health journeys within our HHS and by using evidence based practice models and frameworks.

10. Quality and safety governance committee structure

Quality and Safety roles / activities have been built into the different levels of the organisational structure of TCHHS. A network of related committees exists to facilitate effective clinical governance. This allows for:

- The identification and review of safety, quality and risk at all levels
- Implementation and evaluation of prevention strategies in a continuous improvement cycle
- Promotion of a culture of safety and quality through a focus on Quality and Safety in a cross functional environment.

See Appendix 1. TCHHS Quality and Safety Committee Governance Structure

10.1 Quality and safety at a regional level

Each region operates a Quality and Safety Committee and is responsible for escalating issues to the HHS wide Quality and Safety Governance Committee, if issues cannot be dealt with at the local level and if the issues have HHS wide implications. These committees are supported by the staff of the Quality, Safety and Risk Unit. These committees are responsible for:

- Reviewing local performance
- Monitoring local audit data and actions arising
- Monitoring local complaints, compliments
- Monitoring local clinical incidents and actions arising
- Sharing information from the HHS wide Quality and Safety Committee
10.2 Quality and safety at an organisational level

The TCHHS Quality and Safety Governance Committee (the Committee) is a multidisciplinary committee comprised of:

- Executive Director of Medical Services (co-chair)
- Executive Director of Nursing & Midwifery Services (co-chair)
- Executive General Manager North and South
- Director of Quality, Safety & Risk
- Director Mental Health Alcohol and Other Drugs Service
- Director of Pharmacy
- Patient Safety and Quality Manager
- Quality Coordinator
- Infection Prevention and Control CNC North and South
- Executive Director Allied Health
- Executive Director Aboriginal and Torres Strait Islander Health.

The Committee is responsible for the overall monitoring and support of clinicians and managers in the safe and effective delivery of care to our communities. The Committee takes on the organisation-wide accountability for ensuring that the whole organisation provides safe, high quality care and provides:

- Definition, assessment and monitoring of the organisational response to critical incidents
- Internal in-depth reviews of quality issues
- Performance monitoring and risk management of clinical issues
- Identification and oversight of key quality, safety and risk projects
- Review of organisation wide clinical indicators, complaints and clinical audit data
- Quality improvement and assurance activities such as clinical audit and compliance to the National Standards
- An assurance role to the Board and ELF.

The committee is responsible for making recommendations and referring specific quality, safety and risk issues to relevant committees and departments for addressing.
The committee is responsible to contribute to the development and review of strategic documents such as:

- Quality and Safety Strategy
- Quality and Safety Priorities
- Quality and Safety Monitoring Plans
- Quality and Safety Committee Terms of Reference.
- Annual Attestation Statement

11. Obligations

11.1 Statutory obligations

11.1.1. Board charter

The purpose of the Board Charter is to set out the authority, role, operation, membership, functions and responsibilities of the Board in exercising control over Torres and Cape Hospital and Health Service (TCHHS) through sound corporate governance practices. See 11.1 Statutory obligations.

The Board Charter is an outline for corporate governance by Board Members, in accordance with statutory obligations under the Hospital and Health Boards Act 2011.

The role and function of the health service and the responsibilities of the Hospital and Health Service Board are prescribed under the Hospital and Health Boards Act 2011 (The Act).

These include:

Delivery of the hospital services, other health services, teaching, research and other services stated in the service agreement for the health service

- To ensure the operations of the health service are carried out efficiently, effectively and economically
- To enter into a service agreement
- To comply with the health service directives
- To contribute to, and implement, State-wide service plans applicable to the health service and undertake further service planning ensuring alignment with the state-wide plans
• To monitor and improve the quality of health services being delivered
• To develop local clinical governance arrangements
• To undertake approved minor capital works, and major capital works
• To maintain assets owned by the health service or the State
• To cooperate with other providers of health services, including other HHS, the department and providers of primary healthcare, in planning for, and delivering, health services
• To cooperate with local primary healthcare organisations
• To arrange for the provision of health services to public patients in private health facilities
• To manage the performance of the health service against the performance measures stated in the service agreement
• To provide performance data and other data to the chief executive (of the department), and
• To consult with health professionals working in the health service, health consumers and members of the community about the provision of health services

The Board (Governing Body) has ultimate responsibility for the governance of the health service and for patient safety and quality.

In addition to those obligations of the Hospital and Health Boards Act 2011, the health service as a statutory authority has additional obligations under other statutes, including:

• The Office of the Health Ombudsman (OHO). The OHO is Queensland’s health service complaints agency. The agency is an independent statutory authority for all Queenslanders to be able to make a complaint about a health service provided to them, a family member or someone in their care.
• The provision of an annual Attestation Statement to the Australian Commission on Safety and Quality in Health Care attesting responsibilities to ensure the safety and quality of services have been met.

11.1.2. Contractual obligations

The National Health and Hospitals Network Agreement (NHHNA) states:

• TCHHS Service Agreement will include the quality and service standards applicable to services delivered by the health service.
• The health service will have a Performance and Accountability Framework
• The health service will be responsible for local clinical governance arrangements and implementation of national clinical standards.
11.1.3. Accreditation and Regulatory obligations

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is established as a permanent national body and has developed a national accreditation scheme against eight National Safety and Quality Health Service Standards. All Queensland Hospital and Health Services are required to be accredited, and to maintain accreditation, against these standards.

11.1.4. Attestation statement

The provision of an annual Attestation Statement to the Australian Commission on Safety and Quality in Health Care atesting responsibilities to ensure the safety and quality of services is an annual requirement for the Board.

Attestation statements are:

- The Governing Body has fully complied with, and acquitted, any Actions in the National Safety and Quality Health Service (NSQHS) Standards, or parts thereof, relating to the responsibilities of governing bodies generally for Governance, Leadership and Culture.
  - has provided leadership to develop a culture of safety and quality improvement within the Organisation, and has satisfied itself that such a culture exists within the Organisation
  - has provided leadership to ensure partnering by the Organisation with patients, carers and consumers
  - has set priorities and strategic directions for safe and high-quality clinical care, and ensured that these are communicated effectively to the Organisation’s workforce and the community

---

− has endorsed the Organisation’s current clinical governance framework
− has ensured that roles and responsibilities for safety and quality in health care provided for and on behalf of the Organisation, or within its facilities and/or services, are clearly defined for the governing body and workforce, including management and clinicians
− has monitored the action taken as a result of analyses of clinical incidents occurring within the Organisation’s facilities and/or services
− has routinely and regularly reviewed reports relating to, and monitored the Organisation’s progress on, safety and quality performance in health care, and

• The Governing Body has, ensured that the Organisation’s safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people.

12. Health Service Directive obligations

The Hospital and Health Services Act 2011, authorises the Director-General of the Department, in the role of system manager, to issue health service directives. Directives may be issues to set standards and policies for the safe and high-quality delivery of health services and to ensure consistent approaches to the delivery of health services across the state. These directives are binding on the health service to provide a lever for the department to ensure system-side approaches are maintained where necessary and beneficial for patient care.

13. Consultation

• TCHHS Quality and Safety Governance Committee
• TCHHS Executive Leadership Forum
• TCHHS Safety and Quality Board Committee.
• Patient Safety and Quality Manager
14. Approval governance pathway

14.1 Document author

The following officer is the author of this document

- A/Director Quality Safety Risk

14.2 Document custodian

The following officer will have responsibility for implementation of this document

- TCHHS Board Chairperson

14.3 Endorsing committee/position

The following committee/officer will have responsibility for implementation of this document

- Safety and Quality Board Committee

14.4 Approving officer

The following officer has approved this document

- Mr Robert McCarthy, TCHHS Board Chairperson

Signature: ___________________________ Date: _________________

15. Effective dates

- Approval date: 7/02/2019
- Effective from: 7/02/2019
- Next review date: 7/02/2021
- Superseded document: New
16. Version control

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Prepared by</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1</td>
<td>30/10/2018</td>
<td>Allison Wilkinson</td>
<td>A/Director QSRU</td>
</tr>
<tr>
<td>0.2</td>
<td>1/12/2018</td>
<td></td>
<td>Consultation</td>
</tr>
<tr>
<td>1.0</td>
<td>7/02/2019</td>
<td></td>
<td>Approved by Safety and Quality Board Committee</td>
</tr>
</tbody>
</table>

17. Evaluation criteria

The strategy will be evaluated every two (2) years in terms of its effectiveness and performance against key performance indicators (KPIs). For example, but not limited to:

- Evidence feedback to frontline staff about the findings from clinical incident analysis has been provided
- Demonstrated progress to implement organisational recommendations from SAC 1 events
- Demonstrated facilitation and documented system assessments for the Primary Health Care Centres has commenced.
- Demonstrated provision of monthly dashboard reporting to relevant governance and board committees.
- Demonstrated provision of an annual Attestation Statement to the Australian Commission on Safety and Quality in Health Care
- Number of ‘Not Met’ criterion of the National Standards Version 2 at the latest accreditation survey.

18. Appendix

Appendix 1: TCHHS Quality and Safety Committee Governance Structure