BEECHWORTH
HEALTH SERVICE

CLINICAL GOVERNANCE COMMITTEE CHARTER

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Clinical Governance Committee Charter

Contents

Document Control Sheet

Version history

Versio	Version	Summary of Changes
1.0	23 October 2014	Development of a Clinical Governance Committee Charter and Annual Work Plan having regard to the roles and responsibilities outlined in the *Health Services Act, Australian Safety and Quality Framework for Health Care and the Victorian Clinical Governance Policy Framework*
1.1	18 December 2014	Change of name to Clinical Quality Committee. Minor change to role in that it provides advice to Board
1.2	23 February 2015	Change Duties and Responsibilities.
1.3	8 February 2017	Whole of document revision
1.4	10 August 2017	Incorporation of recommendations from Delivering High Quality Healthcare – Victorian Clinical Governance Framework
1.5	6th March 2020	Changed logo Added date to signature page. Re-Signed.
1.6	5th March 2021	General update reflecting title changes and practical workings of the committee.

The Charter

This document, to be known as the Clinical Governance Charter has been approved by the Beechworth Health Service Board of Management (the Board).

Any previous version of the Charter / Terms of Reference is hereby revoked.

The purpose of this Charter is to outline the role, responsibilities, composition and operating guidelines of the Clinical Governance Committee (the committee).

Authority and Independence

Beechworth Health Service is incorporated as a Public Hospital and is listed within Schedule 1 of the *Health Services Act 1988.*

The committee functions under the authority of the Board in accordance with the *Health Services Act 1988*, Section 65.

In discharging its responsibilities the committee has the authority to:

- Examine any matter in relation to its objectives as it sees fit or as requested by the Board
- Engage external resources if necessary to obtain independent advice in relation to committee matters with the approval of the Board; and
- Have access to all levels of management in accordance with agreed protocols in order to seek information from any employee to assist in carrying out the committee's responsibilities.

Clinical Governance

Is the integrated systems, processes, leadership and culture that are at the core of providing safe, effective, accountable and person-centered healthcare underpinned by continuous improvement Dept. Health and Human Services, (2017), Delivering high-quality healthcare Victorian clinical governance framework. Melbourne.

The Board remains accountable for all decisions related to Clinical Governance.

Implementation of the clinical governance framework at BHS is focused on five domains of quality and safety as defined by the Victorian clinical governance policy framework. These are:

- Leadership and Culture – visible, accountable and purposeful leadership which cultivates an inclusive and just culture to encourage the engagement of staff and consumers to participate in organisational strategy, planning and review.

- Consumer partnerships - increasing awareness and understanding of the consumer perspective, designing systems and processes to enhance their participation, and to lift and respond to the consumer voice.

- Workforce – supporting and protecting a skilled, competent and proactive workforce with strategies for recruiting, allocating, developing, engaging, and retaining high-performing staff.

- Risk management – safeguarding against clinical risk through a structured approach to safety focused on prevention and repair, built on staff awareness and knowledge, and a culture that encourages staff to act.
- Clinical Practice – the development of clinical practice systems for the provision of safe and appropriate care which focus on patient inclusion, patient centeredness, and cohesion and

integration of care across the care continuum. This enhances a shared understanding of the care pathway and goals between clinicians and consumers.

Role

The Clinical Governance Committee is responsible to the Board for ensuring that;

- There is leadership, focus, direction, and support for ongoing development of a quality improvement structure and culture within the health service
- A quality improvement culture is aided and assisted by staff education and development
- Communication and problem resolution is facilitated across programs in relation to quality issues
- Systems are in place that facilitate adequate oversight of the assessment and evaluation of the quality of health services provided by the health service
- Systems are in place that facilitates adequate oversight for the review of clinical practices or clinical competence of persons providing health services.

The Clinical Governance Committee does this on the basis of reference to the following:

- The Board's external accountability responsibilities as prescribed in the *Health Services Act 1988*, *Health Services (Governance) Act 2000, Occupational Health and Safety Act 2004*, and the *Health Professions Registration Act 2005*; Statement of Priorities, Australian Framework for Safety and Quality in Health Care, Victorian Clinical Governance Framework 2017.

The committee does not replace or replicate established management responsibilities and delegations, the responsibilities of other executive management groups, committees, working parties or steering groups within the health service, or the reporting lines and responsibilities of either internal audit or external audit functions.

The committee will provide prompt and constructive reports and feedback on its business directly to the Board, particularly when issues are identified that could present a material risk or threat.

Duties and Responsibilities in carrying out its Role

The committee's duties and responsibilities are to:

Oversee an Effective Clinical Governance System

- Ensuring that consumers are central to identifying safety and quality issues and the solutions that should be implemented.
- Ensuring that appropriate clinical service and clinical expertise relationships exist with clinical service delivery partners to mitigate clinical risk and enhance the quality, safety and patient experience of care.
- Ensuring that the right care is provided to the right person who is informed and involved in their care at the right time by the right clinician with the right skills in the right way, with the right resources.
- Ensuring that all staff employed within the health service have the appropriate skills and knowledge required to fulfill their roles and responsibilities
- Ensuring that clinical risk management and improvement strategies are integrated within improvement and performance monitoring functions through the development of a system-level response and a just culture.
- Ensuring that strategies and systems are in place to encourage the pursuit of continuous improvement and excellence.

Integrity Oversight and Misconduct Prevention

- Provide oversight, direction and guidance on the ongoing development and deployment of the BHS integrity framework to ensure it is functioning appropriately.
- Monitor the effectiveness of BHS' Statutory Disclosure requirements.

- Ensure the BHS complies with relevant integrity legislation whole of government policies, principles and guidelines (including the Victorian Public Sector Commission Code of Conduct).
- Provide advice and recommendations on service delivery integrity issues to the Board and Executive as necessary.
- Monitor BHS misconduct trends and prevention approaches and address any gaps in dealing with integrity issues in relation to misconduct.
- Ensure that BHS complies with any Independent Broad-based Anti-Corruption Commission (IBAC) requirements and recommendations to improve misconduct prevention and response.

Risk Management

- Review, ratify and oversee the clinical risk management framework for identifying, monitoring categorizing and managing significant risks.
- Satisfy itself that insurance arrangements are appropriate for the risk management framework, where appropriate.
- Liaise with management to ensure there is a common understanding of the key clinical risks to BHS. These risks will be clearly documented in a risk register which will be regularly reviewed to ensure it remains up-to-date.
- Assess and contribute to the audit planning processes relating to the service delivery risks and threats to BHS.
- Review effectiveness of the BHS' processes for identifying and escalating risks, particularly strategic clinical risks.

Internal Control

- Review through the internal and external audit functions, the adequacy of the internal control structure and systems, including information technology security and control.
- Review the service capability of BHS and ensure that there are systems in place to align service scope with clinician capability across recruitment, training and clinical relationship planning.
- Review, through the internal and external audit functions, whether relevant clinical governance policies and procedures are in place and up-to-date and whether they are complied with.
- Ensure through timely and accurate reports & assurance certifications, that the clinical internal controls are operating efficiently, effectively and economically.

Performance Management

- Review BHS's compliance with the clinical performance management and reporting requirements of the *Health Services Act 1988* through the achievement of quality targets as agreed to in the Statement of Priorities and other service agreements.
- Review whether performance management systems in place reflect BHS's role/purpose and objectives (as stated in its strategic plan and by-laws).
- Identify that the performance reporting and information that is reported to the Board of Management uses appropriate benchmarks, targets and trend analysis to enable effective and efficient clinical governance to occur.

Internal Audit

- Review the budget, staffing and skills of the internal clinical audit function.
- Review the internal clinical audit annual plan progress, and any significant changes to it, including any difficulties or restrictions on scope of activities
- Review and approve the proposed internal clinical audit plan to ensure they cover key risks
- Review the findings and recommendations of defined internal audits and the response to them by management.
- Review the implementation of internal clinical audit recommendations accepted by management.

- The committee will act as a forum for internal audit and oversee its planning, monitoring and reporting processes. This process will form part of the governance processes that ensure that the BHS' internal audit function operates effectively, efficiently and economically.
- The Chair and Committee members may hold executive sessions with internal clinical auditors if required.

External Audit

- Oversee the development of the external clinical audit strategy and audit plans for the year.
- Oversee the internal analysis and implementation of any recommendations appropriate to BHS coming from external clinical audits at an industry level, best practice guidelines and clinical improvement / risk advice.
- Review the findings and recommendations of clinical external audit (including from performance audits) and the response to them by management.
- Review responses provided by management to ensure they are in line with BHS' clinical risk management framework.
- The committee has no power of direction over external audit or the manner in which the external audit is planned or undertaken, but will act as a forum for the consideration of external audit findings and will ensure that they are balanced with the views of management.
- The Chair may hold executive sessions with the external clinical auditors if required.

Compliance

- Determine whether management has considered legal and compliance risks as part of BHS' risk assessment and management arrangements.
- Review the effectiveness of the system for monitoring BHS' compliance with relevant laws, regulations and government policies.
- Review the findings of any examinations by regulatory agencies, and any auditor observations.

Reporting

- The Committee responsible for Clinical Governance oversight will report (or produce minutes of committee meetings to be made available) to the Board outlining relevant matters that have been considered by it as well as the committee's opinions, decisions and recommendations. This shall contain a record of all issues, resolutions and agreements considered or determined by the Committee.
- Prepare an annual report to the Board summarizing the performance and achievements for the previous year.

Membership and Meetings

Membership

- At least three Board Directors appointed to the committee by the Board
- At least two independent community member representatives appointed by the Board

Attendees

- Director of Medical Services
- Director of Clinical Services
- Director Excellence Innovation
- Chief Executive Officer

Board Directors of the Clinical Governance Committee will have the ability to nominate a proxy of equal qualification.

The Clinical Governance Committee will have the power to co-opt those persons it deems necessary to fulfill its purposes and terms of reference, but those co-opted persons will not have the power to vote.

Sub-Committees

The Clinical Governance Committee will have the power to establish those Project Teams and Working Parties, it deems necessary to fulfill its purposes and terms of reference in accordance with Beechworth Health Service's By-Laws

Ethical practices

- Members are required to declare any interests that could constitute a real, potential or apparent conflict of interest with respect to participation on the committee.
- The declaration must be made on appointment to the committee and in relation to specific agenda items at the outset of each committee meeting, and be updated as necessary.
- Members of the Committee may from time to time be in receipt of information that is regarded as 'commercial in confidence', clinically confidential or have privacy implications. Members acknowledge their responsibility to maintain confidentiality of all information that is not in the public domain. Members will maintain the Committee papers in a confidential manner from any other business or responsibilities of the member. Members will not comment publicly on matters related to the activities of the committee other than as authorised by the Board.

Chair

- The Clinical Governance Committee Chair will be a Board Director appointed by the Board.
- The Chair is to preside at all meetings of the Committee at which the Chair is present.

Decisions

Decisions of the Clinical Governance Committee will be taken by consensus. Where a consensus cannot be achieved, decisions will be taken by a simple majority vote. In these circumstances, each member will have a single vote.

The Chair of the Committee will have a casting vote in the event that a simple majority is not achieved.

Executive Officer

- The Executive Officer of the Clinical Governance Committee will be the Director of Excellence and Innovation.
- The Executive Officer will be responsible for facilitating the Committee's meetings and reporting duties.
- The Executive Officer, in consultation with the Chair, will prepare and send notices of meetings and agendas no less than five business days prior to a meeting and will ensure the accurate transcription of all decisions of the committee.
- The Executive Officer will table all correspondence, reports and other information relevant to the committee's activities and operations.
- Draft Minutes will be provided to the Chair for 'approval' review within five business days of the meeting.
  Minutes will be included in the papers for the next meeting, and are 'approved but draft' until they are confirmed by the committee.
- The Executive Officer will ensure the preparation, maintenance and retention of electronic and written records of the committee's activities, including agendas, minutes, related papers and out-of-session papers from all meetings in accordance with the requirements of the *Public Records Act 1973*.
- The Executive Officer will work with the Committee Chair to coordinate the annual self-assessment of the Committee.

Meetings and Attendance

- The Committee shall meet not less than six (6) times per year, at such place and time as the Committee may from time to time determine and the schedule of meetings will be agreed in advance.
- The Chair may call additional meetings as required.
- Urgent matters can be progressed out-of-session by a flying minute with agreement of the Chair.
- The Executive Officer for the Committee will manage the out-of-session process with the Chair's approval.
  Generally two working days is allowed for consideration by members of an out-of- session item. The Secretariat will collate members' responses and prepare for endorsement by the Chair. The final decision in respect of the paper will be recorded in the minutes of the next meeting.
- A quorum will consist of a simple majority of members.
- Attendance by tele/video conference carries the same rights and responsibilities as actual attendance.

Meeting Agenda

- The committee will determine its own agenda, ensuring appropriate consultation to include emerging issues and emphasis on the most significant risks and threats.
- Late agenda items will be tabled at the discretion of the Chair.

Other Committees

The committee shall liaise with other groups as required to ensure:

- That its statutory and operational responsibilities are met.
- That there is no material over-lap between the functions and duties of the groups.
- a frank and meaningful interchange of information.

Evaluation of Committee Activities

- The committee will undertake an annual self-assessment of its performance each financial year.
- The committee will provide a report of the annual review outcomes to the Board.
- At least once every three years the committee will consider an external peer review of its operations and activities. The results of this review are to be provided directly to the Board.
- The Chair will provide each individual member with feedback on that person's contribution to the committee's activities at least once during each member's term of office. This assessment will include a review of any training needs of the member.

Review of the Charter

- The charter will be reviewed annually by the committee to ensure it remains consistent with the committee's authority, objectives and responsibilities.
- All amendments to the charter will be discussed and approved by the Board.

Approval of the Charter

The BHS Clinical Governance Charter is endorsed by the resolution of the committee and approved by the Board.

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Name: Ms. Isabel Paton
Chair of Clinical Governance Committee
Date: 31st March 2021

Name: Mr. Harry Thomas
President Board of Management
Date: 31st March 2021