Clinical governance

15 July 2021

What do the VAGO clinical governance recommendations mean for your organisation?

The Victorian Auditor-General's Office (VAGO) tabled the Clinical governance: health services report in June 2021. The report makes a total of 18 recommendations – some to all four audited health services, and others to some or one of the audited health services.

VHA has developed the questions below as a series of prompts that encapsulate the expectations of the VAGO recommendations. VHA members may find these questions useful when considering their own clinical governance against the VAGO recommendations.

Embedding a clinical governance framework

- ✓ Has your service developed its own clinical governance framework that meets the expectations of the Victorian Clinical Governance Framework?
- ✓ Are staff and board members familiar with your service's clinical governance framework, and the current priorities within that framework?
- ✓ Is the clinical governance framework being used as the primary tool for reporting quality and safety activities and performance to the board?
- ✓ Do staff have an understanding of the role they play in applying the clinical governance framework and contributing to patient safety in their day-to-day activities?

Promoting a patient safety culture

- ✓ What initiatives or activities are used within your service to promote a patient safety culture across all service areas?
- ✓ Do your organisation's People Matter Survey results show improving (or existing high levels of) confidence among staff to report any patient safety concerns?

Monitoring and reporting quality and safety performance indicators

- ✓ Does your organisation monitor its performance against the quality and safety indicators in your statement of priorities (SOP), and routinely report performance against these indicators in regular key performance indicator (KPI) reports to the board?
- ✓ In addition to SOP performance indicators, services will need other quality and safety performance indicators in place to allow comprehensive monitoring of quality and safety. Has your service identified additional quality and safety KPIs within your clinical governance framework, and do you monitor and report performance against these quality and safety KPIs to the board?

Identifying and investigating poor performance against performance indicators

- ✓ Does your system for monitoring quality and safety indicators enable your service to promptly identify poor performance?
- ✓ Does your system collect and report on data that allows longer-term trend analysis (more than two data points) so that performance changes can be distinguished from expected variations (e.g. seasonal differences)?

- ✓ Does your clinical governance framework include stated thresholds for when staff need to account for and address underperforming indicators?
- ✓ Once a threshold is reached, does your service:
  a. investigate reasons for poor performance?
  b. initiate an action plan to address underlying causes of the poor performance?
  c. report to board on the reasons for underperformance, actions taken, and staff responsible for addressing underperformance?

Responding to serious incidents

- ✓ Does your organisation regularly report to the Board Quality and Safety Committee on the progress of investigations of serious incidents, and the implementation of recommendations and actions following serious incidents?
- ✓ Does your clinical governance framework set timeframes for the initiation and completion of investigations into serious incidents (not only sentinel event investigations)?
- ✓ Does your organisation have the necessary staff capacity and capability in place to complete incident investigations within timeframes?
- ✓ Do regular reports to the Board Quality and Safety Committee identify delayed investigations and delayed implementation of recommendations, and provide explanations for delays?
- ✓ Does your service monitor the average time taken to implement recommendations from an investigation, and take actions to reduce this time when necessary?
- ✓ Does your organisation systematically and periodically (six-monthly recommended) analyse clusters and themes of serious and less serious incidents to identify common contributing factors, and report findings to the Board Quality and Safety Committee?
- ✓ Are the results of cluster analyses used to inform improvement projects and enhance patient care?

Assessing the impact of implemented recommendations

- ✓ When developing serious incident action plans, does your service routinely include a relevant 'outcome measure' to assess the effectiveness of the action plan?
- ✓ Does your serious incident action plan template provide guidance to staff on how to identify suitable outcome measures to assess the impact of an action plan?
- ✓ When reporting to the Board Quality and Safety Committee on responses to serious incidents, does your service routinely include the results of an impact assessment of the action plan?

More information

- Victorian Clinical Governance Framework, Safer Care Victoria
- Safer Care Victoria: notify and review a sentinel event
- Targeting zero, the review of hospital safety and quality assurance in Victoria

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