Sydney
Local Health District

Clinical Governance Framework

April 2024

Pre-design - interim publication version

Acknowledgement of Country

Sydney Local Health District (the District) acknowledges that we live and work on Aboriginal land. We recognise the strength, resilience, and capacity of Aboriginal people who live and work on this land. We would like to acknowledge the traditional owners of the land and to pay our respects to Aboriginal Elders past, and present. Our District acknowledges the three clans within the boundaries of the District comprising the Gadigal, Wangal, and Bediagal people. In the wider Sydney metropolitan area, around 29 clan groups comprise the Great Eora Nation.

The District's *Aboriginal Health Strategic Plan 2018 to 2022* sets out how the District commits to improving the health and wellbeing of Aboriginal communities through the Sydney Metropolitan Local Aboriginal Health Partnership in collaboration with the Redfern Aboriginal Medical Service (AMS) and our local Aboriginal communities. We strive to close the gap in health outcomes by providing culturally competent health services which are continually enhanced to optimise Aboriginal people's wellbeing.

Your feedback

If you have any comments or suggestions on this *Clinical Governance Framework*, we would welcome your feedback. Please contact:

Dr Andrew Hallahan, Executive Director Medical Services, Clinical Governance and Risk through:

email SLHD-Quality@health.nsw.gov.au phone 02 9515 9646

Contents

Please note – this document includes links to the SLHD Intranet that are not accessible for staff working outside of NSW Health. Should you wish to request a copy of documents listed in this document, please contact slhd-quality@health.nsw.gov.au

Introduction

The SLHD Clinical Governance Framework ('the Framework') sets out how we structure and govern our activities to meet statutory, regulatory and sector best practice. It aligns with the 2017 National Model Clinical Governance Framework of the Australian Commission on Safety and Quality in Health Care.

The traditional custodians of the land on which SLHD provides healthcare are the *Gadigal, Wangal* and *Bediagal* people of the *Eora Nation*. Corresponding to the central and inner west of Sydney, SLHD provides healthcare services to our community, including in partnership with primary care, government, and non-government services. Our SLHD Strategic Plan provides the strategic vision on which this Clinical Governance Framework rests, and describes how our District is enriched by its cultural and social diversity. This Clinical Governance Framework, our Strategic Plan, and key supporting documents, outlines how SLHD will achieve its strategic vision *of Excellence in Health, and Healthcare for all*.

What good clinical governance looks like at SLHD

We have clear relationships, responsibilities and accountabilities for governance between:

- The District, NSW Ministry of Health and its pillar organisations (in particular the CEC and the ACI), health organisations, other Local Health Districts and Specialty Health Networks, and affiliated agencies.
    - Our governing body – the SLHD Board – and executives, clinicians, and support staff.
    - The District and our patients, consumers and other people we serve.

Good clinical governance is integrated with good corporate governance:

- Everyone knows how they contribute to delivery of excellent patient care.
- Committee and organisational structures align to ensure safe and high-quality care.
- Our processes are documented in policies and guidance that people understand.
- We systematically improve our clinical and corporate services to be more efficient and effective.
- Staff have the capability and capacity to continually improve health care safety, patient experience, quality and clinical effectiveness.
- Clinical governance provides an integrated approach to what we do each day.

Clinical governance is everyone's responsibility

All staff are responsible for knowing how they work with their colleagues to be accountable for providing excellent care to our patients. Teams can access data and information about their service outcomes to guide improvement. Executives and governance teams support and guide our staff to achieve this. Our roles and responsibilities for clinical governance are summarised below.

Patients and consumers are provided with a range of opportunities to participate in feedback and clinical service re-design initiatives. Patients/consumers are actively encouraged to be partners in their own care (see Section 4., Partnering with Consumers).

Clinicians work within a robust clinical governance structure that are supported by policies and procedures with effective co-ordination between all parts of the system. Every clinician

contributes to healthcare safety and quality by being responsible for their own professional practice. This is achieved by following policies and procedures, and professional codes of conduct, while ensuring our team members are supported and appropriately supervised.

People in managerial roles across all areas work within Board endorsed strategic, operational, policy and risk parameters. Management has the primary responsibility of ensuring that our governance systems work effectively through robust monitoring to demonstrate that desired outcomes from care design and delivery are achieved.

The SLHD Board has ultimate responsibility as the governing body to ensure the District is well-run and that the organisation delivers safe high-quality care. The Board achieves this by establishing an effective clinical governance system with a strong safety culture and by monitoring that governance systems operate effectively with ongoing quality improvement.

System partner oversight by organisations within NSW Health and beyond provide regulatory oversight of SLHD as part of state and national governance systems. Sector oversight includes accreditation, benchmarking, and policy guidance.

These roles work collaboratively to deliver effective clinical governance systems. The core components of our governance systems at SLHD are set out below.

Clinical governance at SLHD

Sydney Local Health District's clinical governance responsibilities align with the five core components of the *National Model Clinical Governance Framework* (ACSQHC, 2017).

Table 1 – Overview – Summary of Clinical Governance at SLHD

Core clinical governance component	How each governance component is operationalised at SLHD
Governance, leadership culture	• Effective integration of clinical and corporate governance with committee and organisational structures to communicate peoples' responsibilities • Corporate governance attestation statement to NSW Ministry of Health • Aligned District and facility/service governance • Strategy and plan monitoring • Board and committee reporting including dashboards and feedback including the annual Safety and Quality Report • An independent Internal Audit Department • External accreditation schemes • Legislation and compliance reviews • Education and training to enhance safety and quality • A risk management framework • Promoting organisational and safety cultures that aim to be open, accountable, and drive learning • Delegations manual • Codes of conduct; appointment of clinical staff, credentialing and scope of practice

	processes
Patient safety and quality improvement systems	• A commitment to excellence and innovation that drives a District-wide approach to continuous quality improvement • A policy framework that provides quality, evidence-based documents to all staff • System improvement is everyone's responsibility • Robust incident management processes – including a positive reporting culture • Human factors safety communication
Clinical performance and effectiveness	• Strategies to monitor clinical variation and health outcomes • A Quality and Safety/morbidity and mortality program • Clinical indicator monitoring • Providing evidence-based care • A clinical audit framework • Robust professional credentialling and scope of practice oversight
Partnering with consumers	• Organisational commitment to delivering patient/consumer and family centred care • Health equity and diversity governance • Planning through experience-based co-design • Providing a range of opportunities for consumer feedback • Communicating healthcare rights and ensuring informed consent
A safe environment for care delivery	• A work health and safety program – including routine processes for review, escalation and resolution • Promoting safety culture • Staff safety and security processes • Excellence in facility design and capital infrastructure development

1. Governance, Leadership and Culture

Governance, Leadership and Culture

SLHD Board Clinical Governance Mechanisms

Governance, leadership and culture (GLC) encompasses the integration of clinical governance within the overall corporate governance systems of the District. The SLHD Corporate Governance Plan 2023 ('the CGP') describes key committees, policies and processes which are integral to good clinical governance including those reporting to the SLHD Board and holding clinical governance roles.

- **SLHD Clinical Quality Council** (CQC) monitors health care quality delivered to patients/consumers with a focus on consumer experience, safety and quality improvement, clinical outcomes, patient/consumer/carer feedback and incidents.
- **SLHD Clinical Council** (CC) has a remit including strategic service redevelopment, state-wide initiatives and population health.

- **SLHD Patient and Family Centred Care Steering Committee** (PFCC) ensures care design and delivery reflects the needs and voice of stakeholders including patients, consumers, families and carers.
- **SLHD Finance, Risk and Performance Management Committee** (FRAP) monitors clinical and operational performance and use of resources.
- **SLHD Audit and Risk Committee** (ARC) monitors clinical and non-clinical risk management and internal audits.
- **SLHD Strategic Communications and Partnerships Committee** has oversight of working with partner organisations. Executive Directors and General Managers ensure processes exist to monitor quality of externally sub-contracted services.
- **SLHD Education and Research Committee** monitors education, training and research activity.

Strategic planning

Strategies are Board approved and our vision and mission is communicated via the SLHD Strategic Plan 2018 – 2023. Facilities/Services deliver this through operational and quality plans monitored at local committees. Examples of key supporting frameworks include:

- The **Aboriginal Workforce Action Plan 2023 – 2028, Dyi Bulbuwul Ngia Djural** - In Strength We Grow sets out how our District is continuing to work towards being an employer of choice for Aboriginal and Torres Strait Islander people. Our vision for our Aboriginal community to be one of the healthiest in Australia, through our dedication and commitment to 'Closing the Gap' is monitored by the SLHD Aboriginal Health Steering Committee.
- The SLHD **Workforce Strategic Plan 2023 – 2028** sets out how we will continue to strive to build the workforce of the future to meet the needs future local populations.
- The **Digital Health Strategy 2022 - 2027** sets out how digital health and innovation will ensure our clinical services are optimised to deliver safe, high-quality care, now and in future.
- The **Sydney Education Strategic Plan 2023 – 2028** supports our workforce to learn, innovate and build new care models.
- The **Culturally and Linguistically Diverse (CALD) Health Strategic Plan 2022 – 2026** sets out how we seek to continually improve equitability of healthcare.

Leadership and Clinical Governance

Leaders influence, communicate and progress our strategic vision by modelling behaviors and motivating teams to deliver our aims. Clinical Stream leaders and Heads of Department monitor services to operationalise strategic priorities as set out in Clinical Stream Position Papers and the SLHD Management Accountability Toolkit.

Accreditation Schemes

The District maintains accreditation with all required statutory and regulatory schemes which are monitored at SLHD CQC and other committees. Voluntary accreditations add further value and assurance for our patients, consumers, and staff. SLHD's clinical services and facilities are accredited to the Australian Commission on Safety and Quality in Health Care's (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards. The Australian Council on Healthcare Standards (ACHS) is our accrediting body. The NSQHS Standards Short Notice Assessment Program is operationalised by SLHD policy compliance procedures: SLHD_PCP2023_030 Short Notice Accreditation and

SLHD_PCP2023_031 on Short Notice Accreditation Internal Assurance. Other specialist services, for example aged care, are also accredited by the most appropriate corresponding standards and service, such as the Aged Care Quality Standards overseen by the Aged Care Quality and Safety Commission.

Clinical Governance and Risk Management Services

The Executive Director Medical Services, Clinical Governance and Risk reports to the Chief Executive and is accountable for the clinical governance and risk portfolio across the District. At a facility/service level, this responsibility rests with the General Manager, and in the Mental Health Service with the Clinical Director. Line management of General Manager positions is through to the Chief Executive via the Executive Director of Operations, or Executive Director, Clinical Services Integration & Population Health (see also 'Our Executive Team').

The District Clinical Governance Unit (CGU) supports District services with clinical governance and risk. The CGU works collaboratively with facility/service Clinical Governance Units to monitor and assure on clinical governance and risk across the District in line with this Framework. Portfolios include policy, audit, accreditation and regulation, patient safety, quality improvement and assurance, patient/consumer experience, consumer engagement and participation, risk, carers programs, prevention of hospital acquired complications, infection prevention and control, blood management, and research. The CGU also works closely alongside the District's legal team.

Risk Management Framework

The **SLHD Audit and Risk Management Committee** (ARC) monitors risk management, advised by the SLHD Executive Risk Management Committe. These committees are guided by the NSW Health Enterprise-wide Risk Management Policy, and the District Policy Compliance Procedure SLHD_PCP2023_034 ('the Risk Policy'). The Risk Policy sets out how the Board and District as whole, delivers integrated, effective risk management into culture and practice, and how this is monitored and documented in the Enterprise Risk Management System (ERMS). The Risk Policy supports staff to apply risk management in their roles by describing responsibilities of people and committees across facilities/services. There are defined processes for communicating and escalating risks and mitigating these within tolerance levels, supported by the Board's risk appetite statement. The Risk Policy describes the role staff have in modelling a positive risk culture.

Committee Reporting Structure for Safety and Quality

District, service and facility-level committees have central roles in safety and quality. The NSQHS Standards are integrated into SLHD Governance Committees and each facility/service locally tailors their committee structure for safety and quality, reflecting and responding to District-level structures.

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Sydney Local Health District

Clinical Governance Framework – Reporting Structure

SLHD Safety and Quality Committees and Meetings

SLHD District Level Clinical Governance Committees

Safety and Quality Committees

- Emergency Care Assessment & Treatment (ECAT) Committee
- HACs Steering Committee
- Clinical Variation Committee
- Comprehensive Care Committee
- Medication Safety Committee
- Blood Management Committee
- Recognising and Responding to Clinical Deteriorating Steering Committee
- Policy Committee
- Infection Prevention Control Committee
- End of Life Care Steering Committee
- Security & Violence prevention Committee
- Communicating for Safety Committee
- Executive Risk Committee
- Single Digital Patient Record (SDPR)Taskforce
- SLHD Young People Steering Committee
- Trans & Gender Diverse Health Committee

SLHD Board

Patient and Family Centred Care Steering Committee (PFCC)

SLHD Health Care Clinical Quality Council

and

SLHD Clinical Council

Finance, Risk and Performance Committee (FRAP)

Research and Education Committee

Audit and Risk Committee

Facility / Service Level Clinical Governance Committee

Facility Patient Safety and Quality Improvement Committee

For example:
- Facility Clinical Quality Council
- Facility Clinical Council
- Facility Patient Care Committee

Facility / Service Sub-Committees

A range of Committees (at the discretion of General Managers) such as:

- Blood Management
- Drug Committee
- Death Review Committee
- Team/Department meetings with safety and quality on the agenda

Local escalation and reporting process

Updated April 2024

2. Patient Safety and Quality Improvement Systems

Patient safety and quality improvement systems within SLHD include the following key elements which work together to ensure a safe and high-quality service delivery.

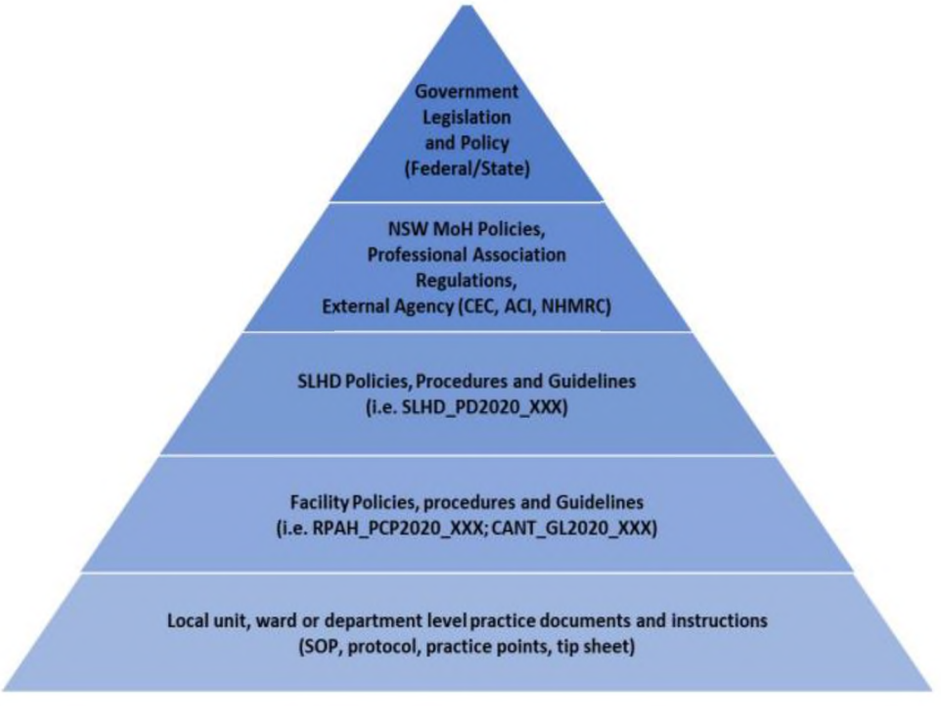
The SLHD Policy Framework

The District and its facilities/services are committed to delivering safe, high-quality, responsive, clinically effective care that delivers positive experiences for patients and consumers. The SLHD Policy committee oversees our policy governance framework (Table 3). All staff have a key role to play in adherence to policy.

NSW Health mandated policies must be followed and are further operationalised (as required) through Policy Compliance Procedures (PCP). The SLHD has a dedicated intranet resource to publish local policy, PCPs, procedures, and guidelines which are visible and accessible to all staff. NSW Health, SLHD, and local service documents that are updated, rescinded, or made obsolete are published to the SLHD intranet and notified via regular email communication from the SLHD Policy Manager to staff in senior operational and clinical positions across facilities/services.

An overview of the NSW Health process is outlined in NSW Health policies and other policy documents, further operationalised in SLHD_PCP2021_002 Governance and Development of Policy, Procedure and Guidelines.

Table 2 - Policy Hierarchy within SLHD



The SLHD Policy, Procedure and Guideline Committee ('the Policy Committee') oversees delivery of streamlined, high-quality policies, procedures and guidelines that are responsive to the clinical and corporate settings within the District. All District policies are tabled at the Policy Committee for consideration by subject matter experts and service/facility representatives for comment and/or approval before final endorsement at the SLHD Clinical Quality Council (CQC). The Policy Committee

works strategically and collaboratively with our services/facilities to develop District-wide policy (where possible) and takes an active role in the implementation and communication of newly published NSW Health policies to members of the SLHD Executive and staff as a whole.

People in managerial roles are critical points of escalation for policy questions and to communicate the need for new/changed policies to facility and District committees and executive. All committees are engaged in policy development and evaluation to ensure staff have opportunities to contribute to the strategic aims of each policy area. The appropriate committee is required to provide endorsement of documents which fall within their responsibility (i.e. Medication Safety to approve high risk medication documents) before tabling at the District Policy Committee.

Many departments and services have clinicians who use clinical policies and guidelines which are maintained and accessed through external organisations. The SLHD facilitates access to resources such as CIAP, the ACI, and CEC through links accessible via the intranet and internet. It is the responsibility of managers that staff in their teams know how to access suitable and reliable external policies and guidelines as indicated by their clinical setting.

Principal Clinical Governance Policies and Practices

This section sets out some of the principal NSW Health and District policies and practices for patient safety, quality and patient/consumer experience systems informed by NSW Health's Clinical Governance in NSW Policy (PD2024_010).

Incident Management Processes

NSW Health's Incident Management Policy (PD2020_047) guides staff on incident management and improving systems from lessons learned. Additional District guidance operationalising this is within SLHD PCP 2021_024 Serious Incident Management and the *SLHD Harm Score 2 Incident Investigations Reference Guide*. The District actively promotes a culture of reporting actual and near miss incidents through daily surveillance at a District, service and facility-level based on the statewide incident management system (ims+).

NSW Health Open Disclosure Policy (PD2023_034) sets out the roles and responsibilities of staff when communicating with and supporting patients/consumers and their families when there has been harm or an unexpected clinical outcome has occurred.

Systems Improvement is Everyone's Responsibility

All staff are responsible for ensuring their work aligns with safety, quality and patient/consumer experience requirements and to contribute toward improvements for patients, consumers and staff. At SLHD this includes:

- Monitoring to ensure to work aligns with policies and guidance applicable to our roles and specialty activity areas including professional regulatory requirements and codes of conduct.
- Actively participating in audits, outcome reviews, professional supervision, patient care reviews, learning from incidents, patient and staff feedback, risk management and mitigation, and where available, using benchmarking to inform change.
- Ensuring mandatory and local education and training is completed to meet current service needs.
- The organisation provides training on clinical change management and quality improvement, including the Safety and Quality Essentials Program (SQEP) program and Accelerated Implementation Methodology (AIM).

- Resource allocation is aligned to District safety and quality priorities set by the Board and executive in the annual SLHD Safety and Quality Report, supported by longer-term strategies, operational plans, quality plans and other risk-informed improvement programs.
- Promoting consultation among colleagues to ensure clinical and other service user feedback informs system redesign and review. Consultation is key to ensuring data collection meets peoples' needs and that system performance is evaluated.

Systems Assurance

All staff are responsible for identifying and responding to patient/consumer care outcomes which are not in line with safety, quality or patient/consumer experience expectations. Systems assurance means that as an organisation, we can demonstrate our quality, safety, experience, and clinical effectiveness systems:

- Are operating as intended by our clinical and corporate governance systems.
- Are not able to be bypassed by unintended or intentional actions.
- Have set tolerance limits so that significant deviation from expected outcomes are quickly detected and corrected.
- Enable intended patient/consumer care outcomes, and that our governance systems monitor and report these.

Safety Alert Communication

State-wide patient safety alerts are communicated to staff in line with the NSW Health PD2013_009 Safety Alert Broadcast System.

Clinical Record Keeping

Electronic clinical record keeping is supported by system innovations in line with our Digital Health Strategy 2022-2027. This strategy aims to achieve optimal point of care integration and communication capability along with system and frontline tailored process efficiencies. Together, these initiatives support care co-ordination, and improved safety and quality for patients and staff. SLHD collaborates with system partners, including eHealth, to support standardisation across health care providers. The electronic medical record (eMR) is enabled to align with the Commonwealth My Health Record system to support communication with general practice and other external care providers. Hybrid paper records are used when no feasible electronic capability exists.

SLHD leverages informatics solutions to achieve timely, accurate and informative data collection across patient/consumer care encounters and governance systems. This allows systems to generate and triangulate the right information to inform safety and quality improvement, reporting, and benchmarking.

Healthcare records are only released in line with legislation and regulatory guidance. Health informatics and information governance policies supports this with emphasis on maintaining confidentiality of identifiable patient information, with practical guidance available for relevant staff.

The Legal and Privacy Portfolio

The SLHD Legal Service oversees the legal and privacy portfolio which incorporates practical application of health care law, contractual compliance (including research agreements), and privacy and right to information requests under the NSW Government Information (Public Access) Act 2009 (GIPA). The department supports facilities/services with Coronial cases, civil claims, and other

litigation. The team advises on privacy law and NSW Health privacy requirements. The team monitors access to patient clinical records to ensure this use is authorised and appropriate at all times.

A District-wide Approach to Continual Quality Improvement (QI)

Continual quality improvement in healthcare includes improving the clinical quality, safety, responsiveness, clinical effectiveness, and patient/consumer experience and outcomes.

SLHD has collaborated with the CEC to build staff capability in QI using the Safety and Quality Essentials Pathway (SQEP). The SQEP is a practical improvement science methodology which supports people to translate learning from safety and quality systems into different ways of working for improve processes for patients/consumers, carers and staff. Human factors training is included. Participants can progress through foundational, intermediate, and adept modules with additional support for practical QI initiatives in their teams to embed QI at the bedside and beyond.

QI at SLHD is underpinned by these improvement science principles:

Measuring to improve means we will measure outcomes using quantitative and qualitative measures of success. Audits, plan-do-study-act (PDSA) cycles and clear aims and targets are used. For example, hospital acquired complications (HACs) are improved in this way using peer benchmarking. Outcomes and learning from both successes and incidents are shared to drive ongoing improvement.

Human factors safety communication in healthcare is the science of how people interact at work and how this impacts the safety of healthcare delivery systems (refer to the Clinical Excellence Commission - Human Factors). SLHD provides practical support to our teams to become adept at applying human factors, including through the SQEP. We have a deep commitment to celebrating our successes and sharing learnings, including through the annual Innovation Symposium. We learn from errors and put things right to prevent harm and improve human experience. Evidence demonstrates that when people understand how to consider human factors approaches in healthcare facilities our patients receive safer, more effective care.

Research and Innovation activity adheres to regulatory approved ethical methods with governance previously outlined. Research governance includes two Human Research Ethics Committees (HRECs). New interventions/clinical innovations are also governed by SLHD PD2015_022 The Safe Introduction of New Interventional Procedures and Clinical Innovations into Clinical Practice. The District collaborates with system partners where there is an opportunity to do so, and maintains compliance with the National Clinical Trials Governance Framework.

3. Clinical Performance and Effectiveness

Strategies to Monitor Clinical Variation and Health Outcomes

Clinical Variation

Clinical variation is a difference in healthcare processes and/or outcomes when compared to peers or to a gold standard, such as an evidence-based guideline recommendation. Some variation is expected and associated with need-related factors such as underlying differences in the health of specific populations, patient needs, and personal preferences. If the variation does not reflect these factors, it may be unwarranted and represent an opportunity for the system to improve.

Our approaches to monitor and reduce unwarranted clinical variation are described in the SLHD Clinical Variation Framework and include:

- Monitoring of HACs with oversight at the SLHD HAC Steering Committee.
- Review of potentially preventable hospitalisations at the SLHD Whole of Health Steering Committee.
- Mortality and morbidity monitoring including death review processes.
- Participation in national and international clinical registries.

Health Outcomes

Health outcomes are any measure of patient/consumer safety, quality, experience, responsiveness, timeliness, effectiveness, efficiency, and integration of care across organisational and system boundaries. In addition to the systems and processes set out elsewhere in this Framework, assurance mechanisms to review health outcomes across the District include:

- Learning from deaths as set out in the mortality section below.
- Patient reported measures (PRMs) as set out in section 4.
- Clinical performance metrics as set out in the annual agreement with the NSW Ministry of Health, which are monitored in performance meetings through the SLHD Health System Performance (HSP) Reports and tabled at a range of committees.
- Clinical audit outcomes governed by the SLHD Audit Framework (below).
- Every committee that holds governance responsibility reviews the outcomes aligned with its terms of reference.
- Health outcomes are also assured through external accreditations.

Morbidity and Mortality Program

Facility morbidity and mortality meetings oversee learning and provide assurance on death reviews. The CEC monitors deaths across the state including through the Death Review Reporting System. Screening staff flag surgical mortality and those involving anaesthetic for further notification to the Collaborating Hospitals' Audit of Surgical Mortality (CHASM) and Special Committee Investigating Deaths Under Anaesthesia (SCIDUA). Benchmarked mortality data is collated by the Bureau of Health Information (BHI).

Clinical Indicator Monitoring

The District uses an extensive suite of clinical indicator information from a range of sources in its committees, clinical stream, and facility performance meetings. Where possible, benchmarked information is provided for additional comparison. Clinical indicator data is provided by the SLHD Performance Unit, the CEC's Quality Improvement Data System (QIDS) and Quality Audit Reporting System (QARS), local audits, and specialty-level data collections. ims+ provides critical safety and patient experience metrics to inform ongoing improvements in service quality and performance. Clinical indicators are built into committee reports and dashboards to provide assurance from the frontline to specialties, facilities/services and the Board.

Providing Evidence-based Care

The District is committed to safe, high-quality, evidence-based care to give positive patient/consumer experiences, deliver effective clinical care, achieve excellent outcomes, and maintain minimal unwarranted variation.

Clinicians have access to best-practice guidelines and policies, integrated care pathways including

Health Pathways, decision support tools, and clinical care standards relevant to their practice. These include relevant clinical care standards developed by the ACSQHC.

The District has a range of initiatives to support our staff and facilitate the delivery of evidence-based care. These include culture and leadership initiatives to help staff develop their practice and improve processes to enhance their care environment. For example, the Leading Better Value Care (LBVC) program identifies and scales evidence-based initiatives for specific diseases or conditions. The District promotes the use of evidence-based programs from the CEC, ACI, and other organisations to support staff to benchmark their performance internally and externally. Current programs include the Recognise, Engage, Act, Call, Help (REACH) program to support patients/consumers and families to urgently escalate care concerns, Patient Reported Measures (PRMs), and the Sepsis Kills program to improve early recognition and resuscitation. The Between the Flags (BTF) system supports staff to escalate within specified observation parameters, and there is an extensive infection prevention and control program.

Clinical Audit

This section sets out the **SLHD Clinical Audit** approach when performing, monitoring and reviewing and responding to outcomes from clinical audits. This section does not apply to audits performed by the SLHD Internal Audit which maintains an independent regime for monitoring corporate and clinical systems.

Inclusion criteria involves audits of clinical care – including professional practice, clinical outcomes and variation, policy/guidelines/regulations/legislation, patient safety, quality, and experience, clinical effectiveness, models of care, risk management, NSQHS standards, or education.

Audit schedules are maintained by each department, facility, and clinical stream or service which contains core audits for their area. A core audit is identified by a Director of Governance/Head of Department, guided by its clinical standards, patient safety, clinical effectiveness and outcomes, quality improvement and assurance, legislative or regulatory requirements, and patient or consumer experience. Audit schedules are updated annually or more frequently if there are material changes such as new services/significant regulatory changes.

Approval processes for core audit schedules are as follows: a core audit schedule should be approved by a nominated committee or Director of Clinical Governance/Head of Department. Core audits should be designated as annual or recurring. Recurring core audits can only be discontinued with the approval of a Director. If audit data is submitted or circulated outside of the District, this must be approved by the Director of Governance/Head of Department permission following data validation to ensure its accuracy (if required).

Monitoring occurs through committee oversight of core audit completion, findings and outcomes, learning, timeliness and effectiveness of improvement actions, and to guide whole of service opportunities for improvement. Committees also identify opportunities to share the findings with staff and consumers.

Scope and design of audits are informed by risk, including sample sizes, frequency, subject matter, and supporting evidence. Audits are designed to detect unwarranted clinical variation using benchmarks and best practice parameters, which can include the NSQHS Standards. Audit criteria should reflect sector best practice, policies and guidelines and other suitable guidance where possible. Many external audits have a set tool and data dictionary to guide the auditor and minimise interrater variation.

Audit recording occurs in the CEC's Quality Audit Reporting System (QARS) where this is practicable. The District CGU facilitates the use, training and development of audits in QARS.

Non-core audits on a broad range of subject areas are performed across the District as part of ongoing practice development and quality improvement. Department Heads ensure that the audits are retained and reviewed. When a finding raises an actual or potential significant clinical concern, action plans are developed and monitored, with reporting through to the corresponding committee.

Credentialling and Scope of Clinical Practice

Clinical staff who are credentialled and work within their scope of practice is key to patient safety and clinical effectiveness. The following processes achieve this:

- Clinical supervision of registered professionals who are suitably qualified, trained, supervised and have ongoing professional development to maintain skills and experience.
- Competency assessments for applicable areas of clinical practice.
- Monitoring staff maintain their credentialling requirements in line with professional body and SLHD procedures.
- Annual professional development reviews including goal setting and monitoring. This is required for all staff in line with the NSW Public Sector Performance Development Framework and the NSW Health PD2016_040 NSW Health Managing for Performance Policy. Goals and reviews are documented in the Performance and Talent (PAT) system. Governance of performance reviews and mandatory training occurs monthly at facility/service and District committees.

SLHD District policies which set out clinical supervision by staff group:

- SLHD_GL2021_030 Clinical Supervision of Junior Medical Staff Guideline
- SLHD_PD2017_036 Group Clinical Supervision (reflective) for Nurses and Midwives
- SLHD_GL2022_025 Allied Health Professionals and Allied Health Assistants Clinical Supervision

Credentialling of doctors and dentists is governed by the SLHD Medical and Dental Appointments Advisory Committee (MDAAC) in accordance with the requirements of the Health Services Act Model By-Laws as detailed in SLHD_PCP2021_042 Procedures for Appointment and Determining Scope of Practice for Senior Medical and Dental Practitioners in Sydney Local Health District. Nursing and allied health professional credentialling is overseen by the Directors of Nursing and Allied Health.

Professional Commitment to Clinical Governance

The professional commitment of our clinicians is demonstrated through embracing opportunities to improve and work collaboratively to support the delivery of safe, high-quality healthcare. Our staff:

- Actively communicate this commitment among team members so everyone understands their role in safety and quality.
- Actively embrace opportunities to learn more about safety and quality and how this can be applied by teams and services.
- Seek opportunities to identify and progress quality and safety projects in their areas such as new models of care and service re-design.

- Work constructively and collaboratively in multi-professional teams to improve clinical effectiveness and safety culture.
- Participate in clinical networks across the District, across other LHDs, and with system partners to share learnings and benefit from other organisations' experiences.
- Foster a culture where a broad and diverse group of consumers participate in driving improvements by working with consumer advisory groups and committees.
- Provide advocacy and support for patients/consumers who need assistance to express their needs.
- Ensure information provided to patients/consumers meets their needs and is tailored to their level of health literacy.
- Have access to, and are supported to participate in, education and training to maintain currency.
- Support and role model good clinical governance to new and training clinicians, supported by formal and informal mentoring.
- Model professional conduct consistent with legal, professional, and ethical frameworks in delivering excellent care.
- Comply with regulatory requirements and codes of conduct.

Supporting our Workforce through Education and Professional Development

SLHD supports our staff to continue to provide safe high-quality care through education, training, and professional development opportunities. New staff receive District SLHD orientation and local orientation aligned to their roles. All staff access ongoing education and training aligned to their roles which is a combination of:

- mandatory training
- professional training in line with external organisation specifications (e.g. for doctors in training),
- state-wide education from the Health Education and Training Institute (HETI), courses provided by Sydney Education
- local and externally developed courses as indicated.

Many HETI courses are available via the My Health Learning platform. People can apply for supported postgraduate programs including Masters and PhD programs. Staff participate in a range of external conferences, forums and other professional networks.

4. Partnering with Consumers

The District partners with consumers as a key component of delivering truly patient and family centred care. Staff are supported to operationalise clinical governance through involving patients and consumers in a partnership throughout their own care. All staff provide opportunities for patients and consumers to feedback to the District to improve services for the future.

Patient and Family Centred Care (PFCC)

Governance for partnering with consumers is monitored by the SLHD PFCC Steering Committee which monitors how we involve patients/consumers, families and our community in decision making about their care and care needs. The *Sydney Local Health District Strategic Plan 2018-2023* highlights PFCC as a key priority area and a key driver to support the achieving the District's vision of *Excellence in*

Healthcare and Healthcare for all.

The District is particularly grateful to have an extensive and experienced network of consumer engagement groups, with committed members who inform us about how we deliver PFCC. Our consumer network spans across District, facility and service areas to continually expanding the breadth and lived experiences across our pool of consumers. This creates accessible engagement opportunities which is representative of our valued diverse population.

Our collective responsibility to provide patient/consumer and family centred care

We all have vital roles to play to ensure our District provides PFCC now and in the future, including:

- Consulting with service users and responding to their feedback, promoting involvement of disadvantaged and harder to reach community groups, and giving our consumers suitable platforms to have a voice in what quality healthcare looks like for them and their families.
- Enabling consumers to be involved in governance.
- Enabling feedback information through formal and informal routes, to actively inform quality improvement, the design of our services, and our strategic planning. Feedback also helps us to identify 'what works' and to celebrate success.
- Setting District strategies which are informed by a deep understanding of our population, which incorporate patient/consumer views and health outcomes. These are also driven by a commitment to health equity and diversity, are designed to overcome access barriers and promote health literacy, and which incorporate partnerships across the health and care system to benefit all consumers.
- Being fit for the future through experience-based co-design.

Health Equity and Diversity Governance

The District is committed to ensuring our services are inclusive of the diverse people who live and work in our communities. The District has a particular focus on meeting the needs of vulnerable and high risk people.

1. **Aged care** is governed by the Aged Care Clinical Stream and by committees to monitor conditions which are more common in older people, such as the SLHD Falls and Cognition Steering Committee. The SLHD Infection Prevention and Control Committee monitors working with Residential Aged Care Facilities (RACFs) to minimise the spread of outbreaks.
2. **Disability** related strategies and initiatives are governed by the SLHD Disability Action Plan Committee which oversees inclusion of people with disabilities across the District.
3. **Children, young people, and women and babies** are cared for in various service lines. Maternity and paediatrics are overseen by the Women's and Babies Clinical Stream. Community Health Services monitor specialist community-based services (including youth health), with specialist child and adolescent and mother and baby services provided by the Mental Health Service. SLHD is one of four partner agencies who are delivering the collaborative Inner West Youth Health Wellbeing Plan 2018-23 (nsw.gov.au) which is governed by SLHD Community Health Services.
4. **Aboriginal and Torres Strait Islanders -** SLHD is committed to being the first LHD in NSW to close the gap in health outcomes for Aboriginal and Torres Strait Islanders. Through its longstanding partnership with the Redfern Aboriginal Medical Service (AMS), the SLHD provides integrated and culturally appropriate services.

5. **Mental Health** hosts a large and engaged peer worker program. Peer workers with lived experience support and advocate for people accessing mental health service in their health care and recovery journey and have input into service planning and delivery.
6. **LGBTIQ+ health** is a key priority and our District aims to be a leading provider of LGBTIQ+ inclusive healthcare. The program is informed by the NSW Health LGBTIQ+ Health Strategy 2022 – 2027, and is overseen by the SLHD Priority Populations Program.
7. **Men's health** is overseen by Community Health Services, Cancer Services, Mental Health Services, and Population Health. The District's men's health portfolio is also governed through the SLHD Priority Populations Program, guided by the NSW Men's Health Framework.
8. **Multicultural and refugee health** is informed by the NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023 and the NSW Refugee Health Plan - 2022-2027 - Multicultural health. The District has integrated approaches for ensuring the needs of culturally and linbguistically diverse (CALD) community members are embedded throughout our services, such as the Sydney Healthcare Interpreter Service (SHCIS).
9. **End of life care** (EOLC) provision including palliative care is monitored by the SLHD EOLC Committee.
10. **Support for carers** is monitored as part of the SLHD - Carers Program . The SLHD has been recognized for its support for staff and patient carers as a Carer Friendly Employer through achieving level two under the Carers NSW Carers and Employers Program.
11. **Integrated care delivery across locations** includes increasing our footprint of virtual and community-based care to increase equity of access. This includes a range of initiatives such as programs for homeless people, , population health based programs, hospital-in-the-home and our new community health service RPA HealthOne. Moving care out of hospitals and closer to home is particularly important for harder to reach consumer groups. Virtual care continues to be pioneered by **rpa**virtual. Governance of integrated care is via a range of forums including the Aboriginal Health Steering Committee, **rpa**virtual Clinical Council, SLHD Clinical Council and SLHD Clinical Quality Council.

Being Fit for the Future Through Experience-based Co-design

To ensure the District is fit for the future, we need to have ways to determine what best meets the needs of our patients/consumers, and considering the scale of our services now and for future demand. Consulting with consumers as part of state and SLHD strategic planning, is further enabled by horizon scanning and robust projections of population demographics. The District is committed to incorporating stakeholder views through an experience-based co-design (EBCD) process. This involves collaboration between staff and service users to design models of care together so we build the right services based on consumer feedback about their specific needs.

We invite consumers to participate in our governance and operational systems to the extent they choose. This is through a range of working groups, committees, and programs partnering with our staff to help improve our services. Consumers can be involved across the lifespan of a program from planning, design, and review of outcomes through providing in-person or written feedback, evaluation surveys and other input.

The District significantly benefits from longstanding relationships with consumers and partner organisations who generously offer their time including:

- The Naamuru Parent and Baby Unit provides holistic, multidisciplinary specialist health care that is parent and infant centred, family and carer inclusive and culturally sensitive which sits within the Mental Health Service.
- Redevelopment programs at RPA Hospital and Concord Hospital have improved following extensive consumer involvement to inform design workability.
- Our Aboriginal Cultural Garden at Canterbury Hospital provides a space for patients, visitors and staff to enjoy together. The garden provides connection for Aboriginal people whilst they are in hospital and depicts the local Aboriginal history of the Bediagal people who lived along the banks of the Cooks River and surrounding areas.

Providing Culturally and Linguistically Diverse (CALD) Healthcare

The **SLHD Culturally and Linguistically Diverse (CALD) Health Strategic Plan 2022 – 2026** sets out how we improve equitable healthcare, as an integral component of safe and patient/consumer and family centred care. The strategy aims to improve the health and wellbeing of CALD people across the District. It promotes good health, preventing ill-health, increasing access, and enhancing health literacy through a wide range of initiatives including:

- Partnering with CALD community organisations and local councils to develop and implement community based and informed health and social care programs.
- Expanding timely access to health information through targeted, evidence-based community education to CALD communities, and translating key District resources into local community languages.
- The District's Equity Framework.
- Widening interpreter services to include greater use of technology so patients can access information in a way which they can understand and strengthen health literacy and actively participate in decisions about their own care.

Partnering with Patients to Promote Health Literacy

Health literacy is important for all people and the District targets aims to support people from CALD communities to enhance their health literacy. To provide health information in an accessible way to a broad group of patients, families and community members we involve consumers in reviewing our patient/consumer-focused health information publications.

Our Culturally and Linguistically Diverse Health Strategic Plan includes the consumer voice through extensive consultation with our local community groups and consumers. This has informed the ways we can continue to improve the health and wellbeing of culturally and linguistically diverse people in the District.

The plan sets out our ongoing commitment to expanding CALD community and consumer input in policy development, clinical service planning and capital works.

Our Oral Health Service has taken steps to increase the health literacy of its consumers by educating patients, families and carers in a clear yet informative way through web-based resources.

The eMR Comprehensive Care Plan (CCP) supports patient, family, and carer involvement in a person's healthcare journey. This is informative for staff and outlines individual care needs and preferences. The CCP is used across all SLHD inpatient facilities as a shared communication platform between clinical team members and the patient. This plan also documents what matters most and particular communication methods for an individual.

Opportunities for Consumer Feedback

Patient experience feedback is encouraged to inform care quality performance initiatives. This is captured through complaints, compliments, patient and consumer surveys, Bureau of Health Information (BHI) reports, conversations with service users, and patient/consumer stories shared in our Sydney Connect publication.

Management of complaints are operationalised as set out in the NSW Health Complaints Management Policy and the NSW Health Complaint Management Guidelines .

SLHD captures feedback from the Patient Reported Measures (PRMs) Program including Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs). PRMs cover a range of inpatient, outpatient and community settings as set out in the Implementation of Patient Reported Measures (PRMs). PREMs have been translated into 10 languages to support health literacy of people from CALD communities, while the Mental Health Service uses the statewide YES and CES surveys. Patient feedback is used by teams to inform ongoing care improvements, and is monitored through the SLHD CQC and SLHD PFCC Committees.

Healthcare Rights and Informed Consent

The District is committed to ensuring patients/consumers understand their healthcare rights and responsibilities. This includes shared decision-making about care planning and delivery that meets each individual's needs – as outlined in patient information document Your rights and responsibilities Information for patients and visitors.

5. A Safe Environment for Care Delivery

An important element of providing care involves maintaining a safe environment that supports safety and quality. Patients and consumers play an important role in this through providing feedback about their experiences to inform safety and quality improvement (see section 5).

Our organisation provides a range of avenues to report, learn and improve issues about the environment where we deliver care. Safety risks are clearly identified and communicated in line with our policies for incident management, risk management, and other guidance. All staff are encouraged to develop opportunities to enhance the safety and quality of their environment by identifying risks and sharing learning. Leaders and managers, including clinicians, work collaboratively to take account of the safety and quality of the environment when planning and developing services in strategies, plans, models of care and other aspects of redesign.

Work Health and Safety

Work Health and Safety (WHS) at SLHD is operationalised to meet regulatory and legislative requirements set out in NSW Health policy directives PD2018_013 WHS: Better Practice Procedures and PD2022_065 SLHD WHS Policy which outline the WHS roles of executives, people in managerial and supervisory roles, and all staff members. The WHS aims of our District include:

- Ensuring we provide and maintain a safe work environment and safe systems of work.
- Eliminating WHS risks where practicable, and in other situations to appropriately mitigate them.
- Monitoring the effectiveness of staff safety and working conditions through complaint and incident reviews and investigations, audits, risk register reviews and other processes.

- Consulting with staff and external stakeholders about WHS.
- Providing appropriate education, training and guidance to staff about WHS, including safe work practices.
- Promoting staff health and wellbeing through initiatives designed to enhance our workforce experience, and monitoring this through staff feedback initiatives including surveys and feedback events.
- Our work health safety program documents monthly inspections and risk informed processes.

The SLHD policy WHS Consultation PD2019_038 outlines how SLHD consults with staff to enable them to contribute in making decisions that affect their health and safety at work. This includes consultation through ward/department staff meetings, WHS committees, workgroups and Health and Safety Representatives (HSRs), engagement with external stakeholders, and issue resolution processes.

Physical Environment

All staff are responsible for maintaining a safe work environment. SLHD seeks to create safe and welcoming environments for all patients/consumers, visitors and staff – especially for Aboriginal and Torres Strait Islander community members.

The Aboriginal Health Unit provides advocacy, leadership, cultural support, and education to the mainstream health services as well as to the Aboriginal Health workforce. The SLHD has a deep commitment to consult, engage and co-design with our Aboriginal and Torress Strait Islander community in service design and development, and Aboriginal Impact Statements are developed with local Aboriginal people for key strategic documents, including facility Strategic Plans and models of care. community To support engagement and improved outcomes with Aboriginal and Torres Strait Islander people, SLHD conducts the annual Aboriginal and Torres Strait Islander Cultural Engagement Self Assessment Audit Tool (ACESAAT) at every level of the organisation. The annual audit informs a District action plan to further improve cultural appropriateness healthcare for Aboriginal and Torres Strait Islander people.

Capital works planning is prioritised according to risk, and is undertaken in consultation with key stakeholders, clinicians, carers and consumers. The SLHD Patient and Family Centred Care Steering Committee informs improvements to ensure the physical environment meets community needs.

Staff Safety and Security

The safety of our staff is maintained through a range of approaches including safe work practices, policies and initiatives. The District has clear guidance to provide a secure and risk-informed workplace to protect both people and property in line with the NSW Health Protecting People and Property Policy and Manual. Policies support staff in a range of activities including working with patients/consumers with acute behavioural needs, or in exceptional circumstances when consumers are unable to continue visiting our facilities/services.

The Behavioural Escalation and Support Team (BEST) program supports frontline staff to optimise care for patients/consumers whose behaviour poses a risk to themselves or others. The Mental Health Service provides training in Violence Prevention and Management and duress systems to support staff to respond safely to acute behavioural disturbance. The District has a system to communicate about patients/consumers with increased risk of aggression towards staff via eMR

alerts and through Safety Huddles. A range of multi-professional training supports staff to de-escalate and manage situations involving a risk of aggression from patients and visitors.

Organisational Safety Culture

Organisational culture is a key driver of safety culture. The ACSQHC National Model Clinical Governance Framework describes organisational culture as the values, beliefs and assumptions shared by occupational groups which are translated into how people commonly behave as part of everyday life in an organisation.

The components of a resilient and reliable safety culture are one where safety is everyone's responsibility, and compassionate behaviours are seen at all levels. SLHD is committed to delivering the CEC's Safety Culture Framework.

The District **sustains safety culture** in a wide range of ways including:

- Communicating our Excellence in Healthcare, and Healthcare for all, through all SLHD strategies and delivering on this vision through operational plans, quality plans and policies.
- Promoting workforce wellbeing initiatives including the MDOK program, the Colleague Care Program, and Employee Assistance Program (EAP).
- Promoting engagement and opportunities for learning through our annual Innovation Week Symposium.
- Implementing multi-professional governance and strategic leadership through our committee network, clinical streams and specialty governance.
- Establishing measures to evaluate how well we are achieving safety culture through a range of safety and quality indicators. These include benchmarked, NSW Government surveys such as the People Matter Employee Survey (PMES), Bureau of Health Information (BHI) data, and how patients/consumers say we do in Patient Reported Measures (PRMs). We encourage our staff to learn from what works well and what has not through review and reflection on incidents, concerns, and complaints.
- Modelling the organisation's values in a way which promotes safety.
- An integrated risk management framework which underpins patient/consumer, staff, and visitor safety.
- Including education and training on safety culture as part of the SQEP program run by Sydney Education.
- Establishing Safety Huddles to provide a forum for frontline staff to discuss safety concerns or security risks and develop timely, appropriate management plans.