18h September 2025

Australian Commission on Safety and Quality in Health Care (ACSQHC)

Consultation on Draft National Model for Clinical Governance: The Foundations of High-Quality Health Care

Submitted online

Contact Persons for this Consultation:

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Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. Our 'friends' include more than 11,500 people with lived experience of mental health concerns across Australia. This includes lived experiences with all parts of the mental health care system, NDIS, psychosocial disability support outside the NDIS, PHN commissioned services, public and private service options, and service provision across urban, regional, rural and remote Australia. We are recognised as the lived experience Peak representing the perspectives of people with mental health challenges and their family/carers/kin who use Private Mental Health Services (ie. within General Practice, private psychiatry and psychology services, and pharmacy). All members of our Board and staff have mental health lived experience as either a consumer, family/carer/kin/supporter, or both.

We welcome the opportunity to provide our feedback to this consultation.

Background & Purpose of this Consultation

The Foundations of High-Quality Care is a new draft national model for clinical governance from the Australian Commission on Safety and Quality in Health Care. It will replace the 2017 National Model Clinical Governance Framework. The Commission would like to know how useful the model is likely to be in practice, what changes are needed, and whether there are gaps.

This model is designed for public and private health service boards and executives in the acute sector, including day procedure services. Health service leaders can use the model to review and strengthen their clinical governance arrangements, and to identify and monitor what their organisation needs to do to achieve consistently high-quality care.

Clinical governance establishes the conditions for high-quality care. It builds an environment and culture where working together and with patients and consumer advocates to provide high-quality care is everybody's main goal. This model aims to provide national guidance on clinical governance that is clear, relevant and effective in today's context and that helps health services build on the basics to strive for consistently high-quality care.

The model provides a definition of high-quality care and describes the six foundations of clinical governance required to achieve this care:

1. Leading culture and systems
2. Partnering with patients, carers and consumers
3. Building a healthy workforce culture
4. Enabling high-quality and integrated clinical practice
5. Managing and reducing risk
6. Using data for better care

The final model will be released in early 2026.

This survey is in three parts:

Part 1 focuses on how helpful the model will be for its intended audience **(board members and executive leadership teams)**, what changes are needed, and whether there are any gaps.

Completed, with limited feedback due to time constraints.

Part 2 (optional) asks about what future resources are needed to support adoption of the model.

Not completed.

Part 3 (optional) seeks your feedback on areas of focus on clinical governance in the third edition of the National Safety and Quality Health Service (NSQHS) Standards.

Not completed.

Part 1 Questions and Responses

1. What best describes your organisation? * Consumer Organisation, Peak Organisation

2. Are you responding on behalf of an organisation? * Yes

If yes, what is the name of your organisation? (optional) Lived Experience Australia

3. Is the definition of clinical governance clear? * Adequate.

Six foundations of high-quality care

The model describes six clinical governance foundations of high-quality care (see page 12). Each foundation sets out key examples of good practice for delivering high-quality care in a health service organisation. The examples are not a complete list – rather they are designed to capture the most important activities so that health services can review their work in each foundation area.

Foundation 1 - Leading culture and systems

4. How helpful is foundation 1 in describing what good practice looks like for health services? * Only somewhat helpful.

Comments - The notion of 'service' could be elevated, given services tend to be very inward focused on their own focus and sometime forget that they are 'serving' the community.

5. Do the key examples of good practice capture the most important activities? *

If no, what has been missed? all of these examples seem to place the organisation as deciding how and if they approach connections. Being part of and collaborating with the communities they serve is missing from the tone of the document. Feels very hierarchical still.

6. Is cultural safety appropriately addressed in the model? No, only partially.

If no, please provide suggestions for strengthening the model to improve governance for cultural safety

Unsure - something more explicit about what cultural safety means and what it looks like would be useful.

Foundation 2 - Partnering with patients, carers and consumers

7. How helpful is foundation 2 in describing what good practice looks like for health services? * Only somewhat helpful.

Comments - I notice the first sentence on p.7 doesn't really position the person within families and/or communities. Still has tone of a very individualist traditional, and somewhat narrow cultural lens too. Families/kin are also 'invisible' in this statement.

"Clinical governance establishes the conditions for high-quality care. It builds an environment and culture where working together and with patients and consumer advocates to provide high-quality care is everybody's main goal."

In the section, 'patients, carers and consumers' look a little bit 'weird as terminology. Also order with carers before consumers - maybe should be other way around?

8. Do the key examples of good practice capture the most important activities? * No, only partially.

If no, what has been missed? suggest example 6 be strengthened? 'they receive information about outcomes' - this needs to also be timely and understandable, etc

9. Is diversity, including the needs of people from culturally and linguistically diverse communities, appropriately addressed? No, only partially.

If no, please provide suggestions for strengthening the model to improve governance so that it is inclusive

It could be strengthened?

'Person-centred care is equitable, culturally safe and free from racism' - wonder if stigma and discrimination should be also noted. Also 'respect'.

Literacy also as a 2-way process, equally something the workforce needs, rather than continually positioning the service recipient as outside the 'norm' and adjustment then made hopefully for them. (Their culture is their 'normal')

Foundation 3 - Building a healthy workforce culture

10. How helpful is foundation 3 in describing what good practice looks like for health services? *

Comments - the concept of leadership at all and any level, as everyone's responsibility might be useful. workforce that feel they have a say in decisions make for a healthy workforce culture, versus us (the workers) and them (management). Classic cultural problem in workplace when operational staff feel management are distant, don't understand, etc.

11. Do the key examples of good practice capture the most important activities? * No, only partially.

If no, what has been missed? Not all organisational cultures have management structures sorted. Hence, dot point 6 could be strengthened? - 'without fear of blame, and promotes transparency and learning from mistakes" - should add without fear of retribution or negative impact on role/career/reputation/standing within the organisation.

Foundation 4 - Enabling high-quality and integrated clinical practice

12. How helpful is foundation 4 in describing what good practice looks like for health services? *

Comments - Communication gaps are such a pervasive experience for people who use services, and so frustrating. integration in large services especially is often a 'myth' as people have to repeat their story over and over, and worry that important communication is lost in the complex systems where 'right hand doesn't seem to know what left is doing' and mistakes can be made in everyday things, with real consequences for the person.

13. Do the key examples of good practice capture the most important activities? * No, only partially.

If no, what has been missed?

As per above comment, I notice 'communication' is not mentioned as a core aspect of examples.

Foundation 5 - Managing and reducing risk

14. How helpful is foundation 5 in describing what good practice looks like for health services? *

Comments - Currently states 'allows people to openly share' - wonder if this is more than 'openly' and is also about equity re listening to those involved regardless of their power/status within the organisation?

15. Do the key examples of good practice capture the most important activities? * No, only partially.

If no, what has been missed?

Should seminal events / serious adverse events (SAEs) also be mentioned.

I also notice that 'timely' isn't mentioned anywhere in the descriptor or examples.

whilst beyond the internal safety investigations, coroner processes are particularly long, taking several years sometimes.

Foundation 6 - Using data for better care

16. How helpful is foundation 6 in describing what good practice looks like for health services? *

Comments

17. Do the key examples of good practice capture the most important activities? * No, only partially.

If no, what has been missed?

There is no mention of co-designing how good practice measures are developed with people who use the services. Lived Experience Australia has done research with people on the Your Experience of Service (YES) survey, for example, which found:

Three Main Themes:

1. Opportunity (for voice and agency) - people really valued providing feedback because it gave them a sense of agency and control, that things would improve.

2. Delivery (of the survey) - people felt the process of collection of feedback could be vastly improved - Some felt it was tokenistic - “I'll be honest, I just wanted to say whatever I had to say to go home…Here's what we have to do to tick the boxes to allow you to walk out that door and so let's get it done.”

3. Change (must be seen) - people really wanted to know what happened with their feedback: "I think there's a culture across the board of predominantly ignoring feedback."

"I wrote so many pages on that first question. Because I found there wasn't enough room to actually give any kind of reasonable amount of feedback about the service, so I added pages and pages and pages and then after I finished it, I was like, I'm not even going to hear back from this."

Source: Dee-Price B, Dickson R, Coombes T, Earle Bandaralage L, Gould A, Keith S, Lau W, Milne P, Nowak H, Lawn S. (2025) YES Survey: Lived Experience Perspectives of Completing the Your Experience of Service survey.
https://www.livedexperienceaustralia.com.au/_files/ugd/07109d_931049712d0c4df784e61fc6881ea867.pdf

18. Reflecting on the model's six foundations of high-quality care, what key concepts, if any, are missing? *

Trauma-informed seems missing.

19. Please rate the appropriateness of the language and tone for the model's intended audience and purpose *

Comments - Tone seems to still reflect 1-way dominant service-driven perspectives and decisions about actions, ie. not authentically collaborative.

20. Do you have any further comments?

No further comments.

Contact

We thank you for the opportunity to put our views forward. We wish you well with the next steps and would be pleased to contribute our Lived Experience perspectives to any future discussions about this important topic.

Your sincerely

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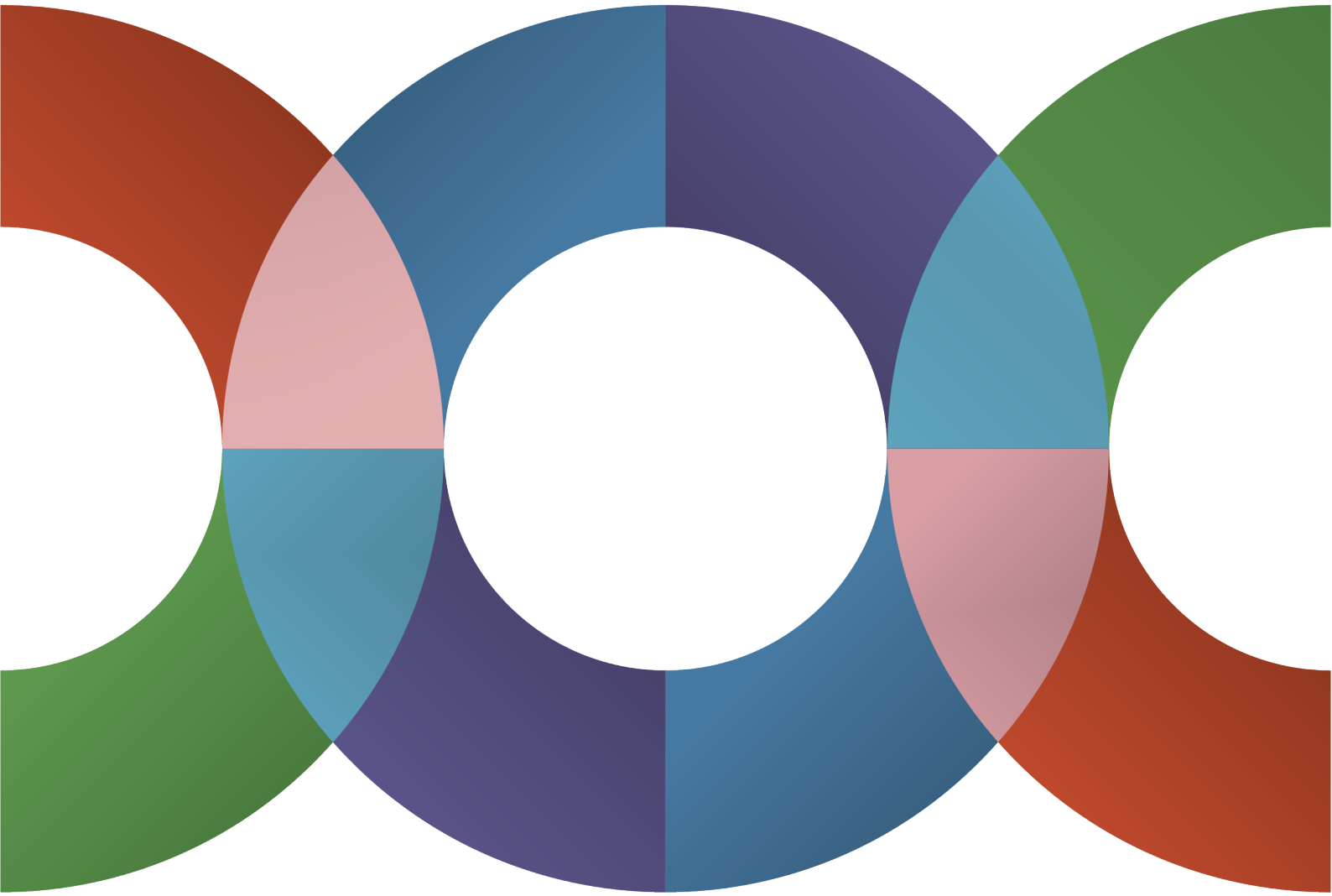
AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE



The Foundations of High-Quality Care

A national model for clinical governance

Consultation draft, July 2025

About this consultation

The Foundations of High-Quality Care is a new draft national model for clinical governance from the Australian Commission on Safety and Quality in Health Care. This model will replace the 2017 National Model Clinical Governance Framework.

The Commission is seeking your input. We would like to know how useful the model is likely to be in practice, what changes are needed, and whether there are gaps.

The final model will be released in early 2026.

Next steps

We will use feedback from this consultation to update the draft model and to develop practical resources that support health services to review and strengthen their clinical governance arrangements.

Questions

If you have any questions about the draft model or about participation in the consultation, please contact the team at clinicalgovernance@safetyandquality.gov.au

Overview

What is the model?

The draft model offers national consistency in how Australia defines and understands clinical governance, and provides clear, relevant and up-to-date guidance for health services on aligning leadership, systems and culture to achieve high-quality care.

This model is for boards and executives of public and private health services in the acute sector, including day procedure services.

Health service leaders can use it to review and strengthen their clinical governance arrangements, and identify and monitor what their organisation needs to achieve consistently high-quality care.

State and territory health departments and private hospital groups can use the model to inform new clinical governance systems and to shape detailed guidance for health services in their jurisdictions.

Why a new model is needed

New national guidance on clinical governance is needed to steer the health system to provide consistently high-quality care in the face of evolving challenges such as workforce shortages, growing demand for health care, the need for environmentally sustainable care, changing patterns of illness, and constrained resources.

Robust governance can harness the opportunities and manage the risks of other changes, such as the rise of artificial intelligence and emerging technologies, and the growth of community-based models of care.

While many health services have been able to embed strong clinical governance in this changing environment, some find it difficult to implement systems that engage the workforce and make a difference to the care that patients receive.

The evidence on what works has also evolved. The link between a positive workforce culture and high-quality care is now stronger and more widely accepted than when the first national model on clinical governance was released.

How the new model was developed

We reviewed the latest evidence to understand challenges in implementing effective clinical governance structures and systems and how to overcome them. We talked to leaders, clinicians, patients and consumers across the health system to understand how clinical governance is understood and applied, gaps in capability and delivery, and what high-performing organisations do differently.

We worked closely with state and territory health departments to design a model that meets the needs of diverse services and settings, and used a collaborative approach to test and refine the model with public and private health services across Australia.

Thank you

In developing this draft model, we have drawn on the collective wisdom and expertise of people across the health system, including in interviews with many health service board chairs and chief executives. We thank them for generously sharing their insights and enthusiasm for the crucial role of clinical governance in achieving and maintaining high-quality care and the best possible patient outcomes.

We also thank the Clinical Governance Advisory Committee (below) for their valued leadership and expert advice.

Name	Position
Mr Michael Gorton AM (Chair)	Consultant, Russell Kennedy Lawyers Chair, Monash Health, Wellways Australia and Holmesglen Institute Board member, Latrobe Regional Hospital, Victorian TAFE Association
Professor Christine Kilpatrick AO	Chair, Australian Commission on Safety and Quality in Health Care Board Professor (Enterprise), Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne Chair, Healthdirect Australia and The Royal Children's Hospital
Dr Cathy Balding	Adjunct Professor, James Cook University Board Director, RSL LifeCare Director, Qualityworks PL
Ms Elleni Bereded-Samuel AM	Executive Manager, Diversity and Inclusion, Great Care Pty Ltd. Board member, Royal Children's Hospital
Dr Peggy Brown AO	Consultant psychiatrist Chair, Mental Health Australia
Ms Suzanne Cadigan	Board member, Children's Health Queensland, Ronald McDonald House Charities and Karuna Hospice Board member, Nursing and Midwifery Board of Queensland
Ms Christine Gee AM	Chair, Australian Commission on Safety and Quality in Health Care Private Hospital Sector Committee Director, Ramsay Mental Health Australia
Professor David Greenfield	Professor of Health Leadership and Management, School of Population Health, Faculty of Medicine and Health, University of New South Wales
Mr Tony Kiessler	Chief Executive Officer, Australian Indigenous Psychologists Association Member, National Indigenous Health Leadership Alliance

Dr Audrey Koay	Chair, Australian Commission on Safety and Quality in Health Care Inter-Jurisdictional Committee Executive Director, Patient Safety and Quality, Clinical Excellence Division, Department of Health, Western Australia
Ms Louise McKinlay	Deputy Chair, Australian Commission on Safety and Quality in Health Care Inter-Jurisdictional Committee Chief Executive Officer, Safer Care Victoria
Professor Jennifer Martin	Chair of Clinical Pharmacology, School of Medicine and Public Health, University of Newcastle President, Royal Australasian College of Physicians
Associate Professor Aunty Carmen Parter	Chief Executive Officer, Girudala Community Cooperative Society Board member, Ahpra
Professor Judy Searle	Chair, Northern Adelaide Local Health Network Governing Board
Ms Maureen Williams	Consumer representative, Emergency Medicine Foundation Consumer consultant, Institute for Communication in Health Care, Australian National University Member, Consumer Leaders Taskforce, Health Consumers NSW

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About this model

Purpose of the model

Clinical governance establishes the conditions for high-quality care. It builds an environment and culture where working together and with patients and consumer advocates to provide high-quality care is everybody's main goal.

This model aims to provide national guidance on clinical governance that is clear, relevant and effective in today's context and that helps health services build on the basics to strive for consistently high-quality care.

Health service leaders can use the model to review and strengthen their clinical governance arrangements, and identify and monitor what their organisation needs to achieve consistently high-quality care.

The model provides a definition of high-quality care and describes the six foundations of clinical governance required to achieve this care:

1. Leading culture and systems
2. Partnering with patients, carers and consumers
3. Building a healthy workforce culture
4. Enabling high-quality and integrated clinical practice
5. Managing and reducing risk
6. Using data for better care

Who this model is for

This model is for public and private health services in the acute sector, including day procedure services.

It is primarily intended for health service board members and executives or equivalent[1] who are responsible for directing and implementing clinical governance systems essential for high-quality care. At the same time, the model is designed to be understood by all of the workforce as everyone has a role in providing or supporting the delivery of high-quality care.

> *When board members, executives and clinical leaders champion clinical governance as fundamental to achieving high-quality care, it sets the tone for the rest of the organisation.*
> Health system leader (to be named with permission)

[1] Where an organisation does not have a board and executive, these roles fall to the key decision-maker and accountable person or group in the organisation.

How to use the model

Boards and executives (or equivalent) can use the model to govern[2], lead and plan for high-quality care through:

- designing systems and processes to achieve consistently high-quality care
- building a shared language and understanding across the workforce of the definition of high-quality care and the six clinical governance foundations required to support it
- enhancing accountability and clarifying roles and responsibilities
- guiding their approach to meeting safety and quality standards.

State and territory health departments and private hospital groups can use the model to inform clinical governance systems and to shape detailed guidance for health services in their jurisdictions.

This model is a principles-based document – it is designed so that health services can apply the six foundations in a way that meets the needs of their organisation, no matter their size, type or location. Practical resources and case studies will support health services to use the model.

How does the model fit with safety and quality standards?

Good clinical governance goes beyond accreditation. It is about building and maintaining the culture of the whole organisation to support delivery of high-quality care every day.

The model's six clinical governance foundations of high-quality care will shape the development of the next edition of the National Safety and Quality Health Service Standards.

Boards and executives should use the model's six foundations to check that their organisation's strategy, systems and culture are aligned to deliver care that is consistently high quality and improving.

The model will guide health services' approach to applying safety and quality standards in a meaningful way. By orienting every role and every system in the organisation to focus on high-quality care, everyone in a health service can be confident that standards are being met every day – not just during accreditation assessments.

Health care is constantly changing and new models of care are continually emerging. Applying the foundations of high-quality care in this complex environment will help health services to deliver the best outcomes for patients and prevent system failures even if there are not specific standards for new types of care.

[2] The model provides practical guidance for health service leaders and does not replace legal and regulatory requirements.

About clinical governance

What is clinical governance?

Clinical governance is central to providing the best outcomes for patients**.** It is the combination of culture, systems and processes that enables everyone in a health service to deliver care that is consistently high quality and improving.

It is the system by which boards, executives, clinical leaders and the workforce are accountable to patients and the community for providing high-quality care – care that is person-centred, safe, effective, accessible and integrated, in a health system that is equitable, efficient and sustainable.

Effective clinical governance builds trust across the health service. Patients experience care that better meets their needs. The workforce is confident that their organisation backs them with the right culture, structures, support and leadership to provide consistently high-quality care. Boards and executives have the oversight and tools they need to realise their strategy for achieving high-quality care.

Clinical governance is part of a health service's overall governance system and is closely integrated with corporate governance, such as financial and legal functions. The board sets the strategy to combine these systems to achieve the central purpose of a health service – providing high-quality care.

> *There is no corporate governance without clinical governance, because we are in the business of providing clinical care.*
> Health service CEO (to be named with permission)

More than compliance

Clinical governance activities are sometimes implemented primarily to comply with accreditation requirements. But clinical governance is not just about accreditation; it is vital to support leaders to make the right decisions, and to engage and enable the workforce to provide high-quality care. Clinical governance systems are most effective when the workforce sees that the purpose is to support high-quality care.

How clinical governance applies to digitally enabled care

Robust clinical governance is needed for all types of care, whether delivered face to face or digitally enabled. Digitally enabled care includes virtual care, remote monitoring, and decision making supported by artificial intelligence.

As digitally enabled models of care evolve and clinical workflows change, governance structures and systems need to adapt.

Clinical governance systems and frameworks must continue to develop to harness the benefits of digitally enabled care – such as enhanced diagnostic accuracy, streamlined clinical workflows and support for personalised care – while safeguarding the safety and quality of care for patients.

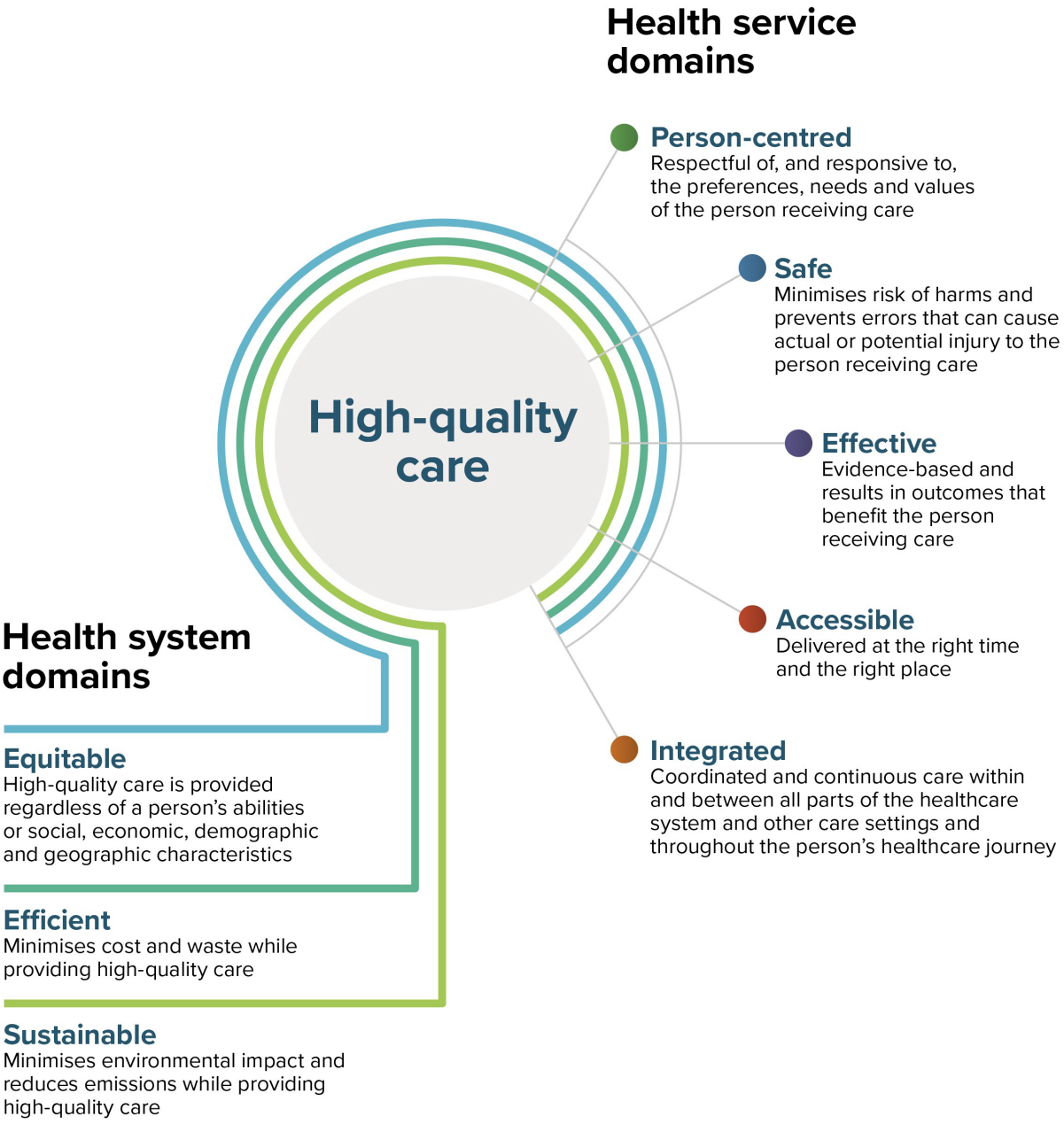
High-quality care

Defining high-quality care

The central aim of clinical governance is to deliver care to patients that is consistently high quality and improving. The Commission's domains of high-quality care (Figure 1) describe the quality of care patients should receive and that boards and executives are responsible for achieving through effective clinical governance.

> *There can be no safe health care without cultural safety. It must be embedded into every aspect of how we plan and provide the right care for our patients.*
> Health system leader (to be named with permission)

Figure 1: Domains of high-quality care



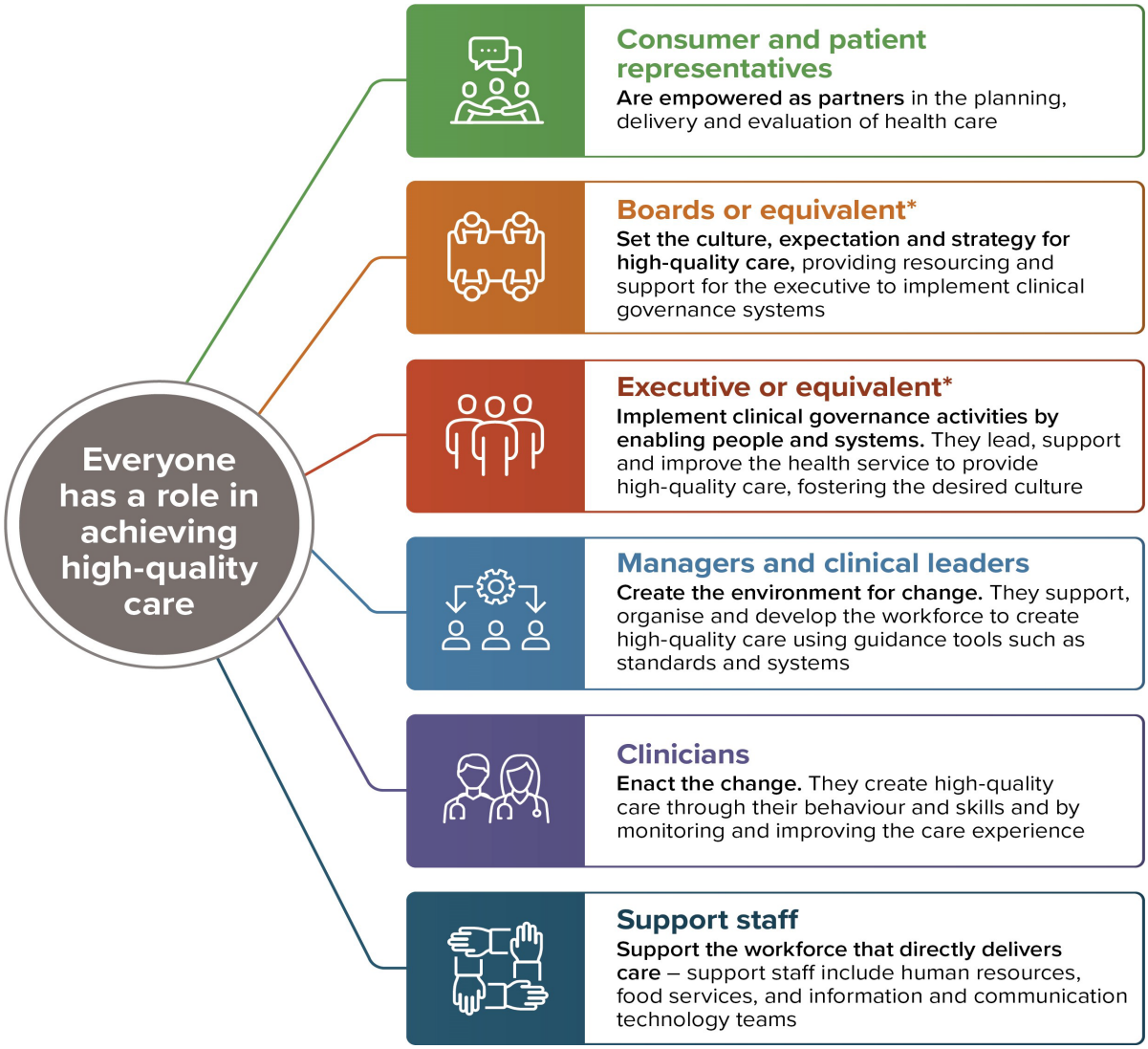
Roles in supporting high-quality care

Everyone in a health service – whether directly or indirectly involved in patient care – is responsible for achieving consistently high-quality care for every patient. To be effective, clinical governance needs to involve the board, executive and the workforce at all levels (Figure 2). Engagement and partnerships with patients, carers and consumers are critical to achieving high-quality care and better patient outcomes.

A note about patients and consumers

This model uses the term 'patient' for the person receiving care. It uses 'consumer' when referring to a consumer advocate or representative involved in clinical governance activities.

Figure 2: Roles in supporting high-quality care



This illustration has been adapted from an Australasian Institute of Clinical Governance (AICG) resource – 'I take responsibility'.

* Governance models differ across Australia – health services in some states and territories do not have boards. Where an organisation does not have a board and executive, these roles fall to the key decision-maker and accountable person or group at the organisation.

The six clinical governance foundations of high-quality care

Clinical governance is the set of organisational systems designed to support health services to deliver high-quality care. In this model, these systems are structured into six clinical governance foundations (Figure 3) that, when combined, underpin an organisational approach to delivering consistently high-quality and improving care.

The six foundations are connected and interdependent. The effectiveness of each foundation can vary as the environment changes. This means that continuous monitoring, evaluation and improvement are required to check that a health service's activities are aligned with each foundation and remain fit for context, culture and purpose – and achieve high-quality care as a result.

Of the six foundations, leadership is a critical enabler of effective clinical governance. The board and executive provide clear strategic direction while creating a culture in which there is leadership and accountability at all levels of the organisation for providing high-quality care.

This section sets out the key points of good practice for each foundation. It is not a complete list – rather it is designed so that health services can assess their work in each foundation area. Accompanying practical resources provide more detailed information on effective practice for each foundation.

Figure 3: The six clinical governance foundations of high-quality care

1. Leading culture and systems

Leadership and organisational culture (shared values and ways of thinking and acting) are central to how care is delivered and the outcomes of that care. Effective leadership at all levels of a health service is critical to achieving high-quality care, influencing and reinforcing all the foundations of high-quality care. The board and executive set the strategy and culture for high-quality integrated care, and collaborate with the workforce and patients, carers and consumers to achieve better care and patient outcomes.

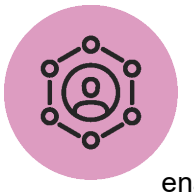
Safety and quality inquiries have highlighted that leadership actions – or lack of action – have a major impact on the operations and culture of a health service. Ineffective operations and negative culture contribute to poor staff morale, system failures and suboptimal care, while positive organisational culture and robust operations are associated with more satisfied and motivated staff and better patient outcomes.

What good practice looks like – key examples

1. The board and executive have a clear vision and strategy for providing high-quality care that is communicated and understood across the organisation. The clinical governance framework underpins and supports achievement of the strategy.
2. The structure and operations of the board, executive and committees are designed to enable collaboration and accountability for providing high-quality care.
3. Board decision-making considers the perspectives of people with personal knowledge and insights gained through direct involvement with a health condition.
4. Active engagement with Aboriginal and Torres Strait Islander people and communities prioritises their leadership and ways of knowing to provide culturally safe care that is free from racism.
5. Governance arrangements explicitly include and empower Aboriginal and Torres Strait Islander staff and community representatives.
6. There is systematic engagement with culturally and linguistically diverse patients, carers and communities as active partners in health service planning and delivery.
7. The board and executive collaboratively engage with the workforce, patients and community. For example, board members and executive regularly visit frontline services to talk with staff and patients, and staff present to board and executive meetings on quality of care.
8. Open disclosure reporting processes are valued, supported and embedded at all levels of the organisation.
9. The board and executive lead strategies to deliver environmentally sustainable health care through minimising unwarranted variation in care and wasteful care.
10. Leadership of digitally enabled care is rigorous and proportional to risk, just as it is for traditional care. There is effective oversight of digital health infrastructure and applications (including patient self-management platforms), data privacy and the ethical use of automated systems in clinical decision-making and patient care.
11. Safety and quality standards are implemented as enablers of effective clinical governance to achieve consistently high-quality care, not just to meet compliance requirements.

> *Leaders need to understand what it is like for both staff and patients. Talk with frontline staff first – that will give you an idea of why this is important. Sit with patients and pretty quickly you will realise that you need to do something about the point of care.*
> Health system leader (to be named with permission)

> *Culture is the hardest thing to sustain. Reputations are hard to earn and easy to lose. You need to stay vigilant.*
> Health system leader (to be named with permission)



2. Partnering with patients, carers and consumers

Partnering with consumers in clinical governance – and with patients in their own care – is critical to achieving high-quality care, contributing to better outcomes and experiences for patients, carers and families. Governance systems at all levels of the health service enable patients, carers and consumers to shape their care. The board and executive lead systems that build a culture of person-centred care so that everyone in a health service partners with patients, carers and consumers to provide or support the delivery of high-quality care.

What is person-centred care?

Person-centred care is health care that respects the patient, their family and carers, and responds to the person's preferences, needs and values. Person-centred care is equitable, culturally safe and free from racism.

What good practice looks like – key examples

1. Meaningful and active partnerships with patients, carers and consumers inform priorities and processes for providing high-quality care.
2. A consumer engagement strategy recruits, trains, supports and connects consumers to health service activities and projects and measures this engagement.
3. The board and executive act on patient outcome and experience measures alongside other performance measures and allocate resources to embed person-centred care.
4. The organisation partners with patients, carers and consumers who reflect the diversity of the wider community to design, measure and review health services. Insights from people with personal knowledge of a health condition strengthen clinical governance by informing policy development, quality improvement and education.
5. Formal and informal ways are used to gather feedback from a diverse and representative range of patients, carers and consumers.
6. Both positive and negative feedback is encouraged. There are clear processes to receive this feedback and to use it to improve care. Patients, carers and consumers know how to provide feedback and they receive information about outcomes.
7. Patients, carers and consumers are encouraged to speak up for safety and their concerns are acted on. There are culturally safe processes for patients and carers to voice concerns about deterioration during clinical care.

> *We start all board meetings with a report of a patient experience to set the context. It highlights the importance of patient care.*
> Health system leader (to be named with permission)

3. Building a healthy workforce culture

A supported and satisfied workforce is essential to delivering high-quality care and improving clinical outcomes. Many factors contribute to building and retaining an engaged workforce, including a physically, psychologically and culturally safe workplace, effective staff development and performance management systems, management of workload and adequate staffing, and supervision and support of junior clinicians. A positive organisational culture in which staff feel respected, valued and safe to speak up for safety is a critical factor in boosting workforce morale and enabling staff to provide or support consistently high-quality care.

What good practice looks like – key examples

1. The board and executive define the workforce's responsibilities for delivering high-quality care and provide appropriate and effective workforce planning and resourcing to meet them.
2. The board receives regular reports on workforce risks, pressures and gaps. Succession planning is proactive and occurs regularly for all key roles.
3. The board, executive, clinical leaders and managers understand the link between workforce health and wellbeing and the quality of care. They systematically measure and improve workforce safety, satisfaction and engagement, and manage and reduce risks and adverse events.
4. Operational systems and processes are designed so that the workforce can focus on patients and their needs, enabling them to provide high-quality care.
5. Education and training programs, competency frameworks and performance reviews enable the workforce to provide or support high-quality care.
6. The workforce feels safe to speak up for safety. The culture encourages identifying, monitoring and reporting risks, incidents (including near misses) and complaints without fear of blame, and promotes transparency and learning from mistakes.
7. The organisation attracts, recruits and retains a diverse workforce that reflects the community it serves. The workplace is safe and culturally responsive, acknowledging, respecting and accommodating difference.
8. The workforce receives practical support to develop and integrate new evidence-based technologies into their practice.
9. Clinical and corporate systems enable the workforce to provide and measure the quality of care through:
    - evidence-informed policies, procedures, clinical protocols and standards accessible at the point of care
    - clinical information systems and digitally enabled care
    - responding to feedback from the workforce about actions to address risks and improve care.

> *Clinical governance is important to all of the workforce – everyone should talk about patient care. You can't imagine the difference it makes to the finance department when they realise they're doing something meaningful – that they contribute to the patient experience at the point of care.* Health system leader (to be named with permission)

> *A clinical governance system enables every staff member to understand that we are here for patient care and how we all contribute.*
> Health system leader (to be named with permission)

> *We don't have a no-blame culture as this sends the message that there is no accountability. Instead we have 'just' decision-making – a restorative culture.*
> Health system leader (to be named with permission)

4. Enabling high-quality and integrated clinical practice

A key purpose of a health service is to provide clinical care to achieve the best patient outcomes. Patients are likely to have the best outcomes when their clinical care respects their needs and preferences, is informed by the best available evidence, and is integrated across clinical care providers and settings.

Clinicians have the skills and expertise to deliver care that is most likely to achieve the best outcomes for patients across the continuum of care. They work collaboratively to provide high-quality care and contribute to, and participate in, an organisation's clinical governance systems. Leaders and managers create the systems and environment that support clinicians to provide consistently high-quality care. Clinicians, the board, executive and managers are accountable for providing high-quality care.

What good practice looks like – key examples

1. There is regular review of a range of measures to determine whether the organisation is consistently providing all the dimensions of high-quality care. This information is used to improve care.
2. Quality improvement activities monitor and continuously refine care to ensure it aligns with best practice.
3. The organisation's responsibility for patients, their families and carers extends across the continuum of care, including improving care and managing risks at transitions of care. Collaboration and coordination of services promotes integration of care across providers and settings.
4. Clinicians and clinical teams actively participate in peer review and quality improvement activities, act to improve care and receive information on outcomes of actions.
5. The organisation reinforces and supports clinicians' dual roles – as healthcare professionals and stewards of system improvement – and develop their leadership skills to drive and support high-quality care.
6. There are robust and transparent systems to protect patient safety through credentialling, re-credentialling and defining scope of clinical practice, and the effectiveness of these systems is monitored.
7. A range of clinician groups is represented in clinical governance roles. The reporting system provides the board and executive with an accurate view of clinical perspectives on care quality.
8. There is strong collaboration between clinical and technical teams, ensuring quality, safety and accountability in the use of digitally enabled models of care.
9. Clear protocols guide when and how digitally enabled tools support clinical decisions, with defined accountability and human oversight.
10. Clinicians' leadership, teamwork and communication skills are developed to enable them to work in teams to deliver high-quality care.

> *Clinicians need to have time and space to lead on quality.*
> Health system leader (to be named with permission)

5. Managing and reducing risk

Health services are, by their nature, high-risk environments. Risk management frameworks need to be robust and adaptable as new technologies and digitally enabled health care continue to evolve. A strategic approach to risk management informs monitoring, planning and allocation of resources. It requires systems and a culture in which everyone in a health service is accountable for identifying circumstances in which patients or the workforce could be harmed and acting to prevent or control those risks. A safety culture allows people to openly share lessons from safety investigations, and to speak up when something is of concern.

What good practice looks like – key examples

1. The clinical risk culture aligns with the organisational purpose and strategic plan. The board agrees on the level of risk that the organisation is willing to tolerate to achieve the strategic vision for high-quality care.
2. A systematic approach to risk management involves every part of the health service. The organisation identifies, reports on and acts to minimise risk and harm, and proactively identifies causes of risks.
3. Data about risks, near misses and incidents are used to improve patient outcomes and experience, and to inform training and development – creating a learning organisation.
4. Investigations of safety incidents accurately identify root causes and draw together findings from related investigations to develop systematic and effective solutions.
5. Clinical incident and risk reports are analysed to look for trends to inform improvement efforts.
6. The safety culture is monitored, including patient and workforce perception of safety culture, and findings inform improvement strategies.
7. The organisational structure and reporting processes help to identify and address risk:
    - Committees are structured to increase communication about risk, for example, the chair of the safety and quality committee sits on the audit and risk committee.
    - The board understands risks to patient safety at the point of care, aligns the risk register with issues identified by patients and the workforce, and management addresses these issues.
    - The board receives distilled risk reports that enable a strategic response.

> *We spend a lot of time categorising and framing risks and setting appetite for risk. Our risk register is used as a reference for resource allocation and planning. We bring the risk register to life by including patient stories.*
> Health system leader (to be named with permission)

> *It's important to set a risk tolerance for the organisation. You can't eliminate risk. Health care is unavoidably high risk.*
> Health system leader (to be named with permission)

> *We have the flexibility to do deep dives into particular areas of risk and to respond to emerging risks.*
> Health system leader (to be named with permission)

6. Using data for better care

Collecting and analysing data about health service systems and performance, patient outcomes and experience – and acting on the findings – is fundamental to providing high-quality and continuously improving care. Effective use of data enhances health service management, including risk management. Responsive governance is needed to use findings across the health service to inform learning, improvement and accountability.

The board and executive champion a data-driven improvement culture by making data-informed decisions and providing information to all who need it. Data are used to identify areas for improvement and to provide feedback to the workforce to prompt behaviour change. Insights from multiple data sources (triangulated quantitative and qualitative performance, experience and outcome measures, and complaints) provide a deeper understanding of the quality of health care and the impact of efforts to improve care.

What good practice looks like – key examples

1. The board and executive use data to monitor all domains of high-quality care and to allocate resources to respond to key findings.
2. The board directs what data it receives and how it is presented. Quality and risk data are summarised and communicated so that trends and issues are clear to all, including managers and board members who do not have a clinical background.
3. The organisation reviews and uses multiple sources of trend and comparative data to reduce unwarranted healthcare variation, manage risk, measure performance, and drive innovation to promote high-quality care.
4. The organisation develops the capability of the executive, safety and quality team and workforce to use evidence-based improvement and change methods to achieve consistently high-quality care.
5. Clinicians receive timely information about the quality of care and care outcomes so that they can identify priority areas for improvement. These priority areas are reported to the board.
6. The organisation works with Aboriginal and Torres Strait Islander people and communities to interpret and respond to data in a culturally appropriate way and prioritises their right to data sovereignty (the right to govern the collection, ownership and application of data about their communities).
7. The organisation uses robust data governance, ensuring data sovereignty, and implements processes to continuously monitor and validate the performance of digitally enabled systems to ensure they remain high quality, accessible and effective.

> *Leaders need to be inquisitive about all types of data, including the soft signs that could have an impact on patient care. It's important to triangulate multiple data sources or perspectives. If you know that staff have high rates of sick leave and overtime, you need to dig further to find out what's happening with the workforce.*
> Health system leader (to be named with permission)

Clinical governance: what not to do

Health services are less likely to deliver high-quality care when they:

- delegate responsibility for clinical governance to a clinical governance or quality team rather than accepting that this is an organisational responsibility that must engage the board, executive and workforce across the organisation
- deal with incidents as they occur rather than anticipating and addressing potential risks
- focus more on complaints and errors than on celebrating and learning from success
- fail to recognise social and cultural diversity and do not adapt responses and service delivery to meet people's unique needs
- produce detailed reports with a lot of data but no insights
- inadequately monitor healthcare variation and do not know how clinical outcomes and patient experiences compare with similar organisations or trends over time
- make positive statements on quality and safety performance without evidence
- do not seek meaningful reporting on the quality of care and/or the clinical governance systems that support it
- accept poor outcomes with no clear actions for improvement or monitoring the effectiveness of these actions
- fail to set clear and shared aims for the desired quality of care
- conduct safety and quality meetings in isolation and do not report to the executive.

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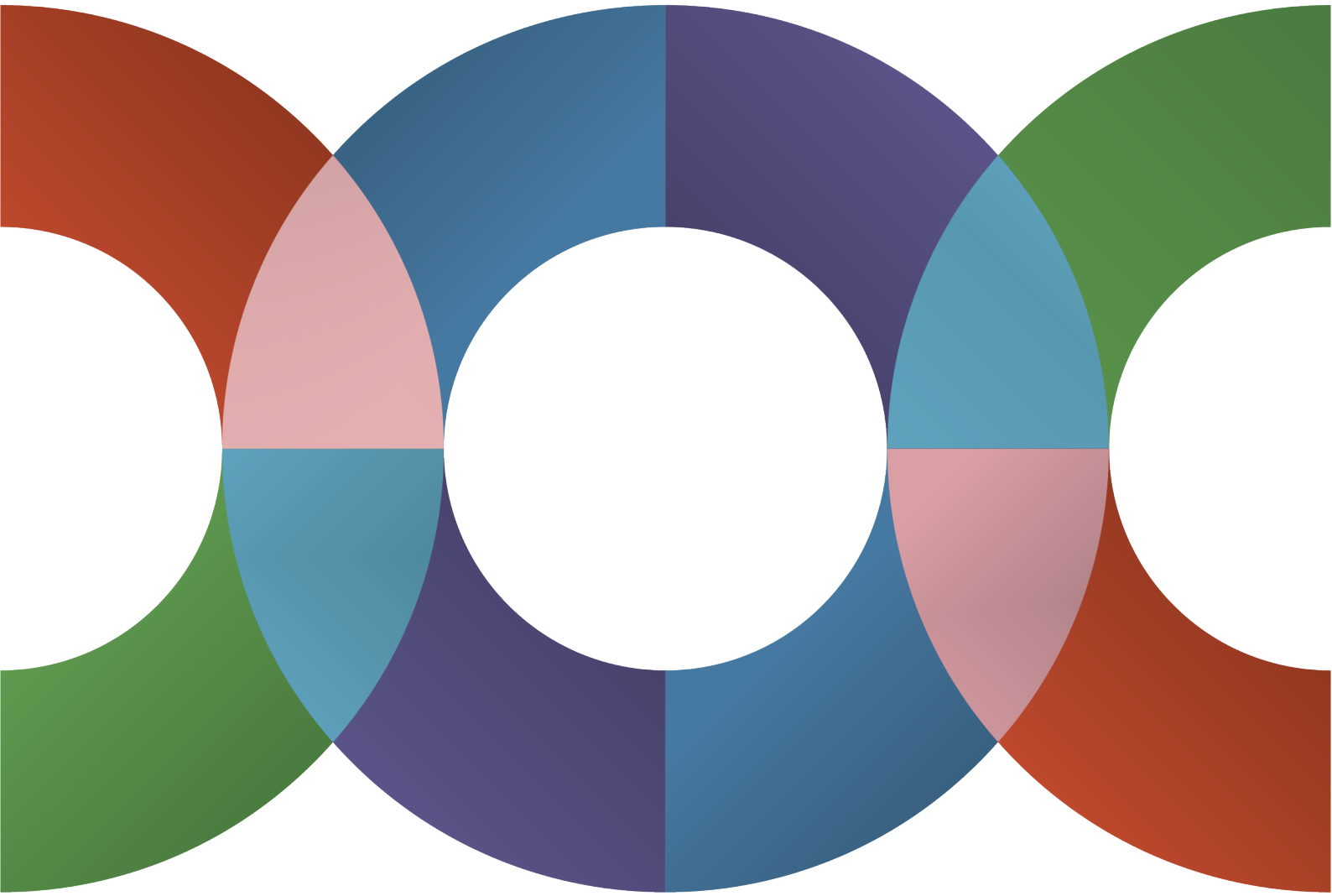

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