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authors **Amanda Jones**
Manager, Deeble Institute for Health Policy Research
Australian Healthcare and Hospitals Association
Email: ajones@ahha.asn.au

Susan Killion
Director, Deeble Institute for Health Policy Research
Australian Healthcare and Hospitals Association
Email: skillion@ahha.asn.au

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Key messages

The framework for commissioning of health services sets out an approach for deciding how to use the available health resources to improve outcomes in the most efficient, effective, equitable and sustainable way.^{1,2} It is an inclusive partnership between Primary Health Networks (PHNs) health planners, funders, contract managers, boards, clinicians and consumers. Clinical governance supports high quality health outcomes through clinical leadership and accountability to commission primary health services that are both safe and effective.

PHNs are leaders for change and while they are responsible for creating a culture of safety and quality there are boundaries to their capacity to control health outcomes. While commissioners are not direct service providers, they have responsibility for clinical governance in articulating safety requirements and monitoring the quality of processes and outcomes. PHNs also have a role in primary health care workforce development and influencing the uptake of quality improvement activities including the interface between primary care, acute care and community services.

Clinical governance principles are a critical element of health commissioning frameworks and can be built into established models. With oversight from the PHNs, the intention of clinical governance frameworks is to build capacity for providers to self-manage clinical governance where clinical safety is included in standard contract management procedures, risk management plans and organisational policies and procedures.

The critical areas in ensuring clinical governance are:

- Consumers having opportunities to manage their own health and also participate in innovation and value creation through co-design processes.
- Clinician-led workforce that enables PHNs to make informed decisions about commissioning health services with providers who have the appropriate capacity and expertise to deliver safe care.
- Delivery of safe quality care through identifying areas for practice improvement and those practices that may put consumers at risk of harm, and making recommendations to prevent or control those risks.
- Clinical risk management to ensure that service providers have the capacity to meet legislative requirements and national and jurisdictional standards when designing best practice for their service.

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Introduction

Responding to the needs of people who are most at risk of poor health outcomes is a priority for governments and communities across Australia. While definitions vary, there is widespread agreement in the literature that the commissioning of health services is more than traditional planning, funding and procurement. It is the process for deciding how to use the total health resources available in order to improve outcomes in the most efficient, effective, equitable and sustainable way.^{1,2}

This issues brief sets out the rationale for developing and implementing a clinical governance framework for PHNs in commissioning the provision of primary health services that are safe and effective. It provides principles that inform clinical governance policy including recommendations on how clinical governance should be supported in commissioning undertaken by PHNs for contract development, management, auditing and compliance. PHNs also have a role in influencing the uptake of quality improvement activities in general practice including the interface between primary care and community services.

This brief describes an outcome-based approach to clinical quality and safety, broadening the focus from what things are done, to how they can be done to deliver safe, clinically effective care. It is a challenging task.

What is clinical governance and why do we need it?

Clinical governance is about leadership. It includes establishing a learning environment that is focused on creating safe, effective and responsive services. It ensures the boards, managers, service providers, clinicians and health workers understand their role and responsibility for the safety and quality of care they commission or provide. Good clinical governance also creates a 'just' culture that supports reporting, service improvement and embeds the experience of consumers into service design and delivery.³

Health service providers are responsible for the quality and safety of the services provided by their facilities, staff and contractors.⁴ PHNs as commissioners have an obligation to prevent clinical care which could be reasonably foreseen to injure or harm others. Anticipating risks for consumers and taking care to prevent them from coming to harm can only occur with oversight and understanding of clinical outcomes.

Primary health care and PHN commissioning frameworks

As part of the Australian Government's reform agenda, the establishment of PHNs in July 2015 signalled a policy intention to utilise commissioning for primary health care in Australia. The Australian Government Department of Health defines commissioning as:

“a strategic approach to procurement that is informed by the baseline needs assessment and associated market analysis. Commissioning will enable a more holistic approach in which PHNs can plan and contract medical and health care services that are appropriate and relevant to the needs of their communities. Commissioning is further characterised by ongoing assessment to monitor the quality of services and ensure that relevant contractual standards are fulfilled.”⁵

Commissioning is a core function of PHNs. A number of commissioning models have been implemented across Australia based on broad values to provide services that are:

- accessible, clinically and culturally appropriate, timely and affordable;
- patient centred and based on population health needs;
- well integrated, coordinated and provide continuity of care, particularly for those with multiple ongoing and complex conditions;
- safe, and of a high quality and which are underpinned by relevant research and innovation; and
- efficient and cost effective in order to ensure fiscal sustainability.⁶

The Australian policy environment

PHNs support general practice, primary, aged and community care to better meet the health needs of the community. The transition from Medicare Locals has included enhanced responsibility for the PHNs around the health outcomes of the communities they serve. PHNs are responsible for finding more effective and efficient ways of making public money deliver better health outcomes by bringing together regional clinicians and agencies to assess need, plan and deliver services. This represents a policy shift away from a system that rewards occasions of service to one that places greater emphasis on outcomes, quality and value for money in service delivery.⁷ In the absence of national standards for safety and quality when commissioning health services, this paper provides guidance to PHNs on how and when clinical governance can and should be incorporated into the commissioning cycle.

Fundamentally, commissioning is about health outcomes and not just the financial bottom line. While work in the establishment phase has placed emphasis on consumer engagement, contract and resource management, commissioners also have clinical governance responsibilities for service provision that have yet to be fully realised.

Where are we now?

Clinical governance in commissioning for health is relatively new to the Australian primary health system with evidence consisting largely of case studies and grey literature. Notably, gaps in the literature were identified around safety, credentialing and monitoring and to date there have been few Australian evaluations, service reviews or published peer-reviewed journal articles. Internationally there has been a considerable amount of research conducted into various aspects of clinical commissioning in the UK, USA and New Zealand.

International perspectives

International literature supports the assertion that a more integrated approach to health services with primary healthcare at the centre is key to the provision of efficient, effective, high quality and sustainable patient-centred systems.⁸ Commissioning health services emerged in the UK in the late 1980s to introduce competitive tendering and expand services to non-government and private providers. In New Zealand in 2010 the Alliance concept was derived from the construction industry, where independent companies collaborate rather than compete to deliver projects.⁹ In the US commissioning has been used to organise affordable health care for people within specific health insurance arrangements, for example military veterans.⁷ Work undertaken by the AHHA in partnership with the Public Health Association of Australia highlights work by the US Accountable Care Organisations that provide some learnings for Australia, including engagement of patients in self-management, strategic partnerships and a movement from fee for service, beyond fee for performance, to fee for outcomes.¹⁰ However all have had mixed results.

Commissioning, when used as a strategic planning approach to link resources with assessed need has a strong rationale. Using evidence of need and best practice to underpin spending decisions, rather than funding on the basis of historical spending and funding patterns is a sound approach, however, there is a need for more evidence to demonstrate that commissioning results in better outcomes.¹¹ Similarly, recent research by Gardner et al found that the international evidence base for the impact of commissioning requires further development. Most studies examined commissioning for populations while few explored commissioning for subpopulation groups or for individuals.⁷ There is also insufficient evidence to identify a preferred method of commissioning. Although planning, contracting and monitoring are all critical elements in the process, the emphasis has been on planning, with some attention to contracting but very little on monitoring contracts and performance, or supporting patient choice.

What are PHN clinical governance roles and responsibilities?

While PHNs are responsible for creating a culture of safety and quality, there are boundaries to their capacity to control health outcomes. Navigating the complexities of implementing safety and quality will require management of two distinct requirements. Commissioners are responsible for service delivery, however, **clinical governance for commissioning** involves responsibility in articulating the requirements and monitoring the quality of health care processes and outcomes. In the **clinical governance for general practice** space PHNs have a role in system improvement, workforce development and influencing the uptake of quality improvement activities including the interface between primary care and community services.

The **Board** has ultimate responsibility for the governance of clinical care within the PHN. The Board appoints the CEO, provides oversight of management, assists in developing strategy and ensures the achievement of strategic objectives. The Board is assisted in its governance role by the Safety and Quality and Audit and Risk committees (or similar) and its decision-making should be informed by curiosity, judgement and openness to "difficult news".¹²

The **CEO and senior managements' role** in clinical governance is to implement and provide oversight in the implementation of quality systems within the organisation. Where the implementation is delegated, a system of monitoring should be in place that provides a mechanism to confirm that quality and safety systems and processes are functioning effectively.

Health service managers and health care teams have responsibilities in facilitating the effective implementation of the framework through the establishment of clinical competence, evidence-based care and ongoing monitoring and supervision. Monitoring outcomes includes implementing a system for reporting complaints, compliments and identifying practices that need quality improvement intervention.

Consumers, carers and community members also have a role in implementation through meaningful engagement in decision-making about health policy and planning, care and treatment, and the wellbeing of themselves and the community.

The way forward

Clinical governance frameworks can drive behaviour, both individual and organisational, that lead to better patient care including processes to ensure high standards of clinical performance, clinical risk management, clinical audit and ongoing professional development. Services underpinned by clinical governance principles have well developed processes to take action to manage adverse events.¹³

Dickinson identified risks associated with healthcare commissioning in the developing Australian context, identifying that individuals and organisations might engage in an uncritical and superficial manner by simply creating an organisation tasked with commissioning that will not deliver a changed approach or the expected positive outcomes. PHNs may not take the opportunity to deliver a more strategic approach.¹⁴ The path to developing clinical governance is not straightforward and requires joint accountability between commissioners and health professionals for both financial and clinical performance and quality.⁹

The critical areas for consideration in ensuring clinical governance are:

1. Clinical leadership and supervision

With clinical leadership and supervision expertise, PHNs will be able to make clinically informed determinations about commissioning health services with providers who have the appropriate capacity and expertise to deliver safe care. While PHN Boards are informed by Clinical Councils and Community Advisory Committees, appropriate quality and safety or clinical committees may be established to support councils by providing subject matter expertise in areas that are not necessarily within the scope of practice of council members. Clinical leadership provides a focus for standard setting and appropriate delegation of responsibilities.⁶ For example, in the UK, clinical communities have been developed to allow decision makers access to clinicians with the knowledge and motivation to drive effective change, share best practice, knowledge and experience combined with an understanding of the system they work in.¹⁵

2. Clinical risk management

Clinical risk management is part of the broader enterprise risk management system that includes strategic, financial and operational risk management. Clinical risk identifies care or system issues that puts consumers at risk of harm or poor quality care and then identifies strategies to prevent or control those risks.

The role of PHNs as commissioners is different from direct service provision and establishing the right level of oversight to match this role, rather than a day-to-day operational role is important. In order to prevent or control clinical risk, as recommended by the National Safety and Quality Health Service Standards¹⁵, PHNs should consider and take the following steps to identify risk in their organisation including:

- Agreement about the standard of care and the clinical outcomes is required. This needs to be shared by the Community Advisory Committee and Clinical Council, executive, PHN commissioning staff, service deliverers, consumers of the service and endorsed by the Board.
- Consideration of the risk appetite of each PHN. This means discussions with the Board about the amount and type of risk that PHNs are willing to accept in order to meet their strategic objectives.
- Identifying data requirements and how these will be collected and interpreted including audit and data collection systems that identify safety and quality concerns, clinical incidents, patient complaints, quality activities and safety audits. These systems should be supported by clinically led risk reviews to identify areas of high risk, ascertain what adverse events are occurring or could potentially occur. This could be undertaken by service providers if they have the experience and capacity to do so, however the commissioner needs to ensure that safety structures are in place.
- Agreement about how the above will be reported and jointly monitored by the service and the PHN as a standing meeting agenda item for the network.
- Development of strategies to ensure the effective exchange of data, knowledge and expertise.¹⁷

These steps are a natural part of service co-design and are fundamental to establishing clinical governance using a ground up approach.

3. Legislation and quality standards

There are a number of parameters that are set through legislative and regulatory mechanisms to provide assurance to the public on standards of health care provision. Commissioners need to ensure that service providers have the capacity to meet these legislative requirements. In addition, they must consider national standards and guidelines when designing best practice for their service.

An example of quality standards can be seen in the National Standards in Mental Health Services developed by the National Mental Health Commission and revised in 2010.¹⁸ These standards were designed to be implemented across the range of mental health services, including those in public, private and community-managed sectors. Implementation is not mandatory. There are similar examples for aged care services. Accreditation and quality standards for general practice and

primary care are other examples. While some services and health professionals have service and professional standards with which they should comply, not all community based services have mandatory national or accreditation standards.

Understanding clinical risk and building governance into existing structures

PHNs across Australia operate similar commissioning frameworks. Commissioning is a continuous process that requires PHNs to be responsible for three main areas of activity:

Strategic planning – assessing the needs of the community and available health services and determining priorities based on service analysis and professional and community input

Service procurement – purchasing health services in line with outcomes of strategic planning, the PHN objectives and the identified local and national priorities for the PHN

Monitoring and review – assessing the efficiency and effectiveness (including value for money) of health services, and implementing strategies to address gaps and underperformance.¹⁹

Clinical governance is a critical element of health commissioning frameworks and there is scope to build clinical governance principles into existing models. Clinical governance doesn't stand outside of this process, but should be incorporated into key aspects of the framework. With oversight from the PHNs the intention of a clinical governance framework is to foster self-management where clinical safety is included in standard contract management plan, risk management plan and organisational policies and procedures.

The commissioning process provides points of opportunity to incorporate and reflect on clinical governance principles during co-design.²⁰

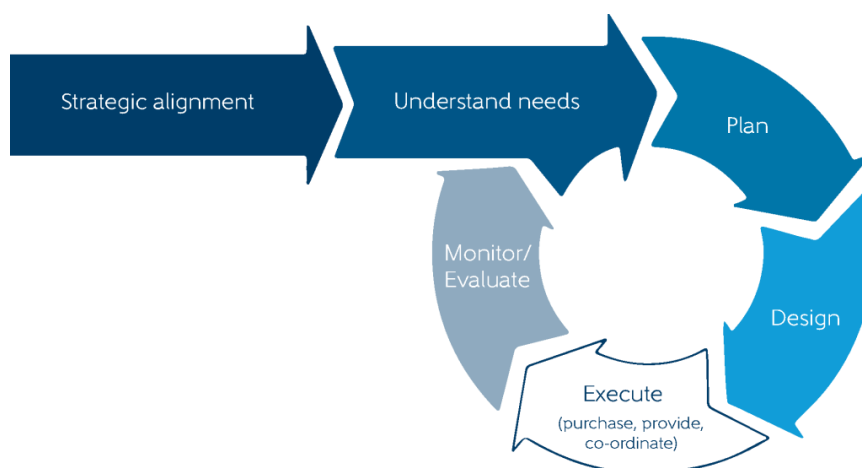


Figure 1 North Queensland Primary Health Network Commissioning Process

In Figure 1, which exemplifies the commissioning process implemented by the North Queensland PHN, in the **Understand needs** phase, the PHN in concert with consumers and service providers needs to identify the desired outcomes for a population and how these outcomes can be supported by various services. This phase should also consider what constitutes a minimally safe or good

service defined by both process and outcome measures and the consumer experience of those services.

In the **Plan and Design** phases in Figure 1, the PHN should ensure workforce resources are available to perform the service. Clinicians need to be adequately trained, continue to undertake ongoing education and strive for constant improvements in care and personal skill sets. This includes formal credentialing and defining health workers' scope of practice. Procedures and processes should be developed for the performance of services to clearly define the services to be provided including the potential use of clinical pathways or guidelines and clinical supervision to support care delivery. Standardised procedures will promote more consistent and appropriate management in primary care as well as highlight when patients need to be referred to secondary or tertiary care.

In the **Monitor and Evaluation** phases, regular review of service provision, case management, delays in access and activity data monitoring should be undertaken. A core set of measures of quality and safety should be developed to include process (provider) and patient-reported outcome indicators. At a minimum measures should include:

- compliance with legislative, regulatory and policy requirements
- process indicators that have supporting evidence to link them to outcomes
- indicators of the outcomes of care
- the ability to undertake trend analysis

It is recommended that self-assessment and audit must be supported by independent evaluation at an agreed point.

From a clinical governance perspective the monitor and evaluation phase requires analysis of variances to planned care, adverse effects or complications noting that these can have serious consequences for consumers and the health service. Variances require review to understand why outcomes were worse than expected to allow corrective actions to be developed. Clinical incidents occur throughout health services, ranging from near misses, minor or temporary harm to serious permanent harm or death. Serious events must be managed with a formal investigation including the development of remediation strategies to drive system change and prevent reoccurrence. Incidents that may result in permanent harm or death are reported to the Executive and Board. In a similar way a complaints management system or database is necessary to formally document, manage and respond to consumer or clinician concerns as a means of also identifying instances of sub optimal clinical care.²¹

Clinical Governance Framework developed for Queensland PHNs

The figure below shows how clinical governance can be embedded within the commissioning framework. It is adapted from the New Zealand commissioning framework for mental health and addiction and uses the four domains from the Victorian clinical governance framework. We acknowledge the originators of these frameworks. This hybrid framework was developed with the

Queensland PHNs.

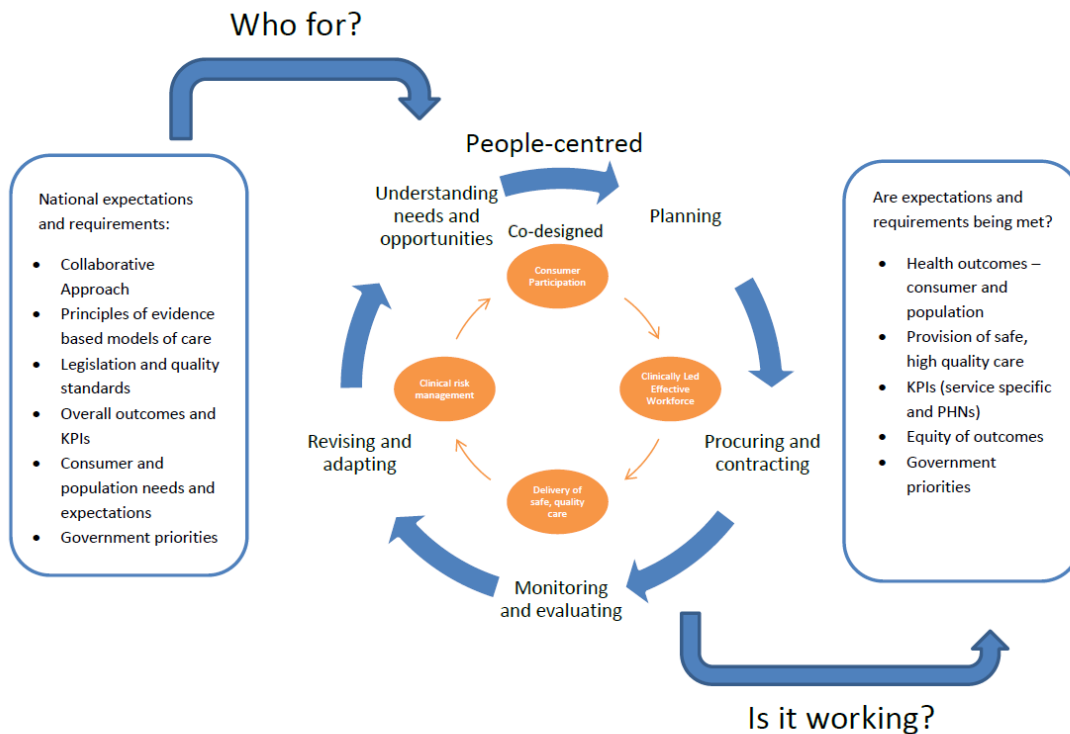


Figure 2 Queensland Primary Health Networks Clinical Governance in commissioning model—adapted from the NZ Commissioning Framework for mental health and addiction and the Victorian Clinical Governance Framework

The critical areas for consideration in ensuring clinical governance using this framework include:

Consumers having opportunities to manage their own health and participate in innovation and value creation.

A clinically led effective workforce that enables PHNs to make informed decisions about commissioning health services with providers who have the appropriate capacity and expertise to deliver safe care.

Ensuring the delivery of safe quality care through creating a culture that supports reporting, service improvement and embeds the experience of consumers.³ Commissioning health services that can articulate and deliver required standards of care as well as identify and correct poor quality care.

Clinical risk management is in place to ensure that service providers have the capacity to meet legislative and accreditation requirements. This includes the development of a system that can identify practices that put consumers at risk of harm and take action to prevent or control those risks.

How can clinical governance be implemented in PHNs?

Feedback received from the PHNs indicates that the development of clinical governance roles and structures within the networks will require ongoing effort and may present challenges. Given that commissioning is new to Australia and PHNs, this is not surprising and it is clear that clinical governance expertise will evolve over time. It is recommended that PHNs take a practical and realistic approach that accelerates this process through adaptation of existing clinical governance frameworks to their commissioning role.

Next steps

- Agree on a common national approach that meets the requirements of PHNs as commissioners of health services.
- Establish appropriate governance including Board oversight of a clinical governance committee structure to drive quality and safety across all services.
- Facilitate access to clinical expertise and a requirement for evidence based practice in service design and delivery.
- Build the capability of PHN Boards, commissioning staff and primary health service providers to fulfil clinical governance roles across primary care so that health care is safe and evidence based.
- Include identifying and monitoring clinical risk in existing enterprise-wide risk management frameworks.
- Establish a common approach for clinical incident, compliments and complaints management.
- Include clinical governance principles in contract documentation.

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Contact

The Deeble Institute
Australian Healthcare and Hospitals Association
T: 02 6162 0780
E: deeble@ahha.asn.au