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Amendment History

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Introduction

The purpose of this Framework is to define the Clinical Governance requirements for commissioned services of South Eastern Melbourne Primary Health Network (SEMPHN).

Primary Health Networks (PHNs) were established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes and improving coordination of care to ensure patients receive the right care in the right place at the right time.

SEMPHN’s strategic vision is to provide a primary care system that is accessible, inclusive and integrated, providing consumers with care that is responsive and targeted to their needs. SEMPHN has a commitment to work with its stakeholders (Government, Community, and Providers and Practitioners) to achieve its vision and purpose.

Commissioning and Clinical Governance

SEMPHN has adopted a commissioning approach to procuring medical and health care services which are based on an assessment of the health and wellbeing needs of the community. Consistent with the Commonwealth’s PHN Guidelines, SEMPHN has established and maintained appropriate clinical governance and quality assurance arrangements for commissioned services.

The commissioning of health services sets out an ideal approach for deciding how to use the total health resources available in order to improve outcomes in the most efficient, effective, equitable and sustainable way for SEMPHN. It is an inclusive partnership between PHN’s, health planners, service providers, funders, contract managers, Boards, and consumers.

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. Clinical governance principles are a critical element of health commissioning frameworks and can be built into existing models.

With oversight from the PHN the intention of a clinical governance framework is to foster self-management where clinical safety is included in standard contract management procedures, risk management plans, and organisational policies and procedures¹.

¹ SEMPHN Commissioning Framework
This framework aligns closely with the Victorian Clinical Governance Framework\(^2\). The figure below illustrates the five domains of clinical governance which are imbedded within the five key stages of SEMPHN’s commissioning cycle.

**Figure 1: Clinical governance domains**

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\(^2\) Delivering high-quality healthcare, Victorian Clinical Governance Framework (Safer Care Victoria) June 2017, Department of Health and Human Services, State of Victoria
The Clinical Governance Framework and Commissioning Framework\textsuperscript{3} will support the PHN and service providers to meet their objectives and support safer and better care for patients and consumers in the services commissioned by the PHN. Systems should be in place to ensure\textsuperscript{4}:

- Evidence-based clinical care is delivered within the clinical scope and capability of the health service;
- Evidence-based clinical care standards and protocols are clearly articulated, communicated and adhered to across the organisation;
- Clinicians regularly review and improve clinical care, preferably in a multidisciplinary manner;
- Credentialing, scope of practice and supervision processes support clinicians to work safely and effectively within their scope of practice;
- Active clinical partnerships are developed with consumers and include a shared understanding of the care plan;
- Consumers are transitioned across care settings and services smoothly;
- Clinicians participate in the design and review of clinical systems and processes, and support clinical innovation;
- Data on the safety, clinical effectiveness and person-centeredness of care is collected, analysed and shared for the purposes of both accountability and improvement;
- Clinical care processes and outcomes are measured across all services;
- Clinicians regularly review their own performance and clinicians lead activities to improve clinical practice, and these activities are planned, prioritised, supported by change and improvement science, and are sustainable;
- Clinical practice variation is closely monitored and regularly reviewed to ensure quality outcomes for high-risk, high-volume and high-cost services;
- There is a ‘just’ process for addressing issues with individual clinician performance that prioritises consumer safety;
- Clinical quality improvement activities undergo external reviews;
- New procedures and therapies are introduced in a way that ensures quality and safety issues have been identified;
- Clinical practice is regularly and rigorously evaluated to ensure its effectiveness in supporting high-quality care; and
- Appropriate utilisation of healthcare is monitored and reviewed as a component of quality\textsuperscript{4}.

\textsuperscript{3} SEMPHN Commissioning Framework
\textsuperscript{4} Delivering high-quality healthcare, Victorian Clinical Governance Framework (Safer Care Victoria) June 2017, Department of Health and Human Services, State of Victoria
Contracting and Procurement of Commissioned Services

SEMPHN ensures that appropriate clinical governance and quality assurance arrangements are in place for all commissioned services by conducting due diligence at several stages of the commissioning cycle and provides operating guidelines to support the commissioned services. This includes the following:

- Due diligence at procurement (Appendix 6)
- Annual Audit Check List (Appendix 6)
- Performance monitoring and feedback throughout the life of the contract (stage 4 of the commissioning framework)
- Consumer surveys, feedback and complaints process (Appendix 2)
- Program Guidelines issued to support commissioned services (Appendix 14)
- Termination for poor performance and poor clinical practice (Appendix 13 to be developed)

Organisations must demonstrate that the services they provide are clinically safe by:

1. **Ensuring the workforce is practicing within their area of qualification and competence**

   **Workforce requirements for commissioned services**

   The provider organisation is expected to ensure an appropriate mix of qualified staff are engaged to competently deliver commissioned services, with consideration to both formal qualifications and professional experience. The provider organisation must maintain evidence of current qualifications and experience of employed or contracted staff who are delivering commissioned services.

   Provider organisations must have appropriate clinical and quality assurance processes in place for selecting and monitoring practitioners, including the use of credentialing, ensuring clinical supervision is provided and mandatory continuing professional development (CPD) in line with the standards of the relevant profession.

   **Accreditation**

   - All Service Providers delivering commissioned mental health services must have current accreditation with the National Standards for Mental Health Services 2010 or be working towards an accreditation to meet the Standards in a timeframe agreed with SEMPHN.
   - Alcohol and other drug treatment services in Victoria must comply with the requirements of relevant accreditations and standards. They are required to continue to

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5 Schedule: PHN Program: Primary Mental Health Care
be accredited within existing generic accreditation frameworks by an entity certified by either the International Society for Quality Health Care (ISQua) or the Joint Accreditation System of Australia and New Zealand.

- SEMPHN encourage and support GPs to become accredited and to align with the national legislative and quality standards as outlined in the commissioning model. General Practices funded by SEMPHN to deliver mental health services must have current accreditation with the National Standards for Mental Health Services 2010 or be working towards an accreditation to meet the Standards in a timeframe agreed with SEMPHN.

2. **Ensuring appropriate clinical supervision arrangements are in place**

Clinical staff supervision aims to provide staff with a confidential and supportive environment to critically reflect on their professional practice. This process is essential for quality management and aims to improve quality patient services by improving health practice.

When a clinician’s work performance does not meet the satisfactory standard, an appropriate process of investigation and corrective action must be taken (see Appendix 4) for further details on the process for professional conduct.

3. **Ensuring appropriate risk assessment and management procedures are in place**

*Clinical Risk Management and Practice*

SEMPHN acknowledge that all commissioned organisations have their own policies and procedures in place to manage risk. SEMPHN requires that all providers comply with the clinical incident management policy and procedures for service providers (Appendix 2 and 3). The clinical incident management system aims to improve client, contractor and staff safety and leads to enhanced learning regarding the causation of the incidents and systemic changes which will reduce the risk of reoccurrence.

**Clinical Governance Working Group**

The South Eastern Melbourne Primary Health Network (SEMPHN) Clinical Governance Working Group (CGWG) has authorship under the Clinical Governance Framework to ensure systems and structures are in place to monitor quality of care, minimise risks and promote continuous improvement.

The CGWG is responsible for the review, management and escalation of Clinical Complaints and incidents and will inform and make recommendations to the SEMPHN Board via the Risk Management Steering Group and the Finance Audit and Risk Committee (see Figure 2).

The role and functions of the Clinical Governance Working Group are outlined in the South Eastern Melbourne Primary Health Network Clinical Governance Working Group Terms of Reference (Appendix 7).
Clinical Incidents – Management

SEMPHN reviews and monitors all incidents until they reach a satisfactory conclusion. Trends are tracked and reported to the commissioned organisations and to SEMPHN Risk Management Committee.

The Clinical Incident Management Procedure – Internal (Appendix 8, draft) provides a framework for SEMPHN to process, monitor and manage the incidents, monitor outcomes, identify best practise and ensure that high quality and safe commissioned services are provided.

Clinical Incidents – Analysis

It is expected that all sentinel events and incidents with an incident severity rating (ISR) of 1 or 2 will be subject to a Root Cause Analysis or in-depth investigation and review process. Once actions and recommendations are developed, and it is expected that outcomes are shared with SEMPHN.

All reported incidents will be analysed to understand how and why the incident occurred and identifying factors to prevent a recurrence. Actions and recommendations are developed to prevent recurrence of the incident in accordance with Clinical Incidents Reporting Procedures (Appendix 8, 9 and 14).

ISR 3 & 4 incident data related to SEMPHN commissioned services will be reported by the Commissioned Providers as part of their annual audit reporting. The aim of the analysis is to ensure quality and safety improvement.

Complaints to SEMPHN

SEMPHN is committed to fairness, accessibility, responsibility and efficiency in dealing with complaints. All complaints will be managed in an equitable, objective, and confidential manner (Appendix 10).

SEMPHN endeavours to respond to all complaints within a three (3) business day timeframe and resolve complaints within a ten (10) business day timeframe. Exceptions to these timeframes are allowed with permission from the relevant General Manager, in consultation with the General Manager, Strategic Relations.

Complaints to SEMPHN- Escalation

The purpose of this procedure (Appendix 11) is to provide guidance on the processes to be undertaken when an external party registers a concern, complaint or feedback about SEMPHN or services commissioned by SEMPHN, where the complaint is clinical in nature and requires escalation.
4. Establishing and maintaining appropriate consumer feedback procedures including compliant handling procedures

Clinical Incidents – Service Providers

The clinical incident management system Folio is accessible online to all internal and external staff, Consumers and/or service providers via the SEMPHN website. Folio allows ease of access to report clinical incidents.

For commissioned services there is a mandatory requirement to escalate reportable incidents with an Incident Severity Rating (ISR) 1 or 2 (see below table) to SEMPHN as part of standard contractual arrangements. This monitoring process fosters the safe delivery of commissioned services and examines the systems and processes in place to support a continuous improvement culture.

All contracted services are required to have a sound clinical risk management framework in place that is compliant with relevant legislation and Australian standards (see Appendix 4).
Feedback

SEMPHN’s feedback and complaints management system is consistent with industry best practice standards and compliant with legislation and regulatory requirements. SEMPHN is committed to providing a timely response to feedback and complaints provided to the organisation and will manage feedback and complaints in an equitable, objective and unbiased manner. All feedback and complaints are treated confidentially.

SEMPHN welcomes feedback on the organisation, programs and services to help with identifying and reviewing areas requiring improvement. Feedback can be provided in a number of ways:

- Online: [http://www.semphn.org.au](http://www.semphn.org.au), click Contact Us and complete the Contact form.
- Email: info@semphn.org.au
- Write a letter: Level 2,15 Corporate Drive, Heatherton VIC 3202

For commissioned services, there is a requirement to notify SEMPHN of complaints received and report these via the systems detailed above, in order to meet contractual obligations.

SEMPHN reviews and monitors all ISR 1 and ISR 2 incidents until they reach a satisfactory conclusion. This monitoring process fosters the safe delivery of commissioned services and examines the systems and processes in place to support a continuous improvement culture (see [Appendix 4](#)).
SEMPHN Services

Access and Referral

The SEMPHN Access and Referral service provides a central point of access for the SEMPHN commissioned services. The Access and Referral service is integral to the SEMPHN stepped care model and its principles of person-centred, effective, flexible, efficient, timely and coordinated.

Daily clinical oversight of the team is undertaken by the Intake Lead and the team is situated with the Service Innovation directorate. Clinical oversight is provided to support staff in relation to the following:

- Appropriately manage suicide related calls and referrals;
- Provide clinical input for screening difficult referrals and ensure they reach the right service;
- Manage the redirection of referrals as per No Wrong Door principles; and
- Provide input into the development and refinement of processes and systems that support the delivery of intake related functions.

The Clinical Lead is responsible for managing risks and incidents on a local level and in line with approved escalation processes as per SEMPHN’s clinical incident management policy.

Documented processes and guidelines are reviewed regularly to ensure a high quality, safe service is delivered by the access and referral team.

Clinical Reflection/Supervision

**Clinical Reflection** is one aspect of a wider framework ([Appendix 12](#)) of clinical governance activities that are designed to support staff and manage and monitor the delivery of high-quality services and effective outcomes. The clinical reflection process for SEMPHN staff will provide:

- a formal, purposely constructed, regular meeting that provides for critical reflection on experiences within the work setting
- a process of support and reflection and is separate to a formal system of individual performance appraisal
- a process that promotes personal and professional development within a supportive relationship
- participants the opportunity to explore learning, critical review, engage in personal or self-development and empowerment, and
- appropriate information management and confidentiality processes.
Nellie

Nellie® is an SMS-based system for promoting patient self-care. It is the most researched and effective of its kind in the world. The underpinning methodology and technology is Simple Telehealth, which was invented in 2008 in the UK, known there as Florence (or Flo).

The system is clinician led. Using existing or newly developed shared action plans, doctors and nurses work together on the priorities in their clinics. The action plans shape the development of the technical protocols that manage the sending and receiving of messages. In 2016, SEMPHN partnered with the Simple Telehealth organisation to develop an upgraded version of the technology.

Nellie protocols are developed following established procedures (see Appendix 5 for an example). Nellie protocols that are used by SEMPHN are endorsed by the Clinical Governance Working Group. Nellie is being implemented across South Eastern Melbourne.

GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Accreditation</td>
<td>An evaluation by an independent body of the degree of compliance by an organisation with previously determined standards and, if adequate, the award of certificate.</td>
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<tr>
<td>Adverse event</td>
<td>An incident in which harm resulted to a person receiving health care.</td>
</tr>
<tr>
<td>Benchmarking</td>
<td>A continuous process of measuring quality or performance specifically in relation to efficiency and effectiveness.</td>
</tr>
<tr>
<td>Clinical audit</td>
<td>A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structures, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual team, or service level and further monitoring is used to confirm improvement in health care delivery.</td>
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<tr>
<td>Clinician</td>
<td>Health care staff involved in clinical aspects of patient care, mainly, but not restricted to, allied health, nurses and doctors.</td>
</tr>
<tr>
<td>Clinical governance</td>
<td>The system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimizing risks, and fostering an environment of excellence in care for consumers/patients/residents.</td>
</tr>
<tr>
<td>Consumer</td>
<td>People who are current or potential users of health services. This includes children, women and men, people living with a disability, people from diverse cultural and religious experiences, socioeconomic status and social circumstances, sexual orientations, health and illness conditions.</td>
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<tr>
<td>Credentialing</td>
<td>The formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners, or other health professionals for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.</td>
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<tr>
<td>Framework</td>
<td>A set of principles and long-term goals that form the basis of making rules and guidelines, and to give overall direction to planning and development.</td>
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<td>Incident</td>
<td>An event or circumstance which could have, or did lead to, unintended and/or unnecessary harm to a person and/or complaints, loss or damage.</td>
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<tr>
<td>Open disclosure</td>
<td>The open discussion with a patient or their carer when things go wrong with their health care.</td>
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<tr>
<td>Performance measures</td>
<td>Measures of structures, processes and outcomes of quality and safety of care. Includes clinical indicators as a subset which are measures of the effectiveness and efficiency of health providers in providing health care.</td>
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<tr>
<td>Quality</td>
<td>Doing the right things, for the right people, at the right time and doing them right the first time.</td>
</tr>
<tr>
<td>Safety</td>
<td>A state in which risk has been reduced to an acceptable level.</td>
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<tr>
<td>Strategy</td>
<td>A range of actions, programs, activities, and policies that provides a guide for implementation to achieve a goal.</td>
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**Related Documents**

- SEMPHN Commissioning Framework
- SEMPHN Stepped Care Model
- SEMPHN Health and Safety Policy
- SEMPHN Strategic Plan
- SEMPHN Risk Management Plan
Appendix 1

Clinical Risk Management Policy

1. Purpose


2. Scope

2.1 The Clinical Risk Management policy pertains to all contracted clinical service providers and SEMPHN staff.

3. Policy Statement

3.1 SEMPHN has developed a risk profile that clearly documents possible risks to the organisation and outlines management strategies to mitigate those risks. The profile articulates the following:

- Rating of all risks according to the impact severity and likelihood of occurrence
- Executive Areas of responsibility for risks
- Review process for identifying new risks and reassessing existing risk

3.2 Clinical service providers are required to report, communicate and act on incidents with an Incident Severity Rating (ISR*) of 1 and 2, as outlined in their contractual agreement with SEMPHN. For further details refer to SEMPHN Clinical Incident Reporting Procedures for Service Providers.

*Incident Severity Rating (ISR) Table

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<td>Moderate</td>
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<tr>
<td>ISR 3</td>
<td>Mild</td>
</tr>
<tr>
<td>ISR 4</td>
<td>No harm/near miss</td>
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Source: Victorian Health Incident Management System (VHIMS)
4. Definitions

4.1 **SEMPHN** - South Eastern Melbourne Primary Health Network

4.2 **Risk** - Risk is the "effect of uncertainty on objectives" and an effect is a positive or negative deviation from what is expected.

4.3 **Risk management** - Risk management refers to a coordinated set of activities and methods that is used to direct an organisation and to control the many risks that can affect its ability to achieve objectives.

4.4 **Risk Management framework** - A risk management framework is a set of components that support and sustain risk management throughout an organisation.

4.5 **Risk Management Plan** - An organisation's risk management plan describes how it intends to manage risk. It describes the management components, the approach, and the resources that will be used to manage risk.

4.6 **Risk identification** - Risk identification is a process that involves finding, recognising, and describing the risks that could affect the achievement of an organisation's objectives. It is used to identify possible sources of risk in addition to the events and circumstances that could affect the achievement of objectives. It also includes the identification of possible causes and potential consequences.

4.7 **Risk assessment** - Risk assessment is a process that is, in turn, made up of three processes: risk identification, risk analysis, and risk evaluation. Risk identification is a process that is used to find, recognise, and describe the risks that could affect the achievement of objectives.

4.8 **Risk analysis** - Process that is used to understand the nature, sources, and causes of the risks that you have identified and to estimate the level of risk. It is also used to study impacts and consequences and to examine the controls that currently exist.

4.9 **Risk evaluation** - Process that is used to compare risk analysis results with risk criteria in order to determine whether or not a specified level of risk is acceptable or tolerable.
5. References

SEMPHN adhere to a range of legislative guidelines. Risk management is an integrated part of strategic planning, performance management and governance across the organisation and is consistent with AS/NZS ISO 31000:2018 Risk Management – Principles and Guidelines. Staff are also required to comply with SEMPHN processes and workflows.

Associated documentation:
- SEMPHN Clinical Governance Framework
- SEMPHN Risk Register
- SEMPHN Business Continuity Plan
- SEMPHN Disaster Recovery Plan
- SEMPHN Risk Appetite Statement
- Delivering high-quality healthcare: Victorian clinical governance framework (2017)
- Victorian health incident management policy guide (2011)
- Victorian Health Incident Management System (VHIMS)(2009)

6. Approval and Review Details

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<th>Service Innovation</th>
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<td>Lori Schell</td>
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<td>Service Innovation</td>
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Appendix 2

Clinical Incident Reporting Policy

1. Purpose
   a. The purpose of the policy is to provide governance that clearly outlines individual, health service, agencies and South Eastern Melbourne Primary Health Network (SEMPHN) responsibilities in incident management by ensuring consistency in the approach to incident management across all SEMPHN’s contracted providers. SEMPHN will provide a system that facilitates the identification, reporting, and evaluation of all reported incidents in a timely and effective manner. The policy will ensure organisational monitoring and learning from incidents, including near-miss events and system failures, to mitigate future risk and increase awareness of reporting requirements and related legislation.
   b. SEMPHN is committed to ensuring a robust and easily accessible process is in place for internal and external service providers to report clinical incidents directly to SEMPHN, at any time, on any day.

2. Scope
   a. This policy applies to all contracted and commissioned service providers. This policy applies to SEMPHN as a whole, including all employees whether permanent, temporary, fulltime, part time or casual and any contractor or consultant.

3. Policy Statement
   a. Incident management is the responsibility of everyone within an organisation’s healthcare team. This reflects the overall Risk Management Standard (AS/NZS 3100:2018). Effective incident management requires a whole-of-organisation approach with clear points of accountability for reporting and feedback at all levels of the organisation.
   b. All internal and external clinical service providers are bound by their contractual obligations to report clinical incidents to the appropriate authorities and directly to SEMPHN.
   c. Clinical incident data is reported to the SEMPHN Clinical Governance Working Group, SEMPHN Risk Management Steering Group, CEO, SEMPHN Finance Audit and Risk Management Committee and the SEMPHN Board.
d. SEMPHN maintains a risk management plan that delivers an organisation wide approach to risk management and is consistent with AS/NZS ISO 31000:2018 Risk Management – Principles and Guidelines.

4. Definitions

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<tr>
<td>Clinical Incident</td>
<td>Clinical event or circumstance that could have, or did, lead to unintended and/or unnecessary harm</td>
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<tr>
<td>Incident Reporting</td>
<td>The process by which clinical incident data is sent directly to SEMPHN</td>
</tr>
<tr>
<td>Clinical Incident Data</td>
<td>All data submitted by the service provider, which includes but is not limited to personal details, incident details, incident management and outcome</td>
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5. References

SEMPHN adhere to a range of legislative guidelines (e.g. risk management) which are an integrated part of strategic planning, performance management and governance across the organisation and are consistent with AS/NZS ISO 31000:2018 Risk Management – Principles and Guidelines. Staff are also required to adhere to SEMPHN values, processes and workflows.

Associated documentation:

- SEMPHN Clinical Incident Reporting Process
- SEMPHN Clinical Governance Framework
- SEMPHN Clinical Risk Management Policy
- SEMPHN Clinical Risk Register
- SEMPHN Business Continuity Plan
- SEMPHN Disaster Recovery Plan
- SEMPHN Risk Appetite Statement
- SEMPHN Risk Management Plan
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<td>Service Innovation</td>
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Appendix 3

Clinical Incident Reporting Procedures for Service Providers

Procedure Purpose

SEMPHN are committed to ensuring robust and easily accessible procedures are in place for service providers to report clinical incidents.

Procedure Scope

Clinical service providers are required to report, communicate and act on incidents that are classified incident severity rating 1 (ISR1) and 2 (ISR2) as defined in the Victorian Health Incident Management System (VHIMS).

a. All clinical incident reports of ISR1 (severe/death)

b. All clinical incident reports of ISR2 (moderate)

Procedure

1 Clinical incident occurs which is deemed ISR1 or ISR2 level of severity.

2 The Service Provider initiates their internal clinical incident procedures, including notifying relevant authorities. They are required to report the incident to SEMPHN within 24 hours (if a notifiable death) and 48 hours (if ISR2), in accordance with commissioned contracts.

3 The clinical incident is reported by the Service Provider via the SEMPHN website (under the 'Contact' heading), which feeds directly into the online clinical Incident management system Folio.

4 The Clinical Governance Working Group will be informed within 24 hours of notification. The incident report will be reviewed to ensure all required data is provided and complete (including copies of Notice of Death Form, where applicable). If additional information is required from the service provider, this will be requested within 24 hours.

5 Immediate risks will be managed by the Chief Operations Officer, General Manager of Service Innovation, and General Manager of Strategic Relations. The Chief Executive Officer will also be made aware of the risks and the actions that have been taken. The Chief Executive Officer will alert the Board in the event of any significant reputational risk to SEMPHN (refer figure 2).
6 Service Providers will conduct an internal investigation and make improvement recommendations. A report of the outcomes will be provided to SEMPHN (within 90 days).

7 Clinical Governance Working Group receive the incident report, review and assess if there are quality improvement recommendations identified from the incident. If there are none, the process is complete. If recommendations are made in the incident report, the Committee will continue to monitor and review to completion.

8 If the incident report identifies significant risks, the Clinical Governance Working Group will escalate to the Risk Management Steering Group and CEO.

9 The Clinical Governance Working Group review and monitor the aggregate data from clinical incidents for trend analyses and continuous improvement purposes.

10 The Clinical Governance Working Group adhere to regular monitoring and reporting requirements of the organisational Risk Management Plan.

Exceptions to Procedures Flow

- Clinical Incidents of ISR3 or ISR4 are excluded from this process as these incidents are managed locally by each service provider as articulated in their contract.

Control Points

- Clinical incidents must only be rated using the Incident Severity Rating (ISR) Table as standardised by the Victorian Health Incident Management System (VHIMS):

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<thead>
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<th><em>Incident Severity Rating (ISR) Table</em></th>
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<tbody>
<tr>
<td>ISR1</td>
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<td>ISR2</td>
</tr>
<tr>
<td>ISR3</td>
</tr>
<tr>
<td>ISR4</td>
</tr>
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*Source: Victorian Health Incident Management System (VHIMS)*
### Approval and Review Details

<table>
<thead>
<tr>
<th>Process Owner Service Innovation</th>
<th>Service Innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Reference Number</td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Lori Schell</td>
</tr>
<tr>
<td>Authorised by</td>
<td>/</td>
</tr>
<tr>
<td>Review By</td>
<td>Service Innovation</td>
</tr>
</tbody>
</table>

### References

Associated documents:

- Delivering high-quality healthcare: Victorian clinical governance framework (2017)
- Victorian health incident management policy guide (2011)
- Victorian Health Incident Management System (VHIMS)(2009)
Workflow

- **Reports received**
  - **End process**

- **Reporting is received**
  - **Issue reports to Board**
  - **Issue to F.A.R.M.**

- **Quarterly report is received**
  - **Issue to G.E.D.**

- **Are there any risks?**
  - **Yes**
    - **End process**
  - **No**
    - **Incident report is received**
      - **Review clinical incident reports**
      - **Continuous improvement**

- **Further data required?**
  - **Yes**
  - **No**
    - **Receive incident report**
      - **Check report data is complete**
      - **Incident monitoring**

- **Incident is reported into Data**

- **Incident occurs**
  - **Service Provider reports to SEMPHN**

- **Finance, Audit & Risk Management**

- **CEO**

- **Clinical Incident Reporting (ICD or ICR)**

- **SEMPHN Directorate**

- **Clinical Governance Committee**

- **Service Provider (Internal & External)**

- **Board**

- **Portfolio**
Appendix 4

Clinical Risk Management for Commissioners

Commissioners have a role in articulating the requirements and ensuring effective mechanisms are in place for monitoring the quality and safety of clinical services. This guide supports a consistent approach to commissioning, managing, documenting and improving the quality of clinical care delivered through Primary Health Networks (PHN) and can be used to inform clinical safety:

1. When evaluating quality management or improvement systems at the service level during commissioning. The reporting of incidents and complaints in combination with audit, contribute to an overall picture of quality service, with PHNs providing leadership in defining the standards required;
2. In crisis management; and
3. When analysing trends, creating organisational memory and evaluating reported quality and safety outcomes from service providers to inform corporate accountability at the Board level.
**COMPLAINTS**

Consumer feedback is an integral part of quality improvement and assists managers and clinicians to better understand gaps in the quality of service and opportunities for service improvement.

1. **Register and formally acknowledge and clarify events / viewpoint (link).** Manage the complainant’s expectations by notifying:
   - Who will handle the complaint
   - How the investigation will be managed
   - The expected timeframe for completing the review

2. **Timeframe: 30 days**

3. **Not every complaint requires formal investigation (link) dependant on how serious the outcome or potential impacts. The following require immediate escalator by the service provider to the PHN:**
   - harm to consumers
   - abuse
   - bullying
   - serious breach of code of conduct

   Investigate and document findings and actions using [TEMPLATE 1](#)

4. **Analysis includes identifying:**
   - facts that may be in dispute
   - if information provided is relevant and reliable
   - whether standards have been met
   - whether independent verification has been obtained
   - systemic and/or performance factors that may have led to the outcomes

5. **Resolve the complaint with all parties advised of the outcome.**
   - If the complainant remains aggrieved refer them to the Health Complaints Commissioner or body relevant to your service.
   - Monitor to ensure the issues identified have been addressed.
Please note that prior to undertaking a clinical risk review, steps should be taken to ensure any immediate risk is managed.

**CLINICAL INCIDENT**

A clinical incident is any event or circumstance which has or could lead to unintended and/or unnecessary mental or physical harm to a consumer.

**REVIEW**

The investigation method should be determined by the outcome, potential risk and complexity of the incident as determined by the incident Severity Rating (ISR) (link)

- ISR1 Severe harm or death
- ISR2 Moderate harm
- ISR3 Mild harm
- ISR4 No harm or near miss

Incidents that are outcome rated ISR1 and 2 require escalation to the PHN.

**Timeframe: 90 days**

Investigate with the aim of providing a complete picture of what happened.

- Fact finding, determine sequence of events
- Understand immediate and potential underlying or systemic cause
- Examination of documentation including clinical files and medical records
- Interview staff involved in incident as well as manager / supervisor
- Seek expert opinion

Investigate and document findings and actions using <TEMPLATE 2>

**ANALYSE**

Depending on severity of incident, analysis could be undertaken by 1-2 people or a team with independent expertise. Seek to understand immediate and underlying or system causes.

**ACTIONS & MONITORING**

Make improvement recommendations for implementation in agreed timeframes.

- What needs to be done to prevent the incident from reoccurring?
- Record and monitor for completion and effectiveness to ensure the issues identified have been addressed and reoccurrence risk mitigated
- Communicate feedback incident findings and recommendations, consistent with open disclosure (link) principles
Please note that prior to undertaking a clinical risk review, steps should be taken to ensure any immediate risk is managed.

PROFESSIONAL CONDUCT

When a clinician’s work performance does not meet the satisfactory standard an appropriate process of investigation and corrective action must be taken.

Certain professional misconduct requires mandatory notification to AHPRA (link), including:
- Practice while intoxicated by alcohol or drugs
- Sexual misconduct
- Placing the public at risk of harm due to clinician impairment
- Practice that constitutes significant departure from accepted professional standards

Timeframe 90 days

Investigate with the aim of providing a complete picture of what happened.
- Fact finding, determine sequence of events
- Understand immediate and potential underlying or systemic cause
- Examination of documentation including clinical files and medical records
- Interview staff involved in incident as well as manager / supervisor
- Seek expert opinion

Investigate and document findings and actions using <TEMPLATE 3>

Consider if actions constitute:
- Deliberate harm or unacceptable risk
- Deficiencies in training, experience or supervision
- Effectiveness of protocols (link)

Apply the substitution test – would another professional in a comparable situation behave in the same way under similar circumstances?

Formalise the investigation findings and determine the action required, which can include:
- Staff suspension
- Relocation or modified duties
- Peer to peer discussion
  - no action
Appendix 6

Due Diligence at Procurement

The Respondent must be:

- an Incorporated association incorporated under Australian state/territory legislation, or
- an Incorporated cooperative incorporated under Australian state/territory legislation, or
- an Aboriginal corporation registered under the Corporations (Aboriginal and Torres Strait Islander) Act 2006, or
- a Company incorporated under the Corporations Act 2001 (Commonwealth of Australia), or
- a Trustee on behalf of a trust.

The Respondent must provide:

- evidence of appropriate and current public liability, professional indemnity and WorkCover insurances and, relevant certificates of currency
- copies of the last 2 years audited annual financial statements
- confirmation that there is no past, current, pending or finalised litigation against the Service Provider, or an explanation of any such litigation
- particulars of any petition, claim, action, judgement or decision which is likely to affect the Service Provider’s performance
- evidence of an ABN and be registered for GST
- evidence of current accreditation with the National Standards for Mental Health Services 2010. SEMPHN expects all our contracted services engaged in the delivery of mental health services to be accredited or be working towards an accreditation to meet the Standards
- contact details for at least 2 referees for whom the Service Provider has provided similar services
- Evidence of a robust clinical governance framework that supports development and design of relevant policies, procedures, guidelines and templates to enable safe, effective, efficient and appropriate service delivery

If lodging the Response as a lead agency, the Respondent must:

- provide full details of that legal entity, the consortium members and any proposed subcontractors, together with letters of support from each member
Annual Audit Checklist

Due Diligence

☐ Is there any change to your company structure, ABN, address, phone or internet details?
☐ Have there been any changes in personnel at your organisation that you would like to tell SEMPHN about? E.g., accounts, CEO, Program or Project Management.
☐ Has there been any changes to your organisation that has resulted in you not being able to deliver services outlined in your Contractor Work and Evaluation Plan?
☐ Confirmation that there is no past, current, pending or finalised litigation against the Service Provider, or an explanation of any such litigation
☐ Particulars of any petition, claim, action, judgement or decision which is likely to affect the Service Provider’s performance

Licensing and Credentialing

The following items are required to be verified at least annually or, when roles change.

☐ Professional Registration (APHRA or relevant professional body) is up-to-date and in good standing (no notifications)
☐ Mandatory continuing professional development (CPD) in line with the standards of the relevant profession
☐ Working with Children Check of all relevant staff is up to date
☐ Drivers’ Licence - please confirm that all staff members requiring a current driver’s license hold a current license

Insurance

Please advise if your insurance as required by your contract is current. If there have been any changes, please provide your most recent certificate of currency.

☐ Public Liability Insurance (minimum $20m)
☐ Professional Indemnity Insurance (minimum $10m)
☐ Workcover Insurance
☐ Motor Vehicle Insurance - if required for this contract you must hold comprehensive motor vehicle insurance for all vehicles used in the performance of this contract

Clinical Governance Systems in place for the following:

☐ Staff clinical supervision
☐ To ensure all clients are informed of their rights and responsibilities, privacy, consent to treatment and sharing of information, and mandatory reporting
☐ Reporting of clinical incidents that is compliant with relevant legislation and feedback to clients and families adheres to open disclosure
☐ If there were updates to the Clinical Governance Framework, policies or procedures provide updated copies
☐ Provide a summary on clinical incidents and resolutions

NOTE: For transitioned contracts, service providers need to send a copy of most recent Clinical Governance Framework, policies and procedures.
Appendix 7

SEMPHN Clinical Governance Working Group Terms of Reference

Purpose
The South Eastern Melbourne Primary Health Network (SEMPHN) Clinical Governance Working Group (CGWG) is responsible for overseeing the Clinical Governance Framework, to ensure systems and structures are in place to facilitate quality of care, minimised risks and continuous improvement.

The CGWG will inform and make recommendations to the SEMPHN Board via the Risk Management Steering Group and the Finance, Audit and Risk Committee.

Roles and Responsibilities
The role of the Clinical Governance Working Group are as follows and will be standing agenda items:

- Oversee and input into the systems and structures that underpin the clinical governance framework;
- Ensure safe and high quality clinical services are provided, whether directly or contracted from other providers;
- Review commissioning framework for clinical risk management;
- Review commissioning activities for clinical risk management;
- Review and monitor clinical incidents reports, investigations and improvement plans;
- Review and monitor audit and data collection systems that identify safety and quality concerns including incidents, quality activities and safety audits;
- Conduct trend analysis of aggregate data of clinical incidents;
- Endorse clinical program and system improvements of SEMPHN and service providers;
- Improve clinical quality and safety through recommendations to SEMPHN and service providers;
- Provide reports and recommendations to the SEMPHN Board where appropriate; and
- Other duties as required by the Board or the Risk Management Steering Group.

Reporting
The Clinical Governance Working Group is accountable to the SEMPHN Board via the Risk Management Steering Group and the Finance, Audit and Risk Committee. The Clinical Governance Working Group will be listed as a standing item on the Risk Management
Steering Group meeting agenda. The Clinical Governance Working Group’s activity is reviewed and monitored through the SEMPHN Board’s annual performance review process.

**Authority**

The Clinical Governance Working Group has authority of the Clinical Governance Framework and endorsement of clinical program and system improvements of SEMPHN and service providers.

**Membership**

The Clinical Governance Working Group will be approved by the CEO and led by a SEMPHN Executive Member and have up to five members.

Its composition will include:

- General Manager Service Innovation
- Manager Service Development, Mental Health and AOD
- Manager Service Development, Youth Mental Health and Suicide Prevention
- Mental Health Intake Lead
- Clinical Council member representative or other representative approved by the CEO

Other specialists or subject matter experts and representatives of the SEMPHN may attend meetings of the Clinical Governance Working Group by invitation and on an “as needs” basis. Employees of the SEMPHN may also attend in order to present information on the SEMPHN region.

**Meetings and secretariat support**

- The Clinical Governance Working Group will meet bi-monthly for two hours.
- Meetings will generally be held at 15 Corporate Drive, Heatherton.
- Agenda and supporting materials will be developed and circulated the week prior to meetings.
- Secretariat support will be provided to the Clinical Governance Working Group.

Any Clinical Council Members will be required to comply with SEMPHN conflict of interest, confidentiality and privacy policies.

Minutes will be prepared, approved by the Clinical Governance Working Group Chair and circulated to Members within seven working days of the meeting date. The minutes will be ratified by Members present at the next meeting and signed by the Chair.

A quorum will be regarded as 50% + 1 of Members.

Any matters requiring decision will be decided by a majority of votes of Members present.
External members of the Clinical Governance Working Group will be paid a sitting fee of $450 per meeting. The sitting fee shall be paid for all preparation, attendance at and any follow up from each of the meetings listed below and includes all and any expenses associated with a Member’s attendance at those meetings.

**Evaluation and review**

The Clinical Governance Working Group will review the Terms of Reference (TOR) annually. These TOR may be revised and updated to reflect the Clinical Governance Working Group progress, subject to Clinical Governance Working Group, SEMPHN CEO endorsement and mutual agreement.

There will be an annual evaluation of the Clinical Governance Working Group by the Clinical Governance Working Group.
Appendix 8

Internal Clinical Incident Management Procedure

<table>
<thead>
<tr>
<th>Procedure ID</th>
<th>SI-004</th>
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<td>Clinical Governance Working Group</td>
</tr>
<tr>
<td>Version</td>
<td>1.4</td>
</tr>
<tr>
<td>Document Reference</td>
<td>Governance Framework for Commissioned Clinical Service Providers</td>
</tr>
<tr>
<td>Approval Date</td>
<td>7 January 2020</td>
</tr>
<tr>
<td>Approved By</td>
<td>Clinical Governance Working Group</td>
</tr>
<tr>
<td>Review Date</td>
<td>January 2021</td>
</tr>
<tr>
<td>Procedure Sponsor</td>
<td>General Manager Service Innovation</td>
</tr>
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</table>

Purpose

The purpose of this procedure is to provide a structure for SEMPHN to review, monitor, escalate and report on clinical incidents for our commissioned clinical services.

Scope

Clinical service providers are required to report, communicate and act on incidents that are classified incident severity rating 1 (ISR1) and 2 (ISR2) as defined in the Victorian Health Incident Management System (VHIMS). SEMPHN as the commissioning agent has a responsibility to monitor incident management, trend analysis and identify any commonality of incident causes or recommendations across the commissioned clinical service. This procedure provides guidance to the Clinical Governance Working Group, the GM Service Innovation and SEMPHN’s commissioned clinical service providers, on the management of the Clinical Services reported data which is described in more detail in subsequent sections of this document.

Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ISR</td>
<td>Incident severity rating, taking into account degree of impact, level of care, treatment required.</td>
</tr>
<tr>
<td>Open Disclosure</td>
<td>A process for ensuring that open, honest, empathic and timely discussions occur between patients (and/or their support person) and health care staff after a patient safety incident.</td>
</tr>
</tbody>
</table>

Responsibilities

<table>
<thead>
<tr>
<th>Clinical Governance Working Group</th>
<th>Follow procedure outlined below.</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Manager, Service Innovation</td>
<td>Report immediate risks to the COO and GM Strategic Relations. The CEO will also be notified.</td>
</tr>
</tbody>
</table>
Report and escalate to SEMPHN Risk Management Committee, and Board as required.

Procedure
NB: Clinical Incidents of ISR3 or ISR4 are excluded from this process as these incidents are managed locally by each service provider as articulated in their contract.

Nominated SEMPHN Delegate (Access & Referral Clinician) to check that:

- Incident is appropriately reported as ISR 1 or 2
- Appropriate, mandated and complete documents attached to Folio Incident Report
- Provider has complied with the incident reporting timelines
- Incident was managed at time of reporting of incident
- Review: Root Cause Analysis (RCA) documentation
- Provider has implemented RCA recommendations as per timeline attributed to recommendation
- Review: Coronial recommendation for trends
- Provider has implemented Coronial recommendations as per timeline attributed to recommendation
- Immediate risks will be reported to the COO and General Manager Strategic Relations. The Chief Executive Officer will also be notified
- Report and escalate to SEMPHN Risk Management Committee, and Board as required
- The Chief Executive Officer will alert the Board of significant reputational risks to SEMPHN
- Incident closure.

Action / Decision Table
The Action/Decision table provides a framework to manage incidents reported through Folio to SEMPHN. Please refer to Appendix 1.

Open Disclosure
It is expected that open disclosure processes will be followed whenever a consumer has suffered an adverse event as per the open disclosure procedure and confirmation that the process has occurred and communicated to SEMPHN.

Annual Contract Review
Performance of incident management is to be reviewed with the commissioned clinical service provider at the annual contract review. This is an opportunity to discuss trending incident types and reporting of incidents.

However, any identified trends or risk will be discussed with the commissioned clinical service provider as they occur. The aim is that the commissioned clinical service provider
communicates any changes that they have made or intend to make in response to trend feedback.

**Organisational Escalation**
The monitoring report will be disseminated to the Risk Management Committee Working Group and the Financial and Risk Management Committee.

**Control Points**
Clinical incidents must only be rated using the Incident Severity Rating (ISR) Table as standardised by the Victorian Health Incident Management System (VHIMS). Please refer to Appendix 2 for table.

**Management of this procedure**
The Clinical Governance Working Group is accountable for managing and maintaining this procedure, which includes:
- monitoring and reviewing the procedure
- simultaneously reviewing all documents directly relating to this procedure.

Any major changes to this procedure must be:
- endorsed by the General Manager Service Innovation
- approved by the Clinical Governance Working Group

**Forms/Templates/Checklists**
- Folio – Clinical Incident Register

**Legislative Frameworks and Standards**
- None

**References**
- Clinical Incident Policy
- Clinical Incident Reporting Process for Service Providers
- Victorian Health Incident Management System

**Appendices**
- Appendix 1: Incident Severity Rating (ISR) Table
- Appendix 2: Action / Decision Table
**Amendment History**

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<tr>
<td>1.0</td>
<td>Document created</td>
<td>Manager Service Development, Youth Mental Health and Suicide Prevention</td>
<td>7/12/18</td>
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<td>1.1</td>
<td>Revisions made by Clinical Governance Working Group</td>
<td>CGWG</td>
<td>22/8/19</td>
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<tr>
<td>1.2</td>
<td>Transposed to new Corporate Procedure template</td>
<td>Project Support Officer</td>
<td>27/8/19</td>
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<td>1.3</td>
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<td>Project Support Officer</td>
<td>6/1/2020</td>
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<td>1.4</td>
<td>Revisions suggested by Quality Team</td>
<td>Project Support Officer</td>
<td>10/1/2020</td>
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**Appendix 1: Incident Severity Rating (ISR) Table**

<table>
<thead>
<tr>
<th>ISR</th>
<th>Description</th>
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<tbody>
<tr>
<td>ISR1</td>
<td>Severe / death</td>
</tr>
<tr>
<td>ISR2</td>
<td>Moderate</td>
</tr>
<tr>
<td>ISR3</td>
<td>Mild</td>
</tr>
<tr>
<td>ISR4</td>
<td>No harm / near miss</td>
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</table>

*Source: Victorian Health Incident Management System (VHIMS)*
# Appendix 2: Action / Decision Table

<table>
<thead>
<tr>
<th>Incident</th>
<th>Action</th>
<th>Timeframe</th>
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| ISR 1 Incident | Check that appropriate, mandated and complete documents attached to Folio Incident Report  
Provider has complied with the incident reporting timelines  
Management of incident at time of reporting  
Was there an immediate action taken by the organisation as a result of the incident?  
Were staff de-briefed/supervised and communication forwarded to support staff?  
Were relatives contacted and provided support? | Within 1 week |
| Coronal Review date | Request copy of Root Cause Analysis recommendations  
Ensure the organisation has implemented recommendations as per timeline attributed to recommendation | TBC |
| Request Coronial reviews for recommendations for trends  
Ensure the organisation has implemented the recommendations as per Coronial instructions and as per timeline attributed to recommendation | Within 2 years |
| Did Open Disclosure occur? | | Within 1 month |
| ISR 2 | Confirm the incident is appropriately reported as ISR2  
Check that appropriate, mandated and complete documents attached to Folio Incident Report  
Provider has complied with the incident reporting timelines  
Management of incident at time of reporting  
Was there an immediate action taken by the organisation as a result of the incident?  
Were staff de-briefed/supervised and communication forwarded to support staff?  
Were relatives contacted and provided support? | Within 1 week |
| Request copy of Root Cause Analysis recommendations  
Ensure the organisation has implemented recommendations as per timeline attributed to recommendation | Within 3 months of incident |
| Did Open Disclosure occur? | | Within 1 month |
| ISR 3 | Request annual trended data as applies to SEMPHN | Annually |
| ISR 4 | Request annual trended data as applies to SEMPHN | Annually |
Appendix 9

Internal Clinical Incident Management Procedure (WORKFLOW)
Appendix 10

External Complaints Policy

<table>
<thead>
<tr>
<th>Policy ID</th>
<th>SR-001</th>
</tr>
</thead>
</table>
| Prepared by | Brian O’Sullivan, General Manager Strategic Relations  
Kiera Mansfield, General Manager Service Innovation |
| Version | 1.0 |
| Approval Date | 17 September 2019 |
| Approved By | Chief Executive Officer |
| Review Date | September 2021 |
| Policy Sponsor | General Manager Strategic Relations |

Policy Statement

SEMPHN is committed to fairness, accessibility, responsibility and efficiency in dealing with complaints. All complaints will be managed in an equitable, objective, and confidential manner.

SEMPHN endeavours to respond to all complaints within a three (3) business day timeframe and resolve complaints within a ten (10) business day timeframe. Exceptions to these timeframes are allowed with permission from the relevant General Manager, in consultation with the General Manager, Strategic Relations.

Objectives of this policy

- To provide employees, partners, clients, families/carers and stakeholders with a clear policy that enables people to register concerns and complaints about SEMPHN or services commissioned by SEMPHN
- To ensure complaints are appropriately recorded and investigated
- To provide a resolution to the complaint and instigate changes to ensure issues identified in the complaint are reviewed and changed if required
- To ensure risks to SEMPHN or other organisations are managed effectively

Scope

Complaints may be received from an organisation or person external to SEMPHN who falls into one or more of these categories:

- is a member of the public
- is or was the intended or actual recipient of services provided by SEMPHN or a service provider commissioned by SEMPHN
- is a third party acting in good faith on behalf of an aggrieved person (e.g. a carer, a parent of a minor, an elderly person’s child who has medical power of attorney)
- has or intends to submit a tender for commissioned services
- is or has been a commissioned service provider, or other provider to SEMPHN of goods and services
- Complaints can be verbal or written, formal or informal and may be anonymous.
This policy provides direction around the receipt, management and resolution of complaints and applies to:

- all staff
- contractors and consultants
- Clinical and Community Council members
- Board members.

**Exclusions**

This policy does not apply to:

- complaints made by a staff member. For information about internal complaints, refer to the Complaint Resolution Policy.

**Definitions**

| Anonymous complaint | A complaint made but the person making the complaint does not wish to disclose their identity.  
|                     | See also Informal Complaint |
| Complaint           | A written or verbal expression of dissatisfaction about SEMPHN or one of our commissioned service providers or a service provided by SEMPHN. Complaints are typically about, but not limited to, an act, decision, situation, omission or behaviour that the person making the complaint believes is unfair, illegal, discriminatory or inadequate |
| Formal complaint    | When a person making the complaint brings a problem or issue to the attention of the organisation and expects some redress and a response to their complaint |
| Informal complaint  | A complaint is made but the person making the complaint does not require a response or an outcome. For example, the person making the complaint says something like “I just want you to know that...” and when asked if they want to make a formal complaint or require a response or outcome, they refuse.  
|                     | It may also be a complaint is made where the person making the complaint does not wish to disclose their identity. |
| Suggestion          | A written or verbal idea for an improvement. |

**Policy in Practice**

**SEMPHN has an appointed Feedback Officer**

SEMPHN has assigned the role of Feedback Officer to a permanent staff member within the Strategic Relations team.

The Feedback Officer is responsible for managing and executing the overall process for complaints; and manages complaints in conjunction with a General Manager Strategic Relations.

**Employees must ask the person making the complaint if they wish to make a formal complaint**
Employees who receive a complaint (by whatever means) must ask the person making the complaint if they wish to make a formal complaint and advise them of the process they can use to make a formal complaint. These are provided in the Complaints Procedure.

**Employees must not offer opinions, apology or compensation**

If someone makes a complaint, do not express an opinion or offer an apology or compensation. The Feedback Officer in conjunction with a General Manager, manages complaints.

Thank them for contacting SEMPHN and ask them to complete a formal complaint via our website at [https://www.semphn.org.au/contact/feedback.html](https://www.semphn.org.au/contact/feedback.html). Employees can inform the person making the complaint that they will be contacted by the appropriate person within three (3) business days from the date of the receipt of the complaint.

**SEMPHN maintains a Complaint Register**

The Feedback Officer will log each complaint into SEMPHN’s Complaints Register and manage the response and/ resolution with managers and General Managers within SEMPHN. Refer to the Complaints Procedure.

The Victorian Health Complaints Commissioner may re-open any complaint at any time after the case has been closed. For this reason, SEMPHN must maintain the Complaint Register in perpetuity.

**Informal and Formal complaints will be triaged**

The Feedback Officer will triage informal and formal complaints as follows:

- the General Manager Strategic Relations will be informed of every complaint
- an anonymous complaint may, in some cases, be of a serious nature. Despite the person making the complaint’s refusal to provide their name, the Feedback Officer will record this complaint and the General Manager, Strategic Relations will determine if investigation is warranted. Any outcome will be captured in the Complaints Register.
- other General Managers will be informed, via email, of the nature of the complaint, on a need-to-know basis, as it relates to their directorate.

The following table provides information on triaging complaints the organisation may receive and is not exhaustive. In addition to taking the person’s details and nature of complaint, further action for various complaint types are provided:
<table>
<thead>
<tr>
<th>Nature of complaint</th>
<th>How SEMPHN will action (via the Feedback Officer)</th>
<th>If the person making the complaint is not happy with the resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fraud</strong> e.g. suspected fraud by SEMPHN against the Commonwealth e.g. misuse of Commonwealth funds or assets purchased with Commonwealth funds</td>
<td>Refer to Fraud &amp; Corruption Control Policy for reporting the suspected fraud internally</td>
<td>Advise the person making the complaint to contact the Department of Health via: <a href="mailto:phn.complaints@health.gov.au">phn.complaints@health.gov.au</a></td>
</tr>
<tr>
<td><strong>Contractual</strong> e.g. non-compliance with the terms and conditions of the funding agreement with the Commonwealth</td>
<td>Inform Chief Operating Officer</td>
<td>Advise the person making the complaint to contact the Department of Health via: <a href="mailto:phn.complaints@health.gov.au">phn.complaints@health.gov.au</a></td>
</tr>
<tr>
<td><strong>Conflict of interest</strong> e.g. inappropriate or poor handling of conflicts of interest</td>
<td>Inform Chief Operating Officer</td>
<td>Advise the person making the complaint to contact the Department of Health via: <a href="mailto:phn.complaints@health.gov.au">phn.complaints@health.gov.au</a></td>
</tr>
<tr>
<td><strong>Breaches of privacy</strong> e.g. a consumer is concerned that their private data has been shared by the Department of Health without permission e.g. a consumer believes or is aware that data about them has been shared with or between Service Providers without their permission</td>
<td>Inform SEMPHN's Privacy Officer, the General Manager Human Resources</td>
<td>Advise the person making the complaint to contact the Department of Health via: <a href="mailto:phn.complaints@health.gov.au">phn.complaints@health.gov.au</a> Also advise them to contact the Office of the Australian Information Commissioner (OAIC) at <a href="http://www.oaic.gov.au">www.oaic.gov.au</a></td>
</tr>
<tr>
<td><strong>Commissioned Clinical Services</strong> Complaints related to all commissioned clinical services (Also refer to Governance Framework for Commissioned Clinical Services, particularly Appendix 4.)</td>
<td>Inform General Manager Service Innovation, who will inform the Clinical Governance Working Group</td>
<td>The Governance Framework for Commissioned Clinical Services provides direction on escalation and review.</td>
</tr>
<tr>
<td>An Administrative concern</td>
<td>Inform General Manager Corporate Services</td>
<td>Issues are escalated to the Chief Executive Officer</td>
</tr>
<tr>
<td>Dissatisfaction with the outcome of a tender process</td>
<td>Inform Chief Operating Officer</td>
<td>Issues are escalated to the Chief Executive Officer</td>
</tr>
<tr>
<td>Dissatisfaction with SEMPHN’s engagement</td>
<td>Inform General Manager Strategic Relations</td>
<td>Issues are escalated to the Chief Executive Officer</td>
</tr>
<tr>
<td>Dissatisfaction with data governance</td>
<td>Inform General Manager System Outcomes</td>
<td>Issues are escalated to the Chief Executive Officer</td>
</tr>
</tbody>
</table>
Any person reporting fraudulent and/or other illegal transactions or activities, has protection under the Whistleblower Policy. In these cases, the Whistleblower Protection Officer must be contacted. Both the person’s name and the information they provide must be given to the Whistleblower Protection Officer. This information must be treated in accordance with the Whistleblower Policy. If information of this type is received, then the matter must be dealt with as prescribed in the Whistleblower Policy.

**People making a complaint may use external support**

A person making a complaint or people - such as carers - acting on their behalf may:

- use an advocate to help them present their complaint, or respond to our investigation of a formal complaint, with written permission from the person making the complaint to act on their behalf
- seek support from an external organisation or body (e.g. solicitors, community bodies).

**SEMPHN will promptly acknowledge and investigate all formal complaints and keep relevant parties informed**

Every formal complaint will be acknowledged within three (3) business days of receipt, by the Feedback Officer and investigated, as outlined in the Complaints Procedure.

**SEMPHN will identify and implement changes to prevent a recurrence**

If the investigation of a complaint identifies reasonable changes (e.g. to systems, policies, procedures or behaviour) that could prevent a recurrence of the problem, SEMPHN will plan and implement those changes and notify the person making the complaint of these changes, if appropriate.

**Escalation of a complaint**

If the person making the complaint is not satisfied with the response and/or resolution provided, SEMPHN must inform them that they have the right to contact the Victorian Health Complaints Commissioner. Contact details are available at [www.hcc.vic.gov.au](http://www.hcc.vic.gov.au).

The person making the complaint may at any time choose to contact the Victorian Health Complaints Commissioner to re-open a complaint investigation even though the complaint may have been closed by SEMPHN or the Victorian Health Commissioner in the past. For this reason, SEMPHN must maintain the Complaint Register in perpetuity.

If the Health Complaints Commissioner asks SEMPHN to provide further information, the appropriate manager, the General Manager Strategic Relations and the Chief Executive Officer must be informed.

**Responsibilities**

<table>
<thead>
<tr>
<th>General Manager Strategic Relations</th>
<th>Management of the Feedback Officer and their performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regular reporting to the CEO any trends or contentious issues or escalation of any complaints</td>
</tr>
<tr>
<td></td>
<td>Reporting complaints data to the SEMPHN Board</td>
</tr>
<tr>
<td>Feedback Officer</td>
<td>Registering complaints and suggestions for improvement</td>
</tr>
</tbody>
</table>
- Informing relevant parties of information they need to know
- Monitoring the progress of complaints, to ensure timely responses to the person making the complaint
- Reviewing communication with the relevant manager before sending communications or resolution of the complaint to the complainant
- Maintaining the Complaints Register
- Capturing data on complaints for provision to the General Manager Strategic Relations

| Everyone covered by this policy | • Recording and reporting any complaints they receive and providing these to the Feedback Officer to progress and monitor |
| Managers mentioned in this document | • Reviewing complaints received  
• Investigating complaints (either personally or through delegation) as required to identify issues, causes and potential solutions  
• Ensuring any remedial action required is undertaken, in partnership with the relevant staff member |

**Procedures/Forms/Templates/Checklists**
- Complaints Procedure
- Complaints Register
- Complaint acknowledgement letter or email template
- Complaint resolution letter or email template
- Internal Clinical Complaints and Escalation Procedure

**Legislative Frameworks and Standards**
- Protected Disclosure Act 2012 (Vic)
- Criminal Code Act 1995 (Cth)
- Privacy Act 1988 (Cth)
- Australian Privacy Principles
- Treasury Laws Amendment (Enhancing Whistleblower Protections) Bill 2019 (Cth).

**References**
- Complaint Resolution Policy
• Whistleblower Policy
• Fraud and Corruption Control Policy
• Privacy Policy

Management of this policy

The General Manager Strategic Relations is accountable for managing and maintaining this policy, which includes:

• monitoring and reviewing this policy
• simultaneously reviewing all documents directly relating to this policy.

Any major changes to this policy must be:

• endorsed by the General Manager Strategic Relations
• approved by the Chief Executive Officer.

Amendment history

<table>
<thead>
<tr>
<th>Version</th>
<th>Details of change</th>
<th>Amended by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>New policy – approved by CEO at ELT meeting 17/09/19</td>
<td>GM Strategic Relations</td>
<td>15/07/19</td>
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<tr>
<td></td>
<td></td>
<td>GM Service Innovation</td>
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</table>
Appendix 11

Internal Clinical Complaints and Escalation Procedure

<table>
<thead>
<tr>
<th>Procedure ID</th>
<th>SI-002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared by</td>
<td>Lori Schell, Service Development Manager</td>
</tr>
<tr>
<td>Version</td>
<td>1.2</td>
</tr>
<tr>
<td>Document Reference</td>
<td>Victorian Clinical Supervision Framework for Mental Health Nurses</td>
</tr>
<tr>
<td>Approval Date</td>
<td>13 September 2019</td>
</tr>
<tr>
<td>Approved By</td>
<td>Clinical Governance Working Group</td>
</tr>
<tr>
<td>Review Date</td>
<td>September 2020</td>
</tr>
<tr>
<td>Procedure Sponsor</td>
<td>General Manager, Service Innovation</td>
</tr>
</tbody>
</table>

Purpose

The purpose of this procedure is to provide guidance on the processes to be undertaken when an external party registers a concern, complaint or feedback about SEMPHN or services commissioned by SEMPHN, where the complaint is clinical in nature and requires escalation.

Scope

This procedure provides direction around the escalation of clinical complaints to SEMPHN and applies to:

- The Clinical Governance Working Group
- The Chief Executive Officer, SEMPHN.

This procedure applies to:

- All clinical complaints that require escalation to the Australian Health Practitioner Regulation Agency (AHPRA).

Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint</td>
<td>A written or verbal expression of dissatisfaction about SEMPHN or one of our commissioned service providers or a service provided by SEMPHN. Complaints are typically about, but not limited to, an act, decision, situation, omission or behaviour that the complainant believes is unfair, illegal, discriminatory or inadequate. Complaints may come directly to SEMPHN, or via a commissioned service provider.</td>
</tr>
<tr>
<td>AHPRA</td>
<td>AHPRA is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia.</td>
</tr>
</tbody>
</table>

Responsibilities
Procedure

1. The complaint is received by SEMPHN directly:

The SEMPHN Feedback Officer is responsible for receiving and logging of complaints received directly to SEMPHN (refer to External Feedback and Complaints Procedure). As per the triaging of complaints process, complaints of a clinical nature will be referred to the GM Service Innovation.

   i. If the complaint or issue is raised because there is concern for:
      - An explanation
      - An apology
      - Access to a health record or to amend them
      - A change in policy or practice with a SEMPHN commissioned service provider

The complaint will be referred to the commissioned service provider organisation for review and investigation if necessary.

The commissioned service provider will action the complaint as outlined in the Clinical Governance Framework for Commissioned Clinical Services

   ii. If the complaint or issue is raised because there is concern about:
       - harm to consumers
       - abuse

<table>
<thead>
<tr>
<th>General Manager Strategic Relations</th>
<th>Management of the Feedback Officer and their performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback Officer</td>
<td>Inform General Manager Service Innovation of feedback related to all commissioned clinical service complaints. Reviewing communication with the relevant manager before sending communications or resolution of complaint to the complainant.</td>
</tr>
<tr>
<td>General Manager Service Innovation</td>
<td>Receives clinical complaint from Feedback Officer. Convenes the Clinical Governance Working Group to assess the complaint. Escalates the findings of the Working Group to the CEO as required. Escalates complaint to AHPRA as required, in cases of breach of AHPRA Guidelines.</td>
</tr>
<tr>
<td>Clinical Governance Working Group</td>
<td>Assesses the complaint. Makes recommendation via CEO Briefing Note for GM to escalate to CEO.</td>
</tr>
<tr>
<td>CEO</td>
<td>Receives clinical complaint from GM. Approves recommendations as outlined in CEO Briefing Note.</td>
</tr>
<tr>
<td>AHPRA</td>
<td>Investigate whether or not the practitioner is practicing appropriately and safely. Present information about individual practitioners to the National Board who registered the individual.</td>
</tr>
</tbody>
</table>
• bullying
• serious breach of code of conduct
• a practitioner’s behaviour that is placing the public at risk
• a practitioner is practising their profession in an unsafe way, or
• a practitioner’s ability to make safe judgements about their patients might be impaired because of their health.

The matter must be referred to the GM Service Innovation, who will raise the matter with the Clinical Governance Working Group. This Group will review the complaint as per the procedure for reviewing clinical incidents, and where appropriate, formulate a CEO Briefing Note recommending notification of the incident/complaint to AHPRA. The GM Service Innovation will present the CEO Briefing Note and the CEO will be responsible for lodging the notification to AHPRA.

Further to this, the following examples of professional misconduct require mandatory notification to AHPRA:
• Practice while intoxicated by alcohol or drugs
• Sexual misconduct
• Placing the public at risk of harm due to clinician impairment
• Practice that constitutes significant departure from accepted professional standards.

2. The complaint is escalated to SEMPHN by the commissioned service provider:

The commissioned service provider logs the complaint as a clinical incident via Folio. The relevant processes outlined in Step 1 are followed.

Management of this procedure

The Clinical Governance Working Group is accountable for managing and maintaining this procedure, which includes:
• monitoring and reviewing the procedure
• simultaneously reviewing all documents directly relating to this procedure.

Any major changes to this procedure must be:
• endorsed by the General Manager, Service Innovation
• approved by the Clinical Governance Working Group.

Forms/Templates/Checklists
• N/A

Legislative Frameworks and Standards

Refer to the Victorian Clinical Supervision Framework for Mental Health Nurses.
References

- Clinical Governance Framework for Commissioned Clinical Services

Appendices

- Appendix 1: Complaints Process for AHPRA practitioners - Nurses, OTs, Psychologist

Amendment History

<table>
<thead>
<tr>
<th>Version</th>
<th>Details of change</th>
<th>Amended by</th>
<th>Date</th>
</tr>
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<tr>
<td>1.0</td>
<td>New procedure</td>
<td>Lori Schell</td>
<td>5/9/2019</td>
</tr>
<tr>
<td>1.1</td>
<td>Amendments made by CGWG members</td>
<td>Fotini Strongyllos</td>
<td>12/9/2019</td>
</tr>
<tr>
<td>1.2</td>
<td>Document finalised by CGWG</td>
<td>Kristen Bell</td>
<td>13/9/2019</td>
</tr>
</tbody>
</table>
Internal Clinical Complaints and Escalation Procedure
Procedure ID: SI-002

Complaint is received by SEMPHN from an external party

Complaint is lodged by a commissioned service provider as a clinical incident via Folio

SEMPHN Feedback Officer triages complaint

(Non-clinical) complaint relates to:
- a need for an explanation or apology,
- access to or amendment of a health record,
- change in policy or practice with a SEMPHN commissioned service provider

Complaint is referred to the commissioned service provider organisation for review and investigation if necessary

Commissioned service provider will action the complaint as outlined in the Clinical Governance Framework for Commissioned Clinical Services

End

Complaint is of a clinical nature and relates to:
- harm to consumers
- abuse, bullying
- serious breach of code of conduct
- a practitioner’s behaviour that is placing the public at risk
- a practitioner practicing their profession in an unsafe way
- a practitioner’s ability to make safe judgements about their patients might be impaired due to health

SEMPHN Feedback Officer refers complaints of a clinical nature to GM Service Innovation

GM Service Innovation refers complaint to the Clinical Governance Working Group for review and action

CGWG reviews the complaint as per procedure for reviewing clinical incidents

Where appropriate, the CGWG will formulate a CEO Briefing Note recommending notification of the incident/complaint to AHPRA

The following examples of professional misconduct require mandatory notification to AHPRA:
- practice while intoxicated by alcohol or drugs
- sexual misconduct
- placing the public at risk of harm due to clinician impairment
- practice that constitutes significant departure from acceptable professional standards

End
Appendix 12

Clinical Reflection Procedure

<table>
<thead>
<tr>
<th>Procedure ID</th>
<th>SI-003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared by</td>
<td>Yolande Maltman, Access &amp; Referral Clinician</td>
</tr>
<tr>
<td>Version</td>
<td>1.3</td>
</tr>
<tr>
<td>Document Reference</td>
<td>Victorian Clinical Supervision Framework for Mental Health Nurses</td>
</tr>
<tr>
<td>Approval Date</td>
<td>31 October 2019</td>
</tr>
<tr>
<td>Approved By</td>
<td>Clinical Governance Working Group</td>
</tr>
<tr>
<td>Review Date</td>
<td>May 2020</td>
</tr>
<tr>
<td>Procedure Sponsor</td>
<td>General Manager, Service Innovation</td>
</tr>
</tbody>
</table>

Purpose

Clinical Reflection is one aspect of a wider framework of clinical governance activities that are designed to support staff and manage and monitor the delivery of high-quality services and effective outcomes. The clinical reflection process will provide:

- a formal, purposely constructed, regular meeting that provides for critical reflection on experiences within the work setting
- a process of support and reflection and is separate to a formal system of individual performance appraisal
- a process that promotes personal and professional development within a supportive relationship
- participants the opportunity to explore learning, critical review, engage in personal or self-development and empowerment, and
- appropriate information management and confidentiality processes.

Scope

This procedure applies to:

- Access and Referral Officers
- Access and Referral Clinician

Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRA</td>
<td>Clinical Reflection Agreement</td>
</tr>
<tr>
<td>A &amp; R</td>
<td>Access and Referral</td>
</tr>
</tbody>
</table>

Responsibilities

<table>
<thead>
<tr>
<th>Access &amp; Referral Clinician</th>
<th>Develop Clinical Reflection Agreement (CRA) (attached)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ensure monthly meeting schedule is completed and in place</td>
</tr>
<tr>
<td></td>
<td>Facilitate a safe and trusting environment</td>
</tr>
<tr>
<td></td>
<td>Provide Clinical Reflection</td>
</tr>
<tr>
<td></td>
<td>Provide feedback about identified opportunities for professional/self-development (which are then linked to a broader</td>
</tr>
</tbody>
</table>
Professional development plan which is developed with operational management as well

| Access & Referral Officers | • Agree on goals for Clinical Reflection meetings  
• Attend monthly Clinical Reflection meetings with A&R Clinician  
• Be prepared when attending scheduled monthly meetings |

Procedure

- Access & Referral Clinician to ensure Clinical Reflection Agreement is completed with A & R Officers
- Access & Referral Clinician to schedule monthly Clinical Reflection meetings with Access and Referral Officers for one hour on a consistent day
- Attend meeting with correct documentation (CRA) and notebook
- Prioritise Clinical Reflection meetings, except where A & R needs are a priority
- Working with A & R Officers to agree on goals for Clinical Reflection meetings
- Validating good practice and providing constructive feedback
- Working within the agreed boundaries of confidentiality
- Clinician has responsibility for reporting any serious issues to Operational Manager

Management of this procedure

The General Manager Service Innovation is accountable for managing and maintaining this procedure, which includes:

- monitoring and reviewing the procedure in line with the process stated in the Documentation Governance Framework
- simultaneously reviewing all documents directly relating to this procedure.

Any major changes to this procedure must be:

- endorsed by the General Manager, Service Innovation
- approved by the Clinical Governance Working Group

Forms/Templates/Checklists

- Clinical Reflection Agreement
- Clinical Reflection Meeting & Action Plan

Legislative Frameworks and Standards

Refer to the Victorian Clinical Supervision Framework for Mental Health Nurses

References

- Australian College Mental Health Clinical Supervision Position Statement
- LaTrobe University Reflective Practice Models
- Queensland Health Clinical Supervision Guidelines
Appendices

- N/A

Amendment History

<table>
<thead>
<tr>
<th>Version</th>
<th>Details of change</th>
<th>Amended by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Document creation</td>
<td>Yolande Maltman</td>
<td>6/9/19</td>
</tr>
<tr>
<td>1.1</td>
<td>Document revised</td>
<td>Fotini Strongylos</td>
<td>13/9/19</td>
</tr>
<tr>
<td>1.2</td>
<td>Document revised</td>
<td>Yolande Maltman</td>
<td>13/9/19</td>
</tr>
<tr>
<td>1.3</td>
<td>Document revised</td>
<td>Fotini Strongylos</td>
<td>25/09/19</td>
</tr>
</tbody>
</table>
## Clinical Reflection Agreement

<table>
<thead>
<tr>
<th>Date</th>
<th>Mental Health Clinician</th>
<th>A&amp;R Officer</th>
</tr>
</thead>
</table>

### Goals

1) 

2) 

### Clinical Case Scenario

### Outcome
<table>
<thead>
<tr>
<th>Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Areas Covered</td>
<td></td>
</tr>
<tr>
<td>Issues Arising</td>
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</tr>
<tr>
<td>Action/Update</td>
<td></td>
</tr>
<tr>
<td>Resolved Y/N</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 13

Procedure for termination due to poor performance and poor clinical practice
**Appendix 14**

**Clinical Governance Document Register**

This register details documents endorsed by the SEMPHN Clinical Governance Working Group and as articulated in the Terms of Reference and Roles and Responsibilities of the group, to “endorse clinical program and system improvements of SEMPHN and service providers”.

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Process owner Service Innovation</th>
<th>Process/Document reference number</th>
<th>Authorised by</th>
<th>Review by (date and person/group)</th>
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</thead>
<tbody>
<tr>
<td>Part B: BounceBack Program Guidelines</td>
<td>Lori Schell</td>
<td>003.201912</td>
<td></td>
<td>July 2020</td>
</tr>
<tr>
<td>Part B: Psychosocial Support Services</td>
<td>Fotini Strongylos</td>
<td>004.202001</td>
<td></td>
<td>July 2020</td>
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<td>Part B: National Psychosocial Support – Brokerage Program Guidelines</td>
<td>Fotini Strongylos</td>
<td>005.202001</td>
<td></td>
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<tr>
<td>Part B: Accessible Psychological Interventions Program Guidelines</td>
<td>Fotini Strongylos</td>
<td>006.202001</td>
<td></td>
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<tr>
<td>Part B: Residential Aged Care Facilities Psychological services</td>
<td>Fotini Strongylos</td>
<td>007.202002</td>
<td></td>
<td>July 2020</td>
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<tr>
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<td>Process/Document reference number</td>
<td>Authorised by</td>
<td>Review by (date and person/group)</td>
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<tr>
<td>Part B: MHICC Program Guidelines</td>
<td>Fotini Strongylos</td>
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<td>Pending outcome of Workshop with Consultant/providers</td>
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</tr>
<tr>
<td>Referral pathways eAPI</td>
<td>Fotini Strongylos</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ResetLife Operations Manual</td>
<td>Allen Curry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ResetLife Youth Operations Manual</td>
<td>Allen Curry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Governance Framework Part B - Commissioned Services (Internal)</td>
<td>Kiera Mansfield</td>
<td>Version 1.4</td>
<td>Endorsed by Board, April 2020</td>
<td></td>
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