

Clinical governance of co-located and well-located after-hours general practice services

A framework and toolkit

Department of Human Services

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Introduction

In February 2007, the Department of Human Services (the Department) commissioned a review of co-located after-hours general practice clinics. The review concluded, amongst other things, that there was a need to strengthen clinical governance in relation to collocations in order to ensure mutual confidence in referring patients and, therefore, clinic viability.

The Department commissioned DLA Phillips Fox (the consultants) to develop a clinical governance framework and toolkit capable of use by a health service and a general practice clinic in the context of an agreement to deliver after-hours primary medical care. This is the framework and toolkit developed by DLA Phillips Fox.

This clinical governance framework and toolkit can be applied by health services and general practice clinics as part of agreements on the provision of after-hours primary medical care by collocated or collaborative (well-located) general practice clinics.

Co-located and well-located general practice clinics in Victoria

There are six co-located after-hours clinics in Victoria:

- Two independently-owned after-hours general practice clinics are located within the Frankston Hospital and within the Royal Children's Hospitals, adjacent to their emergency departments.
- A general practice clinic which is owned and operated by a company limited by guarantee, the members of which are Northern Health and the Northern Division of General Practice and the directors of which are nominated by the Board of Northern Health Service and the Board of Northern Division of General Practice, is located adjacent to the Northern Hospital emergency department.
- Two general practice clinics owned and operated by Southern Health are located in the grounds of Dandenong Hospital and within the emergency department of Monash Medical Centre.
- A general practice clinic owned and operated by Austin Health is located adjacent to the Austin Hospital emergency department.

The clinics that are owned and operated by their host health services engage general practitioners as independent contractors to provide services to certain types of patients who present to the emergency department and who elect to receive services from the general practice clinic.

In addition a large number of well-located after-hours general practice clinics operate in Melbourne and rural Victoria. Some are full service practices providing after-hours services and some focus on after-hours service provision only.

Both the Australian and Victorian governments provide financial support to some general practice clinics that provide after-hours primary medical care. The capacity to attach conditions

to this funding enables both levels of government to exert significant influence over the way in which these services are provided.

The Department considers the purpose of co-located after-hours general practice clinics is to:

- ensure care is provided in the most appropriate setting (GP practice);
- minimise hospital utilisation;
- optimise the use of emergency services for more acute presentations; and
- manage unmet demand in the community for emergency primary medical care.

Departmental policy is to support clinics which have the structure and feel of a general practice and are physically separated from the emergency department. The Department strongly supports a service model based on collaborative partnerships between the clinic, the health service, local general practitioners and the relevant general practice divisions. Clinics which are supported by the Department are required to retain the character of community based general practice clinics even though they may be physically located adjacent to a public hospital emergency department.

The regulatory framework

Co-located public health services and general practice clinics operate within a complex regulatory framework. A summary of the key features of the regulatory framework is at Attachment 1.

Clinical governance concepts

Clinical governance is, simply, the governance of clinical care.

The elements of clinical governance should mirror the well-documented and researched elements of corporate governance. These elements translate into the clinical context as follows:

- strategic leadership of clinical services, including their safety and quality;
- effective delegation of authority and responsibility for the safety and quality of clinical services;
- accountability for the safety and quality of clinical services, throughout the organisation to the governing entity;
- effective clinical risk management systems; and
- strong cultural leadership including a culture of questioning and reflection.

Strategic leadership

In the context of a collaborative service such as a collocated emergency department/general practice clinic, leaders of each organisation should be able to articulate an agreed vision and strategy for the collaborative service - what is it trying to achieve, what are its key strategies, what are its primary objectives/goals?

In light of what is known about opportunities, risks and adverse events in health care a meaningful strategy for any health care organisation should comprehensively address the safety and quality of clinical services.

Delegation of authority and responsibility for safety and quality of care

Governing entities of all but the smallest organisations should delegate substantial operational authority and responsibility to their appointed chief executive officers or managers and simultaneously implement effective mechanisms to ensure appropriate accountability for organisational performance.

Effective delegation requires that adequate resources are made available for deployment by those to whom a delegation is made.

Clarity of who is responsible for ensuring the adequacy of safety and quality systems is a key criterion for effective clinical governance.

Accountability for the safety and quality of clinical services

Each individual who delivers health services has a personal, professional and legal responsibility to do so with appropriate care, but contemporary approaches to safety and quality also emphasise the need to focus on organisational systems rather than individuals¹. The legal system recognises organisational responsibilities to ensure safe systems of care and the community expects that organisational systems will be in place to safeguard the safety and quality of care. It is critically important that:

- professionals are supported to deliver safe, high quality care in organisational settings. This requires care delivery systems which are structured in accordance with known good practice;
- the processes and outcomes of care are monitored against expected standards; and
- any deficiencies in processes or outcomes are addressed.

Complementing effective systems of delegation, therefore, good governance requires implementation of appropriate organisational systems to support service delivery, monitor and review service quality and respond to any deficiencies in quality. These systems should be in place throughout the organisation. Regular comprehensive reports should be provided to the governing entity, enabling it to gain a clear picture of the organisation's operational and strategic performance. In health care, these reports should have an appropriate focus on both business and clinical performance.

¹ Denis O'Leary, President, Joint Commission, http://www.jointcommission.org/NewsRoom/OnCapitolHill/testimony_061104.htm

A positive governance culture enables the governing entity to monitor performance, scrutinise service development proposals, engage in healthy debate about organisational performance, challenge assumptions and question recommendations.

An effective risk management system

A health care organisation's risk profile will consist of risks in a range of domains including financial, reputational, human resources and clinical. Ensuring an effective clinical risk management system is in place, especially in the context of the known high clinical risks of health care, is a core responsibility for the governing entity. As well as a retrospective analysis of adverse events, the risk management system needs to have a prospective focus on the safe design of clinical systems and support mechanisms.

Effective cultural leadership

Responsibility for cultural leadership clearly rests with the governing entity. The governing entity and managers have a significant influence on culture through their statements, actions, staff supervision and responses to events. Conveying a consistent expectation of quality is a key responsibility. In a positive organisational culture:

- staff are supported to provide quality care.
- clinicians work within an agreed scope of clinical practice.
- effective quality systems are in place, in accordance with known standards.
- policies, procedures, position descriptions and associated documentation create a clear framework that allows each staff or contractor to understand their roles and responsibilities and the expectations that apply regarding service safety and quality.
- intentional breaches of relevant policies and procedures are not tolerated.
- adverse events are disclosed and investigated and lessons are learned and applied.
- the effectiveness of processes and outcomes is monitored, within an environment that supports and expects continuous improvement.

Figure (drawing on concepts developed by the Health Care Standards Unit of Keele University²) depicts a clinical governance framework for collaborating health services. Figure demonstrates the clinical risk management elements of a clinical governance framework for collaborating health services.

² See Health Care Standards Unit. *The Standards for Better Health: Improving Board Assurance*. April 2006, accessed on 8 February 2009 at http://www.hcsu.org.uk/index.php?option=com_docman&task=doc_view&gid=634.

Figure : A clinical governance framework for collaborating health services

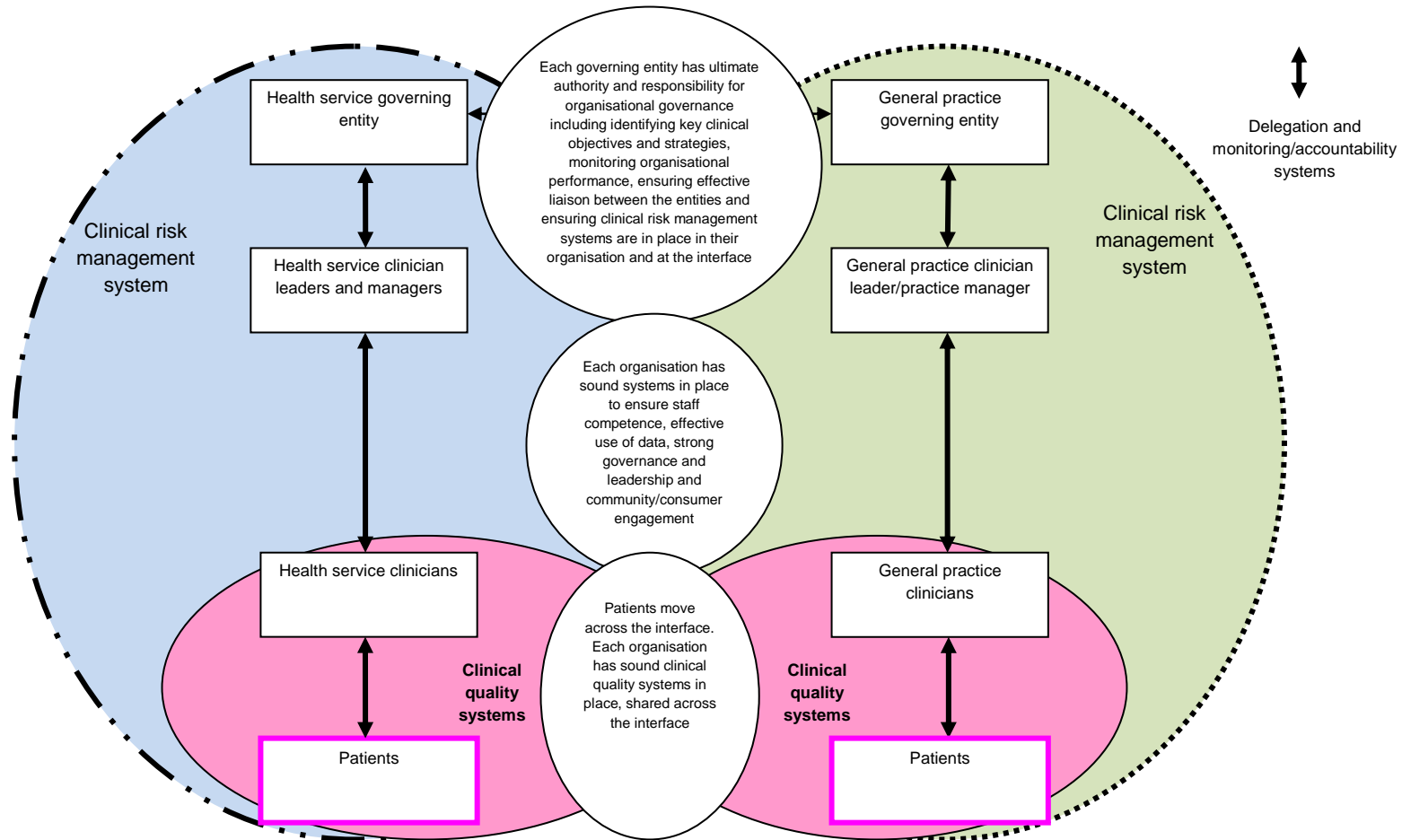
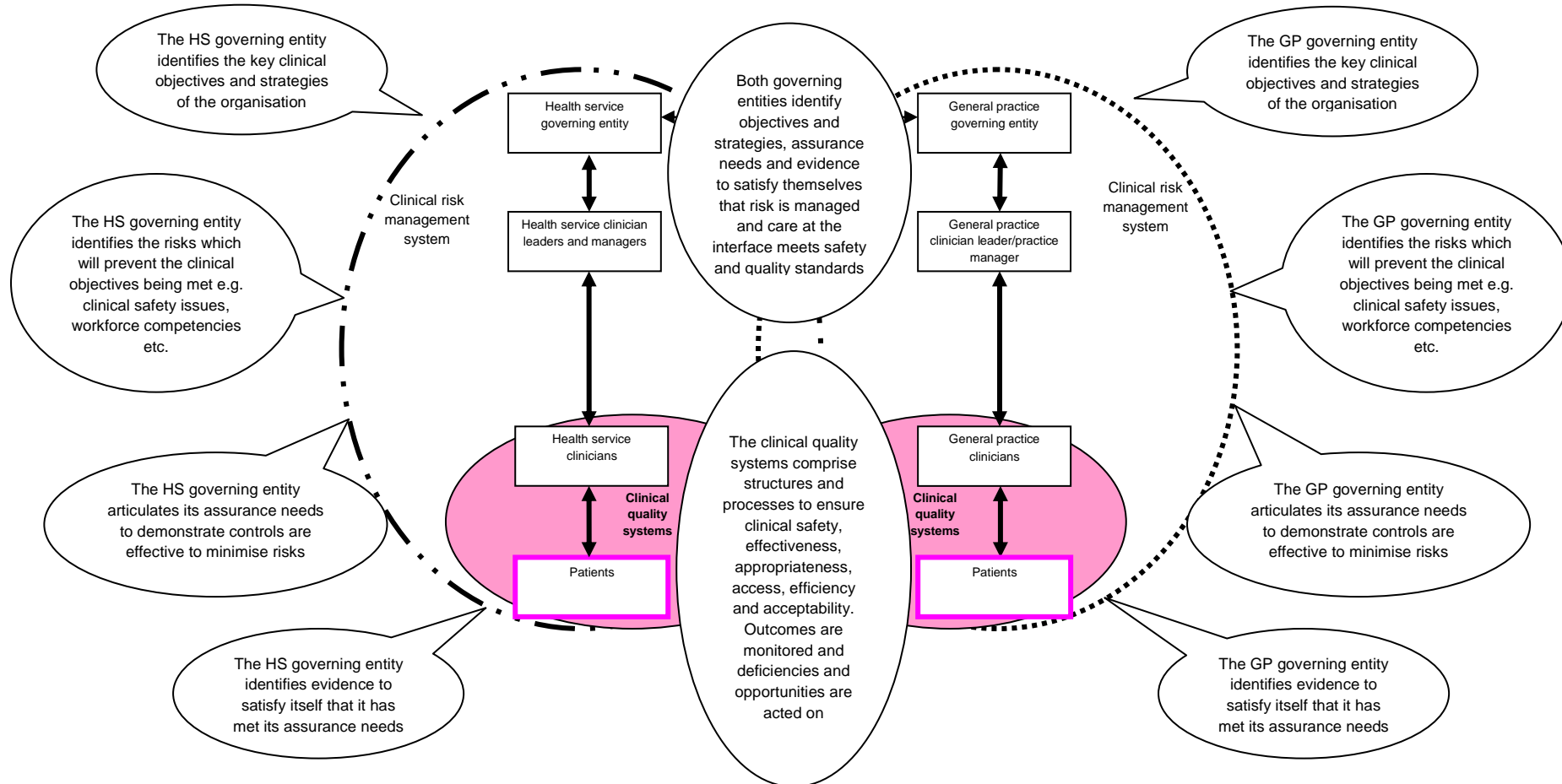


Figure : A clinical risk management framework for a collaboration between two health services



Legal issues relevant to co-located general practice clinics

The 2007 review of co-located After Hours General Practice Clinics in Victoria by the Department of Human Services found that the clinics had underutilised capacity and also found some reluctance by public hospital health care professionals to refer patients to such clinics. If such collaborations are to be successful, it seems clear that both public hospital health care professionals and general practitioners will require reassurance that 'medico-legal risk' has been adequately addressed. The existence and scope of duties of care at law are obviously crucial in assessing medico-legal risk.

DLA Phillips Fox undertook a comprehensive analysis of medico-legal issues associated with co-located general practice clinics as part of this project. A summary of this analysis is at Attachment 2 and the full analysis is contained in our final report to the Department. It can be seen that under certain circumstances a health service and a general practice may be liable for the other party's conduct, suggesting that to manage that risk, each party should consider the adequacy of the quality and governance systems of the other.

A clinical governance framework for co-located and well-located general practice clinics

Rationale for the framework

A number of issues necessitate special attention to the governance of clinical services provided in settings in which a general practice clinic is co-located or well-located with a public hospital emergency department.

Firstly, before offering a patient who has approached a public hospital emergency department an option to seek care from an alternative provider, health service staff make judgements about the clinical condition and needs of the patient. If, in making those judgements, an acceptable standard of care is not provided and the other elements of negligence exist (causation, foreseeability and ensuing harm), it is likely that the health service will be vicariously liable for that negligence. This applies whether the general practice clinic to which a patient is referred is well-located or co-located.

Secondly, depending on the arrangements that are in place between a general practice clinic and a health service, a co-located general practice clinic to which a patient is referred may be considered to be an agent of the health service, in which case the health service may be vicariously liable for the negligence of the general practice clinic. This is unlikely to be the case if the general practice clinic is not physically or organisationally linked to the health service. Alternatively, the health service may employ and manage non-medical staff who provide an integrated support service to the general practice clinic - in these circumstances, the health service is likely to be vicariously liable for any wrongful acts of those staff.

Thirdly, depending on what services a health service undertakes to provide to a patient, the health service may be considered to owe a duty of care to the patient - a duty of care that cannot be delegated to a co-located or well-located general practice clinic - the health service will remain liable for the wrongful acts of the general practice clinic.

And finally, the risk of poor quality of care may increase where arrangements require collaborative action by different entities - for example, there may be gaps in clinical quality systems if each party assumes the other is managing them, or there may be risk intrinsic to the process of communication between different organisations (e.g. a risk of failure to communicate essential investigative results).

Any increase in risk, however, may be counterbalanced by improvements in quality associated with the provision of more appropriate care in appropriate settings.

Clearly, it is in the shared interests of health services and general practice clinics to establish stable arrangements that enable clinical and medico-legal risks to be understood and managed, and quality services to be delivered. The purpose of this project has been to identify a framework for this process and develop tools to assist health services and general practice clinics to achieve the desired outcome of high quality care delivered in an environment in which risk is both understood and managed, through sound clinical governance arrangements.

Clinical governance - principles

Good clinical governance of collaborative entities is based on the following principles:

- The consumer is the focus of care.
- Clinical care is evidence-based or, where evidence is not available, based on professionally-accepted good practice.
- Roles and responsibilities for designing clinical systems and monitoring their performance are clear.
- Clinicians are expected and supported to be engaged in designing clinical systems and monitoring their performance.
- Data and information inform service review and development.
- There is a systems approach rather than an approach based on blame when things go wrong - the culture is supportive and encourages learning and continuous improvement.
- There is a strong focus on accountability
- Partnerships are respectful and collaborative.
- Consumers are engaged in service development and performance.

Clinical governance - key domains

This clinical governance framework for co-located and well-located general practice clinics proposes 6 domains of governance, which are listed below.

- 1 Governance structures.
- 2 Clearly defined purposes, roles and responsibilities.
- 3 Best practice systems for the delivery of quality clinical care.
- 4 Provider competence and performance
- 5 Data and information to inform decisions at all levels of the organisation.
- 6 Strong risk management, with a focus on the clinical interface.

Implications for stakeholders

Good clinical governance in the co-located or well-located general practice clinic setting will have the following outcomes:

- Patients/consumers - will be confident that they are receiving quality care in the most appropriate setting, provided by competent staff working within a learning culture, where there is continuous monitoring and review of standards of practice.

- Staff - will understand their roles and responsibilities, will be supported to provide quality care and will be engaged in service system design, performance monitoring and improvement.
- Partnering organisations - will understand each others' roles and responsibilities and be able to demonstrate their accountability for ensuring evidence-based care is delivered safely, efficiently, effectively and appropriately at appropriate times and in accessible locations.
- Members of governing bodies - will understand their roles and responsibilities, demonstrate effective leadership, monitor and respond to performance and ensure risk is identified and managed.

Clinical governance domain 1 - governance structures and relationships

The responsible governing entity

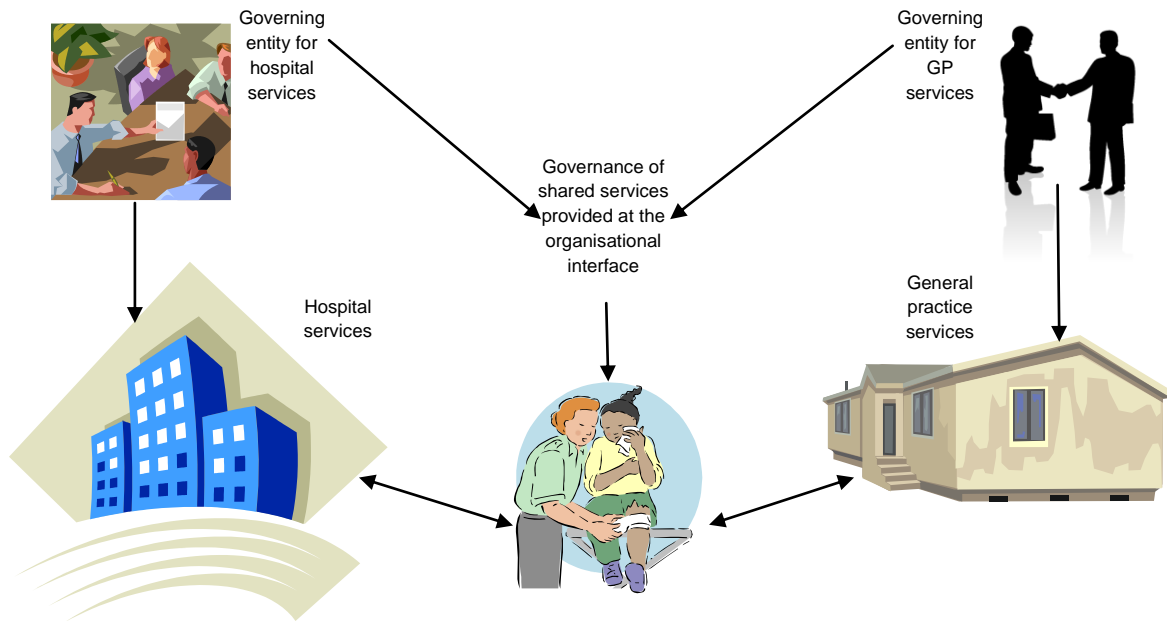
The governing entity of a health care organisation ultimately has the authority and responsibility to ensure clinical systems are well designed and perform effectively.

Identifying the organisational governing entity is a simple task when a service delivery organisation is a single, discrete entity. This is particularly so if the organisation is a corporation - under these circumstances, responsibility for the governance of services provided by the organisation ultimately rests with the board.

Victorian public health services are corporations formed under the *Health Services Act 1988* and governed by a board of directors. General practice clinics may be formed under a variety of structures including solo practices, partnerships, private companies and public companies. The identity of the governing entity will depend on the organisational structure, but often there will be either an individual or a board that ultimately is responsible for the good governance of the practice.

Each of the parties to the collaboration (i.e. the general practice clinic and the health service) will have their own governance and management roles and responsibilities for the services they provide directly to patients. Some of the services they provide will interface with services of the other collaborating organisation - for these services, either or both parties may be responsible for aspects of governance and management (Figure).

Figure : Hospital/general practice clinic collaborations



The first step in good clinical governance is to ensure that all parties clearly understand which entity is responsible for governance and management of each aspect of the service, including:

- those aspects of the service which are the responsibility of one provider alone; and
- those aspects of the service which are delivered at the interface between the two providers.

Arrangements that are in place in Victoria at present reflect a continuum of levels of engagement, from loose collaborations based on shared geography to close functional integration where the health service provides all infrastructure for the general practice clinic and engages the general practitioners directly as independent contractors who work in a designated general practice clinic area.

A methodology for determining which party is responsible for governance and which party carries medico-legal risk is demonstrated below using a number of models.

Option : A well-located clinic which is independently owned and operated and located separately from the hospital

Under this arrangement, the health service has no direct legal relationship with the general practice clinic.

The general practice clinic is independently owned and operated. It is located near but not in the hospital. Appropriate patients who attend the emergency department may be offered the option to access the general practice clinic instead of waiting for emergency department care. Other patients access the general practice clinic directly, without passing through the emergency department triage process.

Option : A co-located clinic which is structurally independent of the host health service

Under this arrangement, the health service acts as a host to a general practice clinic, offering a lease or license to use the health service's facilities for a commercial, semi-commercial or nominal fee.

The general practice clinic may be owned by a corporation or an individual. It engages local general practitioners via employment or contracting arrangements to provide services to patients. The practice employs a practice manager and nurses and provides all necessary infrastructure (records services, telephones etc.).

Patients are billed on behalf of the individual practitioner and some or all of the Medicare revenue usually is assigned to the practice to cover the facility costs.

The general practice clinic is located within the hospital building, close to the emergency department. Appropriate patients who attend the emergency department may be offered the option to access the general practice clinic instead of waiting for emergency department care. Other patients access the general practice clinic directly, without passing through the emergency department triage process.

Option : A co-located clinic which is owned and operated by a company limited by guarantee, the members of which are the health service and the Division of General Practice

Under this arrangement, the health service acts as a host to a general practice clinic, offering a lease or license to use the health service's facilities for a commercial, semi-commercial or nominal fee.

The general practice clinic is owned by a company limited by guarantee, the members of which are the health service and the Division of General Practice and the directors of which are nominated by the health service and the Division of General Practice respectively, in accordance with the company's constitution.

The practice engages local general practitioners via employment or contracting arrangements to provide services to patients. The practice employs a practice manager and nurses and provides all necessary infrastructure.

Patients are billed on behalf of the individual practitioner and some or all of the Medicare revenue usually is assigned to the practice to cover the facility costs.

The general practice clinic is located within the hospital building, close to the emergency department. Appropriate patients who attend the emergency department may be offered the option to access the general practice clinic instead of waiting for emergency department care. Other patients access the general practice clinic directly, without passing through the emergency department triage process.

Option : A co-located clinic which is owned and operated by a health service utilising the services of independently contracted general practitioners

Under this arrangement, the general practice clinic is a business unit or department of the host health service. General practitioners are engaged by the health service as independent contractors to provide services to patients. The health service manages the premises in which the general practitioners operate, employs all support staff and provides all necessary infrastructure.

Patients are billed on behalf of the individual practitioner and some or all of the Medicare revenue usually is assigned to the health service to cover the facility costs.

The general practice clinic is located within the hospital building, close to the emergency department. Appropriate patients who attend the emergency department may be offered the option to access the general practice clinic instead of waiting for emergency department care. No patients access the general practice clinic directly, without passing through the emergency department triage process.

Option : A well-located clinic which is independently owned and operated and located separately from the hospital

	Health service	Independent general practice clinic	Individual general practitioner providing patient care
Legal structure	Public statutory authority	Varies - may be a corporate or sole provider	Individual general practitioner
Governing entity	Health service board	Varies - may be a board or sole proprietor	Individual general practitioner
Scope of operational responsibilities and duty of care	<p>The organisation is personally responsible for the provision of quality triage services that meet accepted standards</p> <p>The organisation is vicariously liable for the negligence of nurses, who provide triage services, and other staff it employs to provide services on its behalf to patients</p> <p>Because there is no physical proximity and providing there is no representation of agency, the organisation is most unlikely to have a non-delegable duty to ensure care it taken by the general practice clinic, or to be vicariously liable consequent on the relationship with the general practice clinic</p>	<p>Depending on the circumstances, the organisation may be personally responsible for the provision of quality care (including referral to other providers) that meets accepted standards</p> <p>The organisation is vicariously liable for the negligence of nurses and other staff it employs</p> <p>Depending on the circumstances, the company or sole provider may be vicariously liable for the negligence of contracted general practitioners if the relationship is characterised as an agency relationship</p> <p>Depending on the circumstances, the company or sole provider may have a non-delegable duty to ensure care is taken by contracted general practitioners</p>	<p>The individual general practitioner is responsible for the provision of quality care (including referral to other providers) that meets accepted standards</p>
Responsibility for premises and safety of staff, contractors and visitors	Unless special circumstances apply, the organisation has no direct responsibility for occupational health and safety of the general practice clinic	The employer must provide a safe and healthy workplace for employees and contractors and must ensure that other people (e.g. patients) are not endangered by the conduct of the business. Both individuals and companies can incur penalties	The individual general practitioner must ensure, so far as is reasonably practicable, that persons are not exposed to risks to their health or safety arising from their conduct

Option : A co-located clinic which is structurally independent of the host health service

	Health service	Independent general practice clinic	Individual general practitioner providing patient care
Legal structure	Public statutory authority	Varies - may be a corporate or sole provider	Individual general practitioner
Governing entity	Health service board	Varies - may be a board or proprietor	Individual general practitioner
Scope of operational responsibilities and duty of care	<p>The organisation is personally responsible for the provision of quality triage services that meet accepted standards</p> <p>The organisation is vicariously liable for the negligence of its employee nurses, who provide those triage services, and other staff it employs to provide services on its behalf to patients</p> <p>Depending on the circumstances, the organisation may be vicariously liable for the negligence of the general practice clinic if the relationship is characterised as an agency relationship</p> <p>Depending on the circumstances, the organisation may also have a non-delegable duty to ensure care is taken by the co-located general practice clinic</p>	<p>The organisation may be personally responsible for the provision of care that meets acceptable standards</p> <p>The organisation will be vicariously liable for the negligence of nurses, practice managers and other staff it employs</p> <p>Depending on the circumstances, the organisation may be vicariously liable for the negligence of contracted general practitioners if the relationship is characterised as an agency relationship</p> <p>Depending on the circumstances, the organisation may have a non-delegable duty to ensure care is taken by contracted general practitioners</p>	<p>The individual general practitioner is responsible for the provision of quality care (including referral to other providers) that meets accepted standards</p>
Responsibility for premises and safety of staff, contractors and visitors	<p>The organisation is responsible as host/landlord for the safe condition of premises and repair of known defects</p> <p>To the extent to which the organisation manages and controls the workplace, it must ensure so far as is reasonably practicable that the workplace and the means of entering and leaving it are safe and without risks to health.</p> <p>Individual directors and senior officers are responsible for taking reasonable care not to contravene the Act</p> <p>The organisation may have contractual obligations to the co-located general practice clinic to provide security and safety services</p>	<p>The employer must provide a safe and healthy workplace for employees and contractors and must ensure that other people (e.g. patients) are not endangered by the conduct of the business. Both individuals and companies can incur penalties</p>	<p>The individual general practitioner must ensure, so far as is reasonably practicable, that persons are not exposed to risks to their health or safety arising from their conduct</p>

Option : A co-located clinic which is owned and operated by a company limited by guarantee, the members of which are the health service and the Division of General Practice

	Health service	Co-located general practice clinic	Division of general practice	Individual general practitioner providing patient care
Legal structure	Public statutory authority	Company limited by guarantee, of which the health service and the Division are members	Company limited by guarantee	Individual general practitioner
Governing entity	Health service board	Company board, consisting of nominees of health service and Division	Company board	Individual general practitioner
Scope of operational responsibilities and duty of care	<p>The organisation is personally responsible for the provision of quality triage services that meet accepted standards</p> <p>The organisation is vicariously liable for the negligence of its employee nurses, who provide those triage services, and other staff it employs to provide services on its behalf</p> <p>Depending on the circumstances, the organisation may be vicariously liable for the negligence of the general practice clinic if the relationship is characterised as an agency relationship</p> <p>Depending on the circumstances, the organisation may also have a non-delegable duty to ensure care it taken by the general practice clinic</p> <p>The organisation may be required to contribute up to the amount of the guarantee in the event of the company being wound up</p> <p>The organisation nominates directors to the board of the company</p>	<p>The company may be personally responsible for the provision of care that meets acceptable standards</p> <p>The company is vicariously liable for the negligence of nurses, practice managers and other staff it employs to provide services on its behalf</p> <p>Depending on the circumstances, the company may be vicariously liable for the negligence of contracted general practitioners if the relationship is characterised as an agency relationship</p> <p>Depending on the circumstances, the company may have a non-delegable duty to ensure care is taken by the general practitioners it contracts to provide care</p>	<p>The Division may be required to contribute up to the amount of the guarantee in the event of the company being wound up</p> <p>The Division nominates directors to the board of the company</p>	<p>The individual general practitioner is responsible for the provision of quality care including referral to other providers that meets accepted standards</p>
Responsibility for premises and safety of staff, contractors and visitors	<p>The organisation is responsible as host/landlord for the safe condition of premises and repair of known defects</p> <p>To the extent to which the organisation manages and controls the workplace, it must ensure so far as is reasonably practicable that the workplace and the means of entering and leaving it are safe and without risks to health.</p> <p>Individual directors and senior officers are responsible for taking reasonable care not to contravene the Act</p> <p>The organisation may have contractual obligations to the general practice clinic to provide security and safety services</p>	<p>The employer must provide a safe and healthy workplace for employees and contractors and must ensure that other people (e.g. patients) are not endangered by the conduct of the business. Both individuals and companies can incur penalties</p>	<p>Nil, unless the Division has responsibility for management and control of the workplace</p>	<p>The individual general practitioner must ensure, so far as is reasonably practicable, that persons are not exposed to risks to their health or safety arising from their conduct</p>

Option : A co-located clinic which is owned and operated by a health service utilising the services of independently contracted general practitioners

	Health service	Individual general practitioner providing patient care
Legal structure	Public statutory authority	Individual general practitioner
Governing entity	Health service board	Individual general practitioner
Scope of operational responsibilities and duty of care	<p>The organisation is personally responsible for the provision of quality triage services that meet accepted standards</p> <p>The organisation is vicariously liable for the negligence of nurses, who provide triage services, and other staff it employs to provide services on its behalf to patients</p> <p>The organisation is vicariously liable for the negligence of the staff it employs to provide services to the general practice clinic</p> <p>The organisation may be vicariously liable for the negligence of general practitioners engaged to provide services to the general practice clinic, if the relationship is characterised as an agency relationship</p> <p>Depending on the circumstances, the organisation may have a non-delegable duty of care to ensure care it taken by the general practitioners engaged to provide services to the general practice clinic</p>	<p>The individual general practitioner is responsible for the provision of quality care (including referral to other providers) that meets accepted standards</p>
Responsibility for premises and safety of staff, contractors and visitors	<p>The organisation is responsible for the safe condition of premises</p> <p>To organisation must ensure so far as is reasonably practicable that the workplace and the means of entering and leaving it are safe and without risks to health.</p> <p>Individual directors and senior officers are responsible for taking reasonable care not to contravene the OH&S Act</p>	<p>The individual general practitioner must ensure, so far as is reasonably practicable, that persons are not exposed to risks to their health or safety arising from their conduct</p>

Agreeing on the form of the collaboration

All collaborations involving co-location of a health service and a general practice clinic which is owned and governed by an independent party (this includes options 2 and 3 above) should be based on the Department's *Framework for Victorian Co-located After Hours GP Clinics* and underpinned by a formal written agreement which defines the purpose of the collaboration, the relationship between the parties, the respective commitments and obligations of each party, the structures and processes that will support communication and mechanisms for resolving issues and disputes.

The agreement should not simply address issues of legal risk. The agreement also should define how each party will support achievement of the vision and purpose of the collaboration and address areas of common interest, which may include:

- planning of new services;
 - service profile of after-hours primary medical services;
 - endorsement from local general practitioners;
 - relationships with well-located after-hours clinics;
- general practitioner workforce strategies;
 - staffing of the service;
 - centralised employment management services;
- continuing professional development;
- the quality of clinical care and clinical governance processes;
- connecting patients at discharge with a regular general practitioner;
- information exchange between health services and local practices;
 - notification and recall processes;
 - referrals from local general practitioners;
 - promotion of the service;
- provision and management of physical facilities and equipment; and
- reporting and evaluation.

Health services also may consider formalising their relationships with well-located general practice clinics in a formal written agreement. Agreements with well-located general practice clinics are likely to be simpler and address fewer issues than agreements with co-located general practice clinics, where the issues are more complex.

Establishing a liaison structure

Ultimately, if there is a dispute about legal liability for wrongful acts which cause harm to patients, respective liabilities will be determined by legal processes.

To minimise risk and ensure opportunities are captured, each organisation needs to ensure the effectiveness of its own clinical governance structures in promoting and assuring quality and minimising clinical risk.

The key to successful collaborations, however, is for the partners to work together to support the delivery of quality services, identify risk and opportunities and monitor and respond to performance.

The agreement between the parties to a co-location should include a commitment to establishing a liaison committee or similar process. A committee may have a variety of clinical and non-clinical roles but at a minimum it should monitor performance of the collaborative venture, identify clinical governance risks and opportunities and develop shared strategies to address risks and capture opportunities for patient benefit. With respect to clinical services, the liaison committee should:

- provide a forum for the collaborating organisations to demonstrate their commitment to quality care in the collaborative setting;
- monitor an agreed set of information about the adequacy of clinical systems and the quality of clinical services, with a focus on care that is delivered at the interface between them, and advise both organisations on the implications of assessed performance;
- consider and analyse emerging clinical opportunities and risks, and advise on their management;
- focus particularly on advising on the causes and remedies for any quality risks or opportunities arising at the interface between the two organisations (e.g. patient information, patient referral, follow up of results);
- consider and advise on the implications for safety and quality of the strategic direction of the co-located clinic.

The agreement between the parties also should identify a process for agreeing policies and procedures addressing issues such as clinical safety and quality and occupational health and safety, when the conduct of one party may affect the other. Each party should maintain a current, consolidated policy and procedure manual.

The liaison committee between the entities provides an ideal forum for establishing and implementing an evaluation framework. The general practice liaison officer is in a position to understand the interests of a range of stakeholders (health services, general practitioners and divisions) and should be considered for membership of the liaison committee.

Health services and well-located general practice clinics also may choose to establish a liaison committee or similar structure to assist in providing direction to and monitoring the effectiveness of the collaboration.

Managing third party obligations and relationships

All after-hours general practice clinics which have a legal relationship with a public health service (e.g. a lease or license to use the health service's facilities) or which access state or Commonwealth government funding through specific programs aimed at supporting co-located or well-located after-hours clinics need to operate within the policy frameworks which support those funding programs.

Both the state and Commonwealth governments have supported the provision of discrete 'general practice-type' care in collaboration with public hospital emergency departments. Both levels of government recognise the critical role of other stakeholders including independent general practitioners, divisions of general practice, General Practice Victoria and the RACG. The Department has been very clear about its intention to support the development of collaborative partnerships between the clinic, the health service, local general practitioners and general practice divisions.

It is a governance responsibility to ensure stakeholder relationships are managed effectively and also to ensure that conditions associated with funding provided by the Department and the Australian Government are fulfilled.

Clinical governance domain 2 - purposes, roles and responsibilities

Strategic leadership and planning

A co-location should be based on a strategic plan which is agreed between the parties. A strategic plan usually incorporates a vision, purpose, strategies and actions and creates a basis for running the general practice clinic and monitoring the progress of the collaboration over time.

Defining a vision and purpose for the collaboration is important, because it enables specific strategies to be developed and roles and responsibilities to be allocated systematically.

More than one purpose may apply to a collaboration between a health service and a general practice clinic. The vision and purpose should, however, align with the directions established by the *Framework for Victorian Co-located AHGP Clinics*, and should be consistent with the clinic having the character of a community-based general practice clinic. Once the vision and purpose are agreed, the participants in the co-located general practice clinic should mutually define the key strategic objectives for the co-located clinic. These objectives should be achievable and measurable and should provide a basis for operating the collaborative venture and monitoring its performance. Strategic plans should be reviewed and updated regularly.

Health services and well-located general practice clinics also may decide to adopt a strategic plan to guide their partnerships, but these plans are likely to be simpler than those applying to co-located practices.

Appointing a practice manager

After-hours general practice clinics operate within a complex compliance framework and have to balance the objectives of multiple stakeholders. Demands for effective management, including the management of occupational health and safety, the management of multiple

employees and/or contractors and the management of relationships with a large number of stakeholders, are significant.

Good governance requires the appointment of a practice manager, who should play a key role in managing and representing the after-hours clinic and ensuring it has a strong general practice orientation, particularly if the clinic is owned and operated by a health service.

Appointing a clinical leader

In a setting in which there are large numbers of medical practitioners who work part time and outside normal working hours and who may rarely interact as a peer group, identifying a clinical leader and supporting them to undertake a clinical governance role is likely to be a key success factor.

There should be an identifiable medical practitioner in all co-located practices who should:

- provide strong medical cultural leadership;
- be a focus for communication with general practitioners and the health service on clinical issues;
- participate in setting the safety and quality agenda and assume significant responsibility for implementing it;
- lead the establishment of clinical practice guidelines;
- lead the design of clinical systems;
- advise on physical facilities and equipment;
- contribute to determining priorities for resource allocation;
- be responsible for ensuring key clinical governance controls are in place in relation to medical practitioners, including an effective system of credentialing and defining the scope of clinical practice of general practitioners;
- with other senior staff, oversee the monitoring and performance of the co-located clinic;
- participate, and encourage other general practitioners to participate, in education programs offered in the emergency department; and
- participate in the liaison committee.

Clarity of roles and responsibilities - clinical care

Consistent with the principles of good governance, there should be a clear delegation of responsibility from the governing entity throughout the organisation to those who deliver services to consumers.

At the organisational level, responsibility needs to be clear in relation to roles such as:

- providing and maintaining equipment and consumables;

- sterilising equipment;
- maintaining medical records;
- developing patient screening criteria;
- maintaining an imprest store of medication;
- maintaining and managing medical records;
- designing and negotiating the adoption of care pathways;
- advising patients on options for treatment in the emergency department and after-hours clinic;
- re-prioritising patients who return to the emergency department from the after-hours clinic;
- following up patients who have abnormal pathology or imaging;
- communicating with the patient's usual general practitioner; and
- participating in shared clinical governance activities.

Typical responsibilities for clinicians, which should be included in clinician position descriptions, would include:

- delivering care and services according to agreed policies and procedures;
- participating in the development, implementation and evaluation of quality and safety plans, systems and activities;
- openly communicating and reporting safety and quality problems and adverse events, and participating in developing solutions;
- adhering to policies and procedures for preventing, reporting and disclosing adverse events;
- participating in activities that identify and address areas for improvement from the patient and staff perspective; and
- participating in a team approach to patient care, quality improvement and problem-solving.

Health services also should consider what types of arrangements for clinical leadership are in place in well-located clinics, prior to entering into formal collaborative arrangements with them.

Clarity of roles and responsibilities - occupational health and safety

A related concern is to make sure that there is clarity of authority and responsibility for ensuring a safe environment for staff and visitors. While not strictly a clinical governance responsibility,

this is nevertheless a key governance obligation for both collaborating entities in a co-located setting.

The *Occupational Health and Safety Act 2004* establishes a basic duty for an employer, so far as is reasonably practicable, to provide and maintain for employees of the employer a working environment that is safe and without risks to health. The Act also creates an obligation for a person who (whether as an owner or otherwise) has, to any extent, the management or control of a workplace to ensure so far as is reasonably practicable that the workplace and the means of entering and leaving it are safe and without risks to health.

Breach of these duties can result in substantial penalties for individuals and corporations. It is imperative, therefore, that the occupational health and safety system that applies to the co-located clinic is defined and responsibilities for implementing it are clear. Amongst other things, this requires consideration of which entity manages or controls the workplace.

An occupational health and safety plan should be developed for the co-located clinic which defines risks, controls and responsibilities. Roles and responsibilities of all parties for implementing the plan and monitoring its effectiveness need to be agreed, and reporting arrangements need to be instituted to ensure appropriate governance controls.

Evaluating achievement of strategic objectives

Although collaborations between co-located or well-located general practice clinics and health services have been operating informally for many years, more recently they have taken different forms and have different objectives. Many health services and general practice clinics are more explicit about what they are seeking to achieve from these collaborations, enabling evaluation of progress over time.

Clinical governance domain 3 - systems to deliver quality clinical care

Agreeing a quality framework

The agreement between the participating providers should clearly define who is responsible for designing, implementing and monitoring the performance of systems to ensure the quality of clinical care, and any agreed key design aspects of those systems. Each provider is then responsible for ensuring that their management systems are effective.

It can be helpful for the collaborators to agree a quality framework, which provides the basis for designing quality systems and monitoring and reporting on their effectiveness.

The Victorian Quality Council (VQC) has published a framework document: *Better Quality, Better Health Care: A safety and quality improvement framework for Victorian health services*. The RACGP also has published a framework document: *A quality framework for Australian general practice*. Both of these documents identify the following dimensions of quality:

- Acceptability (the degree to which services meet or exceed the expectations of informed consumers).
- Accessibility (related to how readily consumers are able to access care without barriers of distance, discrimination, affordability and restriction of service, and encompasses the objective of equity).

- Appropriateness (using up-to-date evidence to do the right thing for the right patient, at the right time, avoiding over and under utilisation).
- Effectiveness (the extent to which a treatment, intervention or service achieves the desired outcome).
- Efficiency (achieving desired results with the most cost effective use of resources).
- Safety (avoiding and minimising harm arising from care, by omission or commission, as well as from the environment in which it is carried out).

Both documents identify key domains or organisational elements necessary for the improvement of quality of health care. Three of the domains are common to both frameworks:

- Competence of health care providers.
- Information management.
- Patient focus/consumer and community involvement.

The RACGP framework also identifies capacity, financing and professionalism while the VQC framework identifies governance, leadership and culture as key domains.

The liaison committee, recommended for establishment earlier in this framework, would be an appropriate entity to facilitate agreement on a shared quality framework.

Agreeing shared systems for the delivery of quality care

A commitment to evidence-based practice should underpin all aspects of the relationship.

Each provider organisation will have well-established clinical systems and methods of service delivery, and it should not be necessary to disrupt these. There may be considerable benefit, however, in adopting shared clinical systems for the management of some conditions or for the care of patients at the interface between the two providers.

For example, there should be an agreed system for the management of acute medical emergencies which occur in the co-located clinic setting. In addition, there may be considerable benefit in agreeing protocols for the management of common conditions and protocols for ensuring effective follow up of abnormal pathology or imaging results.

Clinical governance domain 4 - provider competence and performance

Competent, well performing providers will provide quality care if they work within well designed systems of care.

Ensuring all providers have appropriate credentials and are working within an agreed scope of clinical practice which reflects the needs and capability of the organisation and the competence of the provider is a key clinical governance responsibility.

Health services and general practice clinics now generally have well-established systems for verifying provider credentials, defining scope of clinical practice and monitoring performance.

There are some challenges in the after-hours general practice clinic setting where the nature of service provision means that some general practitioners will be working intermittently and in relative professional isolation. Under such circumstances, it is extremely important to ensure that sound systems for monitoring performance have been implemented.

Similarly, there are specific skills relevant to the triaging of emergency department patients. Health services need to ensure that their triage staff are well-trained and perform competently with respect to triage processes.

Clinical governance domain 5 - data and information to inform decisions

Performance measurement and monitoring

Good clinical governance requires the implementation of a performance measurement and monitoring system with different emphases at all levels of the organisation, from the clinical 'coal face' to the governing entity.

The quality framework which has been agreed by the collaborating parties should form the basis for the development of a measurement and monitoring system. Each organisation may have its own approach to monitoring performance, but there will be a suite of information 'at the interface' which is relevant to both organisations and which should form the basis for a shared approach to monitoring quality.

For example, if it is agreed that the key dimensions of quality are safety, effectiveness, appropriateness, efficiency, access and acceptability, the parties may agree to the routine or periodic measurement and monitoring of a range of indicators of those dimensions, for example:

- frequency of reported adverse events (safety).
- frequency of repeat visits to the emergency department with an unresolved complaint (effectiveness);
- frequency of referrals back to the emergency department because of inappropriate triage to the general practice clinic (appropriateness);

- proportion of primary care-type patients eligible for referral to the general practice clinic but not referred (appropriateness);
- average patient attendances per hour or session (efficiency);
- waiting times (access);
- results of patient satisfaction surveys (acceptability); and
- frequency and type of complaints and compliments (acceptability).

Agreement also will be required on which party will monitor the adequacy and performance of clinical systems in each agreed dimension and organisational domain. These decisions need to be made in the context of the discussion earlier in this report about non-delegable duties of care - in general, if a duty is assessed to be non-delegable, it may also be prudent risk management not to delegate responsibility for ensuring the associated systems are adequately structured and performing well.

Accreditation

Accreditation is a useful independent mechanism for verifying that an organisation has acceptable clinical and management systems in place and a culture of continuous improvement. There are well-established accreditation systems available for the general practice clinic and public hospital environments, but none that apply specifically to the co-located clinic environment. It is likely that such systems will be developed in the future - in the interim, it may be appropriate for the agreement between the parties to identify a commitment to compliance with relevant accreditation standards, even if an accreditation assessment process is not available.

Clinical governance domain 6 - clinical risk management

Ensuring an effective clinical risk management system is in place, especially in the context of the known high risks of health care, is a core responsibility for each of the governing entities. As well as enabling retrospective analysis of adverse events, the risk management system needs to have a prospective focus on the safe design of clinical systems and support mechanisms.

The nature of the collaborative arrangement means that risks are likely to differ in scope or significance from the clinical risks faced by emergency departments or by general practice clinics operating alone, under traditional models.

Some specific risks associated with collaborative arrangements may include:

Risks for the health service	Shared risks	Risks for the general practice clinic
<ul style="list-style-type: none"> • Unsatisfactory triage practices resulting in inappropriate advice • Inadequate recording of informal clinical advice provided by hospital staff to general practice clinic staff • Inadequate management and supervision of staff employed by the health service to support the co-located clinic • Failure to accord appropriate priority to assessing patients referred back to the emergency department • Failure to maintain equipment and consumables in safe working order when there is an obligation to do so • Medico-legal risk associated with potential vicarious liability or non-delegable duty of care • Risk to reputation if inadequate care is provided by the general practice clinic 	<ul style="list-style-type: none"> • Inappropriate presentations to the general practice clinic of people requiring urgent care from an emergency department • Unsatisfactory clinical performance of staff employed by the health service to support the co-located clinic • Poor communication of clinical information on referral of patients between the parties • Inadequate protocols for the management of clinical emergencies in the co-located clinic • Inadequate arrangements for monitoring and responding to complaints and adverse events • Inadequate OH&S practices (co-located clinics) • Inadequate or unclear insurance arrangements • Inadequate or unclear arrangements for managing staff/identifying poor performance • Breaches of patient privacy • Loss of support from local GPs and GP divisions for AHGP clinic. 	<ul style="list-style-type: none"> • Inadequate arrangements for credentialling and defining the scope of clinical practice • Inadequate management and supervision of reception, nursing and contracted medical staff • Failure of general practitioners to follow clinic protocols because of unfamiliarity and high staff turnover • Direct presentations of people more requiring urgent care from the emergency department • Inability to access necessary equipment and consumables • Failure to maintain equipment and consumables • Inability to arrange priority assessment for patients requiring referral back to the emergency department • Inadequate arrangements for follow up of pathology and imaging • Inadequate hand over of the patient to their usual general practitioner • Risk to reputation if inadequate care provided by the health service • Viability risk from unsatisfactory triage processes resulting in under-referral • Risk to reputation and ability to provide general practice care if clinic staffed by hospital staff inexperienced in general practice clinic operations

While some clinical risks may be intensified in collaborative arrangements, it should be noted that some risks which normally occur in a general practice clinic setting or an emergency

department setting are likely to be reduced by the collaborative arrangements. The general view of stakeholders is that risks are relatively low and amenable to risk control strategies in these settings. In particular, in settings with effective protocols defining which patients are suitable for general practice care and with robust triage processes, it is likely that higher risk patients will be streamed into emergency department settings and away from the general practice clinic, and it also is possible that 'failure to wait' rates will fall.

Nevertheless, a collaboration such as a co-located general practice clinic requires a collaborative approach to clinical risk management. The liaison committee, recommended for establishment earlier in this framework, would be an appropriate entity to facilitate development and implementation of a shared risk management system.

Clinical governance tools for co-located and well-located general practice clinics

A range of tools to assist health services and general practices to develop sound collaborative arrangements is presented in the following section, including:

- a checklist for good governance
 - independent co-located general practice clinics (page 30)
 - integrated co-located general practice clinics (page 33)
 - well-located general practice clinics (page 36)
- sample vision statements (page 39)
- a checklist for agreeing on the purpose of the collaboration (page 40)
- a checklist for assessing the risk of shared liability (page 41)
- a clinical risk management checklist to apply at the interface (page 42)
- an example of triage criteria for an integrated co-located general practice clinic (kindly provided as an example by Southern Health)(page 44)
- an example of patient information - option to attend a general practice clinic (page 45)
- an example of a disclaimer of liability clause - health service (page 45)
- an example of patient information - independent co-located general practice clinic (page 45)
- an example of a clinical governance agreement between a health service and a co-located clinic (page 46)
- an example of a general practitioner information handbook (kindly provided as an example by Southern Health) (page 65)
- an example of a general practitioner contractor checklist page (kindly provided as an example by Southern Health) (page 76)
- an example of a 'professionalism' checklist for general practitioners (kindly provided as an example by Southern Health) (page 78)
- useful references and links (page 80).

A checklist for good governance - independent co-located general practice clinics

Note: this checklist applies to INDEPENDENT co-located general practice clinics and their host health services. An independent co-located general practice clinic is one which is:

- owned and operated by a entity which is legally independent of the health service;
- conducted in hospital facilities in or near the emergency department in accordance with a contractual agreement between the parties - see options 2 and 3 on pages 15 and 16.

A more detailed version of this checklist is available at Attachment 3 (page 86)

This checklist does not apply if the general practice clinic is not:

- co-located; and
- independently owned and operated.

See, instead, a checklist for an INTEGRATED general practice clinic on page 33 or a checklist for a WELL-LOCATED general practice clinic on page 36.

Governance questions - independent co-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Clinical governance domain 1 - governance structures		
What is the structure of the health service?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
What is the structure of the general practice clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Do the members of the governing bodies and/or senior managers of the health service and the general practice clinic understand their legal and governance roles and responsibilities?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a formal written agreement between the parties?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is the relationship between the parties defined clearly?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Does the health service and/or the co-located clinic have legal obligations to the Australian or Victorian Governments associated with funding for the co-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Does the written agreement between the parties include a commitment to establish a liaison committee?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a process for agreeing policies and procedures addressing issues that impact on the relationship between the health service and the co-located clinic	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Governance questions - independent co-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Is there an agreed process for the settlement of disputes?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 2 - defined purpose, roles and responsibilities		
Is there an agreed vision and defined purpose for the co-located clinic and its relationship with the health service?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a strategic plan for the co-located clinic?		<input checked="" type="checkbox"/>
Is there agreement on the scope of services that will be provided in the co-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a business plan for the co-located clinic?		<input checked="" type="checkbox"/>
Is there an agreed evaluation framework and process?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an appointed manager who is responsible for the operations of the co-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an identified clinical leader who is responsible for clinical leadership and safety and quality systems in the co-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Are respective responsibilities clearly defined for: <ul style="list-style-type: none"> • the provision and maintenance of equipment and consumables • sterilising equipment • maintaining and sharing medical records • patient screening criteria • redirecting patients between the emergency department and general practice clinic • reprioritisation of patients returned to the emergency department • maintenance of medication imprest • following up patients who have abnormal pathology or imaging • communicating with the patient's usual general practitioner • developing and maintaining care pathways • participating in shared clinical governance activities. 	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Do all employees and contractors who work in the co-located clinic have clear position descriptions which define their responsibilities and accountabilities and the requirement for them to comply with relevant policies and procedures?		<input checked="" type="checkbox"/>
Is there an occupational health and safety system which ensures that risks to health and safety in the co-located clinic are eliminated so far as is reasonably practicable, and if it is not reasonably practicable to eliminate risks to health and safety, are reduced so far as is reasonably practicable?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Governance questions - independent co-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Clinical governance domain 3 - systems to deliver quality clinical care		
Are there an agreed safety and quality framework and systems that apply to the health service triage and acceptance of re-referred patients processes?	<input checked="" type="checkbox"/>	
Is there an agreed safety and quality framework that applies to the co-located clinic?		<input checked="" type="checkbox"/>
Are there quality and continuous improvement standards that apply to the co-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed approach to the management of patient records in the co-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed approach to the management of common patient conditions?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 4 - provider competence and performance		
Are clinicians (medical, nursing and other) who provide services in the co-located clinic subject to a robust process of credentialing and defining the scope of clinical practice?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Are triage clinicians appropriately trained and is their performance (relating to clinic referrals) monitored?	<input checked="" type="checkbox"/>	
Clinical governance domain 5 - data and information to inform decisions		
Do the relevant managers of the emergency department and co-located clinic report regularly to senior management and/or the relevant governing bodies on achievement by the collaboration of strategic and business goals and service quality and safety?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a system for monitoring and addressing patient complaints and compliments?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Does the manager report regularly to senior management and/or the governing body of the collocated clinic on occupational health and safety issues?		<input checked="" type="checkbox"/>
Is there a requirement that the co-located clinic will maintain accreditation with an independent body?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 6 - clinical risk management		
Is there a clinical risk management plan?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed process for reporting and investigating adverse events that occur in relation to triage, management, re-referral or outcomes of patients referred to the co-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Are there adequate insurance arrangements in place in relation to the activities of the health service and the co-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Governance questions - independent co-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Is there a requirement for each party to notify the other of major incidents, events or risks that could affect the provision of safe, high quality care?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

A checklist for good governance - integrated co-located general practice clinics

Note: this checklist applies to INTEGRATED co-located general practice clinics. An integrated co-located general practice clinic is one in which the health service owns and operates the general practice clinic, which is conducted in hospital premises and staffed by employed or contracted general practitioners - see option 4 on page 17.

A more detailed version of this checklist is available at Attachment 4 (page 90).

This checklist does not apply if the general practice clinic is not:

- co-located; and
- managed by the health service, utilising employed or contracted general practitioners.

See, instead, a checklist for an INDEPENDENT general practice clinic on page 29 or a checklist for a WELL-LOCATED general practice clinic on page 36.

Governance questions - integrated co-located general practice clinics	
Clinical governance domain 1 - governance structures	
What is the structure of the health service?	<input checked="" type="checkbox"/>
Do the members of the governing body and/or senior managers of the health service understand their legal and governance roles and responsibilities?	<input checked="" type="checkbox"/>
Is the relationship between the parties defined clearly?	<input checked="" type="checkbox"/>
Does the health service have legal obligations to the Australian or Victorian Governments associated with funding for the co-located clinic?	<input checked="" type="checkbox"/>
Is there a steering committee or reference group for the co-located clinic that provides a forum for leading and monitoring performance of the collaborative venture	<input checked="" type="checkbox"/>
Is there a process for establishing policies and procedures that involves and engages the clinicians who work in the co-located clinic?	<input checked="" type="checkbox"/>
Is there an agreed process for the settlement of disputes?	<input checked="" type="checkbox"/>
Clinical governance domain 2 - defined purpose, roles and responsibilities	
Is there an agreed vision and defined purpose for the co-located clinic and its relationship with the health service?	<input checked="" type="checkbox"/>

Governance questions - integrated co-located general practice clinics	
Is there a strategic plan for the co-located clinic?	<input checked="" type="checkbox"/>
Is there agreement on the scope of services that will be provided in the co-located clinic?	<input checked="" type="checkbox"/>
Is there a business plan for the co-located clinic?	<input checked="" type="checkbox"/>
Is there an agreed evaluation framework and process?	<input checked="" type="checkbox"/>
Is there an appointed manager who is responsible for the operations of the co-located clinic?	<input checked="" type="checkbox"/>
Is there an identified clinical leader who is responsible for clinical leadership and safety and quality systems?	<input checked="" type="checkbox"/>
Are respective responsibilities clearly defined for: <ul style="list-style-type: none"> • the provision and maintenance of equipment and consumables • sterilising equipment • maintaining and sharing medical records • patient screening criteria • redirecting patients between the emergency department and general practice clinic • reprioritisation of patients returned to the emergency department • maintenance of medication imprest • following up patients who have abnormal pathology or imaging • communicating with the patient's usual general practitioner • developing and maintaining care pathways • participating in shared clinical governance activities. 	<input checked="" type="checkbox"/>
Do all employees and contractors who work in the co-located clinic have clear position descriptions which define their authority and accountability and the requirement for them to comply with clinic and relevant health service policies and procedures?	<input checked="" type="checkbox"/>
Is there an occupational health and safety system which ensures that risks to health and safety in the general practice clinic are eliminated so far as is reasonably practicable, and if it is not reasonably practicable to eliminate risks to health and safety, are reduced so far as is reasonably practicable?	<input checked="" type="checkbox"/>
Clinical governance domain 3 - systems to deliver quality clinical care	
Are there an agreed safety and quality framework and systems that apply to the co-located clinic service including triage, clinic services and management of re-referred patients?	<input checked="" type="checkbox"/>
Are there quality and continuous improvement standards that apply to the co-located clinic?	<input checked="" type="checkbox"/>
Is there an agreed approach to the management of patient records in the co-located clinic?	<input checked="" type="checkbox"/>
Is there an agreed approach to the management of common patient conditions?	<input checked="" type="checkbox"/>
Clinical governance domain 4 - provider competence and performance	
Are clinicians (medical, nursing and other) who provide services in the co-located clinic subject to a robust process of credentialing and defining the scope	<input checked="" type="checkbox"/>

Governance questions - integrated co-located general practice clinics	
of clinical practice?	
Are triage clinicians appropriately trained and is their performance (relating to clinic referrals) monitored?	<input checked="" type="checkbox"/>
Clinical governance domain 5 - data and information to inform decisions	
Does the manager report regularly to senior management and/or the governing body on achievement by the collaboration of strategic and business goals and service quality and safety?	<input checked="" type="checkbox"/>
Is there a system for monitoring and addressing patient complaints and compliments?	<input checked="" type="checkbox"/>
Does the manager report regularly to senior management and/or the governing body on occupational health and safety issues?	<input checked="" type="checkbox"/>
Is the clinic accredited as part of the health service's accreditation?	<input checked="" type="checkbox"/>
Clinical governance domain 6 - clinical risk management	
Is there a clinical risk management plan?	<input checked="" type="checkbox"/>
Is there an agreed process for reporting and investigating adverse events that occur in relation to triage, management, re-referral or outcomes of patients referred to the co-located clinic?	<input checked="" type="checkbox"/>
Are there adequate insurance arrangements in place in relation to the activities of the health service and the co-located clinic?	<input checked="" type="checkbox"/>
Is there a requirement for each party to notify the other of major events or risks that could affect the provision of safe, high quality care?	<input checked="" type="checkbox"/>

A checklist for good governance - well-located general practice clinics

Note: this checklist applies to WELL-LOCATED health services and general practice clinics. A well-located general practice clinic is one in which:

- the general practice clinic is separated physically and organisationally from the health service;
- the general practice clinic is located in proximity to the health service; and
- the general practice clinic and the health service agree to collaborate for mutual benefit - see option 1 on page 14.

A more detailed version of this checklist is available at Attachment 5 (page93).

This checklist does not apply if the general practice clinic is:

- located in health service premises or grounds; or
- managed by the health service, utilising employed or contracted general practitioners.

See, instead, a checklist for an INDEPENDENT CO-LOCATED general practice clinic on page 29 or a checklist for an INTEGRATED CO-LOCATED general practice clinic on page 33.

Governance questions - well-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Clinical governance domain 1 - governance structures		
Is there a formal written agreement between the parties?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is the relationship between the parties defined clearly?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Does the written agreement between the parties include a commitment to establish a process for regular liaison?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a process for agreeing policies and procedures addressing issues that impact on the relationship between the health service and the well-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed process for the settlement of disputes?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 2 - defined purpose, roles and responsibilities		
Is there an agreed vision and defined purpose for the relationship between the well-located clinic and the health service?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Governance questions - well-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Is there agreement on the types of patients who may be appropriate to be offered the option of attending the well-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an identified clinical leader who is responsible for clinical leadership and safety and quality systems in the well-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed evaluation framework and process?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 3 - systems to deliver quality clinical care		
Is there an agreed safety and quality framework that applies to the health service triage and acceptance of re-referred patients processes?	<input checked="" type="checkbox"/>	
Is there an agreed safety and quality framework that applies to the well-located clinic?		<input checked="" type="checkbox"/>
Are there quality and continuous improvement standards that apply to the hospital triage process and the well-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed approach to the management of communication of patient information between the health service and the well-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed approach to the management of common patient conditions?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 4 - provider competence and performance		
Are clinicians (medical, nursing and other) who provide services in the well-located clinic subject to a robust process of credentialing and defining the scope of clinical practice?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Are triage clinicians appropriately trained?	<input checked="" type="checkbox"/>	
Clinical governance domain 5 - data and information to inform decisions		
Is there a system for monitoring and addressing any issues relevant to safety and quality of care at the interface between the two organisations?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a system for monitoring and addressing patient complaints and compliments?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is the clinic committed to maintaining accreditation with an independent body?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 6 - clinical risk management		
Is there a risk management plan?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed process for reporting and investigating adverse events that occur in relation to triage, management, re-referral or outcomes of patients referred to the well-located clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Are there adequate insurance arrangements in place in relation to the activities of the health service and well-located general practice clinic?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Governance questions - well-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Is there a requirement for each party to notify the other of major events or risks that could affect the provision of safe, high quality care?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Sample vision statements for the collaboration

The vision statement creates an image of the future - what the general practice clinic will become. It helps to set the broad direction for the collaboration. Some examples of vision statements are shown below.

To work together to develop a vibrant general practice clinic which offers high quality after-hours primary care to patients who present to the *XX hospital* emergency department

To offer patients who seek after-hours primary care from the *XX hospital* emergency department a quality general practice clinic option

In collaboration with the general practice community, to increase options for the provision of after-hours primary care to patients of the *XX region*

To offer high quality after-hours primary care in an appropriate setting to patients of the *XX region*

A checklist for agreeing on the purpose of the collaboration

A mission statement sets out the purpose of the business and what it aims to achieve. It adds a practical focus to the vision.

There may be one or more purposes for collaborating in an after-hours general practice clinic. Some common purposes may include:

- Offering patients access to quality primary care services appropriate to their needs.
- Offering general practitioners the opportunity to work after-hours in a supportive and learning environment with a more acute scope of practice and the opportunity to develop or maintain procedural skills.
- Ensuring after-hours primary care is provided in the most appropriate setting.
- Assisting to manage unmet community demand for emergency primary care
- Enhancing relationships and engagement between the public health system and general practitioners.
- Operating a viable practice that provides a commercial return on investment.
- Decongesting the emergency department, assisting it to manage demand.
- Enabling more effective use of emergency department resources.
- Other purpose (specify)

A checklist for assessing the risk of shared liability

Is the co-located general practice clinic located within the main hospital facility or in a separate building?

Does the general practice clinic have prominent signage which distinguishes it from the hospital?

Note: Both proximity to the emergency department and lack of distinguishing signage will increase the risk that the health service will be liable for the negligent acts or omissions of the general practice clinic

Do patients access the general practice clinic directly or via a triage process?

Note: If the health service is providing a triage service, it will be responsible for the negligent acts or omissions of its staff in the triage process. Triage is likely to reduce the risk of an adverse event occurring in the general practice clinic

Does the health service represent (by words or conduct) that the co-located general practice clinic is an agent of the health service?

Does the general practice clinic represent (by words or conduct) with the knowledge of the health service that it is an agent of the health service?

Note: If the health service or its staff represent that the general practice clinic is an agent of the health service, or allows the general practice clinic and/or a general practitioner to represent themselves as an agent of the health service, the health service may be held vicariously liable for the negligent acts or omissions of the general practice clinic or the general practitioner. It is less likely that the health service would be considered to be an agent of the general practice clinic

Are patients who present to the emergency department provided with written information about the services available at the general practice clinic, the relationship between the clinic and the health service and what each party undertakes to provide for them?

Are patients asked to sign a document confirming that they have received and understood this information?

Note: The extent to which these issues should formally be brought to the attention of patients will vary depending on the extent to which each party is willing to assume a risk that they will be liable for the acts or omissions of the other.

Do emergency department staff advise general practice clinic staff on clinical issues?

Note: The ready availability of specialist support and advice is likely to be a factor that encourages general practitioners to work in co-located clinic settings. A record of the advice provided should be maintained in accordance with a documented policy and procedure. Medico-legal liability may attach to such advice.

A clinical risk management checklist to apply at the interface

Triage

- Is there a policy defining the types of patients that are suitable for the co-located general practice clinic option?
- Does the policy reflect the skills and expertise of the general practitioners available at the time of referral?
- Are triage staff trained in implementation of the policy?
- Is there clear signage and/or written information for patients describing the role of the general practice clinic?
- Is there a procedure to ensure patients who are referred back to the emergency department from the general practice clinic are assessed promptly and not disadvantaged in terms of waiting times?
- Is there a system to identify and review the frequency and causes of patients being referred back to the emergency department and acting on any lessons learned?

Equipment and consumables

- Is there a reliable process to ensure that equipment, pharmaceuticals and consumables utilised in the general practice clinic are maintained in good order and availability?
- Is it clear who is responsible?

Staff

- Do the staff who work in triage and the co-located clinic have appropriate expertise?
- Have their credentials been reviewed?
- Is there an adequate induction process for all staff who provide triage or general practice clinic services?
- Do the staff who work in the co-located clinic have access to relevant professional education?
- Are all staff who work in the co-located clinic subject to regular performance review?

Clinical services

- Can general practice clinic staff seek the advice and support of clinicians working in the emergency department?
- Is that advice documented by emergency department staff for clinical and medico-legal purposes?
- Are there opportunities to introduce common clinical tools in the emergency department and clinic?
- Is there a process for receiving client feedback about satisfaction with the clinic's services?
- Has a quality system (including audit) been implemented in the emergency department and clinic?

Referral for X-rays and pathology

- Is there a reliable process to ensure that X-ray and pathology results are followed up (referral back to local general practitioner PLUS clinic review) to ensure any missed pathology is followed up?

Referral back to emergency department

- Is there an agreed protocol to enable quick referral back of patients requiring emergency department care?
 - Are general practitioners in the co-located clinic encouraged to seek the support and advice of emergency department staff?
 - Do referral links need to be established with other providers?
-

A clinical risk management checklist to apply at the interface (cont.)

Medical emergency while in the co-located clinic

- Is there an agreed protocol for the immediate management of patients who suffer a medical emergency in or near the co-located clinic?
-

Communication

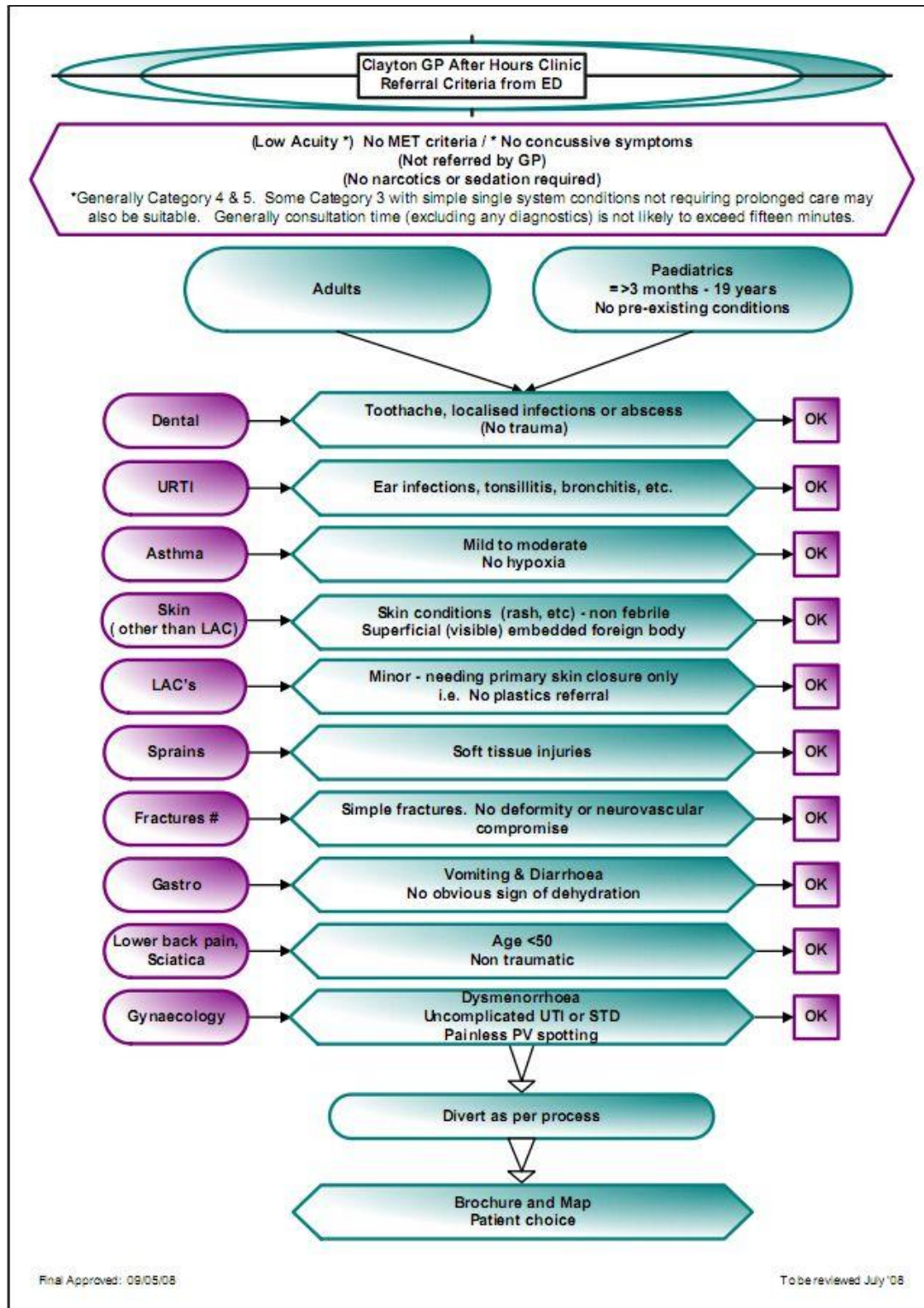
- Is there an agreed protocol for communication about individual patient care issues between the general practice clinic and the emergency department?
 - Is there an agreed protocol for communicating clinical information to the patient's usual general practice clinic on discharge from the clinic?
-

General

- Is there an identified clinical leader who is responsible for leading clinical safety and quality and governance processes in the clinic
 - Is there an agreed process, involving clinic and the emergency department staff, for analysing and responding to adverse events which occur anywhere in the pathway from triage, clinic management and discharge or referral back?
 - Is there a reliable system for maintaining medical records?
-

An example of triage criteria for an integrated co-located general practice clinic

(This checklist is not endorsed by the authors - it has been kindly provided as an example by Southern Health)



An example of patient information - option to attend a general practice clinic

This emergency department is often very busy. Priority will be given to patients who are assessed as having serious conditions requiring emergency hospital care. If you are not assessed as having such a condition, there may be some delay before you are seen by an emergency department doctor or nurse and you may prefer to attend your own GP or the general practice clinic located at [give location of clinic]. That clinic is a private clinic operated and run by general practitioners, not by the [name of health service]. As such, you will be privately billed for medical services provided by the clinic doctors and for any other services (such as pathology and X-ray services) arranged for you by those doctors.

An example of a health service disclaimer of liability clause relating to an independent co-located general practice clinic in which all staff are engaged or employed independently of the health service

I acknowledge that the doctors and nurses who treat me, and other staff who provide services to me, at this general practice clinic are not employees or agents of the [name of health service].

I acknowledge also that I will not hold the [name of health service] responsible or liable for any injury to me caused by the treatment or other services provided to me by those doctors, nurses or other staff, or by any other doctor or health professional engaged by a doctor at this clinic or engaged by me to provide me with medical, pathological, radiological or other medical-type services.

An example of patient information provided by an independent co-located general practice clinic

This is a private general practice clinic operated by the [name] Medical Group. It is not operated by the [name of health service]. You will be privately billed for any consultations with doctors of this clinic and for pathology and medical imaging services arranged for you by the doctors of this clinic.

If you believe you are suffering from a condition that requires emergency hospital treatment, you should immediately see the triage nurse in the emergency department.

An example of a clinical governance agreement between a health service and a co-located clinic



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Co-located Clinic Agreement

Health Service The Clinic

DLA Phillips Fox is a member of DLA Piper Group, an alliance of independent legal practices. It is a separate and distinct legal entity.

DLA Phillips Fox offices are located in Adelaide Auckland Brisbane Canberra Melbourne Perth Sydney and Wellington.

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Parties

Health Service of Address (**the Health Service**)

Clinic of Address (**the Clinic**)

Background

The Health Service is a public hospital established pursuant to the Health Services Act 1988 (Victoria). The Clinic conducts a general practice of medicine at premises which are co-located with the Health Service.

The Health Service prompts patients to consider treatment at the Clinic when they attend the emergency department of the Health Service and:

- they are assessed as not requiring emergency care; and
- they are unwilling or unable to wait for care from the Health Service.

This Agreement records the arrangements between these co-located Organisations.

Operative provisions

Vision and purpose

Co-located Clinic

- 1.1 The Organisations have agreed to work together as separate, but co-located bodies, as specialists in their area, to improve the delivery of targeted health services to members of the public seeking health care in a circumstance of accident or emergency with the purpose of improving the patient experience and rationalising scarce resources.

Strategic plan

- 1.2 The Organisations must develop a strategic plan for their co-location through the Liaison Committee. They must establish review points for reconsideration of the strategic plan by reference to time or other factors.
- 1.3 The Liaison Committee must consider whether the operation of their co-location is meeting the needs of the Organisations, and fulfilling the vision and purpose expressed in this document.

Governance Structures

Parties to ensure understanding.

- 1.4 Each Organisation must ensure that the other understands its legal structure.
- 1.5 The Clinic must give the Health Service a copy of its constituent documents and details of all owners and managers. The Health Service must ensure that the Clinic is aware of its legal and organisational structure. Both Organisations must notify the other of changes.

Liaison Committee

Liaison Committee

- 1.6 The Organisations must establish a Liaison Committee with representatives from both of them. They must give their representatives adequate delegated authority to ensure that meetings of the Liaison Committee are effective.

Commitment to work together

- 1.7 Through the Liaison Committee, the Organisations must work together to improve the cooperation between their staff, to enhance patient safety, to improve communication, to improve the patient experience, to reduce inefficiency and to reduce waste.

First meeting

- 1.8 At the first meeting of the Liaison Committee, its members must establish processes for the efficient functioning of the Liaison Committee. These should include:
 - 1.8.1 who will chair and organise meetings;
 - 1.8.2 the location, date and frequency of meetings;
 - 1.8.3 the standard agenda for meetings;
 - 1.8.4 the process by which extraordinary items are brought to the Committee;
 - 1.8.5 voting processes for the Committee;
 - 1.8.6 arrangements in the absence of members; and
 - 1.8.7 communication of resolutions of the Committee.

Not separate legal entity

- 1.9 The Liaison Committee will not be a separate legal entity. It will be a mechanism for collaboration and communication between the two Organisations.

Clinic fails to participate etc

- 1.10 If either of the Organisations:

- 1.10.1 fails to participate in the Liaison Committee in a constructive way,
- 1.10.2 consistently breaches a non-material obligation in this document, or
- 1.10.3 breaches a material obligation in this document, then

in any of these cases, the other Organisation may give the first a Show Cause Notice.

Show Cause Notice

- 1.11 If one Organisation gives the other a Show Cause Notice, the other must provide the first with a reasonable explanation of the behaviour complained of in the Notice, or some reasonable assurance that it will not reoccur. If the first Organisation is dissatisfied with the explanation or assurance, it may initiate the dispute resolution provisions in this document.

Protocols

- 1.12 The Organisations must develop written protocols to record their practical, recurrent requirements of one another. They should do so through the Liaison Committee.
- 1.13 The protocols are to be amended on the basis of experience. Amendments should be promulgated generally to ensure a clear understanding of roles and responsibilities.

Communication generally

- 1.14 In addition to the Liaison Committee, both Organisations must appoint an individual (by role or by person) to enable simple communication between them. Each Organisation must ensure that the other is kept informed of arrangements during periods of absence, and any change in personnel.

Patients

Organisations must identify referred patients

- 1.15 Both Organisations must establish procedures to identify when a patient attends one of them for treatment of a condition having just attended the other for the same condition.

Cross notification

Organisations to obtain consent

- 1.16 Subject to any restrictions imposed by the law, each Organisation must seek the consent of a patient to notify the other Organisation of the patient's particulars where the patient has been referred in the terms of clause 4.1. Those particulars should include:
 - 1.16.1 name, address and contact details of the patient;
 - 1.16.2 the time of attending the second Organisation; and

- 1.16.3 an epitome of the diagnosis of the patient.

Clinic to warn

- 1.17 If a referred patient (in accordance with clause 4.1) attends the Clinic and is diagnosed by the Clinic as having a medical emergency or condition requiring specialist expertise beyond that of the treating medical staff in the Clinic:
- 1.17.1 subject to the law, the Clinic must notify the designated person in the Health Service of the diagnosis;
 - 1.17.2 the Clinic must advise the patient that they must be treated in the emergency department of the Health Service; and
 - 1.17.3 the Clinic must co-ordinate the treatment of the patient with the Health Service.

Services

Defining the scope of services for the Clinic

- 1.18 Through the Liaison Committee, the Organisations must agree upon the scope of services which can be provided by the Clinic, taking into account the skills and experience of its medical staff, hours of operation, resources available to the medical staff and also their preferences.
- 1.19 As part of its ongoing review of the relationship, the Liaison Committee must review the Clinic's scope of services on a regular basis.

Defining the scope of services for the health service

- 1.20 Through the Liaison Committee, the Health Service must keep the Clinic reasonably informed in relation to the collective scope of practice of its medical staff.

Responsibility for Clinical issues

Organisations must agree

- 1.21 Through the Liaison Committee, the Organisations must discuss and agree upon the following:
- 1.21.1 whether the Health Service will make any equipment available for use by the Clinic, and if so, on what basis. In particular, the Organisations must agree upon any protocols which are necessary for the use of equipment;
 - 1.21.2 access to and use of sterilising equipment by the Clinic.
 - 1.21.3 the form and content of medical records to be used by the Clinic, where those records are to be stored, and whether and on what basis the Clinic could have access to any of the medical records of the Health Service. The

Organisations must also agree upon the protocols in relation to be completion of medical records by the Clinic.

- 1.21.4 The development of protocols and follow-up in relation to those patients who attend the Clinic and are found to have abnormal pathology or imaging.
- 1.21.5 The development of protocols for communication with the usual general practitioner of a patient who attends the Clinic.
- 1.21.6 The development of protocols for participation in shared clinical governance activities.

Standards

Organisations to maintain standards

- 1.22 Through the Liaison Committee, the Organisations must create processes which are intended to achieve comparable and complimentary standards of hygiene and infection control.
- 1.23 As the accepted industry standards change over time, the Liaison Committee must ensure that those standards are reflected in the practices of both Organisations.

Skills audit

- 1.24 On or about the commencement of this Agreement the Clinic must undertake an audit of the skills and experience of its medical staff. The Clinic must inform the Health Service of the results of that audit through the Liaison Committee.

Credentials and scope of practice

- 1.25 The Clinic must develop processes of assessment intended to ensure both the technical competence and consistent performance of all medical staff who work in the Clinic. In particular:
 - 1.25.1 through the Liaison Committee, the Clinic must develop, adopt and implement defined standards for credentialling and for scope of practice;
 - 1.25.2 the Clinic must establish processes which ensure that all medical staff are reviewed against those standards;
 - 1.25.3 if any medical staff in the Clinic undertake procedural general practice, in consultation with the Health Service, the Clinic must develop specific requirements for credentialling and scope of practice; and
 - 1.25.4 the Clinic must ensure that medical staff maintain vocational registration;
 - 1.25.5 the Clinic must ensure that the terms of engagement of medical staff place limitations on them to perform professional services within the Clinic within their scope of practice.

- 1.26 The Health Service must give reasonable assistance to the Clinic in the development of an effective contract of engagement of its Medical Staff.

Triage

- 1.27 The Health Service must ensure that the medical staff engaged in the triage of patients are appropriately trained. In addition, the Health Service must create a system to review the engagement with patients who continue their treatment with the Clinic, having first initiated treatment with the emergency department of the Health Service.

Material Change

Health Service to be notified

- 1.28 The Clinic must notify the Health Service of any material change in relation to each of the following:
- 1.28.1 the hours of operation of the Clinic;
 - 1.28.2 the service capacity of the Clinic;
 - 1.28.3 the safety of the Clinic.

Obligation to keep fully informed

Health Service to be kept informed

- 1.29 The Organisations must keep one another informed of all material facts, matters and circumstances which have (or could have) a material effect on their capacity to deliver medical services to the standards of this Agreement.

Complaints

- 1.30 The Organisations must advise one another of any complaints made to them by patients who have sequentially attended both the Clinic and the Health Service, regardless of the order of doing so.

Malpractice claims

- 1.31 The Organisations must advise one another of any medical malpractice claims made by patients who have sequentially attended both the Clinic and the Health Service, regardless of the order of doing so.

Insurance

Clinic to maintain insurance

- 1.32 The Clinic must ensure that each of its medical staff is insured against medical malpractice claims by an established insurer, subject only to traditional exclusions, for an amount considered sufficient by the insurer for Health Service from time to time.

- 1.33 The Clinic must provide the Health Service with evidence of its medical malpractice insurance when requested to do so.

Lease or licence

Health Service to provide

- 1.34 The Health Service must grant the Clinic a right to occupy that area which the Health Service has set aside for the conduct of a co-located general practice clinic. If the Health Service does not own the area (for instance, if it is reserved Crown land), it must do what is necessary to procure that right of occupancy.

Formal document to be prepared

- 1.35 The right of occupancy must be recorded in a formal document appropriate to the area. The Health Service will arrange for the preparation of the document. Both parties must bear their own costs in relation to the document.

Particulars of document

- 1.36 Unless the parties agree in writing to the contrary, the occupancy document for the Clinic will be in standard form (appropriate to the land and other considerations), except for the following:
- 1.36.1 the term of the document will be 5 years with an option for a further 5 years exercisable at the option of the Clinic;
 - 1.36.2 subject to clause 12.4, the rent will be nominal;
 - 1.36.3 there will be no requirement for a personal guarantee if the Clinic is a corporation;
 - 1.36.4 the document will record that the Clinic must pay its reasonable share of occupancy costs. Examples of these costs are power, medical gases, air conditioning, water, building maintenance, cleaning, waste removal and laundry.
 - 1.36.5 in addition to the standard provisions concerning breach of covenant and non payment of rent, termination of the occupancy will also happen if this Agreement is terminated according to its terms.

Fit-out and alterations

- 1.37 If the Clinic requires fit-out or alteration of the co-located facility, or services, in any way to accommodate the Clinic (for instance partitioning, air conditioning alterations, plumbing etc), then the Health Service will be entitled to recover that capital cost over the first term of the lease as rent. The Health Service can also recover as rent a market return on the money paid for this work.

Service Agreement

Clinic must enter into service agreement

- 1.38 The Health Service will prepare and the Clinic must execute a service agreement for the provision of (amongst other things) housekeeping, maintenance and IT services by the Health Service. The service agreement is entitled to charge the Clinic a fee for all such services on a full cost recovery basis.
- 1.39 The Clinic must enter into a service agreement on or before the time that it first occupies its co-located area.
- 1.40 The service agreement will end when the Clinic ceases to occupy its co-located area.

Training

Clinic to participate

- 1.41 The Clinic must ensure that its medical staff participate in the training made available to the medical staff of the Health Service if that training is relevant to their activities.

Junior medical staff

- 1.42 If junior medical staff engaged by the Health Service wish to gain experience in general practice, the Clinic must give reasonable assistance to facilitate a programme for that purpose.

Safety and quality

OH&S

- 1.43 The Clinic must establish guidelines for occupational health and safety which mirror those of the Health Service at all times. The Clinic must ensure its staff satisfy those requirements at all times. The Clinic must submit details of its management systems, plans and programs relating to occupational health and safety to the Chief Executive Officer of the Health Service at the commencement of this Agreement, and also when requested to do so.

Development of a quality framework

- 1.44 The Organisations must agree upon who is responsible for the design, implementation and monitoring of a system of quality clinical care in each of their environments; the Health Service in relation to triage and also patients referred from the Clinic, and the Clinic in relation to patients from the emergency department of the Health Service.
- 1.45 Each Organisation must then implement management processes designed to ensure that every person engaged by them executes the system. That system should address the dimensions of quality in the publication from the Victorian Quality Council entitled *Better Quality, Better Health Care: A safety and quality improvement*

*framework for Victorian health service and also the publication from the RACGP entitled *A quality framework for Australian general practice*.*

Accreditation

Accreditation of the Clinic

- The Clinic must be or become an accredited general practice clinic formally accredited against the RACGP *Standards for General Practices* (3rd edition).
- The Clinic must seek formal accreditation through one of the following accreditation organisations:
 - Australian General Practice Accreditation Limited; or
 - Quality Practice Accreditation Limited (GPA Accreditation plus).

Accreditation of the Health Service

- The Health Service must be or become accredited through one of the following accreditation bodies:
 - The Australian Council on Healthcare Standards' Evaluation and Quality Improvement Program (ACHS EquiP);
 - The International Organisation for Standardisation's Quality Management System 9000 (ISO 9002); or
 - Quality Improvement Council's Health and Community Services Standards (QIC).

Obligations associated with accreditation

- Both Organisations must ensure that they:
 - meet and maintain the standards required for accreditation;
 - follow the processes required for accreditation; and
 - renew their accreditation in a timely manner.

Resolution of Disputes

Disputes covered

- 1.46 The procedures set out below must be followed in relation to the resolution of a dispute concerning this Agreement, its subject matter or the rights or liabilities of the parties to this Agreement.

Notice in writing

- 1.47 If a dispute of the type referred to in clause 16.1 arises, either party may at any time give written notice to the other party. The written notice must adequately specify the nature of the dispute.

Meeting to resolve dispute

- 1.48 On receipt of a notice delivered in accordance with clause 16.2, the nominated representatives of both parties must meet within five business days of the notice and, in good faith and acting reasonably, do their best to resolve the dispute quickly through negotiation.

Mediation

- 1.49 If the dispute has not been resolved within 7 days from the meeting under clause 16.3 or such later date as the parties may agree, the dispute must be referred to mediation.
- 1.50 If the parties do not agree on a mediator, then the mediator must be appointed by the President of the Law Institute of Victoria.
- 1.51 Unless the parties agree otherwise, the mediator's fee and any other costs of the mediation itself (such as for venue hire or refreshments) must be shared equally between the parties, but the parties must each pay their own costs of preparing for and participating in the mediation (such as for travel and legal representation).

Implementation of agreement reached through negotiation or mediation

- 1.52 The parties must do whatever is reasonably necessary to put into effect any negotiated or mediated agreement or other resolution of the dispute.

Litigation

- 1.53 If the dispute is not resolved within either three months from the date of a notice delivered in accordance with clause 16.2, or any other period agreed by the parties, then either party is free to pursue its rights at law.

Rights and obligations during a dispute

- 1.54 Despite the existence of a dispute, each party must continue to perform its obligations, and remains entitled to any benefits, under this Agreement.

Interlocutory relief and right to terminate

- 1.55 This clause 16 does not restrict or limit the right of either party to obtain interlocutory relief, or to immediately terminate this Agreement where this Agreement provides such a right.

Notices

Giving notices

- 1.56 Any notice or communication given to a party under this Agreement is only given if it is in writing and sent in one of the following ways:
- 1.56.1 Delivered or posted to that party at its address and marked for the attention of the relevant department or officer (if any) set out below.
 - 1.56.2 Faxed to that party at its fax number and marked for the attention of the relevant department or officer (if any) set out below.

the Health Service

Name: Health Service
Address: Address
Fax number: [Fax number]
Attention: the Chief Executive Officer

the Clinic

Name: the Clinic
Address: address
Fax number: [Fax number]
Attention: the Manager

Change of address or fax number

- 1.57 If a party gives the other party three business days notice of a change of its address or fax number, any notice or communication is only given by that other party if it is delivered, posted or faxed to the latest address or fax number.

Time notice is given

- 1.58 Any notice or communication is to be treated as given at the following time:
- 1.58.1 If it is delivered, when it is left at the relevant address.
 - 1.58.2 If it is sent by post, two (or, in the case of a notice or communication posted to another country, nine) business days after it is posted.
 - 1.58.3 If it is sent by fax, as soon as the sender receives from the sender's fax machine a report of an error free transmission to the correct fax number.
- 1.59 However, if any notice or communication is given, on a day that is not a business day or after 5pm on a business day, in the place of the party to whom it is sent it is to be treated as having been given at the beginning of the next business day.

Miscellaneous

Approvals and consents

- 1.60 Unless this Agreement expressly provides otherwise, a party may give or withhold an approval or consent in that party's absolute discretion and subject to any conditions determined by the party. A party is not obliged to give its reasons for giving or withholding a consent or approval or for giving a consent or approval subject to conditions.
- 1.61 Where this Agreement refers to a matter being to the 'satisfaction' of a party, this means to the satisfaction of that party in its absolute discretion.

Assignments and transfers

- 1.62 A party must not assign or transfer any of its rights or obligations under this Agreement without the prior written consent of each of the other parties.

Costs

- 1.63 Except as otherwise set out in this Agreement, each party must pay its own costs and expenses for preparing, negotiating, executing and completing this Agreement and any document related to this Agreement.

Entire agreement

- 1.64 This Agreement contains everything the parties have agreed in relation to the subject matter it deals with. No party can rely on an earlier written document or anything said or done by or on behalf of another party before this Agreement was executed.

Execution of separate documents

- 1.65 This Agreement is properly executed if each party executes either this document or an identical document. In the latter case, this Agreement takes effect when the separately executed documents are exchanged between the parties.

Further acts

- 1.66 Each party must at its own expense promptly execute all documents and do or use reasonable endeavours to cause a third party to do all things that another party from time to time may reasonably request in order to give effect to, perfect or complete this Agreement and all transactions incidental to it.

Governing law and jurisdiction

- 1.67 This Agreement is governed by the law of Victoria. The parties submit to the non-exclusive jurisdiction of its courts and courts of appeal from them. The parties will not object to the exercise of jurisdiction by those courts on any basis.

Joint and individual liability and benefits

- 1.68 Except as otherwise set out in this Agreement, any covenant, agreement, representation or warranty under this Agreement by two or more persons binds them jointly and each of them individually, and any benefit in favour of two or more persons is for the benefit of them jointly and each of them individually.

Severability

- 1.69 Each provision of this Agreement is individually severable. If any provision is or becomes illegal, unenforceable or invalid in any jurisdiction it is to be treated as being severed from this Agreement in the relevant jurisdiction, but the rest of this Agreement will not be affected. The legality, validity and enforceability of the provision in any other jurisdiction will not be affected.

Variation

- 1.70 No variation of this Agreement will be of any force or effect unless it is in writing and signed by each party to this Agreement.

Waivers

- 1.71 A waiver of any right, power or remedy under this Agreement must be in writing signed by the party granting it. A waiver only affects the particular obligation or breach for which it is given. It is not an implied waiver of any other obligation or breach or an implied waiver of that obligation or breach on any other occasion.
- 1.72 The fact that a party fails to do, or delays in doing, something the party is entitled to do under this Agreement does not amount to a waiver.

Definitions and interpretation

Definitions

- 1.73 In this Agreement the following definitions apply:

Agreement means this document and the obligations to which the parties have agreed which are recorded in it.

A&E means the accident & emergency department, or emergency department, (howsoever named) of the Health Service;

Clinic means the second named party to this Agreement;

Health Service means the first named party to this Agreement;

Liaison Committee means the committee representing both Organisations brought into existence in accordance with clause 3;

Organisations means both the Clinic and the Health Service; and Organisation means one of them.

Show Cause Notice means a notice pursuant to clause 3.6 from one Organisation to another.

Interpretation

- 1.74 In the interpretation of this Agreement, the following provisions apply unless the context otherwise requires:

- 1.74.1 Headings are inserted for convenience only and do not affect the interpretation of this Agreement.
- 1.74.2 A reference in this Agreement to a business day means a day other than a Saturday or Sunday on which banks are open for business generally in Melbourne, Victoria.
- 1.74.3 If the day on which any act, matter or thing is to be done under this Agreement is not a business day, the act, matter or thing must be done on the next business day.
- 1.74.4 A reference in this Agreement to 'dollars' or '\$' means Australian dollars and all amounts payable under this Agreement are payable in Australian dollars.
- 1.74.5 A reference in this Agreement to any law, legislation or legislative provision includes any statutory modification, amendment or re-enactment, and any subordinate legislation or regulations issued under that legislation or legislative provision.
- 1.74.6 A reference in this Agreement to any document or Agreement is to that document or Agreement as amended, novated, supplemented or replaced.
- 1.74.7 A reference to a clause, part, schedule or attachment is a reference to a clause, part, schedule or attachment of or to this Agreement.
- 1.74.8 An expression importing a natural person includes any company, trust, partnership, joint venture, association, body corporate or governmental agency.
- 1.74.9 Where a word or phrase is given a defined meaning, another part of speech or other grammatical form in respect of that word or phrase has a corresponding meaning.
- 1.74.10 A word which indicates the singular also indicates the plural, a word which indicates the plural also indicates the singular, and a reference to any gender also indicates the other genders.
- 1.74.11 A reference to the word 'include' or 'including' is to be interpreted without limitation.
- 1.74.12 Any schedules and attachments form part of this Agreement.

Execution and date

Executed as an agreement.

Date:

An example of a general practitioner information handbook

(Kindly provided as an example by Southern Health)

GP After Hours & Employee Clinic Services General Practitioner Contractor

Information Handbook

GP liaison Services
Acute Ambulatory Services

Date:

Dear Doctor,

The next step

Congratulations on the success of your interview. The next step to be undertaken is the submission of your completed *credentialing & scope of clinical practice* documentation to the XXX health service Medical Advisory Committee's Credentialing Sub Committee (MACCSC). GP Liaison Services is unable to appoint General Practitioners without approval from the MACCSC.

About credentialing & scope of clinical practice

Credentialing is the formal process used to verify qualifications, registration, experience, professional standing and other professional attributes of health care professionals for the purpose of forming a view about their competence, performance and professional suitability to provide safe, quality health care services within XXX health service.

Defining the scope of clinical practice involves delineating the extent of the health professional's clinical practice within XXX health service based on the individual's credentials, competence, performance and professional suitability, and the needs and the capability of XXX health service to support the health care professional's scope of clinical practice.

XXX health service's Credentialing & Scope of Clinical Practice Policy along with the GP After Hours Governance Framework will ensure that the right health professionals, with the right skills are providing the right services within the right facilities.

Submission to the MACCSC

Submission to the MACCSC will be carried out by the Director of GP Liaison Services (GPLS) in conjunction with the Medical Lead of GPLS. This can take several weeks to finalise and in the interim we will progress the following:

- Issuing of the General Practitioner Information Handbook
- Your application for a HIC provider number
- HIC online authority
- GP Liaison Services GP Contract (*for signing only on confirmation from the MACCSC*)
- Prepare an orientation plan

Updates on progress

The Practice Manager will keep you informed of progress regarding your credentialing & scope of clinical practice application and coordinate the interim activities.

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About GP After Hours Services

The **XXX Hospital GP After Hours Service** was originally established in 2004 under the Commonwealth Medicare Round the Clock funding program. This service was established with support from the local Division and General Practitioners and was intended to provide support to the Emergency Department in the support of low acuity patients.

Due to the community need for an extended hours GP service in the XXX district, this service has built into a defacto GP Clinic with the service currently seeing approximately 70% of patients who are direct 'walk ins', as opposed to those diverted from the Emergency Department. There is considerable work being undertaken to reverse this situation and improve relationships with the Emergency Department to provide support as originally designed.

The **YYY Hospital GP After Hours Service** was established under State Government funding grant and is located within the YYY hospital building. This clinic provides support to low acuity patients triaged in the Emergency Department. Only those patients diverted from ED can attend the clinic – there is no direct access.

The **YYY Hospital Employee Clinic** is an initiative under the Healthy Opportunities program of Human Resources at XXX health service to improve productivity and decrease absence due to illness. Staff are encouraged to maintain links with their 'usual' GP and are referred back to their GP for any follow up or ongoing treatment.

In all clinics under the GP Liaison Services umbrella, considerable focus is placed on ensuring care is maintained by the patients usual GP, and that appropriate discharge documentation is forwarded to the GP to enable them to manage this. In no setting are we attempting to offer ongoing care.

Communication

As GP Liaison Services continually strives to improve discharge communication to GPs from within XXX health services, it is vitally important that our own services raise the bar and provide the lead example in this area.

All episodes of care require discharge communication to be issued to: 1) the patients usual GP, or 2) handed to the patient for them to hand on to their chosen practitioner at their next visit.

Please refer to the *Providing a Discharge Summary Protocol* – Appendix 1.

Parking & Identification

GPs will be provided with secure parking where possible. Across XXX health service sites parking remains a constant challenge.

GP Liaison Services is committed to ensuring the provision of a safe parking area for GPs and Practice Staff. Depending on the shifts being worked these areas may vary.

Please discuss your parking arrangements with the Practice Manager who will provide you with the available options.

You will be required to obtain an XXX health service identification badge which enables your access to parking and other secure areas. The Practice Manager will coordinate this activity with you once your employment has been officially confirmed by the MACCSC.

Tax Invoices & Payments

In accordance with the GP Liaison Services GP Contracts, invoices are to be provided **after** the worked period on either a fortnightly or monthly basis. Other arrangements can be made if this arrangement is likely to cause problems. Please discuss with the Practice Manager.

Please note, however, that initial payments can take some time to be processed due to the setup required on the finance system. On occasions, there can be a 3 to 4 week turnaround of payment from your first Invoice. We would encourage the fortnightly submission of your invoices to minimise the impact of this delay in the interim.

The Practice Manager will provide you with a hard copy and electronic copy of the Tax Invoice template required to be submitted.

Pathology

ZZZ Pathology provide equipment for the collection of samples and provide an urgent response service where required.

Nurses within the clinics are informed of requirements for taking and submitting samples for processing and a protocol is in place for results follow up.

Where a sample is urgently required – GPs and Nurse should ensure that this is clearly articulated to Pathology for their prompt response.

Radiology

GP Liaison Services have arrangements with the Imaging Departments at XXX Hospital and YYY Hospital which enables patients to be seen during the after-hours period without diverting through ED.

A referral form is required and advance notice should be given by telephone. Results can be instantly viewed through access to the Radiology system. Reception staff and nursing staff can facilitate this and will enable the GP to view the results.

Fracture Management

Simple non displaced fractures can be suitably managed in the GP Clinics with assistance from the Practice Nurse. Appropriate equipment for plastering is provided. Where the clinic is not open on the following day, ED will see the patient for their 24 hour plaster check. It is important that patient details are provided to ED so they are aware of this.

Ongoing management can be undertaken by the patients usual GP. A letter should be sent to the GP stating the 50/50 arrangement in regard to the claiming of the Fracture Management Item no. A template is available on Medical Director for this scenario.

Emergency Department

The YYY hospital GP After Hours Clinic has developed a detailed triage screening tool (see Appendix 2) in conjunction with ED to determine patient suitability for treatment. The XXX hospital GPAHC will move towards a similar screening tool in the near future. GPs should be cognisant of the need to support ED in the management of their low acuity patients and ensure that primary care type patients are effectively managed and not diverted back to the ED. Where a GP has concerns regarding a patient's suitability they may call the AO within ED to discuss this (if the patient was diverted). If a patient deteriorates to a level which is not considered a primary care condition, the AO should be contacted and the patient sent to the ED accompanied by the RN or GP.

Met Calls and Code Blues can be called within XXX health service premises and instructions on these including criteria will be found next to the phone in the GP rooms.

GP Accountabilities

The GP Liaison Services After Hours & Employee Clinic Services have an important role to play in the management of low acuity patients within the XXX Health Service. These clinics are unique in structure and function and unlike a standard General Practice clinic (where staff are generally accountable to the GP) staff are contractors / employees of the Health Service and function as a multi disciplinary team.

Roles and responsibilities of each staff member will be clearly delineated by Management and the Practice Manager will be responsible for authorising or actioning any changes to these roles and functions.

GPs should consult with the Practice Manager promptly should there be any concerns with other staff and their functioning in their allocated roles, or their behaviour whilst working within the Clinics.

It is the aim of GP Liaison Services to provide a professional, enjoyable and attractive place of work for us to spend our time.

The Medical Lead/GP Consultant of GP Liaison Services will provide mentorship and clinical guidance when and if required and can be the preferred point of contact for GPs with clinical concerns. Contact details for all staff are found at the back of this handbook.

The structure below outlines the lines of escalation relating to the GP After Hours & Employee clinic services and the strategic position within the organisation.

[Insert org structure chart]

GP Contracts

GPs working within GP Liaison Services at any of the after hours or employee clinic services are required to sign the GP Liaison Services contract which outlines requirements for the health service and the general practitioners in relation to their role at the after hours or employee clinic service.

The contract details the contractual obligations of each party and sets down the expectations regarding clinical documentation and clinical handover to the patients usual GP.

Contracts will be renewed (or extended) annually.

General Practitioners commencing with GPLS are encouraged to thoroughly review the contract and discuss the obligations with their legal representatives if they desire.

Discharge Communication

Appropriate handover of information **must** be provided to either:

- 1) the patients usual GP
- 2) the patient to provide to their practitioner on their next visit

This information must be legible, comprehensive and include follow up management required. If results of investigations are pending, details should be included along with the follow up and action plan.

Appropriate templates are provided within the Medical Director software to assist GPs with this requirement.

The Practice Manager will upon discussion with individual practitioners, modify, create or amend any such templates to improve processes or reflect additional scenarios.

Team Work

The After Hours and Employee Clinic services will function the most effectively if all staff are committed to creating a dynamic, supportive and efficient environment. The management structure will enable the appropriate escalation and resolution of any issues promptly and efficiently and staff are expected to act in a courteous, professional and supportive manner **at all times.**

Governance Framework

The GP After Hours & Employee Clinic services are supported by a robust governance framework which addresses the follow criteria:

- Credentialing & Scope of Practice
- Clinical Indicators & Audits
- Risk Management
- Incident Reporting
- Mandatory Training & Professional Development
- Organisational Key Performance Indicators

This Governance Framework is monitored and maintained by the GP After Hours Governance Steering Committee. Membership is made up of the following representatives:

- ✚ General Manager, Acute Ambulatory Services, XXX Health Service (*Chair*)
- ✚ Medical Director, Medicine Program, XXX Health Service
- ✚ Executive Director of Emergency Services, XXX Health Service
- ✚ Director of Emergency Department, YYY Hospital
- ✚ Director of Emergency Department, XXX Hospital
- ✚ DDON/Operations Director, XXX Hospital
- ✚ CEO/General Practitioner Representative, XXX GP Assoc
- ✚ CEO/General Practitioner Representative, YYY Division of GP
- ✚ GPLS/HITH Program Medical Director, XXX Health Service
- ✚ Director, GP Liaison Services

Reporting to this Governance Committee is the GP After Hours Executive Group comprising the following representatives:

- ✚ GPLS/HITH Program Medical Director, XXX Health Service (*Chair*)
- ✚ Practice Manager/s, GP After Hours & Employee Clinic Services
- ✚ Project Manager, GP Liaison Services
- ✚ Quality Coordinator, Acute Ambulatory Services, XXX Health Service
- ✚ Director, GP Liaison Services

Escalation Process

General Practitioners working within the After Hours or Employee Clinic Services may at any time escalate an issue of concern in the first instance to the GP After Hours Executive, or if not resolved satisfactorily, to the GP After Hours Governance Steering Committee. Please refer to contact information for the appropriate escalation methods.

The Governance Framework is available for review by contacting the Director, GP Liaison Services.

Leadership

The unique setting of GP After Hours Clinics requires a team focused approach to the day to day management of the clinic. The Practice Manager is responsible for all training, orientation, management and day to day functions of the clinic in an operational capacity and will liaise regularly with all staff during their allocated shifts. However, the Practice Manager is not on duty during each shift and therefore staff are often unsupervised. We believe that by careful recruitment processes and clearly articulated expectations staff will be appropriately self directed in accordance with the protocols of the clinics.

Any concerns regarding processes or systems should in the first instance be discussed with the Practice Manager via telephone or email if not available face to face. Due to the structure of the clinics and the health service management there may be certain processes or systems that seem unfamiliar in a normal general practice setting. For example, there are specific tasks we are required to undertake to enable the clinics to utilise the services of Diagnostic Imaging at YYY Hospital during the after hours period. Normally, only the Emergency Department has access to this service after hours. Reception staff are aware of these requirements and it is their responsibility to ensure adherence.

As referred to in the preceding section on Governance, concerns not resolved at the local level with the Practice Manager can be escalated for discussion/review at: 1) The GP After Hours Executive Group, or 2) The GP After Hours Governance Steering Committee. These groups meet monthly or quarterly respectively, however, depending on the nature of the issue for escalation an extraordinary meeting can be convened.

Opening & Closing Times

The GP After Hours Clinics are open to the public* from 6pm until 10.30pm during weekdays, and 1pm until 10.30pm on weekends.

Note – Reception & Nursing Staff begin work half an hour earlier than each start time to ensure the clinic is appropriately setup before opening. All staff work until 11pm. This should give the GPs the opportunity to finalise clinical documentation and discharge communication, nursing staff to clean treatment rooms and bedding, and Reception to close off and batch accounts as required. It also provides a 'buffer' for sessions to run over due to lengthy unexpected consults or delays in X-ray procedures.

These times are not changed unless agreed by the Practice Manager and/or Director (*with the exception of extended close times due to unexpected delays as mentioned above*). Staff will generally begin to advise ED regarding patient flow around 9.30pm to ensure clinic closure time is on target.

**Public = patients diverted from ED*

Contacts

AAA

BBB

CCC

DDD

To propose an item to be escalated to either the GP After Hours Executive or the GP After Hours Governance Steering Committee please email AAA. Additional information may be requested to adequately address the issue.

For specific clinical queries or concerns please contact CCC, Program Medical Lead.

Thank You & Welcome to the Team

On behalf of GP Liaison Services and all staff working within the GP After Hours & Employee Clinic Services we would like to warmly welcome you to the team. We look forward to a long and mutually beneficial association as we provide valuable support to our Emergency Departments and our primary care patients.

Warm regards,

AAA
Director, GP Liaison Services

CCC
Program Medical Lead
GP Liaison Services

August 2008

An example of a general practitioner contractor checklist

(Kindly provided as an example by Southern Health)

General Practitioner Contractor

Orientation Checklist

Note: Items in blue - may be commenced prior to authorisation of scope of practice

Item	Task	Completed	Date
0	GP Contractor Handbook given to GP prior to authorisation (step1)	<input type="checkbox"/>	
1	Confirmation of authorised scope of practice received from Director.	<input type="checkbox"/>	
2	GP Contract given to GP for review only.	<input type="checkbox"/>	
3	GP Contract Signed and returned clearly identifying dates of service (12 months from start date).	<input type="checkbox"/>	
4	GP Contract signed by Director.	<input type="checkbox"/>	
5	Copy of all signed GP Contract sent to GP and filed in GP personnel file.	<input type="checkbox"/>	
6	HIC Online Authority completed and sent to HIC	<input type="checkbox"/>	
7	HIC Provider No. Application completed and sent to HIC	<input type="checkbox"/>	
8	ID badge and parking arranged – green form completed & signed and GP taken to Security for ID badge.	<input type="checkbox"/>	
9	GP informed of obligations regarding conduct and GP communication to patients usual GP – in accordance with handbook and contractual requirements.	<input type="checkbox"/>	
10	GP instructed in use of templates on Medical Director and provided additional training if no prior experience in this software.	<input type="checkbox"/>	
11	GP given orientation of clinic facilities and staffing profiles.	<input type="checkbox"/>	
12	GP introduced to emergency department staff and key personnel.	<input type="checkbox"/>	

Item	Task	Completed	Date
13	GP provided with details of arrangements with pathology and radiology – as outlined in GP handbook.	<input type="checkbox"/>	
14	GP given advice re escalation of any clinical or operational issues in accordance with governance framework and as outlined in GP handbook.	<input type="checkbox"/>	
15	GP given an electronic and hard copy of Tax Invoice template with details on completing – particularly regarding the format for invoice numbers and the requirement to submit at least monthly.	<input type="checkbox"/>	

An example of a 'professionalism' checklist for general practitioners

(Kindly provided as an example by Southern Health)

Clinical and professional code of conduct assessment form for General Practitioners

For assessment at 3 months

To be discussed with Scope of Practice.

No	Professional Area	Satisfactory	Unsatisfactory	Development Plan
	Professional appearance i.e. attire, grooming			
	Personal conduct i.e. reliability, punctuality.			
	Communicates appropriately with patients and staff			
	Act in a way that does not discriminate on the basis of age, disability, race, sex, sexual preference, marital status or religion			
	Act honestly and in good faith, and in the best interests of the health service			
	Use best endeavours to avoid conflicts of interest and declare conflicts of interest as soon as they arise.			
	Treat personal information obtained in a professional capacity as private and confidential and not disclose that information to third parties without the consent of the person concerned or a specific legal authorisation or requirement to do so.			
	Handle commercially sensitive or confidential information acquired in the course of employment in a secure manner and only for the purposes for which it was received.			

No	Professional Area	Satisfactory	Unsatisfactory	Development Plan
	Demonstrates appropriate skill mix for scope of practice.			
	Carries out duties according to law, using due care and diligence.			
	Displays proficiency in patient education			
	Organises and priorities work appropriately			
	Documents accurately			
	Adherence to protocols			
	Keeps professional knowledge and skills up to date.			

Signature	
Print Name	
Position	

Useful references and links

Audit Scotland, COSLA and the Scottish Government 2007. *Governance for Joint Services Principles and Advice*. Available at <http://www.sehd.scot.nhs.uk/chp/GovernanceforjointServices.pdf>

Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004. Available at www.safetyandquality.org/internet/safety/publishing.nsf/Content/formerpubs-archive-credentialling

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- *Partnership Self-Assessment Tool - Coordinator Guide*. Available at <http://www.cacsh.org/pdf/coordinatorguide.pdf>
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The Victorian Quality Council. *Better Health, Better Health Care: A Safety and Quality Improvement Framework for Victorian Health Services*. November 2003, revised July 2005. Available at <http://www.health.vic.gov.au/qualitycouncil/downloads/framework.pdf>

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VicHealth. *Partnerships Fact Sheet*. Available at http://www.vichealth.vic.gov.au/en/~/_media/ResourceCentre/PublicationsandResources/General/Fact%20Sheet_Partnerships.ashx

VicHealth. *The Partnerships Analysis Tool for Partners in Health Promotion*. Available at http://www.vichealth.vic.gov.au/~/_media/ResourceCentre/PublicationsandResources/General/HP%20part%20tool%20res.ashx

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Attachment 1 - Key features of the regulatory framework

Introduction

Together, the provisions of the *Health Insurance Act 1973* (Cth) (which establishes the framework of eligibility of medical services for Medicare benefits) and the 2003-2008 Australian Health Care Agreement between the Victorian and Australian Governments (the AHCA) create special conditions which apply to the Medicare eligibility of private services rendered to patients within public hospital facilities.³ The interaction of the Act with the AHCA has influenced the way in which co-located general practice clinics are both owned and operated.

In addition, the *Health Services Act 1988* (Vic) creates an independent regulatory framework for Victorian public health services which host co-located general practice clinics.

Other legislation which impacts (actually or potentially) on the provision of primary care services in co-located general practice clinics includes:

- the *Health Professions Registration Act 2005* (Vic), the purpose of which is to protect the public by providing for the registration of health practitioners and a common system of investigations into the professional conduct, professional performance and ability to practise of registered health practitioners (s.1); and
- the *Corporations Act 2001* (Cth), which establishes a regulatory framework for public and private companies including companies limited by guarantee (which may be used as a corporate structure for a co-located general practice clinic).

With respect to the AHCA and the *Health Insurance Act 1973* provisions:

- The AHCA requires that public hospitals must continue to provide the range of services to public patients free of charge that were publicly provided on 1 July 1998.
- Medicare benefits must not be claimed for general practice services which are provided "under an arrangement with a public hospital". This phrase has not been subject to judicial interpretation and its exact meaning is unclear. Correspondence from the Australian Government Department of Health and Ageing suggests that in the Department's view assistance to a general practice clinic in the form of buildings, equipment, administrative staff and other support services does not breach this prohibition, nor do payments to general practitioners for the purposes of retaining their services and/or for professional development purposes.

³ Under the 2003-2008 Australian Health Care Agreements, State and Territory Governments were responsible for the provision of public hospital services to eligible persons in accordance with the terms and conditions of the Agreements. On expiry of the Agreements on 30 June 2008, the Minister for Health and Ageing made a series of determinations after an amendment to the Health Care (Appropriation) Act 1998. These determinations, known as 2008-09 Health Care Determinations, effectively rolled over the terms and conditions of the 2003-08 Agreements to 30 June 2009.

- A patient presenting to a public hospital emergency department must be provided with free treatment if they choose to be treated at the hospital. A choice will not be made until the patient or legal guardian is fully informed of the consequences of that choice, and patients must not be directed by hospital employees towards a particular choice.
- Medicare benefits are not payable for services rendered by practitioners acting as emergency medicine specialists in the accident and emergency departments of public hospitals. These services are defined in the Medicare Benefits Schedule on the basis of the urgency and severity of the patient's condition and the time within which treatment is initiated rather than the specialist qualifications of the practitioner providing the service.
- The AHCA contemplates the provision of private general practitioner services to patients who present to public hospital emergency departments in the following circumstances:
 - hospitals rely on general practitioners for the provision of medical services and patients request treatment by their own general practitioner, either as part of continuing care or by prior arrangement with the doctor; or
 - the patient elects to access alternative services.
- The AHCA does not specifically contemplate the provision of alternative services within the public hospital emergency department.

Although the issue of physical demarcation is not addressed specifically in the AHCA or the *Health Insurance Act 1973*, all of the co-located general practice clinic models to date provide for a clear physical demarcation from the public hospital emergency department. A general practice clinic which is physically demarcated offers a different model of primary health care from that which is likely to be offered when general practitioners work alongside other hospital doctors within an emergency department. Departmental policy is to support clinics which have the structure and feel of a general practice and are physically separated from the emergency department.

The Health Services Act 1988 (Vic)

The *Health Services Act 1988* establishes Victoria's public health services as incorporated entities (s.65P) and establishes their boards of directors (s.65S(1)), which are responsible for organisational governance. Section 17AA of the *Health Services Act 1988* incorporates the AHCA into the guidelines for public hospitals.

The Health Professions Registration Act 2005 (Vic)

This legislation, the purpose of which is to protect the public, creates a framework for registration of health care professionals including medical practitioners. The legislation establishes a 'responsible board' for each relevant profession and enables the responsible board to register health care professionals and vary, suspend or cancel or impose conditions on registration.

Attachment 2 - Potential liability for wrongful conduct by the other party

Summary of issues

Generally, the relationship between the health service and general practice clinic in a collaboration would be intended to be that of independent contractors.

A party to a collaboration could be held liable for wrongful conduct by the other party to the collaboration:

- (a) if the other party is considered by a court to have acted as an 'agent' of the first party when it acted wrongfully; or
- (b) if a court concludes on all the facts available that the first party undertook to provide the particular aspect of care or the particular service out of which the wrongful conduct arose so that it breached a non-delegable duty of care to the patient.

The first party could also be liable for the consequences (usually injury to the patient) of the other party's wrongful conduct if its own conduct in referring the patient to the other party was wrongful. The party would have breached its personal duty of care to the patient by its wrongful referral and would be liable for the patient's injury if that injury was reasonably foreseeable (at law, negligent medical treatment is considered to be reasonably foreseeable unless it is grossly negligent). In practice, the two parties in such a scenario are likely to share liability.

Let us say, for example, that a patient attends a hospital complaining of severe chest pain lasting 20 minutes with features typical of ischaemic heart disease, and the hospital's triage nurse tells the patient that the emergency department is extremely busy and that he might instead choose to attend the co-located general practice clinic. Let us say that the general practitioner in that clinic then sends the patient home after concluding (unreasonably) that the pain is of gastro-intestinal origin and the patient goes on to suffer a massive heart attack. In such a scenario, the hospital is likely to be vicariously liable for the triage sister's failure to arrange for the patient to be urgently assessed by a doctor in the emergency department. The hospital is also likely to be in breach of its personal duty to the patient. The general practitioner is likely to be personally liable for his own wrongful conduct and the general practice clinic is likely to be vicariously liable for that conduct if the general practitioner is an employee or agent of the clinic.

Minimising legal risk

If there is a desire to minimise the risk that a relationship of agency will be found between the parties to a collaboration (thereby minimising the risk of a finding of vicarious liability) it should be clearly stated in the contract between the parties that their relationship is not one of agency but that they are independent contractors. A court will not, however, be bound by this and it is open to a court to find a relationship of agency in all the circumstances even in the face of a specific clause purporting to deny it.

To ensure appropriate distribution of legal risk it is important, particularly in view of the doctrine of ostensible authority, that each party does not hold out to patients that it is representing or acting on behalf of the other party. Thus, for example, a general practitioner should not wear a

badge bearing the name or logo of the hospital. Nor should the 'paperwork' (such as letterhead and pathology and medical imaging request forms) bear the other party's name or logo.

Such measures will also reduce the likelihood that one party will be held to owe a non-delegable duty with respect to the care and services provided by the other party. It should be made clear to patients that co-located general practice clinics are operated independently of the hospital, by persons or organisations other than employees or agents of the hospital. Each party should make clear which services it undertakes to provide for the patient by way of its own employees or agents (e.g. nursing, medical, pathology, medical imaging services) and which services it is not undertaking to provide.

Signage and written information (such as patient information sheets) should, therefore, clearly explain the relationship between the general practice clinic and the health service. Where practicable, patients could be asked to sign a document confirming their understanding of the relationship and of what each party undertakes to provide for them.

The risk that a hospital would be found liable for a breach of a non-delegable duty of care is likely to be less if patients access a co-located clinic directly, particularly if the co-located clinic has a different entrance to the emergency department and essentially looks like a separate general practice clinic except that it is within the hospital grounds.

It would be wise also to include in the contract between the health service and the general practice clinic indemnity and insurance clauses. Indemnity clauses will make it clear that each party to the collaboration is not liable for wrongful conduct by the other party (or by the other party's employees and agents). Typical insurance clauses usually state that each of the parties is to obtain and maintain appropriate professional indemnity insurance covering its employees and agents.

Attachment 3 - Expanded governance checklist, independent co-located general practice clinics

Governance questions - independent co-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Clinical governance domain 1 - governance structures		
What is the structure of the health service? Public health services are statutory corporations with boards of directors who are responsible for governing the organisation	☑	☑
What is the structure of the general practice clinic? General practice clinics may have a variety of structures including public or private corporations, partnerships or sole proprietorships. There may or may not be a board and there may or may not be members or shareholders of the company	☑	☑
Do the members of the governing bodies and/or senior managers of the health service and the general practice clinic understand their legal and governance roles and responsibilities? Consider education and training for directors on their legal and governance roles and responsibilities	☑	☑
Is there a formal written agreement between the parties? The written agreement between the parties should define the purpose of the collaboration, the relationship between the parties and the obligations of each party, the structures and processes that will support communication and mechanisms for resolving issues and disputes	☑	☑
Is the relationship between the parties defined clearly? Consider the extent to which each party is prepared to assume potential liability for the actions of the other party If the shared intent is to minimise risk of liability for the actions of the other party: <ul style="list-style-type: none"> • State in the written agreement between the parties that the relationship is <u>not</u> one of agency but that they are independent contractors; • Incorporate a requirement in the written agreement between the parties that each party will not hold out to patients that it is representing or acting on behalf of the other; and/or • Implement policies and procedures to reduce the risk that the actions of either party could convey an impression that they are acting on behalf of the other. 	☑	☑
Does the health service and/or the co-located clinic have legal obligations to the Australian or Victorian Governments associated with funding for the co-located clinic? Consider incorporating in the written agreement between the parties an obligation for both parties to operate in accordance with the fundamental terms of the funding agreement and associated policies, to give recognition to the policy requirements of the various programs that fund the clinics	☑	☑
Does the written agreement between the parties include a commitment to establish a liaison committee? Consider incorporating in the written agreement between the parties an agreement to establish a liaison committee which includes nominees of key stakeholders such as local general practitioners and divisions of general practice, the role of which includes monitoring the performance of the collaborative venture, identifying clinical governance risks and opportunities and developing shared strategies to address risks and capture opportunities for patient benefit	☑	☑
Is there a process for agreeing policies and procedures addressing issues that impact on the relationship between the health service and the co-located clinic Consider incorporating in the written agreement between the parties a commitment to work together to agree policies and procedures that are consistent with the policy framework set by the state and Commonwealth programs that fund the clinic and that address issues such as clinical safety and quality and occupational health and safety where the conduct of one party may affect the other Ensure each party maintains a current consolidated policy and procedure manual	☑	☑
Is there an agreed process for the settlement of disputes? Consider incorporating in the written agreement between the parties an agreed process for settling disputes	☑	☑

Governance questions - independent co-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Clinical governance domain 2 - defined purpose, roles and responsibilities		
Is there an agreed vision and defined purpose for the co-located clinic and its relationship with the health service? Consider incorporating in the written agreement between the parties a vision and purpose consistent with the context of the policy framework set by the state and Commonwealth programs that fund the clinic	☑	☑
Is there a strategic plan for the co-located clinic? Ensure senior managers and/or the governing body endorse, periodically review and monitor achievements against the co-located clinic's strategic plan, which is consistent with policy framework set by the state and Commonwealth programs that fund the clinic		☑
Is there agreement on the scope of services that will be provided in the co-located clinic? Ensure the development and implementation of an agreed policy defining the types of patients who attend the emergency department who may be advised of the option of attending the co-located clinic. If patients are able to access the co-located clinic directly, ensure the policy addresses the types of patients who should be on-referred to the emergency department and the processes that will apply when such on-referral occurs to ensure these patients receive appropriate priority	☑	☑
Is there a business plan for the co-located clinic? Ensure senior managers and/or the governing body endorse, periodically review and monitor achievements against the clinic's business plan		☑
Is there an agreed evaluation framework and process? Consider establishing an evaluation framework and monitoring achievements against agreed objectives and goals, established within the context of State and Commonwealth program monitoring requirements	☑	☑
Is there an appointed manager who is responsible for the operations of the co-located clinic? Consider incorporating in the written agreement between the parties a commitment to appointment by the co-located clinic of a senior individual with overall operational responsibility including responsibility for ensuring representation of the clinic and maintenance of its general practice clinic orientation and character	☑	☑
Is there an identified clinical leader who is responsible for clinical leadership and safety and quality systems in the co-located clinic? Consider incorporating in the written agreement between the parties a commitment to appointment by the clinic of a senior clinician with responsibility for clinical leadership and safety and quality systems in the co-located clinic	☑	☑
Are respective responsibilities clearly defined for: <ul style="list-style-type: none"> • the provision and maintenance of equipment and consumables • sterilising equipment • maintaining and sharing medical records • patient screening criteria • redirecting patients between the emergency department and general practice clinic • reprioritisation of patients returned to the emergency department • maintenance of medication imprest • following up patients who have abnormal pathology or imaging • communicating with the patient's usual general practitioner • developing and maintaining care pathways • participating in shared clinical governance activities. Consider incorporating in the written agreement between the parties a clear statement of respective responsibilities and commitments	☑	☑
Do all employees and contractors who work in the co-located clinic have clear position descriptions which define their responsibilities and accountabilities and the requirement for them to comply with relevant policies and procedures? Define position responsibilities clearly and incorporate a requirement in employee and contractor agreements of compliance with agreed policies and procedures		☑
Is there an occupational health and safety system which ensures that risks to health and safety in the co-located clinic are eliminated so far as is reasonably practicable, and if it is not reasonably practicable to eliminate risks to health and safety, are reduced so far as is reasonably practicable? The health service and the co-located clinic both have duties to provide a working environment that is safe and without risk to health. Provision of relevant safety measures depends on who has control of the work environment and must be agreed in advance. Consider incorporating in the written agreement between the parties a description of each party's management responsibilities and reporting responsibilities to the other, and create a mechanism by which occupational health and safety issues can be raised and addressed promptly	☑	☑

Governance questions - independent co-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Clinical governance domain 3 - systems to deliver quality clinical care		
Are there an agreed safety and quality framework and systems that apply to the health service triage and acceptance of re-referred patients processes? Consider adopting the VQC framework, the RACGP framework, or a combination of both, and referencing it in the written agreement between the parties Ensure triage staff utilise agreed screening criteria to determine suitability of patients for treatment in the co-located clinic Consider establishing criteria for reprioritising patients deemed unsuitable for treatment in the co-located clinic who need to return to the emergency department for treatment	<input checked="" type="checkbox"/>	
Is there an agreed safety and quality framework that applies to the co-located clinic? Consider adopting the VQC framework, the RACGP framework, or a combination of both, and referencing it in the written agreement between the parties		<input checked="" type="checkbox"/>
Are there quality and continuous improvement standards that apply to the co-located clinic? Consider incorporating in the written agreement between the parties a requirement to comply with accepted standards as they apply from time to time	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed approach to the management of patient records in the co-located clinic? Consider incorporating in the written agreement between the parties the standards that will apply to the management of patient records at both the triage desk and in the co-located clinic and a requirement for staff and contractors to comply with those standards Ensure that protocols for informing the patient's usual general practitioner of the patient's condition are clear	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed approach to the management of common patient conditions? Consider adopting shared patient care protocols where appropriate	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 4 - provider competence and performance		
Are clinicians (medical, nursing and other) who provide services in the co-located clinic subject to a robust process of credentialing and defining the scope of clinical practice? Consider incorporating in the written agreement between the parties a requirement for the co-located clinic to adopt and implement defined standards for credentialing and defining the scope of practice of clinicians Consider incorporating in the written agreement between the parties: <ul style="list-style-type: none"> • A requirement that all general practitioners who work in the co-located clinic participate in the health service's processes for credentialing and defining scope of clinical practice • A requirement that the co-located clinic verifies the registration status of all health care professionals it employs or engages • A requirement that all general practitioners who work in the co-located clinic maintain vocational registration • Specific credentialing and scope of practice requirements for procedural general practice 	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Are triage clinicians appropriately trained and is their performance (relating to clinic referrals) monitored? Ensure triage clinicians participate in appropriate education and training Consider establishing screening criteria to support clinical decision making at triage	<input checked="" type="checkbox"/>	
Clinical governance domain 5 - data and information to inform decisions		
Do the relevant managers of the emergency department and co-located clinic report regularly to senior management and/or the relevant governing bodies on achievement by the collaboration of strategic and business goals and service quality and safety? Consider formalising a shared reporting framework that is based on the business and safety and quality plans and incorporates regular monitoring and periodic review of key standards, processes and outcomes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a system for monitoring and addressing patient complaints and compliments? Consider implementing a client feedback system based on best practice principles	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Does the manager report regularly to senior management and/or the governing body of the collocated clinic on occupational health and safety issues? Consider formalising a reporting framework that is based on accepted occupational health and safety standards		<input checked="" type="checkbox"/>
Is there a requirement that the co-located clinic will maintain accreditation with an independent body? Consider incorporating in the written agreement between the parties a requirement that the co-located clinic maintains accreditation (noting that RACGP accreditation is difficult to achieve for after-hours general practice clinics because of the way in which a general practice clinic is defined under that system) and that results and recommendations will be shared with the health service	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Governance questions - independent co-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Clinical governance domain 6 - clinical risk management		
Is there a clinical risk management plan? Consider incorporating in the written agreement between the parties a commitment to developing, implementing and maintaining an agreed clinical risk management plan	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed process for reporting and investigating adverse events that occur in relation to triage, management, re-referral or outcomes of patients referred to the co-located clinic? Consider incorporating in the written agreement between the parties a requirement for both parties to report known adverse events to the other and participate in shared quality processes designed to elucidate and address underlying causes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Are there adequate insurance arrangements in place in relation to the activities of the health service and the co-located clinic? Each party should consult with their insurer to ensure adequate insurance is in place Consider incorporating in the written agreement between the parties a requirement for both parties to insure in accordance with defined policy scope and limits (workers compensation, public liability insurance, professional indemnity insurance and vicarious liability insurance) Consider incorporating in the written agreement between the parties a requirement that the co-located clinic ensures that third party contractors hold insurance of an agreed scope and amount	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a requirement for each party to notify the other of major incidents, events or risks that could affect the provision of safe, high quality care? Consider incorporating in the written agreement between the parties a requirement that each party notifies the other if certain events occur	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Attachment 4 - Expanded governance checklist, integrated co-located general practice clinics

Governance questions - integrated co-located general practice clinics	
Clinical governance domain 1 - governance structures	
What is the structure of the health service? Public health services are statutory corporations with boards of directors who are responsible for governing the organisation	<input checked="" type="checkbox"/>
Do the members of the governing body and/or senior managers of the health service understand their legal and governance roles and responsibilities? Consider education and training for directors on their legal and governance roles and responsibilities	<input checked="" type="checkbox"/>
Is the relationship between the parties defined clearly? Consider the extent to which the health service is prepared to assume potential liability for the actions of contracted medical practitioners. If the shared intent is to minimise risk of liability for the actions of the other party: <ul style="list-style-type: none"> • State in the written agreement between the parties that the relationship is <u>not</u> one of agency but that they are independent contractors; • Incorporate a requirement in the written agreement between the parties that each party will not hold out to patients that it is representing or acting on behalf of the other; and/or • Implement policies and procedures to reduce the risk that the actions of either party could convey an impression that they are acting on behalf of the other. 	<input checked="" type="checkbox"/>
Does the health service have legal obligations to the Australian or Victorian Governments associated with funding for the co-located clinic? Ensure the senior managers responsible for the clinic are aware of obligations relating to the funding agreement and associated policies and have implemented a compliance process	<input checked="" type="checkbox"/>
Is there a steering committee or reference group for the co-located clinic that provides a forum for leading and monitoring performance of the collaborative venture Consider establishing a regular forum for leadership, monitoring, trouble-shooting and direction-setting, which includes nominees of key stakeholders such as local general practitioners and divisions of general practice	<input checked="" type="checkbox"/>
Is there a process for establishing policies and procedures that involves and engages the clinicians who work in the co-located clinic? Consider a protocol for establishing policies and procedures that are consistent with the policy framework set by the state and Commonwealth programs that fund the clinic, and that promotes clinical engagement Ensure each party maintains a current consolidated policy and procedure manual	<input checked="" type="checkbox"/>
Is there an agreed process for the settlement of disputes? Consider incorporating in the written agreement with subcontracting general practitioners an agreed process for settling disputes	<input checked="" type="checkbox"/>
Clinical governance domain 2 - defined purpose, roles and responsibilities	
Is there an agreed vision and defined purpose for the co-located clinic and its relationship with the health service? Document a vision and purpose consistent with the policy framework set by the state and Commonwealth programs that fund the clinics	<input checked="" type="checkbox"/>
Is there a strategic plan for the co-located clinic? Ensure senior managers and/or the governing body endorse, periodically review and monitor achievements against the co-located clinic's strategic plan, which is consistent with policy framework set by the state and Commonwealth programs that fund the clinic	<input checked="" type="checkbox"/>
Is there agreement on the scope of services that will be provided in the co-located clinic? Ensure the development and implementation of a clear policy defining the types of patients who attend the emergency department who may be advised of the option of attending the co-located clinic. If patients are able to access the co-located clinic directly, ensure the policy addresses the types of patients who should be re-referred to the emergency department and the processes that will apply when such re-referral occurs to ensure these patients receive appropriate priority	<input checked="" type="checkbox"/>
Is there a business plan for the co-located clinic? Ensure senior managers and/or the governing body endorse, periodically reviews and monitors achievements against the clinic's business plan	<input checked="" type="checkbox"/>
Is there an agreed evaluation framework and process? Consider establishing an evaluation framework and monitoring achievements against agreed objectives and goals, established within the context of State and Commonwealth program monitoring requirements	<input checked="" type="checkbox"/>
Is there an appointed manager who is responsible for the operations of the co-located clinic? Consider appointing a senior individual with overall operational responsibility including responsibility for ensuring representation of the clinic and maintenance of its general practice clinic orientation and character	<input checked="" type="checkbox"/>
Is there an identified clinical leader who is responsible for clinical leadership and safety and quality systems? Consider appointing a senior clinician with responsibility for clinical leadership and safety and quality systems in the co-located clinic	<input checked="" type="checkbox"/>

Governance questions - integrated co-located general practice clinics	
<p>Are respective responsibilities clearly defined for:</p> <ul style="list-style-type: none"> • the provision and maintenance of equipment and consumables • sterilising equipment • maintaining and sharing medical records • patient screening criteria • redirecting patients between the emergency department and general practice clinic • reprioritisation of patients returned to the emergency department • maintenance of medication imprest • following up patients who have abnormal pathology or imaging • communicating with the patient's usual general practitioner • developing and maintaining care pathways • participating in shared clinical governance activities. <p>Consider incorporating in the written agreement between the parties a clear statement of respective responsibilities and commitments</p>	<input checked="" type="checkbox"/>
<p>Do all employees and contractors who work in the co-located clinic have clear position descriptions which define their authority and accountability and the requirement for them to comply with clinic and relevant health service policies and procedures?</p> <p>Define position responsibilities clearly and incorporate in employer and contractor agreements a requirement to comply with agreed policies and procedures</p>	<input checked="" type="checkbox"/>
<p>Is there an occupational health and safety system which ensures that risks to health and safety in the general practice clinic are eliminated so far as is reasonably practicable, and if it is not reasonably practicable to eliminate risks to health and safety, are reduced so far as is reasonably practicable?</p> <p>The health service has a duty to provide a working environment that is safe and without risk to health. Ensure that the general practice clinic is included in the health service's occupational health and safety system. Consider incorporating in employment and contractor agreements requirements to: ensure a working environment that is safe and without risk to health; report occupational health and safety risks promptly; and cooperate with the health service in eliminating or reducing those risks so far as is reasonably practicable.</p>	<input checked="" type="checkbox"/>
Clinical governance domain 3 - systems to deliver quality clinical care	
<p>Are there an agreed safety and quality framework and systems that apply to the co-located clinic service including triage, clinic services and management of re-referred patients?</p> <p>Consider adopting the VQC framework, the RACGP framework, or a combination of both Ensure triage staff utilise agreed screening criteria to determine suitability of patients for treatment in the co-located clinic Consider establishing criteria for reprioritising patients deemed unsuitable for treatment in the co-located clinic who need to return to the emergency department for treatment</p>	<input checked="" type="checkbox"/>
<p>Are there quality and continuous improvement standards that apply to the co-located clinic?</p> <p>Consider adopting accepted standards as they apply from time to time</p>	<input checked="" type="checkbox"/>
<p>Is there an agreed approach to the management of patient records in the co-located clinic?</p> <p>Consider developing a policy defining the standards that will apply to the management of patient records at both the triage desk and in the clinic and a requirement for staff and contractors to comply with those standards Ensure that protocols for informing the patient's usual general practitioner of the patient's condition are clear</p>	<input checked="" type="checkbox"/>
<p>Is there an agreed approach to the management of common patient conditions?</p> <p>Consider adopting shared patient care protocols where appropriate</p>	<input checked="" type="checkbox"/>
Clinical governance domain 4 - provider competence and performance	
<p>Are clinicians (medical, nursing and other) who provide services in the co-located clinic subject to a robust process of credentialing and defining the scope of clinical practice?</p> <p>Consider implementing:</p> <ul style="list-style-type: none"> • A requirement that all general practitioners who work in the clinic participate in the health service's processes for credentialing and defining scope of clinical practice • Regular verification of registration status of all health care professionals employed or engaged in the co-located clinic • A requirement that all general practitioners who work in the clinic maintain vocational registration • Specific credentialing and scope of practice requirements for procedural general practice 	<input checked="" type="checkbox"/>
<p>Are triage clinicians appropriately trained and is their performance (relating to clinic referrals) monitored?</p> <p>Ensure triage clinicians participate in appropriate education and training</p>	<input checked="" type="checkbox"/>
Clinical governance domain 5 - data and information to inform decisions	
<p>Does the manager report regularly to senior management and/or the governing body on achievement by the collaboration of strategic and business goals and service quality and safety?</p> <p>Consider formalising a reporting framework that is based on the business and safety and quality plans and incorporates regular monitoring and periodic review of key standards, processes and outcomes</p>	<input checked="" type="checkbox"/>

Governance questions - integrated co-located general practice clinics	
Is there a system for monitoring and addressing patient complaints and compliments? Consider implementing a client feedback system based on best practice principles	<input checked="" type="checkbox"/>
Does the manager report regularly to senior management and/or the governing body on occupational health and safety issues? Consider formalising a reporting framework that is based on accepted occupational health and safety standards	<input checked="" type="checkbox"/>
Is the clinic accredited as part of the health service's accreditation? Ensure that there is a process for reviewing accreditation reports and recommendations and acting on them	<input checked="" type="checkbox"/>
Clinical governance domain 6 - clinical risk management	
Is there a clinical risk management plan? Ensure the development, implementation and maintenance of an agreed clinical risk management plan	<input checked="" type="checkbox"/>
Is there an agreed process for reporting and investigating adverse events that occur in relation to triage, management, re-referral or outcomes of patients referred to the co-located clinic? Define policies and procedures for the identification, reporting, investigation and management of adverse events and incorporate in contractor agreements a requirement to participate in accordance with health service policy	<input checked="" type="checkbox"/>
Are there adequate insurance arrangements in place in relation to the activities of the health service and the co-located clinic? There is a comprehensive insurance policy in place for all public health services. Consider liaising with VMIA insurance personnel to verify the adequacy of coverage in the context of specific arrangements Consider incorporating in contractor agreements a requirement to insure in accordance with defined policy scope and limits	<input checked="" type="checkbox"/>
Is there a requirement for each party to notify the other of major events or risks that could affect the provision of safe, high quality care? Consider incorporating in the written agreement with contractors a requirement that each party notifies the other if certain events occur	<input checked="" type="checkbox"/>

Attachment 5 - Expanded governance checklist, well-located general practice clinics

Governance questions - well-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Clinical governance domain 1 - governance structures		
Is there a formal written agreement between the parties? If the parties elect to enter a written agreement, it could define the purpose of the collaboration, the relationship between the parties, the obligations of each party, the structures and processes that will support communication and mechanisms for resolving issues and disputes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is the relationship between the parties defined clearly? If the shared intent is to minimise risk of liability for the actions of the other party: <ul style="list-style-type: none"> • State in the written agreement between the parties that the relationship is <u>not</u> one of agency; • Incorporate a requirement in the written agreement between the parties that each party will not hold out to patients that it is representing or acting on behalf of the other; and/or • Implement policies and procedures to reduce the risk that the actions of either party could convey an impression that they are acting on behalf of the other. 	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Does the written agreement between the parties include a commitment to establish a process for regular liaison? Consider incorporating in the written agreement between the parties an agreement to establish a liaison process, the role of which includes monitoring the performance of the collaboration, identifying clinical governance risks and opportunities and developing shared strategies to address risks and capture opportunities for patient benefit. Membership may include nominees of key stakeholders such as local general practitioners and divisions of general practice	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a process for agreeing policies and procedures addressing issues that impact on the relationship between the health service and the well-located clinic? Consider incorporating in the written agreement between the parties a commitment to work together to agree policies and procedures addressing issues such as clinical safety and quality where the conduct of one party may affect the other	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed process for the settlement of disputes? Consider incorporating in the written agreement between the parties an agreed process for settling disputes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 2 - defined purpose, roles and responsibilities		
Is there an agreed vision and defined purpose for the relationship between the well-located clinic and the health service? Consider incorporating in the written agreement between the parties a vision and purpose	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there agreement on the types of patients who may be appropriate to be offered the option of attending the well-located clinic? Consider developing and implementing an agreed policy defining the types of patients who attend the emergency department who may be advised of the option of attending the well-located clinic.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an identified clinical leader who is responsible for clinical leadership and safety and quality systems in the well-located clinic? Consider incorporating in the written agreement between the parties a commitment to appointment by the clinic of a senior clinician with responsibility for clinical leadership and safety and quality systems	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed evaluation framework and process? Consider establishing an evaluation framework and using the liaison process to monitor achievements against agreed objectives and goals, established within the context of State and Commonwealth program monitoring requirements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 3 - systems to deliver quality clinical care		
Is there an agreed safety and quality framework that applies to the health service triage and acceptance of re-referred patients processes? Consider adopting the VQC framework, the RACGP framework, or a combination of both, and referencing it in the written agreement between the parties Ensure triage staff utilise agreed screening criteria to determine suitability of patients for treatment in co-located clinic Consider establishing criteria for reprioritising patients deemed unsuitable for treatment in the co-located clinic who need to return to the emergency department for treatment	<input checked="" type="checkbox"/>	

Governance questions - well-located general practice clinics	Who should ask?	
	Health service	General practice clinic
Is there an agreed safety and quality framework that applies to the well-located clinic? Consider adopting the VQC framework, the RACGP framework, or a combination of both, and referencing it in the written agreement between the parties		<input checked="" type="checkbox"/>
Are there quality and continuous improvement standards that apply to the hospital triage process and the well-located clinic? Consider incorporating in the written agreement between the parties a commitment to continuous improvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed approach to the management of communication of patient information between the health service and the well-located clinic? Consider incorporating in the written agreement between the parties the standards that will apply to the management of patient information and a commitment by both parties to comply with those standards	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed approach to the management of common patient conditions? Consider adopting shared patient care protocols where appropriate	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 4 - provider competence and performance		
Are clinicians (medical, nursing and other) who provide services in the well-located clinic subject to a robust process of credentialing and defining the scope of clinical practice? Consider incorporating in the written agreement between the parties a commitment by the well-located clinic to maintain a system of credentialing and defining scope of clinical practice that meets accepted standards	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Are triage clinicians appropriately trained? Ensure triage clinicians participate in appropriate education and training	<input checked="" type="checkbox"/>	
Clinical governance domain 5 - data and information to inform decisions		
Is there a system for monitoring and addressing any issues relevant to safety and quality of care at the interface between the two organisations? Consider agreeing on what will be monitored, by which party, and how any issues will be managed	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a system for monitoring and addressing patient complaints and compliments? Consider implementing a client feedback system based on best practice principles and consider committing to sharing complaints and compliments relevant to the other party	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is the clinic committed to maintaining accreditation with an independent body? Consider incorporating in the written agreement between the parties a commitment by the clinic to maintain accreditation (noting that RACGP accreditation may be difficult to achieve because of the way in which a general practice clinic is defined under that system) and that relevant results and recommendations will be shared with the health service	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical governance domain 6 - clinical risk management		
Is there a risk management plan? Consider incorporating in the written agreement between the parties a commitment to developing, implementing and maintaining an agreed risk management plan for managing patients across the interface between them	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there an agreed process for reporting and investigating adverse events that occur in relation to triage, management, re-referral or outcomes of patients referred to the well-located clinic? Consider incorporating in the written agreement between the parties a requirement for both parties to report known adverse events to the other and participate in shared quality processes designed to elucidate and address underlying causes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Are there adequate insurance arrangements in place in relation to the activities of the health service and well-located general practice clinic? Each party should consult with their insurer to ensure adequate insurance is in place Consider incorporating in the written agreement between the parties a requirement for both parties to insure in accordance with defined policy scope and limits (workers compensation, public liability insurance, professional indemnity insurance and vicarious liability insurance) Consider incorporating in the written agreement between the parties a requirement that the well-located clinic incorporates in its contracts a requirement for third party contractors to hold insurance of an agreed scope and amount	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a requirement for each party to notify the other of major events or risks that could affect the provision of safe, high quality care? Consider incorporating in the written agreement between the parties a requirement that each party notifies the other if certain events occur	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>