CPL Clinical Governance Committee Charter

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CPL
Clinical Governance Committee

1. Purpose

1.1. The Clinical Governance (the Committee) assists the Board in fulfilling its governance and oversight responsibilities in relation to clinical, quality of care, patient outcomes, clinical risk, and organisational compliance with relevant health standards, legislation and regulatory requirements.

1.2. The Committee provides oversight and assurance that CPL delivers safe, effective, accessible, patient-centred, and continuously improving health services, consistent with the organisation's strategic objectives, values, and risk appetite.

2. Scope of Responsibilities

2.1. The Committee will assist the Directors in discharging the Board's oversight and governance responsibilities regarding clinical governance for CPL's medical centres and pharmacies as related to client and patient safety.

2.1.1. The Committee does not manage operational clinical services but provides governance oversight, challenge and assurance to the Board regarding the effectiveness of CPL's clinical governance systems."

2.2. The Committee's responsibilities include:

2.2.1. **Clinical Safety and Quality:**

2.2.1.1. Oversight of systems to ensure safe, effective and high-quality clinical care

2.2.1.2. Monitoring clinical quality indicators, patient outcomes and service performance.

2.2.1.3. Oversight of patient safety frameworks and continuous improvement systems.

2.2.1.4. Reviewing regular clinical governance reporting, trends, audits and benchmarking data to identify systemic risks and improvement opportunities

2.2.1.5. Monitoring implementation of evidence-based clinical practices and standards.

2.2.1.6. Oversight of infection prevention and control systems.

2.2.1.7. Oversight of medication stewardship, dispensing safety, prescribing governance, pharmaceutical risk management, and compliance with applicable pharmacy legislation, regulatory standards and professional obligations

2.2.2. **Compliance and risk**

2.2.2.1. Oversight of clinical risk management frameworks and processes.

2.2.2.2. Review of significant clinical incidents, sentinel events and adverse outcomes.

2.2.2.3. Monitoring management responses and corrective actions arising from incidents and complaints.

2.2.2.4. Oversight of compliance with applicable legislation, accreditation standards, licensing requirements and professional obligations.

2.2.2.5. Monitoring organisational preparedness for accreditation and external review processes.

2.2.3. **Consumer and Community Experience**

2.2.3.1. Oversight of patient, client and community feedback systems.

2.2.3.2. Monitoring complaints, compliments and consumer experience data

2.2.3.3. Promoting culturally safe, respectful and patient-centred care.

2.2.3.4. Monitoring equity of access and outcomes, including for vulnerable or underserved populations

2.2.3.5. Ensuring strong links to CPL Foundation

2.2.3.6. Ensuring effective referral pathways for patients experiencing family, sexual and domestic violence

2.2.4. **Workforce and Clinical Capacity**

2.2.4.1. Oversight of credentialing, scope of practice and clinical workforce governance systems.

2.2.4.2. Monitoring clinical workforce capability, training and professional development.

2.2.4.3. Oversight of workforce wellbeing issues where they may impact patient safety or quality of care.

2.2.4.4. Monitoring staffing risks affecting clinical service delivery.

2.2.5. **Strategy and Organisational Improvement**

2.2.5.1. Advising the Board on emerging clinical governance risks and opportunities.

2.2.5.2. Monitoring alignment between clinical governance systems and the organisation’s strategic direction.

2.2.5.3. Supporting a culture of clinical excellence, transparency, accountability and continuous improvement.

2.2.5.4. Oversight of quality improvement initiatives and innovation in care delivery. Oversee compliance with applicable legal and regulatory requirements relating to remuneration and review any significant findings from regulatory or audit reviews

3. Authority

3.1. The Committee may examine any matter in relation to its role and responsibilities within the overall framework approved by the Board, either on its own initiative or at the request of the Board.
3.2. Unless expressly delegated by the Board, the Committee does not have decision-making powers but acts on the direction of, and makes recommendations to, the Board.
3.3. In discharging its responsibilities, the Committee has the authority to:
  3.3.1. request or authorize investigations into matters within the Committee's scope of responsibility and access information, records and personnel for that purpose;
  3.3.2. request the attendance of any employee, including executive staff and clinicians at Committee meetings; and
  3.3.3. seek advice from independent external consultants to perform its role and responsibilities with the board's approval and subject to appropriate budgetary provision.

4. Membership

4.1. Committee members are formed from amongst the Non-Executive Directors, excluding the Chair. The Committee shall have at least two (2) Non-Executive Directors, all of whom must be independent.
4.2. At least one member should possess significant health, clinical governance or patient safety expertise.
4.3. The Board may appoint additional Non-Executive or Non-Directors with specialized skills to assist the Committee.
4.4. Membership is reviewed by the Board annually.
4.5. Each member must be able to make a valuable contribution to the Committee.
4.6. The Chair of the Committee will be an appropriately experienced independent Non- Executive Director and will be appointed by the Board.
4.7. A quorum for any meeting must be a minimum of two (2) members.
4.8. The Secretary of the Committee shall be a representative from the CPL Company Secretariat or such other person as nominated by the Committee. In consultation with the Committee Chair, the Secretariat will
  4.8.1. prepare and send notices of meetings and agendas to committee members; and
  4.8.2. record, keep and distribute minutes of Committee meetings
4.9. The effect of ceasing to be a Director of the Board is the automatic termination of appointment as a member of the Committee, unless otherwise approved by the Board.

5. Meetings and Attendance

5.1. Proxies are not permitted if a Committee member is unable to attend meetings.
5.2. If the Committee Chair is absent from any meeting, the members present will appoint a chairperson for that meeting.
5.3. There is no formal voting procedure as the Committee aims for consensus decision-making. However, dissenting views of Committee members will be recorded in the Committee's minutes and reported to the Board.
5.4. The Committee will meet at least three times per year and at such additional times as the Committee considers necessary to fulfil its responsibilities.
5.5. In accordance with its role and responsibilities outlined in this document, the Committee should determine its own agenda, ensuring appropriate consultation to include emerging issues and an emphasis on the most significant risks and threats.
5.6. Agendas and other papers for Committee meetings will be provided to Committee members at least 5 working days prior to the date of the relevant Committee meeting.

6. Conflicts of Interest

6.1. The Board's Conflict of Interest policy applies to all proceedings of the Committee.
6.2. In accordance with that policy, Committee members are required to declare any interests that could constitute an actual, potential or perceived conflict of interest with respect to their participation on the Committee.
6.3. Such declarations must be made on a member's appointment to the Committee and in relation to specific agenda items at the outset of each committee meeting.

7. Reporting

7.1. Minutes of Committee meetings shall be included in the board papers for the next subsequent board meeting. In addition, the Committee Chair shall provide a verbal report to the board on the Committee's activities if required.

8. Review

8.1. The Board shall review this charter every two years.