

FACT SHEET
for medical oncologists
and haematologists

Clinical governance

For medical oncologists and haematologists in cancer care

Clinical governance ensures that everyone, from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, high quality and continuously improving.

National Model Clinical Governance Framework

Clinical governance is a shared responsibility to ensure all patients receive the best care. Medical oncologists, haematologists, other members of the treating team and managers share the common goal of optimising patient care. Medical oncologists and haematologists share accountability for the care delivered, the equitable use of resources and building a positive workplace culture.

Optimising patient care requires that all medical oncologists and haematologists actively take part in patient safety processes, including:

- Understanding and fulfilling your role in implementing the organisation's clinical governance framework
- Safely prescribing evidence-based cancer care treatment protocols that are approved for use in the organisation
- Using and improving the organisation's safety and quality processes
- Involving patients, carers and families in best practice informed consent processes including the discussion and documentation of all relevant treatment options, any dose changes, treatment delays or cancellations that vary from approved protocols
- Participating in credentialing and training to enable the delivery of safe and high quality care in line with your scope of clinical practice
- Reporting incidents and near misses when they occur
- Following through incidents and near misses with open disclosure with patients, carers and families
- Analysing and addressing adverse events

- Appropriately escalating patient safety issues and understanding state or territory escalation processes when reported concerns are not reasonably addressed.

Optimising patient care requires the active participation of medical oncologists and haematologists for quality improvement, including:

- Actively contributing to a multidisciplinary team to ensure that planning for care is comprehensive, evidence-based and in consultation with patients, carers and their families
- Ensuring that patients receive timely, appropriate care and information on their care, and any anticipated out-of-pocket costs
- Ensuring supervision of junior members of the workforce who provide patient care
- Taking part in regular performance appraisal
- Regularly reviewing patient's clinical outcomes with the multidisciplinary team to identify opportunities for improvement in delivering appropriate and safe care
- Assisting with quality improvement audits in cancer services and acting on opportunities for improvement
- Participating in the review of unwarranted variations in clinical practice and patient outcomes.

Medical oncologists and haematologists should have regular discussions with their direct managers and other clinician managers or unit managers about issues that affect patient care, balancing the needs of their own patients with the needs of other patients. Managers equally have an obligation to manage identified risks, and support medical oncologists and haematologists to meet their professional responsibilities that enable them to optimise patient care.

Fulfilling your role in clinical governance aligns with doctor's obligations under your professional code of conduct.



Roles and responsibilities of medical oncologists and haematologists in cancer care for clinical governance

1. Governance, leadership and culture

- a. Actively take part in the development of an organisational culture that enables and prioritises patient safety and quality.
- b. Actively communicate the profession's commitment to the delivery of safe, high-quality, evidence-based health care.
- c. Model professional conduct that is consistent with a commitment to safety and quality at all times.
- d. Embrace opportunities to learn about safety and quality theory and systems.
- e. Embrace opportunities to take part in the management and leadership of clinical services.
- f. Encourage, mentor and guide colleagues in the delivery of safe, high-quality, evidence based care.
- g. Take part in all aspects of the development, implementation, evaluation and monitoring of governance processes.

2. Patient safety and quality systems

- a. Contribute to the design of systems for the delivery of safe, high-quality, evidence-based clinical care.
- b. Provide clinical care within the parameters of these systems.
- c. Ensure contemporary knowledge about safe system design.
- d. Actively look for opportunities to improve the safety of existing systems.
- e. Ensure that opportunities for improvement are raised and reported.
- f. Educate junior clinicians about the importance of working within organisational systems for the delivery of clinical care.
- g. Take part in the design and implementation of systems in the health service organisation for:
 - Quality improvement and measurement
 - Risk management
 - Incident management
 - Open disclosure
 - Feedback and complaints management.

3. Clinical performance and effectiveness

- a. Maintain personal professional skills, competence and performance.
- b. Contribute to relevant organisational policies and procedures.

- c. Comply with professional regulatory requirements, codes of conduct and model expected behaviour to support safety and quality culture.
- d. Monitor personal clinical performance as part of a multi-disciplinary team.
- e. Supervise and manage the performance of junior clinicians.
- f. Ensure timely reporting of specific performance concerns.
- g. Work constructively and collaboratively in clinical teams.
- h. Take part in the design and implementation of the organisation's systems for:
 - Credentialing and defining scope of clinical practice
 - Clinical education and training
 - Performance monitoring and management
 - Clinical, and safety and quality education and training.

4. Safe environment for the delivery of care

- a. Contribute to the planning and development of activities relating to the environment of the health service organisation.
- b. Actively look for opportunities to improve the safety of the clinical environment.
- c. Ensure opportunities for improvement are reported.

5. Partnering with consumers

- a. Understand the evidence on consumer engagement and its positive contribution to healthcare safety and quality.
- b. Understand how health literacy affects the way a consumer gains access to, understands and uses health information.
- c. Support patient access to, and use of high-quality, evidence-based, easy-to-understand information about health care.
- d. Support patients to share decision-making about their own health care, to the extent that they choose.
- e. Work with consumer representatives to ensure that the systems of care are designed to aid consumer engagement in decision-making.
- f. Assist consumer access to their own health information, as well as complaints and feedback processes.

Resources

[Good Medical Practice: A code of conduct for doctors in Australia](#)

[National Model Clinical Governance Framework](#)

[NSQHS Standards User Guide for Medication Management in Cancer Care](#)

[Clinical governance framework monitoring tool: A self-audit for medication management in cancer care](#)