1 ORGANISATIONAL CONTEXT
Safer Care Victoria is the state’s healthcare quality and safety improvement agency. SCV works with patients, families and carers, clinicians and health services to monitor and improve the quality and safety of care delivered across our public health system.

Staffed and led by clinicians and researchers, SCV puts patient safety front and centre, supporting health services to provide the safest and best possible care to patients every time.

1.1 Clinical networks
Clinical networks are the formal mechanism for Safer Care Victoria to harness clinical leadership and engage clinicians to inform, drive and promote quality improvement, innovation, research and address variation in clinical practice. Meaningful engagement with clinicians, healthcare managers, consumers and the wider system of healthcare will ensure Victoria enjoys sustained improvement in the safety and quality of care and that Victorian consumers have better health care experiences.

Safer Care Victoria defines clinical networks as groups of health professionals, health organisations and consumers who will work collaboratively and in a coordinated way to achieve a shared goal of high-quality health care.

Clinical networks are part of the Clinicians as Partners branch and work collaboratively across Safer Care Victoria drawing on expertise in leadership development, innovation, systems improvement, and consumer experience to achieve their improvement objectives.

1.2 Infection Clinical Network
The Infection Clinical Network governance structures include a governance committee, a clinical lead, the information and evidence (INSIGHT) subcommittee and any time-limited working groups or subcommittees established to deliver on network priorities.

2 THE VICTORIAN SEPSIS PROGRAM
Sepsis is the overwhelming response of the body to severe infection. Sepsis is a medical emergency and early recognition and treatment can save lives. It was identified by clinicians that there is significant variance in practice in relation to recognising and initiating appropriate and timely treatment. To address this practice-gap a sepsis clinical pathway was developed and tested by the Emergency Care Clinical Network and a funded Better Care Victoria project. Both projects have reported between 5–20 per cent reductions in sepsis related mortality.
Sepsis work: the current state

Two branches within Safer Care Victoria have led quality improvement work related to sepsis. The following outlines the current state (scope and breadth) of this work to date.

Emergency Care Clinical Network (ECCN)

A total of 62 Emergency Departments and Urgent Care Centres have been involved in implementing a sepsis clinical pathway over a three-year period:

- 2016: 22 Emergency Departments were enrolled from both metro and regional settings and reported improved recognition of sepsis at triage (20 per cent), and a four per cent reduction in sepsis related mortality.
- 2017: a further nine emergency departments were enrolled and a 5% reduction in sepsis related mortality was reported.
- 2018: a modified version of the “Think Sepsis. Act Fast” clinical pathway has been introduced to 32 Emergency and Urgent Care Centres throughout Victoria. The outcomes of this project are due to be reported in April 2019.
- 2019: resources (pathway and change package) will be consolidated into the Victorian sepsis program. It is intended that this project will be accessible to units via this platform.

Better Care Victoria innovation fund project

A Better Care Victoria (BCV) whole of hospital “Think sepsis. Act fast” pilot study was undertaken at Melbourne Health in 2016-2017. At the end of the 12-month project Melbourne Health reported a 50 per cent reduction in sepsis related mortality. Other outcomes included: 67 per cent reduction in sepsis attributable intensive care admissions, 57 per cent reduction in a median length of stay (from seven to four) for patients who were placed on the sepsis six pathway.

In 2018-2019, BCV funded a sepsis scaling collaborative where the “Think sepsis. Act fast” was implemented at a further 11 Victorian healthcare services. The outcomes of this 12-month project are due to be reported in April 2019.

A third round of BCV funding will be provided in 2019-2020 to replicate the ‘Think sepsis, Act fast’ program.

There is a need for a governance framework to support the gains made by the two projects and bring the work under a single Victorian sepsis program.

2.1 Victorian sepsis program subcommittee purpose

The purpose of the subcommittee (the group) is to:

- act as an information and evidence expert sepsis advisory group to the Infection Clinical Network governance committee and the sepsis scaling collaborative steering committee
- help build network collaboration around information and evidence to drive sector-wide service improvement pertaining to sepsis.

3 CORE OPERATING PRINCIPLES

The group will operate in a manner consistent with a set of core operating principles. It will:
* act in the best interests of consumers and the wider Victorian community by engaging with the broader network membership in a bottom up approach to provide information and best practice guidance on improving patient outcomes pertaining to sepsis
* by ensuring consumers participate in a meaningful way (with an emphasis on co-design) in all sepsis related activities of the clinical network, including decision making
* collaborate with other networks and organisations on relevant improvement initiatives pertaining to sepsis
* support the governance committee to monitor delivery against the annual sepsis work plan.

4 ROLE AND RESPONSIBILITIES

The specific roles and responsibilities of the group are to:

* to ensure a sustainable approach to recognising and managing sepsis occurs within Victoria
* act as a reference group to provide clinical expert guidance on the Victorian sepsis program.
* identify outcome measures to monitor and evaluate the Victorian sepsis program
* evaluate the efficiency and effectiveness of these outcome measures
* provide advice on specific matters referred to the group by the Infection Clinical Network governance group and the sepsis scaling collaboration steering committee, as required
* review emerging evidence and provide advice on appropriate use of new and emerging technologies which might influence the delivery of best practice.

5 DELIVERABLES

The group will:

* develop and deliver a set of measures to monitor the Victorian sepsis program
* identify best practice ‘evidence-based data gaps’ where appropriate
* ensure a standardised approach to recognising and managing sepsis occurs within Victoria.
* describe a workforce capability required to support the recognition and management of patients with sepsis.
* support the development of messaging to raise community awareness of sepsis
* describe the minimum requirements for an electronic medical record system to enable Victorian healthcare services to monitor and report sepsis cases
* establish a platform to enable healthcare services to access materials to implement a sepsis improvement program.

6 GOVERNANCE

The group will work in partnership with the infection clinical network governance committee and the sepsis scaling collaboration steering committee (see Figure 1). The Infection Clinical Network governance committee will be kept informed of all decisions made by both the group and the sepsis scaling collaboration steering committee through a standing agenda item.

There will be an interface between the sepsis scaling collaboration steering committee by having a representative on the subcommittee and vice versa.
7 WORKING GROUPS

The group will establish time limited project/working groups to undertake work and report back to the group on deliverables and outcomes. The group will endorse an individual to chair the activities of the project/working group under their guidance. Network-wide collaborative project/working groups will be encouraged to facilitate widespread engagement and impact.

A group member can be endorsed by a majority vote to act as a lead of a time limited working group. If this is the case the member will be required to step down from their role in evaluation of the project work and deliberations of the group related to this project as per section 9.9 Conflicts of Interest.

The group will consider recommendations arising from these project/working groups and their potential impact on safety and quality, guidelines and policy.

8 MEMBERSHIP

8.1 Members

Membership will include seven to ten experienced, interested and skilled members comprised of the following:

- **Nominees** appointed to provide their organisation’s perspective and expertise to the group, and/or
- **Expert Individuals** appointed to provide specialist knowledge/expertise to the group on a particular topic/subject.

In relation to this there will be representation from,

1. Clinical Experts from a range of disciplines (medical, nursing, allied health) and across the care continuum – four
2. Clinical experts from emergency care and intensive care – two
3. Clinical experts from infectious diseases and infection control - two
4. Patients and carers - two (expert individual member)
5. Regional director of nursing - one (expert individual member)
6. Regional medical executive sponsor – one (expert individual member)
7. Private hospital – one  
8. General practitioner – one  
9. Ambulance – one  
10. Epidemiology or biostatistics (infection interest preferred) – one (expert individual members)  
11. Sepsis 2.0 project working group member - two

- Observers (non-members)  
- Director, Clinicians as Partners, Safer Care Victoria (executive sponsor)  
- Manager, Acute Care Networks, Clinicians as Partners  
- Manager, Clinical Safety and Monitoring, Safer Care Victoria  
- Manager, Rural and Regional Partnerships, Department of Health and Human Services  
- Manager, Aged Care Services, Department of Health and Human Services  
- Manager, Private Hospital Branch  
- ICN Clinical Lead, Clinicians as Partners  
- ICN Project Lead, Clinicians as Partners

Safer Care Victoria will provide secretariat support and maintain a register of members. Guests may be invited to take part in meetings as appropriate. Guest participants will not have authority to vote and will be required to sign confidentiality statements prior to the meeting.

The network will provide secretariat support and maintain a register of members.

8.2 Appointments

Inaugural members will be appointed via an expression of interest process, with appointments-based on merit and ensuring that the final group has the right mix of knowledge, experience and expertise. Members will be requested to complete a deed of confidentiality and to register any conflicts of interest (see section 9, below).

A formal review of membership will be undertaken at the end of twelve months (see Section 10) ensuring the necessary mix of diversity, knowledge, experience and expertise.

8.3 Expectation of members

Members are expected to:

- commit to a 12-month term  
- attend a minimum of 75 per cent of meetings and forums scheduled by the chair  
- participate in the work of the clinical network including subcommittees and working groups, as needed  
- register any conflicts of interest  
- complete a deed of confidentiality  
- advocate for and promote the clinical network and its activities  
- adhere to the core operating principles for the group  
- notify the secretariat if they are unable to attend a scheduled meeting.
8.4 Accountability
The group works in partnership with the infection clinical network governance committee and reports through the chair to this group. The group chair will provide a verbal or written update to the infection clinical network governance committee at each scheduled governance committee meeting. A standing agenda item will be in place.

8.5 Proxies
Absent members cannot be represented by proxy.

8.6 Co-option of members
If the group agrees that specific expertise and/or organisational representation is needed to progress work against specific priorities, and that expertise is not present in the group, the group may co-opt members for a set period of time for that work. The role of the co-opted member is to contribute constructively to discussions and deliberations in the same way as other members. Co-opted members however, do not have voting rights.

8.7 Tenure
Founding members are appointed for a period of twelve months.

8.8 Mid-term vacancies
Mid-term vacancies will be filled via an expression of interest process.

9 Meetings

9.1 Meeting frequency
Meetings are to be held up to 12 times each year and will be a minimum of 1.5 hours in duration or as otherwise determined by the chair.

9.2 Decision making
Decision making will be on a consensus basis. In the event there is no consensus, a simple majority will suffice.

9.3 Chair
The inaugural chair will be nominated by the Network leadership team and endorsed by the Director, Clinicians as Partners.

The chair will lead the activities of the group. Specific responsibilities are to:
- set the agenda for the meeting
- lead the meeting
- maintain order at the meeting
- ensure the conventions of the meeting are being followed
- ensure fairness and equality at the meeting
- keep the meeting to time
- approve the formal minutes of the meeting
• report to governance committee on group activities.

9.4 Secretariat
The clinicians as partners branch will provide the secretariat function for the group. This function will be overseen by the clinical network manager. The role of the secretariat is to:
• support the day-to-day running of the subcommittee by developing the agenda, preparing and distributing background papers, and recording and preparing minutes of subcommittee meetings
• update, manage or log any potential conflicts of interest
• ensure group decisions and/or recommendations are accurately documented for endorsement by Director, Clinicians as Partners and/or others within Safer Care Victoria with appropriate delegation.

9.5 Out-of-session resolutions
When an issue arises that, in the opinion of the chair, requires resolution before the next scheduled meeting, the chair may seek an out-of-session resolution. An out-of-session resolution shall be achieved and may be acted upon if:
• written information about the issue, together with a proposed resolution, is distributed to all members of the group
• sufficient members of the group to constitute a quorum respond and a consensus or simple majority agree with the proposed resolution, or an amended form of the resolution, within a timeframe agreed upon by the Chair.

9.6 Attendance
Group members must attend no less than 75 per cent of meetings per year. At least half of the meetings must be attended in person.

To support participation of people living in regional or rural locations, teleconference or videoconference should be made available by prior arrangement, if requested.

9.7 Quorum
Half plus one members meeting together and/or via tele/videoconferencing will constitute a quorum. In the event a quorum is not achieved, the meeting may proceed with voting held over until such time as a quorum is achieved.

9.8 Confidentiality
All members will be required to sign a confidentiality agreement on commencement of their term of appointment.

Members will not reveal any confidential or proprietary information entrusted in the course of their duties.

Upon cessation of membership, and thereafter, the member shall not reveal any confidential or proprietary information that they obtained while a member of the subcommittee, and may not use or retain, or attempt to use or retain, any such information, documents or data.

Guests will be required to sign a confidentiality agreement prior to meeting attendance.
The Chair will provide direction to members on outcomes or recommendations that may be disclosed publicly.

9.9 Conflict of interest
A conflict of interest will arise if a person's personal interest (actual or perceived) conflict with their duties as a group member such that the person may not be independent, objective and impartial in relation to their duties. All declarations of conflict of interest will be declared as part of the membership documentation, and where appropriate for additional circumstances in any given meeting.

Where a potential conflict of interest has been declared the member will remove themselves from voting on matters concerning the declared conflict and be guided by the chairperson on how to best proceed and advise the meeting accordingly. A formal declaration will be completed and signed along with documented action taken by the chairperson.

9.10 Remuneration
Consumer members and private practitioners such as general practitioners will be eligible for remuneration for attendance to scheduled meetings. Other members may apply for remuneration on a case by case basis.

All members, whether remunerated or unremunerated, are eligible to be reimbursed for reasonable out-of-pocket expenses such as travelling, accommodation, meals and other incidental expenses associated with attendance at meetings, overnight absence from home or absence from the normal work location in the course of formal network duties.

10 REVIEW
The group will review its progress against its stated role and responsibilities and work plans toward the end of its twelve-month tenure and will report to the governance group on any proposed changes to the Terms of Reference. Changes to the Terms of Reference will be subject to approval by the infection clinical network governance committee and the Director, Clinicians as Partners.