General Purpose Standing Committee No. 2

Review of Inquiry into complaints handling within NSW Health

Ordered to be printed 21 November 2006

New South Wales Parliamentary Library cataloguing-in-publication data:

New South Wales. Parliament. Legislative Council. General Purpose Standing Committee No. 2
Review of Inquiry into Complaints Handling within NSW Health: [report] / General Purpose Standing Committee No. 2. [Sydney, N.S.W.] : the Committee, 2006. – 60 p.82; 30 cm. (Report; no. 23)

Chair: Hon. Robyn Parker MLC.
ISBN 1921286075

1. New South Wales. Parliament. Legislative Council. General Purpose Standing Committee No. 2. Inquiry into Complaints Handling within NSW Health.
2. NSW Health.
3. Health facilities—Complaints against—New South Wales.
I. Title.
II. Parker, Robyn.
III. Series: New South Wales. Parliament. Legislative Council. General Purpose Standing Committee No. 2. Report; no. 23

DDC 362.1

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Terms of Reference

That General Purpose Standing Committee No. 2 inquire into and report on the implementation of the Government's response to the recommendations of the report of the Committee into "Complaints handling within NSW Health".

These terms of reference were self-referred by the Committee on 14 March 2006.

Committee Membership

Hon Robyn Parker MLC (from 25/09/06)*	Liberal Party	*Chair*
Hon Patricia Forsythe MLC (to 19/09/06)*	Liberal Party	*Chair*
Hon Tony Catanzariti MLC	Australian Labor Party	*Deputy Chair*
Hon Dr Arthur Chesterfield Evans MLC	Australian Democrats	
Ms Sylvia Hale MLC	The Greens	
Hon Melinda Pavey MLC	The Nationals	
Hon Christine Robertson MLC	Australian Labor Party	
Hon Henry Tsang MLC	Australian Labor Party	

* The Hon Robyn Parker MLC was nominated as a Member of General Purpose Standing Committee No. 2 on Tuesday 19 September 2006 to replace the Hon Patricia Forsythe (Legislative Council, New South Wales, *Minutes of Proceedings, No 14,* 2nd session of the 53rd Parliament, 19 September 2006, item 9)
The Hon Robyn Parker was elected Chair of the Committee on 25 September 2006 (*GPSC No. 2 Minutes No. 79 – Monday, 25 September 2006)*

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Chair's Foreword

In 2004, General Purpose Standing Committee No 2 conducted an inquiry into complaints handling within NSW Health. While the inquiry was generated by serious allegations regarding patient care at Campbelltown and Camden Hospitals, it dealt with issues relevant to the entire health system. The inquiry identified a pressing need to develop a health care culture that is open about mistakes and able and willing to learn from them.

The Committee's 2004 report included 19 recommendations designed to improve patient safety and quality in NSW, and an undertaking that the Committee would review the implementation of these recommendations. This current report presents the findings of the review.

While the Government accepted the vast majority of the Committee's original recommendations, progress on the implementation of some of these is not satisfactorily advanced. According to review participants, a significant number of health care staff are either unaware of, or unclear about many aspects of the new patient safety agenda. As was demonstrated in the previous inquiry, the attitudes and knowledge of health workers are pivotal to the development of a safer health system. For this reason, the Committee has recommended that the Minister for Health conduct an urgent review of the nature and extent of privilege relevant to incident investigations and that NSW Health accelerate staff training and education in quality and safety principles, including open disclosure.

Timely feedback regarding the outcomes of investigations is another critical feature of effective incident management. The review has revealed frustration among some health care staff that the outcomes of incident investigations are not adequately communicated back to them in a timely manner and recommends that NSW Health explore ways to address this issue.

Public awareness of, and confidence in, patient safety initiatives is crucial to the successful implementation of a quality agenda. The Committee therefore reiterates the view expressed in its previous report that NSW Health implement an extensive public education campaign within the next 12 months, to increase awareness of adverse incidents and promote realistic public expectations of the health care system.

An effective incident management system must strike a balance between the need to protect the privacy of health workers and consumers, while ensuring the system is transparent and accountable. The Committee believes more frequent publication of its Incident Management Reports will facilitate greater openness in relation to adverse events.

On behalf of the Committee, I thank the review participants for their time and expertise. I am also grateful to my Committee colleagues for the work they have undertaken on this review, including the previous Chair of this Committee, the Hon Patricia Forsythe. On their behalf I would like to acknowledge the contribution of the Secretariat: Ms Glenda Baker, Ms Marie Burton and Ms Beverly Duffy.

I commend this report to the Government.

Hon Robyn Parker MLC

Chair

Summary of Recommendations

Recommendation 1 *Page 15*

That the NSW Minister for Health instigate an urgent review of the nature and extent of privilege relevant to incident investigations. The proposed review should examine:

- the possible extension of privilege in relation to incident investigations, including root cause analysis
- the methods used to ensure root cause analysis investigations are conducted with procedural fairness.

The report of this review, to be completed by September 2007, should involve key stakeholders, and be tabled in the NSW Parliament. The results of this review should be considered as part of the statutory review under Division 6C of the *Health Administration Act 1982*.

Recommendation 2 *Page 24*

That NSW Health, in conjunction with the Clinical Excellence Commission, undertake a review of the level and timeliness of feedback provided to staff following the investigation of an incident.

That this review be completed by July 2007.

Recommendation 3 *Page 24*

That NSW Health expand and accelerate training programs in quality and safety issues for health care staff in relation to:

- the identification of health care incidents
- how to distinguish between investigative pathways
- the principles of open disclosure
- the use of the Incident Information Management System
- root cause analysis, including the application of privilege.

Recommendation 4 *Page 27*

That the Clinical Excellence Commission in conjunction with NSW Health undertake an extensive public education campaign within the next 12 months to inform the community about:

- simple steps to make health care complaints
- the nature and extent of adverse events in the health care system
- realistic expectations of health care
- changes to the regulatory framework for health care complaints and consumer rights.

Recommendation 5 *Page 32*

That NSW Health publish Incident Management Reports on a biannual basis.

Glossary[1]

Area Health Services (AHS)

Provide the operational framework for the provision of public health services in NSW. They are constituted under the Health Services Act 1997 and are principally concerned with the provision of health services to residents within the geographic area covered by that health service.

Clinical Excellence Commission (CEC)

A statutory health corporation established under the Health Services Act to promote and support improvement in clinical quality and safety in NSW health services.

Clinician

A health practitioner or health service provider regardless of whether the person is registered under a health registration act.

Department

The NSW Department of Health.

IIMS

The NSW Health Incident Information Management System. The statewide incident management system which electronically captures data about incidents across all NSW public health facilities.

Incident

Any unplanned event resulting in, or with the potential for, injury, damage or other loss. An **Adverse event** is an unintended patient injury or complication from treatment that results in disability, death or prolonged hospital stay and is caused by health care management5. This term is not used in the policy as the more generic term "incident" is used.

Incident Management

A systematic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident.

Open Disclosure

The process of open discussion with the patient and their support person/s of incidents that result in unintended harm to a patient while receiving health care and the associated investigation and recommendations for improvement.

[1] The following definitions are based on the Glossary included in the Department's Incident Management Policy, see NSW Health: *Policy Directive: Incident Management Policy*, 19 May 2006, pp8-11 <www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_030.pdf>

Public health organisation (PHO)

This term refers to a statutory health corporation or an affiliated health organisation in respect of its recognised establishments and recognised services as defined in the Health Services Act and the Ambulance Service of NSW.

Reportable Incident Brief (RIB)

The method for reporting defined health care incidents to the NSW Department of Health. The RIB process encompasses clinical and corporate incidents occurring in the health care setting under 4 incident categories:

1. clinical;
2. staff, visitor, contractor;
3. property, security, hazard; and
4. complaints.

Reportable Incident

An incident requiring a RIB. This includes both clinical and corporate SAC 1 incidents and also any matter that requires direct notification to the Department under existing legislative reporting requirements or Departmental policy directive.

Root Cause Analysis (RCA)

A method used to investigate and analyse a clinical SAC 1 incident to identify the root causes and factors that contributed to the incident and to recommend actions to prevent a similar occurrence. SAC 1 Reportable Incidents A clinical SAC 1 incident requiring an RCA. See PD2005_634 Definition of a Reportable Incident – Section 20L of the Health Administration Act.

Severity Assessment Code (SAC)

A numerical score applied to an incident based on the type of event, its likelihood of recurrence and its consequence. A matrix is used to stratify the actual and/or potential risk associated with an incident.

Statutory Privilege according to Division 6C of the Health Administration Act 1982

Provides that documents created by an RCA team during an RCA investigation (other than the final report of the investigation team containing causation statements) cannot be disclosed, or produced in answer to a court order and provides that RCA team members are neither competent or compellable to give evidence about the RCA before a court or tribunal.

Abbreviations

ACSQHC	Australian Council for Safety and Health Care
AHS	Area Health Service
AMA	Australian Medical Association
CEAC	Citizens Engagement and Advisory Committee
CEC	Clinical Excellence Commission
CGU	Clinical Governance Unit
HCCC	Health Care Complaints Commission
IIMS	Incident Information Management System
MDO	Medical Defence Organisation
PSCQP	Patient Safety Clinical Quality Program
RIB	Reportable Incident Brief
RCA	Root Cause Analysis
RCNA	Royal College of Nursing Australia
SABS	Safety Alert Broadcast System
SAC	Severity Assessment Code
UMP	United Medical Protection

Chapter 1 Introduction

This chapter provides an overview of the background to this review and its key findings. It also details the methods used to invite participation in the review, and a brief summary of the focus of each chapter in the report.

Background to the review

1.1 In 2004 General Purpose Standing Committee No. 2 (GPSC 2) conducted an inquiry into complaints handling within NSW Health. This inquiry followed the release of a report by the Health Care Complaints Commission into allegations of inadequate patient care at Campbelltown and Camden Hospitals.

1.2 Several other investigations were also conducted in relation to these hospitals, including the Special Commission of Inquiry into Campbelltown and Camden Hospitals, which gave rise to the 'Walker Report.'[2]

1.3 The terms of reference for the original GPSC 2 inquiry were:

> That General Purpose Standing Committee No.2 inquire into and report upon the complaints handling procedures within NSW Health, and in particular:
>
> - the culture of learning and the willingness to share information about errors and the failure of systems, and
>
> - an assessment of whether the system encourages open and active discussion and improvement in clinical care.

1.4 The Committee tabled its report, *Complaints handling within NSW Health,* in June 2004[3]. The report contained 19 recommendations for action to be taken by the NSW Government. These recommendations are included at Appendix 3.

1.5 A major finding of the original inquiry was that there was 'routine non disclosure of adverse events in the health system' and a pressing need to develop 'a health care culture that is open about mistakes and willing to learn from them.'[4] It also included an undertaking that '… the Committee will institute a review of the recommendations made in this report in June 2005'.[5]

1.6 Under Legislative Council Standing Order 233 the NSW Government is required to provide a response to the recommendations of a Legislative Council committee report within six

2 Walker, B (SC), *Final Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals*, 2004

3 NSW Legislative Council, GPSC 2, Report 17, *Complaints handling within NSW Health*, June 2004

4 NSW Legislative Council, GPSC 2, Report 17, *Complaints handling within NSW Health*, June 2004, p3

5 NSW Legislative Council, GPSC 2, Report 17, *Complaints handling within NSW Health*, June 2004, p84

months of the tabling of that report.[6] In December 2004 the Government provided this response and advised what action, if any, it proposed to take in relation to each of the Committee's recommendations.[7] This response is included at Appendix 4.

1.7 In March 2006 the Committee adopted terms of reference relating to an inquiry to review the implementation of the NSW Government's response to the Committee's recommendations, under the Committee's power to make a self-reference.[8] The terms of reference for this review are:

> That General Purpose Standing Committee No. 2 inquire into and report on the implementation of the Government's response to the recommendations of the report of the Committee into "Complaints handling within NSW Health".

Conduct of the review

Focus

1.8 The Committee noted in its report of June 2004: 'Given the emphasis on 'systemic' issues in the terms of reference, the Committee has not sought to make findings on specific incidents or allegations regarding patient safety …'[9] The Committee also chose to focus on systemic issues during the current review. Some members wanted to revisit the evidence of the Campbelltown hospital to see in particular what had happened to the participants, but the Committee chose not to do this.

Submissions

1.9 Given the review's focus on systemic issues, the Committee in the first instance invited submissions from NSW Health, the Clinical Excellence Commission and the Health Care Complaints Commission.

1.10 After considering these submissions the Committee decided to seek public submissions. The Committee was keen to ascertain whether the account provided by NSW Health, the Clinical Excellence Commission and the Health Care Complaints Commission of the progress in implementing the Committee's recommendations accorded with the opinions of interested organisations and individuals.

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6 Legislative Council, New South Wales, *Standing Orders and Rules,* May 2004, No. 233 <www.parliament.nsw.gov.au/prod/lc/LCProcedural.nsf/V3ListStandingOrders>

7 NSW Government response to the Legislative Council GPSC 2 inquiry into Complaints handling within NSW Health, Correspondence from Hon Michael Egan MLC, Leader of the Government in the Legislative Council, to Mr John Evans, Clerk of the Parliaments, 23 December 2004, found at: www.parliament.nsw.gov.au/prod/PARLMENT/Committee.nsf/0/D7658C3FD2F0476CCA256EBD00043A73 (accessed 2 October 2006)

8 GPSC 2 Minutes No. 66, 14 March 2006, item 4

9 NSW Legislative Council, GPSC2, Report 17, *Complaints handling within NSW Health*, June 2004, p2

1.11 The Committee advertised the review in major metropolitan and regional newspapers and by writing to a number of stakeholders who participated in the original inquiry. The Committee received 15 submissions. The list of submissions is included at Appendix 1.

1.12 The conclusion of this review, as further discussed in Chapter 2 tends to accept the managerial changes that the Health Department has created. It is noted that the Department and the Clinical Excellence Commission have done a lot of work and that the Australian Medical Association (AMA) (NSW) has been supportive and feels that there has been a culture change, though they are also concerned that there has not been adequate public education as stated in 5.6. The Royal College of Nurses Australia was more cautious in their appraisal of the success of Root Cause Analysis. The lack of a significant number of public submissions to this review meant that the Committee is not in a good position to look at what has actually happened on the ground. The Committee is aware that management intentions, programmes and parliamentary submissions are not always reflected in practice and believes this should be addressed in a future inquiry.

Hearings

1.13 The Committee held one public hearing on Thursday 14 September 2006 at Parliament House at which it heard evidence from representatives of NSW Health, the Clinical Excellence Commission, the Australian Medical Association (NSW), United Medical Protection and the Royal College of Nursing, Australia. The transcript of this hearing is available on the Committee's webpage www.parliament.nsw.gov.au/gpsc2. The list of witnesses appearing at the hearing is included at Appendix 2.

Chapter outline

1.14 Chapter 2 looks at recent developments in patient safety initiatives in NSW since the Committee's complaints handling inquiry in 2004.

1.15 Chapter 3 examines issues relating to the protection or 'privilege' afforded to participants in the conduct of root cause analysis investigations.

1.16 Chapter 4 discusses training requirements for health care workers in quality and safety principles, and the need to expedite feedback to clinical staff from incident investigations.

1.17 In Chapter 5 the Committee reiterates its earlier recommendation that NSW Health and the Clinical Excellence Commission collaborate on a public education campaign to promote realistic expectations of the health system by health consumers, and an understanding of the changes to the management of health complaints in NSW.

1.18 Chapter 6 examines public access to information about serious clinical incidents, via reportable incident briefs. It also discusses the frequency of reporting aggregated data on incident management in NSW Health.

Chapter 2 Recent patient safety initiatives in NSW

There have been extensive changes to the patient safety agenda in NSW over the past two years. The momentum created by the Special Commission of Inquiry into Campbelltown and Camden hospitals and GPSC 2's inquiry into complaints handling within NSW Health, have stimulated many of these reforms. This chapter provides an overview of some of these changes, as well as an update on the progress of the implementation of the recommendations from the Committee's June 2004 report.

Response to GPSC 2 recommendations

2.1 According to the joint submission of NSW Health and the Clinical Excellence Commission, the NSW Government 'accepted' 17 of the 19 recommendations made by GPSC 2 in its original report. As of May 2006, NSW Health advised that nine of these recommendations have been fully implemented and seven are in progress. The sole recommendation that had not been addressed by this time – the conduct of a National Summit on Adverse Events – is apparently 'in progress'.[10] NSW Health and the Clinical Excellence Commission also informed the Committee that all of the 17 legislative recommendations arising from the Special Commission of Inquiry conducted by Mr Bret Walker SC have been implemented, as have four out of the five general recommendations.[11]

2.2 The progress made by NSW Health and the Clinical Excellence Commission in implementing the recommendations of both inquiries has been comprehensively documented in their submission to this inquiry, and in their response to questions taken on notice during the hearing held on 14 September 2006. Suffice to say, the implementation of this Committee's recommendations, and those of the Walker inquiry, have resulted in substantial changes to incident management practices in NSW Health, largely via the introduction of the Patient Safety and Clinical Quality Program. There are four elements to the new program. These include the:

- establishment of the Clinical Excellence Commission
- establishment of Clinical Governance Units in each Area Health Service
- introduction of the Incident Management Program
- introduction of a Quality System Assessment Program.

2.3 Some of the most important initiatives introduced as part of the Patient Safety and Clinical Quality Program include the Incident Information Management System, the roll-out of training courses in root cause analysis methodology and the annual reporting of incident

[10] A proposal for a National Summit on Adverse Events in 2007 is being jointly developed by the Australian Commission on Safety and Quality in Health Care Standards Interjurisdictional Committee and NSW Health. Answers to questions on notice taken during evidence 14 September 2006, Ms Robyn Kruk, Director General NSW Health, Question 6, p6

[11] Submission 2, NSW Health and Clinical Excellence Commission, p2 (while Submission 2 is a joint submission from NSW Health and the Clinical Excellence Commission, future references to this submission will refer solely to NSW Health as the author).

management in NSW Health. Given many of the issues raised during the review touch on these aspects of the Patient Safety and Clinical Quality Program, a more detailed description of these initiatives is provided at the end of the chapter.

2.4 Relevant professional organisations, including the Royal College of Nursing, Australia have welcomed the new approach to patient safety:

> The college supports measures taken by the NSW Government following the recommendations made from the inquiry in 2004, which has sought to address processes for data collection and the monitoring of complaints made by consumers of health care, and protective strategies for health care professionals.[12]

2.5 AMA (NSW) recognised a change in attitudes with regard to open disclosure and drew particular attention to the positive relationship it has developed with NSW Health:

> AMA (NSW) recognises NSW Health's ongoing commitment to advancing quality assurance and disclosure issues. To date, AMA (NSW) has enjoyed an open and constructive working relationship with NSW Health which has been conducive to significant reform already in the area of incident handling and investigation. AMA (NSW) is optimistic that this culture of co-operation can continue and further agreements on improvement of this regime can be reached to the benefit of health service providers and patients alike.[13]

2.6 Professor Clifford Hughes, Chief Executive Officer of the Clinical Excellence Commission, has discerned an encouraging shift in attitudes to incident reporting in recent times:

> … we had a system that in part relied on the courage of the occasional whistleblower to report incidents. They were often then beset by fear, paranoia and sometimes mistrust. They were occasionally ignored. They were sometimes denied and occasionally even ostracised, even in the system itself. But in the short time since then and with the co-operation of the Department of Health and the CEC we now have a system that voluntarily provides 10,000 incident reports per month.[14]

2.7 Despite these improvements, systemic and cultural change can only be achieved over time and much remains to be done. According to Mr Robert O'Donohue, Vice President, Royal College of Nursing Australia:

> There certainly have been some structured processes put in place. There has been information technology put in place; there have been some efforts through the clinical governance. However, all of that is resting on the fact that staff have the means to be able to spend the time to deal with and to improve their care in an environment which is supported by evidence. … [with regard to] the fundamental structures … there is still a need for those areas to be strengthened. … Overall, I think there is still a long way to travel. There is still a culture out there that has not wholly embraced evidence-

12 Ms Elizabeth Foley, Director Policy, Royal College of Nursing Australia, Evidence, 14 September 2006, p34

13 Submission 13, TressCox Lawyers for AMA (NSW), p2-3

14 Professor Clifford Hughes, Chief Executive Officer, Clinical Excellence Commission, Evidence, 14 September 2006, p6

> based practice, let alone adopted it … That has not been seized as it is not happening to any great extent. There are pockets of it. However, it is not wholesale.[15]

2.8 Ms Elizabeth Foley, Director Policy, Royal College of Nursing Australia, added:

> Any cultural change will take a while to take effect, plus a process of trust has to be developed. Even though these processes have been put in place, for staff to fully embrace them … they need to be able to see that a genuine attempt is being made at executive levels to want to make a change.[16]

Key quality and safety reforms

2.9 Below is an outline of some of the most significant initiatives introduced as part of the Patient Safety and Clinical Quality Program.

Incident Information Management System

2.10 The Incident Information Management System (IIMS) is a statewide, electronic database which provides for the notification of all incidents and near misses that occur in health facilities across the State.

2.11 Each notification includes an initial assessment of severity using the Severity Assessment Code (SAC). This matrix applies a numerical rating from SAC 1 (most serious) to SAC 4 (least serious). The SAC matrix can be seen at Appendix 5. The incidents may be clinical in nature, for example, the death of a patient, or corporate, such as staffing and contractor incidents.

2.12 All incidents entered into the Incident Information Management System are subject to some form of investigation; the type of investigation is determined by the SAC score for any particular incident.

2.13 Clinical SAC 1 incidents - relating to serious clinical incidents, must undergo a root cause analysis, the report of which must be provided to the Department within 70 days.[17] Corporate SAC 1 incidents - must undergo a detailed investigation and the report must be provided to the Department within 70 days.[18] SAC 2, 3 and 4 incidents are not required to be forwarded to the Department but are investigated at either the area or local level. [19]

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15 Mr Robert O'Donohue, Vice president Royal College of Nursing Australia, Evidence, 14 September 2006, p36

16 Ms Foley, Evidence, 14 September 2006, p36-7

17 NSW Health Policy Directive: Incident Management Policy, p16 <www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_030.pdf>

18 NSW Health Policy Directive: Incident Management Policy, p16

19 NSW Health Policy Directive: Incident Management Policy, pp16-17

Reportable incidents and Reportable Incident Briefs

2.14 A sub set of all health care incidents entered into IIMS must be reported directly to NSW Health. These include all SAC 1 incidents, both clinical and corporate.[20] The usual method for reporting these incidents to the Department is via a reportable incident brief.

2.15 Reportable incident briefs contain all known facts and background material relating to a particular incident, the reasons for reporting an incident, an initial analysis and suggestions for future actions. Reportable incident briefs must be de-identified and treated as confidential.[21]

2.16 All reportable incident briefs relating to the most serious, or SAC 1 events, and a small number of other defined incidents,[22] are required to be emailed to NSW Health within 24 hours of the notification of the event in the Incident Information Management System.[23]

Root cause analysis

2.17 Root cause analysis is a method used to identify the root causes of a health care incident with a view to recommending actions to prevent a similar occurrence.[24] A root cause analysis *must* be conducted for all serious clinical incidents (SAC 1 clinical) .[25] A root cause analysis program was rolled out across the system and devolved to health services through a 'Train the Trainer 'program in April 2005. More than 3,000 staff have been trained in root cause analysis investigative techniques and 100 health professionals have been trained to train others in this methodology.[26] Root cause analysis is discussed further in chapter 3.

Annual Reports on incident management in the NSW public health system

2.18 For the past two years NSW Health has published aggregated data relating to serious clinical incidents in its 'Annual report on incident management in the NSW public health system'.[27] Plans are also underway to produce the first annual public report on *all* clinical incidents (not just serious incidents) occurring in the health system in 2007.[28]

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20 Various other types of incidents are required to be reported to the Department.. These include a fire, bomb or other threats, serious power or water failure and critical equipment breakdown. NSW Health Policy Directive: Incident Management Policy, p21 <www.health.nsw.gov.au/policies/pd/2006/pdf/ PD2006_030.pdf> accessed 6 October 2006

21 NSW Health Policy Directive: Incident Management Policy p22

22 These 'other incidents' are defined under the *Health Administration Act* (1982) http://bulletin/prod/parlment/NSWActsRegsXML.nsf/Key1/Act-1982-135

23 NSW Health Policy Directive: Incident Management Policy, p21

24 NSW Health Policy Directive: Incident Management Policy p10

25 *Health Administration Act 1982*, Div 6

26 Ms Robyn Kruk, Director-General, NSW Health, Evidence, 14 September 2006, p2

27 Submission 2, p4. These reports can be found at www.health.nsw.gov.au/pubs/a-z/a.html

28 Answers to questions taken on notice during evidence 14 September 2006, Ms Robyn Kruk, NSW Health, Question 5, p8

Committee view

2.19 While NSW Health is confident it has implemented many of the recommendations from the Committee's inquiry into complaints handling, as this report will show, the progress in relation to some of these may not be as advanced as the Department suggests.

2.20 Since 2004, NSW Health has made significant changes to its quality and safety agenda, including the introduction of the Incident Information Management System, the roll out of root cause analysis training and the publication of annual incident reports. While participants in this review were generally positive about these reforms, they also firmly believe that much more needs to happen to ensure the successful implementation of this agenda.

Chapter 3 Root cause analysis and statutory privilege

This chapter examines some of the concerns raised by review participants regarding the privilege attached to the conduct of root cause analysis (RCA). This issue highlights one of the challenges facing NSW Health in implementing its safety and quality agenda: the need to develop a culture in which staff feel confident about reporting adverse events, at the same time as ensuring that the reporting system provides accountability, both to the public and to health care consumers.

Root cause analysis

3.1 Root cause analysis is a method used to identify the root causes of a health care incident with a view to recommending actions to prevent a similar occurrence.[29] An RCA *must* be conducted for all Clinical SAC 1 incidents.[30] Clinical SAC 1 incidents, which are also known as 'reportable incidents', include:

> … those incidents with serious clinical consequences that have either a frequent, likely, possible or unlikely probability of recurrence and those incidents with major clinical consequences that have a frequent or likely probability of recurrence.[31]

3.2 Under the *Health Administration Act 1982*, the proceedings of a team established to conduct an RCA in relation to SAC 1 clinical events, attract statutory privilege. This means that documents created by a RCA team (other than its final report) cannot be disclosed or produced in answer to a court order and RCA team members are prohibited from giving evidence about their investigation before a court or tribunal.[32] NSW Health's Incident Management Policy Directive also includes certain privilege matters relevant to RCAs.

3.3 According to Ms Kruk, Director General, NSW Health, privilege is a critical factor in ensuring the efficacy of quality assurance initiatives, such as RCA:

> First, it guarantees participation in reporting. Secondly, it facilitates frankness and candour of participants in the examination of individual incidents. Third, it protects the privacy of individual patients. [33]

3.4 The basis and extent of the privilege afforded to teams undertaking an RCA was a key issue for two stakeholders participating in this review: AMA (NSW) and United Medical Protection. While they completely support the aims and objectives of this methodology, their concerns about the privilege that attaches to these investigations are threefold:

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29 NSW Health Policy Directive: Incident Management Policy <www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_030.pdf>, p10 accessed 6 October 2006

30 *Health Administration Act 1982*, Div 6, s20M

31 NSW Health Policy Directive: Incident Management Policy, PD2006_030, p24

32 NSW Health, Incident Management Policy, PD2006_030, pp29-30

33 Ms Robyn Kruk Director General, NSW Health, Evidence, 14 September 2006, p4. The special privilege that applies to the Reportable Incident Review Committee is set out in section 23 of the *Health Administration Act 1982*

- a lack of clarity regarding certain aspects of this privilege
- the inadequacy of existing provisions regarding privilege
- the uncertain legal status of policy directives.

3.5 The following section examines these issues and the response of NSW Health to the concerns raised.

Clarifiying the privilege attached to root cause analysis

3.6 According to Mr Alan Thomas, the Director of Medico-legal Strategic Policy and Training, AMA (NSW), existing provisions regarding RCA and privilege, under both the *Health Administration Act* and the Incident Management Policy, are 'unclear'.[34] United Medical Protection also believes there is a lack of clarity surrounding certain aspects of the privilege conferred on RCA teams:

> … root cause analysis can work extremely successfully as long as the appropriate protections are in place. Currently there appears to be confusion as to what is or is not protected.[35]

3.7 AMA (NSW) considers that a lack of certainty about aspects of privilege may limit doctors' participation in such processes:

> The thrust of our submission is that we just want certainty and clarity—as much as one can achieve that … so that … those who are involved in these processes understand where they stand.[36]

3.8 Examples of this apparent lack of clarity cited by AMA (NSW) include:

- While documents submitted to an RCA team by a non RCA team member are privileged, it is not clear whether privilege applies to a *copy* of a document made by that person.[37]
- While privilege only attaches to a properly constituted RCA team, the *Health Administration Act* and regulations do not define what is meant by this term.[38]
- It is not clear whether reports which are not required to be prepared under the *Health Administration Act* attract privilege. [39]
- Neither the *Health Administration Act* nor the Incident Management Policy offers sufficient guidance as to how the principles of natural justice are to be given practical effect.[40]

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34 Submission 13, Australian Medical Association (NSW), p6

35 Submission 12, United Medical Protection, p4

36 Mr Scott Chapman, Legal Advisor to AMA (NSW), Evidence, 14 September 2006, p23

37 Submission 13, p8

38 Submission 13, p8

39 Submission 13, p9

Adequacy of existing provisions regarding privilege and root cause analysis

3.9 AMA (NSW) and United Medical Protection argue that statutory privilege should be considerably expanded.. AMA (NSW) also consider that the relevant provisions should be amended to allow RCAs to be conducted with procedural fairness. The following section examines these proposed reforms.

Extend privilege to participants in an RCA

3.10 At present all team members involved in a RCA investigation are covered by statutory privilege. AMA (NSW) believes that privilege should be extended to *all* participants in such a process, not just the team members:

> …this is the most effective way of ensuring that those involved in the incident or asked to comment on the incident, feel comfortable participating fully in the root cause analysis process.[41]

3.11 At the very least, AMA (NSW) argue, clinicians involved in or asked to comment on an incident should be fully advised of the limitations of privilege in relation to any particular incident.[42]

Extend privilege to all incidents involving a root cause analysis

3.12 At present, only SAC 1 incidents with serious or major clinical consequences ('reportable incidents') are subject to a privileged RCA process. While an RCA may be conducted in relation to other types of SAC 1 incidents, for instance, those involving staff injury or financial loss, these are not privileged investigations. AMA (NSW) is opposed to this demarcation:

> …there appears to be no basis for allowing some incidents the benefit of privilege and others not, particularly as many matters may require closer investigation to reveal whether they are in fact a 'reportable incident'.[43]

3.13 Extending privilege, AMA (NSW) argues, does not mean doctors will be less accountable:

> … What we are saying is that privilege does not mean no accountability. If reckless indifference or negligence or—Heaven help us—criminality, is found to have occurred in the delivery of health services, there are processes by which the doctor would still be dealt with by both, I believe, common law and the disciplinary provisions that arise under the Medical Practice Act and also the Health Care Complaints Act.[44]

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40 Submission 13, p11

41 Submission 13, p6

42 Submission 13, pp2-3

43 Submission 13, p9

44 Mr Allen Thomas, Director, Medico-legal, Strategic Policy and Training, AMA (NSW), Evidence, 14 September 2006, p19

3.14 United Medical Protection also argue that privilege should be extended to all documents relevant to an RCA investigation, whether or not they concern SAC 1 clinical incidents:

> Whether the root cause analysis team is carrying out an investigation into a "reportable incident" or some other incident, it is submitted that all documentation which has been prepared for the purposes of root cause analysis must attract privilege.[45]

Root cause analysis and procedural fairness

3.15 AMA (NSW) also suggest that current provisions do not ensure that RCA investigations are conducted with procedural fairness. For example, they do not include a right to notice (the right to be notified about an allegation), to seek legal advice, and to be heard before an unbiased tribunal.

3.16 AMA (NSW) argues that the *Health Administration Act* and regulations are silent on what notice and in what form notice is to be given to the staff involved in a reportable incident and that this oversight should be addressed:

> … staff involved in any incident which is reported (including but not limited to "reportable incidents") ought to be given written notice of the report prior to any root cause analysis being commenced.[46]

3.17 AMA (NSW) point out that neither the *Health Administration Act* nor the Incident Management Policy expressly allow for a clinician involved in an incident being investigated by an RCA to seek legal advice or support from a relevant professional association. Nor do they provide a clinician involved in an incident a reasonable opportunity to respond to an incident subject to an RCA. AMA (NSW) consider such 'rights' should be provided for, especially if privilege is not extended to all participants in an RCA.[47]

3.18 Further to this, AMA (NSW) suggest that the *Health Administration Act* and regulations be amended to ensure that a clinician involved in an incident subject to an RCA has the right to object to the selection of members of the team if they have grounds for a reasonable apprehension of bias.[48]

Legal status of policy directives

3.19 A key concern expressed by AMA (NSW) during the review was that RCA processes are largely regulated by the Department's Incident Management Policy rather than by the *Health Administration Act* or regulations. This situation is problematic, it argues, because the legal status of policy directives is uncertain. AMA (NSW) believes that enshrining provisions regarding RCA in the relevant legislation would foster greater compliance and accountability:

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45 Submission 12, p4

46 Submission 13, p12

47 Submission 13, p13

48 Submission 13, p13

> … they do not have the force of law … unless the processes, privileges and protections relating to root cause analysis are provided for in legislative form, there is nothing to compel Area Health Services to abide by and observe these processes, privileges and protections.
>
> Change to the existing statutory framework governing root cause analysis is both possible and the most effective way of providing the fairest and most powerful reform of complaints handling in NSW because it diminishes the risk of piecemeal compliance and ensures that those bodies applying root cause analysis processes are accountable.[49]

Response from NSW Health

3.20 Many of the concerns raised by AMA (NSW) and United Medical Protection regarding privilege and RCA were addressed by NSW Health in its response to questions taken on notice during the hearing on 14 September 2006. [50]

3.21 In this response, the Department stated that NSW Health facilities deal with a broad range of non clinical incidents for which this methodology is not suitable and/or privilege should not be provided. It argued that privilege should not be attached to any adverse incident review process unless there are 'compelling' public policy reasons:

> The Department recognises the need to encourage candour in staff and service provider participation in internal quality assurance processes designed to improve provision of care. The Department does not however consider this public policy rationale automatically applies to other investigative/complaints management procedures, particularly those looking at performance, staffing and conduct.[51]

3.22 The Department considers that extending privilege to 'all parts' of these types of investigations could prevent patients from gaining access to information relevant to their care. While it may be possible to design legislation to broaden coverage and widen privilege, substantial exemptions would need to be built into such legislation in order to address these concerns.[52]

3.23 NSW Health does not consider that legislation is the only means to ensure policies are complied with, nor that the status of its policy directives is uncertain, citing the following 'benefits' of using policy directives in tandem with legislation to guide and direct conduct:

- Policy directives are widely available to the community via the NSW Health website.
- Compliance with policy directives is incorporated into Area Health Services' performance agreements with the Department.

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49 Submission 13, p5-6

50 Answers to questions taken on notice during evidence 14 September 2006, Ms Robyn Kruk, NSW Health, Questions 3, 4 & 5, p3,4,5

51 Answers to questions taken on notice during evidence 14 September 2006, Ms Robyn Kruk, NSW Health, Question 4, p4

52 Answers to questions taken on notice during evidence 14 September 2006, Ms Robyn Kruk, NSW Health, Question 4, p4

- All policy directives are reviewed every five years to ensure they are relevant and appropriate.

3.24 The real test for the efficacy of the current framework for the conduct of an RCA, the Department argues, is how the system is working, noting that under Division 6C of the *Health Administration Act* the Minister is required to review the part of the Act concerning RCA teams '…to determine whether the policy objectives of the Division remain valid and whether the terms of the Division remain appropriate for securing these objectives.[53]

3.25 The review, scheduled to occur in the 12 months commencing 1 August 2008, will:

> … provide an opportunity to consider and test the concerns raised by the AMA and identify if they are in fact barriers that undermine the effectiveness of the root cause analysis process.'[54]

Committee view

3.26 The extension of privilege to all RCA investigations and to all participants involved in any way with an RCA, as proposed by AMA (NSW) and United Medical Protection, would be a far reaching reform of the Department's incident management system. While the Department has suggested that the matter will be examined in the statutory review proposed under section Division 6c of the *Health Administration Act 1982*, this is not due to commence until August 2008 - at the earliest. Given the level of concern and confusion that currently surrounds the issue of privilege, the Committee considers that an urgent review of the matter needs to be commenced immediately and completed by September 2007. This review should consider not only the extension of privilege but also the procedural fairness that surrounds RCA investigations.

3.27 Notwithstanding the results of such a review, the Committee is concerned that some practitioners may be unaware of their rights and duties in relation to incident investigations and in particular root cause analysis. The Committee supports the view of AMA (NSW) that clinicians should be more fully advised of the limitations of privilege in relation to their participation in a RCA.[55] As will be seen in Chapter 4, some stakeholders believe there is a pressing need to conduct a comprehensive education campaign for clinicians about many aspects of the new quality and safety agenda in NSW. Such a campaign should include information about the nature and extent of statutory privilege in quality assurance committees, including RCA teams. This suggestion is included in the relevant recommendation in the following chapter.

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53 *Health Administration Act, 1982,* s20U <www.austlii.edu.au/au/legis/nsw/consol_act/haa1982221/s20u.html>

54 Answers to questions taken on notice during evidence 14 September 2006, Ms Robyn Kruk, NSW Health, Question 3, p3

55 Submission 13, p2-3

Recommendation 1

That the NSW Minister for Health instigate an urgent review of the nature and extent of privilege relevant to incident investigations. The proposed review should examine:

- the possible extension of privilege in relation to incident investigations, including root cause analysis
- the methods used to ensure root cause analysis investigations are conducted with procedural fairness.

The report of this review, to be completed by September 2007, should involve key stakeholders, and be tabled in the NSW Parliament. The results of this review should be considered as part of the statutory review under Division 6C of the *Health Administration Act 1982*.

Chapter 4 Training and feedback in quality and safety issues

In implementing its quality and safety agenda, NSW Health is seeking to develop a 'culture of learning': a health system which is open about errors and in which lessons learned are shared and errors hopefully prevented. While NSW Health has undertaken significant initiatives to educate its workforce about patient safety and to ensure staff receive timely feedback on the outcomes of incident investigations, some review participants consider much more needs to be done to educate health workers about effective incident management.

The first part of this chapter discusses training needs for healthcare workers in quality and safety principles. The second part looks specifically at the need to expedite feedback to clinical staff from incident investigations.

Training in safety and quality

4.1 The Committee's earlier report *Complaints handling within NSW Health* recommended that 'all health managers in NSW undergo training in quality and safety principles, including the Open Disclosure Standard, and that this become essential for their continued employment.'[56]

4.2 NSW Health, in its submission to this review, indicated that the following progress has been made in relation to this recommendation:

- the release of an updated Incident Management Policy Directive incorporating the Open Disclosure policy based on the National Open Disclosure Standard
- the development of education and training programs by the Open Disclosure Committee
- the development, by the Clinical Excellence Commission, of quality and safety training e-modules for Clinical Practice Improvement which will become the statewide standard
- the training of over 2500 staff in root cause analysis investigative techniques. A train-the-trainer program has been developed and is currently delivering local training programs in relation to root cause analysis.[57]

4.3 The current inquiry has revealed that, despite these initiatives, concerns remain regarding training of health care workers in quality and safety principles, including open disclosure. According to the NSW branch of the Australian Medical Association (AMA) (NSW):

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56 NSW Legislative Council, GPSC2, Report 17, *Complaints handling within NSW Health*, June 2004, Recommendation 7, p35

57 Submission 2, NSW Health, p13-14.This figure was updated by the Department in evidence: as of 13 September, 3,000 staff have been trained in RCA.

> Very little is being done to educate and train existing medical practitioners in incident reporting and open disclosure.[58]

4.4 In summary, review participants consider there is a need to provide further training in the following areas:

- how to identify an adverse incident
- how to differentiate various investigative pathways
- the open disclosure process
- the conduct of root cause analysis, including how to identify instances of possible professional misconduct
- how to use the Incident Information Management System.

Identifying an adverse incident

4.5 Mr Scott Chapman, Lawyer, TressCox Lawyers and Legal Officer for AMA (NSW) believes clinicians do not fully understand what should be reported. The Association believes that this information has not been well distributed or communicated to public health organisations and practitioners. To address this issue, Mr Chapman suggested:

> … simple guidelines on how to recognise and report an adverse event and when open disclosure is necessary would assist doctors in this respect and also ensure greater consistency and co-ordination in the type of matters reported. [59]

What triggers an investigation and how to distinguish between pathways?

4.6 Ms Helen Turnbull, Legal Manager, Disciplinary Services, United Medical Protection suggested that further training is required for administrators to understand and effectively implement proper investigative methodologies in relation to adverse events:

> Our observation is the apparent lack of awareness by the administrators as to precisely what ought to trigger an investigation process and what should not. … [T]here must be a sufficient level of training for the administrator to make a sound judgement as to the significance of information provided.[60]

4.7 Ms Turnbull outlined how a single adverse medical incident may give rise to a combination of investigative pathways, such as root cause analysis, a Health Care Complaints Commission inquiry and a corporate incident investigation.[61] Ms Turnbull also noted that, although the type of document prepared for each pathway may be similar, the purpose and consequences of that documentation may differ. United Medical Protection's view is that clinicians need further

58 Submission 13, TressCox Lawyers for Australian Medical Association (NSW), p17

59 Submission 13, p18

60 Submission 12, United Medical Protection, p5

61 Submission 12, p2

training so they know why they are providing information; clinicians can then decide if information is privileged or not.[62]

4.8 During the hearing on 14 September 2006, Mr David Brown, General Manager, Claims and Legal Services, United Medical Protection expanded on the importance of the need for training for clinicians to discern different investigative pathways:

> It is often quite unclear how or why [clinicians] are being required to prepare a report or attend an interview. That is very relevant, we think, in terms of issues such as root cause analysis, open disclosure and other investigative streams within the hospital system … the difference between those different streams of investigation and complaint can be very important in terms of the nature of the process, the documents that are produced in the process and the consequence for our member … there is a lot more work to be done to ensure that clinicians are aware and confident about each of those streams.[63]

Educating doctors about open disclosure

4.9 United Medical Protection supports the principles of open disclosure and is eager for doctors to be aware of its support:

> It is essential through education and training that doctors are aware not only of the endorsement by Defence Organisations of the [Open Disclosure] Standard but also that the Defence Organisations will play a significant role in assisting members in implementing the Standard.[64]

4.10 AMA (NSW) also supports the principles of open disclosure, but feel that 'doctors' confidence in the open disclosure process may be improved by … greater clarification of the circumstances in which a matter should be disclosed to a patient and the consequences of doing so.'[65]

4.11 NSW Health informed the Committee that education and training programs for open disclosure are currently being developed by the NSW Health Open Disclosure Steering Committee[66] and that the principles of open disclosure in the management of incidents and complaints has been incorporated in the Australian Council on Healthcare Standards Evaluation and Quality Improvement Program, with the revised standards coming into effect from January 2007. As part of the implementation of the Incident Management Policy Directive, which incorporates the Open Disclosure policy, NSW Health has also been liaising with the relevant Registration Boards responsible for determining registration requirements for health care practitioners.[67]

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62 Submission 12, p3

63 Mr David Brown, Lawyer and General Manager, Claims and Legal Services, United Medical Protection, Evidence, 14 September 2006, p27

64 Submission 12, p3

65 Submission 13, p4

66 Submission 2, p14

67 Submission 2, p13

Education about root cause analysis

4.12 NSW Health reported that 'more that 3,000 NSW Health employees have been trained in incident management. This includes specific training in root cause analysis.'[68] NSW Health informed the Committee that, after undertaking a pilot training program in April 2005,[69] it has commenced "train-the trainer" courses, with over 100 health professionals now trained to train others in root cause analysis investigative techniques.[70]

4.13 Despite these initiatives, AMA (NSW) believe there is a need for:

> [a] more thorough and comprehensive educative campaign directed at new and existing health care practitioners focussing on the principles of and rationale for … RCA.[71]

4.14 Specifically, AMA (NSW) is concerned that there is a lack of clear guidelines regarding root cause analysis and a lack of detail in the current provisions.[72] AMA (NSW) considers that further training will reduce the concerns of both practitioners and consumers of health care services:

> Further education of health care practitioners as well as the public is still necessary to allay many of the concerns practitioners have about … participating in RCAs. [73]

4.15 Specific concerns about root cause analysis and the statutory privilege that applies to root cause analysis teams are discussed in Chapter 3.

Reporting possible professional misconduct

4.16 Under s20 of the *Health Administration Act 1982*, a root cause analysis team must notify a health service organisation if it considers a reportable incident raises matters that may involve professional misconduct or unsatisfactory professional conduct. Both United Medical Protection and AMA (NSW) commented on apparent confusion among their membership about this provision. According to United Medical Protection:

> Our members who have had to consider this particular section are concerned that they do not have sufficient expertise to form an opinion whether an incident may amount to professional misconduct or unsatisfactory professional conduct. UNITED accepts that there does need to be a mechanism to report certain conduct however it is submitted that alternative wording be considered with clear guidance and training on how to apply this section. [74]

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68 Ms Robyn Kruk, NSW Health, Evidence, 14 September 2006, p2

69 Submission 2, p3

70 Ms Kruk, Evidence 14 September 2006, p2

71 Submission 13, p4

72 Submission 13, p5

73 Submission 13, p20

74 Submission 12, UMP, p5

4.17 AMA (NSW) commented on the:

> … lack of clear guidelines directing how and when a matter which is the subject of an RCA may involve the practitioner being referred to the Health Care Complaints Commission and or the NSW Medical Board and how these processes will interrelate.[75]

4.18 In response to these concerns, NSW Health informed the Committee that the responsibility of a root cause analysis team to refer a matter to the appropriate disciplinary processes is clearly stated in the revised Incident Management Directive. Under the policy, the team is responsible for referring the matter to the Chief Executive, who decides on the appropriate action to take. According to the Director General of NSW Health, Ms Robyn Kruk:

> I am advised that there have been no complaints received from health services about the process of informing the Chief Executive of matters of individual performance since the first release of the Incident Management Policy Directive in August 2005.[76]

Specific concerns about the Incident Information Management System

4.19 The introduction of the Incident Information Management System across all Area Health Services is a major initiative under the Patient Safety and Clinical Quality Program.[77] NSW Health informed the Committee that training modules for the use of this system include awareness training for all staff on how to notify an incident, on-line training via the internet for specified users and administrator training for staff required to manage logins and security issues.[78] Notwithstanding this training, NSW Health is aware of some dissatisfaction regarding the recording and finalisation of information in the Incident Information Management System, and acknowledges the need for further training:[79]

> Ongoing education and training remains a high priority, as with any new information system implemented of this size – particularly where there is high staff mobility as in the public health system, and this work is continuing.[80]

4.20 Among the participants to raise specific concerns regarding the Incident Information Management System was the New South Wales Nurses' Association. According to its General Secretary, Mr Brett Holmes, inconsistency in the implementation of the Incident Information Management System may reflect a lack of training:

> Our members have also brought to our attention a number of issues regarding the Incident Information Management System (IIMS). Most of the issues relate to the

75 Submission 13, AMA, p5

76 Answers to questions on notice taken during evidence 14 September 2006, Ms Robyn Kruk, Director General, NSW Health Question 5, p5

77 Ms Kruk, Evidence, 14 September 2006, p2

78 Answers to questions on notice taken during evidence 14 September 2006, Ms Robyn Kruk, Question 1, p1

79 Submission 2, p2

80 Answers to questions on notice taken during evidence 14 September 2006, Ms Robyn Kruk, Question 1, p1

> inconsistent implementation of IIMS. This may reflect a lack of sufficient training and education. We recommend that further training and education be conducted to ensure standardised implementation of IIMS. There are many inconsistencies across Area Health Services in relation to IIMS reporting. The NSWNA recommends instigation of consistent education, training, and implementation processes across the state.[81]

Feedback on the outcomes of an incident investigation

4.21 NSW Health recognises that the success of its quality and safety agenda rests, in part, on the provision of timely feedback to staff on the outcomes of incident investigations:

> The success of incident management is dependent on feedback to all staff on the results/outcomes of investigations in a timely manner. Staff involved in the incident need to be informed of the recommendations arising from any investigation.[82]

4.22 AMA (NSW) regards feedback as 'crucial if the reporting process is to be regarded as a valuable tool for risk management and implementing change.'[83] Mr Scott Chapman, Legal Officer for AMA (NSW), complimented the Department on the level of communication between the Department and health services:

> AMA (NSW) regards the present flow of information from the NSW Health Department to public health organisations on critical clinical pathways, better practice guidelines, treatment regimes and public health issues to be extensive, relevant and commendable. This is consistent with and conducive to a strong culture of learning and willingness to share information promoting good medical practice.[84]

4.23 Notwithstanding some positive developments, specific concern was also expressed by AMA (NSW) regarding feedback in relation to root cause analysis processes:

> Whilst the systems are being improved, there is still a widespread perception that the reporters and staff involved in an adverse event are not given sufficient, if any, feedback on the [RCA] investigation and its outcomes and that there is a lack of timely feedback.[85]

4.24 Mr Allen Thomas, Director, Medico-legal, Strategic Policy and Training, AMA (NSW) stated that while the outcomes of a root cause analysis investigation may be reported to the chief executive, anecdotal evidence suggests that 'information does not flow back to the clinicians at the coalface'.[86] Given the serious nature of incidents that give rise to a root cause analysis, AMA (NSW) is concerned with the apparent lack of impetus:

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81 Submission 9, New South Wales Nurses' Association, General Secretary, p1

82 NSW Health Policy Directive - Incident Management Policy, p20

83 Submission 13, p19

84 Submission 13, p16

85 Submission 13, p19

86 Mr Allen Thomas, Director, Medico-legal, Strategic Policy and Training, AMA (NSW), Evidence, 14 September 2006, p20

> …. if you are going to have these processes, hopefully for educative purposes there needs to be feedback to not only individual clinicians but area health services and hospitals to allow them to compare and contrast themselves to what is occurring in other parts of the State. We do not believe there is enough impetus at that final end of the process now.[87]

4.25 Concerns about feedback are not limited solely to root cause analysis investigations. The Incident Information Management System allows for information to be collected about all level of incidents. Feedback related to these matters is also required to make systemic changes, as Mr Thomas noted:

> All outcomes are not necessarily from RCA matters that require action … What we are concerned about is that there does not appear to be enough of that flowing back to the clinicians.[88]

4.26 In some instances feedback is provided but it is not timely. Mr Thomas made the following suggestion to improve the timeliness of feedback from incident reports:

> A better process would be to have critical timelines, that is, once the [investigation] report comes out there would be a timeline for making that available to the persons involved rather than perhaps a discretionary overview that can be taken by a chief executive, as occurs at the moment.[89]

4.27 It would appear that the concerns expressed by review participants in September 2006 regarding timely feedback from root cause analysis investigations can be confirmed by figures from the Clinical Excellence Commission. In August 2006, the Commission reported that only 25% of root cause analysis reports were completed within the 70 day timeframe required by the Department, and that the quality of recommendations were 'variable and often weak'.[90] Updated statistics from NSW Health demonstrate a significant improvement in the timeliness of root cause analysis reports: by October 2006, 74% of root cause analysis reports were received within the stipulated timeframe.[91]

4.28 NSW Health informed the Committee that it has undertaken several other initiatives to improve the flow of information from an incident investigation, including root cause analysis, to health workers. These include:

- The annual publication of a report on incident management in the NSW Public Health System.
- The establishment of Clinical Governance Units. These units work closely with health services to assist clinicians to review their incident data and to develop initiatives to ensure the incident information is being communicated back to clinical staff.

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87 Mr Thomas, Evidence, 14 September 2006, p20

88 Mr Thomas, Evidence, 14 September 2006, p21

89 Mr Thomas, Evidence, 14 September 2006, p21

90 Michael, S, Ryan K and Hughes C, *Raising the Bar in Incident Management – A State Journey,* poster presented at the 4th Australasian Conference on Safety and Quality in Health Care 21-23 August 2006, Melbourne, tabled by Professor Hughes, 14 September 2006

91 Email from Mr Matt Monahan, NSW Health, 31 October 2006

- Increased staff access to incident data via the Incident Information Management System, newsletters to inform services of remedial activity arising from incident investigation and the conduct of audits to determine the scope of discussion of incident management data.
- The presentation of trended data from Incident Information Management System to clinical staff at ward and other quality/patient safety meetings and ongoing staff education throughout Area Health Services regarding the management of incidents.
- The development of an interactive website as part of its 'Lessons Learned Strategy' which allows health service staff to develop, publish, access and respond to patient safety strategies and techniques in a timely manner. The website is designed to become a point of first referral on organisational and practice issues related to patient safety, and to allow services to compare their own strategies and approaches with other services across the State.
- The introduction of the Safety Alert Broadcast System introduced by NSW Health in 2006. The system provides early and rapid warning of issues affecting patient safety and clinical quality. Each health service is required to confirm with the Department the action that has been taken in response to each alert. [92]

Committee view

4.29 If clinicians and health care workers at all levels are to actively participate in effective incident management, it is essential that they be well trained in how to work within the Department's new Incident Management Program.

4.30 This review has identified a pressing need to expand and accelerate training for health care practitioners in quality and safety issues, in particular, how to use the Incident Information Management System, as well as the investigative techniques pertaining to root cause analysis.

4.31 Timely feedback to staff is a critical feature of a successful incident management system. While the Committee acknowledges there have been improvements in the timeliness of reports generated by RCA investigations, these comprise only a small proportion of all incident investigations. The review has revealed frustration among some health care staff that the outcomes of incident investigations are not adequately communicated back to them in a timely manner.

4.32 The setting up of a large training system for reporting and analysis of adverse events can distract from the efforts and resources need to prevent them. It is essential that the resources, skills and actions within the clinical workplace are maintained and improved.

[92] Answers to questions on notice taken during evidence 14 September 2006, Robyn Kruk, Director General, NSW Health, Question 7, p9-10

Recommendation 2

That NSW Health, in conjunction with the Clinical Excellence Commission, undertake a review of the level and timeliness of feedback provided to staff following the investigation of an incident.

That this review be completed by July 2007.

Recommendation 3

That NSW Health expand and accelerate training programs in quality and safety issues for health care staff in relation to:

- the identification of health care incidents
- how to distinguish between investigative pathways
- the principles of open disclosure
- the use of the Incident Information Management System
- root cause analysis, including the application of privilege.

Chapter 5 Public awareness campaign on adverse events

This chapter discusses a key recommendation in the Committee's previous report concerning the conduct of a public awareness campaign to inform the community about safety and quality issues. While NSW Health has undertaken important initiatives to enhance community understanding of its patient safety and quality agenda, it has not undertaken such a campaign. This chapter examines the response by the NSW Government and NSW Health regarding this recommendation.

Need for a public awareness campaign

5.1 In its previous report *Complaints handling within NSW Health*, this Committee recommended that the proposed Clinical Excellence Commission, in conjunction with NSW Health, undertake an extensive public education campaign to inform the community about:

- simple steps to make health care complaints
- the nature and extent of adverse events in the health care system
- realistic expectations of health care
- changes to the regulatory framework for health care complaints and consumer rights.[93]

5.2 In its response to the report, the Government expressed its support for a public education campaign, stating that 'informing the community about adverse events and the organisation of health care delivery systems will greatly help the community understand the limitations of medical science.'[94] It further advised that:

> [t]he CEC, the HCCC and the NSW Department of Health will jointly undertake an education campaign on the issues listed … [t]he Government will ask these agencies to ensure the education campaign is appropriate to meet the different needs of clinicians and the general community.[95]

5.3 During the current review, NSW Health and the Clinical Excellence Commission stated its support for this recommendation and informed the Committee that the following initiatives were in progress to address this issue:

- The complaints management policy has been updated by a working party of senior managers for each Area Health Service, Justice Health, NSW Ambulance Service, the Children's Hospital and the Clinical Excellence Commission.

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93 NSW Legislative Council, GPSC 2, Report 17, *Complaints Handling within NSW Health*, June 2004, p36

94 NSW Government Response to the Legislative Council GPSC 2 inquiry into Complaints handling within NSW Health, p13

95 NSW Government Response to the GPSC 2 inquiry into Complaints Handling within NSW Health, p13

- The publication of two annual reports on incident management in public hospitals.
- NSW Health is distributing the Australian Council for Safety and Health Care booklet "10 Tips for Safer Health Care: What everyone needs to know" via the NSW Health Quality and Safety internet site.
- Each Area Health Service has established Health Care Advisory Councils to increase clinician, consumer and community involvement in planning and delivery of health services.
- Clinical Excellence Commission has undertaken a needs analysis on the best way to engage the community regarding safety and the quality of health care.
- Planned establishment of a Citizens Engagement and Advisory Committee (CEAC) to engage the community about safety and quality of health care. The committee will be comprised of community members with the skills to increase the capacity of the Clinical Excellence Commission to inform and meet community expectations. Expressions of interest for membership are to be sought in November 2006.
- A National Summit on Adverse Events to inform the community about key events to be held in 2007.
- *Frequently Asked Questions* and *Fact Sheets*, on safety and quality issues are now available.[96]

5.4 While acknowledging the distribution of the Australian Council for Safety and Health Care booklet "10 Tips for Safer Health Care: What everyone needs to know," the Australian Medical Association (AMA) (NSW) stated that:

> [T]his document does not discuss open disclosure, nor does it attempt to educate health consumers about the importance of a no-blame culture … it does little to promote more realistic community expectations about what medicine can deliver, its limitations and its susceptibility to error, even when undertaken by competent, well intentioned practitioners.[97]

5.5 Despite assurance by NSW Health that these initiatives are addressing the Committee's recommendation, some organisations questioned whether a public awareness campaign has been conducted. According to Ms Rosemary Bryant, Executive Director, Royal College of Nursing Australia:

> … we would expect that we would have also been made aware of an adverse event/complaints and consumer rights campaign if it were occurring. RCNA has kept a watching brief on the CEC website and has not seen any public information regarding complaints handling.[98]

5.6 Mr Scott Chapman, Legal Officer for AMA (NSW) stated that the need for such a campaign is still apparent:

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96 Submission 2, NSW Health, p15 and 16 and Answers to questions taken on notice during evidence 14 September 2006, Ms Robyn Kruk, Director General, NSW Health, Question 6, pp 6&8

97 Submission 13, TressCox Lawyers for AMA (NSW), p19

98 Submission 10, Royal College of Nursing, Australia, p2

> Further education of health care practitioners as well as the public is still necessary to allay many of the concerns practitioners have about open disclosure and participating in RCAs and to level some of the unrealistic expectations health consumers continue to hold in relation to what medicine can deliver.[99]

5.7 The Chairman of the Royal Australian College of Surgeons (RACS), Mr Phillip Truskett, expressed support for a public education campaign:

> The RACS supports all efforts to improve performance and evaluation including the proposal for the Clinical Excellence Commission to undertake an extensive public education campaign to inform the community regarding the nature and extent of adverse events, complaints processes and the realistic expectations of health care within NSW.[100]

5.8 Ms Bryant also agrees with the continued need for such a campaign and stated: 'We look forward to this taking place'.[101]

Committee view

5.9 Public awareness of and confidence in patient safety initiatives is crucial to the successful implementation of a quality agenda. The release of GPSC 2's Report into Complaints handling in NSW Health, and that of the Walker inquiry, in 2004, generated significant momentum in the patient safety agenda. It would be highly regrettable if this momentum were to dissipate, especially in relation to educating health consumers about their rights and responsibilities under the new system.

5.10 While the Committee welcomes the awareness raising initiatives documented by NSW Health in its submission, the need for an extensive public awareness campaign remains. The Committee therefore reiterates the view expressed in its previous report that the Department, in conjunction with the Clinical Excellence Commission, implement an extensive public education campaign within the next 12 months, to increase awareness of adverse incidents and promote realistic public expectations of the health care system.

Recommendation 4

That the Clinical Excellence Commission in conjunction with NSW Health undertake an extensive public education campaign within the next 12 months to inform the community about:

- simple steps to make health care complaints
- the nature and extent of adverse events in the health care system
- realistic expectations of health care
- changes to the regulatory framework for health care complaints and consumer rights.

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99 Submission 13, p20

100 Submission 6, Royal Australasian College of Surgeons, p2

101 Submission 10, p2

Chapter 6 Public access to incident reports

This chapter discusses access to reportable incident briefs concerning serious clinical incidents, as well as the publication of annual incident management reports.

Reportable incident briefs.

6.1 Serious health care incidents, both clinical and corporate, must be reported to NSW Health via the Incident Information System and reportable incident briefs. Reportable incident briefs include: all of the known facts and background information about a particular incident, the reasons for reporting an incident, and an initial analysis. The brief needs to include a SAC score, ranging from SAC 1 (the most serious) to SAC 4 (least serious). Reportable incident briefs must be de-identified and are treated as confidential documents.[102]

6.2 Reportable incident briefs concerning SAC 1 clinical incidents are sent to the Reportable Incident Review Committee.[103] These incidents are defined as 'reportable incidents' under the *Health Administration Act 1982*.

Reportable Incident Review Committee

6.3 The Reportable Incident Review Committee was established two years ago to ensure that all SAC 1 reportable incident briefs were sent to an appropriate point with a view to:

> … examining and monitoring serious clinical incidents within the health system and overseeing investigations, identifying issues relating to morbidity and mortality that may have statewide implications, and providing advice and policy development to affect health care system improvement.[104]

6.4 Until recently, the proceedings of this committee did not attract statutory privilege and copies of the reportable incident briefs were available as a public document, as noted in the Department's Incident Management Policy Directive, as at May 2006:

> The advanced classification information in IIMS [in relation to SAC 1 incidents] is not subject to statutory privilege … and is therefore available to the Department as a public document.[105]

6.5 This changed, however, on July 29 2006 when the Health Minister, the Hon John Hatzistergos MLC, gazetted the following order under the *Health Administration Act 1982*:

> I …. authorise the NSW Health Reportable Incident Review Committee to conduct research and investigations into morbidity and mortality in NSW in relation to certain

102 NSW Health Policy Directive: Incident Management Policy p22

103 Ms Kruk, Evidence, 14 September 2006, p7

104 Ms Kruk, Evidence, 14 September 2006, p4

105 NSW Health Policy Directive: Incident Management Policy www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_030.pdf, p10 accessed 6 October 2006

> adverse clinical incidents within NSW . … I further authorise that the privilege arising from this authority shall apply on and from 14 December 2004, being the date that Committee was established.[106]

6.6 It is understood that the effect of this gazettal is to confer privilege on the Review Committee, and that this privilege encompasses the reportable incident briefs sent to the committee (that is, SAC 1 'reportable incidents'). This effectively prevents the public release of reportable incident briefs in relation to serious clinical incidents. Non clinical incidents, such as staff issues and matters of individual misconduct, are not classified as 'reportable incidents' under the *Health Administration Act 1982*, even if they are accorded a SAC 1 rating, and therefore do not attract statutory privilege.[107]

6.7 According to Ms Robyn Kruk, Director General, NSW Health, the extension of privilege now gives the Reportable Incident Review Committee the same privilege that has applied to similar quality assurance committees for more than 25 years.[108]

Access to reportable incident briefs

6.8 During the hearing on 14 September 2006, a number of questions were raised about the recent extension of privilege to the Reportable Incident Review Committee and whether reportable incident briefs should be publicly available. The issue received media attention during September 2006, following unsuccessful attempts to access reportable incident briefs under the *Freedom of Information Act 1989*.[109]

6.9 In reply, the Director-General of NSW Health, Ms Robyn Kruk, stated that privilege had been granted in response to the concerns of health care practitioners and users,[110] noting that the need for a 'culture of openness, which allows staff to report errors in confidence without fear of reprisal or public humiliation, is critical to an effective incident reporting system'[111]:

> … we are endeavouring to strike an appropriate balance between providing health professionals with sufficient protection so that we can encourage them to report and participate frankly in reviewing incidents with the need for transparency and ongoing reporting.[112]

6.10 Although reportable incident briefs in relation to serious clinical incidents are no longer available to the public, NSW Health assured the Committee that transparency is nonetheless facilitated by:

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106 *Government Gazette of the State of New South Wales* 2006, No 95, Sydney, 29 July

107 Answers to questions taken on notice during evidence 14 September 2006, Ms Robyn Kruk, Director General, NSW Health, Q4, p4

108 Ms Kruk, Evidence, 14 September 2006, p7

109 'Hospitals gagged over errors,' *Sydney Morning Herald*, 11 September 2006, p5*;* Openness in hospital errors vital, say critics*,*' *Sydney Morning Herald*, 12 September 2006, p6

110 Ms Kruk, Evidence, 14 September 2006, p4

111 Ms Kruk, Evidence, 14 September 2006, p4

112 Ms Kruk, Evidence, 14 September 2006, p5

- making root cause analysis reports available to patients and their families
- publishing de-identified, aggregated data on an annual basis, detailing serious clinical incidents and the measures that have been taken to address these issues
- extending the information provided in these annual reports by including the number and type of all incidents reported through the Incident Information Management System, not just serious clinical events.[113]

6.11 Ms Kruk also informed the committee that NSW Health had met with the NSW Ombudsman in relation to the 'appropriate controls that should be in place surrounding reportable incident briefs and…reporting generally.'[114]

> The Ombudsman has in personal discussions with me, been very supportive of the need to protect the integrity of the system and to ensure we have the continuing engagement of the clinicians. He made that comment on the clear understanding that we would publicly report …. [and] that the patient … has total access to the outcome of any RCA.[115]

6.12 During the hearing it was noted that the recent request made under Freedom of Information legislation was for *de-identified* copies of the reportable incident briefs. Ms Kruk responded that de-identification of reportable incident briefs for these reports is 'not as simple as blacking out a name'. [116] It is also about preserving patient privacy and clinician willingness to participate in the process:

> It goes back to what sits at the heart of the preparedness of a clinician to actually actively participate … there is an issue of individual patient privacy, which I think is quite critical, but there is also the preparedness of an individual to put their hand up and say … they have a concern about the conduct of a colleague or a particular piece of equipment.[117]

6.13 The Committee received very little evidence about this issue from other stakeholders, as it only arose just prior to the Committee hearing on 14 September 2006. While the Royal College of Nursing, Australia made the following comment:

> … the summaries and reports of the reportable incidents briefs should not be privileged. Provided that the reports are de-identified, we consider that consumers of healthcare and their families should be able to have access to these documents.' [118]

6.14 It is not clear from their statement whether they think such information should only be available to patients and their families or to the public at large.

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113 Ms Kruk, Evidence, 14 September 2006, p5

114 Ms Kruk, Evidence, 14 September 2006, p7

115 Ms Kruk, Evidence, 14 September 2006, p8

116 Ms Kruk, Evidence, 14 September 200, p 8

117 Ms Kruk, Evidence, 14 September 2006, p8-9

118 Answers to questions taken on notice during evidence 14 September 2006, Ms Rosemary Bryant, Executive Director, Royal College of Nursing, Australia (RCNA), p1

Public reporting of incident management by NSW Health

6.15 One of the issues raised during the Committee's hearing on 14 September 2006, was the frequency of the publication of statewide incident reports.

6.16 For the past two years NSW Health has published aggregated data relating to serious clinical incidents in its 'Annual report on incident management in the NSW public health system'.[119] Plans are also underway to produce the first annual public report on *all* clinical incidents (not just serious incidents) occurring in the health system.[120]

Frequency of public reporting

6.17 According to Ms Kruk, aggregated incident data is published annually because:

> … it gives you the opportunity to look at trends. It gives you the opportunity to get a very detailed picture of where major vulnerabilities are on a systemwide basis.[121]

6.18 Mr David Brown, Lawyer and General Manager, Claims and Legal Services, United Medical Protection was asked to comment on the ideal frequency of these reports:

> I think you need a period of time in which to spot a trend. I think reporting has to be about system trends. … I do not think … there is any … point in reporting publicly the outcomes of RCAs immediately after the event … I do not think there is any particular benefit in that.[122]

6.19 AMA (NSW) was also asked to reflect on this issue:

> … generally my view of trends is that they need to be looked at over a period of time for a trend to be established. The shorter the period, even though there may be a movement in the trend, [it] may be of little statistical significance.[123]

6.20 Ms Elizabeth Foley, Director Policy, Royal College of Nursing Australia told the Committee that the first priority should be to provide information in a timely manner to those involved in a health care incident:

> I think it is academic discussing time frames … The important thing is the process of open disclosure at the time, so those people immediately involved in the incident get resolution … that is much more important than the time frame in which the public might hear about the incident.[124]

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119 Submission 2, NSW Health and Clinical Excellence Commission, p4. These reports can be found at www.health.nsw.gov.au/pubs/a-z/a.html

120 Answers to questions taken on notice during evidence 14 September 2006, Robyn Kruk, NSW Health, Question 6, p9

121 Ms Kruk, NSW Health, Evidence, 14 September 2006, p9

122 Mr Brown, Evidence, 14 September 2006, p32

123 Mr Allen Thomas, AMA (NSW) Evidence, 14 September 2006, p21

124 Ms Elizabeth Foley, Director Policy, Royal College of Nursing Australia, Evidence, 14 September 2006, p41

6.21 Ms Foley, commented on the need to balance resource management with the preparation of these reports:

> … we want to make sure that any reporting process does not cause a burden to people, and the reports can be prepared in a timely manner and sensible consideration can be given to making sure that reports are giving information that people need, rather than putting pressure on people to spend all their days collecting data and not being able to do any other work around that. [125]

6.22 Ms Kruk subsequently informed the Committee that quarterly incident reports from the NSW Health Quality and Safety Branch were under consideration.[126]

Committee view

6.23 The Committee recognises that an effective incident management system must protect the privacy of health care workers and consumers, while ensuring the system is transparent and accountable. The Committee welcomes the Department's plans to publish aggregated data for *all* clinical incidents.

6.24 The Committee acknowledge the need to examine trends in relation to health care incident data. The Committee is also mindful of the need to ensure incident reports allow for public scrutiny and transparency. The Committee therefore recommends more frequent reporting of incident data to allow for greater transparency.

6.25 The Committee appreciates that to be effective, the activities of quality assurance initiatives, such as the Reportable Incident Review Committee and root cause analysis teams should be covered by statutory privilege. Please see Recommendation 1, Chapter 3.

Recommendation 5

That NSW Health publish Incident Management Reports on a biannual basis.

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125 Ms Foley, RCNA, Evidence, 14 September 2006, pp40-41

126 Answers to questions taken on notice during evidence 14 September 2006, Robyn Kruk, NSW Health, Question 10, p16

Appendix 1 Submissions

No	Author
1	Mr Kieran Pehm (Health Care Complaints Commission)
2	Ms Robyn Kruk (NSW Health) & Professor Clifford Hughes (Clinical Excellence Commission)
3	Mr Steve Lewis
4	Ms Fiona Murphy
5	Name suppressed
6	Mr Phillip G Truskett (Royal Australasian College of Surgeons)
7	Mr Brian Johnston (Australian Council on Healthcare Standards)
8	Confidential
9	Mr Brett Holmes (NSW Nurses' Association)
10	Ms Rosemary Bryant (Royal College of Nursing, Australia)
11	Dr Yolande Lucire (Forensic & Medico-Legal Psychiatry, Akathisia Clinic)
12	Ms Helen Turnbull (United Medical Protection)
13	Mr Scott Chapman (Australian Medical Association (AMA))
14	Name suppressed
15	Confidential
15a	Confidential

Appendix 2 Witnesses

Date	Name	Position and Organisation
Thursday 14 September 2006	Ms Robyn Kruk	Director-General, NSW Health
	Prof. Clifford Hughes	Chief Executive Officer, Clinical Excellence Commission
	Mr Allen Thomas	Director, Medico-Legal Strategic Policy & Training, Australian Medical Association (AMA) NSW
	Mr Scott Chapman	Tresscox lawyer, Australian Medical Association (AMA)
	Ms Helen Turnbull	Legal Manager, Disciplinary Services, United Medical Protection
	Mr David Brown	General Manager, Legal Division, United Medical Protection
	Ms Rosemary Bryant	Executive Director, Royal College of Nursing, Australia
	Ms Elizabeth Foley	Director, Policy & Strategic Developments, Royal College of Nursing, Australia
	Mr Robert O'Donohue	Director, Royal College of Nursing, Australia

Appendix 3 Recommendations – Inquiry into complaints handling within NSW Health

Recommendation 1

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council whether the criteria used by the Australian Council on HealthCare Standards in its accreditation surveys of health services is an appropriate measure of quality.

Recommendation 2

That NSW Health discuss with the relevant health professional bodies in New South Wales to ensure that all training programs incorporate competencies regarding quality and safety issues, including the Open Disclosure Standard, as part of the registration process.

That evidence of ongoing professional development in these issues should be an essential requirement of registration.

Recommendation 3

That Area Health Service boards formally adopt the principles of open disclosure via performance agreements with NSW Health and affirm their commitment to the full implementation of the Open Disclosure Standard developed by the Australian Council for Safety and Quality in Health Care.

Recommendation 4

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council the possible elevation of complaints handling in the Evaluation and Quality Improvement Program, conducted by the Australian Council on Healthcare Standards.

Recommendation 5

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council incorporation of the Open Disclosure Standard in the current version of the Evaluation and Quality Improvement Program conducted by the Australian Council on Healthcare Standards.

Recommendation 6

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council the provision of an annual update on the implementation of the Open Disclosure Standard, for the first two years following its incorporation into the Evaluation and Quality Improvement Program conducted by the Australian Council on Healthcare Standards.

Recommendation 7

That as part of their performance agreements all health managers in NSW undergo training in quality and safety principles, including the Open Disclosure Standard, and that this become an essential requirement of their continued employment.

Recommendation 8

That the proposed Clinical Excellence Commission in conjunction with NSW Health undertake an extensive public education campaign to inform the community about:

- simple steps to make health complaints
- the nature and extent of adverse events in the health care system
- realistic expectations of health care
- changes to the regulatory framework for health care complaints and consumers rights.

Recommendation 9

That NSW Health publish comparative data on adverse events in Area Health Services across New South Wales in Annual Reports and on its Website.

Recommendation 10

That the New South Wales Government convene a summit on medical adverse events within the next 12 months.

Recommendation 11

That a suitable mechanism be identified by NSW Health to ensure the results of accreditation surveys conducted by the Australian Council on Healthcare Standards be provided to the Department within two weeks of their completion.

Recommendation 12

That NSW Health publish all accreditation reports prepared by the Australian Council on Healthcare Standards and any rectification reviews prepared by health services in response to these reports.

Recommendation 13

That NSW Health take steps to ensure senior health managers are aware of the existing protocols in relation to notifying family members about the referral of a death to the Coroner.

Recommendation 14

That NSW Health implement a State-wide protocol to ensure that the patient or next of kin of a patient whose treatment is the subject of a Root Cause Analysis is informed of the conduct and results of this analysis by a suitable clinician.

Recommendation 15

That the NSW Clinical Excellence Commission conduct a study on the feasibility of introducing mandatory reporting of all or certain classes of incidents to health service management and to the Department of Health.

Recommendation 16

That NSW Health ensure that in all area health services each clinical team should have regular review meetings on a protocol set up by management and audited by the Clinical Excellence Commission.

Recommendation 17

The Health Care Complaints Act 1993 and the Protected Disclosures Act 1994 be amended to protect the identity of whistleblowers when they require it and to provide protected disclosure safeguards for health practitioners, including nurses in both the public and private sectors.

Recommendation 18

That the NSW Medical Board be asked to clarify why the practitioner who treated Mrs Daly-Hamilton has not been referred to the South Australian Medical Board.

Recommendation 19

That the proposal to split responsibility for the investigation of systemic and individual complaints between the Clinical Excellence Commission and the Health Care Complaints Commission, be reassessed following the release of the final report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals.

Appendix 4 Government response – Inquiry into complaints handling within NSW Health

NSW Government Response to the Legislative Council General Purpose Standing Committee No. 2 inquiry into Complaints Handling within NSW Health

Introduction

The NSW Legislative Council General Purpose Standing Committee No. 2 (GPSC No.2) announced its inquiry into complaints handling procedures within NSW Health in December 2003, and self referred the following terms of reference.[1]

That the General Purpose Standing Committee No. 2 inquire into and report upon the complaints handling procedures within NSW Health, and in particular:

- *the culture of learning and the willingness to share information about errors and the failure of systems, and*
- *an assessment of whether the system encourages open and active discussion and improvement in clinical care.*

The Committee initiated the inquiry following the release of the Health Care Complaints Commission report into Campbelltown and Camden Hospitals; its members sought to examine systemic issues relevant to complaint handling.[2]

Revd Hon Dr Gordon Moyes MLC chaired the Inquiry.

The Committee called for submissions in late December 2003 and late January 2004 through advertisement in major metropolitan and regional newspapers and by writing to relevant individuals and organisations. The Committee received 71 submissions, and held eight public hearings involving 70 witnesses during 12 March to 21 May 2004.[3]

The Committee handed down 19 recommendations in its report released on 24 June 2004 under the following chapter headings:

- Developing a culture of learning (Chapter 3)
- Whistleblower issues in south west Sydney (Chapter 4)
- Conclusion (Chapter 6)

There were two dissenting reports made by four of the seven Committee members (Appendix 5 of the Report).

The recommendations extended beyond specific complaints handling processes. The focus in the report is on broader issues including accreditation; open disclosure; adverse events; staff training and competency; notification to patient, and or next of kin; community awareness; provisions to protect complainants; as well as one specific recommendation concerning referring a practitioner to the South Australian Medical Board.

The remainder of this section introduces the Government's response to the report and recommendations. The next section reports on recent Government initiatives to improve safety and quality in NSW Health. These initiatives respond to the findings and recommendations of the Special Commission of Inquiry into Campbelltown and Camden Hospitals. The initiatives are also integral to the Government's response to the GPSC No. 2's recommendations on complaints handling within NSW Health. A detailed response to each of the Committee's recommendations commences on page 9.

[1] General Purpose Standing Committee No. 2 *Complaints handling within NSW Health*, Report 17 – June 2004, page iv.
[2] ibid, p. 1
[3] ibid, pp. 86-92

Introduction

The NSW Government welcomes the Committee's report and its contribution to improving complaints handling processes in NSW Health. Open and thorough discussion of issues is important, and a key step in improving the quality of the systems through which we deliver services to the community. This Government is seeking to develop a health system where health practitioners proactively and openly provide patients and their families with timely and frank information when an adverse event has occurred.

The Government particularly supports the process of external and independent review of health services. However, with respect to the six recommendations relating to accreditation, the Government's view is that priority should be given to researching and developing knowledge about the impact of accreditation on the safety and quality of care in health service organisations, and the link between accreditation status and quality of care. This is a broader view of the approach taken by the Committee in Recommendation 1, which questions whether the criteria used by the Australian Council on HealthCare Standards (ACHS) in its accreditation surveys of health services is an appropriate measure of quality. In addition, the ACHS is only one of a number of accreditation providers. The Government's response to recommendations relating to accreditation is discussed later in this report.

The NSW Government supports informing the public and community about health care delivery including adverse events however, the recommendation to publish comparative data is not supported (Recommendation 9). The reasons for this are presented later in the response.

The Government plans to publish a report on serious incidents that have been reported to the NSW Department of Health by public health organisations as part of their compliance with existing reporting requirements. The report will focus on the causes of incidents and the improvements to the health system that have been possible because incidents were reported.

The Government supports open disclosure and has endorsed the National Open Disclosure Standard prepared by Standards Australia for the Australian Council for Safety and Quality in Health Care. NSW Health has committed to participate in the pilot of the open disclosure standard, and will have project sites in five Area Health Services across New South Wales.

However, the Australian Council for Safety and Quality in Health Care advised in September 2004 that the pilot has been placed on hold due to the need to resolve legal and liability issues. The next workshop about the pilot is planned for late February / early March 2005. The duration of the pilot projects is subject to current review through AHMAC but is anticipated to be 18 months, with evaluation built into the pilot projects and conducted by an independent organisation.

The Government will consider the Committee's recommendations about open disclosure following the completion of the evaluation of the pilot projects. In the mean time, the Government has tasked the CEC with responsibility for developing or identifying suitable providers of training on Root Cause Analysis and communication to ensure that appropriate disclosure occurs with patients and next of kin regarding adverse events.

Recent initiatives in patient safety and quality of services

A number of significant initiatives focussed on patient safety and quality of health services across New South Wales have been announced and are being implemented. The key organisations charged with responsibility for patient safety and clinical quality in NSW are the Clinical Excellence Commission, the Health Care Complaints Commission, the NSW Department of Health, and public health organisations.

Clinical Excellence Commission

In the 2004/2005 State Budget, the NSW Government committed $10 million to establish the Clinical Excellence Commission (CEC) to develop evidence-based programs for better clinical governance in NSW. This commitment is part of a $55 million four-year strategy.

The CEC is established as a statutory health corporation (formerly the Institute for Clinical Excellence), in accordance with section 41 of the *Health Services Act 1997*. The new CEC will continue and extend the work undertaken by the NSW Institute for Clinical Excellence to improve standards of care across NSW.

The CEC has a central and pivotal role in NSW Health's organisational structure and systems for patient safety and clinical quality. The CEC's core mission is to identify systems issues that affect patient safety and clinical quality in the NSW health system, and develop and advise on strategies to address these issues.[4]

The CEC will provide advice to the Minister for Health and the NSW Department of Health on the status of safety and quality of healthcare in the NSW health system. It will:

- Promote and support improvement in clinical quality and safety in public and private health services.
- Monitor clinical quality and safety processes and performance of public health organisations and report to the Minister for Health thereon.
- Identify, develop and disseminate information about safe practices in health care on a state wide basis, including and not limited to:
  - Developing, providing and promoting training and education programs.
  - Identifying priorities for and promoting the conduct of research about better practices in health care.
- Consult broadly with health professionals and members of the community in performing its functions.[5]

The CEC will not be involved in investigations regarding individual health practitioners. If the CEC receives complaints about individuals or organisations it will refer them to the appropriate public health organisation or the Director-General, NSW Health.[6]

[4] NSW Health, August 2004, *NSW Clinical Excellence Commission Directions Statement*, p.4
[5] ibid. p.3
[6] ibid. p.4

Recent initiatives in patient safety and quality of services

Ian O'Rourke PhD Scholarship

The Government established the Ian O'Rourke PhD Scholarship in Patient Safety as part of the four-year $55 million program aimed at improving clinical quality and patient safety in NSW. The scholarship is named in honour of the Chief Executive Officer of the former NSW Institute for Clinical Excellence.

The annual scholarship is $35,000. The successful scholar awarded the scholarship will work with the Clinical Excellence Commission to further the essential work that Dr O'Rourke commenced during his time at the Institute for Clinical Excellence. Dr O'Rourke was passionate about the work he undertook at the Redfern Medical Centre and in the Northern Territory where he worked for five years with Aboriginal communities, particularly in the treatment of diabetes. The Scholarship will have a focus on quality improvement as it relates to indigenous health.

NSW Health Care Complaints Commission

The Health Care Complaints Commission (HCCC) is an independent body established under the *Health Care Complaints Act 1993*. The HCCC's role is to investigate and prosecute serious complaints about health practitioners and health organisations, in consultation with relevant health professional registration authorities.

The Special Commission of Inquiry into Campbelltown and Camden Hospitals made a number of findings about the operation of the HCCC which have resulted in proposals to improve the complaints handling process. Significantly, the Commissioner of the Special Inquiry "concluded that the statutory complaints system in New South Wales is well designed and does not require any major changes". However, the Commissioner recommended some changes to improve the statutory framework.[7]

These changes, along with a number of other amendments designed to improve complaints handling and disciplinary systems arising from The Cabinet Office's Review of the *Health Care Complaints Act* were contained in the Health Legislation Amendment (Complaints) Bill (and cognate bills) which were passed by Parliament on 8 December 2004. These Bills also included changes to address some of the GPSC No.2's recommendations. These are identified in the response to specific recommendations later in this document.

In relation to the CEC, the HCCC may identify issues of a systemic nature in the course of its investigations, which in turn can then be referred to the Clinical Excellence Commission through the NSW Department of Health. The HCCC may also provide information to the Minister on trends in complaints to the CEC which could impact on the CEC's functions.

The Government has adopted the principles set out by the Special Commission of Inquiry into Campbelltown and Camden Hospitals to guide the relationship between the CEC and the HCCC. These are reproduced in the Government's response to Recommendation 19.

[7] The Cabinet Office New South Wales, September 2004, *Review of the Health Care Complaints Act 1993 Introductory Paper*, p.4

Recent initiatives in patient safety and quality of services

NSW Department of Health

The NSW Department of Health (the Department) has overall statutory regulatory responsibility for patient safety and clinical quality in the NSW health system. The Department will be advised by the CEC of issues of a systemic nature that may require improvement on a statewide level.

The Department will issue the policy that will be used by the CEC to evaluate and assess public health organisations. The CEC will provide an assessment report to the Chief Executive Officer of the public health organisation with a copy of the report provided to the Department. The Chief Executive Officer of the public health organisation will be required to notify the Department of the actions taken to address safety and quality issues contained in the report and work with the Department to ensure appropriate implementation.

The Department's role in the system for patient safety and clinical quality is to:

- Develop and issue policies and standards for improving patient safety, clinical governance and other dimensions of health care quality in the NSW health system.
- Manage state level action on health care incidents reported to the Department of Health.
- Monitor and report specific aspects of health system performance and accountability.
- Provide knowledge management, advice and warnings to the health system about public health and safety issues that require action by health services, which at times may be urgent.
- Provide coordination and strategic support for state-wide implementation of state and national quality initiatives not covered by the functions of the CEC.
- Provide advice to the Minister and Director-General on issues arising out of its functions.

Area Health Service - Clinical Governance Units

The term public health organisation (PHO) in this response refers to the Area Health Services, Children's Hospital at Westmead, Justice Health, and the Ambulance Service of NSW. PHOs report to the Director-General and are responsible for the safety and quality of services provided in their facilities, by staff and contractors.

"Area Health Services are the main public health service providers in New South Wales". The Area Health Services (also referred to as Area or AHS) manage the public hospital facilities within their defined geographical area; they "have primary responsibility for managing and handling complaints made about public health services within their area".[8]

Clinical Governance Units are being established in every Area Health Service and will be the first port of call for patients and staff wanting to raise serious complaints about patient care. These units will greatly improve the way patients, next-of-kin and staff complaints are dealt with and resolved. The units will be responsible for the overall management of serious complaints and incidents within the Area Health Service and systems for:

- Referral of deaths to the Coroner,
- Referral of serious complaints to the HCCC, and
- Referral of potential systemic issues to the CEC where those issues are likely to have an impact wider than just that Area Health Service.

[8] Special Commission of Inquiry into Campbelltown and Camden Hospitals, July 2004, *Final Report*, p.4

Recent initiatives in patient safety and quality of services

The CEC will work closely with PHOs to identify systems issues that require improvement and will support them in developing strategies and solutions to these issues.

South Western Sydney

On 17 June 2004 the NSW Minister for Health launched the South Western Sydney Health Network: The Way Forward 2004 – 2008, A New Health Plan for the People of South Western Sydney ('the Health Plan') which will deliver significant improvements in patient access to safe and quality services locally through:

- An increase of over $300 million over four years to resource the Health Plan, including $26.2 million in 2004/05, rising to $112 million per annum by 2007/08;
- An area wide network of coordinated services and a new clinical management structure for SWSAHS;
- Increased numbers of medical, nursing and allied health cover in critical areas such as emergency, intensive care and after hours inpatient care;
- Reduced surgical waiting times;
- A boost to the training of clinical staff; and
- A new Health Research Institute for South Western Sydney.

In the 2004/2005 State Budget, the NSW Government announced record health funding for South Western Sydney to improve clinical services at Campbelltown Hospital and improve intensive care and emergency department staffing. Recurrent funding for health services in the South Western Sydney Area Health Service will increase by $49.7 million (or 8.1% over last year). This brings the annual health service budget to $665.2 million in recurrent funding and a further $41 million in capital expenditure.

Features of the Health Budget for South Western Sydney Area Health Service include:

- $18.56 million for the Liverpool mental health facility to provide 50 acute inpatient beds, ambulatory care and research services - total project cost $29.9 million.
- $5.48 million for the Macarthur Sector Strategy - total project $108.66 million - for the redevelopment of Campbelltown Hospital including obstetric, neonatal and paediatric care, medical and surgical services, mental health and aged care; and works at Camden Hospital including rehabilitation and palliative care, day surgery and operating theatre suite, renal dialysis and diagnostic services and inpatient care for medical and surgical cases.
- $8.8 million to reduce access block with extra beds and transitional care places to be available and a further $2 million to conduct more elective surgery.
- $1.2 million for additional intensive care beds at Liverpool and Campbelltown Hospitals.
- $2.5 million for the development of a 20-bed non-acute mental health inpatient unit on the Campbelltown Hospital campus - total project $6 million.

Response to recommendations

Accreditation

A number of the recommendations relate to accreditation (recommendations 1, 4, 5, 6, 11, and 12), placing emphasis on accreditation as a method of assuring the quality of services.

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Conference (Note 1):

- whether the criteria used by the Australian Council on HealthCare Standards in its accreditation surveys of health services is an appropriate measure of quality (Recommendation 1)
- the possible elevation of complaints handling in the Evaluation and Quality Improvement Program, conducted by the Australian Council on Healthcare Standards (Recommendation 4)
- incorporation of the Open Disclosure Standard in the current version of the Evaluation and Quality Improvement Program, conducted by the Australian Council on Healthcare Standards (Recommendation 5)
- the provision of an annual update on the implementation of the Open Disclosure Standard in the current version of the Evaluation and Quality Improvement Program conducted by the Australian Council on Healthcare Standards (Recommendation 6)

That a suitable mechanism be identified by NSW Health to ensure the results of accreditation surveys conducted by the Australian Council on Healthcare Standards be provided to the Department within two weeks of their completion (Recommendation 11)

That NSW Health publish all accreditation reports prepared by the Australian Council on Healthcare Standards and any rectification reviews prepared by health services in response to these reports (Recommendation 12)

Note 1: Recommendations 1, 4, 5, and 6 suggest actions for the NSW Minister for Health to address with his counterparts at the Australian Health Ministers' Advisory Council. As State Health Ministers meet at the Australian Health Ministers Conference (AHMC), AHMC has been used as the reference point in this response.

The Government supports processes of external independent review of health services such as accreditation and audit. It supports accreditation as one useful method of assessing the quality of health care systems.

- Accreditation is a strategy that can be employed to improve safety and quality of systems.
- A health care organisation's participation in accreditation demonstrates a commitment to improve their systems.
- While accreditation in itself does not guarantee quality, it does provide a useful infrastructure for organisations to develop a "quality culture". The structure and processes required to achieve accreditation provide a foundation to achieve outcomes of adequate quality from the services provided. [9]
- As accreditation requires organisations to demonstrate a commitment to quality and continuous improvement, it is NSW Health policy under the *Framework for Managing the Quality of Health Services in New South Wales* (1999) that health care services should seek accreditation.
- The Australian Council for Safety and Quality in Health Care considers that "[a]ccreditation is one strategy (but not the only one) that promotes safety and quality in health care. Integrated approaches to health care safety and quality generally incorporate, at a minimum, quality

[9] NSW Health, 1999, *A Framework for Managing the Quality of Health Services in New South Wales*, p.30

Response to recommendations

improvement, risk management and governance frameworks validated by a third party namely an accreditation agency".[10]

While noting the value of accreditation, the Government has charged the CEC with responsibility for establishing and managing a program to assess the quality systems of public health care services in NSW. The CEC will advise the Minister for Health and the NSW Department of Health on the status of safety and quality of healthcare in the NSW health system. In this respect, relevant CEC functions include:

- conducting quality system assessments of public health organisations and, utilising available information, evidence, expert analysis and evaluation, recommend improvements to the NSW health system;
- working with PHOs, where appropriate, to facilitate implementation of quality improvements;
- providing a source of expert advice and assistance to PHOs, private health care organisations and other interested parties; and
- leading the development and system-wide dissemination of evidence-based guidelines for improving safety and clinical quality.[11]

Across Australia some jurisdictions mandate "that hospitals be accredited", but do not mandate a particular system. In some parts of the health sector accreditation is required for government funding.[12] Accreditation in health care is generally self-regulatory.[13]

"While its direct impact on the safety and quality of the Australian health care system has not been objectively confirmed through research, accreditation is widely recognised by governments, health care organisations, consumers and the public as a worthwhile tool that:

- assists health care organisations to review and improve the systems that support the delivery of safe, high quality health care; and
- provides useful information to stakeholders about the safety and quality of care".

Australian Council for Safety and Quality in Health Care, July 2003, *Standards Setting and Accreditation Systems in Health Care: Consultation Paper*, p.3

In NSW the Department of Health encourages all of its facilities to seek accreditation, but it does not direct facilities to any particular accreditation service provider. At this stage, the Government will continue with this approach for the following reasons:

- As stated by the Australian Council for Safety and Quality in Health Care, "Neither accreditation, nor any quality system, can provide an assurance that an adverse event will not occur in a health care organisation".[14]

[10] Australian Council for Safety and Quality in Health Care, July 2003, *Standards Setting and Accreditation Systems in Health: Consultation Paper*, p.6
[11] NSW Health, August 2004, *NSW Clinical Excellence Commission Directions Statement*, p. 3
[12] Australian Council for Safety and Quality in Health Care, July 2003, *Standards Setting and Accreditation Literature Review and Report*, Prepared by Matthews Pegg Consulting Pty Ltd for the Department of Health and Ageing to inform the development of a National Framework for Standards Setting and Accreditation in Health, p.8
[13] Australian Council for Safety and Quality in Health Care, July 2003, *Standards Setting and Accreditation Systems in Health: Consultation Paper*, p.13
[14] ibid, p.7

Response to recommendations

- The Australian Council for Safety and Quality in Health Care's Working Group on accreditation identified the "urgent need for research to elucidate the relationship between accreditation and health care safety and quality".[15]

- The impact of mandating accreditation is not clear. The following is from a literature review and report on the Australian Council on Safety and Quality in Health Care website.[16]

> "Some suggest that mandating one model (usually accreditation) may have a negative impact on continuous improvement (diminishing opportunities for competition and collaboration and causing the program to become too static and lose its ability to accommodate innovation and positive change). Others suggest that it may be more desirable to legislate in favour of external quality review, without promulgating a single approach".
>
> Australian Council for Safety and Quality in Health Care, July 2003, *Standards Setting and Accreditation Literature Review and Report*, Prepared by Matthews Pegg Consulting Pty Ltd for the Department of Health and Ageing to inform the development of a National Framework for Standards Setting and Accreditation in Health, p.9

> "In fact, accreditation does not 'endorse' or 'guarantee' an organisation's quality of care; nor does it 'prove', 'assure' or 'testify' that an organisation provides high quality care. It certainly does not imply, nor cannot assure, that adverse events will not occur in a health care organisation. It simply signifies that an organisation has achieved compliance with specific standards, thereby improving its capability to prevent, manage and learn from health care safety and quality problems."
> Australian Council for Safety and Quality in Health Care, July 2003, *Standards Setting and Accreditation Systems in Health Care: Consultation Paper*, p.8

The Committee's recommendations regarding accreditation only mention the Australian Council on HealthCare Standards (ACHS). NSW Health notes that the ACHS is one of a number of accreditation service providers in health care.

> "Commonly recognised providers of health care standards and/or accreditation services include the Australian Council for Health Care Standards (ACHS), the Quality Improvement Council (QIC) and the International Organisation for Standardization (ISO). There are, however, standards setting and accreditation processes operating in almost all specialist areas of health care including, for example, mental health, general practice, pathology and ophthalmology".
>
> Australian Council for Safety and Quality in Health Care, July 2003, *Standards Setting and Accreditation Systems in Health: Consultation Paper*, p.7

The Government's support of these recommendations does not extend to the focus on the ACHS to the exclusion of these other bodies.

[15] ibid, p.8
[16] Australian Council for Safety and Quality in Health Care, July 2003, *Standards Setting and Accreditation Literature Review and Report*, Prepared by Matthews Pegg Consulting Pty Ltd for the Department of Health and Ageing to inform the development of a National Framework for Standards Setting and Accreditation in Health, p.9

Response to recommendations

Recommendation 1

The Government's view is priority should be given to researching and developing knowledge about the impact of accreditation on the safety and quality of care in health service organisations, and the link between accreditation status and quality of care. In particular, priority must be given to establishing the outcomes offered by the methodology and determining precisely what reliance the community should place on certification through the accreditation process.

The NSW Minister for Health will discuss with his counterparts on the AHMC the need to commission research on the impact of accreditation on health care safety and quality, and the link between accreditation and health care safety and quality.

The NSW Minister for Health will task the CEC with investigating the status and impact of accreditation on quality and safety of health services in New South Wales, with the aim of making recommendations for implementation across the State.

Recommendations 4, 5 and 6

As the Australian Council on Healthcare Standards (ACHS) is an independent not for profit organisation, Recommendations 4, 5 and 6 are a matter for the Council. The Government notes the following in a statement issued by the Council in response to the Committee's report on its inquiry into complaints handling within NSW Health.

"The ACHS acknowledges the increased importance of complaints handling and has gradually increased the emphasis on this area in previous and current editions of our Evaluation and Quality Improvement Program (EQuIP). This review will inform future revision of the EQuIP framework.

The ACHS has been actively involved in development of the ACSQHC's Turning wrongs into rights complaints handling project, and has already undertaken surveyor education regarding this important initiative, which will continue.

The ACHS introduced the concept of mandatory criteria in 2002. With the application of EQuIP 3rd edition on 1 January 2003, a phase in period of 2 years was established in order to assist member organisations in adapting to an accreditation program that substantially increased the importance of safety, particularly for patients. For all surveys conducted from 1 January 2005, an organisation will have to demonstrate that its complaints handling is effective in order to achieve accreditation."

The Australian Council on Healthcare Standards, Statement, Monday 26 July 2004

Response to recommendations

Recommendation 11

The Government supports this recommendation, but not limited to the ACHS.

The NSW Department of Health has a mechanism for collecting the results of facility/ bed based accreditation assessments. This will be extended to require reports on any conditions or qualifications placed by the accrediting service, and any actions taken by the health service in response to the accreditation assessment, to be provided to the Department.

The Department of Health will expect to receive reports where there is any issue about withholding or limiting accreditation, or where serious issues are raised in a report.

Recommendation 12

The Government supports this recommendation, but not limited to the ACHS.

The NSW Department of Health will publish the results of accreditation reports for all accredited public health organisations.

Response to recommendations

Open disclosure standard

A number of recommendations concern the implementation of the Open Disclosure Standard (Australian Council for Safety and Quality in Health Care) (recommendations 2, 3, 5, 6, 7)

That NSW Health discuss with the relevant health professional bodies in New South Wales to ensure that all training programs incorporate competencies regarding quality and safety issues including the Open Disclosure Standard, as part of the registration process. That evidence of ongoing professional development in these issues should be an essential requirement of registration. (Recommendation 2)

That Area Health Service boards formally adopt the principles of open disclosure via performance agreements with NSW Health and affirm their commitment to the full implementation of the Open Disclosure Standard developed by the Australian Council for Safety and Quality in Health Care (Recommendation 3)

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Conference:

- incorporation of the Open Disclosure Standard in the current version of the Evaluation and Quality Improvement Program, conducted by the Australian Council on Healthcare Standards (Recommendation 5)
- the provision of an annual update on the implementation of the Open Disclosure Standard in the current version of the Evaluation and Quality Improvement Program conducted by the Australian Council on Healthcare Standards (Recommendation 6)

That as part of their performance agreements all health managers in NSW undergo training in quality and safety principles, including the Open Disclosure Standard, and that this become an essential requirement in their continued employment (Recommendation 7)

The Government supports open disclosure and has endorsed the National Open Disclosure Standard prepared by Standards Australia for the Australian Council for Safety and Quality in Health Care. An implementation plan is being developed as part of the AHMAC process and in conjunction with the Council. The implementation plan was considered by Australian Health Ministers' Advisory Council (AHMAC) in November 2004, and will be considered by AHMC in January 2005.

NSW Health has committed to participate in the pilot of the open disclosure standard, and will have project sites in five Area Health Services across New South Wales. The pilot project sites are cancer services in Central Sydney Area Health Service; Wollongong Hospital Maternity Services in the Illawarra Area Health Service; Goulbourn Hospital and Bateman's Bay Hospital in Southern Area Health Service; two rural sites in the New England Area Health Service, and across Western Sydney Area Health Service.

A workshop to commence the project was held in August 2004. However, the Australian Council for Safety and Quality in Health Care advised in September 2004 that the pilot has been placed on hold due to the need to resolve legal and liability issues. At this stage it is not known when the pilots will be recommenced and is dependent on the resolution of liability issues with insurers in each jurisdiction. The next workshop about the pilot is planned for late February / early March 2005. The duration of the pilot projects is subject to current review through AHMAC but is anticipated to be 18 months, with evaluation built into the pilot projects and conducted by an independent organisation.

The Government will consider the GPSC No.2's recommendations about open disclosure following the completion of the evaluation of the pilot projects. In the mean time, the Government has tasked the CEC with responsibility for developing or identifying suitable providers of training on Root Cause Analysis and

communication to ensure that appropriate disclosure occurs with patients and next of kin regarding adverse events.

Other Recommendations

Recommendation 8

That the proposed Clinical Excellence Commission in conjunction with NSW Health undertake an extensive public education campaign to inform the community about:

- simple steps to make health complaints
- the nature and extent of adverse events in the health care system
- realistic expectations of health care
- changes to the regulatory framework for health care complaints and consumers rights

The Government supports this recommendation. The CEC, the HCCC and the NSW Department of Health will jointly undertake an education campaign on the issues listed in Recommendation 8.

The Government will ask these agencies to ensure the education campaign is appropriate to meet the different needs of clinicians and the general community.

The NSW Department of Health will be responsible for ensuring local Area Health Advisory Councils are consulted and involved in the processes of developing the education program.

The Government believes that informing the community about adverse events and the organisation of health care delivery systems will greatly help the community understand the limitations of medical science.

Recommendation 9

That NSW Health publish comparative data on adverse events in Area Health Services across New South Wales in Annual Reports and on its website.

Recommendation 9 is not supported.

NSW Health introduced the Safety Improvement Program (SIP) in 2002 to ensure a standardised coordinated approach to incident management across the state. SIP has two key components:

- Development of a environment where staff feel supported in the reporting of incidents and the provision of training for incident management
- Implementation of a statewide incident information management system to ensure that all incidents are notified, classified, analysed and reported in the same way

As at December 2004, education and training in the review of adverse events using Root Cause Analysis (RCA) had been provided to over 2,500 health service employees, including clinicians, managers and executives across the state.

Response to recommendations

In November 2004, the Incident Information Management System (IIMS) was deployed across the state to ensure that all incidents are now managed in the same electronic environment – this will be progressively rolled out to all NSW health employees and be completed by 30th May 2005.

Following the above two initiatives, all incidents are classified using the Severity Assessment Code (SAC) matrix. The process assesses the consequence or outcome of an incident and the likelihood or frequency of recurrence and provides a numerical rating. Serious adverse events (SAC 1 incidents) are reported through the Area Chief Executive to the Department and are investigated within the Area using the RCA method to identify what happened, why it happened and how it can be prevented from occurring again.

Recommendations and action plans are developed at the Area level to ensure that vulnerabilities are corrected. Each SAC 1 incident and RCA report is also monitored at the state level to ensure that where required, statewide policy is reviewed or developed.

In January 2005, NSW Health will release its first annual report on safety and quality which will include information on SAC 1 incidents in the NSW Health System. The report will focus on the number, type of incidents reported, and the actions that have been taken at the local and state levels.

Reporting comparative data by facility or Area Health Service is a not a robust indicator of quality because it is dependent on context, and incorrect conclusions can be drawn from the measure. For example, a high number of reported adverse events may result from a good reporting ethos and systems rather than reflecting poor performance in the health service. An increase in the number of reported incidents is not necessarily an indication of declining quality, and could be a positive sign of a proactive reporting and or of a quality improvement program. Conversely a health service with few reported incidents may reflect poor reporting systems and the measure will not have provided any useful information about its systems for patient safety and quality care.

For these reasons, the current approach for developing systems for quality improvement from adverse events, combined with the reporting mechanisms described, are sufficient to ensure continuous improvement within NSW Health.

The Government's view is the above suite of initiatives that encourage and enable disclosure and appropriate reporting and investigation, is more beneficial and more likely to facilitate improvement in the quality and safety of patient care.

Recommendation 10

That the New South Wales Government convene a summit on medical adverse events within the next 12 months.

The Government will consider the need for a summit when the Clinical Excellence Commission is fully operational and following the full deployment of the Incident Information Management System, which is due to be fully implemented by 30th May 2005.

Informing the community about adverse events will be undertaken as part of the Government's implementation of Recommendation 8. Clinicians can access national conferences on adverse events and quality and safety in health care.

Response to recommendations

Recommendation 13

That NSW Health take steps to ensure senior health managers are aware of the existing protocols in relation to notifying family members about the referral of a death to the Coroner.

The Government supports this recommendation.

The NSW Department of Health will undertake a review of all circulars related to patient deaths and integrate requirements into one circular. The circular will be issued to public health organisations.

Area Health Service Clinical Governance Units will be required to provide training to senior health managers as well as clinicians about making referrals to the Coroner and the protocol for notification of family members. These processes will be documented in the circular to be developed by the NSW Department of Health.

Recommendation 14

That NSW Health implement a State-wide protocol to ensure that the patient or next of kin of a patient whose treatment is the subject of a Root Cause Analysis is informed of the conduct and results of the analysis by a suitable clinician.

The Government supports this recommendation.

In 2002, NSW Health introduced a system of incident review called Root Cause Analysis (RCA). The aim of undertaking a RCA is to identify any systemic causes of the incident.

Managers who receive an incident report are required to assess the incident using the Severity Assessment Code (SAC), which results in a ranking on a scale of 1-4. Organisations must undertake a RCA of all incidents that are rated SAC 1.

In keeping with the open disclosure standard, the NSW Department of Health will ensure that relevant policy documents include a requirement for a suitable clinician to inform patients and next of kin of the results of a Root Cause Analysis.

Recommendation 15

That the NSW Clinical Excellence Commission conduct a study on the feasibility of introducing mandatory reporting of all or certain classes of incidents to health service management and to the Department of Health.

There already exist requirements to report incidents and complaints. These are: [17]

- NSW Health model policy and guidelines (2001) *Management of a Complaint or Concern about a Clinician* states that anyone who has a concern, or receives a complaint about a clinician's performance must report this to his/her supervisor.

[17] NSW Health, May 2004, *Supplementary Submission to the Legislative Council Standing Committee Inquiry into Complaints Handling Procedures within NSW Health*, pp.3-4

Response to recommendations

- In March 2004, the NSW Medical Board released a draft Code of Conduct for public comment. The draft Code relates to a range of issues, including the requirement to notify when a doctor identifies the health, conduct or performance of a colleague is a threat to the public. The Board has recently written to the Minister advising that the changes are currently being incorporated into the Code, which will be provided to the Minister for his approval shortly.

- The Australian Nursing Council has developed a general *Code of Professional Conduct for Nurses in Australia – 2003*, which recognises a nurse's responsibility to notify the appropriate authority where there are concerns about questionable or unethical practice. The NSW Nurses Registration Board adopted this Code in April 2003.

- NSW Health Circular 2003/88 requires Area Health Services to categorise incidents according to the Severity Assessment Code (SAC), and report any incidents rated as SAC 1 to the NSW Department of Health within 24 hours.

In addition, amendments made by the Health Legislation Amendment (Complaints) Bill 2004, (passed by Parliament on 8 December 2004) includes amendments to the *Health Services Act* to require chief executive officers of public health organisations to report suspected unsatisfactory professional conduct or professional misconduct by staff or contractors of their organisation to the relevant registration authority.

Protection of the general public will be improved by placing a requirement on Chief Executives of public health organisations to report suspected unsatisfactory professional conduct or professional misconduct by staff or contractors to registration authorities. The legislative changes referred to above will also allow the Health Care Complaints Commission to notify a health practitioner's current employer if it decides to investigate a complaint. The NSW Medical Board has also been given power to inform new employers of any orders or conditions imposed on a medical practitioner under the Medical Practice Act.[18]

The Government will task the CEC with responsibility for reviewing incident management and requirements to report as part of its audit and assessment program, and to provide advice on any changes required.

Recommendation 16

That NSW Health ensure that in all area health services each clinical team should have regular review meetings on a protocol set up by management and audited by the Clinical Excellence Commission.

The NSW Health (2001) *The Clinician's Toolkit for Improving Patient Care* provides guidance to public health organisations on peer review meetings.

The CEC will be tasked with auditing public health organisation's implementation of the method, and evaluating its impact on patient outcomes in 2005.

Recommendation 17

The *Health Care Complaints Act 1993* and the *Protected Disclosures Act 1994* be amended to protect the identity of whistleblowers when they require it and to provide protected disclosure safeguards for health professionals, including nurses in both the public and private sectors.

[18] New section 191B(4), inserted by the Health Registration Legislation Amendment Bill 2004

Response to recommendations

The Government supports the recommendation, which also mirrors recommendations made by the Special Commission of Inquiry into Campbelltown and Camden Hospitals.

This recommendation has been implemented through amendments in the Health Legislation Amendment (Complaints) Bill 2004 which vary the provisions relating to protection of identity of complainants to make them consistent with those in the *Protected Disclosures Act 1994*.

- Under the Act the HCCC may keep the identity of whistleblowers and other complainants secret if there is a risk of intimidation or harassment for up to 60 days only. This time limit has been removed to require the HCCC to review its decision to keep the identity of complainants confidential every 60 days, subject to certain limitations.
- Whistleblowers and other complainants are protected by the removal of liability for making a complaint in good faith.

In addition, HCCC documents will be exempt from release under Freedom of Information. [19]

Recommendation 18

That NSW Health Medical Board be asked to clarify why the practitioner who treated Mrs Daly-Hamilton has not been referred to the South Australian Medical Board.

The Government understands that unless immediate action is warranted the normal process when a complaint is received is for the Medical Board and the Health Care Complaints Commission to complete their statutory consultation to determine how a matter should be handled. This may involve obtaining more information about a complaint before reaching a decision. Where it is agreed that a matter warrants formal investigation under the Health Care Complaints Act, an "alert" is generally placed on the National Compendium of Medical Registers, which is accessible by all State Medical Boards. It is understood that this is what occurred in this case. In addition, advice of the outcome of the initial assessment was conveyed to the South Australian Medical Board.

It is understood that the NSW Medical Board has also responded directly to the Committee in relation to this recommendation.

Recommendation 19

That the proposal to split responsibility for the investigation of systemic and individual complaints between the Clinical Excellence Commission and the Health Care Complaints Commission, be reassessed following the release of the final report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals.

The Government is committed to implementing effective strategies to ensure both accountability for patient-safe systems and individual practitioner accountability.

The Government considers these objectives to be complementary rather than competing.

[19] Clause 4.1, Schedule 4, Health Legislation Amendment (Complaints) Bill 2004

Response to recommendations

The organisational structures and systems it has established, which have been described in this document, provide a solid foundation for achieving both of these objectives.

Clear definition and delegation of responsibilities between the HCCC and the CEC, supported by principles to guide the relationship between these agencies, is an appropriate approach to managing a complex health care system. The Government has adopted the following principles set out by the Commissioner for the inquiry into Campbelltown and Camden Hospitals to guide the relationship between the HCCC and the CEC. Principle 2 will be implemented in the context of Principle 6.

"The following principles can be distilled to guide the relationship between these two organisations:

1. The Clinical Excellence Commission should be responsible for investigating and making recommendations with respect to systems issues that have the potential to have an area or State-wide significance.

2. Complaints about patient care received in public hospitals can be made to the clinician concerned, the hospital, the Area Health Service or the Health Care Complaints Commission. In the event the Clinical Excellence Commission receives a complaint it should be referred to one of the above.

3. The Health Care Complaints Commission has the primary responsibility for investigating serious complaints against individuals and initiating any necessary disciplinary action.

4. Where an investigation by the Health Care Complaints Commission raises questions of a systemic nature, and those issues are specific to the individual organisation or person the subject of the allegations, the Health Care Complaints Commission should enter discussions with the Clinical Excellence Commission as to the best forum in which they should be investigated.

5. Following any discussions between the Clinical Excellence Commission and the Health Care Complaints Commission with respect to any investigation being undertaken by the Health Care Complaints Commission with systemic implications, and when the result of that discussion is that the Health Care Complaints Commission is to continue with that investigation, any recommendations made by the Health Care Complaints Commission together with any other information required by the Clinical Excellence Commission should be forwarded to the Clinical Excellence Commission.

6. While it is not expected that in the ordinary course of its work the Clinical Excellence Commission will receive information concerning the conduct of individuals, should that arise, the Clinical Excellence Commission should report any concerns it has to the Director-General. The three levels of concerns set out in the November 2001 Department of Health publication "*Model Policy on the Management of a complaint or concerns about a clinician*" should guide the Clinical Excellence Commission. It will then be a matter for the Director-General to consider whether she should make a complaint to the Health Care Complaints Commission.

7. The Clinical Excellence Commission should have access to all complaint data held by the Health Care Complaints Commission. It would be expected that that would amount to a small component of the information available to the Clinical Excellence Commission because, by definition, that material is biased towards the exceptional or the egregious. It would be expected that its work would be informed by research, medical literature, its own audits and information generated by the Colleges, to name a few obvious sources.

Response to recommendations

8. The Clinical Excellence Commission should have access to all causation statements and recommendations made a result of a root cause analysis in New South Wales.

9. The Clinical Excellence Commission should not be bound, as the Health Care Complaints Commission is, by any equivalent of sec 91 of the *Health Care Complaints Act*".[20]

[20] Special Commission of Inquiry into Campbelltown and Camden Hospitals, July 2004, *Final Report*, p.150-151

Conclusion

The NSW Legislative Council General Purpose Standing Committee No. 2's (GPSC No.2) inquiry into complaints handling procedures within NSW Health followed the release of the Health Care Complaints Commission report into Campbelltown and Camden Hospitals, and was undertaken during the period of the Special Commission of Inquiry into the same hospitals.

The GPSC No.2 made 19 recommendations that addressed a broad range of issues, including accreditation; open disclosure; adverse events; staff training and competency; notification to patient, and or next of kin; community awareness; provisions to protect complainants; as well as one specific recommendation concerning referring a practitioner to the South Australian Medical Board.

A number of significant initiatives focussed on patient safety and quality of health services across New South Wales have been announced and are being implemented. The Government's position on each of the GPSC No.2's recommendations has been addressed in this report.

References

Australian Council on Healthcare Standards, Statement, Monday 26 July 2004

Australian Council for Safety and Quality in Health Care, July 2003, *Standard Setting and Accreditation Systems in Health: Consultation Paper*

Australian Council for Safety and Quality in Health Care, July 2003, *Standards Setting and Accreditation Literature Review and Report*, Prepared by Matthew Pegg Consulting Pty Ltd for the Department of Health and Ageing to inform the development of a National Framework for Standards Setting and Accreditation in Health

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NSW Health, 1999, *A Framework for Managing the Quality of Health Services in New South Wales*

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NSW Health, May 2004, *Supplementary Submission to the Legislative Council Standing Committee Inquiry into Complaints Handling Procedures within NSW Health*

The Cabinet Office New South Wales, September 2004, *Review of the Health Care Complaints Act 1993 Introductory Paper*

Special Commission of Inquiry into Campbelltown and Camden Hospitals, July 2004, *Final Report*

Appendix 5 Severity Assessment Code (SAC) November 2005

APPENDIX A

Severity Assessment Code (SAC) November 2005

This matrix should be used with the NSW Health Incident Management Policy

STEP 1 Consequences Table (For notification, consider the actual consequence or outcome using this table as a guide. The examples listed here are not exhaustive.)

		Serious	Major	Moderate	Minor	Minimum
CLINICAL CONSEQUENCE	Patient	Patients with **Death** unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management or: ▪ **Suspected suicide**[1] ▪ **Suspected homicide**[2] or any of the following: **The National Sentinel Events** ▪ Procedures involving the wrong patien or body part ▪ Suspected suicide in hospital ▪ Retained instruments ▪ Unintended material requiring surgical removal ▪ Medication error involving the death of a patient ▪ Intravascular gas embolism ▪ Haemolytic blood transfusion ▪ Maternal death associated with labour and delivery ▪ Infant discharged to the wrong family	Patients suffering a **Major permanent loss of function (sensory, motor, physiologic or psychologic)** unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ▪ Suffering significant disfigurement as a result of the incident ▪ Patient at significant risk due to being absent against medical advice ▪ Threatened or actual physical or verbal assault of patient requiring external or police intervention	Patients with **Permanent reduction in bodily functioning (sensory, motor, physiologic, or psychologic)** unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ▪ Increased length of stay as a result of the incident ▪ Surgical intervention required as a result of the incident	Patients requiring **Increased level of care including:** ▪ **Review and evaluation** ▪ **Additional investigations** ▪ **Referral to another clinician**	Patients with **No injury or increased level of care or length of stay**
CORPORATE CONSEQUENCE	Staff	Death of staff member related to work incident or suicide, or hospitalisation of **3** or more staff	Permanent injury to staff member, hospitalisation of **2** staff, or lost time or restricted duty or illness for **2** or more staff or pending or actual WorkCover prosecution, or threatened or actual physical or verbal assault of staff requiring external or police intervention	Medical expenses, lost time or restricted duties or injury / illness for **1** or more staff	First aid treatment only with no lost time or restricted duties	No injury or review required
	Visitors	Death of visitor or hospitalisation of **3** or more visitors	Hospitalisation of up to **2** visitors related to the incident / injury or pending or actual WorkCover prosecution	Medical expenses incurred or treatment of up to **2** visitors not requiring hospitalisation	Evaluation and treatment with no expenses	No treatment required or refused treatment
	Serv Loss	Complete loss of service or output	Major loss of agency / service to users	Disruption to users due to agency problems	Reduced efficiency or disruption to agency working	Services: No loss of service
	Financial	**Loss of assets** replacement value due to damage, fire etc > $1M, **loss of cash/investments/assets** due to fraud, overpayment or theft >$100K or **WorkCover claims** > $100K	**Loss of assets** replacement value due to damage, fire etc $100K-$1M, **loss of cash/investments/assets** due to fraud, overpayment or theft $10K-$100K or **WorkCover claims** $50K-$100K	**Loss of assets** replacement value due to damage, fire etc $50K to $100K or **loss of cash/investments/assets** due to fraud, overpayment or theft to $10K	**Loss of assets** replacement value due to damage, fire etc to $50K	No financial loss
	Environment	*Toxic release off-site with detrimental effect. Fire requiring evacuation*	Off-site release with no detrimental effects or fire that grows larger than an incipient stage	Off-site release contained with outside assistance or fire incipient stage or less	Off-site release contained without outside assistance	Nuisance releases

[1] Suspected suicide of a person (including a patient or community patient) who has received care or treatment for a mental illness from an Area Health Service or other PHO where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation.

[2] Suspected homicide committed by a person who has received care or treatment for mental illness from an Area Health Service or other PHO within 6 months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation

STEP 2 Likelihood Table

Probability Categories	Definition
Frequent	Is expected to occur again either immediately or within a short period of time (likely to occur most weeks or months)
Likely	Will probably occur in most circumstances (several times a year)
Possible	Possibly will recur – might occur at some time (may happen every 1 to 2 years)
Unlikely	Possibly will recur – could occur at some time in 2 to 5 years
Rare	Unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)

STEP 4 Action Required Table

Action Required	
1	**Extreme** risk – immediate action required – Reportable Incident Brief (RIB) for all SAC 1 incidents must be forwarded to the DoH within 24 hours. A Privileged Root Cause Analysis (RCA) investigation must be undertaken for all Clinical SAC 1 incidents with a report being submitted to the DoH.
2	**High** risk – need to notify senior management. Detailed investigation required. Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.
3	**Medium** risk – management responsibility must be specified – Aggregate data then undertake a practice improvement project. **Exception** – all financial losses must be reported to senior management.
4	**Low** risk – manage by routine procedures – Aggregate data then undertake a practice improvement project.
NB – An incident that rates a SAC 2, 3 or 4 should only be reported to the DoH if there is the potential for media interest or requires direct notification under existing DoH legislative reporting requirements or NSW DoH Policy Directive.	

STEP 3 SAC Matrix

	CONSEQUENCE				
	Serious	Major	Moderate	Minor	Minimum
Frequent	1	1	2	3	3
Likely	1	1	2	3	4
Possible	1	2	2	3	4
Unlikely	1	2	3	4	4
Rare	2	3	3	4	4

Every incident assessed against the Severity Assessment Code Matrix should be scored separately for both their actual and potential consequence or outcome

Appendix 6 Minutes

Minutes No 66
Tuesday, 14 March 2006
General Purpose Standing Committee No. 2
Parliament House at 1.30 pm, Rm 814/815

1. Members Present
Ms Patricia Forsythe (Chair)
Mr Tony Catanzariti (Deputy Chair)
Dr Arthur Chesterfield-Evans
Ms Sylvia Hale
Ms Melinda Pavey
Ms Christine Robertson
Mr Henry Tsang

2. Correspondence
The Committee noted the following items of correspondence received:

- …
- Letter received from Ms Forsythe, Ms Hale and Ms Pavey (members of GPSC 2) requesting that the Committee meet to discuss a proposed inquiry into a review of the implementation of the response of the NSW Government to the recommendations of the Committee's Inquiry into Complaints Handling within NSW Health (10 March 2006)
- Letter from Dr Michael Holland, obstetrician and gynaecologist in Moruya, re his financial difficulties with the Greater Southern Area Health Service.

3. …

4. Self reference – Health complaints inquiry review
The Committee discussed draft terms of reference, previously circulated to the Committee.

Resolved, on the motion of Ms Robertson: That the Committee adopt the following terms of reference:

That General Purpose Standing Committee No. 2 undertake a review of the implementation of the response of the NSW Government to the recommendations of the Committee's inquiry into complaint handling within NSW Health.

Resolved, on the motion of Ms Pavey: That the Committee

- write to relevant agencies seeking their comments regarding the implementation of the response of the NSW Government to the recommendations of the Committee's inquiry into complaint handling within NSW Health by 13 April 2006
- not seek public submissions to the inquiry.

Members agreed to provide the Secretariat with a list of agencies to receive the proposed correspondence, by Friday 17 March 2006. The list will then be circulated to the Committee for approval.

…

8. Adjournment
The Committee adjourned at 4.50 pm sine die.

Katherine Flemming
Clerk to the Committee

Minutes No 67
Wednesday, 12 April 2006
General Purpose Standing Committee No. 2
Parliament House at 9.45 am, Waratah Room

1. Members Present
Ms Patricia Forsythe (Chair)
Mr Tony Catanzariti (Deputy Chair)
Dr Arthur Chesterfield-Evans
Ms Sylvia Hale
Mr John Ryan (Pavey)
Ms Christine Robertson
Mr Henry Tsang

2. Substitute arrangements
The Chair advised that Mr Ryan would be substituting for Ms Pavey for the purposes of this meeting.

3. Confirmation of Minutes 65 and 66
Resolved on motion of Mr Catanzariti: That minutes No. 65 and 66 be confirmed.

4. …

5. Review of Inquiry into complaints handling within NSW Health

5.1 Correspondence

The Committee noted the following items of correspondence sent regarding the Committee's review of the implementation of the response of the NSW Government to the recommendations of the Committee's inquiry into complaint handling within NSW Health (27 March 2006):

- Letter to the Minister for Health, the Hon John Hatzistergos
- Letter to Ms Robyn Kruk, Director General NSW Health
- Letter to Professor Clifford Hughes, CEO, Clinical Excellence Commission
- Letter to Mr Kieran Pehm, Commissioner, Health Care Complaints Commission

…

9. Adjournment
The Committee adjourned at 11:30 am sine die.

Stephen Frappell
Clerk to the Committee

Minutes No 69
Tuesday, 5 June 2006
General Purpose Standing Committee No. 2
Parliament House at 3.35pm, Rm 1108

1. Members Present
Ms Patricia Forsythe (Chair)
Mr Tony Catanzariti (Deputy Chair)
Dr Arthur Chesterfield-Evans
Ms Kayee Griffin (Tsang)
Ms Sylvia Hale
Ms Melinda Pavey
Ms Christine Robertson

2. Substitute members

The Chair advised the Ms Griffin would be substituting for Mr Tsang for the purposes of this meeting.

3. Confirmation of Minutes 68

Resolved, on motion of Ms Robertson: That minutes No. 68 be confirmed.

4. Correspondence

The Committee noted the following correspondence received:

- Letter from the Audit Office of New South Wales to Director, advising that the Audit Office is auditing the management of the nursing workforce and the impacts this may have on the delivery of health care, and seeking the Committee's views on management of nurses that may be relevant to the audit (15 March 2006)

Resolved, on the motion of Ms Robertson: That the Chair reply to the correspondence from the Audit Office on behalf of the Committee thanking the Audit Office for the opportunity to contribute its view on management of nurses, but indicating that the audit goes beyond the scope of the Committee.

5. Review of Complaints Handling within NSW Health

5.1 Submissions

The Committee noted receipt of submissions from the following organisations:

- The Health Care Complaints Commission (HCCC)
- NSW Health and the Clinical Excellence Commission (CEC) (joint submission).

Resolved, on the motion of Ms Pavey: That the Committee accept and publish submissions 1 and 2.

5.2 Further conduct of the inquiry

Resolved, on motion of Ms Pavey: That the Committee continue its review of the implementation of the response of the NSW Government to the recommendations of the Committee's inquiry into complaint handling within NSW Health by:

- advertising for submissions in major metropolitan and major country newspapers, with a closing date for submissions of 7 July 2006
- advertising for submissions in the NSW Nurses' Association Journal
- issuing a press release announcing the call for submissions to coincide with the advertisement
- inviting stakeholder associations, including the relevant medical associations, to make a submission.

…

7. Adjournment

The Committee adjourned at 4.07 pm until a date to be determined.

Stephen Frappell
Clerk to the Committee

Minutes No 71
Thursday 17 August 2006
General Purpose Standing Committee No. 2
At Parliament House at 2.30pm, Rm 814/815

1. Members Present

Ms Patricia Forsythe (Chair)
Mr Tony Catanzariti (Deputy Chair)
Dr Arthur Chesterfield-Evans
Ms Kayee Griffin (Tsang)

Ms Melinda Pavey
Ms Christine Robertson

2. Substitute members

The Chair advised the Committee that Ms Griffin would be substituting for Mr Tsang for the purposes of this meeting.

3. Correspondence

The Committee noted the following correspondence received:

- …
- Letter from NSW Medical Board to Chair regarding their response to the inquiry (22 June 2006)
- Letter from Royal Australian College of General Practitioners NSW & ACT Faculty to Chair regarding the circulation of invitation to make submissions to their members. (ii July 2006)
- Letter from *name suppressed* to Director regarding review of health care complaints (31 July 2006)
- Letter from Director General NSW Health to Director regarding NSW Health staff making submissions.(2 August 2006)
- …

The Committee noted the following correspondence sent:

- Letter to Hon John Hatzistergos MLC, Minister for Health from Chair requesting that the Minister ask the Director-General of NSW Health to issue a memo regarding the free participation of employees of NSW Health and the Area Health Services in the Committee's current inquiry (7 June 2006)
- Letter sent to Mr Stephen Horne, Audit Office NSW from Chair thanking Mr Horne for the opportunity to contribute to the audit into the management of the nursing workforce, but noting that the as it goes beyond the scope of the Committee's current inquiry. (7 June 2006)

Resolved, on the motion of Ms Robertson: That the Chair forward Submission No. 11 to the Director-General of NSW Health noting that in line with the current terms of reference the Committee:

- is concerned about the issues raised by *named suppressed* regarding complaints handling processes in Greater Murray/Greater Southern Area Health Services
- requests a response from NSW Health regarding the issues raised by Dr Lucire regarding complaints handling processes in Greater Murray/Greater Southern Area Health Services.

4. Review of Complaints Handling within NSW Health

4.1 Submissions

Resolved, on the motion of Ms Robertson: That the Committee publish Submissions 3, 4, 6, 7, 9, 10, 11, 12 and 13.
Resolved, on the motion of Ms Robertson: That the Committee publish submissions 5 and 14, with the exception of the authors' names, which shall remain confidential to the Committee.

4.2 Further conduct of the inquiry

Resolved, on motion of Ms Robertson: That the Committee conduct a public hearing in relation to the review of Complaints handling within NSW Health on Thursday 14 September 2006 and that the schedule include the following witnesses:

- Ms Robyn Kruk, Director General of NSW Health and the CEO of the Clinical Excellence Commission, Mr Clifford Hughes
- Representative of the AMA and United medical Protection.
- Representative, Royal College of Nursing.

5. …

6. Adjournment

The Committee adjourned at 3:10pm until 11 September 2006.

Glenda Baker
Clerk to the Committee

Minutes No 78
Thursday, 14 September 2006
General Purpose Standing Committee No. 2
At Parliament House at 11:30am, Jubilee Room

1. Members present
Mr Don Harwin (Ms Forsythe)
Ms Amanda Fazio (Mr Catanzariti)
Dr Arthur Chesterfield-Evans
Ms Sylvia Hale
Ms Robyn Parker (Ms Pavey)
Ms Christine Robertson
Mr Henry Tsang

2. Election of Chair for the purpose of the meeting
In accordance with paragraph (3) of Standing Order 211, the Clerk called for nominations for a member to act as Chair for the meeting.

Ms Robertson moved: That Ms Hale be elected to act as Chair of the Committee for the meeting.

The Clerk informed the Committee, that there being no further nominations, Ms Hale was therefore declared elected Chair of the Committee for the meeting.

Ms Hale took the Chair

3. Election of Deputy Chair for the purpose of the meeting
Ms Robertson moved: That Ms Fazio be elected to act as Deputy Chair of the Committee for the meeting.

The Chair informed the Committee, that there being no further nominations, Ms Fazio was therefore declared elected Deputy Chair of the Committee for the meeting.

4. Substitute arrangements
The Chair noted the following substitute arrangements, as advised by the Opposition and Government Whips: Mr Harwin will be substituting for Ms Forsythe; Ms Parker will be substituting for Ms Pavey and Ms Fazio will be substituting for Mr Catanzariti.

5. Public Hearing
The media, witnesses and the public were admitted.

The Chair made a brief opening statement.

The following witnesses were sworn and examined:

- Ms Robyn Kruk, Director General, NSW Health
- Professor Clifford Hughes, CEO, Clinical Excellence Commission

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Allen Thomas, Director, Medico Legal Strategic Policy and Training, AUSTRALIAN Medical Association
- Mr Scott Chapman, Partner, TressCox Lawyers

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Helen Turnbull, Legal Manager, Disciplinary Services, United Medical Protection
- Mr David Brown, General Manager, Legal Division, United Medical Protection

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Rosemary Bryant, Executive Director, Royal College of Nursing
- Ms Elizabeth Foley, Director, Policy, Royal College of Nursing
- Mr Robert O'Donohue, Vice President, Royal College of Nursing

The evidence concluded and the witnesses withdrew.

The public hearing was concluded and the media and public withdrew.

6. Deliberative meeting

6.1 Correspondence

The Committee noted the following correspondence sent:

- 22 August 2006, from Chair to Director-General NSW Health, Ms Robyn Kruk requesting information in relation to complaints made by De Lucire regarding complaints handling by the Greater Southern Area Health Service.
- 29 August 2006, from Chair to Ms Nola Fraser inviting a submission to the inquiry.

6.2 Submissions

At the previous Committee meeting the Committee agreed to publish Submission No. 8. The secretariat subsequently advised members that the submission author had requested the submission to be confidential.
Resolved on the motion of Ms Robertson: That submission 8 be confidential to the Committee.
Resolved on the motion of Ms Fazio: That submission 15 be confidential to the Committee.

6.3 Confirmation of Minutes No. 71

Resolved, on the motion of Ms Robertson, that Minutes no 71, as amended, be confirmed (see 4.2)

6.4 Additional questions on notice

Resolved on the motion of Ms Robertson: That

- any additional questions on notice in relation to the Air Pollution inquiry hearing held on 11 September, and in relation to today's hearing in relation to Health Complaints, be provided to the secretariat no later than 5pm on Monday 18 September 2006.
- witnesses be asked to provide the answers to these additional questions on notice within 21 calendar days of the day on which the question is forwarded to the witness by the Committee Clerk.
- witnesses be requested to notify the Committee if they perceive they may not be able to meet this deadline

6.5 Inquiry timeline

Resolved on the motion of Ms Fazio: That the Committee hold a deliberative meeting to discuss the Chair's draft report on a date prior to 14 November 2006.

The Secretariat will circulate possible deliberative meeting and tabling dates in the near future.

7. Adjournment

The Committee adjourned at 4.30pm.

Beverly Duffy
Clerk to the Committee

Minutes No. 79
Monday 25 September 2006
Parliament House at 1.48pm

1. Members present
Mr Tony Catanzariti (*Deputy Chair*)
Dr Arthur Chesterfield-Evans
Ms Sylvia Hale
Ms Robyn Parker
Ms Melinda Pavey
Ms Christine Robertson
Mr Henry Tsang

…

3. Election of chair
The Committee Clerk advised that the Leader of the Opposition has nominated Ms Parker as a member of General Purpose Standing Committee No. 2 in place of Mrs Forsythe (Item 9, Minutes No. 14, Tuesday 19 September 2006).

The Committee Clerk conducted an election under Standing Order 211.

The Clerk called for nominations for Chair of the Committee.

Ms Pavey moved: That Ms Parker be elected Chair of the Committee.

There being no further nominations, the Clerk declared Ms Parker Chair of General Purpose Standing Committee No. 2.

4. Minutes
Resolved, on the motion of Mr Tsang: That minutes no. 72, 73, 74, 75 and 76 be confirmed.

…

8. Adjournment
The Committee adjourned at 4.13pm *sine die*.

Simon Johnston
Clerk to the Committee

Draft Minutes No. 85
Monday 13 November 2006
Room 1108, 11.00am

1. Members present
Ms Robyn Parker (Chair)
Mr Tony Catanzariti (Deputy Chair)
Dr Arthur Chesterfield-Evans
Ms Melinda Pavey
Ms Sylvia Hale
Ms Christine Robertson
Mr Henry Tsang

2. Confirmation of Minutes
Resolved, on the motion of Ms Robertson: That Minutes No. 78 be confirmed.

3. Correspondence

The Committee noted the following correspondence received:

- Letter from Ms Robyn Kruk, Director General NSW Health responding to concerns raised in the submission by Dr Yolande Lucire (20 October 2006)
- Letter from Ms Robyn Kruk, Director General NSW Health responding to questions taken on notice by NSW Health at hearing on 14 September 2006 (18 October 2006)
- Letter from Ms Rosemary Bryant, Executive Director, Royal College of Nursing Australia, responding to questions taken on notice at the public hearing on 14 September 2006
- Email from Mr Matt Monahan, NSW Health, updating data tabled at hearing on 14 September 2006, on Root Cause Analysis reports (31 October 2006)

Resolved, on the motion of Ms Robertson: That the responses to questions taken on notice at the public hearing held on 14 September 2006, be published.

Resolved, on the motion of Ms Robertson: That extra information supplied by NSW Health regarding Root Cause Analysis reports be published.

4. Publication of Submissions

Resolved, on the motion of Mr Catanzariti: That supplementary submission 15a remain confidential.

5. Consideration of Chair's draft report

The Chair submitted her draft report which, having been previously circulated to the Committee Members, was accepted as having been read a first time.

The Committee proceeded to consider the Chair's draft report in detail.

Chapter 1 read.

Resolved, on the motion of Dr Chesterfield-Evans: That paragraph 1.8 be amended by inserting, at the end of the paragraph, the words: 'Some members wanted to revisit the evidence of the Campbelltown hospital to see in particular what had happened to the participants, but the Committee chose not to do this.'

Resolved, on the motion of Dr Chesterfield-Evans: That a new paragraph be inserted following paragraph 1.11, to read: 'The conclusion of this review, as further discussed in Chapter 2 tends to accept the managerial changes that the Health Department has created. It is noted that the Department and the Clinical Excellence Commission have done a lot of work and that the Australian Medical Association (AMA) (NSW) has been supportive and feels that there has been a culture change, though they are also concerned that there has not been adequate public education as stated in 5.6. The Royal College of Nurses Australia was more cautious in their appraisal of the success of Root Cause Analysis. The lack of a significant number of public submissions to this review meant that the Committee is not in a good position to look at what has actually happened on the ground. The Committee is aware that management intentions, programmes and parliamentary submissions are not always reflected in practice and believes this should be addressed in a future inquiry.'

Resolved, on the motion of Ms Robertson: That Chapter 1, as amended, be adopted.

Chapter 2 read.

Resolved, on the motion of Mr Catanzariti: That Chapter 2 be adopted.

Chapter 3 read.

Resolved, on the motion of Dr Chesterfield-Evans: That paragraph 3.26 be amended by omitting the words 'a review of the matter needs to be carried out as soon as possible' and inserting instead the words 'an urgent review of the matter needs to be commenced immediately and completed by September 2007'

Resolved, on the motion of Dr Chesterfield-Evans: That Recommendation 1 be amended by inserting the word 'urgent' after 'a' and before 'review' in the first sentence.

Resolved, on the motion of Ms Pavey: That Chapter 3, as amended, be adopted.

Chapter 4 read.

Resolved, on the motion of Ms Pavey: That Chapter 4 be adopted.

Chapter 5 read.

Resolved, on the motion of Mr Catanzariti: That Chapter 5 be adopted.

Resolved, on the motion of Ms Pavey: That Chapter 4 be recommitted.
Resolved, on the motion of Dr Chesterfield-Evans: That a new paragraph be inserted following paragraph 4.31, to read: 'The setting up of a large training system for reporting and analysis of adverse events can distract from the efforts and resources needed to prevent them. It is essential that the resources, skills and actions within the clinical workplace are maintained and improved.'

Resolved, on the motion of Ms Pavey: That Chapter 4, as amended, be adopted.

Chapter 6 read.

Resolved, on the motion of Dr Chesterfield-Evans: That Recommendation 6 be omitted.

Resolved, on the motion of Mr Catanzariti: That the second half of paragraph 6.25 be amended by omitting the words 'While this privilege should encompass internal working documents, as is the case with root cause analysis investigations, this privilege should not apply to pre existing documents, such as reportable incident briefs. This important issue requires further attention' and inserting instead the words 'Please see Recommendation 1, Chapter 3.'

Resolved, on the motion of Ms Pavey: That Chapter 6 as amended, be adopted.

Resolved, on the motion of Ms Robertson: That Recommendations 1-5, as amended, be adopted.

Resolved, on the motion of Mr Catanzariti: That the report, as amended, be adopted by the Committee, signed by the Chair and presented to the House.

Resolved, on the motion of Ms Robertson: That pursuant to the provisions of section 4 of the Parliamentary Papers (Supplementary Provisions) Act 1975 and under the authority of Standing Order 223, the Committee publish all non-confidential tabled documents, correspondence, minutes, answers to questions on notice, submissions and transcripts.

Resolved on the motion of Ms Pavey: That the report be tabled on Tuesday, 21 November 2007.

6. Adjournment

The Committee adjourned at 12pm until 2pm, 13 November 2006. (Budget estimates supplementary hearing)

Glenda Baker
A/- Senior Council Officer