Minister for Education and Training
Minister for Industrial Relations
Minister for the Central Coast
Minister Assisting the Minister for Finance

22 MAY 2007

Ms Lynn Lovelock
A/Clerk of the Parliaments
C/- Legislative Council
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Ms Lovelock

I refer to the Parliamentary Inquiry which was undertaken by the General Purpose Standing Committee's No 2 report on its Review into Complaints Handling within NSW Health.

Enclosed is the New South Wales Government's response to the recommendations of the Committee's report.

I trust that the Government response will be of assistance to the Committee.

Yours sincerely

John Della Bosca MLC

Received at 4.20pm
Tuesday 22 May 2007
Lynn Lovelock
A/Clerk of the Parliaments

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NSW HEALTH

NSW Government Response to:

Review of Inquiry into Complaints Handling within NSW Health

Legislative Council – General Purpose Standing Committee No. 2

BACKGROUND

The first inquiry into complaints handling procedures within NSW Health was announced by the NSW Legislative Council General Purpose Standing Committee No. 2 in December 2003. This inquiry was generated by the serious allegations regarding patient care at Camden and Campbelltown Hospitals.

The Committee's June 2004 report included 19 recommendations. The recommendations extended beyond specific complaints handling processes to address broader systemic 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
- a specific recommendation concerning referring a practitioner to the South Australian Medical Board.

Of the 19 recommendations made by the Committee, the NSW Government accepted 17 of those recommendations. The remaining two recommendations were related to external agencies. NSW Health has fully implemented nine recommendations, and eight recommendations are currently in progress.

The Health Minister also initiated a Special Commission of Inquiry into Camden and Campbelltown Hospitals. The Inquiry, conducted by Mr Bret Walker SC, examined specific issues at Camden and Campbelltown and the broader issues of regulatory arrangements and administration of the Health Care Complaints Commission to ensure that effective mechanisms existed to address complaints concerning individual and institutional health service providers.

The Government delivered a comprehensive response to the Legislative Council report in December 2004, which also considered recommendations from the Walker report. The Government response outlined a number of initiatives that have been implemented and indicated actions to be undertaken including the launch of the Patient Safety and Clinical Quality Program.

As part of the original review, the Committee undertook to instigate a review of the recommendations made in the 2004 report. In March 2006, the committee reviewed progress on the agreed Government actions. Following the Committees review, five additional recommendations were made in November 2006. This document is the Government's response to these five recommendations.

NSW Health Patient Safety Clinical Quality Program

The NSW Government is investing $60 million over a period of five years to implement the Patient Safety and Clinical Quality Program[1]. The program, launched in 2004, is a systemic approach to improvement in clinical quality and patient safety across the whole of the NSW Health system.

The five (5) components of the Program include:

- A system for managing incidents and identifying risks both at the local and state level.
- The statewide deployment of the electronic Incident Information Management System (IIMS), which supports centralised reporting and recording of incident information and enables incidents to be analysed and managed in real time.
- Establishment of Clinical Governance Units in each Area Health Service, which have clear accountabilities for safety and quality which includes the implementation of the Patient Safety and Clinical Quality Program at the local level.
- The development of a Quality System Assessment program, which is conducted by the Clinical Excellence Commission, and is designed to audit the implementation of safety and quality programs in NSW Health services, and determine whether appropriate structures and processes are in place and that the program is working well.
- The establishment of the Clinical Excellence Commission to provide advice to the Minister for Health and the Director General of Health on ways of improving patient safety and clinical quality throughout the health system.

Incident Management System

NSW has in place a comprehensive and systematic approach to the reporting and monitoring of incidents that occur within the public health system.

The incident management system is underpinned by a State-wide electronic Incident Information Management System (IIMS) allowing the NSW public health system to capture all incidents in a way that has not been possible in the past. Reported incidents are reviewed, so that remedial action and education can be applied across the whole health system. NSW is the first jurisdiction to have such an extensive rollout of a system like IIMS.

The Incident Information Management System (IIMS) enables staff to report errors confidentially and without fear of reprisal. This open reporting provides the NSW Health system and the Department of Health with reliable data from which lessons can be learnt and improvement strategies developed and implemented to prevent recurrence of incidents and to improve the quality and safety of patient care continuously.

A core component of the Incident Management system is in depth investigations of all serious adverse events. It is now legislated that all Clinical incidents with a Severity Assessment Code (SAC) 1 are investigated using the Root Cause Analysis (RCA) methodology.

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[1] *NSW Health media release: Launch of The NSW Patient Safety and Clinical Quality Program 2004*

Root Cause Analysis is a retrospective review of a patient safety incident undertaken in order to identify what, how, and why it happened. The analysis is then used to identify areas for change, recommendations and sustainable solutions, to help minimise the re-occurrence of the incident type in the future.

Statutory Privilege

Effective incident management relies on accurate reporting arrangements to identify systems failures for the purpose of learning and improving the system. It is internationally recognised that the role of healthcare staff is vital in such programs.

To ensure the ongoing involvement of front line clinical staff, and to encourage openness, the Health Administration Act 1982 was amended to give statutory privilege to teams conducting Root Cause Analysis investigations of serious incidents.

The privilege was introduced on the 1 August 2005, and protects the internal workings of the Root Cause Analysis team. This enables staff participating in examining serious incidents to be open and honest, knowing that information they provide to an investigating team is protected.

Incident Management Policy Framework

The incident management system is supported by a policy framework to ensure systems and processes are in place to manage issues of a systems nature and of an individual nature appropriately.

NSW Health has in place the following policies:

- Incident Management policy – management of incidents identified by health care providers, systems approach.
- Management of Concern or Complaint about a Clinician – management of individual performance issue.
- Complaint Management – management of issues identified by patients and consumers.
- Open Disclosure – care for the individual and their family affected by an incident
- Look Back – care for groups of patients affected by an incident

The Policy Framework is underpinned by the Incident Information Management System (IIMS). Notification and tracking the management of incidents and complaints is incorporated into IIMS.

Incident Management Policy

This policy outlines the roles and responsibilities of all staff in the NSW health system in incident management. The policy incorporated the seven steps of incident management and the statutory privilege for RCA team members.

Open Disclosure

A further initiative of the NSW Patient Safety and Clinical Quality Program is the state wide implementation of the Open Disclosure policy. This will ensure that patients and their carers are informed that an incident has occurred, be provided with an apology if appropriate and informed of any follow up action. Patients and their carers will have the results of the incident investigation explained to them.

A comprehensive education program to up-skill staff in the process of Open Disclosure will be implemented in the second half of 2007. The education program will include workshops, online tools and educational resources.

Lookback
In August 2006, NSW Health released the *Lookback Policy*. This policy ensures that when necessary there is a consistent, coordinated and timely approach for the notification and management of potentially affected patients, where the patient may have been the recipient of a faulty medical device or equipment and/or inappropriate/inadequate treatment or diagnostics. The Policy documents the steps, including the communication strategy that is to be undertaken by the health services when a lookback is initiated.

Managing a Complaint or Concern about a Clinician
In 2006, NSW Health introduced a policy and supporting guidelines on the Management of a Complaint or Concern about a Clinician.

NSW has implemented a comprehensive, systematic approach to the investigation of a concern raised about an individual clinician. This process ensures that if a staff member or a member of the public raises a concern about any health professional's conduct there is a clear requirement to act, and the policy directive outlines the principles that guide such action. The complaint or concern will be investigated in a timely and appropriate manner. Immediate risks will be managed, and actions will be taken to provide safe, appropriate care whilst maintaining community confidence.

The policy directive includes the legislative requirement for Health Service Chief Executives to report suspected professional misconduct and suspected unsatisfactory professional conduct to the relevant registration board as well as internal department reporting requirements.

Complaint Management
This complaint management process applies to all complaints about health services made by members of the public or external organisations.

In August 2006, NSW Health released the Complaint Management Policy. The policy provides Area Health Services with a standardised approach, ensuring procedural fairness and timely and effective management of complaints. Implementation of the Policy by Area Health Services is mandatory.

Accompanying the complaints management policy is the complaints management guidelines, which provide Area Health Services with tools and practical information on dealing with complaints.

To improve the reporting and performance of managing complaints by Area Health Services the Department has initiated a number of strategies, which include:

- reinforcing standard steps and processes in complaint handling, including timely acknowledgement of complaints
- enhancements to the Incident Information Management System (IIMS) to enable improved complaint monitoring and tracking of complaint procedures
- the development of training modules and tools specifically designed for complaint data recording in IIMS is currently in progress.

In addition to improvements in complaint management there are a number of initiatives being implemented to enhance consumer involvement in the provision of healthcare. Some of these include:

- Updating of the NSW Health *Consumer Rights and Responsibilities* Brochure in 2007.
- Establishment of a Citizens Engagement and Advisory Council by the Clinical Excellence Commission in 2007.
- Distribution of an amended "10 Tips for Safer Health Care" posters to guide consumers to become more actively involved in decision-making about safer health care. The guide was reviewed in consultation with the Clinical Excellence Commission and is to be progressively redistributed to admitted patients across health services in April 2007.
- "10 Tips" information is also available on the Department of Health website in English and multiple other languages.

Patient Satisfaction

As the then-Director General, Ms Robyn Kruk, indicated in her statement to the Inquiry, the Department of Health aims to deliver patient sensitive and focussed care and the satisfaction of people who have received care from the Department is an increasingly important key performance indicator and forms part of many reporting mechanisms.

To this end, new state-wide satisfaction surveys will occur during 2007, and will then be an ongoing annual activity. The survey will encompass all areas of the patient journey and include all Departments and services. This will complement other activities involving engagement with our consumers.

Feedback

Providing feedback on incident data and outcomes of incident investigations is a vital component of a successful incident management system.

In its report of November 2006, the Committee noted "since 2004, NSW Health has made significant changes to its quality and safety agenda, including the introduction of the Incident Information Management System, the rollout of root cause analysis training and the publication of annual incident reports"[2].

NSW Health provides the public with a range of quality and safety information. This includes making the outcomes of a Root Cause Analysis investigation available to patients and/or their families, publishing performance data on an annual basis, in Department and Area Health Service annual reports and in annual incident management reports. NSW Health has published three annual incident reports on *Serious Incidents in the NSW Public Health System*.

In 2006, the Clinical Excellence Commission (CEC) provided an inaugural report on the first complete year of State wide IIMS data[3]. The report provides valuable insights into the nature and number of clinical incident notifications occurring in the system, and a platform for sustainable clinical improvements. This document

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[2] *NSW Legislative Council, GPSC 2, Report 23, Review of Inquiry into complaints handling within NSW Health, November 2006, p8*

[3] *Clinical Excellence Commission ,Analysis of first year of IIMS data Annual Report 2005-2006*

complements the NSW Health *Third Incident Report on Serious Incidents in the NSW Public Health System 2005-2006,*[4] and plans are being progressed to produce these reports on a more regular basis with a combined report to be published six monthly.

Knowledge Management

In the *First report on Serious Incidents in the NSW Public Health System 2003-2004*, a commitment was made to establish a knowledge management framework and strategy to ensure that lessons learnt from the Root Cause Analysis are shared across the whole system, thereby generating state-wide quality improvement. The "lessons learnt" strategy adopted by NSW Health is based on an interactive website acting as a conduit for patient safety information. The website has been active since November 2006, and allows health service staff to develop, publish, access and respond to patient safety strategies and techniques in a timely manner. Information for the website is sourced from local facilities and Area Health Services, as well as from international research and patient safety programs.

The website provides an important point of contact for organisational and practice issues, and Area Health services are now able to develop, publish and respond to patient safety strategies and access literature reviews, international research and other patient safety programs. The use of list-serves and discussion forums also enable areas to exchange information and knowledge on current and emerging patient safety initiatives.

Safety Alert Broadcast System (SABS)

The Safety Alert Broadcast System (SABS) is a mechanism for providing a systematic approach to the distribution and management of patient safety information to the NSW Health system. From time to time information received from incident reporting systems may highlight a possible or real risk to other patients. The SABS allows the NSW Department of Health to disseminate information quickly and efficiently. Each alert specifies the action to be taken by health services, the timeframe in which such action must occur, and specific responsibility for the actions.

The SABS includes a three tier notification to the system via:

- Safety alert
- Safety notification
- Safety information

These levels of notification ensure that appropriate distribution of the information occurs, risk management strategies are initiated and mechanisms are in place to ensure the effectiveness of SABS.

[4] *NSW Health Patient Safety and Clinical Quality Program, Third Report on Incident Management in the NSW public health system 2005-2006.*

Patient Safety Clinical Quality Program next steps

The next phase of the Patient Safety and Clinical Quality Program has identified priority action areas to improve patient safety. The four focus areas are:

- avoidable deaths due to falls;
- elimination of avoidable errors due to wrong patient, wrong site, wrong procedure incidents;
- sustained reduction in the incidence of health care associated infections with a particular focus on intravenous lines; and
- implementation of the National Inpatient Medication Chart (NIMC) and medication orders charted on the NIMC include which include administration times documented by the prescriber.

Targets have been established in the Area Health Service performance agreements, with reductions in each of these four areas to be achieved by December 2007.

Whilst the Patient Safety and Clinical Quality Program specifically focuses on clinical risk there are also structures in place to manage corporate risk.

In 2005, the Corporate Governance and Risk Management Branch within the Department of Health was established to review and coordinate corporate governance and risk management processes across NSW Health. This Branch monitors and coordinates the Department's responses and ensures that appropriate action and follow-up of recommendations from oversighting bodies such as the Health Care Complaints Commission (HCCC), the Independent Commission Against Corruption (ICAC), the NSW Ombudsmen's Office and the Coroner occur.

In the event that a complainant is dissatisfied with an Area Health Service's handling of a matter, the complaintant is able to refer concerns to the Corporate Governance and Risk Management Branch for consideration.

With the numerous patient safety strategies being implemented and the continued commitment and support of these strategies from NSW Health and the Clinical Excellence Commission, the people of NSW can be confident that the Government is serious about patient safety, and that NSW Health has the most transparent system of reporting and investigation of healthcare incidents in the country.

PART A - RESPONSES TO RECOMMENDATIONS

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, 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.

Response

The Committee has raised some important issues with regard to how privilege applies to the investigation of incidents in the NSW public health system.

The NSW Government agrees that the issues raised by the Committee warrant review, and welcomes the opportunity to examine these issues further.

However, care must be exercised when considering the matter of privilege, as an appropriate balance needs to be struck between the need to encourage staff members participating in investigations to be open and honest and broader policy objectives, such as having information available for the purpose of open disclosure to patients and family, and the availability of information for quality improvement purposes.

Rather than duplicate effort in multiple reviews, the Department will consider these matters as part of the review of Division 6C of the Health Administration Act, 1982, to commence in the second half of 2007. The review will include:

- the extent to which the legislation is serving its stated purpose;
- the effectiveness of the requirement that RCA teams have regard to the rules of natural justice, and whether more detailed procedural fairness protections should be included;
- the effectiveness of the privilege and other statutory protections afforded to RCA team members and documents created by the RCA investigation, and whether this should be extended (eg to include persons who are involved in or assist RCA team investigations);
- the intersection of the RCA processes with investigations into the competency or professional standards of individuals;
- the adequacy of the provisions relating to the procedures to be followed by RCA teams in their investigations; and
- the adequacy of the regulation making power, and the matters in respect of which regulations have been made to date.

Key stakeholders will be consulted in the conduct of the review.

Recommendation 2
That NSW Health in conjunction with the Clinical Excellence Commission undertake a review of the level of timeliness of feedback provided to staff following the investigation of an incident.

Response

The NSW Government supports the recommendation to review the level of timeliness of feedback provided to staff following the investigation of an incident.

The NSW Health Incident Management Policy outlines seven key steps to effective incident management,

- Identification
- Notification
- Prioritisation
- Investigation
- Classification
- Analysis and Action
- Feedback

Timely feedback to staff of the outcome(s) of incident investigation is an important step in the incident management process, as feedback is the key driver for effecting change and improvement, and encouraging involvement in the safety and quality program.

The outcomes of incident investigations are communicated back to clinical staff through the Clinical Governance Units established under the NSW Patient Safety and Clinical Quality Program. Part of the RCA process is for health services to feed back the results from RCAs to clinical units. This feedback loop is a major activity for Clinical Governance Units who work closely with health services to assist clinicians to review their incident data and to develop initiatives to ensure that incident information is being communicated to clinical staff.

Local initiatives used to provide feedback to staff include increasing access to incident data by staff from the IIM System, using newsletters to inform services of remedial activity arising from incident investigation and conducting audits to determine the scope of unit discussions of incident management data.

With the introduction of IIMS, managers are now able to access data and run reports to provide feedback to staff in "real time". Aggregated trend data and outcomes of Root Cause Analysis investigations are currently available for ward / clinical management teams.

NSW Health in collaboration with the Clinical Excellence Commission will undertake a review by October 2007 – using site visits and an online survey - to identify the current feedback practices that are in place and consult staff on how current practice might be built upon and strengthened. This approach will identify and encourage those feedback mechanisms that are working well, and enable NSW Health to facilitate State-wide implementation of the best models.

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.
- The use of the Incident Information Management System (IIMS)
- How to distinguish between investigative pathways
- The principles of open disclosure
- Root cause analysis, including the application of privilege.

Response

The UNSW Centre for Clinical Governance completed an external evaluation of the IIMS education and training program in July 2006. The evaluation identified that IIMS training had been widely accepted in NSW and concluded that overall the web-based training effectively addressed the key issues involved in the reporting and management of incidents in IIMS.

NSW Health and CEC have a comprehensive program of quality and safety training programs delivered, underway and planned in the following areas.

Identification of health care incidents

Staff are provided with education on incident management as part of their hospital orientation programs. These sessions are designed to provide staff with the skills and knowledge to identify and notify an incident using the Incident Information Management System.

To complement these programs, NSW Health will develop and disseminate the *Easy Guide to Incident Management* which is a tool to provide staff with a comprehensive guide to incident identification and subsequent notification into the Incident Information Management System.

The Clinical Excellence Commission is incorporating training on the Incident Information Management System (IIMS) into its State-wide Clinical Leadership Training Programs, which involves frontline staff including doctors, nurses, allied health and ambulance officers. This training focuses on delivering patient centred care based on the very best available evidence. The program aims to develop clinical leaders who will promote best practice safety and quality principles and practices in their workplace. A total of 191 participants attended the first session of the program, which commenced in March 2007

The use of the Incident Information Management System (IIMS)
Training in the use of the Incident Information Management System (IIMS) initially occurred during the implementation phase of IIMS and still occurs state-wide as part of incident management training.

A variety of formats including interactive e-learning modules through intranet training and face to face training are being used. There are three (3) levels of training provided to NSW Health employees,

- Awareness training is provided to all staff and advises them of how to notify an incident.

- On-line training is delivered via AHS local intranets and provides staff with guidance as to the user's role in improving safety- explaining the rationale' for reporting incidents and provides guidance with the incident management process.
- Manager training is provided to those staff who manage incidents.

Distinguishing between investigative pathways:

The review of the Health Administration Act will examine current investigative methods, and the intersection of the RCA processes with investigations into the competency or professional standards of individuals.

In addition, a process map and incident decision tree are currently under development to guide Area Health Services in their decision making.

A Managing a Complaint Concerning a Clinician (MCCC) workshop is being held during 2007 to upskill relevant staff in investigation techniques and investigative pathways. Participants in this workshop will include Directors of Clinical Governance and Area Health Service staff responsible for conducting investigations.

Open Disclosure

Two levels of education and training programs have been developed to support health services with the implementation of Open Disclosure. These will commence in June 2007.

The high level program has been designed for staff, including senior clinicians and managers, who are routinely involved in the open disclosure processes following a serious incident. This level of training will ensure that participants -

- have a detailed and demonstrable understanding of the open disclosure process,
- understand and are able to undertake, if required, the process for notifying incidents events to patients and carers,
- provide appropriate medical care and trauma support to patients, carers and staff, and provide an apology as articulated in the NSW Open Disclosure Guidelines,
- have a clear understanding of what information should be provided to patients and carers immediately after an incident,
- understand the medico-legal and insurance obligations and protections following an incident.

The general level education will target all clinical staff and front line managers to develop their ability to communicate effectively in critical situations, including:

- techniques for informing team members about an incident;
- providing staff members involved in an incident with support and advice; and
- responding appropriately to an emotional staff member.

The program will be delivered by a variety of educational methods including on-line learning, and will be incorporated into existing training and education and orientation programs.

Root Cause Analysis (RCA)
A review of Root Cause Analysis (RCA) was undertaken in July 2006. The review identified the need for Area Health Services to have flexibility with criteria and processes for conducting Root Cause Analysis.

The key elements of the revised Root Cause Analysis investigation model are the development of a cohort of highly skilled team leaders in each Area Health Service with appropriate flexibility as to the Root Cause Analysis investigation process, eg. single meeting or multiple meeting method.

The reviewed model was implemented from 1 August 2006. A targeted education program was developed to update the skills of team leaders in the flexible Root Cause Analysis mode. The training was delivered during November & December 2006.

Additionally, Root Cause Analysis Team Leaders are provided with ongoing support through the establishment of an online discussion forum, which enables Root Cause Analysis Team Leaders and other interested parties to share and discuss aspects of the Root Cause Analysis process.

The Clinical Excellence Commission and the Quality and Safety Branch are currently reviewing the Root Cause Analysis training program provided to Area Health Services. The objective of the review is to provide both Root Cause Analysis team leaders and participants with a two tiered training program for continuing education and professional development. This program is currently under development.

Other education initiatives
In addition to the formal 'training' programs outlined above, and recognising some of the unique characteristics of health workplaces, NSW Health and the CEC have implemented and are continuing to implement other innovative education and awareness-raising activities such as:

- CEC April Falls Day – showcasing some of the key initiatives being implemented in the hospital and community sector;
- Rural Telehealth Project – interactive sessions outlining how to implement fall prevention guidelines for hospitals and residential aged care facilities in the four rural AHS; and
- the NSW Clean Hands Save Lives Campaign.

In addition, NSW Health and the CEC convene and facilitate team-based learning opportunities – such as workshops and/or workplace-based improvement teams - which bring clinicians from a particular professional area together to consider a specific issue or problem and develop strategies and tools that can be disseminated state wide.

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.

Response

Simple steps to make health care complaints.
NSW Health has implemented a complaints management policy which provides reinforcement of standardised processes for complaint management and a guideline which provides practical advice for dealing with assessing, investigating and resolving complaints. To enhance complaint monitoring, NSW Health is currently enhancing the Incident Information Management System (IIMS) to enable improved reporting and tracking of complaint procedures.

The NSW Health Internet site also provides the community with simple advice to guide them with progressing concerns about their healthcare.

The Health Care Complaints Commission provides information to the public and to health service providers regarding making a complaint to the Commission, through brochures, its website and community presentations.

This information includes brochures on:

- Information about the Health Care Complaints Commission (reviewed and re-published in 2005/06)
- How to write a complaint to the Health Care Complaints Commission (reviewed and re-published in 2005/06)
- The Resolution Service (designed and produced in 2005/06)
- New Complaint form (reviewed and re-published in 2005/06)

The Commission's material reflects the changed regulatory framework for health care complaints and consumer rights referred to in the final point of this recommendation.

This information is available to NSW Health and other health service providers for distribution.

The Commission provides current information on how to lodge a complaint on its website and can be also contacted using a toll free number 1800 043 or via e-mail.

In addition, the Commission conducts presentations to community groups and health service providers across NSW about the Commission's role and making complaints. For example, in late March 2007, a number of presentations were conducted in the Coffs Harbour and Macksville area. These presentations covered a variety of topics including: an introduction to the purpose and function of the Commission; how complaints are made; assessment decision options; and information about the Commission's Telephone Inquiry Service.

In preparing its Corporate Plan for 2007–08 the Commission is looking at developing a communications and promotions strategy for 2007–08. It is envisaged that the strategy will include promoting the Commission's role in the handling of complaints through brochures and community presentations, enhanced communication and information sharing with professional health bodies and establishing links with organisations involved in the wider clinical governance agenda.

The nature and extent of adverse events in the healthcare system
As outlined previously in this response, the public health system provides this information through a range of sources, including annual Department and Area Health Services Annual Reports and annual incident reports.

In 2006, the Clinical Excellence Commission (CEC) provided an inaugural report on the first complete year of State wide IIMS data[5]. The report provides valuable insights into the nature and number of clinical incident notifications occurring in the system, and a platform for sustainable clinical improvements. This document complements the NSW Health *Third Incident Report on Serious Incidents in the NSW Public Health System 2005-2006,*[6] and plans are being progressed to produce these reports on a more regular basis with a combined report to be published every six months.

Another important source of information is the NSW Health website. For example, NSW is currently the only state in Australia with a mandatory system of monitoring Healthcare Associated Infections (HAIs). As part of this process, NSW Health publishes a number of performance measures on common Healthcare Associated Infections on the infection control website[7]. Complementing the data are fact sheets, that provide the public with simple explanations about the organisms that cause infections, modes of transmission and prevention strategies. A review of the existing infection control data on the website is in progress. The aim of the review is to provide the public with a more consumer friendly format.

Realistic expectations of healthcare
The public is provided with information to give a clear picture of safety and quality in the NSW Health System.

The Government has also established a range of formal processes and forums in which the broader community and specific consumer representatives are informed about – and provide feedback on - the health system.

The Health Care Advisory Council brings clinicians and consumers together at the highest level to provide advice directly to the Director-General and Minister, while Area Health Advisory Councils bring these groups together at a more local level to advise Area Chief Executives.

NSW Health has undertaken a major community consultation process to develop 20-year future directions for the NSW health system. In addition to a Planning Roundtable involving 90 people and a statewide Futures Forum involving 300 people, NSW Health consulted approximately 1,300 people through 26 public forums held across NSW, three Aboriginal community forums and a culturally and linguistically

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[5] *Clinical Excellence Commission ,Analysis of first year of IIMS data Annual Report 2005-2006*

[6] *NSW Health Patient Safety and Clinical Quality Program, Third Report on Incident Management in the NSW public health system 2005-2006.*

[7] *NSW Health available at http://www.health.nsw.gov.au/health_pr/infection/cons/inf_rates.html*

diverse community forum. At a state level, 31 consultation sessions were held involving over 600 participants. More than 1,500 questionnaire responses, comments and submissions were received by post, telephone, email and online.

Recommendation 5
That NSW Health publish Incident Management Reports on a biannual basis.

Response
The NSW Government supports this recommendation and, as outlined elsewhere in this response, plans are already underway for the introduction of six -monthly incident reporting.