Submission
No 20

EXAMINATION OF THE AUDITOR GENERAL'S PERFORMANCE AUDIT REPORTS JUNE - DECEMBER 2020

Organisation: NSW Health

Date Received: 22 March 2022

Mr Greg Piper MP
Chair, Public Accounts Committee
Parliament of NSW
Macquarie Street
SYDNEY NSW 2000

Our ref H22/7269

Dear Mr Piper

Status update on recommendations made by the Auditor-General of NSW

I am writing in response to the Public Accounts Committee's request of 9 December 2021 for a submission on the status of the implementation of recommendations made by the Auditor-General in their performance audit report titled *Managing the health, safety and wellbeing of nurses and junior doctors in high demand hospital environments*.

Please find attached NSW Health's submission for review by the Committee.

If you require any further information, please contact the Ministry's Director, Corporate Governance and Risk Management, via email to

Yours sincerely

Susan Pearce
Secretary, NSW Health

Encl.

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Status Report - Managing the Health, Safety and Wellbeing of Nurses and Junior Doctors in High Demand Hospital Environments (Tabled 9 December 2020)

Audit Recommendations	Accepted/Rejected	NSW Health Response (December 2020)	Status and Comment (February 2022)		Lead
By December 2021, NSW Health should:					
1. Evaluate the effectiveness of the new incident management system to enable full reporting of health and safety incidents and risks in all hospital wards, including those where incidents and risks are common, and monitor for consistency of reporting over time	Accepted	The Clinical Excellence Commission (CEC) has led the implementation of a new incident management system, IMS+, across the Health System. IMS+ has been developed specifically for NSW Health and enables staff to report clinical, work health and safety and corporate incidents in a timely and effective manner. The system has also been developed to enable analysis of data on a state-wide level, to guide the identification, assessment and mitigation of risks. In 2021, the effectiveness of IMS+ will be assessed as part of a planned program evaluation process, giving consideration to the findings of this report.	In progress	The ims+ system was fully implemented state-wide in November 2020. The evaluation and review of benefits realisation of ims+ will continue to be conducted by the CEC in partnership with eHealth. Consultation with the Directors of Clinical Governance (DCG) has provided positive feedback about the system, although it is acknowledged that there is ongoing development work with the vendor to better align the system with the revised NSW Health Incident Management Policy PD2020_047. As part of the review to date, eHealth presented an update on benefits realisation analysis of ims+ to the NSW Clinical Risk Action Group on 18 August 2021. The CEC conitinues to work with eHealth and LHD/SHN Forums to provide feedback to the ims+ vendor to progressively improve functionality and alignment of the system to the NSW Health Incident Management Policy. The CEC is represented on the statewide ims+ Governance Forum and has established a Joint Operational Committee with eHealth to ensure synergy between technical devleopment and operational application. eHealth presented ims+ Benefits Report – Q3 (July 2021 – September 2021) to DCGs on 26 November 2021.	CEC
2. Expand the categories of hospital incident data reported to Ministry executives in the Work Health and Safety Dashboard reports, including by linking injury data to incident types by hospital ward category, and monitor in conjunction with Local Health Districts for emerging trends and improvement over time	Accepted	The Ministry of Health will review the current dashboard reporting structure to include information on ward category and other data which may assist in identifying system-wide trends for investigation. Consideration will also be given to how data from the new IMS+ system can be used to enhance reporting. The Ministry will continue to work with the Local Health Districts to identify emerging trends and to support Districts in preventing and responding to incidents at a local level.	In progress	The CEC is actively working with the Ministry's Workplace Relations Branch to facilitate access to ims+ for nominated Workplace Relations staff. It has been agreed in principle that a limited number of employees of Workplace Relations should have access to ims+ to meet their obligations under the Work Health Safety Act and to enable them to fulfil their function as a Branch. The agreement to provide access was supported by the Senior Privacy Advisor in Regulatory and Compliance Unit, Legal Branch. A governance framework to support this extended access is in progress and nominated staff in Workplace Relations have been advised of appropriate training to complete prior to access being permitted by the CEC. The CEC provided access to ims+ for three nominated staff in Workplace Relations Branch to facilitate access to statewide WHS incident notifications and reports. CEC and Workplace Relations team meet monthly to ensure governance and oversight is maintained. The CEC continues to build inproved working relations with Workplace Relations, as demonstrated in NSW Health COVID related Health Worker Expert Panel. The Ministry is currently undertaking a review of the the IMS+ data for reporting and trending purposes including linkage between incident and injury data. We anticipate completion of this review in the next three months and the possibility of enhancing management reporting as part of this process.	CEC and MoH Workplace Relations
3. Ensure that nurses and junior doctors have regular opportunities to report on risks to their psychological health and wellbeing, and that system managers have access to aggregate data to guide responses to mitigate these risks	Accepted	For junior doctors, The Ministry of Health will conduct the third and final Your Training and Wellbeing Matters survey in 2021. Post 2021, the Medical Board of Australia's annual survey of trainee doctors will be used to collect relevant data, with a focus on health and wellbeing. Aggregated data will be reported by facility and made available to relevant staff in each Local Health District and Specialty Network. The Ministry will also investigate options for engaging with nursing staff over the same time period.	Complete	The third and final Your Training and Wellbeing Matters Survey was run Monday 26 April to 16 May 2021. The NSW survey results are published at: https://www.health.nsw.gov.au/workforce/culture/Pages/ytwm-survey.aspx. Facility reports have been provided to relevant staff in each LHDs/SN where there were 10 or more junior medical officer responses. The Your Training and Wellbeing Matters Survey questions and the Medical Board of Australia's Medical Training Survey cover the same topics. The Ministry will not run any further Your Training and Wellbeing Matters surveys and will rely on the annual Medical Training Survey to provide data on JMO health and wellbeing. The Medical Board of Australia's third Medical Training Survey was run in August/September 2021 and results released 7 February 2022. These results are available at https://www.medicaltrainingsurvey gov.au/ The Ministry has also provided facility reports to relevant staff in each LHD/SN . Facility reports available where 10 or more junior doctors have responded. The fourth Medical Training Survey will be run in August /Setember 2022 , which aligns with the annual renewal of doctors registration.	MoH Workforce Planning and Talent Development

Audit Recommendations	Accepted/Rejected	NSW Health Response (December 2020)	Status and Comment (February 2022)		Lead
4. Develop and implement an evidence-based guiding framework and strategy to support hospital staff in the aftermath of traumatic or unexpected workplace incidents, and monitor implementation	Accepted	In collaboration with key Health System leads, the findings of this audit will be reviewed and incorporated into activity. Of note, NSW is enacting new legislation with respect to the management of serious incidents from 14 December 2020. At this time a new NSW Health Incident Management policy directive will be introduced. Among other enhancements, the new policy will set revised requirements for the assessment and escalation of risk and will also give a focus to supporting staff psychological wellbeing following a serious clinical incident.	Complete	The NSW Health Incident Management Policy PD2020_047 is based on the principles of immedicacy, accountability and kindness. Health Services must undertake a Preliminary Risk Assessment (PRA) for a serious clinical incident, or a Safety Check for a serious corporate incident, within 72 hours of the incident occurring. Any person appointed to undertake a preliminary risk assessment must immediately escalate to the Chief Executive, in writing, concerns of continuing serious or imminent risk of harm to staff. Both the PRA and Safety Check templates require the assessors to consider staff wellbeing following an incident and prompts the consideration for further actions required to support staff. Supporting information is avaiable at the following link: https://www.cec.health.nsw gov.au/Review-incidents/incident-management-policy-resources. The CEC monitors compliance with submission of Reportable Incident Brief (RIB) and the PRA to identify emerging or immediate statewide risks - all RIBs are reviewed daily in consultation with Patient Safety First Unit. The CEC is working with relevant stakeholders to develop increased resources available to staff to support and respond to risk of vicarious trauma.	CEC and MoH Workplace Relations
5. At regular intervals, publicly report aggregate Root Cause Analysis data detailing the hospital system factors that contribute to clinical incidents	Accepted	The Clinical Excellence Commission will continue to publicly report aggregate root cause analysis data relating to serious clinical incidents, in order to outline key systems factors that contribute to clinical incidents. The effectiveness of this practice will be assessed with respect to the findings of this report and to identify where enhancements can be made.	In progress	following implementation of the revised NSW Health Incident Management Policy PD2020_047, four methodologies can be used for the review of serious incidents; this includes Root Cause Analysis but they are collectively referred to as Serious Adverse Event Review (SAER). Data relating to system and risk factors identifed by SAERs are reported publically in Biannual Incident Report. The July to December 2020 report is currently in final review ahead of being uploaded to the CEC website. The January to June 2021 report is currently in draft form and being reviewed to revise the style, format and content to improve access and readability as a public document . The CEC has also established a Safety Intelligence Unit which has oversight of the Biannual Report; Jan-June 2021 publication is in final stage of drafting and has been redesigned to improveacces, format and readability.	CEC
6. Develop and implement a systemwide platform for sharing research and information about hospital health and safety initiatives across the health system	Accepted	The Ministry of Health will consider opportunities to facilitate information sharing to guide development and implementation of a system-wide platform, in consultation with key stakeholders within NSW Health, including the Clinical Excellence Commission, HealthShare NSW and Local Health Districts and Specialty Networks.	In progress	The CEC continues to work collaboratively with key stakeholders in NSW Health to share information and learnings relating to patient and staff safety. The CEC website demonstrates the extensive work being undertaken to support all staff working at all levels in NSW Health. https://www.cec.health.nsw gov.au/ CEC has commenced a Strategic Redesign of Serious Adverse Event Review (SAER) Framework which will focus on improving access to lessons for learning arising from the SAER reviews. Quaterly updates on progress are provided to the Clinical Risk Action Group (CRAG). In addition to the work by the CEC, a database has been created by the Ministry where all Agencies can log their security and WHS projects. The NSW Health forum meets quarterly where projects and research is shared. HealthShare NSW and the Speciality networks are part of the forum. All agencies report quarterly to the Ministry of Health on quality improvement projects which can be shared.	CEC and MoH Workplace Relations
7. Conduct a post-pandemic 'lessons learned' review focusing on the effectiveness of key strategies deployed in the management of the COVID-19 pandemic and make policy and operational recommendations for future pandemic responses. In particular, ensure:	Accepted	The Ministry of Health will lead a review on NSW Health's response to the COVID-19 pandemic, to inform planning for future pandemic response. It is proposed that this work will be completed when appropriate to do so, post-pandemic. The points highlighted by this recommendation will be included in the terms of reference for review, among other items of priority for the Health System.	In progress	The CEC website contains the publications to date relating staff and patient safety in response to COVID-19. In addition, the CEC is the lead agency in the Health Care Worker Expert Panel which is a multi-agency/multi-disciplinary review of all potential exposures/transmissions of COVID-19 to staff in the workplace; the documentation of this process is currently being finalised and further information is available at https://www.cec.health.nsw.gov.au/keep-patients-safe/COVID-19. The CEC has established the COVID-19 Serious Incident Review (SIR) Sub-Committee of CRAG to review all COVID related SAERs and Corporate Reviews (Clusters/outbreaks) to identify themes, risks, lessons for learning for now and future state. An Interim Report due in late March 2022.	MoH and CEC