

Ms Beverly Duffy
Director
Legislative Council
General Purpose Standing Committee No. 2
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Ms Duffy

Inquiry into the Review of inquiry into complaints handling in NSW Health

I refer to your correspondence requesting a review of the draft transcript and answers to questions taken on notice by NSW Health staff at the hearing on 14 September 2006.

Please find attached responses to the questions taken on notice.

Should you require further information, please contact Mr Matt Monahan, Manager, Parliament and Cabinet Unit, on (02) 9391 9328.

I trust this information is of assistance.

Yours sincerely

Robyn Kruk
Director-General

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Response to Questions on Notice – 14 September 2006

- 1. The NSW Nurses Association is concerned about the inconsistent implementation of the Incident Information Management System across AHSs. They think that further training could encourage more consistent reporting. What is your response to these comments?**

In May 2005, the *Incident Information Management System* (IIMS) was implemented across NSW and training commenced for the approximately 100,000 potential users of the IIMS. Training Modules included awareness training for all staff on how to notify an incident; on-line training available via the intranet for all notifiers and managers with logged-on security access; and administrator training for staff required to manage the logins and security permissions for local users. Training methods used included video, CD-ROM and DVDs, face-to-face, individual and group presentations, tutorials and support from a colleague.

The UNSW Centre for Clinical Governance recently completed an external evaluation of the IIMS education and training program (July 2006). The evaluation identified that IIMS training has been widely accepted in NSW and concluded that overall the web-based training effectively addressed the key issues involved in the reporting and managing of incidents in IIMS. Health service staff's overall experience of the web-based training including content, instructional design, interactivity, navigation, motivational components, use of media, evaluation of learning, aesthetics, record keeping and tone was reported as satisfactory.

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.

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- 2. While the AMA welcomes the Department's Incident Management Policy, the Association argues that training programs for new doctors don't include competencies regarding quality and safety issues and there is a similar lack of information for existing practitioners. How would you respond to these comments?**

NSW Health is aware that the Confederation of Post Graduate Medical Education Councils has drafted an Australian Curriculum Framework for Junior Doctors that includes safety and quality health components as a core part of training interns and Junior Medical Officers.

In 2007, the Clinical Excellence Commission is conducting a 12-month Clinical Leadership program focusing on delivering patient-centred care, incorporating evidence-based practice, quality improvement, clinical risk and incident management, and how to use clinical data to improve patient safety.

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3. The AMA argues that RCA investigations should be regulated by statute rather than policy because the legal status of Policy Directives is uncertain. What is your view on this matter?

Policy Directives (or PDs) are a key mechanism for regulating the NSW Public Health Service. The Department of Health does not consider the status of Policy Directives to be uncertain.

Under section 25 of the Health Services Act, the Chief Executive of an Area Health Service is subject to the direction and control of the Director General of the Department of Health. All Policy Directives are issued by the Director General, and as such are a lawful direction under section 25.

PD's are also publicly available to the system and the broader community via NSW Health websites and compliance is incorporated into Area Health Service performance agreements with the Department, thus ensuring accountability and monitoring to ensure compliance. All PDs are also required to be reviewed every 5 years for ongoing relevance and appropriateness.

The Department does not therefore agree with the AMA's assessment that legislation is the only means to ensure good practice and good policy is implemented and complied with within the NSW Health System.

It is also important to recognise that not all activities or policies can or should be implemented via legislation, which can be a blunt instrument in directing and guiding conduct. Reliance on a combination of legislation (in relation to the privilege) and PDs (in relation to conduct of Root Cause Analysis and other related matters) ensures Area Health Services operate within a comprehensive scheme which provides both guidance and direction.

The real test of the balance between the legislative and policy basis for these processes will be how the RCA process, including the privilege, is in fact working. In this regard, the Department notes that Division 6C of the Health Services Act is required to be reviewed after its first 3 years of operation, that is in the 12 months commencing 1 August 2008. At that time a comprehensive review of the provisions and their effectiveness will be undertaken.

This statutory review will also 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 RCA process.

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4. The AMA argues that doctors are concerned about the negative consequences that may stem from participation in complaints handling processes and that these concerns could be reduced by:

- **Attaching privilege to all parts of the investigation of all incidents, not just those incidents that are the subject of an RCA (SAC 1 incidents)**
- **Extending privilege for all participants involved in a RCA process not just RCA team members.**

Is it possible or desirable to extend statutory privilege in the way suggested by the AMA?

The Department of Health considers that privilege should not be attached to any complaints/adverse incident review process without compelling public policy reasons. The RCA process is specifically designed to investigate serious clinical adverse events, with a view to identify and make recommendations to address systemic errors. It relies on openness and candour from clinicians to identify errors or inadequacies that suggest the need for change. Encouraging this kind of openness was the main reason for according the RCA internal processes with privilege.

NSW Health agencies however, deal with a much wider range of incidents and complaints, including matters involving financial loss, staff issues and matters of individual misconduct. The RCA process is not designed or equipped to address these types of issues.

The RCA legislation particularly recognises this distinction, by providing that concerns about individual conduct cannot be dealt with in the privileged process, but must be referred to health service management. This ensures proper reporting of conduct issues to the relevant authorities, such as registration boards and the Health Care Complaints Commission.

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.

The Department would also be concerned that extending privilege to “all parts” of these types of investigations may undermine their purpose and could prevent patients being informed of information relevant to their care.

While it is clearly possible to design legislation with a broader coverage if this was considered desirable, and a wider privilege could be justified, there would also need to be substantial exemptions to address these concerns.

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5. **The AMA have submitted that the Health Administration Act and the Department's Information Policy directive are not adequately clear about the responsibilities of an RCA team to refer a matter to the appropriate disciplinary processes. Would you like to respond to this comment?**

The responsibilities of a RCA team to refer a matter to the appropriate disciplinary processes is clearly stated in the revised *Incident Management Policy Directive PD2006_030* released in May 2006. 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.

Whilst (RCA) team members do not have the authority to conduct an investigation relating to the competence of an individual in providing services, if the RCA team forms the opinion that an incident may involve professional misconduct, unsatisfactory professional conduct or impairment issues, they have an obligation to notify the Chief Executive in writing. The Chief Executive will consider appropriate action and the RCA team will take no further action on the individual matter. The RCA team also has the discretion to notify the Chief Executive if they consider an incident may involve other performance issues.

The RCA team may continue to investigate the systems issues in the incident. A sample letter that may be used by the RCA Team Leader to inform the Chief Executive of an incident involving individual performance is attached at Appendix G of the policy directive. The team does not refer the matter to the appropriate disciplinary process but does refer the matter to the Chief Executive who decides on the appropriate action as guided by the *Management of Complaint or Concern about a Clinician* policy directive *PD2006_007*¹ and guideline *GL2006_002*².

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.

¹ http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_007.pdf

² http://www.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_002.pdf

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- 6. Several inquiry participants have suggested that more needs to be done to foster community awareness of the occurrence of adverse events and the principles of open disclosure. In its previous report, the Committee recommended that the CEC and NSW Health conduct an extensive public education campaign to inform the community about such matters. Why hasn't this happened?**

NSW Health and the CEC have completed, or are progressing, a number of publicly accessible initiatives to foster community awareness of the principles of Open Disclosure and to advise of key events including the public release of Annual incident reports to the community.

1. Open Disclosure

The *NSW Health Incident Management Policy*³, including Open Disclosure, was released in May 2006. This was followed by the release of a separate *Open Disclosure Policy Directive*⁴ PD 2006_069 on 25 August 2006. An Open Disclosure website with links to educational tools, related policies and contact details is available to any member of the public to access if they have a specific question or require further information at: <http://www.health.nsw.gov.au/quality/opendisc/index.html>.

Open Disclosure Guidelines are in the final stages of completion and have been developed in consultation with key stakeholders including health service Directors of Clinical Governance, Treasury Managed Funds, Medical Defence Organisations and consumer representatives.

Frequently Asked Questions and *Fact Sheets* are now available and include Legal and Insurance questions, a Patient Information Leaflet and a *Medical Defence Organisation (MDO) Open Disclosure Fact Sheet*. A *MDO Notifying an incident or Open Disclosure process* has also been drafted for public release by November 2006.

2. National Summit on Adverse Events in 2007

Other initiatives in progress to inform the community about key events include a proposed National Summit on Adverse Events in 2007. On 13 September 2006, the Australian Commission on Safety and Quality in Health Care Standards Interjurisdictional Committee agreed the Commission and NSW Health would develop a proposal for the summit.

3. 10 Tips for Safer Health Care: What everyone needs to know

A *10 Tips for Safer Health Care: What everyone needs to know* brochure has been distributed in NSW to empower consumers to become involved in decision-making

³ http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_030.pdf

⁴ http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_069.pdf

about their health care. Links to translated information for culturally and linguistically diverse communities is also available from the NSW health *10 Tips* website at: <http://www.health.nsw.gov.au/quality/10tips/index.html>. In November 2006, NSW Health will distribute additional *10 Tips* information to health services to further enhance public awareness.

4. Correct Patient, Correct Procedure, Correct Site Model Policy (PD2005_380)

The *Correct Patient, Correct Procedure, Correct Site Model Policy (PD2005_380)* has been released and outlines 5 steps to be taken to ensure that the correct procedure is performed on the correct patient at the correct site and if applicable, with the correct implant. Information has been distributed widely to the NSW public health system and includes translations into Chinese, Croatian, English, Farsi/Persian, Greek, Indonesian, Italian, Japanese, Khmer/Cambodian, Korean, Lao, Macedonian, Maltese, Polish, Portuguese, Punjabi, Russian, Serbian, Somali, Spanish, Thai, Turkish, Ukrainian, Urdu and Vietnamese. This information is also available for public access from the NSW Health website at: <http://www.health.nsw.gov.au/quality/correct/tools.html>

5. Incident Reporting to the Community

NSW Health and the CEC and have worked closely together to release the two annual incident reports to inform the community on serious adverse events occurring in the NSW health system. NSW is the first Australian State or Territory to publicly release this data.

In the first public report, covering 2003/2004, **452** serious incidents were reported. This compares to **429** serious incidents reported in 2004/2005. The public reporting of incidents demonstrates the commitment of NSW Health to a culture of open reporting where incidents can be reviewed and lessons are learned. The reports are available from the NSW Health website at: <http://www.health.nsw.gov.au/quality/incidentmgt/reports.html>. Plans are now underway to produce the first annual public report on all clinical incidents (not just serious incidents) occurring in the health system in 2007.

In August 2006, the first twelve months of incident data was publicly reported by the CEC at an Australasian conference on quality and safety in Melbourne. The data presented described all the incidents that have been notified to the system and analysis of the types of incidents, including location, time of occurrence, age of persons involved, level of severity and consequence of the incident and more. Articles about this data were also published in *The Australian*, *Sydney Morning Herald* and *The Bulletin*.

6. CEC Citizens Engagement and Advisory Council (CEAC)

To further engage the community, the CEC Board is establishing a Citizens Engagement and Advisory Council (CEAC). The CEAC will be made up entirely of community members with skills to increase the capacity of the CEC to both inform and meet the expectations of the community. Membership will include journalists and people with experience in local government, adult education and service and charity involvement. Expressions of Interest will be sought in November 2006.

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- 7. The AMA is not satisfied that there is sufficient or prompt sharing of information about systems failures among health organisations and the Department. What is NSW Health doing to ensure the outcomes of incident investigations are communicated back to clinical staff and that AHSs respond appropriately?**

1. RCA Process

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 Root Cause Analysis 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 the incident information is being communicated back to clinical staff.

2. Local initiatives

Local initiatives used to feedback to staff include increasing access to incident data by staff from the Incident Information Management System (IIMS), using newsletters to inform services of remedial activity arising from incident investigation, and conducting audits to determine scope of unit discussion of incident management data.

Prior to the implementation of the Incident Information Management System (IIMS), Area Health Services had paper-based systems for reporting incidents. Manual data entry and analysis was required, which led to delays in providing valuable feedback to staff. With the introduction of IIMS, managers are now able to access and run reports to provide feedback to staff in "real-time". Trended data from IIMS is presented to clinical staff at ward and other quality / patient safety meetings. There is ongoing staff education being conducted throughout Area Health Services regarding management of incidents.

3. Lessons Learned/Annual Incident Reports

The need to share the lessons learned from incidents managed in NSW to improve patient safety and quality is an important component of the NSW Patient Safety and Clinical Quality Program. In the First Report on Incident Management in the NSW Public Health System, 2003-2004, a commitment was made to establish a knowledge management framework and strategy: *"During 2005 a comprehensive knowledge management strategy will be activated to ensure that the lessons learned from the RCAs are shared across the whole system and generate state-wide quality improvement"*. The benefits of this have been seen in the later reports.

In the Second Report on Incident Management in the NSW Public Health System, 2004-2005, publicly released in January 2006, lessons learned and supporting strategies to

improve patient outcomes were included on clinical management, suicide, falls, labour and delivery, retained instruments or material and wrong site surgery.

The Third Report on Incident Management in the NSW Public Health System, 2005-2006, is scheduled for release by 30th November 2006 and will refer to the Lessons Learned Strategy, based on an interactive website, which will act as a conduit for patient safety information. The website will allow health service staff from across NSW to develop, publish, access and respond to patient safety strategies and techniques in a timely manner. Information for the website will be sourced from local facilities and AHSs, as well as from international research and patient safety programs. The site is currently being tested in consultation with health services.

The launch of the lessons learned website is scheduled for October 2006 and is one way that the outcomes of incident investigations can be communicated back to clinical staff to enable AHSs to respond appropriately. It is intended that the website becomes a point of first referral on organisational and practice issues related to patient safety. Presentation of lessons learned from across the state will enable local facilities and services to compare and consider their own strategies and approaches.

4. Safety Alerts

The flagging of local, statewide, national and international safety alerts also assists facilities to deal with patient safety issues quickly and effectively. The collation and presentation of findings from and sources of, patient safety literature, conferences and workshops will ensure that health staff has up to-date issues and solutions available to them. A Safety Alert Broadcast System (SABS) was introduced by NSW Health in 2006 to provide this essential safety information to the NSW Health system. This 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. Safety Alerts have included the care and operation of infusion pumps, the degradation of implantable pacemakers late in the life and the crystallisation of a contrast agent for use with X-ray examinations. All Safety alerts are publicly available via the website at:

<http://www.health.nsw.gov.au/quality/sabs/register.html>

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8. One of the five key components of the NSW Patient Safety and Clinical Quality Program is the development of a Quality Systems Assessment Program. Could you please provide an update on progress to date?

The Quality System Assessment Program (QSAP) is a new initiative for the NSW Health System and a key component of the NSW Patient Safety and Clinical Quality program. It is to be conducted independent of the Health Services and the Department of Health by the Clinical Excellence Commission.

The QSAP comprises an annual review of all public health organisations (PHOs) in NSW, to identify, analyse and advise on issues of a systemic nature that affect patient safety and clinical quality in the NSW health system.

Key objectives of the program are to provide evidence of the following:

- Assurance with compliance of:
 - Policies.
 - Standards.
 - Guidelines.
- Assessment of the level of development of:
 - Patient safety system.
 - Clinical quality improvement.
- The level of improvement at a local, facility and systems level.
- The identification of future risks to patient safety.

Elements to be examined in the first year of the QSAP are:

- Quality and safety reporting structures.
- Safety policies and procedures.
- Incident management.
- Complaint management.
- Medical record reviews.
- Audits of clinical practices.

Given the complex nature of PHOs, QSAP will have three levels of organisational focus. Each level is a key accountability point in the system and has responsibility and governance of patient safety and quality systems. The three levels are:

- Area Health Services (AHSs).
- Facilities and / or Clinical Streams.
- Clinical Units.

The CEC has completed the first stage of the development process, which resulted in the development of the QSA Framework and of a review tool called the QSA Activity Statement to record the quality and safety arrangements at the AHS level.

A pilot study of the review tool is currently being conducted at two metropolitan and one rural Area Health Service. The feedback from the trial will be evaluated and the activity statement modified. Rollout to five other AHSs will occur in November 2006.

Second stage development is in progress with an open tender process conducted. This stage will focus on the hospital/facility or clinical stream and clinical unit/ department level. Submissions are currently under consideration

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- 9. When was the Reportable Incident Review Committee extended privilege?
(p. 7)**

The Committee was granted privilege on 28 July 2006.

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10. Would it not be better to report [incidents] more frequently than once a year? (p. 10)

Annual Incident Reports

NSW is the first Australian State or Territory to publicly release annual incident reports to inform the community on serious adverse events occurring in the health system. Public reporting of these incidents demonstrates the commitment of NSW Health to a culture of open reporting where incidents can be reviewed and lessons are learned.

In the *First Report on Incident Management in the NSW Public Health System, 2003-2004*, released in January 2005, **452** serious incidents were reported. This compares to **429** serious incidents reported in the *Second Report on Incident Management in the NSW Public Health System, 2004-2005*, released in January 2006.

Plans are now underway to produce the first annual public report on all clinical incidents (not just serious incidents) occurring in the health system in 2007. The reports are available from the NSW Health website at:

<http://www.health.nsw.gov.au/quality/incidentmgt/reports.html>

In August 2006, the first twelve months of incident data was publicly reported by the CEC at an Australasian conference on quality and safety in Melbourne. The data presented described all the incidents that have been notified to the system and analysis of the types of incidents, including location, time of occurrence, age of persons involved, level of severity and consequence of the incident and more. Articles about this data were published in the *Australian*, *Sydney Morning Herald* and *The Bulletin*.

Lessons Learned website

The need to share the lessons learned from incidents managed in NSW to improve patient safety and quality is an important component of the NSW Patient Safety and Clinical Quality Program. In the *First Report on Incident Management in the NSW Public Health System, 2003-2004*, commitment was made to the establishment of a knowledge management framework and strategy: “*During 2005 a comprehensive knowledge management strategy will be activated to ensure that the lessons learned from the RCAs are shared across the whole system and generate state-wide quality improvement*”. The benefits of this strategy have been seen in the following reports.

In the *Second Report on Incident Management in the NSW Public Health System, 2004-2005*, lessons learned and supporting strategies to improve patient outcomes were included on clinical management, suicide, falls, labour and delivery, retained instruments or material and wrong site surgery.

The Third Incident Report is scheduled for release by 30th November 2006 and will refer to the Lessons Learned interactive website, which will act as a conduit for patient safety information. The website will allow health service staff from across NSW to develop, publish, access and respond to patient safety strategies and techniques in a timely manner. Information for the website will be sourced from local facilities and AHSs, as well as from international research and patient safety programs. The site is currently being tested in consultation with health services and is scheduled for October 2006. Presentation of lessons learned from across the state will enable local facilities and services to compare and consider their own strategies and approaches.

Quarterly incident reports from the NSW Health Quality and Safety Branch are also under consideration.

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11. Can you give us a rundown of the people who gave evidence in the Campbelltown inquiry, for example? Where are they now? How many of them are working in the health system? I gather that none of the nurses is and some of the doctors have left as well. Is that right? (p. 10)

The list below includes those staff known to have given evidence in the Campbelltown Inquiry and their status as advised by Sydney South West Area Health Service.

The Department of Health does not maintain a database containing the names of all personnel employed in the NSW public health system. This level of data would only be available from individual Area Health Services. Inquiries in regard to the employment status of the staff below were made with Sydney South West Area Health Service only. It is possible that some staff that resigned from Sydney South West Area Health Service may be employed in public health facilities in other Areas.

NAME	EMPLOYMENT STATUS (at Sydney South West Area Health Service)
YVONNE QUINN, Registered Nurse	Resigned. 20/9/2002
MARY VALERIE OWEN, Registered Nurse	Resigned. 11/10/2002
NOLA THERESE FRASER, beauty therapist and individual complainant	Employed by the Area Health Service. Has not worked shifts since 2002.
SHEREE ANN MARTIN, beautician and individual complainant	Employed by the Area Health Service on a part time basis.
VANESSA LEANNE BRAGG individual complainant	Employed by the Area Health Service. Has not worked shifts since 2002.
KATHERINE MARIE GROVER, Registered Nurse	Resigned. 12/8/2001
GISELLE CLARE SIMMONS, Registered Nurse	Resigned. 8/2/2004
CHARLES DAVID HUGELMEYER, Director of Emergency Medicine, Macarthur Health Service	Resigned. 10/3/2006
MARY PRENDERGAST, Visiting Medical Officer	Contracted to 31 December 2008
JAMES LESLIE PARKER, Chairperson, Medical Staff Council, Macarthur Health Service	Resigned. 31/1/1999
EDWIN LIM, Visiting Medical Officer and Surgeon	Contracted to 31 December 2008
RICHARD CRACKNELL, Director of Emergency, Liverpool Hospital	Employed by the Area Health Service, on a full time basis.

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12. Have you had any complaints or notifications about a private hospital in the Lismore area? (p. 12)

Incidents reported to the Area Health Service relating to public patients being treated in private facilities are also entered into the Incident Information Management System. These incidents are followed up in the same manner as if the patients were being treated in the public system.

I am advised that in response to concerns raised regarding services provided through a private service provider in the Lismore area, the Area Health Service appointed an independent clinician, nominated by the relevant College, to investigate.

I am advised that the report of this investigation (dated 30 May 2006) found that none of the issues raised by the clinicians could be attributed to the clinical environment, which was found to be suitable for clinical care.

I understand that since the conclusion of this investigation in May 2006 there have been no further incidents reported.

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- 13. There was another incident in Wollongong with regard to pain management where there was what would appear to have been a fairly simple clinical error which was then investigated and the investigation would seem not to have been at arm's length. So while it would seem that acknowledging the mistake and an apology might have been sufficient, in fact, it became highly investigated and highly abstruse—unclear. If you are not aware of that case perhaps you could take it on notice. (p. 13)**

There is not enough information in the question to provide an answer. As noted in the hearing, if the honourable member would care to provide more information about this case then an answer will be provided.

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14. Could you please send me the details of that wonderful program? (p. 15)

NSW FALLS PROGRAM

Background

- The evidence estimates that 1 in 3 people > 65 years in community will fall each year and 30% will require medical attention and 10% will have multiple falls
- Total lifetime cost of falls in NSW is estimated at \$644m (\$333m direct costs & \$311m mortality & morbidity costs). This does not include the cost of falls in health care establishments.
- The cost of fall injury to NSW Health is nearly double the cost of road trauma.
- Falls are the most commonly notified incident in hospitals and represent the leading cause of injury to patients in hospitals.

NSW Falls initiatives 2001 - 2004

The Rural Falls Injury Prevention Program (RFIPP) was formed to increase the access of older people to appropriate fall-safe activities across rural NSW.

One of the best primary prevention strategies for falls injury prevention is the promotion of regular physical activity. Activities that improve balance, strength, mobility, fitness and bone density (referred to as fall-safe activities) can have a protective effect.

In Rural NSW there was a lack of appropriately trained leaders to deliver groups, and a limited range of activities offered. The primary aim of the RFIPP was to increase the access of older people living in rural NSW to appropriate fall-safe activities. The objectives of the program were to:

- Build the capacity of the participating AHSs to develop and implement appropriate and effective local projects.
- Increase the number of leaders providing appropriate fall-safe activities for older people.
- Develop and implement a variety of strategies that support the establishment and sustainability of fall-safe activities for older people.
- Ensure RFIPP investments target areas in greatest need.

The independent evaluation revealed substantial achievements against each of the program objectives and the overall aim of the RFIPP. There were positive outcomes related to the capacity building objectives. Follow-up revealed that a substantial number of fall-safe activities had been created and sustained. Further, AHSs invested in local initiatives.

A full report on this program *Rural Falls Injury Prevention Program: Report of Interventions and Outcomes March 2005* is available on the Department of Health website at

<http://www.health.nsw.gov.au/public-health/health-promotion/injury-prevention/types-of-injury/rural-ahs-partnerships.html>.

Current NSW Falls Initiatives

The NSW Falls Program which is being implemented across the state is building on the work of the rural falls program.

The key objectives of the program are to:

- Reduce fall injury in older people and fall related admission to hospital through:
 - Identification, assessment and management of people at risk from falls.
 - Implementation of best evidence guidelines (Australian Safety and Quality Council, 2005), distribution of good practice tips to hospital wards and education of hospital staff.
 - Showcasing good models of practice.
 - Review and analysis of IIMS Falls incident data at ward level.

- Implement a range of strategies that work across community, hospital and residential care settings such as:
 - Liaison and development of partnerships with other agencies for further development of exercise programs with a focus on strength, flexibility and balance training.
 - Identification and management of early risk factors by GPs, Community Health Teams, Community Service Providers, NSW Ambulance Service.
 - Development of appropriate referral networks.
 - Promotion of community information on benefits of physical activity that promote independence.

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- 15. You will probably have to take this question on notice, but I want to ask you about the percentage of people whose interaction with New South Wales Health is less than satisfactory. (p. 16)**

Satisfaction ratings by health service users are collected as part of the NSW Population Health Telephone Survey. People who had attended a health service in the last 12 months were asked to rate the health care as “excellent, very good, good, fair or poor”: In 2005 satisfaction (excellent, very good, good services) was highest with hospital inpatients (91.8%) followed by emergency departments (80.6%).

This information is reported annually in the NSW Department of Health Annual Report.