

REVIEW OF INQUIRY INTO COMPLAINTS HANDLING IN NSW HEALTH

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Date Received: 9/05/2006

Subject:

Summary

1 May 2006

Hon Patricia Forsythe MLC
Committee Chair
General Purpose Standing Committee No. 2
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Ms Forsythe

Re: NSW Health and Clinical Excellence Commission submission to the General Purpose Standing Committee No. 2 - Inquiry into Complaints Handling in NSW Health.

I refer to the Committee's request for an update on progress of the implementation of recommendations from the above inquiry and enclose the NSW Health and Clinical Excellence Commission submission in response.

Of the 19 recommendations resulting from the Inquiry, 17 were accepted and commitments made by the NSW Government arising from these events. Nine recommendations have been fully implemented, 7 are in progress, and 1 recommendation is yet to be commenced.

This submission provides an overview of the progress on the implementation of the NSW Patient Safety and Clinical Quality Program and details the progress against each recommendation.

The Committee will also recall that the former Minister for Health announced a Special Commission of Inquiry into Camden and Campbelltown Hospitals. The Inquiry, conducted by Mr Bret Walker SC, examined the regulatory arrangements and administration of the HCCC to ensure that effective mechanisms existed to address complaints concerning individual and institutional health service providers.

Also included with this submission is a detailed overview of progress implementing the recommendations of the Walker Inquiry. Significantly, all 17 Legislative recommendations in the Walker report have been completed. Of the 5 General Recommendations 4 have been completed and 1 is in progress.

Please do not hesitate to contact Dr Michael Smith Director, Patient Safety and Clinical Quality, NSW Health on telephone 9391 9200 if you have any questions.

Yours sincerely


Robyn Kruk
Director-General


Clifford Hughes
CEO, Clinical Excellence Commission

Encl.

INTRODUCTION

In June 2004 the General Purpose Standing Committee No 2 of the Legislative Council published a report entitled "Complaints Handling Within NSW Health:

In his Foreword to the report the Committee's Chair, Reverend Dr Gordon Moyes AC MLC observed:

"There is no shame in making a mistake but it is in no one's interest to ignore or hide these incidents, at either an individual or systemic level. Having the courage to be open about adverse medical events is essential to improving patient safety and wellbeing".

The Committee made 19 substantive recommendations that it considered would, if implemented, help to improve the handling of complaints by NSW Health agencies. Some of the recommendations related to other processes including accreditation of health services, open disclosure of adverse events and their management, and provisions to protect complainants.

In a response to the Committee's report, the Government supported the general thrust of the Committee's recommendations. The Government gave qualified support of two of the Committee's recommendations (about accreditation and publication of data).

The Government also detailed for the Committee a significant array of initiatives that it had progressed to improve safety and quality in NSW Health. These initiatives included:

- ❖ the creation of the Clinical Excellence Commission
- ❖ statutory changes arising from the Special Commission of Inquiry into Campbelltown and Camden Hospitals
- ❖ establishment of Clinical Governance Units within Area Health Services
- ❖ substantial increases in funding for South West Sydney Area Health Service to improve clinical services at Campbelltown Hospital and Liverpool Hospital.

In March 2006 the General Purpose Standing Committee No 2 reconvened with the term of reference to:

".....undertake a review of the implementation of the response of the NSW Government to the recommendations of this Committee's inquiry into complaint handling within NSW".

To assist with the review the Committee has sought a submission from NSW Health.

Given their shared interests in patient safety and quality across NSW Health, the Director-General of the Department of Health and the Chief Executive Officer of the Clinical Excellence Commission have agreed that the Committee would benefit in its consideration of progress by a joint submission.

This joint submission is in two sections. The first section deals with a range of developments and improvements in relation to the implementation of the NSW Patient Safety and Clinical Quality Program, the activities of the Clinical Excellence Commission and an update on the expansion of clinical services in South West Sydney Area Health Service. The section concludes with a progress report on the specific recommendations contained within the Standing Committee No 2 June 2004 report.

It is notable that of the 17 recommendations of the Committee that had unqualified support from the Government, 9 have been completed, a further 7 have seen significant progress made, with only 1 yet to be initiated.

The second section of this submission explains the progress made with the implementation of the 22 recommendations of the Special Commission of Inquiry into Campbelltown and Camden Hospitals undertaken by Mr Bret Walker SC. In summary, all 17 legislative recommendations made by the Inquiry relating to changes to State laws have been implemented. Of the 5 general recommendations made by the Inquiry, 4 have been implemented and 1 has been progressed.

Implementation of the NSW Patient Safety and Clinical Quality Program

The NSW Patient Safety and Clinical Quality Program (PSCQP)¹ was announced by the Minister for Health in August 2004. A major aim of the PSCQP is that all significant adverse incidents are reported and reviewed so that education and remedial action can be applied across the whole health system. This shift in thinking about how we deal with error, combined with the rollout of a new system for electronic reporting of incidents, has led to an increasing number of events being reported. A rising number of events reported will be one measure of success for the program.

The five major elements of the Program were to establish the Clinical Excellence Commission (CEC), to establish Clinical Governance Units (CGU) in each Health Service, to implement systematic management of incidents and risks, including an Incident Information Management System (IIMS), and to introduce a quality system assessment program to focus on quality and safety systems across the health system.

Clinical Governance Units are now established in each Health Service with responsibility for implementation of the Program at health service level. In addition to building on existing incident management systems, a key role of the CGUs is to ensure the health service has properly functioning systems to receive and manage serious complaints. Other key functions are to support the implementation of IIMS, undertaking death review and supporting staff to implement quality policies and procedures.

Specific initiatives implemented under the Program include:

- **The Statewide Incident Management Program**

A statewide incident management system is now in place supported by a statewide electronic incident system, the Incident Information Management System (IIMS). IIMS is implemented under a policy framework to guide the notification, prioritisation, investigation, analysis and feedback of healthcare incidents using a Severity Assessment Code (SAC). This system allows for the production of a statewide consolidated report demonstrating trends over time.

All serious incidents (SAC 1) are reported to the NSW Department of Health via a Reportable Incident Brief (RIB) process and an in-depth investigation using the Root Cause Analysis (RCA) methodology is undertaken. This allows timely review and action of issues that may have statewide implications. From August 2005, the conduct of RCAs for SAC 1 incidents became a legislative requirement.

- **Root Cause Analysis Training**

Following a pilot, a RCA training program was rolled out system-wide and devolved to the health services through a Train-the-Trainer program in April 2005.

- **Complaints Management**

Complaints management is a function of the Program and requires the Clinical Governance Units to ensure a single point of access is available for staff and the public to register complaints and to take responsibility for the management of serious complaints². A designated Senior Complaints Officer is required to be accessible within each health service to ensure appropriate action is taken to resolve serious complaints and available 24 hours per day/7 days per week³. This function is fulfilled during business hours by the Director of Clinical Governance and is performed by the senior health service executive on-call after hours.

- **Complaints Management Policy Directive**

A complaints management policy directive and procedural guidelines will be released in May 2006 to provide guidance to the handling of general healthcare complaints and form part of a

¹ http://www.health.nsw.gov.au/policies/pdf/2005/pdf/PD2005_608.pdf

² Patient Safety and Clinical Quality Program PD2005_608 p.14

³ Patient Safety and Clinical Quality Program Implementation Plan PD2005_609 p.9

suite of documents relating to incident management across the NSW health system. The policy directive provides a set of principles which must be addressed when managing complaints and any concerns about the quality of health services and will be applicable to all staff working in the NSW health system, whether employed or contracted.

- **Management of Complaint or Concern about a Clinician Policy Directive and Guideline**
Whilst the statewide incident management system focus is on systemic issues, it is acknowledged that at times there is reason to raise a concern about an individual. In January 2006, NSW Health released the *Complaint Or Concern About A Clinician - Policy Directive*⁴ and the *Guideline*⁵.

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. The policy directive also includes advice for Chief Executives about the management of clinicians suspected of unsatisfactory professional conduct and suspected professional misconduct where there is no registration board. If a concern about an individual clinician is raised, there is a clear requirement to act and the policy directive outlines the principles that guide such action.

The guideline sets out the operational framework for the management of a complaint or concern about an individual clinician and assists in the implementation of the policy directive. There is guidance on the actions required in response to the findings of an investigation of a complaint or concern about a clinician. These actions vary in response to the severity of the findings.

- **Implementation of the Open Disclosure Standard**
NSW is committed to statewide implementation of the National Open Disclosure Standard. Currently there is a Statewide Steering Committee consisting of consumer, Health Service, CEC, medical defence organisation (MDO) and the Department of Health representatives overseeing the statewide roll out. The rollout will be completed in April 2007.
- **Public Reporting**
In January 2005, the NSW Health released the first public report on incident management in public hospitals demonstrating the commitment to a culture of open reporting where incidents can be reviewed and lessons are learned.

The second report was released in January 2006 describing 429 serious incidents (SAC 1) within NSW from July 2004 to June 2005. This compares to 452 incidents reported for 2003 / 2004. NSW Health will continue to produce an annual incident report.

- **Safety Alert Broadcasting System (SABS)**
A safety alert broadcast system has been implemented to provide a systematic approach to the distribution and management of patient safety information. Each alert will specify action to be taken by health services, the timeframe in which such action must occur and specific responsibility for the actions.

⁴ Complaint or Concern about a Clinician - Principles for Action (PD2006_007), January 2006
⁵ Complaint or Concern about a Clinician - Management Guidelines GL2006_002, January 2006

Clinical Excellence Commission

The Clinical Excellence Commission (CEC) was launched by the Minister for Health, the Hon Morris Iemma MP on 24 August 2004 and replaced the former Institute for Clinical Excellence (ICE).

In January 2005, the Minister for Health appointed the Chief Executive Officer of the CEC, Professor Clifford Hughes AO, and in February 2005 appointed a new Board.

In March 2005, the Board held a planning day and developed a Strategic Plan and Key Result Areas to guide the work of the CEC for the next three years. The Strategic Plan and the CEC Directions Statement guided the workforce development plans and informed the organisational structure, with the following directorates being established: Clinical Practice Improvement Projects, Quality System Assessment, Information Management, Organisation Development and Education, and Corporate Services, with key personnel commencing in these portfolios in September 2005.

The CEC Directions Statement provided for a Clinical Council and this was established in April 2005 to contribute to the development and delivery of the CEC's programs and to advise on strategies to achieve high clinician participation. The Clinical Council held an orientation day in August 2005, meets on a regular basis and has proven to be an important mechanism in communicating with clinicians at the coalface. Matters discussed have included the NSW Patient Safety and Clinical Quality Program and specifically, the Incident Information Management System and two other statewide initiatives – the Hand Hygiene Campaign and the NSW Falls Program.

In February 2006, a second Board Planning and Review Workshop was held to review the Board's effectiveness and provide guidance as to directions and priorities for 2006-2007. The following achievements are noted against the CEC's Strategic Plan:

Public Reporting

The CEC has been involved in launching several publications and was actively involved in the first report on incident management in the NSW public health system 2003-2004 with the Minister for Health, in January 2005. The CEC also worked with NSW Health in the preparation and release of the second report in January 2006.

It should be noted that the NSW reports include many adverse events not included in reports in other jurisdictions. In those defined events, agreed by the Australian Council (now Commission) for Safety and Quality in Healthcare for national collection, the performance of NSW was very similar to other reporting states.

The CEC have embarked on a strategy to develop an effective Community Engagement and Advisory Committee (CEAC) to provide advice about the way the CEC educates, communicates and engages with the NSW community on safety and quality matters. A discussion paper on this matter was an agenda item at the recent Board Planning and Review Workshop.

Clinical Improvement

A number of CEC projects have concluded in the last twelve months including:

- Chronic Care Collaborative
- Medication Safety Collaborative
- Patient Flow and Safety Collaborative
- Towards a Safer Culture Project (now the Towards a Safer Culture Program).

In particular, the Chronic Care Collaborative and Towards a Safer Culture (TASC) have been extraordinarily useful in identifying issues, outlining potential solutions and implementing change across the system.

Clinical Improvement projects currently being undertaken include:

- Hand Hygiene Campaign (state-wide initiative)
- Safer Systems Saving Lives (10 sites)
- National Institute for Clinical Studies (NICS) Venous Thromboembolism (VTE) Prevention Program (9 sites)
- Performance Indicators and Medication Safety (PIMS) Project – in partnership with NSW Therapeutic Assessment Group (NSW TAG)
- Falls Initiative (state-wide)
- Children's Emergency Care Project (53 sites)

Quality System Assessment (QSA)

The CEC Directions Statement provides for the conduct of Quality System Assessments (QSA) of Public Health Organisations to identify whether they have effectively implemented the NSW Patient Safety and Clinical Quality Program.

In recognition of the QSA Program as a key function of the CEC, the organisational structure of the CEC established the position of Director of QSA, with this position being recruited to in September 2005.

The interim and current Boards of the CEC recognised the strategic importance of the QSA Program and actively considered the concept of the QSA Program and how it could practically be defined and translated into a program

In considering the complexities of the above, the Board made an early decision to explore options for the external provision of this program and established a steering committee in May 2005, chaired by the CEO, to oversee the procurement of the QSA Program. The process for procuring the QSA Program was conducted in two stages with a call for Expressions of Interest (EOI) being undertaken in June 2005.

The second stage of the process was a Call for Detailed Proposal from four (4) applicants that had been successful at the EOI stage. When the Call for Detailed Proposals closed in October 2005, regrettably only two submissions were received and after detailed evaluation and consideration there was unanimous agreement that a suitable provider had not been identified.

Following further extensive review of the literature on best practice methods of large scale system audit in Quality and Safety processes and discussions with various experts, the CEC has determined a methodology that includes completion of a Patient Safety and Clinical Quality Activity Statement by health services, measurement at three levels of organisational focus, verification audits and the provision of an assessment Report

Work is currently underway to develop the necessary tools from the methodology and it is envisaged that a pilot study will be underway at Sydney South West Area Health Service in July 2006.

Information Management

The Incident Information Management System (IIMS) has been successfully deployed across NSW Health. All 100,000 employees of NSW Health can report any incident online with the Severity Assessment Code (SAC) used to assign severity and, therefore, priority of action around these events.

The CEC has developed a suite of Standard Reports for use by health services and facilities.

A new program entitled Collaborating Hospitals' Audit of Surgical Mortality (CHASM). This program is being rolled out to Sydney West and Hunter New England Area Health Services and once implemented will be extended to all area health services.

In addition, the CHASM will have links and provide de-identified data to the Royal Australasian College of Surgeons National Audit of Surgical Mortality.

Capacity Building

Capacity building initiatives have included:

- A review and analysis of available materials on communication including a series of structured discussions with clinicians, quality managers and academics. This has resulted in the identification of two projects for priority action;
 - Communicating for handover
 - Communicating for clinical care
- The development of a Framework for clinical leadership and a roadmap of programs and available training opportunities. Draft Framework finalised.
- The identification of ways to partner with rural Health Services. Options paper completed and ready for consideration by rural health services.
- A program of Quality Tools Refresher workshops (1 metro and 3 rural) and a master class in facilitation/presentation skills for Quality Leaders to be completed by June 2006
- The development of links to other areas of healthcare such as aged care, chronic care, mental health, general practice and the private sector. Each of these groups has expressed enthusiasm for working in partnership with the CEC.
- The completion of a number of enquiries and reviews. While not a major component of the work of the CEC, the purpose of the reviews is to identify areas in which system change can be made quickly and securely to continue the basic tenant of continuous quality improvement.

Communication and Culture Change

In May 2005, the CEC launched the toolkit entitled "Improving Patient Access to Acute Care Services". This concise, detailed volume and its accompanying CD provide a wealth of information for clinicians wishing to improve not only access but the quality and safety of clinical programs. The first print run was "sold out" almost immediately necessitating a second print run.

In April 2006, the CEC and the NSW Department of Health released 'Improving care for people with chronic disease, A practical toolkit for clinicians and managers'. The NSW Chronic Care Collaborative was a joint initiative of NSW Health and the CEC and a key component of the NSW Chronic Care Program. The toolkit provides a resource for clinicians and managers wishing to improve the care of patients with chronic illness.

All of the activities, programs and projects discussed above will build the organisational capacity of the NSW health system and the attendant cultural change required to bring about improvements in clinical safety and quality.

South Western Sydney Area Health Service

The HCCC Report into Campbelltown and Camden Hospitals released in December 2003 confirmed the need for major systemic changes to the delivery of health care at Campbelltown and Camden and provided evidence of unsafe patient care.

In response to the draft report of the HCCC, the then Minister for Health appointed an Expert Clinical Review Team, headed by Professor Bruce Barraclough AO, to review patient care and safety at the hospitals. The findings of this review contributed to the development of a new plan for the growth of hospital services in South Western Sydney Area Health Service (SWSAHS). *The South Western Sydney Health Network: The Way Forward 2004-2008* was announced by the then Minister in June 2004 supported by an increase of \$300 million over four years.

The Government Response to GPSC No.2 (p.5) included the SWSAHS health plan initiatives incorporated into local service planning, human resource management and clinical practice to respond to the recommendations specific to Campbelltown, Camden and the Area Health Service. The following points are components of the plan updated by the Chief Executive, Sydney South West Area Health Service on 12th April 2006:

An increase of over \$300 million over four years to resource the Health Plan, including \$27 million in 2004/2005, rising to \$113 million per annum by 2007/2008

- Recurrent funding for years 1 and 2 of the Health Plan have been allocated to specific services consistent with the priorities of the Plan. Clinical directors are presently reviewing priorities for allocation of Year 3 funds for the financial year commencing 1 July 2006.

A network of coordinated services and a new clinical management structure for SWSAHS

- Clinical networks and clinical management structure is now well established in the western zone of SSWAHS (formerly SWSAHS). Clinical directors and clinical managers are all appointed. Budgets have been reassigned to reflect the new clinical services configuration. Clinical services in Mental Health, Oral Health, Drug Health, Population and Community Health, and Cancer Services have been expanded to establish single clinical service groups for the entire amalgamated health service.

Increased numbers of medical, nursing and allied health cover in critical areas such as emergency, intensive care and after hours inpatient care

- Additional medical and nursing staff have been funded in intensive care services at Fairfield, Bankstown-Lidcombe, Liverpool and Campbelltown. An additional 22 intensive care nursing staff have been recruited and employed and an additional 40 hours / week of ICU Visiting Medical Officer (VMO) cover has been provided at Fairfield and Campbelltown Hospitals since January 2005.
- Additional funding has been allocated for medical and/or nursing staff in emergency departments at the same hospitals. The equivalent of an additional 2 FTE senior medical staff cover has been provided at Bankstown Emergency Department (ED). A professor of Emergency Medicine and eight nurses have been appointed at Liverpool Hospital. Forty VMO hours of Emergency Medicine specialist care have been provided in Fairfield ED since January 2005, along with a Clinical Nurse Consultant (CNC) (recruitment underway). Five additional nurses have been employed in Campbelltown Hospital Emergency Department.
- There have been staff enhancements of allied health services to the inpatient services of the western zone hospitals in a number of allied health disciplines arising from the *Way Forward*. These include enhancements in the following disciplines:

- pharmacy (2 positions at Liverpool, one at Bankstown, and positions at Bowral, Fairfield and Campbelltown)
 - one social work position at Liverpool Aged Care
 - physiotherapy positions in the Emergency Department at Bankstown, Campbelltown and Fairfield
 - one aged care occupational therapy position at Liverpool and one at Bowral
 - one rehabilitation occupational therapy position and one physiotherapy position at Campbelltown
 - one neurology occupational therapy position and one speech pathology position at Campbelltown
 - one respiratory physiotherapy position at Liverpool
 - one neurology audiologist position at Bankstown.
- After-hours allied health services are provided by social work at Liverpool Hospital and there are some allied health services provided via the emergency department on weekends at some of the facilities of the western zone. For example, the allied health rapid response service at Bankstown–Lidcombe Hospital emergency department.
 - The appointment of a clinical nurse consultant at Campbelltown Hospital to provide leadership and to improve the clinical skills of the nurses.
 - More than 30 new clinical staff have been recruited at Campbelltown/Camden Hospital including 5 clinical nurse consultants, an additional staff specialist in obstetrics, 2 additional senior emergency doctors, 3 additional registered nurses to the Cancer Therapy Centre, additional medical staff in emergency and cardiology medicine.
 - There are now 32 medical registrars working at Campbelltown/Camden Hospital, which is 10 more than 2003.
 - The networking of the Campbelltown Hospital Emergency Department with Liverpool Hospital and the appointment of a joint Director of the two Departments has commenced.
 - A paediatric staff specialist is on site, at Campbelltown Hospital based in the Emergency Department until 10pm Monday to Friday.

Reduced surgical waiting times

- The average waiting time for elective surgery for patients ready-for-care has been reduced from 169 days in December 2003 to 143 days in December 2005: Patients waiting over 12 months for elective surgery reduced from 1,165 in December 2003 to 427 in December 2005.

A boost to the training of clinical staff

- Improved training of clinical staff has been achieved through the appointment of academic positions in:
 - Midwifery nursing at Campbelltown/Camden
 - Rheumatology at Liverpool
 - Ophthalmology at Liverpool
 - Emergency Medicine at Liverpool
- Lead medical clinicians have been appointed in surgery (Professor Reg Lord) and medicine (Professor David Tiller) to Campbelltown/Camden Hospitals.
- Professorial positions have been advertised in Obstetrics and Surgery at Liverpool.

A new Health Research Institute for South Western Sydney

- Progress has been made in the development of a research institute. Planning for Stage 2 at Liverpool Hospital includes the Research Institute. In the interim, Level 4 of the Health Services building at Liverpool Hospital is being renovated to expand wet lab facilities. This will enable the current wet lab program currently based at the University of NSW to be relocated back to Liverpool Hospital. A Research Director, Professor Michael Barton, has been appointed and the Research Committee has been revitalised. Work is being undertaken on governance structures and the development of a comprehensive research plan for SSWAHS western zone.

\$18.56 million in capital expenditure as at June 2005 for the Liverpool mental health facility to provide 50 acute inpatient beds, ambulatory care and research services – total project cost \$32.5 million

- In February 2006 the Premier officially opened the new Liverpool Hospital Mental Health Centre that includes 50 new patient beds, an increase of 20 from the previous facilities. The total capital cost of this project was \$32.5 million and recurrent funds of \$3.8 million in 2004/05 and \$4.5 million annually have been issued to the Area for these additional 20 beds.

Capital funding of \$5.48 million in 2004/05 and \$8.5 million in 2005/06 for the Macarthur Sector Strategy – total project \$108.66 million for the redevelopment of Campbelltown 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

- The Macarthur Strategy capital program at Campbelltown/Camden has continued and additional ward beds are now opened.

\$8.8 million in 2004/05 and per annum to reduce access block with extra beds and transitional care places to be available and a further \$2 million to conduct more elective surgery

- Additional beds have been opened at Liverpool (40), Bankstown (12), Fairfield (20), Campbelltown (23), and Bowral (2) since winter 2004. These beds have been funded through the Sustainable Access Program (SAP). Elective surgery admissions during the July to December increased from 20,034 in 2003 to 20,891 in 2005. Funding has been made available for Transitional care places and it is intended that these be community-based and home-based care and support to best meet the specific needs of the residents of the former SWSAHS. It is intended to further increase these services from July 2006.

In 2004/05 \$1.86 million was provided for 2 additional intensive care beds and an ICU Registrar at Liverpool and additional ICU medical cover and clinical nurse consultant at Campbelltown Hospital.

- In accordance with the Macarthur Strategy and Way Forward, in 2004/05 Macarthur Sector was provided with medical cover and a CNC totalling \$580,000. Liverpool Hospital opened an additional two ICU beds and recruited to an ICU Registrar costing a further \$1.280 million. In 2005/06 two ICU beds were opened for Campbelltown and one ICU bed opened in Liverpool and Bankstown with total recurrent funding of \$2.8 million.

\$2.5 million for the development of a 20 bed-bed non-acute mental health inpatient unit on the Campbelltown Hospital campus – total project \$6.2 million.

- Contingent on availability of staff, ten beds will open by the end of June 2006; a further five beds in October 2006; and the remaining five beds by the end of December 2006. If staffing improves prior to these dates, the beds will be opened sooner. The Sydney South West Area Health Service Mental Health Service is examining ways of making optimal use of available physical infrastructure and improving the attractiveness of recruitment activity across the Area.

Legislative Council General Purpose Standing Committee No. 2 (GPSC No.2) inquiry into complaints handling within NSW Health

Progress on the implementation of recommendations

No	Recommendation	Complete/in progress/ yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
1	<p>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 of health services is an appropriate measure of quality.</p>	<p>Qualified support</p>	<p>The Government's support of this recommendation does not extend to the focus on ACHS at the exclusion of other bodies. The Minister has charged the CEC with responsibility for assessing the quality and safety of public health care services.</p> <p>NSW has placed the issue of standard setting on the Australian Health Ministers' Advisory Council (AHMAC) agenda for the meeting in July 2006. NSW has driven the inclusion of this item on the Agenda and is sponsoring the paper being prepared.</p> <p>On 28 July 2005, Ministers agreed that the Australian Council for Safety and Quality in Health Care established in January 2000, would be succeeded by a national Commission on Safety and Quality in Health Care which will report to Health Ministers and be closely linked to health departments and other government and non-government health bodies.</p> <p>NSW Health has strongly supported the new Commission and has committed ongoing funding as required by the agreed Commission workplan.</p> <p>NSW Health also has representation on the Inter-Jurisdictional Committee who have a direct reporting relationship to the Chief Executive of each jurisdiction</p>	<p>Quality & Safety</p>

No	Recommendation	Complete /In progress /yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
2	<p>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 apart of the registration process.</p> <p>That evidence of ongoing professional development in these issues should be an essential requirement of registration.</p>	In Progress	<p>The NSW Health Incident Management Policy Directive incorporating the Open Disclosure policy, based on the National Open Disclosure Standard, will be released in May 2006.</p> <p>As a part of the implementation of this policy, the Department will be liaising with the relevant Registration Boards whom are responsible for determining registration requirements.</p>	Quality & Safety
3	<p>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.</p>	In Progress	<p>The Deputy Director-General Health System Performance and the Directors of Clinical Governance are committed to implementation of the Open Disclosure Standard by April 2007.</p> <p>The NSW Health Incident Management Policy Directive incorporating the Open Disclosure policy will make implementation of the National Open Disclosure Standard mandatory for NSW Health Services.</p>	Quality & Safety
4	<p>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.</p>	Completed	<p>Complaints handling is a mandatory requirement in v3 of the ACHS Evaluation and Quality Improvement Program (EQulP), which became effective in January 2004.</p>	Quality & Safety
5	<p>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 Health Standards.</p>	Completed	<p>The principles of Open Disclosure in the management of incidents and complaints has been incorporated in v4 EQulP. The revised standards will come into effect from January 2007.</p> <p>NSW Health is progressing the implementation. A State Open Disclosure Steering Committee has been convened and will be overseeing the implementation of the NSW Health Open Disclosure policy which has been incorporated into the revised Incident Management Policy scheduled for release in May 2006.</p>	Quality & Safety

No	Recommendation	Complete/In progress/ yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
6	<p>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 Health Standards.</p>	Completed	<p>Open Disclosure principles are contained in v4 EQUiP effective January 1, 2007.</p> <p>Updates on the progress of Open Disclosure will be provided to NSW Health as part of the implementation of v4 EQUiP.</p>	Quality & Safety
7	<p>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.</p>	In Progress	<p>Education and training programs for Open Disclosure are currently being developed by the NSW Health Open Disclosure Steering Committee.</p> <p>The CEC supports health managers receiving training in quality and safety, including the Open Disclosure Standard. Incorporating training into performance agreements requires a formal approach from Quality and Safety Branch to health service Chief Executives and will be considered as the implementation of the NSW Health Open Disclosure Policy proceeds.</p> <p>As part of the implementation of the NSW Health Patient Safety and Clinical Quality Program (PSCQP) over 2500 staff from across the NSW health system were trained in a methodology called root cause analysis (RCA) to enable them to investigate incidents.</p> <p>In recognition of staff turnover and the need to maintain and enhance skills in systems analysis, a Train-the-Trainer programme was developed. In April 2005, 60 representatives from across NSW attended a program on presentation skills to ensure ongoing deployment and sustainability of RCA training across the system.</p> <p>Training materials required by the local trainers have been developed and provided to each health service. Each health service has now delivered at least one local training program. In the past 6 months, over 400 additional participants have received local RCA training.</p>	Quality & Safety & Employee Relations

No	Recommendation	Complete /In progress /yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
			<p>Education Programs for Clinical Practice Improvement.</p> <p>The CEC currently provides education in quality and safety for area health clinicians participating in collaboratives as part of statewide projects such as the Children's Emergency Care Project. The provision of education as part of these projects is a very important way of educating medical, nursing and allied health staff in the principles of clinical practice improvement.</p> <p>Toolkits showing the lessons learnt throughout the collaborative projects are also developed and published and made freely available across the state to particularly assist those who were not able to participate.</p> <p>The CEC has conducted a number of forums to identify the type of quality and safety training that is currently occurring within NSW Health and to explore with participants various models for enhancing and widening the opportunities for staff to receive such training. In addition, meetings have also been held with tertiary education providers regarding health related e-learning packages. The outcome of these discussions will be the development of a set of learning modules in Clinical Practice Improvement (CPI). These teaching materials will be developed with reference to the Australian Commission (previously Council) for Safety and Quality in Health Care National Patient Safety Education Framework and will function as a statewide standard.</p>	
8	<p>That the proposed Clinical Excellence Commission in conjunction with NSW Health undertake an extensive public education campaign to inform the community about:</p> <ul style="list-style-type: none"> - simple steps to make health complaints - the nature and extent of adverse events in the health system - realistic expectations of health care - changes to the regulatory framework for health care complaints and consumer right 	In Progress	<p>A Working party comprising of senior managers from each Area Health Service, Justice Health, NSW Ambulance Service, the Children's Hospital and the CEC has developed an updated complaints management policy to reflect new health service structures, responsibilities and legislation in NSW. The policy is due for release in May 2006.</p> <p>The second report on incident management in public hospitals was released in January 2006 and demonstrates the commitment to a culture of open and transparent reporting of adverse events in NSW public hospitals. The</p>	Quality & Safety

No	Recommendation	Complete /in progress/ yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
			<p>report presents the data on the most serious, Severity Assessment Code (SAC) 1 incidents reported to the NSW Department and the lessons learned from the investigations of these incidents.</p> <p>A booklet "10 Tips for Safer Health Care: What everyone needs to know" produced by the Australian Council for Safety and Quality in Health Care (ACSQHC) has been distributed to assist consumers to become more actively involved in their health care, to explain how and why errors may occur, and advises consumers of options to consider if they have concerns about their health care. The booklet is accessible from the NSW Health Quality and Safety internet site.</p> <p>Each AHS has now established Health Care Advisory Councils to achieve greater involvement of clinicians, consumers and community members in the planning and delivery of health services.</p> <p>The CEC has completed a needs analysis on the best way to engage with the community around issues pertaining to the safety and quality of health care.</p> <p>The CEC is considering establishing a board committee comprised of experts and community representatives to be known as the Community Engagement and Advisory Committee (CEAC).</p> <p>The role of the Committee will be to effectively engage the community in a meaningful dialogue about safety and quality, ensure that the views of the community about the safety and quality of health services are 'heard' by the CEC and to ensure that the views of the community usefully inform the work of the CEC and any changes or redesign of the system which flow from it.</p>	

No	Recommendation	Complete /In progress /yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
9	That NSW Health publish comparative data on adverse events in Area Health Services across NSW in Annual Reports and on its Website.	Qualified support	Annual reports on serious incidents occurring in NSW Health will be provided to the community. The "Patient Safety and Clinical Quality Program: Second Report on Incident Management in NSW public health system 2004/2005" was released in January 2006. The report contains de-identified statewide data. Comparative AHS data will not be reported.	Quality & Safety
10	That the New South Wales Government convene a summit on medical adverse events within the next twelve months.	Yet to be progressed	NSW Health is currently consolidating the incident management systems processes that have been implemented statewide. This includes the statewide Incident Information Management System (IIMS) and the statewide Incident Management System (IMS) and the statewide Incident Management policy directive incorporating RCA statutory privilege. The Department will be reviewing the results of the first 12 months full implementation of the statewide incident information management system in June 2006 to inform consideration of a summit. The University of NSW has recently completed an evaluation of the Safety Improvement Program (SIP), stating that 'Structurally, educationally and organisationally, the NSW SIP seems to compare favourably with other international SIPs as described in the literature' (p. 16). Recommendations included: <ul style="list-style-type: none"> • Monitoring and support for SIP • Anchoring and extending the gains made by SIP • Further education and training in SIP-related areas • Research, evidence and communication of SIP results The Quality and Safety Branch and the CEC have implemented these recommendations.	Quality & Safety
11	That a suitable mechanism be identified by NSW Health to ensure the results of accreditation surveys conducted by the Australia Council of Healthcare Standards be provided to the Department within two weeks of their completion.	In Progress	NSW Health has established a consultative process with ACHS to progress this matter.	Quality & Safety

No	Recommendation	Complete /In progress /yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
12	That NSW Health publish all accreditation reports prepared by the Australian Council on Healthcare Standards and any recification reviews prepared by health services in response to these reports.	In Progress	A high-level accreditation Committee has been convened to oversight issues including the public release of accreditation reports.	Quality & Safety
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.	In Progress	<p>A number of one-day workshops have been conducted with sessions from the Coroner's Office on issues concerning families, consent and coronial processes for autopsies. The Coroner's Office has a training package they deliver to health services on request.</p> <p>An April 2007 target has been set for implementation of the Open Disclosure policy that is currently being incorporated into the revised Incident Management Policy. Open Disclosure processes will include informing family members of referral of death to the Coroner and will be implemented through health service Clinical Governance Units.</p> <p>In 2004, NSW Health issued the policy directive <i>Coroners' Cases and Amendments to Coroners Act 1980</i> (PD2005_352) that advises:</p> <p><i>...where deaths are reported to the Coroner, whether immediately after death or at anytime thereafter, a senior Hospital Officer should make all reasonable efforts to contact and, where possible, to interview relatives to explain to them the formalities required by the Coroner's Act (p.6)</i></p>	Chief Health Officer
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.	Completed	The NSW Health Incident Management policy directive released in August 2005 outlines the requirements for appropriate staff to provide timely feedback on the conduct and results of Root Cause Analysis to patients / carers.	Quality & Safety

No	Recommendation	Complete /in progress /yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
15	<p>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.</p>	<p>Completed</p>	<p>NSW Health introduced mandatory reporting of serious events in 2003. Mandatory incident reporting is a component of the revised Incident Management policy directive released in August 2005.</p> <p>This policy outlines the mandatory reporting requirements for all clinical SAC 1 (serious) incidents, (and any other matters that require notification to the Department of Health under existing legislative requirements, Departmental directive etc eg: Workcover), reporting timeframes for receipt of RCAs from AHS to NSW Health have been promulgated in the policy</p> <p>There is a daily review of all Reportable Incident Briefs (RIBS) received into NSW Health. This review enables the Department to prioritise actions such as system notifications / alerts to ensure maximised patient safety and quality of care.</p> <p>There is a senior Departmental committee chaired by the Deputy Director General, Health System Performance, which meets monthly to review and monitor all serious SAC 1 incidents that have been reported to NSW Health. This Committee is responsible for identification of system wide issues which potentially impact on patient safety, and makes decisions on strategic directions to improve the safety of the health system.</p> <p>The CEC undertakes routine analysis of all statewide incident data to identify issues of a systemic nature that affect patient safety and clinical quality in the NSW health system. Utilising this information the CEC then advises on implementation strategies to address these issues, including the generation of Safety Alerts, new and amended policies and specific information to clinical groups such as cardiology, mental health and gastroenterology to improve the safety and quality of healthcare.</p>	<p>Quality & Safety</p>

No	Recommendation	Complete /in progress /yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
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.	Completed	<p>It is NSW Department of Health policy that clinical teams participate in regular audits as outlined in the Clinician's Toolkit. The NSW Health Department has included the need for this to be assessed as part of the Quality System Assessments (QSA) that will be undertaken by the CEC.</p> <p>The QSA includes standards of performance against which a Health Service will be assessed and are based on existing Departmental policies and guidelines.</p> <p>The assessment framework is based on the seven (7) standards from the NSW Patient Safety and Clinical Quality Program that Health Services are required to comply with and include: Quality Structures, Policies and Procedures, Incident Management, Complaint Management, Medical Records Review, Peer Review, and Clinical Audits.</p> <p>A component of the QSA are criteria specifically developed that focus on peer review, systems and performance improvement and audits of clinical practice. Specifically, the QSA will assess: existence of peer review processes, ensuring that such meetings address key clinical management issues, change brought about through peer review processes, and existence of audit programs for clinical practice etc.</p>	Quality & Safety
17	The <i>Health Care Complaints Act 1993</i> and the <i>Protected Disclosures Act 1994</i> 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.	Completed	<p>Recommendation implemented through amendments in the Health Legislation Amendment (Complaints) Bill 2004. These changes vary the provisions relating to protection of identity of complainants to make them consistent with those in the <i>Protected Disclosures Act 1994</i>. Changes commenced 1 March 2005.</p>	Legal
18	That the New South Wales Medical Board be asked to clarify why the practitioner who treated Mrs Daly-Hamilton has not been referred to the South Australian Medical Board.	Completed	<p>As noted in the Government Response to the Inquiry: "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</p>	Legal

No	Recommendation	Complete /In progress / yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
			<p>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.</p> <p>It is understood that the NSW Medical Board has also responded directly to the Committee in relation to this recommendation.</p>	
19	<p>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.</p>	Completed	<p>It has been confirmed that matters of individual clinician performance are handled by the HCCC and matters of health system performance are addressed by the CEC. Both of these bodies report directly to the Minister with formal notification to the Director-General.</p> <p>A number of meetings have been held between the HCCC and the CEC to discuss opportunities where both organisations can work together and it has been agreed that meetings will be convened when required.</p>	Quality & Safety

Section 2.0

Special Commission of Inquiry into Campbelltown & Camden Hospitals (Walker)

Bret Walker SC – Final Report of 30 July 2004

Progress report as at 7 April 2006

Overview

On the 11 December 2003 the then Minister for Health, announced a Special Commission of Inquiry into Camden and Campbelltown Hospitals. The Inquiry, conducted by Mr Bret Walker SC, examined the regulatory arrangements and administration of the HCCC to ensure that effective mechanisms existed to address complaints concerning individual and institutional health service providers.

Mr Walker's report, which was released in July 2004, made a number of key points including that there was no cover up at Campbelltown or Camden Hospitals and there was no evidence of any attempt to conceal or prevent the reporting of complaints or adverse events. Mr Walker recognised the need to have ways to monitor and improve health care and patient safety. In this regard the Government has already announced a comprehensive program of reform through the implementation of the NSW Patient Safety Clinical Quality Program, including the formation of the Clinical Excellence Commission and the establishment of Clinical Governance Units in each Health Service.

As at 7 April 2006, all 17 Legislative recommendations in the Walker report have been completed.

Of the 5 General Recommendations 4 have been completed and 1 is in progress.

Special Commission Of Inquiry Into Campbelltown & Camden Hospitals, July 2004 - Bret Walker SC – Final Report of 30 July 2004

Legislative recommendations (Chapter 4, page 82)

No	Recommendation	Complete /In progress /yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
1	The definitions of unsatisfactory professional conduct in para 36(1)(a) of the <i>Medical Practice Act</i> and para 4(2)(a) of the <i>Nurses Act</i> should be changed so as to require the professional deficiencies to appear to a significant degree.	Completed	Addressed in the Cabinet Office Review of the Health Care Complaints Act and implemented in the Health Registration Legislation Amendment Act 2004, with the changes commencing on 1 March 2005.	Legal
2	The reference to experience in the definition of unsatisfactory conduct in subpara 4(2)(a)(ii) of the <i>Nurses Act</i> should be removed.	Completed	Addressed in the Cabinet Office Review of the Health Care Complaints Act and implemented in the Health Registration Legislation Amendment Act 2004, with the changes commencing 1 March 2005.	Legal
3	The deemed complaint following a Coroner's referral under subssecs 71(2) and (3) of the <i>Medical Practice Act</i> should expressly dispense with a complainant and from obligations to provide further particulars.	Completed	Addressed in the Cabinet Office Review of the Health Care Complaints Act and implemented in the Health Registration Legislation Amendment Act 2004, with the changes commencing on 1 March 2005.	Legal
4	Consideration should be given to including duties of co-operation and disclosure in the code of professional conduct under sec 99A of the <i>Medical Practice Act</i> .	Completed	Standard 2 of the Code of Professional Conduct issued by the Board under section 99A includes: <ul style="list-style-type: none"> • Responding appropriately to situations in which a complaint is made about your treatment or where treatment is unsuccessful. • Co-operating fully with the investigating authorities such as the HCCC and the NSW Medical Board in respect of adverse events. 	Legal (NSW Medical Board)
5	Consideration should be given to performance assessment and review provisions being added to the <i>Nurses Act</i> .	Completed	Addressed in the Cabinet Office Review of the Health Care Complaints Act and implemented in the Nurses and Midwives (Performance Assessment) Act 2004. Changes will be commenced once systems are in place to support the program.	Legal

No	Recommendation	Complete /In progress /yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
6	<p>The <i>Health Care Complaints Act</i> be amended to require the Health Care Complaints Commission to identify, and have confirmed by the complainant, the substance of the allegations made in a complaint and the identity of all persons against whom they are made. In cases where the complainant relies on information of others, this should also involve confirmation by those others.</p>	Completed	<p>Addressed in the Cabinet Office Review of the Health Care complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 March 2005.</p>	Legal
7	<p>The Health Care Complaints Commission should be given power to compel production of hospital or medical records to assist its assessment of a complaint.</p>	Completed	<p>Addressed in the Cabinet Office Review of the Health Care complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 March 2005.</p>	Legal
8	<p>Consideration should be given to extending the time for notification that a complaint has been made, under sec 16 of the <i>Health Care Complaint Act</i>. It may be that efficiency and fairness could be differently balanced by permitting, say, notification to be given along with the news that the complaint was not going to be investigated.</p>	Completed	<p>Addressed in the Cabinet Office Review of the Health Care complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 March 2005.</p>	Legal
9	<p>The test for assessment of a complaint in subpara 23(1)(b)(iii) of the <i>Health Care Complaints Act</i> should expressly require consideration whether a complaint, if substantiated, would provide grounds for disciplinary action.</p>	Completed	<p>Addressed in the Cabinet Office Review of the Health Care complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 March 2005.</p>	Legal
10	<p>The test for assessment of a complaint in subpara 23(1)(b)(iv) of the <i>Health Care Complaints Act</i> should expressly require consideration whether a complaint, if substantiated, involves gross negligence.</p>	Completed	<p>Addressed in the Cabinet Office Review of the Health Care complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 March 2005.</p>	Legal

No	Recommendation	Complete /in progress /yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
11	<p>The requirement for complaints to be verified by statutory declaration under subsec 23(3) of the <i>Health Care Complaints Act</i> should be removed.</p> <p>Consideration should be given to compulsory notification to complainants of the criminal sanction against knowingly providing false or misleading information, under sec 99.</p>	Completed	<p>Addressed in the Cabinet Office Review of the Health Care complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 March 2005.</p> <p>On consideration, the amending legislation instead included a note indicating the provision of false or misleading information under the Act was an offence.</p>	Legal
12	<p>Consideration should be given to empowering the Health Care Complaints Commission to compel the attendance of health service providers and persons connected with them for examination, and the production by them of documents, for the purpose of investigating a complaint. This will involve questions of privilege and use-immunity in relation to evidence contained by such compulsion.</p>	Completed	<p>Addressed in the Cabinet Office Review of the Health Care complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 March 2005.</p>	Legal
13	<p>The power of the Health Care Complaints Commission to refer a complaint, after investigation, for disciplinary action by the appropriate registration authority, under para 39(1)(c) of the <i>Health Care Complaints Act</i>, should be amended to clarify that such recommended actions includes performance assessment or review under Part 5A of the <i>Medical Practice Act</i> (and any <i>Nurses Act</i> relevant).</p>	Completed	<p>Addressed in the Cabinet Office Review of the Health Care complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 March 2005.</p>	Legal
14	<p>The Health Care Complaints should also be given the power, after consultation with the appropriate registration authority, at any time after an investigation has started following assessment, and before ending the investigation, to refer some or all of the matters raised in a complaint against a practitioner to the registration authority for recommended performance assessment or review.</p>	Completed	<p>Addressed in the Cabinet Office Review of the Health Care Complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 March 2005.</p>	Legal

No	Recommendation	Complete / In progress / yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
15	Consideration should be given to amending subsec 16(4) of the <i>Health Care Complaints Act</i> to conform with the analogous provision in the <i>Protected Disclosures Act 1994</i> .	Completed	Addressed in the Cabinet Office Review of the Health Care Complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 March 2005.	Legal
16	Consideration should be given to preventing the mere fact of an undetermined complaint pending against a doctor or nurse from being disclosed so as to prejudice a practitioner's capacity to be registered, recognized or to undertake training or education in other jurisdictions. This requires attention to para 191(a) of the <i>Medical Practice Act</i> . The principle of presumed innocence should prevail, subject to the explicit powers given by sec 66 of the <i>Medical Practice Act</i> . There may be implications for the operation of subsec 19(1) of the <i>Mutual Recognition (New South Wales) Act 1992</i> .	Completed	Addressed in the Cabinet Office Review of the Health Care Complaints Act and implemented administratively by the NSW Medical Board.	Legal (NSW Medical Board)

No	Recommendation	Complete /in progress / yet to be progressed	STATUS (as at 7 April 2006)	Responsible Branch
17	<p>The Australian Medical Association (New South Wales) has protested to the Minister that the <i>Health Care Complaints Amendment (Special Commission of Inquiry) Act 2004</i>, being the remedial legislation noted at the beginning of the last Chapter, takes away too many important rights of doctors whose conduct will be investigated pursuant to its terms. Most of the objections do not much matter, it seems to me. One of them is important, and may have identified a consequence of the remedial legislation not intended by me when I supported it in my first Interim Report. I think one reading of subcll 6(1) and (2) of Sched 5 to the <i>Health Care Complaints Act</i>, as inserted by the remedial legislation, may be that such a doctor could not seek to restrain proceedings in the Medical Tribunal on the ground of oppressiveness or abuse of process produced by delay and related circumstances. (The decision and reasoning of the High Court of Australia in <i>Walton v Gardiner, Gill & Herron</i> (1993) 177 CLR 378 are germane to such applications.) Consideration should be given to clarifying these remedial provisions so as to avoid them having the effect of denying the Supreme Court, or indeed the Medical Tribunal itself, the power to prevent an injustice of that kind occurring. The remedial legislation should remove from doctors and nurses prosecuted in the Medical Tribunal the capacity to object that this Special Commission of Inquiry, by its recommendation, has usurped functions and decision-making reposed in the Health Care Complaints Commission, the Medical Board and the Nurses Registration Board – and it has done so.</p>	Completed	Addressed in the Cabinet Office Review of the Health Care Complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 March 2005.	Legal

Special Commission Of Inquiry Into Campbelltown & Camden Hospitals, July 2004 - Bret Walker SC – Final Report of 30 July 2004

General recommendations (page 213 of Bret Walker's Final Report)

No	Recommendation	Completed /In Progress	Status (as at 7 th April 2006)	Responsible Branch
1	<p>To the extent not already done, South Western Sydney Area Health Service create policies consistent with the principles in the Open Disclosure Standard, Best Practice Complaints Handling and the Model for Managing Concerns about a Clinician as well as the Department of Health 2003/88 guideline.</p>	Completed	<p>NSW Health is currently developing an implementation plan for the Open Disclosure Forum was held on the 10 April 2006 to work through the implementation strategies. The SSWAHS Director of Clinical Governance and other members of the Clinical Governance Unit attended the forum. Whilst waiting for the release of this plan staff are already encouraged to practice Open Disclosure at all times.</p> <p>SSWAHS has an existing Area policy on complaint management. NSW Health is currently updating its existing policy. Once this is released SSWAHS, will update its existing policy in line with the updated NSW Health policy.</p> <p>SSWAHS has an existing Area policy in place regarding the Management of a Complaint or Concern about a Clinician. In January 2006, NSW Health released an updated version of the NSW policy. In line with NSW Health policy, SSWAHS has revised the existing Area policy. This Area policy has been forwarded to all general managers (GM's) to be widely circulated to appropriate senior staff for comment prior to implementation.</p> <p>The 2003/88 - Reportable Incident Briefs to the NSW Department of Health policy has been superseded by the Incident Management Policy PD2005_604.</p> <p>This policy outlines the mandatory reporting requirements for all clinical SAC 1 (serious) incidents, and any other matters that require notification to the Department of Health under existing legislative policy requirements.</p> <p>Strict reporting timeframes from the Area Health Service (AHS) to NSW Health have been promulgated in the policy. The NSW Department of Health's Quality and Safety Branch reviews all Reportable Incident Briefs (RIBS) on a daily basis. A monthly review of all clinical SAC 1 incidents occurring at the AHS level are collated in a report reviewed by the Reportable Incident Review Committee (RIRC).</p>	Quality & Safety & SSWAHS
2	<p>All teams conducting a root cause analysis be informed of the three levels set out in the 2001 Model and have regard to them in determining whether the conduct of an individual should be referred to senior managers for the</p>	Completed	<p>The current Incident Management Policy PD2005_604 (2005) outlines an RCA teams' authority in conducting an investigation that relates to the performance of an individual providing services. Where the RCA team form the opinion that an incident may involve professional misconduct, unsatisfactory conduct or impairment issues, the team have an obligation to notify the Chief Executive (CE) in writing. The CE will then consider the most appropriate action in accordance with the Management of a Complaint or Concern about a Clinician Policy Directive.</p> <p>The Policy Directive includes the legislative requirement for Chief Executives to report suspected professional misconduct and suspected unsatisfactory professional conduct to the relevant registration Board as well as internal Department reporting requirements. The Policy Directive also includes advice for chief executives about the management of those clinicians suspected of unsatisfactory professional conduct and suspected</p>	Quality & Safety

No	Recommendation	Completed /In Progress	Status (as at 7 th April 2006)	Responsible Branch
	managers for the appropriate level of review.		<p>about the management of those clinicians suspected of unsatisfactory professional conduct and suspected professional misconduct for whom there is no registration board.</p> <p>In January 2006 the Department released the Policy Directive <i>Managing a Complaint or Concern about a Clinician – Principles for action and the Guideline Complaint or Concern about a clinician – Management Guidelines</i>. These two documents replace the previous 2001 Guideline on the management of a complaint or concern about a clinician.</p>	
3	<p>All teams conducting a root cause analysis of incidents which have a severity assessment code of 1 or 2 should have the same protection as is provided in secs 20A-20K of the Health Administration Act for all functions the teams perform with the exception of the publication of a causation statement and recommendations. Those documents should be provided to the patient and be publicly available.</p>	Completed	<p>Addressed in the Cabinet Office Review of the Health Care Complaints Act and implemented in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 August 2005, with privilege restricted to SAC 1s, in line with obligations on AHSs to conduct SAC 1 reviews.</p> <p>Those incidents that are rated SAC 2 require an in-depth investigation but do not require investigation using Root Cause Analysis and are not covered by privilege.</p>	Legal Branch & Quality & Safety
4	<p>A review be conducted of the effectiveness of the root cause analysis process three years after the recommended protection is provided to ensure that the</p>	In progress	<p>Requirement for 3 year review included in the Health Legislation Amendment (Complaints) Act 2004, with the changes commencing 1 August 2005.</p> <p>This recommendation is due for review in August 2008.</p> <p>In the interim, the Department is in the process of establishing an ongoing audit process of the information provided in Root Cause Analysis reports received.</p> <p>A comprehensive evaluation of the effectiveness of the RCA training program has been undertaken by an</p>	Legal Branch & Quality & Safety

No	Recommendation	Completed /In Progress	Status (as at 7 th April 2006)	Responsible Branch
	<p>balance between the usefulness of the information generated and the protection afforded remains appropriate.</p>		<p>external agency. The recommendations from this evaluation have been implemented.</p> <p>A train-the-trainer program to decentralise RCA training and ensure sustainability of the program was completed in 2005.</p> <p>The Clinical Excellence Commission undertakes an analysis of all RCA's received at a state level, with analysis including the effectiveness of the RCA in terms of completeness, whether root causes and contributing factors were identified and the adequacy of recommendations. The root causes from each RCA are then captured in a database that provides trend information of systemic issues.</p> <p>The QSA Program will audit the effectiveness of the NSW Safety Program and the implementation of recommendations from RCA's.</p>	
5	<p>Documents created by the root cause analysis process be available to the Health Care Complaints Commission, when it has a relevant complaint. That information should not be admissible in statutory disciplinary proceedings or elsewhere.</p>	Completed	<p>The final RCA report is available to the HCCC when it has a relevant complaint.</p>	Quality & Safety