NSW HEALTH
Working as a Team

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

Introduction

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

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

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

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

Revd Hon Dr Gordon Moyes MLC chaired the Inquiry.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Clinical Excellence Commission

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

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

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

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

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

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

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

Ian O'Rourke PhD Scholarship

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

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

NSW Health Care Complaints Commission

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

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

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

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

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

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

NSW Department of Health

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

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

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

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

Area Health Service - Clinical Governance Units

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

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

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

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

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

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

South Western Sydney

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

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

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

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

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

Accreditation

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

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

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

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

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

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

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

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

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

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

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

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

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

> "While its direct impact on the safety and quality of the Australian health care system has not been objectively confirmed through research, accreditation is widely recognised by governments, health care organisations, consumers and the public as a worthwhile tool that:
> - assists health care organisations to review and improve the systems that support the delivery of safe, high quality health care; and
> - provides useful information to stakeholders about the safety and quality of care".
>
> Australian Council for Safety and Quality in Health Care, July 2003, *Standards Setting and Accreditation Systems in Health Care: Consultation Paper*, p.3

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

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

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

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

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

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

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

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

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

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

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

Recommendation 1

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

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

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

Recommendations 4, 5 and 6

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

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

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

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

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

Recommendation 11

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

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

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

Recommendation 12

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

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

Open disclosure standard

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

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

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

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

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

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

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

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

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

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

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

Other Recommendations

Recommendation 8

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

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

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

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

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

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

Recommendation 9

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

Recommendation 9 is not supported.

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

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

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

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

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

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

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

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

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

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

Recommendation 10

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

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

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

Recommendation 13

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

The Government supports this recommendation.

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

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

Recommendation 14

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

The Government supports this recommendation.

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

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

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

Recommendation 15

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

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

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

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

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

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

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

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

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

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

Recommendation 16

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

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

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

Recommendation 17

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

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

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

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

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

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

Recommendation 18

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

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

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

Recommendation 19

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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