

Complaints Handling Procedures and the Quality Agenda in the NSW Health System

Background paper

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1. PURPOSE

This document provides an overview of the current complaints handling procedures within NSW Health. It includes a description of the systems and the policy framework that exist at a system-wide level for high quality care and patient safety, and for dealing with errors and apprehensions that arise from time to time in any health system. A number of these systems and policies are in the early stages of implementation.

This paper does not describe how the frameworks, policies and guidelines identified in this paper have been implemented in each Health Service. The levels of implementation across Health Services is variable. The reasons for and solutions to this are various. All Health Services are working hard on the agenda. Some started a number of years ago, others much more recently.

2. RECENT HISTORY and POLICY CONTEXT

The development of the current framework for delivering quality care in NSW Health Services began following publication of the *Quality in Australian Health Care Study* in 1995¹, which revealed substantial rates of adverse events in the sample hospitals. Adverse events in this context are defined as unintended injury or complications resulting in disability, death or prolonged hospital stay, caused by health care management.²

The Australian study, which was followed by similar studies in the UK, the USA and New Zealand, retrospectively reviewed medical records of 14,000 admissions across 28 hospitals in NSW and South Australia. When corrected for methodological differences, each study revealed similar rates of adverse events in each study area, with 10% of admissions resulting in an adverse event, 2% of all admission associated with a serious adverse event and 0.3% of admissions associated with an adverse event involving the death of a patient. Overall, about 51% of these adverse events were found to be preventable.

A recent analysis of health system clinical indicator data demonstrates that the NSW health system as a whole compares well with the other Australian States, the United States and the European health systems³. An analysis of unplanned readmissions to hospital following elective surgery showed that NSW had a rate of 2.61%, other states 2.5%, the USA 4.37% and Europe 1.52%. These data would suggest that we have similar rates to the other Australian states, we have a higher rate than in Europe but have a lower rate than the average US Health Service. In unplanned readmissions to the Intensive Care Unit (ICU), NSW with a rate of 3.86% performed better than the US with a rate of 3.24%, but had a lower rate than Europe with a rate of 4.08%. Further, the NSW rate for unplanned returns to the operating theatre was higher than other states with NSW at 0.64% and other states at 0.47% but lower than the USA and Europe whose rates were 1.37% and 1.16% respectively. There is a lack of definitive information on the rate of adverse events in Canadian health care. The focus on patient safety in Canada and other countries is increasing with several NSW initiatives being adopted elsewhere. Further comparisons between the patient safety initiatives in these countries are outlined in Appendix A.

In NSW, the Ministerial Advisory Committee on Quality in Health Care was established in October 1996 as part of a raft of strategies to increase clinical input in policy development and priorities. The *Framework for Managing the Quality of Health Services in NSW*⁴ was completed in 1999 and a specialised Quality Branch established in the NSW Health Department in November 1999.

A range of programs has been developed under the banner of the NSW Quality Framework to improve individual skills, organisational capacity and to increase accountability for quality. In November 2001 the NSW Institute for Clinical Excellence was established to take on the implementation role for quality programs and improve clinical practice in NSW.

3. BACKGROUND – STRUCTURE OF THE NSW HEALTH SYSTEM AND OTHER REVIEW BODIES

The NSW public health system (or NSW Health) is made up of a number of different agencies, with differing responsibilities. In this document these agencies are referred to as Health Services.

NSW Department of Health

The NSW Department of Health ('the Department') is established under the *Health Administration Act 1982*. The Department is subject to the direction of the Minister for Health and has primary responsibility for policy development and oversight of the NSW public health system (*Health Administration Act 1982* S.5 Chapter 1). In this capacity the Department issues statewide policies and guidelines to the system, including policies on complaints handling and quality improvement processes.

The Department does not, however, provide direct patient services. Responsibility for service provision and patient care lies with public health organisations, established under the *Health Services Act 1997*.

There are three types of public health organisations:

(i) Area Health Services

Area Health Services are the main public health service providers in NSW. They are established to provide health and related services to residents within a defined geographic area. Their functions include promoting, protecting and maintaining the health of residents, conducting and managing hospitals within their area, achieving and maintaining standards, and planning development of services within the area (*Health Services Act 1997*, S.10 Chapter 2). They also have primary responsibility for managing and handling complaints made about public Health Services within their area.

Area Health Services are statutory corporations separate from the NSW Department of Health, and do not represent the Crown. Area Health Services are controlled by boards which are subject to the direction and control of the Minister (and the Director General of the Department of Health by delegation). There are 17 separate Area Health Services across NSW.

Increasingly, many Area Health Services organise services and accountabilities according to clinical streams. Common patient pathways are used as the basis for coordinating and managing financial and clinical accountabilities on an Area wide basis, rather than according these to individual hospitals or professional groups. For example, cardiac care may encompass physicians, surgeons, physiotherapists, nurses, rehabilitation specialists and associated management and clerical staff, coordinated across more than one physical location. The extent of clinical streaming will depend, in part, on the scope of services operated within the area, geographic factors and availability of appropriate clinical leadership.

(ii) Statutory Health Corporations

Statutory Health Corporations are established to enable certain health and health support services to be provided on other than an area basis. Their functions are determined by the types of services they provide, for example, managing hospitals and achieving and maintaining adequate standards. Again, they have primary responsibility for dealing with complaints arising from services they provide.

They are similar to an Area Health Service in that they do not represent the Crown, their boards are subject to the direction and control of the Minister (and the Director General of the Department of Health by delegation). There are currently five statutory health corporations, including the Corrections Health Service, the Children's Hospital at Westmead and the Institute for Clinical Excellence.

(iii) Affiliated Health Organisations

Affiliated Health Organisations are non-profit, religious or charitable organisations treated as part of the public health system where they control public hospitals or other institutions or services that are regarded and regulated as an integral part of the public health system. Their functions also include achieving and maintaining adequate standards. There is a range of services and establishments in NSW recognised as affiliated health organisations, including St Vincent's Hospital, Darlinghurst.

NSW Ambulance Service

The NSW Ambulance Service is a statutory corporation representing the Crown established under its own legislation to provide ambulance services for NSW. It is controlled by a board which is subject to direction and control of the Minister (and the Director General of the Department of Health by delegation).

Death Review Committees

There are four statewide committees for reviewing deaths in NSW. These are the Special Committee for Investigating Deaths Under Anaesthesia (SCIDUA), the Special Committee for Investigating Deaths Associated With Surgery (SCIDAWS), The Maternal and Perinatal Committee (M&P) and the Mental Health Sentinel Events Review Committee. All of these are Ministerially appointed committees under S.20 of the *Health Administration Act 1982*. They have restrictions placed on them around the disclosure of information under S.22 and have provisions for specially privileged information under S.23 of the *Act*.

The general objective of each of these committees is to review deaths that are referred to them either by Health Services or by clinicians, and to make recommendations for policy development to prevent death and serious harm in that area of healthcare. In addition, both SCIDUA and SCIDAWS provide personal feedback to the referring clinician, on the quality of their care. The members of all these committees can also be called to participate in Root Cause Analysis (RCAs) in Health Services if requested. A RCA is a tool for identifying the causes of an incident and the corrective action that is required to prevent a recurrence (see Page 19).

The Coroner

The role of the Coroner is to review deaths for the purposes of determining the manner and cause of death. The *Coroners Act 1980* sets clear criteria for when a death should be reported to the Coroner. In relation to health care, there are a number of circumstances in which a death must be reported, including a death that is violent or unnatural, a death that has occurred under suspicious or unusual circumstances, a sudden death the cause of which is unknown, a death for which a death certificate is not available, and a death that has occurred as a result of, during, or within 24 hours of an anaesthetic. The Coroner may request that a post mortem be undertaken to assist in the review process. The post mortem results will be given to the clinicians treating the patient if requested. SCIDUA also receives a copy of the report on any anaesthetic deaths to provide further information for their review.

The Health Care Complaints Commission

The Health Care Complaints Commission (HCCC) is an independent body responsible for accepting, reviewing and investigating complaints it receives about health practitioners and health service providers. Any person can make a complaint to the HCCC and it can be made about the professional conduct of a health practitioner or about a Health Service which affects the clinical management or care of an individual.

Most health care incidents do not involve an act by a health care provider that would warrant a review or investigation by the HCCC. Health Services are, however, expected to refer serious concerns (as defined by policy described in a later section) about the performance of an individual practitioner or provider to the HCCC or to the appropriate registration authority. Where a registration authority receives a complaint under the health registration *Act* for a particular profession is also taken to be made to the HCCC. A member of the public can lodge a complaint with the HCCC. Where complaints relate to health practitioners, the

HCCC will consult with the relevant Health Professional Registration Board when determining the appropriate course of action to respond to the complaint.

Health Professional Registration Boards

Professional registration boards are responsible for the occupational registration of certain health professional groups on the basis of training and competence and for ensuring that registered health professionals maintain proper standards of conduct and competence. Relevant professions include medical practitioners and nurses. Complaint and disciplinary provisions of the relevant legislation provide a means by which complaints about registered health professionals can be received by the relevant board, then investigated and prosecuted as required. Health Services are expected to refer complaints about a registered health professional to their professional registration board or the HCCC.

The Ombudsman and Independent Commission Against Corruption (ICAC)

The Ombudsman can investigate the conduct of Health Services in relation to any action or inaction relating to a matter of administration; and any alleged action or inaction relating to a matter of administration. The ICAC is responsible for exposing corruption through investigations, and advising and educating public officials about corruption.

4. THE NSW QUALITY FRAMEWORK – A SUMMARY

The *Framework for Managing the Quality of Health Services in NSW (1999)* identifies the essential elements of clinical governance required of Health Services in managing quality and safety of care.

The framework sets out principles for management and measurement systems, committee and reporting structures for Health Services, and establishes the 6 dimensions of Quality:

- *Safety* (this is about not harming patients)
- *Effectiveness* (this is about achieving a good outcome and doing what we do well; technical proficiency)
- *Appropriateness* (this is about doing the right thing and at the right time)
- *Consumer participation* (patients should be involved in their care and policy level decision making)
- *Access* (this is about being able to receive services when they are needed)

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- *Efficiency* (this is about providing the highest quality care for the lowest cost and about allocating resources to programs that will achieve the greatest benefit for the largest number of people)

Five cross-dimensional issues are identified to assist focus on performance:

- Competence – of individuals, teams and the organisation
- Continuity of care
- Information management
- Education and training – for clinical governance
- Accreditation of Health Services

Each Health Service is required to operate a Board level Quality Council with clear objectives in leadership, measurement and reporting, monitoring and facilitation, education, training and research.

The composition of Health Service Quality Councils includes consumers and general practitioners, and Councils are required to establish formal communication mechanisms between the Council and the Divisions of General Practice and between the Council and a consumer forum.

5. EXISTING MECHANISMS for MANAGING HEALTHCARE INCIDENTS and COMPLAINTS

Health Services have a responsibility for the quality of care they provide. This responsibility is often referred to as governance. 'Corporate governance' is about the functions of the governing body, that is, the Board of Directors. These functions are about leadership, direction and control and ensuring that Health Services are managed effectively and that decisions be based on the best standards of integrity, on the best available information, and in the best interests of the community.

'Clinical governance' refers to the role of the board of a Health Service in ensuring that an effective health system is in place that provides an environment that fosters quality, identifies deficiencies in the quality of care and effectively addresses those deficiencies. The successful implementation of clinical governance requires the development of partnerships between clinicians and managers for the safe and effective provision of health care. One such partnership concerns the shared responsibility of health professionals and managers to identify concerns about the health, conduct or performance of clinicians and to act appropriately upon those concerns.

A key component of quality and clinical governance is the effective management of healthcare incidents and complaints. A health care incident is defined as any event resulting in, or with the potential to result in, death, injury, ill health, damage or other loss.⁵ A complaint is an expression of dissatisfaction by a complainant.⁶ The complainant can be a consumer (a patient, their family, a member of the broader public) or staff.

Health Services are the first point of contact for most health care incidents and complaints. In many Health Services specific staff are identified to deal with questions or concerns arising from patients or their relatives.

While Health Services undertake most reviews and inquiries locally, serious matters involving or likely to involve conduct of individuals may be referred to the relevant professional registration authority, the HCCC, or in the case of suspected serious maladministration or corrupt conduct, to the Ombudsman or ICAC. Under the *Health Services Act 1997* the Director-General also has the authority to initiate reviews and inquiries.

Each Health Service is responsible for managing quality of care issues across hospitals and community based Health Services. Typically, Health Services operate local facility Clinical Review Committees to routinely review patient outcomes (whether or not associated with an adverse event) and quality indicators such as unplanned returns to theatre, infections and other complication rates.

A number of state policies and guidelines exist setting out certain requirements and providing assistance to Health Services in managing healthcare incidents, including complaints. Within these core requirements a number of options exist for reviewing and responding to healthcare incidents. Generally, the actions required depend on the nature and severity of the incident and whether the incident relates specifically to an individual or the systems and procedures of healthcare. If a complaint relates directly to the performance standards of an individual clinician it will be managed in accordance with *The Guideline for the Management of a Complaint or Concern About a Clinician*⁷. This is described further in the performance management section (page 25).

A substantial change to the way incidents are reported, recorded and reviewed was introduced in May 2003. Health Services are now required to manage all health care incidents as prescribed by the Safety Improvement Program (SIP) described below.

All deaths that occur in hospital should be reviewed at the facility level. An additional external review is required of some deaths. Deaths falling within the terms of reference of the SCIDUA, SCIDAWS, Maternal and Perinatal Committee and Mental Health Sentinel Events Review Committee should be reported to those bodies for further review. Deaths coming under the *Coroners Act 1980* are required to be reported to the Coroner. If the case raises concerns about maladministration or corruption, reporting to the Ombudsman or ICAC would also be appropriate.

Incidents and complaints can be reported to a Health Service in a variety of ways eg a letter, by telephone, by completing an incident form. A 1-800 community call line was established on 19th December 2003 to facilitate the registration of complaints and notification of incidents to the NSW Department of Health. This line will remain open permanently and both consumers and health employees will be encouraged to use it.

Some incident and complaint notifications will also need to be managed in accordance with other departmental policy, as described below.

Frontline Complaints Handling

Frontline complaints handling refers to the management of complaints at the point of service delivery by service providers⁸. The resolution and management of frontline complaints are important elements of quality management. Effective complaints handling systems assist in the identification of areas to better meet the needs and expectations of the community.

Complaints handling systems are an important element of quality customer service which:

- identify areas that need improvement

-
- provide an opportunity to give service and satisfaction to dissatisfied customers
 - provide an opportunity to strengthen customer support for agencies and
 - give customers the opportunity to have their legitimate complaints considered in a clearly defined process for complaints handling.

In January 1998 the NSW Department of Health published *Better Practice Guidelines for Frontline Complaints Handling*. The purpose of the document was to provide a framework to enable a consistent and continuous improvement approach to frontline complaints handling in the NSW public health system, specifically in health care facilities providing direct services to consumers.

The Guidelines establish a process for effectively managing a complaint and the timeframe within which all complaints should be managed. They also document a mechanism for the use of complaints information to bring about health system improvement, and performance indicators for complaints management. Health Services report on complaint management to the Department of Health every three months. A report is developed six monthly using these data, to encourage Health Services to benchmark their performance.

Grievance Procedures

A grievance is defined as: a personal complaint or difficulty about a work related issue that affects a staff member and that he/she considers to be discriminatory, unfair or unjustified.⁹ Effective management of grievances is a key element of an organisational culture that operates within a transparent, accountable and ethical framework. Grievances arising in the workplace which are not promptly and effectively resolved can lead to:

- adverse affects on the health and welfare of all the individuals involved
- lost productivity
- reduction in the quality of work and patient/customer service
- distraction from corporate goals
- loss of confidence and communication between staff members, managers and supervisors
- low morale and job satisfaction, which can lead to industrial problems, increased absenteeism and increased staff turnover
- loss of reputation as an employer
- loss of reputation to the staff member
- lost time for everyone involved in dealing with a complaint
- potential for legal action and damages.

As identified in Table 1 (page 14), some incidents and complaints will require the use of appropriate grievance procedures. The *Policy Framework and Best Practice Guidelines for the Development of Health Service Grievance Management Systems*¹⁰ was developed in 1999 to assist public health system Chief Executive Officers (CEOs) and human resource personnel in meeting departmental and legislative requirements. The objectives of the *Policy Framework and Best Practice Guidelines* are to:

- ensure workplace grievances are managed in an effective and fair way for all parties involved
- ensure every staff member has access to an effective and fair process for managing workplace grievances
- satisfy legislative requirements
- reduce the cost to the health system by improving the management of workplace grievances

It is departmental policy that all staff have a right to a workplace that is free from harassment and discrimination. Chief executive officers have a responsibility to demonstrate a leadership role and commitment to the prevention and resolution of work related grievances. Health Services have developed local policy in accordance with this policy and these guidelines.

Workplace Incident Management

Employers under the *NSW Occupational Health and Safety Act 2000* have a duty of care for the health and safety of all people in the workplace. This requires employers to ensure that premises, the systems of work, the work environment and any plant or substance provided for use by employees at work, are safe and without risk. Further, employers are to provide necessary information, instruction, training and supervision and adequate facilities for the health and safety of their employees. *Effective Incident Response: A Framework for Prevention and Management in the Health Workplace*¹¹ was developed to assist Area Health Services to fulfil their responsibilities under this legislation.

Table 1 below, summarises how Health Services should manage incidents and complaints as they are reported.

TABLE 1

When reported, all incidents and complaints are managed according to the Safety Improvement Program. That will involve rating the incident according to the Severity Assessment Code to determine appropriate review process. Serious incidents will be initially reviewed using Root Cause Analysis techniques and the following specific processes may also be actioned.

<p>WHAT IS REPORTED →</p> <p>↓</p> <p>WHO REPORTS IT</p>	<p>Death</p>	<p>Other Clinical Incident</p>	<p>Occupational Health or other corporate incident (eg fraud)</p>	<p>Dissatisfaction with service (eg treatment delay, communication)</p>	<p>A concern about the performance of an individual clinician</p>	<p>Concern about a manager or management of a service</p>
<p>Patient , family or community member</p>	<ul style="list-style-type: none"> - Use <i>Frontline Complaints Handling Guidelines</i>¹² - Use <i>Performance Management Policy and Guidelines</i> if necessary - Report to DoH if required - Refer to external body if appropriate eg SCIDUA, SCIDAWS M&P Committee, Mental Health Review Committee, The Coroner 	<ul style="list-style-type: none"> - Use <i>Frontline Complaints Handling Guidelines</i> - Use <i>Performance Management Policy and Guidelines</i> if necessary - Report to DoH if required - Refer to external body if appropriate eg HCCC, Professional Registration Board 	<ul style="list-style-type: none"> - Use <i>Frontline Complaints Handling Guidelines</i> - Use Workplace Incident Management Framework - Refer to external body if appropriate eg WorkCover, ICAC, Police 	<ul style="list-style-type: none"> - Use <i>Frontline Complaints Handling Guidelines</i> 	<ul style="list-style-type: none"> - Use <i>Frontline Complaints Handling Guidelines</i> - Use <i>Guidelines for the Management of a Complaint or a Concern about a Clinician</i> - Use <i>Performance Management Policy and Guidelines</i> if appropriate - Refer to HCCC, Registration Board 	<ul style="list-style-type: none"> - Use <i>Frontline Complaints Handling Guidelines</i> - Use <i>Performance Management Policy and Guidelines</i> if appropriate
<p>An employee (including visiting or staff, clinicians or managers)</p>	<ul style="list-style-type: none"> - Report to DoH if required - Refer to external body if appropriate eg SCIDUA, SCIDAWS M&P Committee, Mental Health Sentinel Events Review Committee, The Coroner, HCCC or Registration Board 	<ul style="list-style-type: none"> - Report to DoH if required - Report to TMF if appropriate - Performance management if necessary - Refer to external body if appropriate eg HCCC or Registration Board 	<ul style="list-style-type: none"> - Use <i>Workplace Incident Management Framework</i>¹³ - Refer to external body if appropriate eg WorkCover, ICAC, Police 	<p>Not applicable</p>	<ul style="list-style-type: none"> - Use <i>Guidelines for the Management of a Complaint or a Concern about a Clinician</i> - Use <i>Performance Management Policy and Guidelines</i> if appropriate - Refer to HCCC, Registration Board 	<ul style="list-style-type: none"> - Use <i>Grievance Policy and Resolution Procedures</i> if required¹⁴ - Escalate to Health Service or Dept of Health if necessary - Use <i>Performance Management Policy and Guidelines</i> if appropriate - Referral to external body if appropriate eg ICAC or Ombudsman

6. DEVELOPING A CULTURE OF LEARNING

NSW Health and the Institute for Clinical Excellence (ICE) have together initiated a number of programs to promote and develop a culture of learning in the delivery of health services.

The 'collaborative' or 'breakthrough' method was developed by the Institute for Healthcare Improvement (IHI) in the USA. It is a method for implementing known best practices, to achieve significant improvement, over multiple sites, over a relatively short period of time (approximately 12 months). During 2003, ICE and the Department worked together to conduct The Patient Flow and Safety Collaborative in NSW hospitals. The collaborative is aimed at improving access to hospitals and reducing harm specifically by reducing pressure ulcers and patient falls. Thirty-five teams from 16 Area Health Services are participating.

A second collaborative, The Chronic Care Collaborative, commenced in February 2004. It will involve approximately 22 teams from 17 Area Health Services in improving the care of patients who suffer from heart failure or a chronic respiratory disease. The aim is to reduce the number of admissions to hospital for people with these diseases, to reduce the number of times they need to present to the emergency department and to improve the quality of life for the patients and their carers.

The Towards a Safer Culture Project (TASC) is being conducted by ICE with the Australian College of Physicians. This project employs a slightly different method for disseminating better practices and implementing clinical practice guidelines. The TASC project seeks to improve the acute management of patients who present to an Emergency Department with acute chest pain or stroke. At present 29 hospitals from 12 Area Health Services are involved in the program with a further 11 hospitals from these Areas to join the program in 2004. Sustainability of improvement via this method is also being evaluated.

The NSW Health Awards¹⁵ aim to acknowledge innovative quality health projects implemented by NSW Health and NSW Health Services. The Awards were established in 1999 to acknowledge the innovative quality health projects conducted in health facilities resulting in positive changes to the delivery of healthcare in NSW.

In 2003 the 5th Awards were held with 230 entries submitted in 10 categories: Safety, Effectiveness, Appropriateness, Consumer Participation, Efficiency, Access, Competence, Information Management, Continuity of Care and Education & Training.

The projects submitted by the winners, finalists and commended projects are released in a health awards book.

The Annual Quality in Health Care Forum¹⁶ aims to showcase the projects being undertaken in NSW Area Health Services that have demonstrated improvement in clinical practice. The quality themes of the 2003 Forum were Governance, Patient Safety and Leadership, Clinical Policy, Health Priorities and Consumer Participation in Quality.

In 2003, 33 projects were presented and 33 storyboards displayed demonstrating the outstanding work currently being undertaken to improve healthcare in NSW.

Projects utilise the Clinical Practice Improvement methodology taught by the Institute for Clinical Excellence.

7. INFORMATION SHARING AND OPEN AND ACTIVE DISCUSSION ABOUT ERRORS AND SYSTEM FAILURES

Clinical improvement – the Clinician’s Toolkit for Improving Patient Care

The Clinician’s Toolkit¹⁷ was developed and published in 2001 as an ‘easy guide’ for clinicians and managers outlining NSW Health expectations for individuals in improving the quality of care provided to patients. The Toolkit is applicable to all clinicians and managers, whether they are employed by the public or private system, or self-employed.

The Toolkit identifies the three components of clinician action that are required to improve the quality of care they provide:

1. *Developing knowledge and skills for understanding human performance, the systems of care and for minimising and dealing with error.* This requirement identifies that all health care workers should understand the human factors of health care. Human factors research is the study of how humans perform in the workplace, both individually and in teams. If we are to improve the ‘system’ of care it is essential that we understand how the system works, and how humans work and communicate in that system. Some Area Health Services have funded the conduct of human factors training courses with their clinicians; the Department has funded the conduct of the course with other clinical groups. The aim is to train all health care providers in human factors over the next few years.

2. *Using methods to identify, measure and analyse problems with care.*

Managers are required to ensure all clinicians participate in the following activities:

- incident and sentinel event management
- peer review
- ad hoc audits
- retrospective medical record review
- mortality and morbidity reviews to review all deaths and serious injuries or illnesses
- examination of clinical indicators.

3. *Action to improve care.*

The third requirement is that clinicians and managers take the information obtained through participation in the above activities and act on it using a sound scientific method (Clinical Practice Improvement or CPI) to improve care.

The NSW Clinical Practice Improvement (training) program was commenced in 1999 and trains approximately 40 people in each of two courses a year to develop capacity for clinicians and managers in all Areas.

The NSW Department of Health has commenced a program with clinical 'craft groups' (specialist clinical groups) to advance the effective use of the *Toolkit*. The first program was specially developed for neurosurgeons and involved all 37 neurosurgeons in the state along with relevant members of their clinical teams.

Human Factors training was provided (during the first half of 2003) over a day and a half, and risk management consultants were provided to work with neurosurgical teams as they started using clinical indicators, participating in morbidity and mortality and peer review as well as training in the use of the Clinical Practice Improvement method¹⁸. Subsequently, neurosurgeons have observed significant improvements in the care they and their teams provide. Data collection and assessment of the consultant process is currently taking place. This program involves a small 'craft' group and provides an excellent example of the type of work that needs to be undertaken with clinical teams and 'craft' groups, in order to achieve significant change.

A similar clinical risk management program has been developed involving rural Health Services and the Divisions of General Practice for an estimated 1,440 general practitioners working in small rural hospitals with a view to commencing in March 2004¹⁹. A program for obstetricians is also under development and scheduled for commencement in the second half of 2004.

All Visiting Medical Officers (VMOs) must comply with the *Clinician's Toolkit* requirements as a condition of their indemnity contracts. Health Service Performance Agreements with the Director-General of Health also require Health Services to assist clinicians to implement and comply with the *Clinician's Toolkit*. Implementation of appropriate organisation systems and capabilities is in progress but not yet complete in all Health Services.

Safety Improvement Program – Management of incidents

The NSW Safety Improvement Program was implemented in all Health Services during 2003. Training commenced in December 2002 and was completed in November 2003. The program provides a state-wide, comprehensive and consistent approach to the management of all health care incidents. The program ensures that all Health Services are able to identify and classify, report, review, analyse and act on health care incidents so that where possible, the incidents do not recur.

The program is based on the Patient Safety Improvement Program developed by the Veterans Health Administration in the United States.

The program has a number of components, including training for health care providers in incident management, the use of the Severity Assessment Code, the Reportable Incident Brief (RIB) system and the Incident Information System.

- *The Severity Assessment Code (SAC)*

When reported, whether by health staff or as a complaint by a patient or their representative, all health care incidents are to be allocated a SAC score. The SAC is a risk matrix that is used to stratify the consequence and likelihood of an incident so that a numerical rating is allocated to every incident. Serious incidents are rated as SAC 1. These include for example death caused by health care, wrong site surgery or incorrect blood transfusion. The lowest SAC score is 4 and these would include incidents such as delayed reporting of X ray results where this did not affect the care of the patient (See Appendix A)

- *The Reportable Incident Briefing System (RIBS)*

Health Services are now required to report all incidents that are given a SAC of 1 to the NSW Department of Health²⁰. The Department has a responsibility for monitoring and managing health care incidents and for developing strategies to minimise the likelihood of adverse events occurring in the NSW public health system.

Since its implementation on 1st May 2003, the RIB system has been successful in identifying opportunities for the development of state-wide policy for preventing adverse events. These have included a policy for preventing wrong site surgery, a change in the purchasing policy for resuscitation bags to ensure that these ventilator bags cannot be assembled incorrectly, the issue of an alert by the manufacturer of a liver staple gun that has caused harm to a number of patients, and changes to the method used for calibrating radiotherapy machines.

- *The NSW Incident Information System*

An incident information system for the NSW health system has been researched and developed over the past two years. Pilots have been completed and evaluations with final recommendations for state-wide implementation are now underway.

- *Root Cause Analysis (RCA)*

Since 1st May 2003 Health Services are required to investigate serious incidents (i.e. all SAC 1 incidents) using an investigation method known as Root Cause Analysis. This is a powerful tool for identifying exact cause of the incident and what corrective action should be taken to ensure that it will not recur. During 2003 over 2000 people across the state, including all 17 Area Health Services, the Children's Hospital at Westmead, The NSW Ambulance Service and Corrections Health Service, were trained in how to conduct an RCA.

A number of examples of how the Safety Improvement Program has resulted in system wide improvement can now be given. Two incidents that related to separate devices that malfunctioned were notified to the Department via the RIB system. The Department referred both matters to the Therapeutic Goods Administration (TGA) for investigation and action. These notifications resulted in a safety alert being issued by the manufacturer advising of processes to minimise future incidents.

Another example of effective incident management involved an incident at a Sydney teaching hospital that resulted in the administration of radiation to the incorrect location of the correct organ in 9 patients.

An initial review identified that 60 patients may have been involved. However, the incident was reviewed internally using the RCA method and during this process the correct number of 9 was determined. Concurrently the incident was reviewed by an expert panel that concurred with the findings of the RCA team. The recommendations have been implemented locally and are forming the basis of state-wide policy review.

Further, the manner in which the incident was managed was exemplar. The incident was notified to the Department as soon as it was recognised. This set in train a comprehensive communication strategy; all patients or their relatives were notified of the error within 48 hours (as soon as they could be located), a media release was made within 24 hours and the RCA team was established within 48 hours. The RCA and external reviews were completed within 5 weeks and the report from the investigation was made available to the families of the patients involved.

Performance Agreements

It is recognised throughout NSW Health that there is both a corporate and personal responsibility for assessing, achieving and maintaining a high level of organisational, team and individual competence to ensure the safe and effective delivery of health care.

Managing for Performance – A Better Practice Approach for NSW Health states that Health Services are required to develop, implement and regularly review a ‘managing for performance’ system. This system is linked to a continuous quality improvement process and includes:

- clearly listed responsibilities and accountabilities for all parties;
- a statement outlining the chief executive officer’s commitment to all staff that the ‘managing for performance’ process is equitable and confidential;
- integration with other human resource processes, including links to effective grievance management, recruitment and selection, orientation and career development;
- measurable performance criteria which focus on achievements and outcomes and appropriately reflect the context and scope of the individual’s job;

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- a focus on performance improvement including strategies for mentoring, coaching and career development;
 - appropriate training for all staff (including but not limited to integration of information into orientation and workplace induction);
 - A mechanism to regularly evaluate performance management to ensure it meets its stated objectives for the organisation.

Safety Advocate

The *Safety Advocate*, launched in 2002, provides information about the common underlying causes of health care incidents, suggests steps to prevent occurrences in the future and provides knowledge resources to assist organisations in reviewing and updating their own systems.

Topics have included *Infusion Pump Safety*, *Bed Rail Safety*, *Fall Injury Prevention in Acute Care*, *Medication Safety*, and *Sterilisation and Disinfection*.

8. EXISTING APPROACHES TO CONSUMER PARTICIPATION

In recent years, the views of Health Service users have become increasingly important in the delivery of Health Services in NSW. At the state level, improving public participation in the decision-making processes of government and ensuring that these processes are open, responsive and effective is part of the NSW Government's social justice strategy. The Health Participation Council was established in 2002 to formally give consumers a role in decision-making about the delivery of Health Services at a state level.

The Health Participation Council is made up of Ministerially appointed individuals and peak consumer organisations and meets regularly throughout the year to discuss ways in which the health system can better meet the needs of the people of NSW.

There are many ways people can participate at a local level. Each Health Service is different but often includes:

- on-going Health Service advisory groups
- seeking community views about specific issues facing the Health Service

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- working with local groups who have knowledge of particular health problems
 - having consumer and community representatives on Health Service committees

The *Community Consultation and Participation Kit*²¹ has been developed to assist NSW Area Health Service managers and project leaders in establishing and maintaining community and consumer input into planning, policy development and service monitoring.

There are many different ways in which Area Health Services engage their communities to seek consumer feedback and advice when developing policy and planning Health Services.

Area Health Service models for consumer participation

The most prevalent mechanisms are Health Councils. These may be geographically based or issue based. For example, there are 12 Health Advisory Councils in the Far West Area Health Service, 13 Health Councils in Mid Western Area Health Service and 16 Health Councils in Macquarie Area Health Service (based on Local Government Areas).

Issues-based Health Councils (Aboriginal, Mental Health, Hospital and Community) have been established at Northern Rivers Area Health Service, while Central Sydney Area Health Service has appointed consumer representatives to specific Area-wide committees (Mental Health, Aged Care and Clinical Council). South Eastern Sydney Area Health Service utilises a wide network of consumer representatives and has appointed about 400 consumers to participate in about 120 committees and working parties at various levels in the Health Service.

Members of formal Health Councils are chosen in a variety of ways including seeking expression of interest and seeking nominations from local consumer and community organisations.

Reporting structures

Health Councils report in a variety of ways to the Area Health Service Chief Executive Officers and Area Health Service Boards. For example:

- Each Health Council in Greater Murray Area Health Service has a Board member as mentor, who is able to attend Health Council meetings.
- Mid North Coast AHS has established a Community Liaison Committee, comprising 5 Board members and 9 consumer members.
- In Southern AHS, the CEO & Board Chair attends Health Council meetings at least once per year, reporting by exception to Board meetings.

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- In South Eastern Sydney AHS, the Consumer and Community Participation Co-ordinator reports activity to the Area's Quality Council, which has Board Members and consumers as members.
 - Consumer activities in Mid Western Area Health Service are reported through the Health Service & Quality Board sub committee. The Board Chair attends Health Council meetings.

Each AHS has appointed a staff member to be responsible for consumer and community participation. Some of these staff are employed full-time on supporting health councils, health advisory groups and other consumer engagement strategies, while others work part-time on consumer participation activities and have allied responsibilities in public affairs, service development or quality and safety.

Monitoring consumer experience

Performance indicators have been developed to monitor the experience of consumers in the NSW health system. The NSW Health Survey Program interviewed a sample of residents across NSW and found that people attending an emergency department or hospital in the last 12 months were asked to rate the care they received during the attendance. In 2002 the survey found that 93% of people attending a community health centre gave a positive rating of their care. Overall, the proportion of people giving a positive rating of their care at hospitals was similar in the 1997 NSW Health Survey²² and the 2002 NSW Health Survey (91%) while emergency departments experienced a slight decrease in positive rating (77% in 2002).

9. PERFORMANCE MANAGEMENT STRATEGIES

In addition to policies and systems to ensure organisational competence and capability, a focus has also been placed on individuals who provide care within these systems. Accordingly, Health Services are required to ensure key components of effective performance management programs are in place in line with the following NSW Department of Health policies.

i. Appointment of competent staff

The Health Services Model By-Laws establish the need for Health Services to have appropriate staff appointment processes.²³ The Health Services have had access to the draft policy for the *Appointment of Visiting Practitioners* and the *Policy for the Appointment of Staff Specialists* to assist in these processes. These policy documents identify the best mechanisms for ensuring medical appointees are competent, skilled and fit for the appointment in question.

ii. Matching Individuals with the capabilities of the health facility

The *Guidelines for the Delineation of Clinical Privileges of Medical Staff*²⁴, and more recently the draft policy for the *Credentiailling and Delineation of Clinical Privileges for Visiting Practitioners and Staff Specialists*, provide guidance for Health Services to ensure that the skills and experience of individual appointments are consistent with the designated capability of a facility with regard to available support services such as nursing skills and experience, intensive care facilities, ventilating machines, pathology, radiology etc.

For example, it would be unsafe for even the most skilled cardiothoracic surgeon to undertake a heart transplant at a small rural hospital, as the high level of support services necessary for such surgery will not be available at that facility.

The process of aligning skills and expectations of individual practitioners, the capacity of a particular facility and the expectations of communities can be complex. In modern health systems, the principle factor in setting appropriate role levels is increasingly one of safety and ensuring a critical mass of skills, experience and volume of practice is present to achieve safe levels of care.

iii. Regular review and management of the performance of individuals

The draft policy for the *Performance Review of Visiting Practitioners* and the policy *Managing for Performance – A Better Approach for NSW Health*²⁵ have been developed to assist Health Services to structure regular review and evaluation of the performance of all health staff annually and to provide appropriate support to assist in performance improvement when required. Implementation of these processes is progressively underway across Health Services.

iv. Management of specific performance concerns about an individual clinician

The *Model Policy on the Management of a Complaint or Concern About a Clinician*²⁶ was developed in conjunction with the Health Care Complaints Commission and the Medical and Nursing Registration Boards in 2001 to assist Health Services in the development of local policy for this purpose. This model sets out three levels of action:

LEVEL 1 - a relatively minor and general concern is addressed by internal review and if required an assessment of the clinician's performance is undertaken.

LEVEL 2 – for a more specific concern with evidence of patient harm, the action is escalated to that of an investigation with the assistance of independent input, expertise and advice.

LEVEL 3 – a serious concern about a clinician accompanied by a serious adverse event, patient death or harm, poor insight into gaps in performance or serious concern from colleagues requires immediate notification to the HCCC, the appropriate Registration Board and the NSW Department of Health.

A determination will be made jointly between the HCCC and the Area Health Service, as to the most appropriate form of investigation or review.

Any level of review could result in the instigation of performance management processes with the clinician involved.

10. REPORTING AND MONITORING

There are many requirements for Health Services to report various data to the Department. These include legislated reporting requirements eg infectious diseases, Workcover notifications, suicides etc. The full extent of other requirements is documented in the Area Health Service

Performance Agreements with the Director-General. The primary categories for reporting are based on *Strategic Directions for Health 2000–2005*. They are Fairer Access, Quality Health Care, Healthier People and Better Value. It is proposed that the newly developed ‘Dashboard’ of indicators will replace the current performance indicators contained in the Health Service Performance Agreements.

Areas are also required to report serious health care incidents as defined in the Reportable Incident Brief Circular. All incidents that rate a SAC of 1 must be reported within 24 hours of notification to the CEO and must have a full review (RCA) completed within 45 days of the incident.

As stated earlier, Area Health Services also report on complaints management. Quarterly reports are received from Areas on compliance with the *Better Practice Complaint Handling Guidelines*, for example, percentage of complaints that are handled as Ministerials and referred from other organisations (eg HCCC); complaint to patient ratio; complaint classification; complaint handling performance (timeframes) and complaint resolution results.

The Safety Improvement Program Steering Committee is a high level departmental committee that was established in December 2003 to oversee the management of health care incidents reported to the NSW Department of Health. The role of the Committee is to provide strategic direction and advice on policy development that focuses on health care system improvement. Specifically, it will oversee system improvement, policy development, issues management and health system and community feedback.

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²² NSW Health. *NSW Department of Health 2001-02 Annual Report*. November 2002.

²³ NSW Health, *Health Services Model By-Law for Area Health Services, Statutory Health Corporations and Affiliated Health Organisations*, August 2000.

²⁴ NSW Health, Circular 95/24 *Guidelines for the Delineation of Clinical Privileges of Medical Staff*, April 1995.

²⁵ NSW Health, Circular 2000/68 *Managing for Performance - A Better Practice Approach for NSW Health*, August 2000.

²⁶ NSW Health, *Model Policy on the Management of a Complaint or Concern about a Clinician*, November 2001.

THE SEVERITY ASSESSMENT CODE (SAC)

The SAC score is to be applied to all incidents whether they are of a corporate or a clinical nature. The application of this matrix requires only a few minutes of a trained person's time. The SAC matrix is the tool by which the SAC score is derived. The steps are:

1. Using Figure 1 determine the consequence of the incident.
2. Using Figure 2 determine the likelihood of recurrence of this incident. This analysis will require knowledge of the facility or health service in which the incident occurred.
3. Using Figure 3 allocate a SAC score to the incident.
4. Using Figure 4 determine the appropriate action to be taken.

Each incident should be assessed for the actual consequence and the potential consequence of the incident. The potential is the worst case scenario for the incident being assessed. Only **actual** incidents need to be reported via the Reportable Incident Briefing (RIB) System.

Figure 1 - Consequences Table

SEVERITY ASSESSMENT CODE (SAC)

	Serious	Major	Moderate	Minor	Minimum	
CLINICAL CONSEQUENCE	<p>Patients with death unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management</p> <p>or any of the following:</p> <p>Sentinel Events reportable to Australian Council for Safety and Quality in Health Care</p> <ul style="list-style-type: none"> • Procedures involving the wrong patient or body part • Possible suicide • Retained instruments • Unintended material requiring surgical removal • Intravascular gas embolism resulting in death or neurological damage • Haemolytic blood transfusion • Medication error leading to death • Maternal death or serious morbidity associated with labour or delivery • Infant abduction or discharge to wrong family • Requires notification under existing DoH legislative reporting requirements 	<p>Patients with major permanent loss of function (sensory, motor, physiologic or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management</p> <p>or any of the following:</p> <ul style="list-style-type: none"> • disfigurement as a result of the incident • patient at risk absent against medical advice • threatened or actual physical or verbal assault of patient or staff requiring external or police intervention 	<p>Patients with permanent reduction in bodily functioning (sensory, motor, physiologic, or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management</p> <p>or any of the following:</p> <ul style="list-style-type: none"> • Increased length of stay as a result of the incident • Surgical intervention required as a result of the incident 	<p>Patients requiring increased level of care including:</p> <ul style="list-style-type: none"> • Review and evaluation • Additional investigations • Referral to another clinician 	<p>Patients with no injury or increased level of care or length of stay</p>	
	CORPORATE CONSEQUENCE	<p>Staff: Death of staff member related to work incident or suicide, or hospitalisation of 3 or more staff</p>	<p>Staff: Permanent injury to staff member, hospitalisation of 2 staff, or lost time or restricted duty or illness for 2 or more staff or pending or actual WorkCover prosecution</p>	<p>Staff: Medical expenses, lost time or restricted duties or injury / illness for 1 or more staff</p>	<p>Staff: First aid treatment only with no lost time or restricted duties.</p>	<p>Staff: No injury or review required</p>
		<p>Visitors: Death of visitor or hospitalisation of 3 or more visitors</p>	<p>Visitors: Hospitalisation of up to 2 visitors related to the incident / injury or pending or actual WorkCover prosecution</p>	<p>Visitors: medical expenses incurred or treatment up to 2 visitors not requiring hospitalisation</p>	<p>Visitors: Evaluation and treatment with no expenses</p>	<p>Visitors: No treatment required or refused treatment</p>
		<p>Services: Complete loss of service or output</p>	<p>Services: Major loss of agency / service to users, including cancellation of booked surgery more than twice</p>	<p>Services: Disruption to users due to agency problems</p>	<p>Services: Reduced efficiency or disruption to agency working</p>	<p>Services: No loss of service</p>
		<p>Financial: loss of assets replacement value due to damage, fire etc > \$1M, loss of cash/investments/assets due to fraud, overpayment or theft >\$100K or WorkCover claims > \$100K</p>	<p>Financial: loss of assets replacement value due to damage, fire etc \$100K-\$1M, loss of cash/investments /assets due to fraud, overpayment or theft \$10K-\$100K or WorkCover claims \$50K - \$100K</p>	<p>Financial: loss of assets replacement value due to damage, fire etc \$50K to \$100K or loss of cash/investments /assets due to fraud, overpayment or theft to \$10K</p>	<p>Financial: loss of assets replacement value due to damage, fire etc to \$50K</p>	<p>Financial: No financial loss</p>
<p>Environmental: Toxic release off-site with detrimental effect. Fire requiring evacuation</p>		<p>Environmental: Off-site release with no detrimental effects or fire that grows larger than an incipient stage</p>	<p>Environmental: Off-site release contained with outside assistance or fire incipient stage or less</p>	<p>Environmental: Off-site release contained without outside assistance</p>	<p>Environmental: Nuisance releases</p>	

FIGURE 2 – Likelihood Table

Probability Categories	Definition
Frequent	Is expected to occur again either immediately or within a short period of time (likely to occur most weeks or months)
Likely	Will probably occur in most circumstances (several times a year)
Possible	Possibly will recur – might occur at some time (may happen every 1 to 2 years)
Unlikely	Possibly will recur – could occur at some time in 2 to 5 years
Rare	Unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)

FIGURE 4 – Action required Table

ACTION REQUIRED
<ul style="list-style-type: none"> • 1 = Extreme risk – immediate action required – a Root Cause Analysis (RCA) investigation must be commenced. Reportable Incident Brief (RIB) must be forwarded to the DoH • 2 = High risk – senior management attention needed – notification to the DoH and / or RCA investigation is to be undertaken at the discretion of management. If RCA not undertaken, aggregate then undertake a practice improvement project • 3 = Medium risk – management responsibility must be specified – aggregate data then undertake a practice improvement project. Exception – all financial losses > 0 must be reported to senior management • 4 = Low risk – manage by routine procedures – aggregate data then undertake a practice improvement project
<p>NB – An incident that rates a SAC of 3 or 4 should only be reported to the DoH if it is likely to attract external attention or requires notification under existing DoH legislative reporting requirements – do not re score the SAC</p>

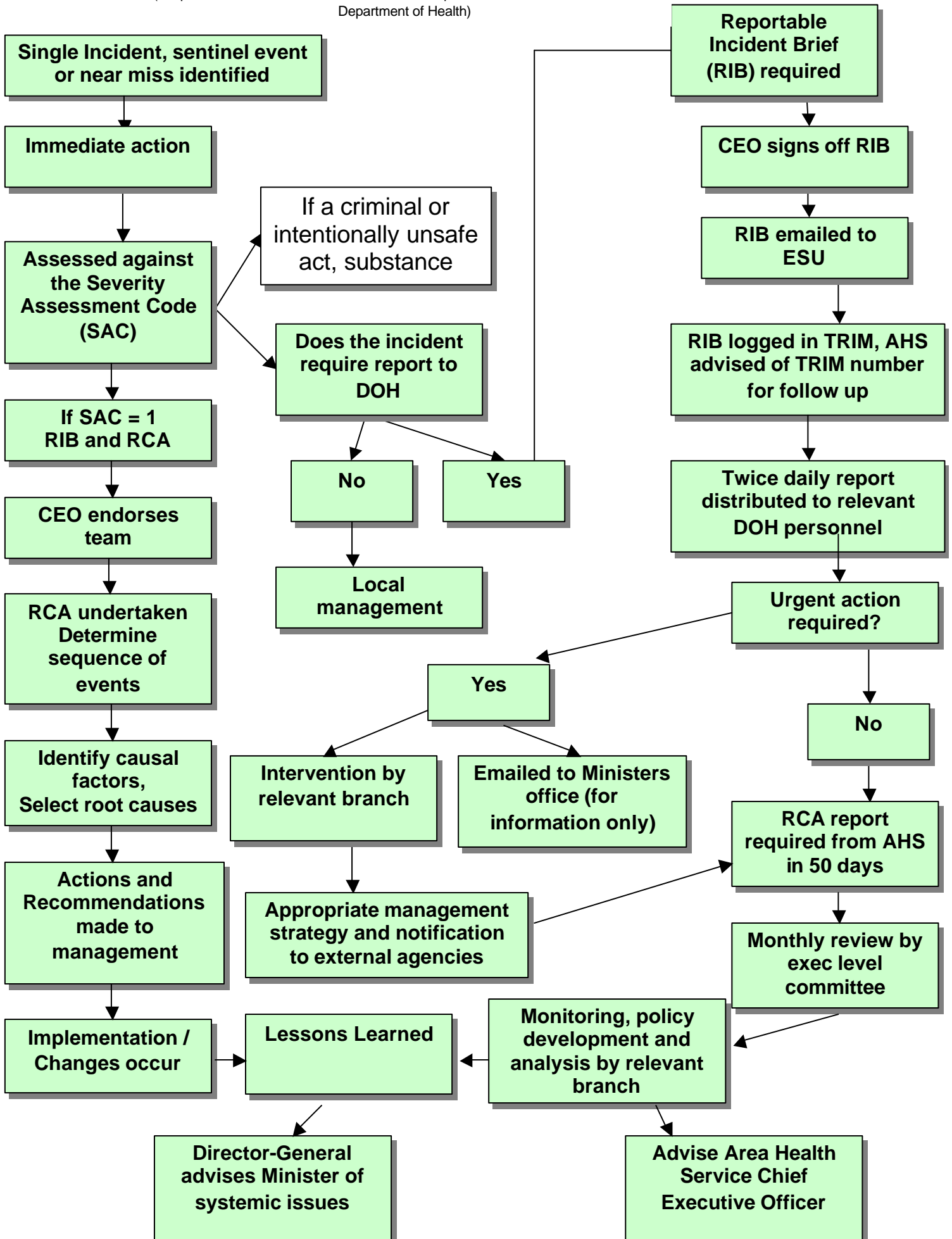
FIGURE 3 – SAC Matrix

CONSEQUENCE \ LIKELIHOOD	Serious	Major	Moderate	Minor	Minimum
Frequent	1	1	2	3	3
Likely	1	1	2	3	4
Possible	1	2	2	3	4
Unlikely	1	2	3	4	4
Rare	2	3	3	4	4

RIB MANAGEMENT PROCESS FLOW

(adapted from NSW Health Circular 2003/ 88 Reportable Incident Briefs to the NSW Department of Health)

APPENDIX B



NSW QUALITY IMPROVEMENT INITIATIVES – A COMPARISON WITH OTHER HEALTH SYSTEMS

Purpose

The purpose of this paper is to provide a comparison between the NSW health system's clinical governance, quality improvement and complaints handling initiatives and those of other health systems.

Introduction

NSW Health led Australia with the release of the first framework for clinical governance - *A Framework for Managing the Quality of Health Services in New South Wales* - in February 1999. The *Framework* was developed following a thorough examination of systems in place in other states and countries and consultation with experts both in Australia and overseas. The most significant input to the *Framework* came from a review of the literature on Clinical Governance that was emerging from the National Health Service in the UK, at that time.

Since the Framework was published, NSW Health has progressively added strategies and initiatives to improve the clinical environment for patients.

NSW Health has taken the lead in introducing new and innovative quality and safety initiatives such as the Quality Framework, the Clinician's Toolkit, the 1-800 Hospital Incident Call line, the NSW Health Awards and the Neurosurgeons Clinical Risk Management program. NSW Health has also critically examined the work of other health services, both in Australia and overseas, to identify initiatives that have been proven to work and assessed how they could be adapted to work in the NSW Health system.

To which health systems should the NSW Health system be compared?

A comparison has been made in this paper between the NSW Health system and four leading overseas health systems. The reasons for the choice of these systems will be addressed individually.

United Kingdom – National Health Service

The UK National Health Service (NHS) provides publicly funded free health care, including primary health care, to the UK population. The overarching directions for health care delivery emanate from a central agency while local health units or trusts are responsible for the management of health care and the application of the central agency's directions at the local level. The NHS recently introduced another layer of management when it established Strategic Health Authorities. This structure is analogous to the NSW Health system, with Authorities having a similar role to Area Health Services and Trusts being similar to our hospitals and other health services.

USA – Department of Veterans Affairs

While the US health system is inherently different from the Australian health system, the Department of Veterans Affairs (VA) has the largest integrated health care system in the USA. It provides medical, surgical and rehabilitation services to a specific population group.

The Veterans Administration supports this health system by providing strategies, policies and integrated data collection systems in areas including quality and performance, patient safety, research, and public health and environmental harm.

The size of the VA health system is similar to that of NSW Health with 172 hospitals compared to 206 in NSW Health.

Canada

In partnership with provincial and territorial governments, Health Canada provides national leadership to develop health policy, enforce health regulations, promote disease prevention and enhance healthy living for all Canadians. Health Canada works closely with other federal departments, agencies and health stakeholders to reduce health and safety risks to Canadians.

Through its administration of the *Canada Health Act*, Health Canada maintains a health insurance system which is universally available to permanent residents, comprehensive, accessible without income barriers, portable within and outside the country and publicly administered. Each province and territory administers its own health care plan with respect for these five basic principles of the Canada Health Act.

Regional Health Authorities within each province and territory have similar responsibilities to Area Health Services in NSW.

Denmark

The Danish health care system provides free and equal access to health services to nearly 5.5 million people with 1.1 million admissions annually compared to NSW 6.7 million population and 1.34 million admissions to NSW health services.

The comparison

The main areas in which the NSW health system has provided leadership and progress over the past five years include the development of structures for clinical governance, policy development, improvement programs and in the development and delivery of teaching and training programs for quality.

Legislatively both the NSW Health system and the NHS require health facilities to provide high quality health services and NSW Health, Canada, the VA and the Danish health systems place an emphasis on reviewing and using the lessons from adverse events to improve the quality of care provided.

NSW Health extensively reviewed local and overseas patient safety programs before adopting the VA model in 2002. The NSW training program and the Safety Improvement Program were developed in consultation with and with a great deal of assistance from the VA, specifically the Director of the program, Dr Jim Bagian. Personnel from NSW Health have been to the VA program in the US to be trained in the techniques and Dr Bagian and his team have visited NSW a number of times to assist with training and the development of the Program.

The Copenhagen Health Authority in Denmark has also developed their Safety Improvement Program along the VA model.

All other Australian states and territories have now also adopted the VA/NSW model. NSW has provided the training for many states. Further, the NHS recently consulted NSW Health and the NSW Institute for Clinical Excellence (ICE) staff about the NSW Safety Improvement Program. NSW Health has been engaged in recent years to provide training to health service personnel in both Hong Kong and Fiji in recognition of the sound nature of our framework, and support documents, and programs.

Lessons from incidents identified by the health system and also those reported by consumers are shared with the health system through initiatives such as the *Safety Advocate* modelled, in part, on the Topics in Patient Safety (TIPS) Newsletter of the VA.

Quality improvements are shared and promoted from one part of the health system across the State through annual events such as the NSW Health Awards and the Quality in Health Care Forum.

A number of significant training and education programs have been developed in NSW for teaching clinicians and managers to improve healthcare and health services. The Clinical Practice Improvement (CPI) Program was developed with the assistance of Dr Brent James from Intermountain Health Care in Utah who is a world leader in quality improvement.

The collaboratives that are currently under way in the NSW Health system have been developed from the Institute for Healthcare Improvement (IHI) collaborative process established in the mid to late 1990s in the USA. Again, members of the NSW Health Department went to the USA to receive training in the method. As with other methods and programs developed overseas, substantial effort is then put into adapting the method to ensure its relevance to the NSW health setting and culture.

The National Centre for Patient Safety in the US is the VA organisation that is responsible for the delivery of the patient safety programs (described earlier) to the VA population. The NCPS is investing significant resources into the implementation of practices that have been proven through human factors research to improve health system design, equipment and device design and use, and practices that make health care safer.

Further comparisons are provided in the following table.

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
Demographics	Population: 6.69M ⁱⁱⁱ No. hospitals: 206 Hospitalisations: 1.34M (2003) ^{iv} Budget: A\$8.87B (2002-03) ^v	Population: 70M No. hospitals: 172 Hospitalisations: 0.56M (2002) Budget: US\$25.9B (2003)	Population: 60.90M ^{vi} No. hospitals: approx 400 ^{vii} Hospitalisations: 12.75M (2002-03) ^{viii} Budget: UK£65.48B (2003-04) ^{ix,x}	Population: 31.71M ^x No. hospitals: approx 970 ^{xi} Hospitalisations: 2.82M (2001) ^{xii} Budget: CAN\$97.6B (2000-01) ^{xiii}	Population: 5.39M ^{xiv} No. hospitals: 71 ^{xv} Hospitalisations: 1.1M pa ^{xvi} Budget: €7.6B (1997) ^{xvii}
Delivery of health care	NSW Health care system: <ul style="list-style-type: none"> - free and equal access - public inpatient & outpatient, and community services - does not provide primary health care 	VA health care system: <ul style="list-style-type: none"> - access to most inpatient and outpatient health care services - co-payments for services 	NHS health care system: <ul style="list-style-type: none"> - free and equal access - all health services 	Canadian health care system <ul style="list-style-type: none"> - health insurance system which is universally available to permanent residents - comprehensive in the services it covers - accessible without income barriers, - portable within and outside the country - each province and territory administers its own health care plan 	Danish health care system: <ul style="list-style-type: none"> - free and equal access - primarily by public health care services - free choice of primary care doctor

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
Clinical Governance					
Legislation – quality improvement	Health Services Act 1997 ^{xviii} states that area health services are to “achieve and maintain adequate standards of patient care and services”		Health Act 1999 ^{xix} states that “it is the duty of each Health Authority, Primary Care Trust and NHS trust to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals”.	Under the Canada Health Act , it is the responsibility of each individual province or territory to manage and deliver health services. Provinces and territories plan, finance, and evaluate the provision of hospital care, physician and allied health care services, some aspects of prescription care and public health.	
Clinical governance framework (clinical governance represents the systematic joining up of initiatives to improve quality ^{xx})	A Framework for Managing the Quality of Health Services in New South Wales ^{xxi} provides a systematic framework for the introduction of clinical governance in NSW. Includes the following:		Clinical governance in the NHS ^{xxii} includes the following elements: - national service frameworks - local duty of quality eg controls assurance - performance procedures,		

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
	<ul style="list-style-type: none"> - principles of a quality health service - six performance areas (safety, effectiveness, appropriateness, consumer participation, access and efficiency) - five cross dimensional issues (competence, continuity of care, information management, education & training, accreditation) - performance indicators - committee structure - reporting frame - governance structure 		<ul style="list-style-type: none"> annual appraisal, revalidation - educational inspection visits - adverse incident reporting, learning networks, continuing professional development - patient empowerment eg better information, patient advocacy service, rights of redress, patients' views sought, patients involved in health system - underpinning strategies eg information and information technology, research and development, education and training 		

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
Clinical Governance Support programs	<ul style="list-style-type: none"> - Clinical Practice Improvement Program - Human Factors Training 		<p>National Clinical Governance Support Team^{xxiii} is a multidisciplinary group that bridges the gap between health service policy and service delivery by helping health service teams to deliver clinical governance in their own units.</p> <p>The Team's objectives are to:</p> <ul style="list-style-type: none"> - raise awareness of clinical governance, prevent concept drift and initiative fatigue - co-ordinate and facilitate accelerated learning - design and deliver a wide access Leadership Development Program - actively support projects arising 	<ul style="list-style-type: none"> - Continuing Education 	

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
			<p>from development initiatives</p> <ul style="list-style-type: none"> - harness generic lessons from worked examples to inform, in a practical way, further guidance for the implementation of clinical governance. 		
Safety Improvement Program					
Legislation – patient safety	<p>Health Administration Act 1982^{xv} grants qualified privilege to the documents (created by or for) and proceedings of an approved quality improvement committee.</p> <p>Committees are required to assess and evaluate health</p>	<p>US Patient Safety and Quality Improvement Act^{xvi}, currently before Congress, provides for the legal protection of information reported voluntarily for the purposes of quality improvement and patient safety.</p> <p>Allows for the</p>	<p>The National Patient Safety Agency (NPSA) is a Special Health Authority set up in July 2001 by the National Patient Safety Agency Establishment and Constitution Order 2001</p>	<p>The Statutes of Alberta, the British Columbia Evidence Act 51 and the Manitoba Evidence Act all provide legal protection from discovery for review activities undertaken by professionals for the purpose of quality assurance</p>	<p>An Act on Patient Safety^{xvii} (June 2003) aims to improve patient safety by establishing a system for the receiving, recording and analysing reports on adverse events occurring in connection with patients within the health care system.</p> <p>Health care professionals are obliged to report an adverse event relating to a</p>

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
	<p>services and report their findings and recommendations to the Minister for Health.</p> <p>Reports are not to identify a patient or health provider.</p>	<p>voluntary disclosure of non-identifiable patient safety data by a provider or a patient safety organisation.</p> <p>The Act provides for penalties for people who negligently or intentionally disclose any patient safety data.</p>		and quality improvement. ^{xxvi}	patient's treatment or stay in hospital.
Patient safety improvement program	<p>Safety Improvement Program^{xxviii}, based on the US Department of Veteran's Affairs program,</p> <ul style="list-style-type: none"> - aims to improve the safety in Healthcare through understanding and correcting the underlying causes and system vulnerabilities that contributed to an adverse event or a near miss, by asking 	<p>US Department of Veterans Affairs National Center for Patient Safety aims to reduce and prevent adverse medical events while enhancing the care given to patients.</p> <p>The patient safety program:</p> <ul style="list-style-type: none"> - focuses on prevention and not punishment - applies human factor analysis - identifies and eliminates system 	<p>The NPSA was created to co-ordinate the efforts of all those involved in healthcare, and more importantly to learn from, patient safety incidents occurring in the NHS.</p>		<p>The Copenhagen Health Authority conducts a Patient Safety program similar to NSW and based on the VA model</p>

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
	<p>“what happened?”, “why did it happen?” and “how can we prevent it from happening again?”</p> <ul style="list-style-type: none"> - uses Root Cause Analysis methodology to identify the true cause of the systems failure. <p>Resources: Staff x 5 Patient Safety Manager x 17; one for each AHS</p>	<p>vulnerabilities</p> <ul style="list-style-type: none"> - uses Root Cause Analysis to identify prevention strategies. <p>Resources: Staff x 30 Patient Safety Managers x 176; one for each facility</p>	<p>Resources: Staff >100 Budget of £12.1 M per annum</p>		
Incident Management including Complaints					
Adverse events monitoring	A key component of the Safety Improvement Program is the implementation of a statewide incident reporting and management system ^{xxix} enabling	Facilities within the VA collect data on adverse events within their facility. Serious adverse events (SAC 1) are reported to the VA's National Center for	The NPSA plans to collect reports from across the country and initiate preventative measures, so that the whole country can learn from each case, and patient safety	The Institute for Healthcare Improvement Collaborative on reducing Adverse Drug Events and Medical Errors documents healthcare incidents	Adverse events are collected locally and reports on adverse events (including the analysis of the event) are sent to the National Health Board's national register . Using the information from

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
	<p>the collection, classification and management of incidents across the health system.</p> <p>The information gained from these data will allow high level analysis of incidents delineating trends and variances and the presentation of the findings in meaningful ways to assist with the sharing of information and lessons learned in publications such as the <i>Safety Advocate</i>.</p>	<p>Patient Safety.</p> <p>From these reports strategies are developed to minimise their recurrence in the VA system</p>	<p>throughout the NHS will be improved every time.</p> <p>by collecting and analysing information on patient safety incidents from local NHS organisations, NHS staff, patients and carers</p> <ul style="list-style-type: none"> • by taking into account other safety-related information from a variety of existing reporting systems • by learning lessons and ensuring that they are fed back into health care and treatment is organised and delivered • by ensuring that where risks are identified, work is undertaken on producing solutions to prevent harm, and to specify national goals and establish mechanisms to track progress. 	<p>whether they are considered an error or not and make changes to improve care.^{xxx}</p> <p>A Medication Incident Reporting and Prevention System is in development for national monitoring of adverse drug events.^{xxx}</p>	<p>the register, the Board will advise the health system on patient safety</p>

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
Patient complaints system	<p>1800 Hospital Incident Call Centre, established in December 2003, aims to</p> <ul style="list-style-type: none"> - collect consistent data about consumer reported health care incidents - standardise management processes for all consumer reported health care incidents - collect sufficient data about each incident to enable the identification of meaningful risk reduction strategies - standardise classification of the attributes of each incident - analyse incident demographics and report trends <p>Better Practice Guidelines for</p>		<p>All NHS trusts, primary care trusts, GPs, dentists, opticians and pharmacists have a complaints procedure for patients.</p> <p>Local Patient Advice and Liaison Services are located in each hospital trust.</p>	<p>The Advisory Committee on Health Services Working Group on Quality of Health Care Services is currently investigating approaches to handling complaints. The Working Group has commissioned the review: Governments and patient safety in Australia, the United Kingdom and the United States: A review of policies, institutional and funding frameworks, and current initiatives to guide future initiatives in complaint handling and patient safety.</p>	

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
	Frontline Complaints Handling ^{xxxii} provides a framework to enable consistent and continuous improvement approaches to the handling of frontline complaints				
Reporting a complaint or concern about a health care professional	Guideline on the Management of a Complaint or Concern about a Clinician ^{xxxiii} sets out the actions that are to be taken by a public health organisation with a complaint or concern about a clinician that may range from concern about clinical outcomes to one or more events concerning unexpected mortality.				The <i>Act on Patient Safety</i> in the Danish Health Care System requires health care professionals to report adverse events. While the Act does not specifically mention the reporting of health care professionals it would appear to be implied in the definition of an adverse event.

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
Knowledge Management					
Dissemination of safety issues to the health system	<p>The Safety Advocate, launched in 2002, provides information about the common underlying causes of sentinel events, suggests steps to prevent occurrences in the future and provides knowledge resources to assist organisations in reviewing and updating their own systems.</p> <p>Topics have included <i>Infusion Pump Safety, Bed Rail Safety, Fall Injury Prevention in Acute Care, Medication Safety, and Sterilisation and Disinfection.</i></p>	<p>Topics in Patient Safety (TIPS) Newsletters^{xxxiv} released by the US Department of Veteran’s Affairs.</p> <p>The TIPS Newsletter aims to provide useful and timely topics concerning patient safety.</p>	<p>The CGST commits significant resources to an excellent, established and sophisticated Knowledge Management Program.</p>	<p>The National Steering Committee on Patient Safety has disseminated information and produced recommendations for action to improve the patient safety.</p>	

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
Sharing and spreading innovation and new practices	<p>The Annual Quality in Health Care Forum^{xxxv} aims to showcase the projects being undertaken in NSW area health services that have demonstrated improvement in clinical practice. The quality themes of the 2003 Forum were Governance, Patient Safety and Leadership, Clinical Policy, Health Priorities and Consumer Participation in Quality.</p> <p>In 2003 33 projects were presented and 33 storyboards displayed demonstrating the outstanding work currently being undertaken to improve healthcare in NSW.</p> <p>Projects utilise the</p>			<p>Patient Safety Working Groups to report to the National Steering Committee on Patient Safety and to share information and innovation relating to the following issues:</p> <ul style="list-style-type: none"> - System Issues - Legal Issues - Evaluation - Professional Development - Communication 	

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
	Clinical Practice Improvement methodology taught by the Institute for Clinical Excellence				
Recognising and sharing quality improvements	<p>NSW Health Awards^{xxvi} aim to acknowledge innovative quality health projects implemented by the NSW Department of Health and NSW Health Services.</p> <p>The Awards were established in 1999 to acknowledge the innovative quality health projects conducted in health facilities resulting in positive changes to the delivery of healthcare in NSW.</p> <p>In 2003 the 5th Awards were held with 230 entries submitted into 10 categories of Safety, Effectiveness, Appropriateness,</p>		<p>The Clinical Governance Development Programme^{xxvii} of the Modernisation Agency requires groups to present case studies that show what groups involved in the Programme have achieved. The emphasis is on practical experience.</p> <p>The case studies provide a detailed description of:</p> <ul style="list-style-type: none"> - starting point - action taken - what has been achieved <p>Groups in the Programme can also prepare a Eureka!. These are moments when groups have</p>	<p>Patient safety and healthcare error in the Canadian healthcare system: A systematic review and analysis of leading practices in Canada with reference to key initiatives elsewhere is a resource document that highlights quality initiatives.</p> <p>The project has three major components:</p> <ul style="list-style-type: none"> - a literature review - telephone and mail surveys - analysis of current activities 	

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
	<p>Consumer Participation, Efficiency, Access, Competence, Information Management, Continuity of Care and Education & Training.</p> <p>The projects submitted by the winners, finalists and commended projects are released in a Health Awards Book.</p>		<p>discovered ways to overcome the barriers they face in their work.</p> <p>Each Eureka! will:</p> <ul style="list-style-type: none"> - describe the problem - steps taken to overcome the problem. - difference it has made to the local situation <p>The case studies and Eureka! are accessible via the Agency's website.</p>		

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
Quality Improvement Agency					
Quality improvement agency	<p>Institute for Clinical Excellence^{xxxviii}, constituted as a statutory health corporation, formally commenced in December 2001.</p> <p>The ICE co-operates with public health organisations and the Department of Health to identify, develop and disseminate information about best practice in health care on a state wide basis by:</p> <ul style="list-style-type: none"> - working collaboratively on high priority clinical projects across multiple sites being orientated solely on improved patient outcomes - driving implementation of Clinical 		<p>Modernisation Agency^{xxxix} formed in April 2001 to help the NHS to make radical and sustainable changes by supporting clinical and managerial leaders to transform services by:</p> <ul style="list-style-type: none"> - building improvement skills and supporting the redesign of care to bring about the transformation of patients' experiences by visit programs, collaborative projects, learning sets and design program to spread good practice - promoting and evaluating innovation 	<p>Canadian Patient Safety Institute^{xl} formed in 2003 to provide leadership and co-ordination in building a culture of patient safety and quality improvement.</p> <p>Resources: CA \$10 M pa on national patient safety initiatives including CPSI.</p>	

	NSW Health	USA (Department of Veterans Affairs – largest integrated health care system in the USA) ⁱⁱ	UK (National Health Service)	Canada	Denmark
	<p>Practice Improvement and championing the lessons learned across the system</p> <ul style="list-style-type: none"> - providing education and training to support the implementation of improvement projects - supporting targeted health services research <p>Resources: Staff x 6 A\$2.5M pa</p>		<ul style="list-style-type: none"> - transferring new learning. <p>Each NHS trust with a zero star rating from the Commission for Health Improvement has its own Modernisation Agency client manager to support the trust.</p> <p>Resources: Staff x 700 A\$300M pa</p>		

STATUTORY COMPLAINTS SCHEME FOR REGISTERED HEALTH PROFESSIONALS

BACKGROUND

Some health professions are also subject to separate statutory schemes, which provide for the registration of practitioners and include processes for investigation, prosecution and disciplining those practitioners. The professions regulated in this manner include medical practitioners, nurses, pharmacists, dentists, physiotherapists, psychologists and optometrists. It should be noted that these statutory disciplinary systems focus on public protection, rather than punishment.

Legislation in this area has been subject to recent review as part of the Government's National Competition Policy obligations under the Competition Principles Agreement 1995. This has led to the staged repeal, amendment and remaking of most health professional acts over the last three years, and an increased level of uniformity between the various schemes. The reviews have also provided an opportunity for a detailed consideration of the statutory disciplinary processes.

Each professional *Act* establishes a board with mixed community, legal and professional representation. Boards have a role in consultation with the Health Care Complaints Commission (HCCC) and in the management, assessment, receipt and actioning of complaints.

The system is generally complaints driven, and any person may make a complaint. The grounds for a complaint include that the practitioner is guilty of unsatisfactory professional conduct or professional misconduct, lacks competence, is impaired or is not of good character. A complaint may be made to the Board or the HCCC and there are some legislative provisions designed to encourage ongoing consultation between boards and the HCCC.

COMPLAINTS MANAGEMENT

The current structure provides a variety of options for dealing with a complaint, depending on the level of seriousness and the level of ongoing risk to the public. These options include:

Direct resolution: minor matters can be declined, or referred to the practitioner for direct resolution with his or her patient. Direct resolution can also utilise the services of patient support officers, employed through the HCCC.

Conciliation: complaints which do not raise concerns about the practitioner's practice or serious public health issues can be referred for conciliation to the Health Conciliation Registry (HCR). The HCR is established as a separate statutory corporation under the *Health Care Complaints Act 1993*. Its function is to arrange conciliations, which are conducted using a panel of expert conciliators appointed by the Minister. A matter may only be referred to the HCR if both the Board and the HCCC considers it appropriate and both the complainant and practitioner consent.

Impaired Registrants Panel: this panel can consider cases where there is evidence that a practitioner suffers an impairment (such as drug or alcohol addiction, mental disorder or physical disability) which detrimentally affects their capacity to practice. Referrals are made by the Board on the basis of a complaint or other information. As such, the panel provides a process for practitioners to self refer and receive support and direction, and an opportunity for intervention prior to any complaint or serious incident occurring.

Options available to the panel include recommending counselling or that conditions be placed on the practitioner's registration. While the process itself is voluntary, if a practitioner fails to agree to the panel's recommendation, the Board can deal with the matter as a complaint.

Performance assessment: the performance assessment program is designed to complement the disciplinary process by providing a pathway for dealing with practitioners who are neither impaired or guilty of professional misconduct, but for whom the Board has concerns about the standard of their clinical performance. It is designed to address patterns of practice rather than one-off incidents.

The process involves a performance assessment of a practitioner by an expert assessor, drawn from panels provided by the medical colleges. An assessment can lead to a more formal Performance Review Panel, the imposition of conditions on practice or other requirements designed to enable the practitioner to improve their performance. Performance assessment also provides for ongoing monitoring

of compliance with orders made by the panel. This option is currently only available under the Medical Practice Act.

Disciplinary Hearings

There are two options for disciplinary hearings:

Professional Standards Committees (PSCs): Where a complaint involves a question of unsatisfactory professional conduct, it will be referred for hearing by a PSC. These committees are designed to operate on an inquisitorial model, with their hearings generally confidential and no legal representation allowed. A PSC has wide powers to caution or reprimand a practitioner, order counselling, order the imposition of conditions on practice, but cannot order a practitioner's removal or suspension from the register.

Tribunal Hearing: Where a complaint is of such seriousness that, if proven it could lead to a practitioner being removed from the register, (ie, it is a matter of possible professional misconduct) it will be referred to the Tribunal for hearing. The Tribunal is chaired by a judge or senior legal practitioner, and has the same powers as a PSC. If it finds a practitioner guilty of professional misconduct it may also suspend their registration for a specified period or cancel that registration.

The above model is adopted in both the *Nurses Act* and *Medical Practice Act*, being the two largest health professional groups. Smaller professions, such as psychologists, physiotherapists and optometrists also rely on a Tribunal for serious matters, but use an assessment committee to deal with other matters. Under this scheme, these less serious matters are not investigated by the HCCC but by an assessment committee made up of professional and lay members. The Committee can resolve the complaint directly with the parties, or if it raises questions of unsatisfactory professional conduct or professional misconduct, refer it for consideration by the Board or Tribunal.

Emergency powers for protection of the public

Finally, powers exist for a board to take emergency action to suspend a practitioner's registration or place conditions on registration at any time where satisfied it is necessary to do so to protect the life or the physical or mental health of any person. Where that action is taken the board must within 7 days refer the matter to the HCCC for investigation.

REFERRAL PATTERNS

In practice, very few complaints end up before a disciplinary hearing, with most being dealt with by the lower level options. Information provided in the 2002 Medical Board annual report demonstrates the general mix in this regard:

OUTCOME/REFERRAL	%
Declined to deal with	20
Referral to practitioner for direct resolution	17
Referral to the Health Conciliation Registry	21
Referral to Medical Board*	21
Referral to another body**	11
Referral to HCCC for investigation	10

KEY

* for example an area health service or other watchdog body

** including the Board's performance and health programs

ENDNOTES

- ⁱ In 2002 NSW Health was invited to provide courses on Clinical Practice Improvement to senior health personnel in Hong Kong and Fiji. Topics covered included human factors in health care, clinical information gathering strategies, Clinical Practice Improvement methods and tools, incident and sentinel event management and Root Cause Analysis.
- ⁱⁱ Department of Veterans Affairs at <http://www1.va.gov/opa/fact/docs/vafacts.htm>
- ⁱⁱⁱ NSW population as at March quarter 2003 at <http://www.abs.gov.au>
- ^{iv} NSW Department of Health Annual Report 2002-03 at <http://internal.health.nsw.gov.au/pubs/a/pdf/ar2003.pdf>
- ^v NSW Department of Health Annual Report 2002-03 at <http://internal.health.nsw.gov.au/pubs/a/pdf/ar2003.pdf>
- ^{vi} Population for 2003 at US Census Bureau at <http://www.census.gov/>
- ^{vii} NHS Hospital Episode Statistics at <http://www.doh.gov.uk/hes/>
- ^{viii} NHS Hospital Episode Statistics at <http://www.doh.gov.uk/hes/>
- ^{ix} NHS Departmental Report 2003-04 at <http://www.doh.gov.uk/dohreport/>
- ^x Population for 2003 at Statistics Canada <http://www.statcan.ca>
- ^{xi} Canada's Hospitals at Statistics Canada <http://www.statcan.ca>
- ^{xii} Total Days of Hospitalization for Canada, Provinces and Territories, 1995/96, 2000/01 & 2001/02 at <http://www.cihi.ca>
- ^{xiii} Health Spending for 2000/01 at Health Canada <http://www.hc-sc.gc.ca/>
- ^{xiv} Population for 2003 at US Census Bureau at <http://www.census.gov/>
- ^{xv} 71 hospitals in 2000 at <http://www.civitas.org.uk/pdf/Denmark.pdf>
- ^{xvi} Royal Danish Ministry of Foreign Affairs at <http://www.um.dk/english/>
- ^{xvii} Blume, D, *Engaging Citizens in the Danish Health Care Sector*, OECD 2001 at <http://www.oecd.org/dataoecd/53/44/2536455.pdf>
- ^{xviii} Health Services Act 1997 (NSW) s10.
- ^{xix} Health Act 1999 (UK) s18 at www.hmso.gov.uk/acts/acts1999/99008--a.htm
- ^{xx} Halligan A, Donaldson L, *Implementing clinical governance: turning vision into reality*. BMJ 9 June 2001;322:1413-1417.
- ^{xxi} NSW Health, *A Framework for Managing the Quality of Health Services in New South Wales*, February 1999.
- ^{xxii} Halligan A, Donaldson L, *Implementing clinical governance: turning vision into reality*. BMJ 9 June 2001;322:1413-1417.
- ^{xxiii} Halligan A, *How the National Clinical Governance Support Team plans to support the development of clinical governance in the workplace*. The Journal of Clinical Governance December 1999;7:155-157.
- ^{xxiv} Health Administration Act 1982, Division 6B, ss 20D-20K.
- ^{xxv} 108th Congress, 'Patient Safety and Quality Improvement Act of 2003' S. 720 and H.R. 663 at <http://thomas.loc.gov/cgi-bin/query/C?108:./temp/~c1080BvmeH> at 20/1/04.
- ^{xxvi} Patient Safety and Healthcare Error in the Canadian Health System: A Systematic Review and Analysis of Leading Practices in Canada with Reference to Key Initiatives Elsewhere, 2002, <http://www.hc-sc.gc.ca/english/care/report/index.html>
- ^{xxvii} An Act on Patient Safety at www.patientsikkerhed.dk/admin/media/pdf/133907d0940e4d5f751852ec8f6b1795.pdf
- ^{xxviii} Safety Improvement Program at <http://internal.health.nsw.gov.au/quality/sip>
- ^{xxix} NSW Health, Circular 2003/88 *Reportable Incident Briefs to the NSW Department of Health*, December 2003 at <http://www.health.nsw.gov.au/fcsd/rmc/cib/circulars/2003/cir2003-88.pdf>.
- ^{xxx} Patient Safety and Healthcare Error in the Canadian Health System: A Systematic Review and Analysis of Leading Practices in Canada with Reference to Key Initiatives Elsewhere, 2002, <http://www.hc-sc.gc.ca/english/care/report/index.html>
- ^{xxxi} Patient Safety and Healthcare Error in the Canadian Health System: A Systematic Review and Analysis of Leading Practices in Canada with Reference to Key Initiatives Elsewhere, 2002, <http://www.hc-sc.gc.ca/english/care/report/index.html>
- ^{xxxii} NSW Health, *Better Practice Guidelines for Frontline Complaints Handling*, January 1998.
- ^{xxxiii} NSW Health, *Guideline on the Management of a Complaint or Concern About a Clinician*, November 2001.
- ^{xxxiv} TIPS Newsletters at <http://www.patientsafety.gov/tips.html>.
- ^{xxxv} Quality in Health Care Forum at <http://internal.health.nsw.gov.au/quality/quality/forum/index.html>.
- ^{xxxvi} NSW Health Awards at <http://internal.health.nsw.gov.au/quality/healthawards/2003/>.
- ^{xxxvii} Clinical Governance Support Programme at <http://www.cgsupport.nhs.uk>
- ^{xxxviii} Institute for Clinical Excellence at <http://www.ice.nsw.gov.au/>.
- ^{xxxix} NHS Modernisation Agency. *Moving Modernisation into the Mainstream: NSW Modernisation Agency Business Plan 2003/2004*, July 2003 at www.modern.nhs.uk.
- ^{xl} Canadian Patient Safety Institute at <http://www.hc-sc.gc.ca/>

