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CHAPTER 9 – HEALTH RECORDS AND INFORMATION

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MENTAL HEALTH CLINICAL DOCUMENTATION (PD2021_039)

PD2021_039 rescinds PD2010_018

POLICY STATEMENT

NSW Health organisations must ensure that all mental health services use available electronic medical record (eMR) systems for the documentation of clinical practice and care. This is required in all service settings, for all service types and age groups, and enables integrated health services and clinical information systems across NSW.

Digital documentation facilitates the recording, retrieval and sharing of medical record information in an accessible, standardised and structured format. This is important at all points in the cycle of mental health care from triage through to transfer or discharge.

All NSW Public Health Organisations must ensure that local processes are in place which comply with this Policy.

SUMMARY OF POLICY REQUIREMENTS

Electronic health systems are to be supported by Local Health Districts (Districts) and Specialty Health Networks (SHNs) by implementing products and functionalities as they become available. Local systems, processes and procedures are to be maintained, including those required for downtime when needed. There must also be training and education provided for clinicians in the areas of mental health clinical documentation, and related eMR systems and processes.

eMR systems must include available electronic mental health (MH) documents, including notes, forms, measures and reports.

Clinical care and information must be documented and are to be recorded within the eMR, with paper records used only where there is no current alternative.

Documentation must occur at appropriate clinical points of care, including triage, assessment, care planning, review, transfer and discharge. It must be made as soon as practically possible in the eMR clinical document(s) relevant to the clinical point of care and needs of the person accessing the service.

Structured documentation is to be used to aid functionalities that auto-populate fields, and transfer information between documents and systems. This is critical to clinical care and support across services and systems within NSW Health. Only relevant fields need to be completed. There are no requirements that all fields or areas of a document are to be completed.

All persons registered to a mental health service must have the following recorded in their documentation: Designated Carer(s) and/or Principal Care Provider information; Diagnosis (issues that are the focus of the current admission or encounter); Legal Status; and Alerts (for care and safety of the person, carer(s) and health workers).

There must be clinical reasons to use non mental health or alternative documentation or free text. In these circumstances, the clinician must be aware that auto-population and transfer functions will not be enabled. The clinician is to ensure that documentation reflects the content of the standardised eMR document, and the format of documentation is legible and locatable by other clinicians involved in care.

For information on Mental Health resources and updates
http://ehnsw.sharepoint.nswhealth.net/apps/ClinP-eMedsHub/Pages/Mental-Health.aspx

PRIVACY MANAGEMENT PLAN (IB2023_012)

IB2023_012 replaced PD2015_036

PURPOSE

The NSW Health Privacy Management Plan has been published on the NSW Health website Patient privacy.

All NSW Health organisations are required to adopt and implement the NSW Health Privacy Management Plan within their organisation and promote it to their staff and the public, including through publication of the Plan on their public facing websites.

KEY INFORMATION

Key actions for NSW Health organisations

All NSW Health organisations must ensure the collection, use, management and disclosure of personal and health information complies with the Information Protection Principles and with the Health Privacy Principles, as detailed in the *Privacy and Personal Information Protection Act 1998* (NSW) and *Health Records and Information Privacy Act 2002* (NSW), respectively.

NSW Health organisations are required to have a Privacy Contact Officer (or a designated staff member), whose role includes to facilitate compliance with privacy laws and NSW Health privacy policy in their organisation.

New staff members in NSW Health organisations are to complete mandatory privacy training as part of their induction and orientation process.

Where staff have access to large data sets of personal and health information in their roles, NSW Health organisations must ensure that, in addition to privacy training, appropriate privacy undertakings have been signed, prior to these systems being accessed.

Appropriate collection notices are to be used to satisfy privacy requirements when personal and health information is being collected, particularly when new programs or systems are being developed.
A request for a privacy internal review must be completed as soon as practicable, and within 60 calendar days.

Any wilful act of unauthorised access to, use, or disclosure of, personal or health information by a staff member is to be referred to human resources for advice regarding appropriate disciplinary action. In consultation with the NSW Ministry of Health, the chief executive must give consideration for referring the matter to the police, and/or informing persons affected by a breach, of the option of referral to prosecution.

NSW Health organisations have privacy-related statutory reporting obligations, including obligations under the *Independent Commission Against Corruption Act 1988* (NSW), the *Privacy Act 1988* (Commonwealth), the *My Health Records Act 2012* (Commonwealth), and the *Security of Critical Infrastructure Act 2018* (Commonwealth). Mandatory reporting obligations include privacy breaches involving inappropriate use/ disclosure of Tax File Numbers, My Health Record data breaches, other privacy matters related to corrupt conduct, and for notifying cyber security incidents to the Australian Cyber Security Centre.

Each NSW Health organisation is to provide a submission to the NSW Ministry of Health by 31 July each year, that outlines the actions it has undertaken in relation to privacy management and compliance, and details of privacy statistics, for the financial year immediately prior.

All NSW Health organisations are to publish their own privacy management actions and statistics (as included in the submission to the NSW Ministry of Health) on their own websites after the NSW Health Annual Report has been published on the NSW Health website, and by no later than 30 November of that same year.

Further information on privacy-related matters is available in the *NSW Health Privacy Manual for Health Information*.

About the NSW Health Privacy Management Plan

The NSW Health Privacy Management Plan:

- Demonstrates to members of the public and other third parties how NSW Health meets its obligations under the *Privacy and Personal Information Protection Act 1998* (NSW)
- Provides an overview of how personal information is managed appropriately and in accordance with the law, and provides advice about the management of staff members' personal information
- Demonstrates NSW Health's commitment to respecting the privacy rights of staff, members of the public, and other third parties together with a Privacy Information Sheet for Personal Information
- Sets out how individuals, whether they are staff or members of the public, can access their personal information, seek to amend their personal information, submit a privacy complaint, and request a privacy internal review and how possible breaches of privacy in relation to personal information will be managed by NSW Health
- Outlines limits on access to personal information and legislative exemptions (including Public Registers, Public Interest Directions and Codes of Practice)
- Sets out the remedies available to individuals, if they have a concern that the privacy of their personal information has been breached.

PHOTO AND VIDEO IMAGING IN CASES OF SUSPECTED CHILD SEXUAL ABUSE, PHYSICAL ABUSE AND NEGLECT (PD2015_047)

PURPOSE

The purpose of this Policy Directive is to:

- Define the NSW Health requirements and minimum standards for the use and management of photo and video imaging in cases of suspected child sexual abuse, physical abuse and neglect
- Guide NSW Health staff when capturing, storing and managing images for the purpose of documenting health and clinical features and informing possible future judicial proceedings that require medical opinion.

MANDATORY REQUIREMENTS

This policy requires that:

- The immediate and longer-term physical and emotional needs of the child and their parent(s) / guardian(s) are identified and taken into account when considering photo and video imaging.
- Imaging is captured for the primary purpose of documenting a clinical finding for the health care record and limited other relevant purposes, and is not excessive or unreasonably intrusive.
- Imaging is only captured where informed consent is sought and obtained for each purpose for which it may be used.
- Capture, recording and storage of images is limited to LHD / SCHN owned memory devices.
- Images are stored securely and are stored separately from the principal health care record, to maintain patient privacy.
- Limited access is provided to images, to maintain patient privacy.
- Capture, use and management of photo and video images in cases of suspected child abuse is conducted in accordance this Policy Directive, in conjunction with:
  Child Wellbeing and Child protection Policies and Procedures for NSW Health (PD_2013_007)
  Current Standards and Practice Guidelines for NSW Health Sexual Assault Services
  Child Wellbeing and Child Protection – NSW Interagency Guidelines,
- Consent, privacy, confidentiality, management and retention is preserved in accordance with the NSW Health Consent to Medical Treatment - Patient Information policy, 2005, NSW Health Privacy Manual for Health Information, 2015, NSW Health Care Records – Documentation and Management Policy (PD2012_069), NSW Health Electronic Information Security Policy (PD2013_033), NSW Government Digital Information Security Policy M2012-15, NSW Health Subpoena policy (PD2010_065) and NSW Government General Retention and Disposal Authority policy (GDA17; 2011).

IMPLEMENTATION

Chief Executives are responsible and accountable for:

- Establishing mechanisms to ensure the directives and requirements of this policy are applied, achieved and sustained
- Ensuring that NSW Health staff understand and are aware of their obligations in relation to this policy and related policies and procedures
- Ensuring resources are available to deliver and meet the directives and requirements of this policy
- Ensuring that NSW Health staff are trained to operationalise and implement this Policy
- Ensuring NSW Health staff are advised that compliance with this policy is part of their patient / client care responsibilities
- Ensuring that procedures for capture, storage, access and security are subject to risk analysis reassessment over time.

Facility managers are responsible for:

- Ensuring the requirements of this policy directive are disseminated and implemented in their service / department / hospital
- Establishing local validated processes for image preparation, capture, processing, storage, transmission, archiving, retention and disposal
- Monitoring implementation and compliance with this policy.

NSW Health workers are responsible for:

- Implementing and complying with the directives and requirements of this policy
- Ensuring that their knowledge of consent, privacy and documentation management processes is maintained, consistent with the requirements of this policy directive.

1 INTRODUCTION

1.1 Rationale

Clinical evaluation of a child or young person who is suspected of having been abused or neglected involves a holistic assessment of their physical needs, psychosocial needs, medical history, and any social or familial risk factors. NSW Health practitioners are required to document and report suspicion of harm and may use clinical photo and video imaging to supplement and enhance the detail in written notes and diagrams. Imaging can assist the physician to review the facts associated with clinical examination and history as part of their clinical diagnosis: in an attempt to ensure the accuracy of a diagnosis this may include professional peer review. Diagnoses in cases of suspected child abuse have an impact on the safety, welfare and wellbeing of a child or young person. Clinical photo and video imaging is an important tool in the achievement of accurate clinical conclusions to support the needs of children and young people.

This policy defines the NSW Health requirements and minimum standards for the use and management of photo and video imaging in cases of suspected child sexual abuse, physical abuse and neglect. It will guide NSW Health workers to know what actions to take when capturing, storing and managing images for the purpose of documenting health and clinical features, and informing possible future judicial proceedings that require medical opinion. A development group was convened to inform the development of this policy. Details of membership appear at Appendix 5.5.

1.2 Who this policy applies to

This policy applies to NSW Health workers in Local Health Districts (LHDs) and the Sydney Children's Hospitals Network (SCHN) who are employed or contracted to capture or manage imaging in cases of suspected child abuse, including:

- Medical practitioners or other specialist staff undertaking medical and forensic examinations of children and young people aged under 18 who are suspected of having been sexually abused, physically abused or neglected
- Psychosocial, sexual assault and child protection practitioners, coordinators and managers
- Medical photographers, Joint Investigation Response Teams (JIRTs), Aboriginal health services and other clinical and allied health staff
- Managers or officers who support the capture, viewing, accessibility, transmission or management of photo and video imaging. This includes data custodians, IT technical and support staff, health information managers and staff in medical records departments.

The policy may also be of interest to:

- NSW Health interagency child protection partners
- Those who work in the wider criminal justice setting and child health and advocacy settings
- Networks that support children and young people who have experienced sexual abuse, physical abuse or neglect and their non-offending family members
- Those who work in private health settings who wish to adopt minimum standards for the use and management of photo and video imaging in cases of suspected child abuse.

1.2.1 Exclusions

This policy does not apply to:

- Sexual abuse examinations utilising clinical colposcopic equipment without capture of imaging
- Photo and video imaging taken in other types of medical examinations (i.e. those that do not relate to suspected child abuse)
- Medical imaging such as Magnetic Resonance Images (MRIs), Computerised Tomography (CT) scans, skeletal surveys, radioisotope scans or post-mortem imaging.

1.3 Service users

Children or young people who use NSW Health services in relation to suspected sexual abuse, physical abuse and/or neglect and, depending on the age of a young person, this may include parent(s), carer/(s) or guardian(s).

1.4 Context for practice

1.4.1 Interagency context

Medical and forensic examinations and associated photo and video imaging take place in the context of an interagency response to child protection. Interagency roles and responsibilities are outlined in the Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013, current standards and guidelines for NSW Health Sexual Assault Services and NSW Interagency Guidelines.

1.4.2 NSW Health context

The psychosocial and medical needs of a child or young person are a priority and need to be responded to appropriately. NSW Health's role is to provide an integrated psychosocial and medical response to all suspected child abuse presentations including assessment, crisis intervention and counselling. The medical response will potentially include a medical and forensic examination.

Medical and forensic examinations are critical to the crisis response required on presentation of: a child victim of sexual abuse to a Sexual Assault Service or Emergency Department; or a child with suspected physical abuse or neglect to a medical practitioner, Emergency Department, or other health service.

Related child protection and violence prevention, privacy, security and document management policies are listed in Appendices 5.1 to 5.4.

1.4.3 Clinical context

Clinical photography has assisted in the development of medical knowledge and skills within the NSW Health workforce over the last two decades, and aided the interpretation and evaluation of injuries, for the benefit of examiners and their patients. Medical and forensic assessment of children suspected of having been abused occurs within a framework that responds to the immediate psychosocial and medical needs of a child and their family – who are often traumatised and distressed.

This context includes:

- Identification of children at risk who require a medical and forensic assessment
- Recording of medical history and examination findings complemented by appropriate clinical photo or video imaging
- Forensic specimen collection where relevant (as in recent sexual abuse)
- Medical treatment of injuries or other sequelae of the abuse, such as the risk of exposure to sexually transmitted diseases or pregnancy
- Interpretation of clinical findings, with a reference to any allegation of abuse.

Anatomical diagrams are useful for recording certain features of an injury, such as the number of injuries, the type of injuries, their overall size and shape and the general location of the injuries on the body. It is difficult for a doctor to record adequately sufficient information for detailed medical and forensic assessment of many injuries with diagrams and words alone. Medical illustration is a specialised career. It takes both skill and time to produce an accurate and useful medical drawing. The extra detail provided by a photo or video record is of particular relevance when a medical and forensic examiner is asked to comment, sometime after the medical examination, on whether a particular account of accidental injury, provided by a caregiver, might reasonably account for the clinical findings.

Several advantages of photography can be summarised as below:

- Photo and video images allow review of injuries or other clinical findings, such as evidence of dermatological conditions or malnutrition, in a more comprehensive manner. Indeed there are many reasons why a child's injuries may need to be reviewed. The original examining doctor may review photos when preparing an expert certificate and/or prior to appearing in court. Photo and video imaging can assist the examining doctor when they review the patient for ongoing clinical care, or if the police provide additional information and ask for a clinical opinion, in regards injury causation. Photo and video imaging is useful for gaining a second opinion by a senior colleague as to the significance of the injury and also helps determine if specialist referral is necessary. It may also prevent the need for a child to travel long distances to a specialist centre
- Imaging can overcome the difficulties presented by children and young people having to lie still for extended periods of time. Children can naturally wriggle and not want to lie still – especially if they have experienced sexual abuse or if there is injury or recent assault. This is particularly relevant to examining the ano-genital regions, especially in pre-pubertal females where there is a need to assess in detail the significance of small anatomical structures which may be a normal variant or an indicator of recent or earlier injury

- Sexual abuse assessment in pre-pubertal children is complex. Paediatric genital anatomy is variable and accurate observation and interpretation is difficult. Forensic colposcopic imaging allows the examination to proceed with the knowledge that a child or young person can benefit from subsequent specialist review of the imaging as a record of the complex clinical findings
- Photo and video imaging may enable the medical examiner to capture a clear picture of an area that was only exposed for a few seconds. The use of photo and video imaging can in many cases prevent the need for a child or young person to return for a repeat examination, or undergo examination under anaesthesia.

It is best practice in Forensic Medicine to rigorously separate the observation and recording of findings from the interpretation of those findings. Photo and video imaging enables the examiner to concentrate on observation, which is demanding, and then to later consider all possible causes.

1.4.4 Intimate images, sensitive evidence and retention

Photo and video imaging captured as part of a medical and/or forensic assessment may include intimate images.

Intimate images are defined as depicting the genitalia, anus or post-pubertal female breast (Faculty of Forensic & Legal Medicine, 2014) and may also include other parts of the body, such as the buttocks or chest of a pre-pubertal child.

These images are considered as 'sensitive evidence' under the *Criminal Procedure Act 1986* (Section 281B). Where they are held by the NSW Police Force and Office of the Director of Public Prosecutions (ODPP) access to them is restricted. These restrictions do not extend to images held by NSW Health. Where a subpoena has been validly lodged, the court is not obliged to restrict access to intimate images held by NSW Health.

In accordance with health care record retention policies, once an image is captured as a medical record it can be subpoenaed, shown in court and remains on a medical record file for at least 30 years (NSW Government General Retention and Disposal Authority policy, 2004, revised 2011).

2 NSW HEALTH MINIMUM STANDARDS

When use of photo and video imaging is being considered during medical and forensic examinations in cases of suspected child sexual abuse, physical abuse and neglect, NSW Health will ensure that:

1. The immediate and longer-term physical and emotional needs of the child and their parent(s)/guardian(s) are identified and taken into account. (Section 2.1)
2. Imaging is captured for the primary purpose of documenting a clinical finding for the health care record and other directly related purposes, and is not excessive or unreasonably intrusive. (Section 2.2)
3. Imaging is only captured where informed consent is sought and obtained for the specific purposes for which it may be used. (Section 2.3)
4. There are standardised procedures for capturing and documenting images to reduce variation across statewide services. (Section 2.4)
5. Capture, recording and storage of images is limited to LHD/SCHN owned memory devices. (Section 2.5)
6. Images are stored securely and separately from the principal health care record, to maintain patient privacy. (Section 2.6)
7. Restricted access is provided to images, to maintain patient privacy. (Section 2.7)
8. The integrity of images is maintained in the longer-term. (Section 2.8)

2.1 Physical and emotional needs of the child or young person

Standard: The immediate and longer-term physical and emotional needs of the child and their parent(s)/guardian(s) are identified and taken into account when considering photo and video imaging

In accordance with the Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013 and current standards and guidelines for NSW Health Sexual Assault Services:

- In cases of suspected physical abuse and neglect, optimally, assessment should be conducted by the medical officer with a social worker or other health professional colleague, e.g. a nurse, present to facilitate a holistic assessment (Suspected Child Abuse and Neglect (SCAN) Medical Protocol, 2014).
- In cases of suspected sexual assault a joint response by the medical practitioner and counsellor from the Sexual Assault Service or Child Protection Unit provides the professional response required in these circumstances (Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013).

When deciding whether and how to capture images in this context, NSW Health workers must:

- Identify and take into account:
  - Factors arising from the life circumstances of the child or young person, their psychosocial development, vulnerability to particular risks and their linguistic, cultural and religious needs
  - The circumstances in which the child or young person was alleged to have been assaulted, abused or neglected
    - The need for an appreciation and understanding of Aboriginal people and communities' inter-generational trauma legacies, the impact of power dynamics, the importance for understanding an Indigenous world-view, including cultural practices and protocols, the multiple and inter-related factors that contribute to the poorer health status of Aboriginal people, and the limitations of Western approaches in the assessment and treatment of trauma (see http://www.health.nsw.gov.au/aboriginal/pages/default.aspx).
- Ensure that children, young people and their parent(s)/guardian(s) have:
  - Access to health information relative to their wellbeing
  - The opportunity to participate in decision making
  - Access to an interpreter if required (see Interpreters – Standard procedures for working with Health Care Interpreters)
  - Access to an Aboriginal Health worker if desired. It is important to determine at the beginning the most appropriate person or people to communicate with in relation to the patient.

2.2 Purpose of imaging

Standard: Imaging is captured for the primary purpose of documenting a clinical finding for the health care record and other directly related purposes, and is not excessive or unreasonably intrusive

In accordance with the NSW Heath Privacy Manual for Health Information, 2015:

- The primary purpose for collecting photo and video imaging is to document a clinical finding for the medical record
- Imaging must be relevant to the purpose, not excessive, accurate, up to date, complete and must not be unreasonably intrusive
- Collection of photo and video imaging must supplement, not replace, other methods of documenting findings

- Other directly related purposes for collecting photo and video imaging may include:
  - Peer review to assist diagnosis
  - Providing an aide-memoire for potential future legal proceedings
  - Teaching, research and quality improvement activities (sections 2.3.3, 2.7.1, 2.8 and 2.9).

LHDs/SCHN must ensure that images are only captured and used for relevant purposes in accordance with the NSW Heath Privacy Manual for Health Information, 2015.

2.3 Seeking consent

Standard: Imaging is only captured where informed consent is sought and obtained for the specific purposes for which it may be used

LHDs/SCHN must ensure that NSW Health workers act in accordance with the NSW Health Consent to Medical Treatment - Patient Information policy, 2005 and the NSW Health Privacy Manual for Health Information, 2015 and comply with 2.3.1 to 2.3.3 below. Additional advice may be sought from NSW Health Legal and Regulatory Services.

2.3.1 Who should seek consent

An examiner must ensure that valid consent has been obtained. An examiner may ask another health care practitioner to seek consent, however the examiner maintains responsibility and may be held responsible in some circumstances if consent is not sought correctly (NSW Health Privacy Manual for Health Information, 2015).

2.3.2 Who can provide consent

Where a child or young person is less than 14 years of age, consent given by a parent or legal guardian is generally necessary. In some circumstances, consent can be given by the young person if he or she is considered by the treating health care practitioner to be mature enough, and if this would be appropriate in the circumstances. See '*Gillick* competence' in the 'Glossary'.

Where a young person is aged 14 or 15 they are generally able to consent, however an assessment of their maturity and understanding will still need to be made. Effort should be made to seek the consent of a parent or legal guardian unless the young person indicates a strong objection, and this is reasonable in the circumstances. Alternatively a parent or legal guardian can provide consent, however it would be exceptional to proceed on the basis of parent or guardian consent without the acquiescence of the young person aged 14 or 15.

Where the young person is 16 years of age or over they should generally be capable of consenting themselves (NSW Health Consent to Medical Treatment - Patient Information policy, 2005; NSW Heath Privacy Manual for Health Information, 2015).

For guidance on capacity to consent see the NSW Health Consent to Medical Treatment - Patient Information policy, 2005 and the NSW Heath Privacy Manual for Health Information, 2015.

Occasionally, a parent delegates their responsibility for consenting to medical treatment on behalf of their minor child, to another adult. This may occur in certain cultures, for example, in relation to Aboriginal children, where an extended family member, rather than the child's mother or father, might be responsible for giving consent on their behalf. Where NSW Health workers require advice about who is able to provide consent for imaging they should consider the following options:

- Refer to policy relating to:
  - The broader context of consent for the examination (NSW Health Consent to Medical Treatment - Patient Information policy, 2005; NSW Heath Privacy Manual for Health Information, 2015)
  - Child Wellbeing and Child protection Policies and Procedures for NSW Health, 2013 and current standards and guidelines for NSW Health Sexual Assault Services
- Contact NSW Health Legal and Regulatory Branch or NSW Kids and Families during business hours
- Contact the Guardianship Division of the NSW Civil and Administrative Tribunal.

2.3.3 The consent process

Where child sexual abuse, physical abuse or neglect is suspected and the capture and use of photo and video imaging is considered as part of a medical and forensic examination, informed consent must:

- Be sought in accordance with the NSW Health Consent to Medical Treatment - Patient Information policy, 2005 and the NSW Health Privacy Manual for Health Information, 2015 and
- Address consent for the capture of the image(s) and the separate specific purposes for which image(s) may be used.

The consent process must include:

- Patient/parent/guardian access to culturally appropriate information
- Seeking written informed consent for the capture of photos to document a clinical finding
- An explanation to the child or young person and/or their parent(s)/guardian(s)
  - What the procedure for capturing imaging will involve
  - That imaging may include ano-genital and breast/chest areas of the body and that they may opt to exclude imaging of these or other specific body areas
  - That any records of examinations, findings, photos, videos, samples/specimens taken in accordance with the consent/s given
    - Will be stored in accordance with NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Government General Retention and Disposal Authority policy, 2004 (revised 2011) for a minimum of 30 years
    - May be referred to another clinician for a second opinion and peer review
    - May be forwarded to the NSW Police Force, ODPP, and by the court under subpoena, including the judge, the jury, the defendant, counsel for both prosecution and defence and any other people whom the judge considers relevant
    - May be produced to comply with a request to a NSW Health organisation under the legislation set out in the *Children and Young Persons (Care and Protection) Act* 1998
    - May be forwarded to parties in Family Court proceedings under subpoena

For the purpose of this policy the consent process must also include:

- Seeking separate informed consent for the use of copies of photo and video imaging for a) teaching and/or b) approved research. All such copies must be de-identified, the teaching and research activities must be compliant with the NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies and research must be approved by a Research Ethics Committee (for example, see https://hrep.nhmrc.gov.au/certification/hrecs, http://www.ahmrc.org.au/ethics2.php and www.ipc.nsw.gov.au/statutory-guidelines-research-purposes-pdf).

Human Research Ethics Committees – Quality Improvement & Ethical Review: A Practice Guide for NSW can help to determine whether an activity constitutes a research or quality improvement activity.

- An explanation that consent for the future use of images for a) teaching and/or b) approved research activities may be withdrawn by the person who provided consent or the person depicted in the image(s) once they are Gillick competent.

An interim NSW Health consent form is located in Appendix 5.6.

2.4 Procedures for capturing and documenting imaging

Standard: There are standardised procedures for capturing and documenting images to reduce variation across statewide services

LHDs/SCHN must support NSW Health workers to comply with 2.4.1 and 2.4.2 below.

2.4.1 Capturing imaging

Capture of imaging in cases of suspected child abuse must be conducted in accordance with the NSW Health Privacy Manual for Health Information, 2015, and must be restricted to NSW Health workers with suitable training and experience in the procedures required to comply with this photo and video imaging policy.

At a minimum, NSW Health workers must:

- Carefully explain to the child or young person, and where appropriate their parent(s)/guardian(s), what the procedure is going to involve in advance of the examination
- Provide the opportunity for the child or young person, and/or parent(s)/guardian(s) to ask questions and receive answers in a way that takes into consideration the person's level of development and understanding as described in section 2.1 of this policy
- Seek informed consent as described in section 2.3 of this policy directive via a process that:
  - Explains what consent means in relation to the separate specific purposes for which images may be used (as described in section 2.3 of this policy directive) and the implications that may arise for the child, young person or their parent/guardian providing consent
  - Provides options for providing or refusing consent at any time during the course of the examination for:
    - The capture of images of specific areas of the body
    - The specific purposes for which images may be used.
- Consider whether the child or young person and their parent(s)/guardian(s) would find it helpful if the practitioner or other NSW Health worker demonstrated the use of the video colposcope and observation monitor. This could be achieved by displaying real time magnified images of objects and/or non ano-genital body parts on a monitor placed in a location easily seen by the child or young person and examiner
- Ensure that images of a child or young person's face are not captured, unless it is required to document a clinical finding
- Capture the minimum number of images required to adequately document a clinical finding
- Adopt the following good practice techniques:
  - Use a RAW (digital negative that requires processing), TIFF or JPEG format for capturing still images
  - Use a procedure that will allow reliable identification of the recording(s) in relation to the particular child or young person and the time that the image(s) was taken. For example, include the child's hospital ID label for identification purposes

- Include some form of further visual identification on the first and last image, including the child's name or initials, Medical Record Number (MRN) and/or Area Unique Identifier (AUID) and the date
- Include a scale in the image, where possible
- Consider anterior, posterior and lateral images of the patient and document the anatomical location of each image (an example 'Request for medical photography services' form is located in Appendix 5.7).

When conducting telehealth NSW Health workers must:

- Consider the professional capacity of the host and remote site examiners as either the supervising or the supervised clinician based on their relevant and appropriate training and experience
- Act in accordance with the requirements of this policy directive
- Consider using the good practice techniques set out in the Agency for Clinical Innovation Guidelines for the use of telehealth for clinical and non-clinical settings in NSW, 2015.

NSW Health does not support recording of an entire telehealth consultation with a patient or any audio recording.

2.4.2 Documenting imaging

NSW Health workers must:

- Act in accordance with NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Health Privacy Manual for Health Information, 2015
- Reference images using an individual health care patient identification system including a child or young person's name or initials, Medical Record Number (MRN) and/or Area Unique Identifier (AUID), date of birth (DOB), the date the images were captured and the name of the treating physician
- Document consent and the existence of images in the patient's medical records. For physical abuse and neglect the Suspected Child Abuse and Neglect (SCAN) Medical Protocol, 2014 may be used, unless this is being assessed in conjunction with suspected sexual abuse when the Child Sexual Assault Medical Protocol in the Sexual Assault Investigation Kit (SAIK) may be used. Details must include:
  - Any refusal of consent for capturing photo and video imaging
  - Any withdrawal of consent for the capture or use of photo and video imaging before and during the examination
  - The name of the photographer, the date and time, and the location of where the images were taken to maintain integrity in the event of legal action or issuing of a subpoena
  - The number and type of images that were taken
- Note that child abuse and neglect images must be stored securely and separately from a child or young person's principal health care record (see section 2.6.2) and a reference placed on the health care record where the images are located to identify the existence of any principal health care record or other relevant health related documents. Index or patient administration systems must reference the existence of satellite/decentralised health care records that address a specific issue and that are kept separate from the principal health care record
- Document authorised permission for release/transmission in the patient's medical records (see section 2.6.3 of this policy directive).

Where telehealth is used, document at both sites that the consultation has occurred and ensure that this documentation concurs.

It is good practice to disclose the existence of images to NSW Police Force on the Expert Certificate.

2.5 Devices used to capture, record, store and transmit images

Standard: Capture, recording and storage of images is limited to LHD/SCHN owned memory devices

LHDs/SCHN must ensure that:

- In cases of suspected child abuse, medical and forensic imaging is captured on dedicated LHD/SCHN owned:
  - Clinical camera imaging devices used for the sole purpose of documenting suspected sexual abuse, physical abuse, and neglect;
    - or where the sole purpose of a clinical camera is not restricted to documenting abuse or neglect, such as in an Emergency Department, the clinical camera must accommodate an LHD/SCHN owned removable memory device and images must be captured onto the removable device and not the camera, using one removable device per patient
  - Clinical colposcope imaging equipment, preferably used for the sole purpose of documenting sexual abuse
  - Portable or removable memory devices, such as DVDs, memory sticks and external hard drives
- Single Lens Reflex (SLR) clinical camera equipment is the preferred option and:
  - Includes a flash
  - Includes a lens with a close up facility
  - Has at least six megapixels.

  A 'stand-alone' personal camera (i.e. one that is not part of a mobile telephone or ipad) may be used in exceptional circumstances and only where:
  - No LHD/SCHN owned equipment is available and
  - The personal camera can accommodate an LHD/SCHN owned removable memory device and use is restricted to capturing images onto the removable device and not the personal camera, using one removable device per patient.
- All equipment complies with NSW Health Electronic Information Security Policy, 2013 and NSW Health Privacy Manual for Health Information, 2015
- Imaging equipment is:
  - Capable of producing an accurate representation of any evidential clinical finding being recorded
  - Appropriately maintained and managed, such as updating date and time settings recharging/replacing batteries
  - Strictly governed and controlled and adequately secured using lockable facilities
  - Monitored in respect of who accesses and uses it.
- Any equipment or devices used for remote access to NSW Health networks from an external location must be authenticated and authorised by the LHD/SCHN and connectivity must be protected by approved controls. This includes mobile devices, smartphones, tablets, netbooks, notebooks, palmtops, handheld personal organisers, laptops, modems, PDAs, wireless access points, portable or removable storage devices, CD/DVD burners and printers
- All imaging is protected and managed according to NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, and NSW Health: Health Care Records – Documentation and Management policy, 2012.

NSW Health does not support:

- The use of any other personal equipment or devices for the purpose of capturing or storing images in relation to suspected child abuse. Examples include cell phones, smartphones, tablet devices, netbooks, notebooks, palmtop, handheld personal organisers, laptops, USB drives, DVDs and removable memory cards and sticks
- Use of Skype or other insecure software/platforms in NSW Health care settings.

2.6 Security and storage of images

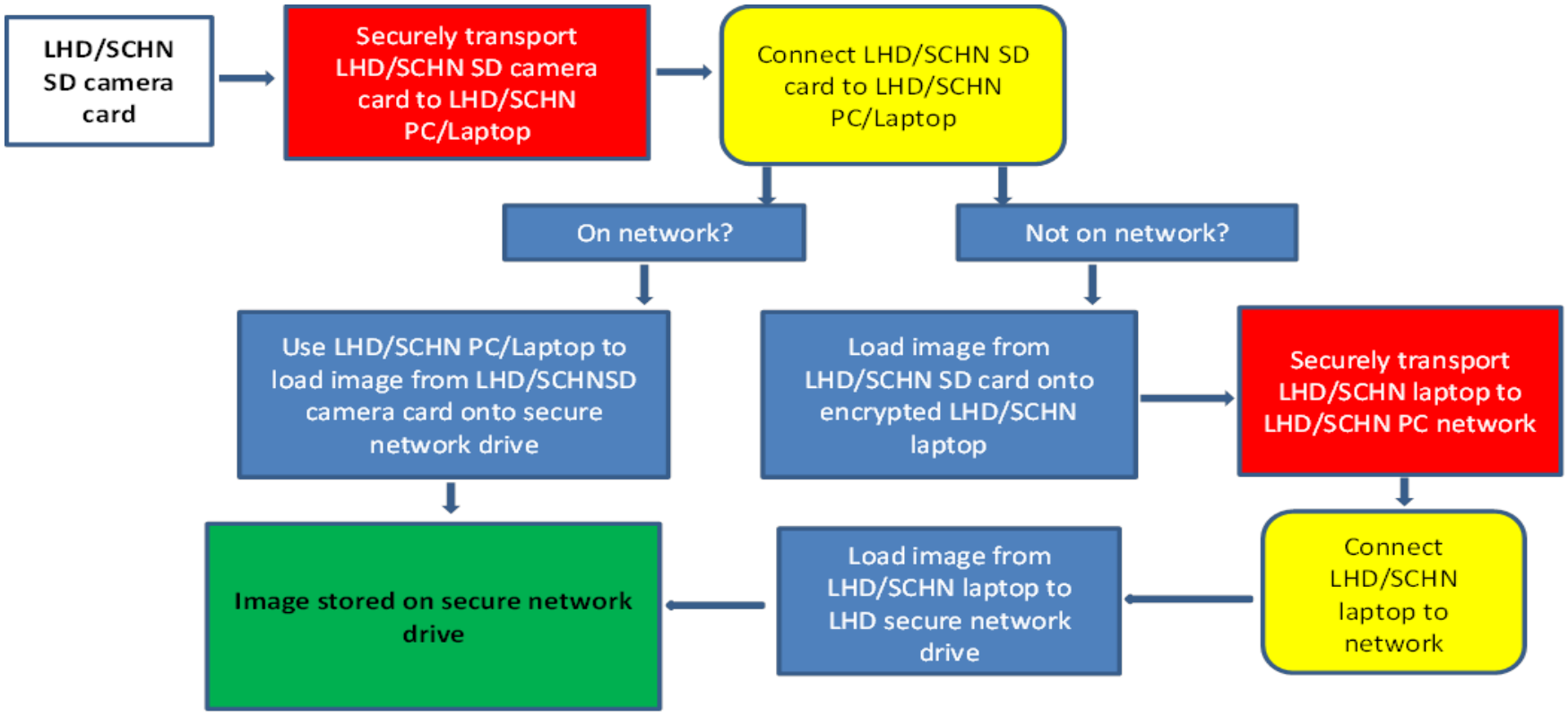
Standard: Images are stored securely and separately from the principal health care record, to maintain patient privacy

LHDs/SCHN must support NSW Health workers to comply with 2.6.1 to 2.6.6 below.

2.6.1 Transfer of images from the capture equipment to secure storage

NSW Health workers who capture and/or support the management of medical and forensic photo and video imaging in cases of suspected child abuse must:

- Check the original images on the camera equipment/LHD removable memory device and:
  - Consider deleting those where at the time the examiner first views the image(s), in the opinion of the practitioner, it is not usable. For example, the image depicts surrounding context rather than the patient or the lighting or exposure impedes what is depicted. Caution must be exercised and where the practitioner is unsure the image must be retained
  - Delete those where the person that provided consent for imaging withdraws consent before completion of the examination
  - Where images are deleted, document the number of images that were deleted and for each image, the reason why it was deleted
- Transfer the retained original image/s from the capture equipment/LHD removable memory device to LHD/SCHN secure network storage facilities as soon as possible and usually within one working day (see Figure 1)
- Archive retained original image/s. A 'read only' format or the equivalent facility is preferred to ensure the integrity of the original image/s and restrict the potential for editing
- Use a separate working copy of an original image for any editing that might be required
- Check images have successfully transferred to LHD/SCHN secure network storage facilities and then delete images that are left on the camera equipment/LHD removable memory device
- Periodically format capture camera equipment/LHD removable memory devices to ensure data recovery processes cannot be used to recover deleted images: Where a removable memory device per patient is used, such as in personal or non-dedicated cameras, formatting must occur as soon as possible after transfer to LHD/SCHN secure network storage facilities and usually within one working day
- Act in accordance with the NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Health Privacy Manual for Health Information, 2015.


LHD/SCHN SD camera card
Securely transport LHD/SCHN SD camera card to LHD/SCHN PC/Laptop
Connect LHD/SCHN SD card to LHD/SCHN PC/Laptop
On network?
Not on network?
Use LHD/SCHN PC/Laptop to load image from LHD/SCHNSD camera card onto secure network drive
Load image from LHD/SCHN SD card onto encrypted LHD/SCHN laptop
Securely transport LHD/SCHN laptop to LHD/SCHN PC network
Image stored on secure network drive
Load image from LHD/SCHN laptop to LHD secure network drive
Connect LHD/SCHN laptop to network

2.6.2 Storage of images

NSW Health workers who capture and/or support the storage and management of medical and forensic photo and video imaging in cases of suspected child abuse must act in accordance with the NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Health Privacy Manual for Health Information, 2015.

Photo and video imaging in cases of suspected child abuse, together with the medical records associated with the imaging, must be stored securely and separately from a child or young person's principal health care record.

LHD/SCHN secure storage facilities may be within a Child Protection Unit, Sexual Assault Service, an Emergency Department or other LHD/SCHN facility offering medical and forensic examinations.

All original photo and video images and any separate working copies used for editing must be stored on LHD/SCHN owned restricted secure network drives. Such restriction(s) to be determined by the Chief Executive Officer, or officer delegated responsibility for the security of LHD?SCHN medical records relating to cases of suspected child abuse.

Where LHD/SCHN owned restricted, secure network drives are not immediately available, in some remote areas for example, electronic/digital photo and video imaging must be:

- Transferred from the camera equipment/removable memory device to an LHD/SCHN owned laptop using appropriate safeguards, such as password or PIN codes, together with encryption technology (see Figure 1)
- Kept in lockable facilities with restricted access.

It is preferred that original images are stored using a 'read only' format, or equivalent, and images must be maintained in an original state and not subject to processes that cause permanent alteration.

All hard copy images must be stored securely in LHD/SCHN owned lockable facilities with restricted access. Such restriction(s) to be determined by the Chief Executive Officer, or officer delegated responsibility for the security of LHD/SCHN medical records relating to cases of suspected child abuse.

To maintain the integrity of the images in the event of legal action, images must be stored with:

- A copy of the consent form and documentation that includes the name of the photographer, the date and time the image/s were taken, and the location where the images were taken (see section 2.4.2)
- Accompanying documentation that includes a child or young person's initials, Medical Record Number (MRN) and/or Area Unique Identifier (AUID), date of birth (DOB), the date the images were captured and the name of the treating physician
- A reference that identifies the existence of any other relevant health related records or documents that are kept separately from the images, such as the location of the principal health care record. The images can be linked to the principal health care record via a notation on the principal record that a 'confidential health record exists'.

The restricted access electronic and hard copy storage facilities must have an auditing or tracking procedure that documents:

- Who, other than restricted access workers, views an image
- When an image leaves the location where it is stored and its destination
- When an image is copied and by whom.

2.6.3 Transmission of images

For the purpose of security and patient privacy, NSW Health workers involved in the transmission of medical and forensic photo and video imaging in cases of suspected child abuse must act in accordance with the NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Health Privacy Manual for Health Information, 2015 and:

- Restrict access to images as described in section 2.7 of this policy directive
- Obtain authorised written permission to release/transmit a copy of an image from a senior member of NSW Health staff, such as the attending medical and forensic practitioner, health information manager or a senior medical records officer/manager. Archived original image(s) should be retained as described in section 2.6.1 of this policy
- Document the authorised permission for release/transmission in the patient's medical record and:
  - The details of the request for release, including the reason for release
  - The number and type of images released
  - The date
  - The person/recipient to whom the image/s have been released
  - Full details of the address/location that the image/s were sent to.

Within NSW Health

- Consideration must first be given to restricted party viewing of the images at the NSW Health source site.
- Where this is not possible and electronic transmission occurs, it must occur:
  - Within NSW Health email
  - From NSW Health email accounts to another recognised NSW Health address
  - Using appropriate safeguards such as encryption technology, password or PIN codes and delivery/receipt confirmations, where available
  - From LHD/SCHN owned computers, equipment or devices or those that are authenticated and authorised by the LHD/SCHN with connectivity protected by approved controls or, through NSW Health Secure File Transfer solutions.

In all cases consider whether it is feasible to remove or abbreviate patient identifiers on the image and in any subject lines whilst the image is in transit in liaison with the recipient.

External to NSW Health

Where it is necessary to release images to restricted parties outside NSW Health, such as the court or under rigorously restricted information sharing practices relating to Chapter 16A and Section 248 of the *Children and Young Persons (Care and Protection) Act* 1998 (see section 2.7.1 to 2.7.4 for details of permitted access):

- Consideration must first be given to restricted party viewing of the images at the NSW Health source site
- Where this is not possible:
  - Electronic copy/copies on a removable memory device under strict governance and control using appropriate security safeguards such as encryption technology, password or PIN codes, or where this is not possible
  - Hard copy/copies

should be transported sealed in an appropriately robust sealed envelope (or similar package) with a unique number allocated from a register held by the NSW Health source site.

The envelope/package should be delivered by hand by an employee of NSW Health, registered post or courier and a receipt should be obtained.

At no time must a portable or removable device be used if it is not securely encrypted and released using these safeguards.

- Where this is not possible it should be noted that electronic transmission of personal health information to destinations external to NSW Health are not considered secure (NSW Health Privacy Manual for Health Information, 2015) and where electronic transmission is necessary, the following must occur:
  - Appropriate safeguards must be used such as encryption technology, password or PIN codes and where available, delivery/receipt confirmations
  - LHD/SCHN owned computers, equipment or devices or those that are authenticated and authorised by the LHD/SCHN with connectivity protected by approved controls must be used.

In all cases consider whether it is feasible to remove or abbreviate patient identifiers on the image and in any subject lines whilst the image is in transit in liaison with the recipient. Images must never be emailed or uploaded via the internet to cloud services. Personal email accounts must never be used to transmit patient information.

- Communication using File Transfer Protocol (FTP), telnet, Mobile SMS, instant messaging and web traffic (HTTP) is not permitted by NSW Health as a secure process for sharing photo and video imaging (NSW Health Electronic Information Security Policy, 2013).

2.6.4 Ownership and copyright

Images, recordings and documentation produced by NSW Health workers in a NSW Health service facility remain the property of the health service, including those taken by visiting medical officers.

Copyright of all recordings is owned by the State of New South Wales through the Local Health District/Speciality Network.

2.6.5 Destruction of images and medical record information

An original image on the camera equipment/device may be deleted in accordance with section 2.6.1 of this policy directive.

In all other cases, NSW Health workers must act in accordance with the NSW Government General Retention and Disposal Authority policy, 2004 (revised, 2011) and retain images for a minimum of 30 years after legal action is completed and resolved (where known), *or* after last contact for legal access *or* 30 years after the individual attains *or* would have attained the age of 18 years, whichever is the longer.

2.6.6 Images received from external sources

With the exception of formal, professional clinical peer group requests, review of an image sent to a practitioner from any other source, for example, a family member, in the context of investigating allegations of child abuse needs to be carefully managed. Offering an opinion on such images needs to done with caution because the practitioner may be exposed to various risks, including difficulties arising from the quality of the image, uncertainties about the date and time it was captured, the identity of the person depicted in the image(s) and an inability to document a clear chain of evidence. In these circumstances:

- Where a person depicted in an image has not been examined by an appropriate practitioner, a NSW Health practitioner that receives the image must not provide advice based solely on the image
- The image should be retained as a record of a request for review, stored separately from images that the examiner has captured and include a notation with full details of the request (for example, the source and date) and any response.

2.7 Access to images for relevant purposes

Standard: Restricted access is provided to images, to maintain patient privacy

LHDs/SCHN must ensure that NSW Health workers comply with 2.7.1 to 2.7.5 below.

2.7.1 Permitted access

NSW Health workers who capture and/or support the management of medical and forensic photo and video imaging in cases of suspected child abuse must ensure that access is restricted to:

- Designated NSW Health workers providing treatment to children or young people or involved in their safety who have unique user identification, individual password authentication and permission controls
- Circumstances where:
  - It is reasonably necessary, and directly associated with the primary purpose/s of collection and
  - The patient/their parent(s)/guardian(s) would reasonably expect the information to be used for that purpose, or
  - Separate informed consent has been obtained for the purpose of a) teaching and/or b) research activities
- The patient or their parent(s)/guardian(s), unless release would affect the personal affairs of any person, including a request by a parent or guardian where such access may lead to child abuse or prejudice a child's physical or mental health. Caution must be exercised and an interpretation and explanation of the clinical findings is preferable to the provision of access to images
- Approved teaching and/or research activities (section 2.8) where:
  - the young person and/or their parent/guardian has provided separate informed consent, and
  - images are de-identified and anonymity of patients is maintained, and
  - the teaching and/or research activities are compliant with the NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies and the research has received ethical approval (for example, see https://hrep.nhmrc.gov.au/certification/hrecs, http://www.ahmrc.org.au/ethics.php and www.ipc.nsw.gov.au/statutory-guidelines-research-purposes-pdf), and
  - electronic and digital information is used in accordance NSW Health Electronic Information Security Policy, 2013 and NSW Government Digital Information Security Policy, 2015
- Quality improvement activities (section 2.9) where:
  - images are de-identified and anonymity of patients is maintained, and
  - Human Research Ethics Committees – Quality Improvement & Ethical Review: A Practice Guide for NSW is used to help to determine the activity, and
  - the quality improvement activities are compliant with NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies.
- Information sharing under Chapter 16A and Section 248 of the *Children and Young Persons (Care and Protection) Act* 1998 (sections 2.72 and 2.7.3)
- Requests under a court subpoena (see section 2.7.4)
- The requirements of the Health Privacy Principles NSW Health Privacy Manual for Health Information, 2015.

Where access to images is deemed necessary, consideration must be given to viewing the images at the NSW Health source site.

Where release is deemed necessary it should be restricted to the above circumstances and integrity of security must be maintained in accordance with section 2.6.3 of this policy directive and NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, the NSW Health Privacy Manual for Health Information, 2015 and NSW Health: Health Care Records – Documentation and Management policy, 2012.

2.7.2 Information sharing under Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998

Chapter 16A establishes a scheme for sharing information relating to the safety, welfare or wellbeing of children and young persons between prescribed bodies.

All applications and requests for access to photo and video imaging under Chapter 16A must be forwarded to an appropriate Health worker, medical and forensic examiner involved in the case, manager of the relevant service that authorised the images to be taken (e.g. Sexual Assault Service, Child Protection Unit, Emergency Department or Paediatric Unit), or LHD/SCHN Central Contact Point, regardless of the author of the recording.

The LHD/SCHN will provide a medical report or Expert Certificate to summarise findings to support investigation, assessment, decision making and coordination of services. Access to images of ano-genital, breast/chest and other sensitive areas of the body must be rigorously restricted and considered in the context that such images can only be interpreted by qualified medical and forensic examiners.

Consideration must be given to the relevance of access to or release of photo and video imaging relating to suspected physical abuse and neglect to prescribed bodies for the purpose of the safety, welfare or wellbeing of the child or young person. Where a request is granted, accompanying interpretation or explanation of clinical findings must also be provided.

- Where a medical examination has taken place in accordance with Section 173 of the *Children and Young Persons (Care and Protection) Act* 1998 a medical report is provided for the Secretary of Family and Community Services (FACS). An existing Expert Certificate could also be provided.

2.7.3 Information sharing under Section 248 of the Children and Young Persons (Care and Protection) Act 1998

Section 248 governs the exchange of information relating to the safety, welfare and wellbeing of children and young people between the Department of Family and Community Services and prescribed bodies

Requests under Section 248 should be directed to the LHD/SCHN Central Contact Point and come from the Secretary, Family and Community Services (or delegate).

Under Section 248 FACS can request access to a child or young person's medical record, which includes the Child Sexual Assault Medical Protocol/SAIK and Suspected Child Abuse and Neglect (SCAN) Medical Protocol, 2014. The LHD/SCHN will provide a medical report or Expert Certificate to summarise findings to support investigation, assessment, decision making and coordination of services. Access to images of ano-genital, breast/chest and other sensitive areas of the body must be rigorously restricted and considered in the context that such images can only be interpreted by qualified medical and forensic examiners.

Consideration must be given to the relevance of access or release of photo and video imaging relating to suspected physical abuse and neglect to the Secretary of the Department of Family and Community Services and prescribed bodies for the purpose of the safety, wellbeing and welfare of the child or young person. Where a request is granted, accompanying interpretation or explanation of clinical findings must also be provided.

Where a medical examination has taken place in accordance with Section 173 of the *Children and Young Persons (Care and Protection) Act* 1998 a medical report is provided for the Secretary of FACS. An existing Expert Certificate could also be provided.

2.7.4 Subpoenas

For the purpose of a subpoena, a 'document' includes 'an electronic medical record or information contained on a computer file, such as photos and/or video' (NSW Health Subpoenas policy, 2010) and

For the purpose of this policy directive a photo or video image captured in a case of suspected sexual abuse, physical abuse or neglect, constitutes a 'sensitive record' (section 4.3: NSW Health Subpoenas policy, 2010).

LHDs/SCHN must act in accordance with the NSW Health Subpoenas policy, 2010, and ensure that the LHD/SCHN designated officer (e.g. medical records health information manager or medico-legal officer or risk manager) is informed about the subpoena, as well as, where possible, the senior health care provider and treating health care provider.

NSW Health workers who manage subpoenas must:

- Be aware of whether any claim for privilege over the images can be applied and take appropriate action
- Follow the precautions for 'sensitive records' (see section 6.4: NSW Health Subpoenas policy, 2010)
- Where images are produced, provide only those that are captured under the schedule of the subpoena
- Retain a copy of the subpoena and the images that the Health service provided under the subpoena.

Where the patient whose records are subpoenaed are not a party to the proceedings before the court, the LHD/SCHN must notify the patient:

- That the subpoena has been received
- The date that the photo/video imaging must be provided to the court, so that the patient can arrange to attend court if they so wish.

2.7.5 Sexual assault communications privilege

Records relating to the counselling of victims of sexual abuse may be protected from production to the court. Photo and video imaging is not covered under this privilege (see Chapter 6 of the *Criminal Procedure Act* 1986).

2.8 Use of imaging for teaching and research

LHDs/SCHN must ensure that NSW Health workers comply with the following:

- Specific informed consent must be obtained from the young person or their parent(s)/guardian(s) for de-identified photo and video imaging to be used for a) teaching and/or b) approved research activities. This must include an explanation that consent for future teaching and/or approved research activities may be withdrawn by the person who provided consent or the person depicted in the image(s) once they are Gillick competent

  For this purpose, where consent is provided for de-identified images to be used for the purposes of teaching and/or approved research activities there must be a process to ensure that withdrawal of consent may be withdrawn. An example of good practice is described in Appendix 5.8

- Anonymity of patients must be maintained during case presentations, demonstrations, teaching, research and at seminars and conferences. Where possible, fictitious data must be used and identification of individuals must not occur. Use of images that would identify the child or young person must not occur. Images of the face must be de-identified and use of blocked sections or cropping, for example, could be used for this purpose

- Research must abide by relevant NSW Health policies and be approved by a Research Ethics Committee (for example, see https://hrep.nhmrc.gov.au/certification/hrecs, http://www.ahmrc.org.au/ethics.php and www.ipc.nsw.gov.au/statutory-guidelines-research-purposes-pdf)

- Act in accordance with the NSW Health Privacy Manual for Health Information, 2015.

2.9 Use of imaging for quality improvement activities

LHDs/SCHN must ensure that NSW Health workers comply with the following:

- Quality improvement activities must:
  - use de-identified images and maintain anonymity of patients, and
  - be determined by reference to Human Research Ethics Committees – Quality Improvement & Ethical Review: A Practice Guide for NSW, and
  - comply with NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies.

2.10 Maintaining the integrity of images in the longer-term

Standard: The integrity of images is maintained in the longer-term

The extent and range of digital image capturing devices, communication technologies and storage systems create a complex environment and significant challenges and opportunities for those that provide forensic science services and their patients (Australia New Zealand Policing Advisory Agency, 2013).

- LHDs/SCHN must use risk analysis and management techniques to reassess the procedures used for capture, storage, access and security for the purpose of maintaining the integrity of images in the longer term. (See, for example, NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, and NSW Health: Health Care Records – Documentation and Management policy, 2012.)

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9. HEALTH RECORDS AND INFORMATION

Glossary

Capture	Capture is the process of recording (acquiring) data, such as an image or video sequence (Australia New Zealand Policing Advisory Agency, 2013).
Child Sexual Assault Medical Protocol (the written protocol in the Sexual Assault Investigation Kit (SAIK))	A written record used by forensic examiners in NSW Health Sexual Assault Services to record all types of sexual abuse examinations for children 0-14 years of age and, where appropriate, may be used for young people 14 -17 years, otherwise an adult Medical and Forensic Examination Record (MFER) may be used. It is part of the Child Sexual Assault Investigation Kit (SAIK). The Adult Sexual Assault Medical Protocol may be used where a young person aged 14 or above attends an adult Sexual Assault Service. In young people aged 14 to 17, which Protocol is used is contingent upon consideration of the circumstances of the child or young person and whether a child or adult SAIK represents the most appropriate pathway. The Protocols provide guidance to facilitate the medical and forensic examination of victims of sexual abuse and ensure that laboratory specimens are collected correctly and legal requirements are fulfilled.
Children and young people	Child: A person who is under the age of 16 years. Young person: A person who is aged 16 years or above but who is under the age of 18 years. (Section 3. *Children and Young Persons (Care and Protection) Act* 1998).
Colposcope	A lighted, magnifying medical instrument used to examine the tissues of the genitalia. It allows an examiner to take a closer look at a child or young person's genitalia and check for abnormal areas. Some devices can be fitted with photographic or video equipment that can capture still (photographic) or moving (video) images.
Cultural competence	Violence, trauma and neglect occur in culturally diverse contexts. Cultural competence is the ability to identify and challenge one's own cultural assumptions, values and beliefs. It is about developing empathy and appreciating that there are many different ways of viewing the world, as this is influenced by culture.
FACS	Department of Family and Community Services
Gillick competence	Whilst parents, or those having parental responsibility rights, generally have the legal authority to provide consent for medical procedures for children and young people under the age of 16 years, the Gillick principle (1985 decision of the House of Lords in Gillick v West Norfolk and Wisbech Area Health Authority and anor) provides that a child's competence to consent to medical procedures increases as they approach maturity, that is a minor under the age of 16 years may be capable of independently consenting to medical treatment when they have achieved a sufficient level of understanding and intelligence to enable them to fully understand what is proposed. Medical practitioners must decide on a case-by- case basis whether a minor has achieved this level of understanding and intelligence.
Guardian	A person with 'parental responsibility' as defined in Section 79A of the *Children and Young Persons (Care and Protection) Act* 1998.
HRIPA	*Health Records and Information Privacy Act* 2002. The Health Privacy Principles (or HPPs) contained in the HRIP Act establish 15 rules for the management of information.

Intimate image	A photo or video image depicting the genitalia, anus or post-pubertal female breast (Faculty of Forensic & Legal Medicine, 2014) and may also include other parts of the body, such as the buttocks or chest of a pre-pubertal child.
JIRT (Joint Investigation Response Team)	JIRT is a collaborative partnership between the Department of Family and Community Services, the NSW Police Force and NSW Health workers that jointly manages statutory child protection matters that may require a criminal justice response and a health response.
JPEG	A digital compression and coding standard (Australia New Zealand Policing Advisory Agency, 2013).
JRU (JIRT Referral Unit)	JRU is comprised of professionals from the Department of Family and Community Services, the NSW Police Force and NSW Health and ensures that reports of risk of significant harm of children and young people to the Child Protection Helpline that require a child protection response, and may require a health and criminal justice response, are jointly assessed for a response by the three JIRT partner agencies.
LHD	Local Health District.
Medical and forensic examiner	A trained Medical Officer, Sexual Assault Nurse Examiner (SANE) or Forensic Nurse who has specialised education and clinical experience in the treatment of children and young people who may have experienced child sexual abuse, physical abuse or neglect and the collection of forensic evidence.
Medical and forensic examination	A medical and forensic examination is an examination of a patient for the purpose of providing medical care and collecting forensic documentation and evidence.
Neglect	Where a child or young person's basic needs (e.g. supervision, medical care, nutrition, shelter and education) have not been met, or are at risk of not being met, to such an extent that it can reasonably be expected to have a significant adverse impact on the child or young person's safety, welfare or well-being. This lack of care could be constituted by a single act or omission or a pattern of acts or omissions such as failing to attend medical appointments or failing to ensure that a school age child attends school. (Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013).
ODPP	Office of the Director of Public Prosecutions.
Original image	The first image that is captured onto any media.
Peer review	The evaluation of work or performance by colleagues in the same field with the aim of maintaining or enhancing the quality of work or performance in that field (Faculty of Forensic & Legal Medicine, 2014a). It includes: • Discussion about clinical decision making and interpretation of examination findings and results of investigations • Meetings undertaken by and with peers with the aim of updating knowledge and improving practice through presenting of work to peers for review (Medical Board of Australia, 2014a).
Personal device	A personal device is one which is not owned by a NSW Health Public Health Organisation. Examples of a personal mobile device include a phone, camera, ipad or other tablet and laptop computer.

9. HEALTH RECORDS AND INFORMATION

Photo and video imaging	Photo and video imaging depicts an image that: Documents the findings of a medical or forensic examination Is captured, recorded and in some cases, transmitted for clinical or forensic purposes Exists in live 'real time' or is stored in hard copy or electronic form Can be transmitted in real time or stored and transmitted at a later point in time May become evidence in a legal proceeding. Photo and video imaging can be captured using a camera or video recorder. Both can be used in conjunction with a colposcope to enhance magnification and lighting. For the purpose of this policy, photo and video imaging constitutes part of a health care record.
Physical abuse	Physical abuse occurs if a child or young person sustains a non-accidental injury or is being treated in a way that may have or is likely to cause injury. The injury may be inflicted by a parent, carer, guardian, other adult or other child or young person. (Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013).
Prescribed body	Chapter 16A of the *Children and Young Persons (Care and Protection) Act* 1998 establishes a scheme for sharing information relating to the safety, welfare or wellbeing of children and young persons between prescribed bodies. A 'prescribed body' is any organisation specified in Section 248 (6), *Children and Young Persons (Care and Protection) Act* 1998 or in clause 7, *Children and Young Persons (Care and Protection) Regulation*, 2000, or in clause 8, *Children and Young Persons (Care and Protection) Regulation*, 2012.
Public Health Organisation	A 'Public Health Organisation' is: A local health district, or A statutory health corporation, or An affiliated health organisation in respect of its recognised establishments and recognised services. Section 7. *Health Services Act 1997*.
SAIK	Sexual Assault Investigation Kit (see 'Child Sexual Assault Medical Protocol').
SCAN Protocol	Suspected Child Abuse and Neglect (SCAN) Medical Protocol, 2014.
SCHN (Sydney Children's Hospitals Network)	The Sydney Children's Hospitals Network comprises The Children's Hospital at Westmead, Sydney Children's Hospital, Randwick, Bear Cottage, the Newborn and Paediatric Emergency Transport Service (NETS), the Pregnancy and Newborn Services Network (PSN) and the Children's Court Clinic.
Sexual abuse	The terms sexual abuse and sexual assault are often used interchangeably. For the purposes of this policy directive 'sexual abuse' is used to refer to sexual activity or behaviour that is imposed, or is likely to be imposed, on a child or young person by another person (Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013).
Sexual assault	See 'sexual abuse'.

Sexual Assault Communications Privilege (SACP)	As set out in the Criminal Procedure Act 1986, the SACP allows courts to exclude evidence that would disclose confidential communications made in the course of a professional or sexual abuse counselling relationship. See Appendix A of the NSW Health Subpoenas policy, 2010, for further information.
Standard	A standard is a key principle that must be followed.
Subpoena	A subpoena is an order from a court or tribunal which directs someone that they must on a given date: a) Produce to a court certain (existing) documents for use in legal proceedings b) Attend a court on a particular date to be a witness in a hearing and give evidence, or c) Do both. A subpoena can only be issued if legal proceedings have been commenced. For the purposes of a subpoena a 'document' includes, 'an electronic medical record or information contained on a computer file, such as photos and/or video' (NSW Health Subpoenas policy, 2010).
Telehealth	Telehealth is the delivery of health care at a distance using information and communications technology (Wade (2014). Available at http://www.e-unicare.com.au/wp-content/uploads/2013/06/unicare_ebook.pdf

References

Australia New Zealand Policing Advisory Agency (2013). *Australia and New Zealand Guidelines for Digital Imaging Processes*. National Institute of Forensic Science, Australia. Docklands, Victoria.

Faculty of Forensic & Legal Medicine (2014a). *Peer Review in Sexual Offences Including Child Sexual Abuse Cases and the Implications for the Disclosure of Unused Material in Criminal Investigations and Prosecutions*. Crown Prosecution Service. March 2014. London, UK.

Medical Board of Australia, 2014. General Registrant CPD FAQ. Available at: http://www.medicalboard.gov.au/documents/default.aspx?record=WD14%2F13816&dbid=AP&chksum=OVSLSa7lkYjLIAM3T9x0LQ%3D%3D

Wade, V. (2013). *How To Make Telehealth Work: Defining Telehealth Processes and Procedures*. Unicare e-health. Available at: http://www.e-unicare.com.au/wp-content/uploads/2013/06/unicare_ebook.pdf

5 APPENDICES

5.1 List of relevant policy documents

Government of New South Wales, 2004, revised 2011	*General Retention and Disposal Authority policy*. Public health services: Patient/Client records. 2011. State Records Authority of New South Wales. ISBN 0-9750563-5-2.
NSW Health PD2013_033	*Electronic Information Security Policy*.
NSW Government OFS-2015-05	*Digital Information Security Policy*.
NSW Health PD2012_069	*Health Care Records – Documentation and Management policy*.
NSW Health PD2013_007	*Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.
NSW Health PD2010_065	*Subpoenas policy*.
NSW Health PD2005_405.	*NSW Health Consent to Medical Treatment - Patient Information policy*.
NSW Ministry of Health 2015	*NSW Health: Privacy Manual for Health Information* (Version 3). ISBN 978-1-76000-002-8.

5.2 Related policies and procedures

Child Sexual Assault Medical Protocol *(2002). (*Often referred to as the SAIK (Sexual Assault Investigation Kit)
Child Wellbeing and Child Protection NSW Interagency Guidelines (2011).
Guidelines for the Use of Telehealth for Clinical and Non Clinical Settings in NSW, (2015). Agency for Clinical Innovation.
JIRT Referral Unit (JRU) + Interim Procedures for NSW Health (2015).
Joint Investigative Response Teams (JIRT) Local Planning and Response Procedures (2013). NSW Health, Human Services – Community Services, and NSW Police Force.
Joint Investigation Response Teams (JIRT) Policy and Procedures (2001). NSW Department of Community Services, NSW Police Service and NSW Health.
Suspected Child Abuse and Neglect (SCAN) Medical Protocol, GL2014_12.
Sydney Children's Hospitals Network and Kaleidoscope Greater Newcastle (SCHN KGN) Clinical Guideline on Photography and Video Recording of Children and Young People under 18 years who are Suspected of Having Been Physically Abused, Neglected or Sexually Abused who Present to any of the Children's Hospitals in NSW (2012).

5.3 Key related policies and procedures to respond to adult sexual assault:

Sexual Assault Services Policy and Procedures Manual (Adult), PD2005_607.
NSW Police, NSW Health and Office of the Director of Public Prosecutions (2006). *Guidelines for Responding to Adult Victims of Sexual Assault*. NSW Department of Health, North Sydney.
Clinical Practices – Adult Sexual Assault Forensic Examinations Conducted by Nurse Examiners, PD2005_614.

5.4 Key Aboriginal health policies and procedures

Aboriginal Health Impact Statement and Guidelines, PD2007_082. NSW Health.
NSW Aboriginal Health Information Guidelines. State Health Publication No. (AHB) 980128. August 1998.
NSW Aboriginal Health Plan 2012-2023, PD2012_066. December 2012. NSW Health.

5.5 Membership of the Photo and Video Imaging Reference Group

Name	Title	Organisation	LHD/SCHN
Professor Graham Vimpani AM	Chair of the Reference Group Senior Clinical Adviser	Child Protection and Wellbeing	NSW Kids and Families
Mr David Bennett	JIRT Police Officer	NSW Police Force	N/A
Ms Sue Burke	District Manager, Sexual Assault Services and JIRT Health	Bloomfield Hospital	Western NSW LHD
Ms Danielle Clark	Manager	Violence Prevention and Response	NSW Kids and Families

9. HEALTH RECORDS AND INFORMATION

Name	Title	Organisation	LHD/SCHN
Ms Lisa Crawford	Senior Analyst	Violence Prevention and Response	NSW Kids and Families
Mr Paul de Sensi	Medical Photographer	Sydney Children's Hospital, Randwick	Sydney Children's Hospitals Network
Dr Rosemary Isaacs	Medical Director, Sexual Assault	Royal Prince Alfred and Liverpool Hospitals	Sydney and South West Sydney LHDs
Ms Robyn Lamb	Dept. Head (Allied Health), Child Protection	Sydney Children's Hospital, Westmead	Sydney Children's Hospitals Network
Ms Jenny Marshall	Acting Director	Child Protection and Violence Prevention	NSW Kids and Families
Ms Julia Martinovich	Telehealth Implementation Officer	NSW Agency for Clinical Innovation	N/A
Dr David McDonald	Senior Staff Paediatrician	Tamworth Rural Referral Hospital	Hunter New England LHD
Ms Lorna McNamara	Director Acting Director	Education Centre Against Violence Child Protection and Violence Prevention	NSW Health NSW Kids and Families
Ms Petra Milnes	Executive Officer	NSW e-health	N/A
Dr Louise Millward	Senior Analyst	Violence Prevention and Response	NSW Kids and Families
Ms Elena Mirenzi	Manager	Violence Prevention and Response	NSW Kids and Families
Ms Lynn Mitchell	Senior Analyst	Violence Prevention and Response	NSW Kids and Families
Ms Chloe Moddel	Telehealth Implementation Officer	NSW Agency for Clinical Innovation	N/A
Dr Maria Nittis	Department Head, Forensic Medical Units	Blacktown Hospital	Western Sydney LHD
Mr Hugh Percival	Legal Officer	Legal and Legislative Services	NSW Ministry of Health
Dr Anne Piper	Community Paediatrician/Training Adviser, Child Protection	John Hunter Children's Hospital	Hunter New England LHD
Detective S/Sergeant Ian Priest	Staff Officer, Child Abuse Squad	NSW Police Force	N/A
Dr Shanti Raman	Paediatrician/Medical and Forensic Practitioner	Liverpool Hospital	South West Sydney LHD
Dr Carol Stevenson	General Practitioner in Aboriginal Health, Medical Educator, Medical Coordinator	Lismore Sexual Assault Service	Northern NSW LHD
Dr Dimitra Tzioumi	Staff Specialist, Child Protection Unit	Sydney Children's Hospital, Westmead	Sydney Children's Hospitals Network

5.6 Interim NSW Health consent form

NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CONSENT FOR IMAGING - SUSPECTED CHILD ABUSE

SMR020028

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

Reference should be made to: Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013 (PD2013_007); current standards and guidelines for NSW Health Sexual Assault Services; NSW Interagency Guidelines; Suspected Child Abuse and Neglect (SCAN) Protocol (GL2014_012) and the Child Sexual Assault Medical Protocol in the child Sexual Assault Investigation Kit (SAIK).

I understand that:

- imaging may include ano-genital and breast/chest areas of the body. I have the option to exclude imaging of these or other specific body areas and can advise the examiner accordingly.
- photo and video imaging will be stored securely and confidentially by the NSW Health organisation. Photo and video imaging must be held by the NSW Health organisation for at least 30 years and cannot be destroyed until that time has passed.
- photo and video imaging may be viewed by another forensic examiner for the purposes of obtaining a second opinion or for peer review or by other authorised health workers.
- photo and video imaging can be subpoenaed by the court system as evidence. Where these images are used as evidence they may be viewed by the Judge, the Jury, the Defendant, Counsel for both Prosecution and Defence and any other people whom the Judge considers relevant.
- access to photos and/or video imaging can be requested by and may be released to the NSW Police Force and/or NSW Department of Family and Community Services.

I consent to de-identified copies of my photo / video imaging being used in: *(Please tick as applies)*

a) teaching ☐ Yes ☐ No

b) research ☐ Yes ☐ No

NOTES: Forensic examiners will:-

a) record any discussions and respect any requests made by me to **exclude imaging of specific body areas**.

b) inform me that I have the option of withdrawing my consent for the future use of images for **teaching and research at any stage**, noting that in some cases it may not be possible for images that have already been used for education or publication prior to the withdrawal of consent to be withdrawn from circulation.

c) inform me that in order to withdraw my consent for **teaching and research I must contact the Hospital/Service attended** for information on the procedure required.

Forensic examiner to document any special requests made by the patient and/or discussions relating to specific consents for imaging below.

_____

_____

Please tick the relevant option:

☐ **I do** / ☐ **I do not** consent to the imaging and specific requests documented above.

Please tick the relevant option:

I am the: ☐ Patient ☐ Patient's Person Responsible ☐ Guardian ☐ Parent ☐ Other _____

Signature _____ Date ____ / ____ / ____

Family Name _____

Given Names _____

For Examiner
I am satisfied the person providing consent has both the capacity and authority to consent to the imaging.

Examiner's name _____ Designation _____

Signature _____ Date ____ / ____ / ____

Interpreters name _____ Designation _____

Signature _____ Date ____ / ____ / ____

NH700101 170915

CONSENT FOR IMAGING - SUSPECTED CHILD ABUSE

SMR020.028

NO WRITING

Page 1 of 1

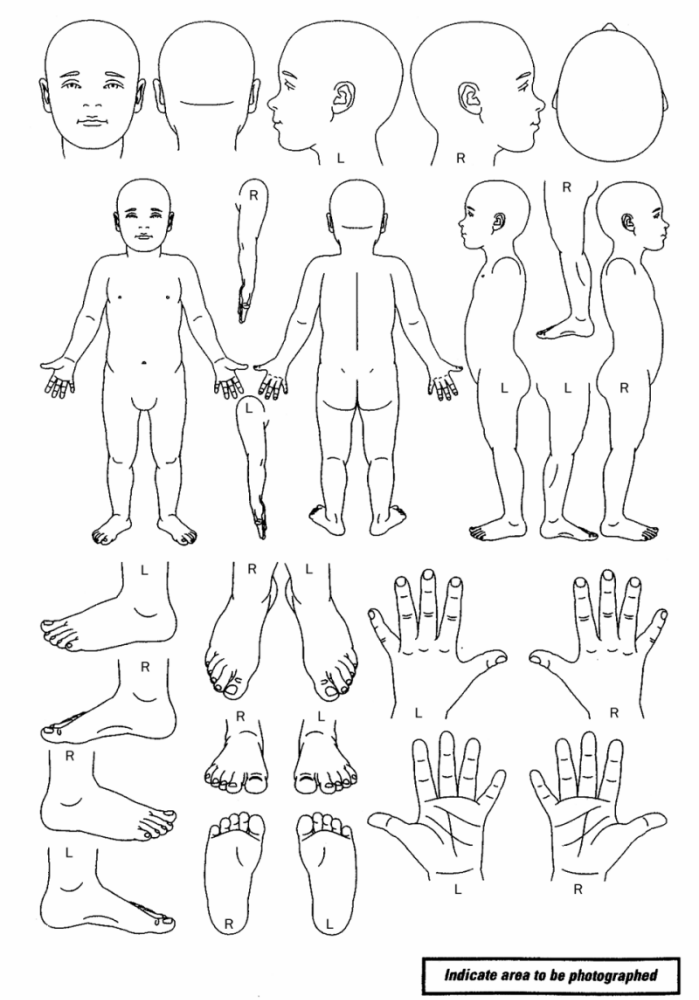
5.7 Request for Medical Photography Services

Consent must be sought before sending this form to the medical photographer.

Request for Medical Photography Services (to be completed by Health Professional requesting service)	
Requester	Diagnosis (If known/please print)
Designation/Department	Location of patient (Outpatient, Inpatient or Ward)
Signature (of Requester)	Date of Request

Type of request	Instructions to photographer (indicate area to be photographed below)
Case history print ☐	
Digital file ☐	
Colour prints ☐	
Black and white prints ☐	
Video/audio ☐	

Name of Reporter/Photographer:



5.8 Good practice example of a process for complying with a withdrawal of consent for de-identified images to be used for future a) teaching and/or b) research activities

For the purpose of complying with a withdrawal of consent for de-identified images to be used for future a) teaching and/or b) approved research activities:

On receipt of consent

- Each de-identified image should be assigned a reference notation
- The reference notation should be recorded in the patient's file
- A register should be:
  - Kept to document and link the reference notation of the de-identified image with the patient file and
  - Maintained for a minimum of 30 years (NSW Government General Retention and Disposal Authority policy, 2004, revised, 2011)
- A copy of the consent must be stored with the de-identified image(s).

On receipt of a withdrawal of consent, for the purpose of compliance and risk analyses, the de-identified image/s must be deleted from:

- Files that are kept and used for the purposes of future teaching and/or research
- Existing training materials, including Powerpoint files, where they are known to exist.

ADOPTION ACT 2000 – RELEASE OF INFORMATION (PD2016_036)

PD2016_036 rescinds PD2010_050

PURPOSE

This Policy Directive provides:

- Information regarding the rights of adopted persons and their families to access information held by Information Sources under the *Adoption Act 2000*
- NSW Health Information Sources with direction and guidance as to what information should be disclosed to adopted persons and their families and the circumstances in which it should be disclosed.

MANDATORY REQUIREMENTS

Each NSW Health Information Source must have effective systems and procedures in place to ensure adopted persons and their families can access information in accordance with the *Adoption Act 2000* and this Policy Directive.

IMPLEMENTATION

Roles and Responsibilities

Chief Executives must ensure:

- The principles and requirements of this Policy Directive are applied, achieved and sustained
- Their medical record staff are made aware of this Policy Directive.

Medical record staff have responsibility to:

- Be aware of this Policy Directive
- Release information to adopted person and their families in accordance with this Policy Directive and the *Adoption Act 2000*.

BACKGROUND

About this document

The *Adoption Act 2000* is administered by the Department of Family and Community Services and sets out the information to which adoptees and their families are entitled to access and the manner in which a person may access that information.

Under the *Adoption Act 2000*, adopted persons, adoptive parents and birth parents are entitled to access prescribed information held by an "Information Source". An Information Source includes:

- The NSW Ministry of Health
- A public hospital under the control of a Local Health District
- A statutory health corporation
- An affiliated health organisation, and

- A private health facility.

This Policy Directive provides specific information on how information about adoptees and their families held by Information Sources should be disclosed.

1.2 Legal and legislative framework

Adoption Act 2000
Adoption Regulation 2015

2 GENERAL MATTERS

2.1 Persons making general enquiries

Telephone enquiries should be directed by switchboard to the medical records department. Persons making enquiries should be informed that the Adoption Information Unit of the Department of Family and Community Services offers services regarding past adoptions, including accessing information.

The Adoption Information Unit can be contacted on 1300 799 023 or via email at **adoption.information@facs.nsw.gov.au**.

Where an enquirer is seeking information held by the NSW Ministry of Health, a public hospital, a statutory health corporation or an affiliated health organisation, this Policy Directive, in conjunction with the Adoption Act 2000 should be complied with.

2.2 Search fees

An Information Source may charge a fee for disclosing information held by the Information Source. Information Sources should refer to PD2006_050 Health Records and Medical / Clinical Reports - Charging Policy in respect of the fees to be charged.

2.3 Information to be provided

Adopted persons, adoptive parents and birth parents are entitled to a variety of information held by an Information Source. This policy only deals with the release of information most likely to be commonly held by NSW Health Information Sources that is health information. If there are further records relating to the adopted person, adoptive parents or birth parents held by an Information Source, you should contact your legal advisor to determine whether the information should be released.

2.4 Proof of identify

Before any information under the Adoption Act 2000 is released to an individual, that individual should provide proof of their identity and, in cases where the individual is seeking information about another person, the individual should provide proof of their relationship to the other person, such as adoption order and birth certificate(s).

2.5 Birth Parents and presumptive fathers

In this policy, a reference to an adopted person's birth parent includes a reference to the "presumptive father" of the adopted person. Under the Adoption Act 2000, the presumptive father of an adopted person means a man who claims to be the birth parent of the adopted person and who:

(a) Is shown on the adopted person's original birth certificate as the adopted person's father, or

(b) Is a person whom the Information Source is entitled to presume under any law to be the adopted person's father.

If you are unsure whether a particular person is the presumptive father of an adopted person, you should contact your legal advisor.

In some cases, an individual man will be named as the "father" in the medical records but will not be named as the father on the adopted person's birth certificate. In these cases, the individual man's identifying information cannot be disclosed to any person. However, in such cases, the medical records department of the Information Source should consider providing the individual man's details to the Department of Family and Community Services who can determine whether the man would like to exchange information with the adopted person.

2.6 General guidelines for the release of information

Under s142 of the Adoption Act, an Information Source must comply with any guidelines prescribed by the Adoption Regulation before releasing information under the Act. Under clause 105 of the Adoption Regulation, the guidelines below must be complied with.

2.6.1 Confirmation of identity

The Information Source must make reasonable inquiries to confirm the applicant's identity and relationship to the person to whom the information relates.

2.6.2 Sensitive information

The Adoption Regulation has special guidelines in relation to "sensitive information". Sensitive information means:

(a) Information indicating that an adopted person was conceived as a result of incest or the sexual assault of his or her birth mother, and

(b) Information indicating that an adopted person has an hereditary condition seriously affecting the current, or that could seriously affect the future, physical or mental health of the adopted person or any descendant of the adopted person, and

(c) Information that could reasonably be expected to be distressing in nature to the person receiving the information.

Before disclosing sensitive information, the Information Source must:

- Make appropriate counselling and support available to the person, and
- Check whether the birth parent's name is entered in the Reunion and Information Register. If the birth parent's name is entered on the Reunion and Information Register, the Information Source must not disclose the sensitive information unless the Information Source has taken reasonable steps to ascertain whether the birth parent wishes to provide the information personally.

2.7 Supply Authority

Information may only be disclosed to an individual if that individual provides the Information Source with a Supply Authority issued by the Department of Family and Community Services if:

- The adoption occurred prior to 1 January 2010, or
- The adoption occurred after 1 January 2010 where the applicant is a birth parent or non-adopted sibling.

In some cases, where a Supply Authority is required before information can be released to an individual, that individual may instead produce to the Information Source an original or amended birth certificate issued under the *Adoption Information Act 1990* prior to October 1998 by the Registrar of Births Deaths and Marriages stamped with the words "Not for Official Use".

If the Information Source is unclear whether the Supply Authority or birth certificate is valid, the Adoption Information Unit should be contacted.

3 RELEASE OF INFORMATION

3.1 Request to access information regarding adoptions occurring on or after 1 January 2010

If an adoption took place on or after 1 January 2010, an adopted person, their adopted parents and birth parents and non-adopted siblings have rights to access information held by an Information Source, including the NSW Ministry of Health, a public hospital, a statutory health corporation or an affiliated health organisation.

3.1.1 Adopted person's rights

3.1.1 (a) Rights to access information by an adopted person who is over the age of 18

An adopted person who is over the age of 18, and was adopted on or after 1 January 2010, is entitled to receive:

- Information regarding the adopted person's birth details (including the time of birth and weight and length at birth) and other medical records about the adopted person, and
- Any non-identifying background information about the adopted person's birth parents, siblings, grandparents, aunts or uncles that will give the adopted person knowledge of his or her origins.

3.1.1 (b) Rights to access information by an adopted person who is under the age of 18

An adopted person who is under the age of 18, and who was adopted on or after 1 January 2010, is entitled to receive information only with the consent of the person's adoptive parents or the Secretary of the Department of Family and Community Services.

If the adopted person produces a written consent of their adoptive parents or the Secretary of the Department of Family and Community Services, the following information should be provided to the adopted person who is under the age of 18:

- Information regarding the adopted person's birth details (including the time of birth and weight and length at birth) and other medical records about the adopted person, and
- Any non-identifying background information about the adopted person's birth parent, sibling, grandparent, aunt or uncle that will give the adopted person knowledge of his or her origins.

3.1.2 Adoptive Parents' rights

An adoptive parent of an adopted person who was adopted on or after 1 January 2010 is entitled to receive the following information held by an Information Source:

- Information regarding the adopted person's birth details (including the time of birth and weight and length at birth), and
- Any non-identifying background information about the adopted person's birth parent, sibling, grandparent, aunt or uncle that will give the adoptive parent knowledge of the adopted person's origins.

3.1.3 Birth Parents' rights

3.1.3 (a) Rights to access information by a birth parent where the adopted child is under the age of 18

A birth parent of a person, under the age of 18, who was adopted on or after 1 January 2010 is entitled to receive information held by an Information Source only if the birth parent produces to the Information Source a Supply Authority issued by the Secretary of the Department of Family and Community Services authorising the disclosure of the information. Where a birth parent provides such a Supply Authority, the birth parent is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Any non-identifying background information about an adopted person or his or her adoptive parents that will give the birth parent knowledge of the adopted child's life, and
- Birth details of the adopted person (including the time of birth and weight and length at birth).

If the birth parent does not have a Supply Authority, information can be released if the head of the Information Source, that is the Health Secretary or the Chief Executive Officer of the relevant Information Source, is of the opinion that the information cannot be used to identify the adopted person or their adopted parents.

3.1.3 (b) Rights to access information by a birth parent where the adopted child is over the age of 18

A birth parent of a person, over the age of 18, who was adopted on or after 1 January 2010 is entitled to receive any of the following information held by an Information Source:

- Any non-identifying background information about an adopted person or his or her adoptive parents that will give the birth parent knowledge of the adopted child's life, and
- Birth details of the adopted person (including the time of birth and weight and length at birth).

3.1.4 Non-adopted sibling's rights

A non-adopted sibling, of a person adopted on or after 1 January 2010, is able to access any non-identifying background information held by an Information Source about the adopted person or his or her adoptive parents and adoptive family that will give the non-adopted sibling knowledge of the adopted person's life. However, if the non-adopted sibling is under the age of 18, information can only be released with the written consent of the non-adopted sibling's parents or the Secretary of Family and Community Services.

3.2 Request to access information regarding adoptions occurring before 1 January 2010

If an adoption took place before 1 January 2010, an adopted person, their adopted parents and birth parents have rights to access information held by an Information Source, including the NSW Ministry of Health, a public hospital, a statutory health corporation or an affiliated health organisation.

3.2.1 Adopted person's rights

3.2.1 (a) Rights to access prescribed information by an adopted person who is over the age of 18

An adopted person who is over the age of 18, and was adopted before 1 January 2010, is entitled to receive information held by an Information Source only if the adopted person produces to the Information Source a Supply Authority issued by the Secretary of the Department of Family and Community Services authorising the disclosure of the information. Where the adopted person provides such a Supply Authority, the adopted person is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Any relevant non-identifying information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of a birth parent, sibling, grandparent, aunt or uncle of the adopted person and that will give the adopted person knowledge of his or her origins, and
- Copies of medical reports of examinations of the adopted person made before the date of the adoption order.

3.2.1 (b) Rights to access prescribed information by an adopted person who is under the age of 18

An adopted person who is under the age of 18, and who was adopted before 1 January 2010, is entitled to receive information only with the consent of the person's adoptive parents or the Secretary of the Department of Family and Community Services.

If the adopted persons produce a written consent of their adoptive parents or the Secretary of the Department of Family and Community Services, the following information should be provided to the adopted person who is under the age of 18:

- Any relevant non-identifying information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of a birth parent, sibling, grandparent, aunt or uncle of the adopted person and that will give the adopted person knowledge of his or her origins, and
- Copies of medical reports of examinations of the adopted person made before the date of the adoption order

3.2.2 Adoptive parent's rights

An adoptive parent of a child, under the age of 18, who was adopted before 1 January 2010 is entitled to receive any relevant non-information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of a birth parent, sibling, grandparent, aunt or uncle of the adopted person and that will give the adoptive parent knowledge of the adopted person's origins.

3.2.3 Birth parent's rights

3.2.3 (a) Where the adopted person is over the age of 18

A birth parent of an adopted person over the age of 18 adopted before 1 January 2010, is only entitled to receive information about the adopted person if the birth parent produces a Supply Authority from the Secretary of the Department of Family and Community Services authorising the disclosure of relevant information. If the birth parent produces such a Supply Authority, the birth parent is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Any relevant information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of an adopted person or his or her adoptive parent and that will give the birth parent knowledge of the adopted child's life after adoption
- Birth details (including the time of birth and weight and length of the person at birth), and
- Copies of medical reports and examinations of the adopted person made before the date of the adoption order.

3.2.3 (b) Where the adopted person is under the age of 18

A birth parent of an adopted person under the age of 18 is only entitled to receive information about the adopted person if the birth parent produces a Supply Authority from the Secretary of the Department of Family and Community Services authorising the disclosure of relevant information. If the birth parent produces such a Supply Authority, the birth parent is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Birth details (including the time of birth and weight and length of the person at birth), and
- Copies of medical reports and examinations of the adopted person made before the date of the adoption order.

If the birth parent does not have a Supply Authority, information can be released if the head of the Information Source, such as the Chief Executive Officer of the relevant Information Source, is of the opinion that the information cannot be used to identify the adopted person or their adopted parents.

ELECTRONIC INFORMATION SECURITY (PD2020_046)

PD2020_046 rescinds PD2013_033

PURPOSE

All NSW Health Organisations must have appropriate systems and processes in place to adequately and appropriately protect their information systems and assets. This includes the fundamental responsibility to protect information from inappropriate, illegal or accidental misuse, modification, loss or release.

This policy applies to all users of NSW Health information systems and assets, including, but not limited to, employees, contractors, service providers and third parties, and all NSW Health information systems and assets, regardless of the media or location where information is stored, and the technology used to process the information.

SUMMARY OF POLICY REQUIREMENTS

All users of NSW Health information systems and assets have the responsibility to uphold confidentiality and protect information entrusted to them.

Information security measures and controls must be developed and implemented to ensure privacy of information is preserved, confidentiality of information is protected, integrity of information is maintained, and availability of information is assured.

NSW Health Organisations must identify and implement the appropriate scope of an Information Security Management System (ISMS) or Cyber Security Management System (CSMS) that is compliant with the relevant recognised standards.

A risk-based approach must be adopted to identify and prioritise information systems and assets security risks, ensure proper security measures are implemented and mitigate security risks to an acceptable level. These measures may be preventative, detective, responsive or recovery in nature.

A continual improvement process must be adopted to respond to, monitor, review and improve the effectiveness and efficiency of information security measures and controls in a changing environment.

NSW Health Organisations must ensure a consistent and effective approach to the management and where relevant, the escalation of information security incidents.

Electronic Information Security: Procedures

1. BACKGROUND

Any persons having access to NSW Health information have a responsibility to maintain the security and confidentiality of critical and sensitive information, including personal and health information.

NSW Health is committed to the provision of appropriate levels of security across all information systems and assets.

Confidentiality, Integrity and Availability are the security objectives that must be applied to NSW Health Organisations' information systems and assets. These objectives will uphold authorised restrictions on access to, and the use and disclosure of, information, to ensure data is protected against unauthorised alteration or destruction and to ensure authorised users are provided with timely and reliable access to information systems and assets.

NSW Health Organisations are required to assure the privacy of information systems and assets that include records containing personal and personal health information about employees and members of the public. This will uphold the individual's expectation and legal right that personal, health and any other identifying information will not be unlawfully disclosed.

Implementation of information security controls to mitigate the risks to sensitive information must be based on a risk management approach to ensure suitable and appropriate information protection.

All information must be classified in accordance with the NSW Government Information Classification, Labelling and Handling Guidelines. The guideline outlines how NSW Government agencies, such as NSW Health, must securely share, handle and protect information according to its sensitivity. Information which needs increased protection is to be either security classified and identified by a protective marking or assigned a Dissemination Limiting Marker (DLM). For NSW Health Organisations, information that has been classified and labelled using any of the six 'OFFICIAL: Sensitive' NSW DLMs or above, must be securely managed to ensure privacy and confidentiality is preserved. This includes the DLMs 'OFFICIAL: Sensitive – Health information' and 'OFFICIAL: Sensitive – Personal'.

The release of information must comply with NSW and Commonwealth legislation and relevant NSW Health policies.

1.1 About this document

This document establishes the provision of appropriate levels of security across all NSW Health Organisations' information systems and assets. It supports the governance of information security and dictates the principles to manage information security.

The security requirements in this document apply to all NSW Health information systems and assets regardless of the media storage location and the technology used to process the information. All security requirements are designed to be technology neutral. The requirements focus is on the fundamental objectives and measures to protect information.

1.2 Key definitions

Availability

Ensuring timely and reliable access to and use of information.

Confidentiality

Handling of information to ensure that it will not be disclosed in ways that are inconsistent with authorised use and its original purpose.

Cyber Security

Cyber Security is the prevention of damage to, unauthorised use of, exploitation of, and - if needed - the restoration of electronic information and communications systems, and the information they contain, in order to strengthen the confidentiality, integrity and availability of these systems.

Electronic information

Electronic information is information that is electronically created, processed, held, maintained and transmitted by NSW Health organisations. It also refers to information held electronically for or on behalf of other government agencies or private entities.

Information systems and assets

Refers to any information or communication infrastructure used by NSW Health Organisations and all personnel that work with it. This includes computer hardware and software, to create, process, hold, maintain or transmit electronic information.

Integrity

To protect information against unauthorised alteration or destruction and prevent successful challenges to its authenticity.

Personal health information

Personal health information is personal information or an opinion which concerns an individual's health, medical history or past or future medical treatment. It also includes other personal information collected in the course of providing a health service or information collected in relation to donation of human tissue.

Personal information

Personal information is information or an opinion (including information or an opinion forming part of a database and whether it is recorded in a material form) about an individual whose identity is apparent or can be reasonably ascertained from the information or opinion.

1.3 Legal and legislative framework

NSW Health Organisations that hold records containing either personal information or personal health information must meet the requirements of the:

1. *Health Records and Information Privacy Act 2002* (NSW); and
2. *Privacy and Personal Information Protection Act 1998* (NSW).

2. PROTECTION OF INFORMATION SYSTEMS AND ASSETS

To safeguard information systems and assets, NSW Health Organisations must have an Information Security Management System (ISMS) or Cyber Security Management System (CSMS) that is compliant with recognised standards and implement the relevant controls based on the organisation's requirements and risk tolerance.

Each organisation's security management system must include the following components:

1. Governance;
2. Risk Management;
3. Allocation of Resources and Training;
4. Evaluation; and
5. Continuous Improvement.

2.1 Governance

NSW Health organisations must have an executive-level governance committee accountable for the effective and efficient management of information security risks, associated plans and implementation of controls.

NSW Health organisations must implement security controls locally according to their needs.

2.2 Risk methodology

NSW Health organisations must use a structured approach to information security risk management, consistent with approaches for assessing and treating all types of risk, at all levels and for all activities within NSW Health.

Information security risk management involves identifying the types of risk exposure within NSW Health, measuring those potential risks and proposing means to mitigate them. While it is impossible to remove all risk, it is important to understand the risks and manage and identify the level of risk NSW Health Organisations are willing to accept in the overall context of effective operation and service provision.

2.2.1 Enterprise Risk Management Framework

NSW Health Organisations must assess and manage information security risks in line with the *NSW Health Enterprise-wide Risk Management Policy and Framework (PD2015_043).*

This framework provides a structure for a consistent risk management approach and for embedding risk management across all operations.

The risk management process includes the following steps:

1. Communication and Consultation;
2. Establish the context;
3. Risk Identification;
4. Risk Analysis;
5. Risk Evaluation;

6. Risk Treatment; and
7. Risk Monitoring, Review and Governance.

2.2.2 Risk assessment

Risk identification, analysis and evaluation are taken together and described as 'risk assessment'. Information security risk assessments are performed to allow NSW Health Organisations to assess, identify and modify their overall security. This process is required to obtain management's commitment to allocate resources and implement the appropriate security controls. All risk assessments must conform to the NSW Health Risk Matrix tool in terms of the relationship between likelihood and consequence.

2.2.3 NSW Health Risk matrix

The NSW Health Risk Matrix provides a tool to apply a severity rating to each risk, by assessing the potential consequence of the risk and its likelihood of occurring. The NSW Health Risk Matrix is required to be used for assessment and management of information security risks, development of risk registers and reporting of risks.

2.2.4 Risk treatment

Information security is a combination of preventive, detective, responsive and recovery security measures. Preventive measures avoid or deter the occurrence of an undesirable event. Detective measures identify the occurrence of an undesirable event. Responsive measures refer to coordinated actions to contain damage when an undesirable event (or incident) occurs. Recovery measures are for restoring the confidentiality, integrity and availability of information systems to their expected state.

Once the risks have been identified, analysed and evaluated; treatments are considered. Risk treatment involves selecting one or more options for addressing the identified information security risk(s) and implementing and managing those options. Risk treatment options include:

1. Risk Management / Reduction - The level of risk is to be reduced through the implementation of some or all recommendations made from the risk assessment. Appropriate and justified controls should be selected to meet the risk acceptance criteria as well as legal, regulatory and contractual requirements. When selecting controls, NSW Health Organisations must weigh up the cost of acquisition, implementation and maintenance of the control(s) against the 'value' of the information being protected;
2. Risk Transfer - This decision requires the risk to be transferred to another party that can effectively manage costs associated with the particular risk;
3. Risk Avoidance - Stop the activity that would give rise to the risk, thus eliminating the risk. Risk avoidance is not commonly selected as it typically results in not being able to exploit the associated opportunity; and
4. Risk Acceptance - This decision relies on the findings of the risk assessment and is applied when the level of risk is assessed within the business's defined risk tolerance level. However, the business may accept when it is not practical to avoid, treat or transfer the risk.

2.2.5 Selection and implementation of security measures

The appropriate security measures must be selected and implemented once security requirements have been identified. Security measures need to ensure risks are reduced to an acceptable level. The extent of the security measures required must be balanced against the potential business impact that may arise from security failures. Security measures can include local policies, standards, procedures, guidelines, practices, technological solutions and organisational structures. Measures will vary for different information systems and assets, depending on the criticality and sensitivity of the particular information asset.

2.2.6 Risk monitoring and review

Risks, threats and impacts will change over time and identified risks are to be reassessed to ensure the security measures selected remain appropriate and effective. Risks must be reviewed annually, or more frequently when major changes are made to information systems and assets.

2.3 Allocation of resources and training

Adequate resources (people, time, money) must be assigned to the operation of the ISMS/CSMS, including all security controls.

Information security training is required for all persons with access to NSW Health information to ensure procedures are followed to adequately protect information

2.4 Performance evaluation

NSW Health organisations must regularly collect and evaluate metrics on existing security measures: The evaluation of these metrics will lead to:

1. Improved information security processes – Quantify improvements in securing information and demonstrate quantifiable progress in information security objectives;
2. Increased accountability – By identifying specific security measures that are implemented incorrectly, not implemented or ineffective;
3. Greater support for decision making - Provide quantifiable information to the risk management process. Measure success/failure of investments and support resource allocation for future investments; and
4. Evidence of meeting requirements - Fulfilling ISMS/CSMS requirements and other applicable laws, rules and regulations.

2.5 Continual improvement

NSW Health Organisations must continually improve their ISMS/CSMS, including information security processes, techniques and controls. Continual improvement will be achieved through the ongoing processes of:

1. Risk assessment and treatment;
2. Evaluation of effectiveness of implemented security measures;
3. Corrective actions from internal audits and management reviews;
4. Reviewing and updating of information security documentation;
5. Training and awareness;
6. Review of information security incidents; and
7. Compliance reviews.

3. INFORMATION SECURITY INCIDENT RESPONSE PLAN

NSW Health Organisations must have an information security incident response plan that outlines the process for reporting and managing information security incidents, events and concerns from internal and external sources. Monitoring tools and processes must be in place for incident identification and response.

All users are responsible for reporting any information security concerns, events or incidents. Security events and incidents must be reported to eHealth NSW, Information Security Services within 48 hours and, to facilitate any investigation, as much relevant information as possible must be provided.

All reported information security concerns, events and incidents must be recorded in an appropriate register, which will be the official record and form the basis for evaluation and investigation. The register will be used to maintain the current status and the history of each incident as well as all decisions, recommendations and actions related to it.

The incident response plan must include the following steps:

1. Preparation;
2. Detection and Analysis;
3. Containment, Eradication, and Recovery; and
4. Post Incident Review.

3.1 Preparation

NSW Health Organisations must establish an information security incident response capability, separate to the security incident plan, so that they are ready to respond to incidents.

3.2 Detection and analysis

NSW Health Organisations must define the process for detecting and confirming an incident has occurred; categorising the nature of the incident and then prioritising the incident.

3.3 Containment, eradication, and recovery

NSW Health Organisations must identify the immediate response actions to deal with the information security incident. The primary objective is to confine any adverse impact to information systems and assets, followed by processes for the eradication of the threat and the return to the normal productive state of information systems and assets.

3.4 Post-Incident Review

NSW Health Organisations must compile a summary of actions and findings once the information security incident has been resolved. Any recommendations for changes to existing procedures or technology that will enhance the incident response plan must be documented.

4. ROLES AND RESPONSIBILITIES

Clearly defined roles and responsibilities ensure the proper protection of the information systems and assets of NSW Health.

4.1 Secretary, NSW Health

The Secretary, NSW Health must ensure all NSW Health Chief Executives establish, maintain and adequately resource an ISMS/CSMS. It is also the responsibility of the Secretary, NSW Health to ensure that the Chief Information Officer (CIO), NSW Health works with NSW Health Organisation Chief Executives and CIOs to implement this policy and that all NSW Health Organisations implement risk-based protections for information systems and assets.

The Secretary, NSW Health must ensure that all NSW Health Organisations comply with the NSW Cyber Security Policy. Reporting on compliance includes completing a yearly attestation report to be provided to Cyber Security NSW, which is completed by eHealth NSW on behalf of the Health Cluster. It is required that a copy of this report is included in the NSW Health annual report.

4.2 Chief Executives

Chief Executives must ensure that an ISMS/CSMS is established, adequate resources are allocated to implement the policy and associated framework, and there is appropriate resourcing and support of cyber security initiatives, including training and awareness and continual improvement initiatives.

It is also the responsibility of the Chief Executive, in collaboration with eHealth NSW, to ensure that their organisation complies with the *NSW Cyber Security Policy* and reports to the Secretary, NSW Health on compliance annually.

4.3 Chief Information Officer, NSW Health

The Chief Information Officer (CIO), NSW Health works with NSW Health Organisation Chief Executives and CIOs to implement this policy and ensures that all NSW Health Organisations implement risk-based protections for information systems and assets. This includes consideration of threats, risks and vulnerabilities that impact the protection of information systems and assets within their risk tolerance.

The CIO, NSW Health advises and guides NSW Health Organisation Chief Executives and CIOs on their responsibilities, which includes ensuring that all staff, including consultants, contractors, third parties and outsourced service providers, understand the cyber security requirements of their roles.

The CIO, NSW Health must also ensure a secure-by-design approach is in place for new initiatives and upgrades to existing systems and that all staff and providers understand their role in building and maintaining secure systems.

4.4 Director Information Security Services, eHealth NSW

The Director Information Security Services (ISS), eHealth NSW assists with defining and implementing risk-based protections for information systems and assets for NSW Health Organisations. Assistance and guidance is provided to NSW Health Organisations to implement policies, procedures, practices and tools that ensure compliance with this policy.

Responsibilities of the Director ISS, eHealth NSW include building an information security incident response plan that links NSW Health incident management and the whole of government cyber response plan. This allows the Director ISS, eHealth NSW to investigate, respond to and report on cyber security events within NSW Health and reports these incidents to the appropriate NSW Health governance forum and Cyber Security NSW.

The Director ISS, eHealth NSW must establish training and awareness programs to increase employees' cyber security capability and collaborate with NSW Health privacy, audit, information management and risk officers to protect NSW Health Organisation information systems and assets.

Other duties of the Director ISS, eHealth NSW include representing NSW Health Organisations on whole of government collaboration, advisory or steering groups, established by Cyber Security NSW as the central cluster Chief Information Security Officer (CISO) for NSW Health.

4.5 Data governance

The *NSW Health Data Governance Framework* outlines the roles and responsibilities involved in data governance and the structures in place to ensure effective and consistent management of the data assets of NSW Health.

The Framework facilitates data quality and comprehensiveness, appropriate access to data, information security, and standardisation of concepts.

Each data asset must have in place processes to protect the privacy and confidentiality of data through access management and security controls. This includes ensuring that the data is appropriately secured, backed up and disposed of according to agreed and documented protocols.

Data must only be disclosed for the purpose for which it is collected. Alignment of data and IT governance must enforce regulatory, architectural and security compliance requirements.

The Framework also provides the 'Principles of Data Governance for NSW Health' that support the structured and consistent management of data assets and outlines the essential components of data governance, including description of the roles of Data Sponsor, Data Custodian and Data Steward.

The Data Sponsor is responsible for the control of strategic direction and undertaking duties of ownership that includes:

1. Enabling strategic management, governance and operation of the asset;
2. Providing direction and guidance, and authorising appropriate resources for management of the data asset; and
3. Appointing a Data Custodian and ensuring the Data Custodian's duties are fulfilled.

The Data Custodian is responsible for the day to day management and oversight of the asset, approval of access to data and the overall quality and security of the asset. This includes:

1. Ensuring any use of the data aligns with the purpose for which it is collected;
2. Establishing a data quality framework that ensures the integrity, accuracy, completeness, timeliness, relevance, consistency and reliability of the data;
3. Controlling access to data in compliance with all relevant legislation, policies, standards and any conditions specified by the Data Sponsor;
4. Regularly reviewing users with access to data and the ongoing need and appropriateness of access; and
5. Appointing a Data Steward.

The Data Steward is responsible for the day to day management and operation of the data asset, its completeness and quality. This includes:

1. Managing the data asset in compliance with all relevant legislation, policies, standards and any conditions specified by the Data Sponsor;
2. Co-ordinating stakeholder engagement and input into the business requirements for the data asset; and
3. Providing advice to the Data Custodian and Data Sponsor on the management of the data asset.

4.6 System administrators

System administrators need to be aware of, understand and follow acceptable procedures for granting/revoking access, identifying and resolving known vulnerabilities, and monitoring system access. They are responsible for developing practices and procedures to support the policy and ensure compliance with the security requirements of information owners.

4.7 IT technical and support staff

IT support staff must manage confidentiality, integrity and availability of information systems. Staff are responsible for ensuring the appropriate access, delivery and ongoing support for systems, including applications, servers, networks, firewalls, routers and cloud services.

IT technical staff and system developers are responsible for delivering reliable software. Technical staff should understand the business use and risks associated with the technologies being used so that security solutions match the criticality and sensitive nature of the systems. They are responsible for developing practices and procedures to support the policy and ensure compliance with the security requirements of information owners.

4.8 Records and Information Managers

Records and Information Managers are responsible for maintaining a record and information management program in conformity with the standards and codes of best practice approved by NSW State Archives and Records. All disposal and destruction of records and information must be carried out in accordance with the relevant approved retention and disposal authority. They are responsible for developing practices and procedures to support organisation's records management policy and to ensure that records held in electronic (digital) or other technology dependent formats are accessible and protected for as long as they are required.

4.9 Users

Users of NSW Health information systems and assets play an important role in overall information security planning and risk management processes. Users must be aware of their responsibilities in relation to information security and privacy. Users have a role in identifying and reporting security concerns and incidents to management for investigation and review. Compliance with this policy and all relevant acts and regulations as they relate to information security is mandatory for all users.

4.10 Third party businesses and organisations, consumers and other agencies

The growing existence of inter-connected networks requires the extension of the 'boundaries' of NSW Health Organisations. All third parties must adhere to NSW Health and agency policies and procedures to ensure that adequate security controls are in place in the third-party environment.

4.11 Auditor

The role of independent reviewers and auditors is to assess the effectiveness and efficiency of implemented controls and whether controls are being adhered to. Independent reviewers and auditors must check compliance against policy and legislative requirements. Review and audit reports should be noted by executive management and, if appropriate, remedial action taken.

The internal auditor will regularly review NSW Health Organisations' adherence to this policy and cybersecurity controls, from a risk management perspective.

5. RELATED DOCUMENTS

5.1 NSW Health policy directives and guidelines

Reference	Policy Document Title
PD2009_076	Communications - Use & Management of Misuse of NSW Health Communications Systems
PD2015_037	Data Collections – Disclosure of Unit Record Data for Research or Management of Health Services
PD2015_036	Privacy Management Plan
PD2015_049	NSW Health Code of Conduct
GL2019_002	NSW Health Data Governance Framework
PD2015_043	Risk Management - Enterprise-Wide Risk Management Policy and Framework – NSW Health
Privacy Manual for Health Information	

5.2 Relevant legislation – NSW

- *Crimes Act 1900*
- *Defamation Act 2005*
- *Government Information (Public Access) Act 2009*
- *Government Sector Employment Act 2013*
- *Health Records and Information Privacy Act 2002*
- *Privacy and Personal Information Protection Act 1998*
- *State Records Act 1998*
- *Workplace Surveillance Act 2005*

5.3 Relevant legislation - Commonwealth

- *Cybercrime Act 2001*
- *Copyright Act 1968*
- *Privacy Act 1988*
- *Spam Act 2003*

5.4 NSW Government policies and directives

- Intellectual Property Management Framework for the NSW Public Sector
- Internal Audit and Risk Management Policy for the NSW Public Sector
- NSW Government Cyber Security Policy
- NSW Government: Information Classification, Labelling and Handling Guidelines

5.5 Standards

AS ISO/IEC 27001:2015. Information technology - Security techniques - Information security management systems – Requirements (this document is the same as ISO/IEC 27001:2013)
AS ISO/IEC 27002:2015. Information technology - Security techniques - Code of practice for information security management (this document is the same as ISO/IEC 27002:2013)
ISA/IEC 62443 - Series of standards, technical reports, and related information that define procedures for implementing secure Industrial Automation and Control Systems (IACS).

SUBPOENAS (PD2019_001)

PD2019_001 rescinds PD2010_065

PURPOSE

This Policy Directive outlines legislative provisions and procedures to be followed when the Ministry of Health and public health organisations are required to produce documents in response to a subpoena.

MANDATORY REQUIREMENTS

Each NSW Health Agency must have effective systems and procedures in place in order to make sure that subpoenas issued on the agency are complied with appropriately.

IMPLEMENTATION

Roles and Responsibilities

Chief Executives must ensure that:

- The principles and requirements of this policy and attached procedures are applied, achieved and sustained.
- All staff are made aware of their obligations in relation to this Policy Directive.
- Documented procedures are in place to support the Policy Directive.
- There are documented procedures in place to effectively respond to and investigate alleged breaches of this Policy Directive.

Hospital Managers and Staff have responsibility to

- Understand the legislative requirements of a Subpoena.
- Provide only the documents which are requested under the schedule of the subpoena.
- To be aware of whether any claim for privilege over the documents can be applied and take appropriate action.

CONTENTS

The Ministry of Health and public health organisations are often required to produce documents on subpoena and a proper officer or staff member may be required to attend court and give evidence. This Policy Directive reflects current legislation and outlines procedures to be followed to assist public health organisations to comply with subpoenas issued by both NSW and interstate courts.

1.2 Key definitions

Approved form in relation to a document, means the form approved under Section 17 of the *Civil Procedure Act 2005* for the purposes of that document.

Care Proceedings are Court proceedings where an application for a "care order" is made for the protection of a child or young person.

Court includes tribunal. For a detailed list of Courts, refer to Appendix C.

Defendant or **Respondent** is the person against whom the action is brought by the Plaintiff/Applicant.

Document means any record of information and includes

(a) anything on which there is writing;

(b) anything on which there are marks, figures, symbols or perforations having a meaning for persons qualified to interpret them; or

(c) anything from which sounds, images or writings are capable of being reproduced with or without the aid of anything else.

Health record is a documented account, whether in hard copy or electronic form, of a patient's health, illness and treatment during each visit or stay at a health service. This may include electronic correspondence regarding the patient's treatment and records (such as x-rays or a community mental health record) that are stored separately from the patient's medical record.

Note: Health record holds the same meaning as: 'health care record', 'medical record', 'clinical record', 'clinical notes', 'patient record', 'patient notes', 'patient file', and so on.

Issuing Party means the person who has caused the subpoena to be issued.

Legal Privilege Protects certain documents being disclosed in court proceedings. These documents are protected from release under subpoena due to a special statutory or legal relationship that applies to the information.

Patient Any person who receives a health service and to whom, as a result, a health practitioner owes a duty of care. Also includes clients of PHOs.

PHO under the *Health Services Act* 1997, a public health organisation is a Local Health District or a statutory health corporation (including Specialty Health Networks), or an affiliated health organisation in respect of its recognized establishments and services.

Proper Officer is a person within the organisation who will have access to the records pertained in the subpoena.

Plaintiff or **Applicant** is the person who has commenced the proceedings.

Record includes any document or other source of information compiled, recorded or stored in written form or on film, by electronic process or in any other manner or by any other means.

Return Date is the last day the documents must be produced to the Court.

Subpoenaed Party or **Addressee** means the person who is the subject of the order expressed in the subpoena. A subpoena can only be addressed to a person, which may be the proper officer of an organisation.

1.3 Legal and legislative framework

* *Children and Young Persons (Care and Protection) Act 1998* (NSW)
* *Civil and Administrative Tribunal Act 2013* (NSW)
* *Coroners Act 2009* (NSW)
* *Commonwealth Service and Execution of Process Act 1992* (Cth)
* *Criminal Procedure Act 1986* (NSW)
* *Evidence Act 1995* (NSW)
* *Health Administration Act 1982* (NSW)
* *Interpretation Act 1987* (NSW)
* *Local Court Rules 2009* (NSW)
* *Uniform Civil Procedure Rules 2005* (NSW)
* *State Records Act 1998* (NSW)

2 INTRODUCTION

2.1 What is a subpoena?

A subpoena is an order from a court requiring the Addressee to:

(i) Produce to a court a copy of the subpoena and documents or things as directed by the subpoena;

(ii) Attend a court to give evidence as directed by the subpoena; or

(iii) Do both,

"***A subpoena to attend and give evidence*** means that the person to whom the subpoena is addressed is required to attend court and give evidence.

A subpoena to produce means that the person to whom the subpoena is addressed is required to provide documents or things. Producing documents to the court can also be done on behalf of the organisation by their legal representative."

Documents or things include written, printed or electronic material that provide information such as reports, emails, letters, photographs, video or audio recordings, diagnostic images, medical images or reports, laboratory results, cameras, phones, other electronic devices, CDs, USBs and so on.

A subpoena can only be issued if legal proceedings have been commenced.

In some courts and tribunals subpoenas are called "summons to produce documents", "orders to produce documents" or "notices for non-party or third party production". In coronial matters subpoenas may be called "section 53 Directions". The general principles that apply to these documents are the same in NSW courts, the Federal Court and the Family Court due to the harmonising of the subpoena rules.

2.2 What to do when you receive a subpoena

A subpoena cannot be ignored and must be dealt with promptly. Failure to comply with a subpoena without lawful excuse is a contempt of court and can result in an arrest.

When a subpoena is received by a PHO, it should be brought to the attention of the appropriate branch and the appropriate person within the PHO. All PHO's should have designated officers to coordinate responses to subpoenas, for example a medico-legal officer or medical records officer.

For particularly sensitive matters, the designated officer should notify the Chief Executive Officer or an executive officer of the PHO about the subpoena.

For matters where a PHO, a unit or employee of the PHO is a party, the subpoena should be brought to the attention of the solicitors acting on behalf of the PHO as soon as possible, and certainly before any documents are forwarded to the court.

3 GENERAL INFORMATION ON SUBPOENAES

3.1 Who is the subpoena addressed to?

A subpoena must be addressed to a person, or to "The Proper Officer" if directed to an organisation. If a subpoena to produce is addressed, for example to the Proper Officer a particular hospital or community health service within a PHO, only records held by that hospital or community health service will need to be produced.

If a subpoena to produce is addressed to the Proper Officer of PHO (i.e. "X Local Health District"), relevant records from all facilities within the PHO will need to be produced. If the subpoena is addressed to the Proper Officer of a PHO requesting all records relating to a particular patient, there are two options that can be considered:

(a) Contacting the issuing party and ask the solicitor to nominate which facilities within the PHO they require records from. Ask for this to be confirmed in writing.

(b) Search all facilities within the PHO for records relating to the patient. If this needs to be done, a separate fee may be charged for each facility searched. The issuing party should be told that fees will be payable for each facility searched. It is not necessary for the issuing party to issue separate subpoenas each addressed to separate facilities within the PHO.

3.2 Is the subpoena in the approved court form?

A subpoena must also be in the approved court form. If a subpoena is defective in this regard, the PHO should promptly inform the issuing party in writing and return any conduct money provided. The letter should explain how the subpoena is defective and be copied to the Clerk or Registrar of the court. A list of approved court forms can be found at www.ucprforms.justice.nsw.gov.au.

3.3 What if the PHO is a party to the proceedings?

If the subpoena lists the PHO or unit of the PHO as a party to the proceedings (for example as the Defendant), the subpoena should be referred to the appropriate person who will then forward it to the solicitor who has been instructed to act for the PHO (or unit) in those proceedings. If no solicitor has been appointed to represent the PHO (or unit) in the proceedings, the executive officer (or delegate) of the PHO (or unit) should be notified so that a solicitor can be appointed.
If a solicitor has been appointed, that solicitor should be instructed to respond to the subpoena. If the PHO decides not to engage a solicitor, the subpoena should be processed in the normal way set out in Part 33 of the UCPR.

3.4 What if the subpoena relates to a coronial inquest?

A subpoena to produce issued by the Coroner's Court needs to be signed by the Coroner or Assistant Coroner issuing it and provide a date and place where the document is to be produced. The Coroner may serve a subpoena by way of facsimile and is not required to provide conduct money.

The subpoena should be referred to the solicitor who has been instructed to represent the PHO's interests at the inquest, or in relation to the investigation to respond to the subpoena. If no solicitor has been appointed, the relevant medical administrator should review the medical records of the deceased and an assessment should be made as to whether the executive officer (or delegate) of the PHO should be notified so that consideration can be given to instructing a solicitor to represent the PHO. It may be appropriate for the relevant medical administrator to also consider notifying the PHO risk manager and the Treasury Managed Fund of the incident, if they have not already been notified.

If the PHO decides not to engage a solicitor, the subpoena should be processed in the normal way.

3.5 Has the subpoena been validly issued?

In most matters, subpoenas must be issued by a court or a tribunal. This means that they should include a court stamp or signature of a court officer.
If a party to the proceedings is represented by a solicitor, a subpoena may be filed electronically with the court except for some Local Court proceedings. If a subpoena is filed electronically, there will be an electronic court stamp. They are still valid subpoenas and should be complied with.
In some Local Court proceedings, Police Officers and Public Officers, rather than the Local Court can

issue subpoenas. These subpoenas do not need to be stamped. For more detail on these types of subpoenas, see Section 3.10.

In criminal, AVO and some civil proceedings, if the subpoena is seeking "counselling communications" for a victim of sexual assault, then the subpoena can only be issued with the leave or permission of the Court. Look for an attached court order or letter from the lawyer who issued the subpoena stating that leave was granted on a particular date. A subpoena issued without such leave will be invalid. For further information, see Appendix A – Sexual Assault Communications Privilege.

3.6 If you are uncertain about whether a subpoena has been validly issued, contact the court in which the proceedings have been commenced and ask for confirmation. What are the proceedings about?

From reading the subpoena you will be able to ascertain whether it is a civil or criminal matter and the identities of the parties. This information is contained within the Subpoena. Matters in the Family Court or Federal Circuit Court may involve children of the named parties.

In criminal matters, one of the parties will usually be the Director of Public Prosecutions, ("DPP"), or 'Regina' or 'R'. It is also possible (but less common) that one of the parties in a criminal matter will be a government department with the power to prosecute offences, such as the Australian Taxation Office or the Environmental Protection Agency.

As well as looking at the names of the parties, subpoenas should state what court, and sometimes what division of the court the matter is to be heard in, which might help ascertain what the proceedings are about. For a description of common courts, see Appendix C.

The Addressee of a subpoena to produce may request a copy of the appropriate Statement of Claim to assist them with determining the relevant documentation so that they are able to comply with the subpoena.

For more information on relevance, or legitimate forensic purpose, see Section 6.2.

3.7 Has the subpoena been properly served and in time?

The subpoena must be personally served on the person to whom it is directed, unless the subpoenaed party agrees to accept service by other means such as by post.

A subpoena to attend and give evidence must specify the date, time and place for attendance.
A subpoena to produce should be served in sufficient time to allow the collection of documents and delivery to court. The subpoena will say on it that you need not comply with it if it is served after the due date. The due date will not be less than five working days prior to the return date (ie. the date that the documents are required by the court) unless the court that issued the subpoena has shortened the time for serving it. If the court has made an order to shorten the period in which you must comply, the subpoena will be marked accordingly.

NB: The Federal Circuit Court requires the issuing party to serve the subpoena at least 10 clear working days before the date for producing documents, and 7 clear working days before giving of evidence. The Family Court is 7 clear working days for both giving of evidence and production of documents.

If the subpoena is served after the due date and there is no note or endorsement on the subpoena from the court stating that the time for service has been shortened, then the subpoena need not be complied with by the due date however you should contact the issuing party and ask that they obtain a further return date (an adjournment) so as to allow sufficient time for the documents to be collated.

Even where a subpoena to produce has been served in time, it may be possible to negotiate an extension of time within which to produce the documents with the issuing party. If the PHO has solicitors acting

on its behalf in the matter, those solicitors may be able to negotiate an extension of time on behalf of the PHO. If the PHO has not engaged solicitors, the person responsible for responding to the subpoena can contact the issuing party to negotiate an extension of time directly.

3.8 Does it make any difference if the subpoena is a facsimile, photocopy or a scanned copy?

As a general rule the original subpoena should be served to ensure it is authentic. Upon receipt of a facsimile, photocopy or scanned copy the issuing party should be contacted. All reasonable steps should be taken to ensure that an authentic subpoena is served. This will protect the PHO from claims by patients that their privacy and confidentiality have been breached by the production of the documents without an authentic subpoena.

However, this must be balanced against the requirements of the *Uniform Civil Procedure Rules* ("UCPR") which applies to all NSW Courts, the NSW Industrial Relations Commission and the Dust Diseases Tribunal only. The UCPR states that despite the requirement that a subpoena must be served personally on the subpoenaed party, the subpoenaed party must comply with the requirements of a subpoena even if it has not been served personally, even if the subpoenaed party has by the last date of service for the subpoena, actual knowledge of the subpoena and its requirements.

In some instances the Court may give approval to a party to serve a subpoena via electronic means, such as email.

Finally, the NSW Coroner's Court can serve a subpoena by way of facsimile (Section 105 *Coroner's Act 2009*).

3.9 What is the date the subpoena must be complied with?

Where a PHO has been ordered to produce documents, a 'return date' should be listed on the subpoena. If electing to send the documents or things via mail they should be received at the Court Registry at least 2 clear working (business) days before the date specified in the subpoena for production.

As noted in paragraph 3.6 above, it may be possible to negotiate an extension of time within which to produce the documents with the solicitor or person who issued the subpoena. This should be done prior to the original return date.

A failure to comply with a subpoena is a serious matter. The return date of each subpoena served on the PHO should be carefully noted as soon as it is received.

3.10 How can documents be produced to the court?

The subpoena allows the PHO to produce documents by attending the Court at the date, time and place specified and produce the subpoena or a copy of it and the documents or things to the court. Alternatively the PHO may deliver or send the subpoena and the documents or things requested in the schedule of the subpoena, via a courier or registered mail to the Registry at the address specified in the subpoena. As noted in paragraph 3.8 above, if documents are being posted, they should be received by the Court Registry at least 2 clear working days before the date specified in the subpoena to produce.

3.10.1 Providing documents electronically to Courts and Tribunals

Some Courts and Tribunals now accept subpoenaed material in an electronic format, such as on a DVD, CD or a USB device.
Sending information that is classified as 'sensitive' to destinations external to NSW Health, such as Courts and Tribunals, should be encrypted using approved encryption technologies or passwords in accordance with relevant regulations and Privacy Manual for Health Information.

Supreme Court of NSW

The Supreme Court of NSW accepts material in electronic formats. If the subpoena or covering letter from the issuing party does not specify that electronic formats are acceptable, you should contact the issuing party and see if they are agreeable to this. Documents should be provided as a PDF file. Electronic subpoena documents can be emailed to the Registry at supremecourt.enquiries@courts.nsw.gov.au. The subject line of the email should state "Producing subpoena documents" and include the case name and number. A scanned copy of the subpoena should also be attached.

District Court

Subpoenaed material may be provided in any electronic form that the issuing party has indicated will be acceptable. If the issuing party does not specify that electronic formats are acceptable and you would like to provide the material electronically, you should contact the issuing party and see if they are agreeable to this.

Tribunals

The NSW Civil and Administrative Tribunal and Administrative Appeals Tribunal generally do not accept subpoenaed material electronically, and require hardcopies to be produced to the Registry.

Local Court Criminal Matter

Police Officers and a Prosecutor who is a Public Officer have the power to issue subpoenas in the following types of Local Court proceedings:

- Local Court criminal summary and committal hearings;
- Local Court Application Notice proceedings;
- Children's Court criminal proceedings; and
- Apprehended Violence Proceedings.

Under the *Criminal Procedure Act*, ***prosecutor*** means the Director of Public Prosecutions or other person who institutes or is responsible for the conduct of a prosecution and includes (where the subject-matter or context allows or requires) an Australian legal practitioner representing the prosecutor.

Public Officer is defined as any of the following persons, if acting in an official capacity:

(a) an employee in the Public Service or the NSW Police Force;
(b) an officer or employee of a statutory body representing the Crown;
(c) an employee of a council within the meaning of the *Local Government Act 1993*;
(d) a member of staff of Local Land Services; or
(e) the Director of Public Prosecutions, Deputy Director of Public Prosecutions or Solicitor for Public Prosecutions.

Subpoenas issued by police officers or a Prosecutor who is a public officer will not have been signed and dated by a registrar of the Local Court. They will not have a court stamp. They are still valid subpoenas and should be complied with.

Children's Court

Any party to care proceedings in the Children's Court may seek leave to issue subpoenas in the proceedings. Subpoenas issued in care proceedings are issued by the Children's Court, Children's Magistrate or Registrar pursuant to Section 109C the *Children and Young Persons (Care and Protection) Act 1998*, and will therefore always be stamped with the seal of the Children's Court and/or signed and dated by the Children's Magistrate or Registrar.

A subpoena issued in care proceedings must be served on the recipient no less than five clear working days, or any such other date specified in the subpoena as endorsed by the Children's Magistrate or Registrar, before the return date. The issuing party is also required by s 108E of the *Children and Young Persons (Care and Protection) Act 1998* to tender conduct money at the time of service for the reasonable expenses of the person in complying with the subpoena.

3.11 What if an interstate court issued the subpoena?

It is common for some hospitals in NSW to receive subpoenas issued by interstate courts. For example, hospitals in northern NSW often receive subpoenas (known as notices of non-party disclosure) issued by courts in Queensland.
The Commonwealth *Service and Execution of Process Act* allows for interstate subpoenas to be validly served in NSW if they are accompanied by notice. The general rule is that subpoenas served interstate should be served 14 days prior to the return date. This time can be shortened by the court that issued the subpoena if a shorter time period is necessary in the interests of justice and there will be enough time for the subpoenaed party to comply without serious hardship or inconvenience. There may however be circumstances where further time is needed to produce the material of the subpoena. In such circumstances, it is generally best for the recipient of a subpoena to contact the party issuing the subpoena.
PHO's are entitled to request that the original subpoena (or a copy of the original) is served, rather than a faxed copy.

4 CONDUCT MONEY AND/OR COSTS OF COMPLIANCE

4.1 What is conduct money?

When a subpoena to give evidence is served on a person or a Proper Officer of an organisation, the person named is not required to attend and give evidence under the subpoena unless conduct money has been paid. This means an amount sufficient to meet the 'reasonable expenses' of attending (which are often prescribed). Conduct money must be provided at the time the subpoena to attend and give evidence is served.

In relation to subpoenas to produce, the Addressee is able to claim the 'reasonable expenses' of complying with the subpoena.

The court in the event of a dispute will determine what is 'reasonable' conduct money or costs of compliance. In reaching a decision the court is likely to take into account NSW Health policy when determining what is reasonable.

The rates to be applied for servicing a subpoena for production are advised annually by NSW Health in an information bulletin titled *Health Records and Medical/Clinical Reports – Rates* and the Policy Directive titled *Health Records and Medical/Clinical Reports – Charging Policy.*
Even if original documents are being produced to court, the photocopying charge will still apply. It will cover the cost of copying the records so that the PHO can maintain a copy whilst the originals are removed.

If a subpoena asks for records relating to more than one patient, the PHO has the discretion to charge separate fees for each patient.

If a subpoena requires searches for records to be undertaken at more than one facility of the PHO, the PHO has the discretion to charge separate fees for each facility searched.
Conduct money does not need to be paid in the following circumstances:
- NSW Civil and Administrative Tribunal
- NSW Coroner's Court
- Local Court proceedings where a Police Officer or Public Officer have issued the subpoena (as discussed in section 3.10)

4.2 What if the conduct money is inadequate?

If the record is lengthy, or will require a number of files to be searched or otherwise take up staff time so that it will cost more than the amount provided to produce the record, the issuing party should be contacted and advised of the estimated cost of compliance including staff time in searching and locating the relevant records, photocopy costs and mail or courier fees. Such contact may be by telephone but should be confirmed in writing.

In the event that the actual costs exceed the estimate, a further account should be raised against the issuing party. Information Bulletin 2017_035 is a useful guide that is updated each year to assist in determining costs of compliance.

If compliance with a subpoena involves a significant amount of work, consideration should be given to discussing with the issuing party whether they are prepared to narrow the scope of the subpoena (see Section 6.1 of this Policy Directive).

If the conduct money and/or amount paid for production expenses is inadequate, the PHO representative should:

(i) Call the issuing party to inform him or her of your requirements.

(ii) If there is still a refusal to provide additional conduct money or production expenses, or you consider it insufficient, contact the issuing party and attempt to negotiate some compromise on the amount.

(iii) In the event that conduct money was not provided by the issuing party and / or the amount of conduct money or amount paid for production expenses is considered to be 'unreasonable' the PHO or solicitor acting on behalf of the PHO should advise the Court on the day the documents are produced to the Court and request the Court make an order to the issuing party that they pay conduct money and/or the amount of any reasonable loss or expense incurred in complying with the subpoena.

4.3 What if too much conduct money has been provided?

The PHO is entitled to retain the minimum amount of conduct money and/or production expenses.

If more than the minimum amount is provided and the cost of producing the records is less than the amount provided, the records should be copied and delivered to the court and the excess amount should be refunded to the issuing party.

4.4 Can the PHO keep the conduct money if it has no documents to produce?

If the PHO receives a subpoena, conducts searches for the records requested, and has no records to produce, it may retain a reasonable amount to cover the cost of conducting the searches, and the cost of writing to the Court explaining that it has no records to produce.

If the records have been lost, misplaced or destroyed, then the court should be advised that there are no records to be produced and the amount paid should be refunded.

5 WHAT DOCUMENTS HAVE BEEN REQUESTED IN THE SUBPOENA TO PRODUCE

5.1 How do I determine the scope of the subpoena?

The schedule to the subpoena must be read very carefully to determine the scope and document required. This is critical because the PHO is under an obligation to produce only those documents covered by the description set out in the subpoena. A subpoena may call for the production of health and/or non-health related records. The applicable procedures are the same.

The next task is to undertake appropriate inquiries to determine whether the PHO is in possession of any records which fall within the scope of the subpoena, the likely location of the records and the number of files that may have to be searched.

The PHO should take care only to copy and produce documents that are within the scope of the subpoena. Do not provide any documents that are outside of the scope of the subpoena.

Documents that do not come within the scope of the subpoena should be removed from the medical record before it is copied and documents are sent to court. This may also mean redacting portions of documents if there is extraneous, irrelevant or privileged information contained within a document to be released. A clear record of which documents have and have not been produced and a copy of the subpoena should be kept by the PHO. This may involve keeping an additional copy of the records that were sent to the Court, if the records that were sent are a small extract from the medical record.

The schedule will generally address one patient, who is mostly a party to the proceedings. Care needs to be taken to protect the information of those parties who are not represented in the proceedings and would not anticipate their personal information being released to a Court without their knowledge.

Sometimes there may be letters from specialists, who state that the letter should not be released to a third party without the consent of the author, contained within the clinical record of a patient whose records have been subpoenaed. If the letters are included in the clinical record which has been requested in the schedule of the subpoena, the documents must be sent to Court. There is no need to obtain the permission of the specialist although the PHO should consider contacting the specialist as an interested party before producing those documents.
Only material specifically referred to in the schedule to the subpoena should be collated.

Examples

Scenario: A patient, Sara X, attends Chester Public Hospital on 28/9/2000 after being sexually assaulted. There are several later attendances to the hospital over the next three months. Some of these admissions being for surgical procedures unrelated to the sexual assault.

On 30/9/2000 Sara also visits the Chesterfield Sexual Assault Service, (a separate facility of the Chester Local Health District, located in Main St, Chester) in relation to the sexual assault, and there are several sessions with a sexual assault counsellor Jenny K, after this initial presentation.

Some months later, the defence in a criminal trial decide to issue a subpoena to the Chester Local Health District seeking access to documents held on Sara X. Some of the requests they consider putting in the subpoena include:

"All notes relating to the visit by Sara X to the Chester Hospital on 28/7/2000"

The Hospital holds no records relating to an admission of Sara X on 28/7/2000. The hospital is not required to, nor should it volunteer any information in relation to other visits Sara X may have made to the Hospital.

"All notes of the visit by Sara X to the Chester Hospital on 28/9/2000"

The only records caught by the subpoena are the actual notes which relate to the visit on 28/9/2000. No reference is made to other visits Sara X made to the Hospital, or the Community Health Centre at later dates, so these documents are not caught by the subpoena.

"All notes relating to the visit by Sara X to the Chester Hospital on 28/9/2000 or any time thereafter"

All notes included on Hospital records are captured, including notes on the unrelated surgical procedures. The subpoena does not, however, capture any records generated by the Sexual Assault Service which are not in the possession of or under the control of the Hospital. The Sexual Assault Service is a separate facility of the Local Health District, and is located outside the hospital campus. As such, the LHD is not required to, nor should it volunteer any information on visits made by Sara X to the Chesterfield Sexual Assault Service. Had the Sexual Assault Service been located within the hospital campus, and its records been in the possession of or under the control of the Hospital (and related to a visit to the Hospital), the result in this case would have been different.

"All notes and counselling records prepared by counsellor Mary G in relation to any counselling sessions conducted with Sara X."

The subpoena does not identify the records of a particular facility. As such, and as the subpoena is addressed directly to the Local Health District, all LHD records should be checked, including those held by the SAS. Note, however, that the subpoena names a specific counsellor, and only requests her notes. Mary G did not see Sara X, so the LHD does not hold any records covered by the subpoena. The LHD is not obliged to inform the court that another counsellor saw Sara X.

"Any records, notes reports or any other written material held by any facility of the Chesterfield Local Health District, including but not limited to the facilities at the Chester Hospital and the Chesterfield Sexual Assault Service relating to Sara X and dealing with an alleged sexual assault on 28/9/2000.

This is a more usual approach. The terms of the subpoena are broad, and clearly captures all the relevant documents held by the LHD on Sara X. The only documents not captured would be those dealing with the unrelated surgical procedures. Note however, the reference to "Chesterfield Local Health District", when the actual legal entity is the "Chester Local Health District". If the subpoena also wrongly names the LHD, arguments could be raised against complying with it.

5.2 What documents need to be produced?

This will depend on the scope of the subpoena to produce. It is important to read the schedule of the subpoena carefully in order to determine what documents are being requested. If this is not clear, contact the solicitor issuing the subpoena.
If the subpoena requests "*any records*" or "*all records*", this means the entire file relating to the patient, including correspondence and x-rays, including when the documents are stored separately to the medical record. For example, a patient's community mental health record, clinical record of sleep studies record would also need to be produced should a PHO receive a subpoena requesting all records within the PHO relating to that patient.
The definition of 'document' captures any electronically held documents and hard copy documents. Electronically held documents are those held, for example, in an electronic medical record, other clinical information systems or information contacted on a computer file, such as photos and / or videos. This would also include emails exchanged by clinicians regarding the particular patient along with any clinical records/reports from other PHO's or referring doctors.
With the continuing expansion of information technology systems across NSW Health, PHO's should keep in mind that a patient's health information may be stored on an electronic database that is an

extension of the patient's health record, for example the HealtheNet Clinical Portal. Depending on the scope of the schedule to the subpoena issued to a PHO, records from state-wide databases or databases that are in the possession of or under control of a particular PHO may need to be collated and produced if they form part of the patient's record at the PHO (whether they have been accessed by clinicians or not).

5.3 What if the subpoena captures reports to Family and Community Services?

Under Section 29 of the *Children and Young Persons (Care and Protection) Act 1998*, risk of harm reports made to the Secretary, Department of Family and Community Services are not produced in response to a subpoena, summons or notice to produce other than:

(i) Care proceedings in the Children's Court;

(ii) Proceedings in relation to a child or young person under the *Family Law Act 1975* (Cth);

(iii) Proceedings in relation to a child or young person before the Supreme Court or Civil and Administrative Tribunal;

(iv) Proceedings before the Civil and Administrative Tribunal that are allocated to the Guardianship Division of the Tribunal or are commenced under the *Victims' Rights and Support Act 2013*;

(v) Proceedings under the *Coroners Act 2009*.

Section 27A(7) of the *Children and Young Persons (Care and Protection) Act 1998* provides that a referral by a mandatory reporter to their relevant Child Wellbeing Unit is also protected from production under Section 29 of the Act.

Although risk of harm reports, or documents evidencing the contents of a risk of harm report, may be produced in response to subpoena, summons or notice to produce issued in certain proceedings, Section 29(f) of the *Children and Young Persons (Care and Protection) Act 1998* prohibits the disclosure of the identity of a person who made a report, except with:

(i) The consent of the person who made the report, or

(ii) With leave of the Commissioner.

Section 29AA of the *Children and Young Persons (Care and Protection) Act 1998* similarly prohibits the disclosure of the identity of a person who made a report to a Royal Commission, except in the circumstances described above.

It is possible for a court or other body before which proceedings relating to the report are conducted to grant leave to a party or a witness to disclose the identity of the mandatory reporter if the court or other body is satisfied that the evidence is of critical importance in the proceedings and that failure to admit the evidence would prejudice the proper administration of justice. If a court or other body grants leave for this to occur reasons must be provided as to why leave is granted, and the court or body must ensure that the holder of the report is informed that evidence as to the identity of the person who made the report, or from which the identity of that person could be deduced, has been disclosed.

5.4 What if the subpoena captures sensitive records?

For medical records, the prime criterion of sensitivity is whether the patient would consider the data sensitive. Records relating to people or patients who are not directly involved in the legal proceedings can also be classified as sensitive. Examples include where genetic counselling or medical records contain information relating to persons other than the patient.
The fact that records are sensitive does not itself mean that privilege can be claimed over them, or that they do not need to be produced. If a subpoena requests sensitive records and there are no grounds for challenging the subpoena or claiming privilege (see Section 6), the procedure set out in Section 7.4 may be followed.

5.5 What if there are no documents or information?

If there are no documents or information, a letter should be written to the court advising the court that there are no documents or information to be produced. This letter should be copied to the issuing party. The conduct money may be retained.

However, if there are no records but there is evidence that there once were relevant records that have been lost, misplaced or destroyed, then the court should be advised that there are no records to be produced and the conduct money should be refunded.

A file note should be created outlining efforts made to find the relevant records.

If records were destroyed in accordance with a disposal authority approved under Section 24 of the *State Records Act 1998*, a copy of the disposal authorisation should be included and the relevant disposal category cited. Disposal authorisation is the consent of public office that is required before records can be disposed of.

6 SUBPOENA TO PRODUCE – GROUNDS TO OBJECT OR SET ASIDE

In most instances, when a subpoena to produce is issued, the issuing party must also serve a copy of the subpoena on all active parties to the proceeding as soon as practicable after the subpoena has been served on the Addressee.

The court may, on the application of a party to the proceedings, or the Addressee, or any person having a sufficient interest, set aside a subpoena in whole or in part. If any party or person files a motion to set aside a subpoena issued to a PHO, the PHO must be notified.

If a subpoena issued to the PHO is set aside, the PHO is no longer required to comply with the subpoena.

The information provided below applies when the PHO itself seeks to set aside a subpoena or object to access to documents required to be produced under subpoena.

6.1 The subpoena is too wide and/or oppressive

A subpoena to produce may be set aside:

- where its terms are so wide and/or insufficiently precise that compliance (i.e. collation and production of documents) would impose an onerous obligation on the PHO; or
- where a subpoena is used for the purpose of "fishing" for information which a party hopes, but does not reasonably expect is in existence. This may apply particularly to broad requests for protocols and investigation documents.

Subpoenas which request the production of medical records relating to persons who are not parties to the proceedings, or which request records relating to multiple, unrelated patients may be an abuse of process or oppressive.
The subpoena may also be oppressive if it is not clear what documents are sought by a subpoena, or if it appears that the documents sought will have little or no relevance to issues in the proceedings. The scope of a subpoena can be narrowed in two ways:

(i) by agreement with the issuing party; and

(ii) by successfully challenging the subpoena in court (see Section 8 of this Policy Directive).

If you believe that the scope of the subpoena is too broad and calls for documents to be produced which are demonstrably not relevant to the proceedings, an option available is to approach the issuing party with a view to seeking a compromise on the range of documents that are required. If a compromise is reached, written confirmation should be obtained from the issuing party as to the terms of the amended schedule to the subpoena.

If the issuing party refuses to negotiate the scope of the subpoena as is suggested above and you still wish to set aside a subpoena on the basis that it is an abuse of process or oppressive, you should consult your immediate manager, who may need to consult the PHO Executive, and obtain advice from the PHO's solicitors if appropriate.
You should be aware that where a subpoena is challenged unsuccessfully, the PHO may be liable to pay the court costs (associated with argument over the subpoena) of the issuing party.

6.2 The subpoena is an abuse of process or lacks a legitimate forensic purpose

A subpoena to produce that has been issued for reasons other than for the purpose of obtaining relevant evidence for the proceedings may be set aside.

In criminal matters, an accused person must have an objective basis for demonstrating a real possibility that the subpoenaed material would assist his or her defence. Only documents that have a legitimate forensic purpose need to be produced. Legal advice is recommended in order to argue that records have no legitimate forensic purpose.

6.3 Public interest immunity

Where the public interest that would be served by withholding certain documents is so strong that it overrides the public interest in the following of due process, a subpoena may be set aside. A challenge on this basis applies only to very limited types of documents and will usually only be available to documents which may affect national security, the workings of the NSW Cabinet or some other extraordinary public interest.

NB: If you wish to challenge a subpoena on a public interest immunity basis, you should contact the Legal Branch on telephone (02) 9391 9606.

6.4 Client legal privilege

Client legal privilege can protect certain documents from being disclosed in court proceedings. This privilege applies to confidential communications between a client and another person, or between a lawyer acting for the client and another person, if the communication was for the dominant purpose of the client being provided with professional legal services relating to a court proceedings or an anticipated or pending court proceedings in which the client is or may be, or was or might have been, a party.
If a claim for legal professional privilege is contested, evidence will be required from the author of the documents and/or the person who requested that the document be created, that it meets this test; and/ or other investigations will need to be undertaken as to the document's dominant purpose.

If a PHO wishes to claim client legal privilege over documents it has created for legal proceedings, the lawyer that the PHO instructs in those proceedings will be responsible for claiming the privilege.

6.5 Qualified privilege

NSW qualified privilege legislation (Division 6B of the *Health Administration Act 1982*) applies to approved quality assurance committees. Qualified privilege operates to prevent committee members and documents produced by the committee from being used in any legal proceedings.
Qualified privilege applies to records that are under the control of an approved quality assurance committee, or a member of an approved quality assurance committee and were created at the request of or solely for the purpose of the committee. If documents were created by an approved quality assurance committee but have been disclosed to other units of the PHO, the privilege may be waived, however, if the committee has not waived privilege over the documents and a subpoena is received for these records, the PHO should write to the party who issued the subpoena and to the court stating that the records are protected by qualified privilege legislation and will not be produced.

If records relating to quality assurance activities and morbidity and mortality case reviews or committees are requested, the PHO Executive should be contacted to confirm whether the records are records created by an approved quality assurance committee.
In addition to approved quality assurance committees, the Minister has approved the following committees under Section 23 of *Health Administration Act 1982*, to be specially approved committees;

- Special Committee Investigating Deaths Under Anesthesia,
- Collaborating Hospitals Audit of Surgical Mortality Committee,
- NSW Maternal and Perinatal Mortality Review Committee,
- Mental Health Sentinel Events Review Committee, and
- Clinical Risk Action Group Committee.

These committees do not need to comply with subpoenas. If one of these committees is subpoenaed, it should not comply with the subpoena unless it has the approval of the Minister to do so, or the consent of the person from whom the information was obtained. A letter should be sent to the solicitor issuing the subpoena, as well as the Court, explaining the committee's special status and stating that records will not be produced

6.6 Sexual Assault Communications Privilege

Records relating to the counselling of victims of sexual assault (protected confidences) may be protected from production if they are covered by sexual assault communications privilege. Sexual assault communications privilege can be claimed in criminal proceedings, including proceedings relating to Apprehended Violence Orders (AVOs) in NSW Courts. The sexual assault communications privilege may also be claimed in NSW Courts in civil proceedings, in limited circumstances, when the privilege was granted in criminal proceedings. The privilege may also be claimed in federal courts, such as the Family Court or Federal Circuit Court, if exercising jurisdiction in NSW and in the courts of other States and Territories of Australia.
PHOs have an obligation to their patients to take steps to protect confidential sexual assault counselling communications from being disclosed where disclosure would harm the patient.

See **Appendix A** for further detail about the privilege.

6.7 Professional Confidential Relationship Privilege

This privilege may apply to a communication made by a person, in confidence, to another person in the course of a relationship in which the confidant was acting in a professional capacity and where the confidant was under an express or implied obligation not to disclose the contents of the communication. The privilege can be claimed in NSW courts. The privilege may also be claimed in federal courts, such as the Family Court or Federal Circuit Court, if exercising jurisdiction in NSW and in the courts of other States and Territories of Australia.

A protected confidence may include a communication between a health professional and a patient. The definition potentially covers many aspects of clinical records.

See **Appendix B** for further detail about the privilege.

7 COURT PROCEDURE FOR CHALLENGING ACCESS TO DOCUMENTS PRODUCED UNDER SUBPOENA

7.1 Subpoenas for records where the Addressee objects to inspection on grounds that they are privileged (other than sexual assault and confidential communications privilege)

A solicitor's assistance will be necessary depending on the complexity of the case. Discussion should be undertaken with the appropriate PHO Unit (e.g. CGU) to ensure that a solicitor is consulted or appointed if necessary.

If a PHO decides to challenge access to documents produced under subpoena without legal representation the following procedures will apply:

(i) Follow 7.1 – should I notify anyone of the subpoena?

(ii) Follow 7.3 – procedure for delivering subpoenaed documents to the court?

(iii) Place the records which are to be produced in a sealed envelope.

(iv) Place any records over which a claim for privilege will be made in a separate envelope and mark the word "privileged" on the envelope.

(v) Attach a copy of the subpoena to the outside of each envelope.

(vi) Place the envelope(s) marked "privileged" inside another envelope and send to the court with a letter to the Registrar notifying the court that the Addressee objects to the documents or things being inspected by any party to the proceedings and setting out :

(a) What type of privilege is claimed; and
(b) The reasons supporting the claim for privilege.

(vii) Consider attending in person on the return date, or instructing the PHO's solicitor to attend, in order to argue in support of the claim for privilege.

NB: For matters in NSW Civil and Administrative Tribunal (NCAT) (called a 'summons'), if the Addressee is unable to resolve the objection to the summons with the issuing party before the time for compliance, the Addressee who is objecting is required to:

a. Inform the registrar and the issuing party of the basis for the objection;
b. Attend NCAT on the date for compliance and be prepared to explain the basis for objection.
c. Objections that cannot be resolved by discussion and agreement will be referred to a Member for decision.

7.2 Steps to follow when a subpoena for sexual assault records or confidential communications records is received

7.2.1 Determine whether either privilege can be claimed in the proceedings

See **Appendix A** for a discussion of the types of proceedings in which sexual assault communications privilege must be considered and how the privilege operates.

See **Appendix B** for a discussion of the types of proceedings in which it is possible to claim professional confidential relationship privilege.

7.2.2 Family Court, Federal Circuit Court and Children's Court subpoenas

Sexual assault communications privilege and professional confidential relationship privilege are created by NSW legislation and apply in NSW courts, and may also apply in Federal Courts where a matter is heard in NSW and in the courts of other States and Territories of Australia.

If you receive a Family Court or Federal Circuit Court subpoena requesting a patient's sexual assault counselling communications records and the subpoena was not issued by the patient or the patient's legal representative, and you are concerned about producing the records, although privilege cannot be claimed, you could consider treating the records as 'sensitive records' (see Section 7.4).
Keep in mind that sexual assault communications records relating to children can be important evidence and highly relevant for the Family Court or Federal Circuit Court to have available when determining parenting orders for the care of a child.

You must file the 'notice of objection' form contained on the last page of the subpoena and serve copies of the notice of objection on each of the parties to the proceedings prior to the return date if you are objecting to the production of documents in response to a subpoena. The court will then assign a date for your objection to be heard and you will need to attend court on that day.
The Children's Court may take different approaches to objections to subpoenas depending upon the location of the court. However, if objecting to a subpoena you must ensure that the relevant Children's Court is given notice of your application to set aside the subpoena or to object to access either by mail, fax, email or in person prior to the return of subpoena. For example if the Children's Court at Parramatta receives notice of an application, the matter will be listed for directions.

7.2.3 Protected Confidence Notice

A protected confidence means a counselling communication that is made by a victim of a sexual assault. The counselling communication does not need to relate to the sexual assault and may predate the sexual assault. If a party wants production and access to a document containing a protected confidence, they must seek leave of the Court and give notice to the patient that production has been sought. Notice should also be given to the other parties. This is a requirement of the *Criminal Procedure Act 1986*.

This means that if the issuing party is aware that the documents sought contain protected confidences, the patient should have been made be aware that they can seek to appear in court on the return date to challenge the subpoena.

7.2.4 The view of the patient

Sexual assault communications privilege and professional confidential relationships privilege belong to the patient.

When a subpoena requesting sexual assault counselling records or records of a protected confidence is received the PHO should contact the patient and inform them that the subpoena has been served. The PHO should then:

(a) explain nature of the privilege which may apply;

(b) ask the patient whether s/he will consent to waive the privilege. If so, a consent to waive the privilege should be obtained from the patient in writing;

(c) if the patient does not want to waive the privilege, advise the patient of the steps (if applicable) that the PHO is taking to claim the privilege on the patient's behalf.

If the patient chooses to waive the privilege, the documents must be produced to the court.
Reasonable attempts should be made to contact the patient if a subpoena for sexual assault counselling records is received. What constitutes reasonable steps will vary depending on the individual circumstances of the patient. If the file shows that there is a potential that the patient will suffer serious harm if the records are disclosed, taking reasonable steps to locate the patient may involve doing more than attempting to telephone the patient or writing a letter, such as contacting the police for assistance. If the patient cannot be contacted, the PHO should write a letter to the court explaining this, and noting that the records contain confidential counselling material. This letter should be sent to the court with the records.
In proceedings where the patient is represented, the PHO will meet its obligation by referring the matter to the patient's legal representative.
Legal Aid NSW's Sexual Assault Communications Privilege Service (SACPS)is a state wide service that assists victims to protect the privacy of counselling notes and other confidential therapeutic records in criminal proceedings.

SACPS can assist the LHD and the victim by:

1. Providing information to health workers about privilege;
2. Advising sexual assault victims about using privilege; and
3. Providing representation in court for sexual assault victims to enforce the privilege.

SACPS can be contacted by phoning (02) 9219 5888 or emailing sacp@legalaid.nsw.gov.au.

7.2.5 Whether harm is likely to occur to the patient if the material is disclosed

The treating counsellor (or, if that person is not available, another qualified professional) should review the file and form a preliminary view as to whether harm is likely to occur to the patient from disclosure. This preliminary view will need to later be supported by the preparation of a harm statement or an affidavit. A harm statement or affidavit made by a professional with appropriate qualifications is an essential element to claiming the privilege. Before a decision is made to claim privilege, the professional/s involved should be comfortable they can adequately prepare a harm statement or affidavit for the court. If a decision is made to claim privilege, the most appropriate way to ensure the claim is argued effectively is for the PHO to obtain legal representation.

7.2.6 Determine whether the PHO should claim privilege on behalf of the patient

The following issues should be considered when deciding if the PHO should claim either sexual assault communications privilege or professional confidential relationships privilege:

- The views of the patient and whether the patient proposes to claim either privilege themselves. You may wish to refer the patient for independent legal advice. Legal Aid's SACP Service can be contacted by phoning (02) 9219 5888 or emailing sacp@legalaid.nsw.gov.au.
- Whether harm is likely to occur to the patient if the material is disclosed.

7.2.7 The harm statement or affidavit

In order to support a claim for privilege, it is necessary for the patient or the PHO to provide the court with evidence about the nature and extent of the harm that the patient would suffer if the documents were disclosed. However, specific details about the patient should not be provided – to do this would negate the purpose for the privilege claim.
If the PHO has instructed a lawyer to argue the privilege, the lawyer will advise staff on whether affidavits, or harm statements, or a combination of both, are required, and will assist staff in preparing these documents.

If the PHO does not instruct a lawyer, it may consider asking staff to draft a harm statement. When drafting harm statements, keep in mind that they are likely to be read by all parties to the proceedings.

A professional with appropriate qualifications should prepare a harm statement. It should include:

(a) the qualifications and experience of the professional preparing the statement;

(b) the employed position of the professional at the time of preparing the statement;

(c) if the person preparing the statement is the treating counsellor, the statement should state this, and explain for how long the counselling relationship has been established;

(d) if the person is not the treating counsellor, the statement should state that fact. It should explain why the treating counsellor is not available to make the statement and state that the person who is preparing the statement has read all the relevant counselling notes;

(e) a statement that the counselling notes that have been subpoenaed were made in confidence and relate to the impact of alleged sexual assaults.

(f) a statement to the effect that the symptoms, concerns, and worries of the patient would be seriously aggravated if the contents of the documents were disclosed.

(g) if applicable, a statement to the effect that the patient expected the counselling records to remain confidential.

(h) a statement that the writer of the harm statement claims sexual assault communications privilege in respect of the records.

7.2.8 Instructions to be given to lawyers engaged by the PHO to argue a privilege claim

If the PHO decides to engage lawyers to argue a claim for privilege, a letter of instruction setting out the following should be sent to the lawyers. The letter should include the following information:

- When the subpoena is returnable (attach a copy of the subpoena);
- The nature of the documents held;
- The patient's views on disclosure;
- If the patient does not wish to waive the privilege, an indication that the PHO is of the view that harm will occur to the patient if the documents are released;
- The name and contact details of the other party / parties to the proceedings (or their legal representatives);
- If the matter is a criminal matter, the name and contact details for the police officer in charge of the criminal investigation;
- The name of appropriate contact officer at the PHO;
- The date that the hearing starts. This information can be obtained from the issuing party. The date that the hearing starts will usually be a date sometime after the return date for the subpoena. This allows time for the return date for the subpoena to be adjourned by the court if the PHO wishes to put forward arguments objecting to disclosure. Where the subpoena is returnable at the start of the trial it is more difficult to negotiate additional time.
- Whether the documents have been subpoenaed before. This is important, as if the records were previously released, it will be more difficult to argue for their non-release in response to a later subpoena. Alternatively, the court may have prevented disclosure in earlier cases and made comments which may assist in arguing for non-disclosure in relation to the later subpoena.

8 PROCEDURES FOR RESPONDING TO A SUBPOENA TO PRODUCE

8.1 Should I notify anyone of the subpoena?

All subpoenas should be brought to the attention of the relevant person or branch with-in the PHO to whom the subpoena relates, for example the medical records department or, to medico-legal person or risk manager if the PHO has one. Where appropriate, the senior health care provider and the treating health care provider are to be advised (where possible) of subpoenas for health records, even if neither they nor the PHO are party to the proceedings.

Where a patient whose health record has been subpoenaed is not named on the subpoena as a party to the proceedings before the court, he or she should be notified by the PHO that the subpoena has been received and advised of the "return date" on the subpoena (i.e. the date the documents must be provided to the court) in sufficient time to allow the patient to arrange to attend the court if the patient wishes. Telephoning the patient, or writing to the patient's last known address is sufficient. A note should be made outlining measures taken to advise the patient of the subpoena.

NB: If you have concerns about the scope of a subpoena you should consult your immediate manager who may need to consult the PHO Executive and obtain advice from the PHO's solicitors if appropriate.

8.2 Are photocopies sufficient or must originals be produced?

Documents can be provided to the Court by way of:

(a) A photocopy;
(b) In PDF format on a CD-ROM;
(c) On a USB; or
(d) In any other electronic form that the issuing party has indicated will be acceptable.

Unless a subpoena specifically requires the production of the original document, photocopies of the records or a CD-ROM or USB should be provided. If the PHO is required to produce originals, it should ensure that a complete copy of the records remains with the PHO to ensure continuity of care.

8.3 What is the procedure for delivering subpoenaed documents to the court?

Documents produced under NSW subpoenas must be produced to the court at the address referred to in the subpoena and **not to** the issuing party. They should not be provided to the person who serves the subpoena, even if the matter is 'urgent'.

Documents produced on subpoena should be delivered to the Registrar or Clerk of the court in question. If the documents are produced to the court, the following procedures should be followed:

(i) The documents should be sealed in an envelope;

(ii) The PHO should allocate a unique number to the envelope from a register held by the PHO in which the name of the patient, the court to which the record is sent and the date of the hearing should be entered against the number;

(iii) a copy of the subpoena should be secured inside the envelope (if the Court requires the original subpoena, the PHO should make a copy for its records);

(iv) the PHO should keep a copy of the subpoena (and any original documents being sent to court with the subpoena); and

(v) the envelope should be delivered to the registry by hand by the return date by an employee of the PHO or by registered post, or courier not less than 2 clear working days before the return date specified in the subpoena.

On delivery, if practicable, a receipt should be obtained from the court which indicates the number of the record, the date the record was received at the court, the name of the court and the signature of the court official receiving the record.

If the PHO is a party to the proceedings in which the subpoena has been issued, or has sought legal advice in relation to the subpoena, the documents collated in response to the subpoena should be forwarded to the solicitor who is acting on behalf of the PHO. That solicitor will review the documents and arrange for them to be forwarded to the court on behalf of the PHO.

8.4 Can any additional precautions be taken for sensitive records?

A subpoena cannot be challenged merely because it requests sensitive records.

When responding to a subpoena that requests sensitive information (and where there are no grounds for setting aside the subpoena or claiming privilege over the documents), the following steps should be followed.

(a) Contact the issuing party and ascertain why the information is required. It may be possible to negotiate with the issuing party to either exclude these records from production, or produce copies of the records with the names of the affected people deleted.

(b) Request that the court limit access to the documents to certain people. For example, courts can give orders limiting access to the parties' legal representatives and independent experts on the condition that they give confidentiality undertakings. The responsibility for raising this issue rests with the subpoenaed party. A letter should be sent to the court setting out the concerns arising if the documents are provided in open court. The letter should not contain any sensitive information itself.

The documents to be produced, should be placed in a separate envelope marked "Sensitive – access restricted", however, this is no guarantee that the Court will treat these records differently.

9 WHAT HAPPENS AFTER THE DOCUMENTS HAVE BEEN PRODUCED

9.1 Who can see the documents after they have been produced to the court?

After documents have been produced to court, the court will make orders about who may access them. Usually, the parties to the proceedings and their legal representatives will be granted access to the documents.

If a patient's medical record has been produced to court, and the patient is also a party to the proceedings, his or her legal representative may ask for 'first access'. This means that the patient's legal representative can inspect the records before the other parties, in order to determine whether a privilege claim can be made to limit further access to the documents.

The question of who may have access, whether a party will have first access, or whether any other special access orders will be made, is often determined on the return date.

The following courts determine access issues in particular ways.

District Court – civil claims

The issuing party in a District Court civil matter is required to include a "proposed access order" on the subpoena. This is an order for access that the issuing party thinks is appropriate. For example, the proposed access order may be "plaintiff to have first access to the documents for 7 days". This type of access order may be appropriate if the plaintiff was the patient whose records had been produced, as it would allow the plaintiff/patient's solicitor to view the records and determine whether any claims for privilege should be made, prior to the other parties accessing the records.

If the PHO wishes to object to the proposed access order (for example, if a privilege is being claimed), the PHO should first notify the issuing party to attempt to negotiate an agreement as to what the proposed access order should be. If an agreement cannot be reached, a representative of the PHO, or the PHO's legal representative will be required to appear at Court on the return date and argue the question before the presiding registrar (see Section 8.1).

In any District Court civil case where there is no appearance at the return date, the proposed access order will be made automatically by default.

Supreme Court

A subpoena in the Supreme Court must include either a proposed access order for the documents to be produced and reasons for that order, or default access orders. Default access orders means general access to all parties, and includes permission to copy documents.

If a general access order allowing all parties access to the subpoenaed documents at the same time is not objected to, the Supreme Court will automatically make a default order for general access to the documents at the return date.

If PHO wishes to object to a general access order being made (for example, by claiming a privilege), it should notify the party that issued the subpoena and attend court, or arrange for a lawyer to attend court, on the return date and inform the Registrar of its position.

9.2 What if I receive a request for permission to 'uplift' documents?

Courts have photocopying facilities available on site; however, occasionally parties to litigation seek permission from the court to uplift, or temporarily remove the documents from the court to arrange for them to be copied externally, or reviewed in a more convenient setting. A party may request to uplift x-rays or scans which have been provided to the Court in order to obtain a copy to provide to a medical expert for an opinion. The documents are then returned to the court.

As the documents still belong to the subpoenaed party while they are at the court, some courts seek the consent of the subpoenaed party before they will allow the documents to be uplifted.

If a PHO is asked to consent to a party uplifting record, it is recommended that:

- If original documents have been produced, consent to uplift should generally be refused;
- If copies have been produced, consent can be granted on the basis that the documents do not leave the custody of the parties' legal representatives and/or the medical or other professional expert whom the parties' legal representatives have engaged to provide an expert opinion and the document/s are returned to the court in the same condition.

If a court allows documents to be uplifted, it will normally require the legal representative uplifting them to sign a receipt, accepting responsibility for the records whilst they are in the legal representative's possession.

9.3 Are subpoenaed documents returned?

Original documents should always be returned to the PHO.

Subpoenaed documents that are copies should be returned by the court at the conclusion of the matter, unless the PHO has informed the court that the documents may be shredded. If you have any queries contact the Clerk or Registrar of the court.

10 REQUESTS FOR INFORMATION UNDER THE CHILDREN AND YOUNG PERSONS (CARE AND PROTECTION) ACT

10.1 Requests for information under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998 (NSW)*

Chapter 16A of the *Children and Young Persons (Care and Protection) Act* provides a mechanism for NSW Health staff to exchange information with other human services and justice agencies, to ensure the safety, welfare and wellbeing of children and young people in NSW.

Please refer to the NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* PD2013_007 where NSW Health's policy on child protection information exchange is set out in full.

10.2 Requests for information from Family and Community Services

Pursuant to Section 248 of the *Children and Young Persons (Care and Protection) Act*, PHOs may be required to provide information to Family and Community Services. Section 248 is designed to allow an exchange of information about the safety, welfare and wellbeing of children and young people between an agency and Family and Community Services.

Information can only be provided in response to a Section 248 request if it relates to the safety, welfare and wellbeing of a particular child or young person.

Once records have been provided to Family and Community Services in answer to a Section 248 request, Family and Community Services may use them as evidence in legal proceedings. If records are to be used in legal proceedings, they are usually annexed to an affidavit (a sworn statement) prepared by Family and Community Services staff in accordance with arrangements agreed upon between NSW Health and Family and Community Services. Family and Community Services staff are not to attach confidential information provided in response to a Section 248 request to affidavits without the consent of the person who provided the information.

If the document that Family and Community Services wish to attach to the affidavit is particularly sensitive, the PHO should refuse to consent (unless the patient's guardian does not object), and ask Family and Community Services to issue a subpoena seeking a copy of the document instead. Once a subpoena has been served, the PHO may consider whether production can be opposed, or whether any type of privilege can be claimed in respect of the document.

For more information regarding responding to S248 requests refer to to the NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* PD2013_007.

11 PRIVACY

Compliance with a subpoena is required by law. Complying with a subpoena will not breach the PHOs obligations under the *Health Records Information Privacy Act 2002* and *Privacy and Personal Information Protection Act 1998* as it is a lawful excuse to release information as long as you provide documents within the scope of the subpoena. For further information about privacy obligations, see Privacy Manual for Health Information.

12 SUBPOENA TO GIVE EVIDENCE

12.1 What should I do if I receive a subpoena to give evidence?

A subpoena to give evidence will require the named person to attend a court on a particular date to be a witness in a hearing and give evidence. The subpoena will be addressed to a specific individual and will indicate the time and place the person will be required to give evidence as a witness.
A person who receives a subpoena should report that fact to his/her administrator/supervisor as soon as practicable.
A person who has been subpoenaed should contact the solicitor who requested the issue of the subpoena to:

(a) confirm that their attendance is still required;
(b) to obtain some better guidance as to when he or she might be required to give evidence; and
(c) confirm that if the solicitor who has issued the subpoena requires the witness to remain on 'standby' rather than come to Court, sufficient notice will be provided if the witness is to be called to Court so that alternative work arrangements can be made.

If the solicitor indicates that a person's attendance is not required, this should be confirmed in writing.

12.2 How much conduct money should I receive if I am required to attend court to give evidence?

Witnesses are entitled to receive conduct money and reasonable expenses from the solicitor or person who has issued the subpoena. Conduct money means a sum of money, or its equivalent, such as pre-paid travel, sufficient to meet the reasonable expenses incurred by the subpoenaed party in attending court as required by the subpoena, and returning from court after attending.

When a subpoena to give evidence is served on a person, the person named is not required to attend court unless conduct money has been handed or tendered to the named person a reasonable time before the date on which attendance is required.
If there is a dispute about conduct money the named person should contact the person who has issued the subpoena and negotiate further conduct money. If no agreement has been reached, but some conduct money has been provided at the time the subpoena was served, the person should still attend the court on the date specified in the subpoena, but advise the court that the conduct money provided is not reasonable and seek an Order from the court that additional conduct money be paid by the person who issued the subpoena.
For medical officers, the AMA has published guidelines relating to reasonable expenses.

13 APPENDIX A – SEXUAL ASSAULT COMMUNICATIONS PRIVILEGE

The Sexual Assault Communications Privilege is set out in the *Criminal Procedure Act 1986*. This privilege protects counselling communication made by, to or about a victim or alleged victim of a sexual assault offence. The Act does this by:

- Requiring the leave (permission) of the court prior to issuing a subpoena seeking access to this information;
- Requiring the leave (permission) of the court prior to accessing documents produced in response to a subpoena; and
- Requiring the leave (permission) of the court prior to this information being used in evidence.

The privilege applies to information regardless of whether it is in written form (for example, a client's file) or in oral form (for example, a health worker being subpoenaed to give evidence).

The privilege applies to criminal, Apprehended Violence orders and some civil proceedings in NSW and may also apply in the courts of other States and Territories of Australia.

13.1 What are counselling communications?

Counselling communications are defined in the Act to include communications made by a person in confidence to a counsellor who is counselling the person in relation to any harm the person may have suffered.

Counselling communications also include communications made in confidence by the counsellor, or by a parent, carer or other support person who is present in the counselling to facilitate communication or to otherwise further the counselling process.

The Act provides that a person counsels another person if the person has undertaken training or study or has experience that is relevant to the process of counselling persons who have suffered harm and the person:

(a) listens to and gives verbal or other support or encouragement to the other person, or

(b) advises, gives therapy to or treats the other person

whether or not for fee or reward.

This wide definition is likely to include counselling provided by a counsellor, health care worker, social worker or youth worker.

A counselling communication is a protected confidence even if:

(a) it was made before the relevant sexual assault offence occurred, or is alleged to have occurred, or

(b) was not made in connection with a sexual assault offence or alleged sexual assault offence.

This means that the privilege could apply to any counselling communications, and not just to counselling following a sexual assault (for example, the privilege could apply to drug and alcohol counselling provided prior to the sexual assault taking place).

13.2 A counselling communication may be made in confidence even if it was made in the presence of a third party if the third party was present to facilitate communication or to otherwise further the counselling process. Can the sexual assault communications privilege be claimed in all types of court proceedings?

The sexual assault communications privilege can be claimed in criminal proceedings, including proceedings relating to Apprehended Violence Orders ("AVOs").

The privilege applies in any courts that exercises criminal jurisdiction, any may also apply in federal courts, such as the Family Court or Federal Circuit Court, and in the courts of other States and Territories of Australia. The federal court or courts of other States and Territories will consider the application of the privilege in the context of their local laws.

The sexual assault communications privilege can also be claimed in civil proceedings in NSW, but only if:

(a) substantially the same acts are in issue in the civil proceedings as were in issue in relation to previous criminal proceedings; and

(b) the evidence was found to be privileged in the previous criminal proceedings.

13.3 Principles applying to sexual assault subpoenas

In the first instance, where a subpoena is received for patient records that may contain sexual assault communications, attempts should be made to contact the patient and advise that a subpoena has been received for their records and indicate they should seek legal advice. If the patient is not a party to the proceedings (for example, in criminal proceedings) they may not be aware that their records have been subpoenaed.

PHOs have an obligation to their patients to take steps to protect confidential sexual assault counselling communications from being disclosed where disclosure would harm the patient.

This obligation is most critical where the patient is a child, or where the disclosure is sought in relation to criminal proceedings and the victim of the assault does not have legal representation. In these cases, the PHO may consider obtaining legal representation to challenge the production of documents under the subpoena.

In cases where there is a high risk of serious harm such as, for example, a high likelihood of suicide or self-harm to the patient if the records are disclosed, the PHO should consider obtaining legal representation to challenge the production of material in response to the subpoena. Harm can be actual physical bodily harm, financial loss, stress or shock, damage to reputation or emotional or psychological harm (such as shame, humiliation and fear).

In proceedings where the patient is represented, the PHO may meet its obligation by referring the matter to the patient's legal representative.

If the patient has legal capacity and chooses to waive the privilege, the PHO must respect that decision.

13.4 How does sexual assault communications privilege operate?

13.4.1 Preliminary Criminal Proceedings

Preliminary criminal proceedings are committal or bail proceedings (whether or not they relate to a sexual assault offence).
In preliminary criminal proceedings:

(a) a person cannot seek to compel any other person (whether by subpoena or any other procedure) to produce a document recording a protected confidence;

(b) a document recording a protected confidence cannot be produced; and

(c) evidence cannot be adduced if it would disclose a protected confidence or the contents of a document recording a protected confidence.

13.4.2 Criminal Proceedings

Criminal proceedings include those relating to the trial or sentencing of a person for an offence (whether or not they relate to a sexual assault offence) and also proceedings for an AVO.
In criminal proceedings, unless the court grants leave:
(a) a person cannot seek to compel any other person (whether by subpoena or other procedure) to produce a document recording a protected confidence;
(b) a document recording a protected confidence cannot be produced; and
(c) evidence cannot be adduced if it would disclose a protected confidence or the contents of a document would recording a protected confidence.
The court will not grant leave unless the court is satisfied that;

(a) the document or evidence will have substantial probative value; and

(b) other documents or evidence concerning the matters to which the protected confidence relates are not available; and

(c) the public interest in preserving the confidentiality of protected confidences and protecting the victim from harm is substantially outweighed by the public interest in admitting into evidence information or the contents of a document of substantial probative value.

The court is also required to take into account certain matters, including the need to encourage victims of sexual offences to seek counselling and the fact that disclosure is likely to undermine the relationship between counsellor and patient.

13.4.3. Civil Proceedings

The privilege can only be claimed in a civil proceeding where substantially the same acts are in issue as the acts that were in issue in relation to a criminal proceeding.
Where evidence was found to be subject to sexual assault communications privilege in the criminal proceeding, that evidence may not be adduced in the civil proceeding.
In civil proceedings where the *Uniform Civil Proceedings Rules 2005* apply, a party can also object to production of a document on the basis of the privilege in these circumstances, and cannot be compelled to produce the document until the objection is overruled.
If you have received a subpoena to produce in a civil proceeding where the documents cover sexual assault communications, you should make enquiries as to whether there were criminal proceedings in relation to the acts which are the subject of the communications.
If you are unable to make such enquiries, you should place the documents into a sealed envelope marked "**Sexual assault communications – may be subject to s 126H of the Evidence Act 1995**" when producing the documents to the court.

13.5 What happens if there is a dispute about whether a document or evidence contains a protected confidence?

If a party has requested leave to subpoena documents that contain a protected confidence or to adduce evidence that contains a protected confidence, notice must be given in writing to each other party and the patient. A patient who is not a party may appear in criminal proceedings if this occurs.

If you have received a subpoena that covers sexual assault communications and you are unsure if leave has been sought, you should contact the relevant Registry and object to production until such time as the Registry confirms leave has been granted.

If leave has been granted, objection to access may still be made.

Before a court can make a decision about the documents, they must be produced to court, with an objection to their production noted, so the court can rule on the objection. This means that the PHO must produce the documents to the court in a sealed envelope marked "**Sexual assault communications privilege claimed**". The court will inspect the documents in order to determine whether the claim for privilege will be upheld. Some courts will not uphold a claim for privilege without hearing legal argument from the issuing party and the subpoenaed party. PHOs should recognise that producing the documents marked privilege may not be sufficient for a claim for privilege to be successful. Legal argument may be necessary.

The court can also make orders to limit the possible harm, or the extent of the harm caused, for example, by ordering that evidence is to be heard 'in camera' (in a closed court), or making orders suppressing the publication of the evidence, or part of the evidence, or the identity of the confider. The court may also make orders limiting who may inspect documents produced.

14 APPENDIX B – PROFESSIONAL CONFIDENTIAL RELATIONSHIP PRIVILEGE

14.1 What is a protected confidence for the purpose of claiming professional confidential relationship privilege?

A protected confidence is a communication made by a person, in confidence, to another person in the course of a relationship in which the confidant was acting in a professional capacity and where the confidant was under an express or implied obligation not to disclose the contents of the communication. A communication may be made in confidence even if it is made in the presence of a third party if the third party's presence is necessary to facilitate communication.

A protected confidence may include a communication between a health professional and a patient. The definition potentially covers many aspects of clinical records.

The aim of the privilege is to protect marginalised groups (other than victims of sexual assault in relation to whom the sexual assault communications privilege may apply) such as mental health patients and HIV positive patients, who may not seek medical treatment if they are concerned that professional confidentiality will not be maintained.

The rationale for the privilege is that some relationships between health professionals and patients will be severed, if trust and confidentiality are not maintained. This rationale may not apply to a patient's relationship with a Hospital or PHO, where the patient is treated by a team, and may not form a special relationship with a particular health professional.

14.2 Can the professional confidential relationship privilege be claimed in all types of court proceedings?

The privilege can be claimed in all NSW courts or federal Courts operating in NSW, such as the Family Court or Federal Circuit Court, and in the courts of other States and Territories of Australia. The federal court or courts of other States and Territories will consider the application of the privilege in the context of their local laws.

14.3 How does professional confidential relationship privilege operate?

The court may direct that evidence not be used in proceedings, if the court finds that using it would disclose a protected confidence, or the contents of a document recording a protected confidence.

The court can come to this decision on its own initiative, or on an application from the protected confider (the patient) or the confidant (the health professional).

The court must decide not to use evidence about a protected confidence if, it is likely that harm would be caused to the protected confider (the patient) if the evidence is used and if the nature and extent of the harm outweighs the desirability of the evidence being given. It is generally desirable, however, for the evidence to be given. The more important the evidence is, particularly if it is not available from an alternative source, the more desirable it is.

Harm includes actual physical bodily harm, financial loss, stress or shock, damage to reputation or emotional or psychological harm (such as shame, humiliation and fear).

The court can also make orders to limit the possible harm, or the extent of the harm caused, for example, by ordering that evidence is to be heard 'in camera' (in a closed court), or making orders suppressing the publication of the evidence, or part of the evidence.

The privilege can be waived if the confider consents.

14.4 What will the court take into account when deciding whether the privilege applies?

The court will consider a range of factors, including the following:

(a) the extent to which the evidence could affect the assessment of a fact in issue in the proceedings;

(b) the importance of the evidence in the proceeding;

(c) the nature and seriousness of the relevant offence, cause of action or defence and the nature of the subject matter of the proceeding,

(d) the availability of any other evidence concerning the matters to which the protected confidence or protected identity information relates,

(e) the likely effect of using evidence of the protected confidence, including the likelihood of harm, and the nature and extent of harm that would be caused to the patient,

(f) the means available to the court to limit the harm or extent of the harm that is likely to be caused if evidence of the protected confidence or the protected identity information is disclosed,

(g) if the proceeding is a criminal proceeding—whether the issuing party is a defendant or the prosecutor, and

(h) whether the substance of the protected confidence or the protected identity information has already been disclosed by the patient or any other person.

15 APPENDIX C – COMMON COURTS AND TRIBUNALS

15.1 The Family Court of Australia and Federal Circuit Court of Australia

The Family Court and Federal Circuit Court resolve and determine family disputes, including disputes about the care, custody and maintenance of children.

The Family Court also provides consent for special medical treatment (such as sterilisation, surgical gender reassignment and the harvest of bone marrow blood cells from a disabled child for transplantation into a relative) to be carried out on minors.

15.2 The Supreme Court of New South Wales

The highest court in the State is the Supreme Court of NSW. It has unlimited civil jurisdiction and handles the most serious criminal matters.

The Supreme Court also deals with Adoption matters and has *parens patri* jurisdiction which can include applications related to the care and protection of children and young persons, medical treatment, and secure detention.

The Court of Appeal and Court of Criminal Appeal hear appeals from decisions made in most of the Courts of New South Wales and from decisions made by a single judge of the Supreme Court.

15.3 The District Court of New South Wales

The District Court deals with criminal and civil cases. The District Court has jurisdiction to hear:

(a) all indictable criminal offences (except murder, treason and piracy); and

(b) civil matters with a monetary value up to $750,000, - or greater with the consent of the parties. The Court also has an unlimited jurisdiction in respect of motor accident cases and work injury damages cases.

The Court's judges hear appeals from the Local Court and also preside over a range of administrative and disciplinary tribunals.

15.4 The Local Court of New South Wales

The Local Courts are the courts of general access in New South Wales. There are 157 Local Courts in NSW. They have jurisdiction to deal with:

- the vast majority of criminal and summary prosecutions;
- civil matters with a monetary value of up to $100,000;
- committal hearings;
- family law matters;
- child care proceedings;
- juvenile prosecutions and care matters; and
- coronial inquiries.

In the Local Court, Magistrates hear criminal cases that do not need a judge and jury. These are called summary offences and include traffic matters, minor stealing, offensive behaviour, and some types of assault. Magistrates also hear applications for apprehended violence orders where one person is seeking a restraining order against another.

A Magistrate conducts committal proceedings to decide if there is enough evidence for a serious matter, such as armed robbery, or attempted murder, to go before the District Court or the Supreme Court.

Children's Courts deal with criminal matters involving children who are younger than 18 and care applications concerning children who are in need of care or protection.

15.5 The NSW Civil and Administrative Tribunal

The NSW Civil and Administrative Tribunal ("NCAT") was established on 1 January 2014 by the *Civil and Administrative Tribunal Act 2013* (NSW), consolidating the work of 22 former tribunals (including the Guardianship Tribunal, Administrative Decisions Tribunal and the occupational tribunals) into a single specialist tribunal service. NCAT is made up of four divisions:

- Consumer and Commercial;
- Occupational;
- Guardianship; and
- Administrative and Equal Opportunity.

NCAT deals with a broad range of matters including review of administrative decisions made by government agencies, discrimination matters, complaints concerning professional conduct and discipline and determining applications for guardianship.

15.6 Workers Compensation Commission

The Workers Compensation Commission deals with workers compensation disputes arising out of work related injury or disease suffered by a worker in New South Wales. In addition, the Commission administers medical panels which assess a worker's condition or fitness for employment in circumstances specified in legislation.

15.7 Coroner's Court of New South Wales

Coroners are situated around New South Wales in Local Courts. They inquire into the circumstances surrounding deaths that are reported to them.

The State Coroner's role is to ensure that all deaths, suspected deaths, fires and explosions which are under the Coroner's jurisdiction are properly investigated, and where the law requires an inquest to be held, or in cases whether the Coroner believes an inquest is necessary, a full inquest is undertaken.

15.8 Drug Court of New South Wales

The Local or District Court in the defined catchment area must refer offenders who appear to meet the Drug Court obligatory criteria, to the Drug Court.

The aim of the Drug Court is to protect the public by ensuring drug dependent offenders engage in longer term treatment. The Court works in collaboration with a number of other organisations. These include Corrective Services NSW and NSW Health.

15.9 Dust Diseases Tribunal

The Dust Diseases Tribunal hears and determines claims for dust related diseases suffered as a result of exposure to dust. Dust diseases include mesothelioma, asbestosis, silicosis and certain types of lung cancer. The Dust Diseases Tribunal follows the procedural rules of the Supreme Court of New South Wales.

15.10 Children's Court of New South Wales

The Children's Court is a specialist court to deal with criminal cases, applications for apprehended violence orders, applications for compulsory schooling orders and cases involving the care and protection of children.

15.11 Industrial Relations Committee

The NSW Industrial Relations Commission is the court which hears matters relating to the workplace. The role of the Commission is to regulate workplace affairs in NSW and arbitrate to resolve industrial disputes.

HEALTH RECORDS AND MEDICAL/CLINICAL REPORTS - CHARGING POLICY (PD2006_050)

PD2006_050 rescinds PD2005_235.

The contents of this policy directive are to be effective from the date of issue and replaces PD2005_235 (dated 14 February 2002).

The following relates to charges for health records and medical/clinical reports that are to apply unless specific legislation specifies a lesser rate or exemption from fees. Health Services should develop local policies, which detail the content of records and reports as they relate to these charges. These policies should take into account the function of the health facility, the type of report produced and the amount of information to be provided.

Rates are advised separately via Information Bulletin.

The decision to charge for requests for health records and medical/clinical reports from researchers is a matter for local determination depending upon the type of request and possible future benefit to the health system. Such charges should be determined on a cost recovery basis.

For the purposes of this policy directive a health record is defined as a documented account, whether in hard or electronic form, of a client/patient's health, Illness and treatment during each visit or stay at a health service (and includes a medical record).

Charges relating to categories A, B and C (below) are taxable supplies (ie subject to GST) unless deemed GST - free under the provisions of the '*A New Tax System (Goods and Services Tax) Act 1999*' (*GST Act*). The criteria to be followed by the Area Health Services/Hospitals in assessing the GST status are advised in the GST section of this circular. Please note that where the service is determined as being 'GST-free' the rates as advised by Information Bulletin apply. Where the GST free test is not satisfied the service is therefore a taxable supply (subject to GST) and the rates as advised by Information Bulletin are to be grossed-up by 10%.

A CHARGES FOR MEDICAL/CLINICAL REPORTS apply based on the following categories:

1. Preparation of a medical report by a medical practitioner appointed to or employed by the health institution/hospital **requiring no further examination of the patient.** This applies to the treating medical practitioner or a medical practitioner who has not previously treated the patient.
2. A report made by a **treating** medical practitioner appointed to or employed by the health institution/hospital **where a re-examination of the patient is required.**
3. A report made by a medical practitioner appointed to or employed by the health institution/hospital **who has not previously treated the patient where an examination is required.**
4. Preparation of a report by an **allied health professional, other than a medical practitioner,** appointed to or employed by the health institution/hospital.

B OTHER CHARGES apply based on the following criteria:

1 (a) Charges for access to clinical notes requested by a patient/client, or by a person acting on behalf of the patient.

A patient/client can apply for access to their own personal health information held by a public health organisation, by contacting the medical records department for that organisation. In addition, the *Freedom of Information Act 1988* and the *Health Records and Information Privacy Act 2002* provide a statutory right for individuals to apply for access to information held about them.

These laws also allow for other persons to apply for access to a client/patient's personal health information. A person can apply for access on behalf of the patient/client with their consent, such as a solicitor, interpreter or employer. Alternatively, where the patient lacks the capacity to consent, or is deceased, a person who is the authorised representative for the patient/client can apply for access to the patient/client's personal health information.

NB. Further details are contained in NSW Health Privacy Manual Version 2, Sections 5.6 and 11.2.2.

Copies of clinical notes supplied in response to the above requests may typically include, as a minimum: patient registration/front sheet, consent to treatment, discharge summary, referral/transfer letters, ambulance report, continuation notes, operation reports (including anaesthetists and nursing reports), radiology and pathology reports, and nursing care plan. Where additional information is held by a hospital but not routinely released, the person making the request should be made aware that such additional information exists but has not been supplied. A further request for such additional information should be considered as forming part of the original request and no additional charge (other than photocopying, where appropriate) should be raised.

(b) Charges for information requested by an insurer.

Health facilities should not provide clinical notes or photocopies of notes to the insurer, but may supply a "Medical Report" or "Summary of Injuries" (Section A or C) if provided with a Statutory Declaration signed by the claimant on the insurer's claim form in respect of Compulsory Third Party (CTP) insurance or a declaration signed by the claimant on the insurer's claim form in respect of Workers Compensation Insurance. Such reports should only provide information **relevant to the claim.** This will necessitate the insurer detailing the nature of the claim. Health facilities will be required to exercise their judgement in determining what is relevant information. A photocopy of the CTP Statutory Declaration is acceptable irrespective of the date of signing.

If clinical notes, or part of the clinical notes, are requested by an insurer, the insurer should be requested to provide written consent from the patient stating that the patient:

- agrees to allow the insurer to have a copy of all or part of the clinical notes and
- the patient is aware that clinical notes, or part of the clinical notes, will inevitably include confidential medical information, which is irrelevant to the claim.

In the absence of clearly documented written consent, as detailed above, hospitals are not required to provide clinical notes to insurers.

The charge applicable in respect of 1(a) and 1(b) (above), which includes search fee, photocopying charges, labour costs, administrative charges and postage, is based on the following criteria:

- A set fee for the provision of a copy of the medical record, or part thereof, eg continuation notes, pathology reports, charts. (Maximum eighty pages.)
- An additional per page rate in excess of eighty
- An additional charge at cost recovery for the provision of other material (eg reproduction of X-rays, audiovisual tapes, copies of photographs & operation footage contained on DVD's).

Where a patient wishes to access her/his records under the *Freedom of Information Act*, the requirements of that Act (including charges) apply.

2 **Search Fees** - Other than requests made by a party concerned with a patient's continued treatment or future management.

The search fee should be charged:

- for searching for the health record, irrespective of whether the health record is found. If however, the Patient Master Index (PMI) or other indexes showed that the patient was treated in that health institution but the record cannot be found because it has been destroyed, misplaced or lost, the fees should be refunded in full;
- where the applicant subsequently advises that a report/record is no longer required, or where a thorough search has ascertained that the patient has never attended that health institution for that particular episode of illness;
- for information on date or time of birth, including requests from the Registry of Births Deaths and Marriages in relation to enquiries on hospitals to verify birth details;
- for Motor Accident and Work Cover medical certificates completed at other than time of consultation;
- **NOTE** - The search fee is a component of the fees charged for the preparation of reports, summaries or the production of health records required by subpoena, ie additional fees should **not** be charged on top of those for the preparation of reports, summaries and the production of health records required by subpoena.

The fee covers processing time, which includes time for locating the information, decision-making and consultation where necessary.

C **SUMMARY OF INJURIES** charges apply based on the following:-

"Summary of Injuries" - this is generally requested by Compulsory Third Party Insurers for patients whose fees are covered by the Bulk Billing Agreement.

The "Summary of Injuries" should include:

- Identifying information (name, date of birth, medical record number)
- Date of first attendance,
- Whether patient was admitted. If so, specify dates,
- Positive findings on examination,
- Level of consciousness, if documented,
- Diagnosis, if known.

A standard form letter may be appropriate.

If a discharge summary, or appropriate correspondence that provides this minimum information, is available at the time of the request, a copy of this may be sufficient. Should further information be required, the appropriate report charge as applicable to Section A or B should be raised. There is no requirement to provide the full clinical notes to third party insurers.

The purpose of the "Summary of Injuries" in relation to the bulk-billing agreement is to establish that the admission occurred as a result of a motor vehicle accident.

If the information contained in the "Summary of Injuries" is insufficient or unavailable and a medical practitioner (or other treating health professional, where appropriate) is required to prepare a report, charges for a medical report (or report by a treating health professional) should be raised.

Health Information Managers should consult with the requesting solicitor/insurer/other party to determine which is required before a fee is raised or report is prepared.

Goods and Services Tax (GST) in relation to categories A, B & C (above).

In relation to categories A, B & C above the fees/charges set by NSW Health that are taxable supplies or that Health Services are to consider for GST implications are as follows:

- Where revenue derived from the preparation of Clinical Reports is in the context of the Medical Officers Rights of Private Practice the service is to be regarded as a taxable supply.
- Where the income derived is treated as public hospital revenue, consideration is to be given as to whether it satisfies GST-free status under section 38-250 of the '*A New Tax System (Goods and Services Tax) Act 1999*' (*GST Act*).
  ie. Supplies are GST-free if:-
  - the charge is less than 50% of the GST inclusive market value of the supply; or
  - the charge is less than 75% of the cost to the supplier of providing the supply.
- NB. Further details are contained in section 3.3 (pages 22 to 24) of the "NSW Health - Finance and Commercial Services - Tax Reform - GST Manual" which is available on the NSW Health Intranet.
- All Area Heath Services need to ensure that documentation/systems exist to compare the costs (including overheads) of providing health records and medical reports, and being able to assess the GST status as detailed above.
- Where the service is determined as being 'GST-free' the rates advised by Information Bulletin apply,
  or
- Where the GST free test is not satisfied the service is therefore a taxable supply (subject to GST) and the rates advised by Information Bulletin are to be grossed-up by 10%.

D HEALTH RECORDS REQUIRED TO BE PRODUCED BY SUBPOENA

This refers to the retrieval of all the information required by the schedule noted on the subpoena and forwarding it to Court.

Charges apply based on the following:

1. where at least 5 working days notice is given for the production of the record to Court
2. where less than 5 working days notice is given

plus a photocopying charge per page as advised by Information bulletin.

- Multiple requests on a subpoena should be charged on a fee-per-patient basis.
- In a situation where no record is found, it is appropriate to raise a Search Fee for each record, particularly in situations where incorrect details are given or "blanket" subpoenas are issued and considerable time is spent in locating the record. However, if the PMI or other indexes shows that the patient was treated in that health institution but the record cannot be found because it has been destroyed, misplaced or lost, the search fee should not be charged.
- Charges under this category are not subject to GST as they are **'out of scope'** under a Division 81 Determination.
- Reference should also be made to **PD2010_065** headed 'Subpoenas', which outlines legislative provisions and procedures to be followed when public health organisations are required to produce documents on subpoena.

E ADMINISTRATIVE PROCEDURES

1 Policies and procedures regarding access to health records and disclosure of personal information should be made in accordance with the NSW Health Privacy Manual Version 2.

2 Applicants should be asked to put all requests in writing and to provide as much information as possible. A patient's solicitor should include consent by the patient for access to personal records as detailed in the Information Privacy Code of Practice.

3 Where the original of a health institution's health record leaves the institution (eg health records being tendered to a Court under subpoena), a copy of those records should generally be made beforehand and kept in the institution. Charges for photocopying should be charged at the appropriate per page rate as advised by Information Bulletin. This charge does not apply to Coroner's or Complaints Unit cases.

4 Charges should be collected in advance, where appropriate. For government departments, reimbursement may be sought subsequently from the relevant department or authority. Even where health records are required to be produced by subpoena, payment should still be sought in advance. It is emphasised that a hospital or organisation is expected to comply in due time with the requirements of a subpoena. Non-compliance may result in contempt of Court, which is punishable by fine or in certain cases imprisonment.

5 It may be decided that an examination of the patient (by either the treating medical practitioner or a medical practitioner who has not previously treated the patient) is required. Under such circumstances, the applicant should be asked to pay the balance of the money for the higher fee before proceeding with the request.

6 Fees collected are to be recorded as revenue in the General Fund.

7 Where there are disputes regarding fees or the amount of information, attempts should be made to resolve the matter between the parties involved. This would normally involve the Chief Health Information Manager and/or the General/Medical administration of the health facility.

F CIRCUMSTANCES UNDER WHICH A CHARGE SHOULD NOT BE RAISED

1 When the request has been made by a party concerned only with the patient's continued treatment and/or future management, no charge should be raised (eg where a medical practitioner requests information from a health institution to assist him/her with that patient's treatment);

2 The GIO or EML as Managers, Treasury Managed Fund or solicitors acting for the GIO or EML in such matters, in respect of claims for workers compensation for employees of Public Hospitals, Public Psychiatric Hospitals (former 5th schedule hospitals), the NSW Ambulance Service and the NSW Department of Health. Health facilities should ensure that solicitors acting for the GIO or EML specify in writing that this is the case;

3 Medical Services Committees of Inquiry established by the Commonwealth Government for purposes of detecting fraud and controlling over servicing;

4 The Department of Community Services or the Police in respect of children suspected of being abused, or of a parent of a child so suspected;

5 The completion of medical certificates at the time of consultation - no charge should be made as the forms for motor accident and WorkCover certificates are in the nature of a certificate and not a report. If not completed at the time of consultation, a search fee may be raised.

G CIRCUMSTANCES UNDER WHICH CHARGES SHOULD BE RAISED

In all cases where the conditions in Section F have not been met including:

1 When medical reports/records are requested by individuals, solicitors, insurance companies, health professionals and government departments (with the exception of those indicated in Section F) for purposes other than the patient's continued treatment or future management.

2 The Department of Veterans' Affairs and Centrelink for the purpose of pension/benefits assessment;

3 Interstate Health Authorities in respect of the eligibility of candidates for appointment to the relevant Public Service.

4 NSW Compulsory Third Party Insurers, in respect of a "Summary of Injuries". (Refer to Section C).

5 Release of information under the NSW *Adoption Information Act 1990*. Charges should be raised in accordance with PD2016_036 or any document subsequently amending its provisions.

ENQUIRIES

- pertaining to the **level of charges and GST implications** refer to the latest Information Bulletin on 'Charges for Health Records and Medical/Clinical Reports and the "NSW Health - Finance and Commercial Services - Tax Reform - GST Manual" (available on the NSW Health Intranet site) respectively or contact Trevor Smith, Finance and Business Management on (02) 9391 9158.
- pertaining to **access of information** refer to Privacy Manual for Health Information (March 2015), or contact Legal Branch on 9391 9606.
- pertaining to **records management policy** should be referred to the Informatics Senior Project Officer on (02) 9391 9155.

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Health Records and Medical/Clinical Reports rates and Fees for Cremation Certificates Issued by Salaried Medical Practitioners of Public Hospital are advised annually by Information Bulletin. Refer to the Policy Distribution System for the latest Information Bulletins. https://www.health.nsw.gov.au/policies/Pages/default.aspx

CONSENT TO MEDICAL AND HEALTHCARE TREATMENT (IB2020_010)

IB2020_010 rescinds PD2005_406

PURPOSE

The purpose of this Information Bulletin is to advise of the release of the *Consent to Medical and Healthcare Treatment Manual.*

KEY INFORMATION

An electronic version of the Manual can be found on the health website at:
https://www.health.nsw.gov.au/policies/manuals/Pages/consent-manual.aspx

The Consent Manual replaces PD2005_406 *Consent to Medical Treatment – Patient Information. (***Note***:* PD2005_406 is rescinded).

The Consent Manual provides operational guidance and procedures to support compliance with the NSW law on obtaining consent to medical and healthcare treatment from patients or their substitute consent providers. It incorporates the following changes:

- Amendments to the *Mental Health Act 2007* including the removal of concept of' primary carers' and the introduction of 'designated carers' and 'principal care providers'
- Amendments to the *Health Records and Information Privacy Act 2002* regarding the disclosure of genetic information to affected relatives
- Clarification that 'mature minors' can consent to or refuse their own treatment, and the circumstances where these decisions can be overridden
- Guidance for Health Practitioners when patients refuse recommended medical treatment in an obstetric setting
- Guidance for Health Practitioners when patients or their parents/guardians seek discharge against medical advice
- Additional information on electronic capture of consent
- Six new state wide consent forms.

The Consent manual is to be implemented by all NSW Health Agencies

327(30/03/20)

ADULT-TO-ADULT LIVING DONOR LIVER TRANSPLANTATION GUIDELINES (GL2008_019)

The purpose of the guideline is to provide guidance to health professionals and additional protection for prospective adult Living Donor Liver Transplantation (LDLT) donors. This guideline is aimed primarily at the jurisdictions that will endorse LDLT, the institutions that will provide LDLT, and the health professionals directly involved in this practice. To the extent that it is adopted by all jurisdictions in line with the particular requirements of their human tissue legislation, and applied in participating liver transplant units, it will promote ethical, lawful and consistent application of quality processes in provision of this complex procedure to donors, recipients and their families.

It should be read in conjunction with **PD2005_406**.

The document can be accessed at: http://www.health.nsw.gov.au/policies/gl/2008/GL2008_019.html

NOTIFICATION OF INFECTIOUS DISEASES UNDER THE *PUBLIC HEALTH ACT 2010* (IB2013_010)

IB2013_010 rescinds IB2012_011.

PURPOSE

Under the provisions of the *Public Health Act 2010* and the *Public Health Regulation 2012*, doctors, hospital chief executive officers (or general managers), pathology laboratories, directors of child care centres and school principals are required to notify certain medical conditions listed on the Ministry of Health website.

NOTIFICATION MECHANISMS

- Infectious disease notifications should be directed to the local Public Health Unit, and should be initiated as soon as possible within 24 hours of diagnosis.
- In order to protect patient confidentiality, notifications must not be made by facsimile machine except in exceptional circumstances and when confidentiality is ensured.
- Disease notification guidelines for notifiers are available at: **www.health.nsw.gov.au/Infectious/Pages/notification.aspx**

NOTIFICATION FORMS

Doctors and Hospitals

- Doctors and hospital chief executive officers (or general managers) must notify scheduled medical conditions and provide information specified in the **Doctor/Hospital Notification Form**, either by telephone or in writing. The notification can be found at: **http://www.health.nsw.gov.au/Infectious/Documents/doctor-hospital-notification-form.pdf**
- Notifications for AIDS must only include the first 2 letters of the patient's first and last names, and date of birth. Full name and addresses are not to be included.
- The **AIDS Notification Form** can be found at: **http://www.health.nsw.gov.au/Infectious/Documents/aids_notification_form.pdf**

Laboratories

- Laboratories must notify scheduled medical conditions and provide information specified in the **Laboratory Notification Form**, either by telephone or in writing.
- The laboratory notification form can be found at: **http://www.health.nsw.gov.au/Infectious/Documents/ph_labs2010b.pdf**
- Notifications for HIV infection should only include the first 2 letters of the patient's first and last names, and date of birth. Full name and addresses are not to be included.
- Laboratories carrying out confirmatory testing for HIV must notify infections directly to Communicable Diseases Branch. The **HIV notification form** can be found at: **http://www.health.nsw.gov.au/Infectious/Forms/hiv-notification-form.pdf**

NSW PERINATAL DATA COLLECTION (PDC) - REPORTING AND SUBMISSION REQUIREMENTS FROM 1 JANUARY 2016 (PD2015_025)

PD2015_025 rescinds PD2010_072.

PURPOSE

This Policy Directive is effective from 1 January 2016. It covers reporting and submission requirements for the Perinatal Data Collection (PDC), which is used for statewide surveillance to monitor patterns of pregnancy care, and maternal and newborn outcomes and to support national and state reporting obligations.

MANDATORY REQUIREMENTS

This policy applies to all midwives and doctors working in public and/or private facilities where a birth occurs. Reporting of all births in NSW to the PDC is a statutory requirement under the NSW *Public Health Act 2010*.

A PDC record must be completed for all births in NSW, including live born babies regardless of gestational age or birth weight, and stillborn babies of at least twenty (20) weeks gestation OR four hundred (400) grams birth weight. In the case of multiple births, a separate record must be completed in full for each baby.

From 1 January 2016 all records must be submitted in accordance with the timeframes described in section 1.3 of the following *Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures*.

Section 3 of the following *Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures* details the data items to be reported. Section 5 details the mandatory security requirements for data management.

IMPLEMENTATION

Chief Executives of LHDs and General Managers of Private Hospitals are to ensure:

- This policy directive is distributed to all staff involved in collecting and supplying data for the PDC. This includes staff of obstetric and neonatal units, medical record and information services staff.
- Staff have access to electronic systems able to collect the data items in accordance with Section 3 of the following *Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures* by 1 January 2016.
- Data collected in accordance with the statutory requirement and this policy directive is submitted in compliance to the schedule provided in the form required for submission.

1. BACKGROUND

1.1 About this document

From 1 January 2016, this Policy Directive rescinds and replaces Policy Directive PD2010_072 concerning the NSW Perinatal Data Collection. This Policy Directive applies to reporting of births to the NSW Perinatal Data Collection (PDC) from 1 January 2016.

The Perinatal Data Collection (PDC) is used for statewide surveillance, monitoring patterns of pregnancy care, and maternal and newborn outcomes and to support national and state reporting obligations.

1.2 Key definitions

PDC records must be completed for **all births in NSW**, including live born babies regardless of gestational age or birth weight and stillborn babies of at least twenty (20) weeks gestation OR four hundred (400) grams birth weight. In the case of multiple births, a separate record must be completed in full for each baby.

1.3 Legal and legislative framework

Reporting of all births in NSW is a requirement of the NSW *Public Health Act 2010*. A record for each birth occurring within a Collection Period Quarter must be reported no later than three months after the close of the quarter, based on the date of birth of the baby. The following table lists the due dates for submission of PDC data:

Collection Period	Last Date for Data Submission in Collection Period	Deadline for Correction and Resubmission
Quarter 1 (1 Jan - 31 Mar)	30 June	11 August
Quarter 2 (1 Apr - 30 Jun)	30 September	11 November
Quarter 3 (1 Jul - 30 Sep)	31 December	11 February (following year)
Quarter 4 (1 Oct - 31 Dec)	31 March (the following year)	12 May

Any errors detected in submitted data are to be corrected and resubmitted **within 6 weeks of the date of final data submission**.

It should be noted that the table above shows the last acceptable date for initial data submission. Data may be supplied and accepted on a more frequent basis (eg weekly or monthly) to allow suppliers to obtain more timely feedback on the quality of births data that may better suit the operational processes of the supplier.

It is intended that the Collection Period and final date will be reduced in subsequent collection years and appropriate advice on the applicable Collection Periods will be published.

2. METHOD OF REPORTING

For births on or after 1 January 2016 PDC records must be submitted electronically in the form specified. The method of submission of PDC records is dependent on the type of collection/ submission entity as follows:

- Public Hospitals with maternity units are to submit records directly to EDWARD using a data extract from their maternity information system.
- Private Hospitals are to submit data to PeriPH. PeriPH will apply further processing prior to sending PDC records to EDWARD.
- Independent Midwives will submit data by direct data entry via a secure web-based form (PeriForm). This data, after processing, will be sent to EDWARD. Hospitals without maternity units will be able to utilise PeriForm to submit records for the individual births they manage.

EDWARD will hold the consolidated PDC data for births occurring on or after 1 January 2016.

While the required PDC data is constant, the receipt and processing platform will determine some differences in the extract format.

Paper forms will not be accepted or processed by the Ministry for any births on or after 1 January 2016.

3. DATA ITEMS TO BE REPORTED

3.1 Overview

This section lists the data that must be reported. Details of each of the items, including definitions, reportable values and guide for collection and use are provided in the PDC 2016 Data Dictionary.

As the data are submitted through different mechanisms and from different sources the requirements differ. The tables below specify the data to be reported by collection entity.

Y Required to be reported
n/a Not Applicable for the collection entity

3.2 Perinatal Data Provider

Item	Public Hospital	Private Hospital	Independent Midwife
Perinatal notifier identifier	Y	Y	Y
Perinatal notifier type code	Y	n/a	n/a

3.3 Mother Details

Item	Public Hospital	Private Hospital	Independent Midwife
Mother Client ID (medical record number or other defined identifier)	Y	Y	n/a
Given name	Y	Y	Y
Middle names	Y	Y	Y
Family name	Y	Y	Y
Full address of residence (including street number and name, locality, postcode and state/territory)	Y	Y	Y
Country of residence	Y	Y	Y
Country of birth	Y	Y	Y
Date of birth	Y	Y	Y
Indigenous status	Y	Y	Y

3.4 Newborn Details

Item	Public Hospital	Private Hospital	Independent Midwife
Newborn Client ID (medical record number or other defined identifier)	Y	Y	n/a
Given name	Y	Y	Y
Middle names	Y	Y	Y
Family name	Y	Y	Y
Indigenous status	Y	Y	Y
Baby birth date	Y	Y	Y
Baby birth status (livebirth/stillbirth)	Y	Y	Y
Sex	Y	Y	Y
Plurality	Y	Y	Y
Birth order	Y	Y	Y
Birth weight	Y	Y	Y
Estimated gestational age	Y	Y	Y
Apgar score at 1 and at 5 minutes	Y	Y	Y
Baby resuscitation type	Y	Y	Y

3.5 Pregnancy Details

Item	Public Hospital	Private Hospital	Independent Midwife
Previous pregnancy indicator	Y	Y	Y
Previous pregnancies count	Y	Y	Y
Last birth by caesarean section indicator	Y	Y	Y
Previous caesarean section count	Y	Y	Y
Mother's height (cm)	Y	Y	Y
Mother's weight (kg)	Y	Y	Y
Antenatal estimated date of birth	Y	Y	Y
Antenatal care received indicator	Y	Y	Y
Pregnancy duration at 1st antenatal care	Y	Y	Y
Number of antenatal visits (Antenatal service contact count)	Y	Y	Y
Mother tested for HIV Flag	Y	Y	Y
Mother immunised against pertussis in this pregnancy	Y	Y	Y
Mother immunised against influenza in this pregnancy	Y	Y	Y
Mother diabetes type	Y	Y	Y
Mother chronic hypertension flag	Y	Y	Y
Mother preeclampsia flag	Y	Y	Y
Mother gestational hypertension	Y	Y	Y
Mother eclampsia flag	Y	Y	Y
Hepatitis B surface antigen positive	Y	Y	Y
Smoking in first half of pregnancy	Y	Y	Y
Average number of daily cigarettes smoked in first half of pregnancy	Y	Y	Y
Smoking in second half of pregnancy	Y	Y	Y
Average number of daily cigarettes smoked in second half of pregnancy	Y	Y	Y
Quit smoking in this pregnancy	Y	Y	Y
If quit smoking in this pregnancy, at what gestation week?	Y	Y	Y

3.6 Labour and Delivery

Item	Public Hospital	Private Hospital	Independent Midwife
Labour onset type	Y	Y	Y
Labour induced with oxytocins	Y	Y	Y
Labour induced with prostaglandins	Y	Y	Y
Labour induced by artificial rupture of membranes	Y	Y	Y
Labour induced by other means	Y	Y	Y
Main indication for induction of labour	Y	Y	Y
Labour augmented with oxytocins	Y	Y	Y
Labour augmented by artificial rupture of membranes	Y	Y	Y
Presentation at birth	Y	Y	Y
Analgesia provided in labour – various types	Y	Y	Y
Type of birth	Y	Y	Y
Main indication for caesarean section	Y	Y	Y
Anaesthesia provided during delivery – various types	Y	Y	Y
Perineal status	Y	Y	Y
Episiotomy indicator	Y	Y	Y
Surgical repair of the vagina or perineum	Y	Y	Y
Management type applied in 3rd stage	Y	Y	Y

3.7 Maternity Care

Item	Public Hospital	Private Hospital	Independent Midwife
Model of care during pregnancy	Y	Y	Y
Model of care at birth	Y	Y	Y
Place of birth	Y	Y	Y

3.8 Postnatal Care

Item	Public Hospital	Private Hospital	Independent Midwife
Postpartum haemorrhage within 24 hours of birth	Y	Y	Y
Postpartum haemorrhage within 24 hours of birth requiring blood transfusion	Y	Y	Y
Postpartum haemorrhage within 24 hours of birth – estimated blood loss	Y	Y	Y
Congenital condition present flag	Y	Y	Y
Congenital condition(s) description	Y	Y	Y
Newborn hepatitis B birth dose	Y	Y	Y

3.9 Discharge status of mother and baby

Item	Public Hospital	Private Hospital	Independent Midwife
Discharge status of mother	Y	Y	Y
Mother's date/time of discharge or transfer	Y	Y	Y
Hospital mother transferred to	Y	Y	Y
Discharge status of baby	Y	Y	Y
Baby's date/time of discharge or transfer	Y	Y	Y
Hospital baby was transferred to	Y	Y	Y
Baby feeding on discharge (various)	Y	Y	Y

3.10 System and Service event details

Item	Public Hospital	Private Hospital	Independent Midwife
Mother client identifier – issuing authority	Y	n/a	n/a
Mother client identifier type code	Y	n/a	n/a
Mother service encounter record identifier	Y	n/a	n/a
Mother service event record identifier	Y	n/a	n/a
Mother service event source identifier	Y	n/a	n/a
Mother service event type code	Y	n/a	n/a
Newborn client identifier – issuing authority	Y	n/a	n/a
Newborn client identifier type code	Y	n/a	n/a
Newborn service encounter record identifier	Y	n/a	n/a
Newborn service event record identifier	Y	n/a	n/a
Newborn service event source identifier	Y	n/a	n/a
Newborn service event type code	Y	n/a	n/a
Perinatal birth record identifier	Y	Y	n/a
Perinatal pregnancy record identifier	Y	Y	n/a
Perinatal record source identifier	Y	n/a	n/a
Source create date and time	Y	n/a	n/a
Source modified date and time	Y	n/a	n/a
Perinatal record action type	Y	Y	n/a

4. DATA QUALITY

Data quality checks are made to ensure that all data submitted is compliant with the PDC as specified by the PDC 2016 Data Dictionary. Checks are made as the data is submitted to PeriPH or EDWARD or entered via PeriForm.

Incomplete records or records with errors will be identified and an error report made available to the submitting hospital. These records must be corrected and re-submitted by the reporting entity within the time stipulated (i.e. within 6 weeks of the date of final data submission).

In order to validate the enumeration of births for each calendar year a list of reported births are sent to each hospital and is to be validated against the hospital birth register.

5. SECURITY OF DATA

The Privacy Manual for Health Information (March 2015) and the Privacy Management Plan (Policy Directive PD2015_036) must be observed for all data relating to the PDC.

Public hospitals with maternity units will submit data to EDWARD from behind the electronic security framework of NSW Health. Files must be directed to the location specified in the EDWARD Perinatal Interface Documentation (refer to supporting documents).

Private hospital users require an authorised user account to access and submit data to PeriPH.

Independent midwives (and users from hospitals without maternity units) require an authorised user account to access and submit data via the secure online PeriForm.

To apply for authorised access to PeriPH and PeriForm contact the Data Integrity Officer in Health Systems Information and Performance Reporting Branch, NSW Ministry of Health.

6. PDC INFORMATION – ACCESS AND DISSEMINATION

Information collected by the PDC is used for the following purposes:

- State wide surveillance to monitor patterns of care for mothers and babies, and outcomes of care. Summary information for NSW is published annually on HealthStats NSW at: http://www.healthstats.nsw.gov.au/
- Planning, monitoring and evaluation of maternity services by the Ministry of Health and Local Health Districts.
- De-identified unit record data are provided to the AIHW National Perinatal Statistics Unit for inclusion in the National Perinatal Data Collection.
- De-identified data and summary data are provided to the NSW Ombudsman to support the work of the NSW Child Death Review Team.
- Research purposes with the approval of a human research ethics committee.

PDC data may be accessed in the following ways:

- De-identified unit record data may be obtained via Secure Analytics for Population Health Research and Intelligence (SAPHaRI), which is the NSW Ministry of Health population health data warehouse, analysis and reporting system. SAPHaRI is administered by the Centre for Epidemiology and Evidence, and is accessible by staff of the NSW Ministry of Health and public health services subject to signing of a confidentiality agreement.
- Access to de-identified PDC unit record data for research purposes may also be sought by written request to the Executive Director, Centre for Epidemiology and Research.

7. GLOSSARY

Term/Acronym	Definition
AIHW	Australian Institute of Health and Welfare
EDWARD	NSW Health's Enterprise Data Warehouse for Analysis, Reporting and Decision Support.
PDC	Perinatal Data Collection
PeriForm	A secure online form to allow the entry and submission of individual PDC records
PeriPH	The application and data base to be used by private facilities for the submission and data quality checks for PDC records

8. FURTHER INFORMATION

Detailed information on the PDC data items, codes and guidance on completion of each data item is contained in the *New South Wales Perinatal Data Collection Data Dictionary 2016.*

Further information concerning the collection and submission of PDC data is available on the NSW Health Intranet from the following URL:

http://internal.health.nsw.gov.au/data/collections/pdc/index.html

Including links to the following resources:

- Data Dictionary – EDWARD Data Stream – Perinatal Notification
- Perinatal Data Collection Classification Changes Effective From 1 January 2016 Information Bulletin
- EDWARD Interface Requirements Specification for File Based Extracts – Perinatal Notification Data Stream
- Data Dictionary EDWARD Control and Audit Data Dictionary (excluding data error concepts)
- PeriPH data submission format specification

- Perinatal Data Set Specification 2015-16 (AIHW; Nov., 2014; http://meteor.aihw.gov.au/content/index.phtml/itemId/581388)
- Perinatal NMDS 2014- (AIHW; March, 2014; http://meteor.aihw.gov.au/content/index.phtml/itemId/517456).

For further information about this policy directive or the PDC, contact:

Komala Goutham
Data Integrity Officer
Information Management and Quality Unit
Health System Information and Performance Reporting Branch
NSW Ministry of Health
Phone: 02 9391 9613
E-mail: kgout@doh.health.nsw.gov.au

NSW REGISTER OF CONGENITAL CONDITIONS – REPORTING REQUIREMENTS (PD2018_006)

PD2018_006 rescinds PD2012_055

PURPOSE

This Policy Directive provides guidance to NSW Health staff on the procedure to be followed for the reporting of congenital conditions to the NSW Register of Congenital Conditions.

MANDATORY REQUIREMENTS

All hospitals must notify the Register of Congenital Conditions (the Register) of scheduled congenital conditions detected in a fetus during pregnancy or in a child up to one year of age. This includes staff of obstetrics, neonatal and paediatric units, prenatal genetic services for chromosomal and DNA testing, feto-maternal units and anatomical pathology departments.

This Policy Directive outlines the process for submitting paper and electronic notifications to the Ministry of Health, and presents information on data quality, security, access and dissemination. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

IMPLEMENTATION

This Policy Directive should be distributed to all LHD staff. Staff involved in the identification of scheduled congenital conditions during pregnancy or the post-natal period must follow the procedure set out in this policy directive.

BACKGROUND

About this document

All hospitals must notify the Register of Congenital Conditions (the Register) of scheduled congenital conditions detected in a fetus during pregnancy or in a child up to one year of age. This includes staff of obstetrics, neonatal and paediatric units, prenatal genetic services for chromosomal and DNA testing, feto-maternal units and anatomical pathology departments.

The Register is located in the Centre for Epidemiology and Evidence of the NSW Ministry of Health. Information from the Register is used to monitor the occurrence of congenital conditions for service planning purposes and to identify changes in incidence that may warrant investigation.

Key definitions for scheduled congenital conditions

The Register is a state wide surveillance system that monitors the occurrence of scheduled congenital conditions to plan services for affected families, and identify changes in incidence that may warrant investigation.

Scheduled congenital conditions include:

1. All structural malformations. Examples include spina bifida, microcephaly, transposition of the great vessels, ventricular septal defects, pulmonary agenesis, polycystic lungs, duodenal atresia, exomphalos, hypospadias, cleft lip/palate, microphthalmia, limb reductions, polydactyly, birthmarks greater than 4cm diameter, cystic hygroma and multisystem syndromes including at least one structural malformation.
2. Chromosomal abnormalities. Examples include Down syndrome and unbalanced translocations.
3. Four medical conditions: cystic fibrosis, phenylketonuria, congenital hypothyroidism and thalassaemia major.

Congenital conditions that are not notifiable include:

1. Minor anomalies occurring in isolation.

   Examples of minor anomalies include skin tags, deviated nasal septum, tongue tie, benign heart murmurs, clicky non-dislocating hips, sacral dimples, positional talipes, abnormal palmar creases, and dysmorphic features.

2. Birth injuries.
3. Congenital infections which do not result in a structural malformation.
4. Tumours and cysts.
5. Conditions arising from prematurity or asphyxiation.

Legal and legislative framework

Congenital conditions occurring in a child under one year of age or pregnancies where the fetus has a congenital condition are required to be reported under the NSW Public Health Act 2010.

REPORTING METHOD

Notification types

1. *Notification of a scheduled congenital condition diagnosed in an infant*
   Information in this format should be supplied for congenital conditions detected in stillborn babies or live born babies up to one year of age.
2. *Notification of a scheduled congenital condition diagnosed by prenatal diagnosis*
   Information in this format should be supplied for congenital conditions detected in the fetus during pregnancy, regardless of whether the pregnancy continues.

Guidelines for notification are printed on the outside cover of each notification pad.

In the case of a multiple pregnancy or multiple birth where both babies are affected, a separate form or electronic record must be completed in full for each fetus or baby.

Methods of notification

Information may be supplied in paper or electronic format.

Paper notifications

For submission on paper forms, forms are provided in triplicate with the original sent to the NSW Ministry of Health, one copy for the hospital medical record and one copy for the parent or family. Information for parents and families concerning the Register is printed on the reverse side of the Parent Copy of both notification forms.

Paper notifications should be mailed to:

The NSW Register of Congenital Conditions
Centre for Epidemiology and Evidence
Level 7
NSW Ministry of Health
Locked Mail Bag 961
North Sydney NSW 2059

Electronic notifications

Electronic notifications of scheduled congenital conditions can be facilitated via a hospital's Maternity Information System – the electronic system that captures birth notifications from hospitals. Notifications should be entered immediately following diagnosis. Notifications should be sent to the Ministry of Health on at least a quarterly basis. For facilities interested in submitting notifications electronically, please contact: roccadmin@moh.health.nsw.gov.au.

Information to be notified

Demographic details (mother)
First name
Last name
Date of birth
Hospital medical record number or laboratory number
Residential address
Country of birth
Indigenous status (mother)
Demographic details (live born or stillborn baby)
First name
Last name
Date of birth
Hospital medical record number or laboratory number
Hospital of birth
Sex
Indigenous status (baby)
Plurality
Baby number
Birth weight
Gestation
Outcome
Autopsy/histopathology
Date of death
Pregnancy details (where applicable)
Indication for prenatal diagnosis
Type of prenatal diagnosis
Date of last menstrual period
Relevant medical or family history
Congenital abnormality/syndrome
Diagnosis
Laterality
Date of Diagnosis
Karyotype – balanced, unbalanced

DATA QUALITY

Data submitted to the Register is checked for any discrepancies and further information is requested from the hospital or reporting clinician if information received is inconsistent or incomplete.

DATA SECURITY

Data collected by the Register is protected under the NSW Public Health Act 2010.
The NSW Health Privacy Manual for Health Information (previously known as the NSW Health Privacy Manual) must be observed for all data relating to the Register. This is located at:
http://www.health.nsw.gov.au/policies/manuals/Pages/privacy-manual-for-health-information.aspx.

The Register database is held on the NSW Ministry of Health's local area network, is password protected and is accessible only to the Register staff.
Paper forms submitted to the Register are securely stored and are destroyed no more than five years after the year of birth or completion of the pregnancy.
Personal identifiers (name, residential street number and name, and medical record number) are removed from the database five years after the year of birth or completion of the pregnancy.

DATA ACCESS AND DISSEMINATION

Information obtained from the Register is made available on request. Specific analyses of Register data, or access to unit record data from the Register, may be obtained on written request to the Executive Director, Centre for Epidemiology and Evidence (email: ceemail@moh.health.nsw.gov.au).

CONTACT INFORMATION

For further information about the Register of Congenital Conditions, or this Policy Directive, please contact: roccadmin@moh.health.nsw.gov.au.

NOTIFYING CANCER-RELATED DATA TO THE NSW CANCER REGISTRY (PD2022_008)

PD2022_008 rescinds PD2009_012

POLICY STATEMENT

NSW Health is committed to reducing the burden of cancer in the NSW population and will do this by continuing to capture cancer-related data into the NSW Cancer Registry.

The data captured will be used to report on incidence and mortality from cancer and support programs that utilise the data to reduce incidence and improve outcomes for people diagnosed and treated for cancer.

SUMMARY OF POLICY REQUIREMENTS

This Policy Directive outlines the requirements for submitting notifications to the NSW Cancer Registry and presents information on data quality, security, access, and dissemination.

Under the provisions of the Public Health Act 2010 and the Public Health Regulation 2012, public and private sector admitted and non-admitted patient facilities, and pathology laboratories are required to notify the NSW Cancer Registry of all cancer cases.

Under these same provisions, the registrar of births, deaths, and marriages is required to notify the NSW Cancer Registry of deaths due to cancer.

The provisions of the Cancer Institute (NSW) Act 2003 also allow for the NSW Cancer Registry to request and collect clinical data relating to cancer treatment from any facility providing care to cancer patients in NSW.

All data submitted to the NSW Cancer Registry undergo a series of quality checks and validations. If data quality issues are detected that require resolution at the source, an error report is generated and sent to the notifier.

The procedures outlined in the NSW Health privacy manual for health information and the Cancer Institute NSW Data Governance Policy are adhered to by NSW Cancer Registry staff in order to ensure that appropriate data security and governance safeguards are in place.

Data held within the NSW Cancer Registry can be used to support the functions of the Cancer Institute NSW:

- Monitor and record the number of new cases of notifiable cancers and deaths due to notifiable cancers in NSW;
- Produce regular and ad hoc reports on cancer incidence, treatment patterns, mortality, and survival;
- Evaluate the effectiveness of cancer screening programs;
- Assist in planning and monitoring services for cancer control and the care of cancer patients;
- Contribute cancer data to national and international agencies to assist in cancer
- control.

- Review adherence to best practice guidelines and optimal care pathways
- Assist in development and implementation of culturally safe cancer care for Aboriginal people across the optimal care pathways
- Review treatment outcomes of standards of care and also review clinical trial outcomes when transitioned into best practice care for a wider cohort.
- Inform reporting which supports quality improvements in cancer care.

Notifying Cancer-Related Data to the NSW Cancer Registry: Procedures

1 BACKGROUND

1.1 About this document

Under the provisions of the Public Health Act 2010 and the Public Health Regulation 2012, public and private sector admitted and non-admitted patient facilities, and pathology laboratories are required to notify the NSW Cancer Registry of all cancer cases.

Under these same provisions, the registrar of births, deaths, and marriages is required to notify the NSW Cancer Registry of deaths due to cancer.

The provisions of the Cancer Institute (NSW) Act 2003 also allow for the NSW Cancer Registry to request and collect clinical data relating to cancer treatment from any facility providing care to cancer patients in NSW.

1.2 Key definitions

Aboriginal person

An 'Aboriginal person' is a person who:

- is of Aboriginal descent
- identifies as an Aboriginal person and
- is accepted as an Aboriginal person by the community in which they live.

Active treatment

A clinical treatment intervention for a specific cancer at a single point in time where the cancer is the principal or an additional diagnosis for the episode of care. Active treatment refers to those under acute or palliative care.

Admitted patient

A person provided a health care service by a hospital, day procedure centre or multipurpose service on an admitted patient basis.

Cancer

Cancer is a Category 3 Scheduled medical condition and is also a notifiable disease under Schedule 2 of the Public Health Act 2010. This document provides guidance regarding the procedures to be followed for the reporting of cancer-related data to the NSW Cancer Registry.

Data custodian

The data custodian is incumbent to the position responsible for day-to-day management and oversight of the data asset, approval of access to data, and the overall quality and security of the data asset.

Non-admitted patient

A person provided a health care service by a hospital, day procedure centre or multipurpose service on a non-admitted patient basis.

Notifiable diseases

A medical condition listed under Schedule 2 of the Public Health Act 2010 (NSW)

Palliative treatment

Treatment aimed at providing pain and symptom relief in order to improve the patient's quality of life

Pathology laboratory

A Pathology Laboratory is a Laboratory where tests are carried out on clinical specimens to obtain information about the health of a patient to aid in diagnosis, treatment, and prevention of disease.

Note: In NSW pathology laboratories include services provided by Pathology NSW, Institute of Forensic Medicine, NSW private sector pathology services providers and interstate pathology laboratories.

Radiology services

Any accredited premises in which radiology services are provided within NSW to diagnose or stage a notifiable cancer or response to cancer treatment, or where interventional radiology treatments for cancer are provided.

Scheduled condition

A medical condition listed under Schedule 1 of the Public Health Act 2010 (NSW).

Tabulated data

Summary data produced from analyses of unit record data using broad categories (e.g. age group) and presented in a way that it is not possible to identify any individual.

Unit record data

Data relating to an individual person, which may be presented in an identified (containing identifying information such as name and address) or re-identifiable (identifying information removed) format

1.3 Legal and legislative framework

The Public Health Act 2010, Public Health Regulation 2012, and Cancer Institute (NSW) Act 2003 give authority to the Policy Directive relating to the collection of cancer-related data and the NSW Cancer Registry.

The Public Health Act 2010 outlines the mandatory requirement to notify cancer cases and cancer-related deaths to the NSW Cancer Registry and describes the penalties for non-compliance. The Cancer Institute (NSW) Act 2003 allows for clinical data relating to cancer treatment to be provided to the NSW Cancer Registry.

The Health Records and Information Privacy Act 2002 outlines the requirements for managing health information, including data collection, storage, use, disclosure, and retention.

The NSW Health Privacy Manual for Health Information provides information to these legislative obligations and outlines procedures to support compliance.

1.4 The NSW Cancer Registry

The NSW Cancer Registry, formerly known as the NSW Central Cancer Registry, is a population-based, central repository of data relating to cases of notifiable cancers, deaths due to notifiable cancers, and clinical treatment data for residents of NSW.
Data is also held in the NSW Cancer Registry for residents of other Australian states and territories who were diagnosed or treated for cancer in NSW. The NSW Cancer Registry also processes all notifications received for the ACT cancer registry.

The Cancer Institute NSW acts as the manager of the NSW Cancer Registry and custodian of the data held within the NSW Cancer Registry on behalf of the Secretary of the NSW Ministry of Health.

1.5 Aboriginal and Torres Strait Islanders

NSW Health Policy Directive *Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients* (PD2012_042) outlines the requirements for collecting and recording accurate information on whether clients of NSW Health services are Aboriginal and/or Torres Strait Islander.

Aboriginal and Torres Strait Islander people are under-reported in many health-related data collections in NSW. Self-report in response to the standard Australian Bureau of Statistics question about a person's Aboriginality is the most accurate means of ascertaining whether a client is Aboriginal and/or Torres Strait islander.

The standard question must be asked of all clients of NSW Health services, and the information needs to be recorded accurately according to national standards.

2 MANDATED NOTIFIERS

Sections 82 and 83 of the Public Health Act requires hospital Chief Executive Officers and medical practitioners to notify each case of cancer if they work for certain health entities including:

- Public hospitals within the meaning of the Health Services Act 1997
- Private health facilities, within the meaning of the Private Health Facilities Act 2007
- Any other types of institutions declared by the Public Health Act regulations to be a hospital.

Section 55 of the Public Health Act requires pathology laboratories to notify each case of cancer where the result for a pathology test for cancer, carried out at the request of health practitioner, is positive.

To meet the cancer notification requirements, the notification must be sent to the NSW Cancer Registry either via the NSW Health data warehouse (public hospitals only), or via direct submission in the prescribed format to the NSW Cancer Registry.

3 REPORTING METHODS

3.1 Incidence Cancer cases

Sections 55 and 83 of the Public Health Act 2010 and the Public Health Regulation 2012 requires chief executives of hospitals and laboratories operated by public sector or the private sector within NSW to notify each case of cancer to the NSW Cancer Registry. A separate notification is required for each primary site of cancer.

Lists of notifiable cancers and exclusion criteria can be found in Appendix 1 and 2.

3.1.1 Hospitals

For admitted patients, a cancer notification must be reported at each episode of care where a notifiable cancer is the principal or additional diagnosis and/or where active or palliative treatment has been provided. These notifications are to be provided within 6 weeks of the admission date.

For non-admitted patients, a cancer notification must be reported following a consultation where a diagnosis of a notifiable cancer is first diagnosed and notated in the patient's medical record and following the start of each course of treatment.

Complete and accurate notifications must be reported within 12 weeks of the consultation or course of treatment start date.
An episode of care refers to an admission, or a treatment sequence from commencement to completion (Course).

The data items to be provided may include, but are not limited to:	
Demographics	name, sex, address, date of birth, country of birth, Aboriginality status
Episode of care	facility ID, AMO/AHPRA registration number of treating clinician, admission date, separation date, status at separation
Diagnostic information	date of diagnosis, primary site, morphology, best basis of diagnosis

For an up-to-date list of notification data items please refer to the *current notification specification.*
NSW health public hospitals, multi-purpose services and affiliated health organisations are required to report cancer notifications through the NSW Health data warehouse via the admitted patient data collection extract formats, or the non-admitted patient and supplementary services data collection extract format.

The data extract requirements for reporting through the NSW data warehouse are issued by the Ministry of Health systems information and analytics branch. Requests for information can be sent to: MOH-SIA-HIE@health.nsw.gov.au

Where reporting cancer notifications via the NSW Health data warehouse has not been established cancer notifications must be submitted via data extracts sent directly to the NSW Cancer Registry. The extract requirements for these direct submissions are issued by the Cancer Institute NSW. Submissions must be made via the cancer notification portal.

Private sector hospitals must report cancer notifications directly to the NSW Cancer Registry either via the batch data extract format, or as individual notifications. These submissions must be made via the cancer notification portal..

3.1.2 Pathology laboratories

Public and private sector operated pathology laboratories are required to notify all cases reported as cancer, as well as benign and uncertain-behaviour neoplasms of the central nervous system, to the NSW Cancer Registry.

A pathology report with a confirmed diagnosis of cancer is regarded as the definitive source for determining a cancer case for NSW Cancer Registry. These notifications are to be provided within 6 weeks of the pathology collection date.

Pathology reports for the diagnosis of notifiable cancers may come from histopathology, cytology, cytogenetics, haematology, or molecular diagnostic tests.

The following qualifiers used in pathology reports are regarded as acceptable for a diagnosis of cancer:		
consistent with	compatible with	comparable with
diagnostic of	equivalent to/of	extension into
in keeping with	indicative of	invasion of
supports a diagnosis of	(the features) are those of	typical of

Pathology laboratories must provide a copy of each complete and final pathology report that confirms the diagnosis of a notifiable cancer or contributes to the staging or grading of a cancer and associated prognostic factors to the NSW Cancer Registry.

Supplementary reports detailing the results of additional tests and expert reviews, must also be provided, especially when the diagnosis has been revised to a benign condition.

Pathology laboratories can provide notifications in hard copy (paper format) or soft copy (Electronic Pathology Solution). Hard copy reports must be marked “Private and Confidential” and can be sent to the mailing address provided in Section 5.

3.2 Cancer deaths

Under the provisions of the Public Health Act 2010 and the Public Health Regulation 2012, the NSW Registrar of Births, Deaths, and Marriages is required to notify the NSW Cancer Registry of deaths due to notifiable cancers and the department of forensic medicine where cancer was an incidental finding at post-mortem. These notifications are to be provided within 6 weeks of the date of death or final determination of the cause of death.

The Australian Bureau of Statistics manages the collation of coded cause of death data from state and territory registrars and the National Coronial Information Service and the consolidated data are sought from the Australian Coordinating Registry (ACR) and provided to the NSW Cancer Registry.

Cancer death data and coded cause of death data are provided to the NSW Cancer Registry via encrypted electronic notification files. Aboriginal status must be recorded.

Lists of notifiable cancers and exclusion criteria can be found in Appendix 1 and 2.

3.3 Clinical data

The provisions within the Cancer Institute (NSW) Act 2003 allow the NSW Cancer Registry to request clinical data relating to cancer treatment from any facility providing treatment for cancers in NSW, including private sector health organisations.

The data that must be reported describes the clinical aspects treatments provided to patients with a notifiable cancer. The treatments include radiotherapy, systemic therapies, interventional radiology and other day procedures which aim to remove, control or prepare the cancer for further treatments, or to treat recurrent and metastatic disease.

Clinical data can be provided via extracts from electronic medical record systems used by oncology services or centralised data repositories, via electronic secure data transfer in the form prescribed by the Cancer Institute NSW. Clinical data must be reported within 12 weeks of treatment completion or cancellation, with a minimum frequency of quarterly supply.

Requests for the data extract format requirement specifications for each type of treatment, and details about the data submission process for clinical cancer treatment data, must be sent to CINSW- ClinicalData@health.nsw.gov.au.

4 DATA QUALITY

4.1 Errors

Staff at notifying facilities are to review notifications prior to submission and address any errors detected in source systems where possible.

All data submitted to the NSW Cancer Registry via any of the reporting mechanisms undergo a series of quality checks and validations. If data quality issues are detected that require resolution at the source, an error report is generated and sent to the notifier.

These error reports are to be checked and corrections made by the notifier within 10 working days.

4.2 Requests for further information

Where a notification is received for an equivocal or unconfirmed cancer diagnosis, further information may be requested before the case is registered. In these instances, the NSW Cancer Registry may contact the notifier, or any medical practitioner involved in the treatment of the person concerned to obtain clarification of test results or the results of any additional tests performed, as well as other information concerning the person's medical condition, transmission and risk factors.

It is a requirement that clarification or further information is provided upon request to NSW Cancer Registry staff. Responses to requests for further information are required within 10 working days.

5 DATA STORAGE AND SECURITY

NSW Cancer Registry data are stored on secure servers located on eHealth's infrastructure hosted in the GovDC with access restricted to authorised personnel only.

The procedures outlined in the NSW Health privacy manual for health information and the Cancer Institute NSW Data Governance Policy are adhered to by NSW Cancer Registry staff in order to ensure that appropriate data security and governance safeguards are in place.

6 DATA ACCESS AND DISSEMINATION

Data held within the NSW Cancer Registry can be used to support the functions of the Cancer Institute NSW:

- Monitor and record the number of new cases of notifiable cancers and deaths due to notifiable cancers in NSW;
- Produce regular and ad hoc reports on cancer incidence, treatment patterns, mortality, and survival;
- Evaluate the effectiveness of cancer screening programs;
- Assist in planning and monitoring services for cancer control and the care of cancer patients;

- Contribute cancer data to national and international agencies to assist in cancer control.
- Review adherence to best practice guidelines and optimal care pathways
- Assist in development and implementation of culturally safe cancer care for Aboriginal people across the optimal care pathways
- Review treatment outcomes of standards of care and also review clinical trial outcomes when transitioned into best practice care for a wider cohort.
- Inform reporting which supports quality improvements in cancer care.

Tabulated data from the NSW Cancer Registry can be made available upon request and may require approval from the data custodian.

Unit record data held within the NSW Cancer Registry can be utilised for epidemiological research upon approval from the data custodian, NSW population and health services research ethics committee, and the NSW Ministry of Health. Depending on the research question and data requested, additional ethics approvals may be required.

Further information on data access and the approvals required can be found at Cancer Institute NSW website.

7 CONTACT INFORMATION

Requests for further information about the mandatory reporting requirements of the NSW Cancer Registry must be directed to the cancer notifications manager, NSW Cancer Registry.

Requests for further information about the provision of clinical data related to cancer treatment must be directed to the manager, registries and data collection.

Contact details for the NSW Cancer Registry are provided below:	
Physical address	Cancer Institute NSW Level 4, 1 Reserve Road St Leonards NSW 2065
Secure postal address	Locked Bag 2011 St Leonards NSW 1590 Must be marked: “Private and Confidential”
Phone	(02) 8374 5749
Secure fax	(02) 8374 3644
Email	CINSW-CCR@health.nsw.gov.au
Website	https://www.cancer.nsw.gov.au/research-and-data/cancer-data-and-statistics/request-unlinked-unit-record-data-for-research/nsw-cancer-registry
Cancer Notification Portal email	CINSW-CNP@health.nsw.gov.au
Cancer Notification Portal website	https://cnp.cancer.nsw.gov.au/Account/Login
Clinical Data notification email	CINSW-ClinicalData@health.nsw.gov.au

APPENDIX LIST

1. List of notifiable cancers
2. Cancers to be excluded from notifications

APPENDIX LIST

Appendix 1: List of notifiable cancers

Description	ICD-10-AM 11th Edition ([1])	
	Topography	Morphology
Human immunodeficiency virus (HIV) disease resulting in malignant neoplasms[2]	B21	Ending with /3
All cases of invasive cancer except those specified in Appendix 2 All cases of unequivocally malignant conditions (haematological[3])	C00.0 to C97 D45-47	Ending with /3
Benign, uncertain-behaviour and malignant neoplasms of the central nervous system	C70.0–C72.9 and C75.1–C75.3	
Squamous cell carcinoma of the vermillion surface and border of the lip	C00	M805X/3 to M808X/3
Squamous cell carcinoma of skin of anus	C44.5 ([4])	M805X/3 to M808X/3
Squamous cell carcinoma of skin of vulva	C51.9	M805X/3 to M808X/3
Squamous cell carcinoma of skin of penis	C60.9	M805X/3 to M808X/3
Squamous cell carcinoma of skin of scrotum	C63.2	M805X/3 to M808X/3
Carcinoma in-situ of bronchus and lung	D02.2	Ending with /2
Melanoma in-situ	D03	Ending with /2
Carcinoma in-situ of breast	D05	Ending with /2
Carcinoma in-situ of bladder	D09	Ending with /2

Notes:

1. ICD-10-AM codes taken from the International Statistical Classification of Diseases and Related Health Problems, 11th Revision, Australian Modification (11th Edition, 31/05/2019), published by the National Centre for Classification in Health: https://sydney.edu.au/health-sciences/ncch/
2. When notifying a Topography= B21, the topography of the primary site of the cancer arising from HIV disease must also be notified.
3. Diseases with ICD-10-AM commencing with 'D' and 'L' were reclassified in ICD-O-3 with a malignant morphology code. Despite being classified under 'Neoplasms of uncertain or unknown behaviour' in ICD-10-AM, these diseases are notifiable when paired with the corresponding morphology codes in this table. The NSW Cancer Registry commenced collection of these notifications for cases diagnosed from 2003 onwards. Cases diagnosed prior to 2003 may also be notified, and if the exact date of diagnosis is unknown a default date of 01/01/2001 should be reported.
4. C44.5 with morphology M805X/3 to M808X/3 also covers squamous cell carcinomas of skin sites other than the anus, which are not notifiable.

Appendix 2: Cancers to be excluded from notifications

Description	Topography	Morphology	Exception
In-situ cancers and intraepithelial neoplasia with no mention of invasion	C00.0 to C97	Ending with /2	Carcinoma in-situ of bronchus and lung (D02.2); Melanoma in-situ (D03.0 to D03.9); Carcinoma in-situ of breast (D05.0 to D05.9). Carcinoma in-situ of bladder (D09*)
Benign and uncertain behaviour tumours			Benign, uncertain-behaviour neoplasms of the central nervous system (topography codes C70.0–C72.9 and C75.1–C75.3)
Basal cell carcinomas of the skin	C44*	M8090/3	
Squamous cell carcinomas of the skin	C44*	M805X/3 to M808X/3	Vermilion surface and border of lip (C00.0 to C00.9); Anus (C44.5); Vulva (C51.9); Penis (C60.9); Scrotum (C63.2).
Pre-cancerous conditions.			
Cases where there is an unclear or equivocal diagnosis of cancer and a definitive diagnosis has not been made radiologically, cytologically, or histologically; and the clinician does not regard the patient as having cancer.			

CHILD WELLBEING AND CHILD PROTECTION POLICIES AND PROCEDURES FOR NSW HEALTH (PD2013_007)

PD2013_007 rescinds PD2005_299, PD2006_104, PD2007_023, PD2011_057, PD2011_065, GL2011_008, IB2010_005 & IB2012_002.

PURPOSE

This policy articulates the professional and legal responsibilities of all health workers to promote the health, safety, welfare and well-being of children and young people, working collaboratively with interagency partners in the shared system of child protection in NSW. These responsibilities apply whether workers are providing health care directly to children and young people or to adult clients who are parents/carers or are pregnant.

This policy informs Local Health Districts, Specialty Health Networks, other health services and health workers about the tools and resources available and the interagency arrangements in place to assist them to meet their responsibilities and provide a consistent NSW Health response to child protection and wellbeing.

MANDATORY REQUIREMENTS

Every health worker has a responsibility to protect the health, safety, welfare and wellbeing of children or young people with whom they have contact.

The legal responsibilities of health services and health workers are identified in the following legislation:

Children and Young Persons (Care and Protection) Act 1998

- Collaborate with interagency partners and comply with information exchange provisions to promote the safety, welfare and wellbeing of children and young people, including taking reasonable steps to coordinate the provision of services with other agencies;
- Meet requirements for mandatory reporting of children and reporting of young people (or classes/groups of children or young people) at suspected risk of significant harm (ROSH);
- Report unborn children where it is suspected they may be at ROSH after their birth;
- Respond to the needs of children and young people after making a report to Community Services or to the NSW Health Child Wellbeing Unit;
- Respond to Community Services' and Children's Court requests to provide health services and or Community Services and Police Force requests to provide medical examinations and treatment;
- Assist with Children's Court proceedings when required.

Commission for Children and Young People Act 1998*/*Child Protection (Working with Children) Act 2012

- Meet requirements to ensure that only people with valid Working with Children Checks are engaged in child related work (where a child is under the age of 18 years).

Ombudsman Act 1974

- Maintain systems to prevent '**reportable conduct**' by health workers and for reporting and responding to alleged reportable conduct involving NSW Health employees.

The policy responsibilities of health workers are to:

- Recognise and respond appropriately to the vulnerabilities, risks and needs of families, children and young people when providing any health service;
- Collaborate across NSW Health services and with interagency partners to support and strengthen families and promote child health, safety, welfare and wellbeing;
- Use the **Mandatory Reporter Guide** and seek assistance from the NSW **Health Child Wellbeing Unit** to help identify children or young people at suspected risk of significant harm (ROSH);
- Seek assistance from the **NSW Health Child Wellbeing Unit** and the **Family Referral Services** to help respond to vulnerable families, children and young people below the ROSH threshold;
- Actively seek feedback from Community Services after making a child protection report and continue to support the child, young person or family consistent with the health worker's roles and responsibilities;
- Follow the **Child Wellbeing and Child Protection - NSW Interagency Guidelines** and other agreed interagency procedures when working with children, young people and families, including in relation to information exchange, High Risk Birth Alerts, Prenatal Reporting, escalation of child protection concerns, assumption of care by Community Services and out of home care health assessments;
- Collaborate in joint investigation and response to matters involving alleged child sexual assault or serious child abuse or neglect leading to criminal proceedings; and
- Participate in mandatory and/or other child protection training for NSW Health workers.

IMPLEMENTATION

Chief Executives across the NSW public health system are responsible and accountable for:

1. Ensuring that this policy and the associated *Child Wellbeing and Child Protection Fact Sheet for NSW Health Workers* are understood and implemented by all health workers; and
2. Enabling frontline staff to operationalise this Policy Statement in accordance with the attached *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.

Please go to **Child Wellbeing and Child Protection Policies and Procedures for NSW Health** to view the above document.

GENERAL RETENTION AND DISPOSAL AUTHORITY: PATIENT RECORDS (GDA17) AND ADMINISTRATIVE RECORDS (GDA21) (IB2019_015)

IB2019_015 rescinds IB2004/20

PURPOSE

The Board of the State Archives and Records Authority NSW has approved a revised General retention and disposal authority: Public health services - patient records (GDA17), and made a minor change to General retention and disposal authority: Public health services - administrative records (GDA 21) in line with the approval of the Functional retention and disposal authority*: Provision and regulation of childcare services* (FA404).

KEY INFORMATION

1. General retention and disposal authority: Public health services - patient records (GDA17)

GDA17 applies to the records of patient care provided by the NSW Health system. The authority underwent a review and was revised on 30 May 2019.

The disposal action for certain patient records has been changed as a result of the review. NSW State Archives and Records website has available the current version of GDA17 and a schedule of amendments and justifications to show where the retention periods have changed. Where they have changed the old entries in GDA17 can no longer be used as the source of legal authority for the disposal of records under the State Records Act 1998.

2. General retention and disposal authority: Public health services - administrative records (GDA 21)

GDA21 applies to records created and maintained to support the management and delivery of public health care services and programs. It was amended on 30 May 2019 to remove classes covered by FA404, Provision and regulation of childcare services. Those sections of GDA21 relating to childcare can no longer be used as the source of legal authority for the disposal of records under the State Records Act 1998.

FA404 applies to the provision of childcare services by NSW public offices including the local health districts.

Refer to the NSW State Archives and Records website for the latest version of both GDA21 and FA404.

ATTACHMENTS

The authorities mentioned in this information bulletin are available from the NSW State Archives and Records website using the following links.

GDA 17	https://www.records.nsw.gov.au/recordkeeping/rules/gdas/gda17
GDA 21	https://www.records.nsw.gov.au/node/490
FA404	https://www.records.nsw.gov.au/sites/default/files/Recordkeeping/FA0404%20Provision%20and%20regulation%20of%20childcare%20services.pdf

GENERAL RETENTION AND DISPOSAL AUTHORITY – ORGINAL OR SOURCE RECORDS THAT HAVE BEEN COPIED (GA 45) (IB2015_052)

IB2015_052 rescinds IB2009_064.

PURPOSE

To notify the Health system that State Records Authority General Retention and Disposal Authority: *Original or source records that have been copied (GA 45)* has been issued to replace General Retention and Disposal Authority: *Imaged records (GA36)*.

GA 45 provides for the authorised destruction of original or source records that have been copied, provided that certain conditions are met.

KEY INFORMATION

GA 45 provides for the authorised disposal of certain State records which have been successfully copied using microfilming or digital imaging processes. In particular, it describes the circumstances and conditions under which the destruction of certain original or source records is permitted under the provisions of the *State Records Act 1998* after they have been copied.

Whereas GA36 established the conditions under which original records that had been microfilmed or imaged could be destroyed, it primarily applied to paper and excluded records identified as State archives or those required to be retained where created prior to 2000.

The main changes from GA36 to GA45 are:

- Records that are required as State archives or required to be retained in agency may now be destroyed after copying (if the conditions have been met and they do not fall within the exclusions categories) if they were created after 1980, rather than 2000.
- The scope of the authority was widened from original records copied using microfilming or digital imaging processes, to original or source records that have been copied.
- The requirement to assess all requirements for retaining originals was removed, as this condition has become less relevant due to digital copies of paper records being widely accepted.
- Additional exclusions have been included in GA 45 to cover State archives on loan from State Records and records that have high personal value to individuals who were subject to Government control.

GA45 can be accessed on the State Records website:
https://www.records.nsw.gov.au/recordkeeping/original-or-source-records-have-been-copied-ga45

GENERAL RETENTION AND DISPOSAL AUTHORITY - DEPARTMENTS OF FORENSIC MEDICINE (PUBLIC HEALTH SYSTEM) GDA19 (IB2004/44)

The Board of the State Records Authority approved under the provisions of the *State Records Act 1998* on 20 October 2004 the attached "General Retention and Disposal Authority – Departments of Forensic Medicine (Public Health System) as the legal authority for disposing of records retained by Departments of Forensic Medicine in the Public Health System.

Public health services are reminded that the authorisations for destruction of records are given in terms of the *State Records Act* only. A public health service must not destroy any records where they are aware the records may be required as evidence for the purposes of possible legal action or an investigation or enquiry.

GA45 can be accessed on the State Records website:
https://www.records.nsw.gov.au/node/8620851

CHILD DEATH REVIEW TEAM - ACCESS TO RECORDS (IB2014_028)

IB2014_028 rescinds PD2005_286.

PURPOSE

The NSW Child Death Review Team (CDRT) reviews the deaths of children in NSW. The purpose of the CDRT is to prevent and reduce child deaths.

The purpose of this information bulletin is to provide advice to the NSW Health system regarding the requirements of current legislation in relation to the CDRT's access to medical/health records.

KEY INFORMATION

Amendments to the *Community Services (Complaints, Reviews and Monitoring) Act 1993 No 2* were made in 2011[81] in response to the Special Commission of Inquiry into Child Protection Services in NSW which was led by the Hon James Wood AO QC in 2008.

These changes had no ostensible impact on the existing requirements for NSW Health agencies in relation to providing full and unrestricted access to records reasonably required for the CDRT to perform its functions. One notable change however, was the transfer of responsibility for support and assistance of the CDRT from the then Commission for Children and Young People to the office of the NSW Ombudsman, and made the Ombudsman the Convenor of the CDRT.

Legislation providing for the Ombudsman to be the Convenor of the CDRT came into effect on 16 November 2011. Under the *Children and Young Persons (Care and Protection) Act 1998* and Section 38 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, there are provisions for the exchange of information about children and young people who have died. The Ombudsman can request full and unrestricted access to NSW Health records when investigating a reviewable death or a death reviewable by the CDRT.

Under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, the CDRT's functions include:

- Maintaining the register of child deaths occurring in NSW.
- Classifying those deaths according to cause, demographic criteria and other relevant factors.
- Data analysis to identify relevant patterns and trends.
- Undertake research to prevent or reduce the likelihood of child deaths.
- Make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths.
- Identify further research required by the CDRT or other agencies or persons.

The following persons are required under Section 34K to provide the CDRT with full and unrestricted access to records reasonably required for the purpose of the CDRT exercising its functions:

- The Director-General, the Department Head, Chief Executive Officer or senior member of any department of the government, statutory body or local authority.
- The Commissioner of Police.
- The State Coroner.
- A medical practitioner or health care professional who, or the head of a body which, delivers health services to children.
- A person who, or the head of a body which, delivers welfare services to children (including family support services, children's services, foster care or residential out-of-home care, and disability services).
- The principal of a non-government school (within the meaning of the *Education Act 1990*).

[19] Children Legislation Amendment (Child Death Review Team) Act 2011 No 60
http://www.austlii.edu.au/au/legis/nsw/num_act/cladrta2011n60480.pdf

This includes the right to inspect and, on request, to be provided with copies of, any record referred to in that subsection and to inspect any non-documentary evidence associated with any such record. In the legislation, 'record' means *any document or other source of information compiled, recorded or stored in written form or on film, or by electronic process, or in any other manner or by any other means*.

The legislation also details the requirements of the CDRT related persons in relation to maintaining confidentiality of any information acquired for the purposes of the CDRT.

Each Local Health District must ensure requests for information by the CDRT are met as required, and should implement protocols to facilitate this.

It is noted that:

- Any request from the CDRT should be in writing and reference the legislative provisions relied upon by the CDRT for the release of patient information, namely section 34K of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* ("the Act"). The release must be required for the purpose of the CDRT exercising its functions pursuant to section 34D of the Act.
- Any request from the Ombudsman should be in writing and reference the legislative provisions relied upon for the release of patient information, namely section 38 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* ("the Act"). The release must be required for the purpose of the Ombudsman's functions pursuant to section 36 of "the Act."

NSW privacy legislation allows the release of personal and/or health information in circumstances where the organisation (a Local Health District for example) is lawfully authorised to disclose the information; as outlined above.

Where information requested by the Ombudsman or the CDRT contains any reference to reports of Risk of Significant Harm (ROSH), the Health service or health worker handling the request should confirm whether details of the reporter's identity and/or the ROSH report itself are required. If not, de-identified information should be provided. Refer to section 29 of the *Children and Young Persons (Care and Protection) Act 1998* for further information regarding the protection of reporter identity and legal exceptions. Also see PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health Section 9.1.2 for legal and policy advice on the protection of a reporter's identity.

NOTIFIABLE CONDITIONS DATA SECURITY AND CONFIDENTIALITY
(PD2012_047)

PD2012_047 rescinds PD2005_181.

PURPOSE

The purpose of this policy is to provide guidance for NSW Health staff to manage the security and confidentiality of Notifiable Conditions data in any form, either unit records or aggregated form. This includes:

- Paper notification records;
- Electronic notification records;
- The Notifiable Conditions Information Management System (NCIMS);
- The Secure Analytics for Population Health Research and Intelligence (SAPHaRI); and/or
- Any other form of data that has not been approved for release in the public domain.

MANDATORY REQUIREMENTS

All NSW Health and Local Health District staff must comply with this policy when accessing, managing or analysing notifiable conditions data.

Prior to accessing notifiable conditions data, NSW Health staff must sign each page of the Notifiable Conditions Data Security and Confidentiality Policy Directive, to confirm that they have read, understood and agreed to comply with the policies, procedures and conditions set out in it.

Release of notifiable conditions data must be managed according to section 4 – Data and information release.

IMPLEMENTATION

This policy directive should be distributed to all NSW Health staff. Staff with access to notifiable conditions data must follow the procedure set out in this policy directive.

All staff with access to notifiable conditions data in any form must sign the Notifiable Conditions Data - Confidentiality and Security Agreement at Appendix 1.

1. INTRODUCTION

1.1 About this document

Notifications of Scheduled Medical Conditions made under the Public Health Act include highly confidential information. NSW Health staff from Local Health Districts and the NSW Ministry of Health with access to such information should always protect the security and confidentiality of this information.

1.2 Key definitions

This policy refers to the security and confidentiality of Notifiable Conditions data in any form, either unit records or aggregated data. This includes paper or electronic notifications, the Notifiable Conditions Information Management System (NCIMS), the Secure Analytics for Population Health Research and Intelligence (SAPHaRI), or any other form that has not been approved for release in the public domain.

Notifiable Condition	A medical condition listed under Schedule 1, 2 or 3 in the NSW *Public Health Act* (excluding category 1 conditions and cancer).
Unit record data	For the purpose of this policy directive, 'unit record data' are line listed electronic records of information that relate to the health of an individual which are held by NSW state data collections and owned by NSW Health.
Identifiable data	Information that allows identification of a specific individual.
De-identified data	Information from which identifiers have been permanently removed, or where identifiers have never been included. De-identified information cannot be re-identified.
Aggregate data	Summary data from analysis of unit record data by broad categories (such age group, sex or geographic location) so that it is not possible to identify the individual.
Disclosure	Communication or transfer of information outside NSW Health or Local Health District to Universities, and all other organisations or individuals.
Data custodian	The person with responsibility and administrative control over the ongoing development, data collection, maintenance, review of the data collection and granting access to data.

2. LEGAL AND LEGISLATIVE CONTEXT

The conditions and procedures set out in this document are supplemental and subordinate to any State or Commonwealth statutes, legislation or regulations and any NSW Health policies or guidelines subsequently issued by the Director-General which relate to confidentiality and data security.

Specifically, management of confidential notification data are referred to in the following legislation:
- *NSW Public Health Act 2010*
- *Health Administration Act 1982*

NSW Health Employees with access to notifiable conditions data must also acquaint themselves with the NSW *Health Records and Information Privacy Act 2002* and the Privacy Manual for Health Information (March 2015).

3. ACCESS TO SCHEDULED MEDICAL CONDITIONS DATA

3.1 Personnel

Access to notifiable conditions data for NSW Health Staff should be limited to the minimum level required to fulfil the functions of their position. Individuals requesting access to scheduled medical conditions data (and their managers) must:
- Be aware of their responsibilities with regard to information privacy.
- Undertake training on the operation of any databases or systems which they will operate to record or access personal health information in relation to notifiable conditions data.
- Complete the Confidentiality Agreement (Appendix 1) and identify the appropriate level of access according to their position and role.

3.2 Security

3.2.1 Password Security

NSW Health staff with access to databases containing information on notifiable conditions must observe the following measures in order to maintain security:
- Each individual is assigned a unique username. Access to the data will be controlled by a password. The password must be known only to the individual.

- Passwords are required to be a minimum 6 and maximum 12 characters and contain at least one numeric and at least one text character.
- The individual must not record their password in any file or other electronic document, no matter where or how such a file or document is stored.
- Individuals must change their passwords when requested by system administrators.

3.2.2 Electronic Security

- Access to notifiable conditions data through the NCIMS web based application is to be through individual login passwords only.
- When an individuals' access to the notifiable conditions data is no longer required (i.e. the role of the staff member changes, or their employment by the organisation at which they worked when the Confidentiality Agreement was signed), the staff member and or manager must notify the System Administrators of their changed circumstance, so that role changes can be made or logins disabled.
- System administrators will undertake an audit of NSW Health staff with access at least twice annually.

3.2.3 Physical Security and Storage of Data

- Electronic notifiable conditions data should be password protected and stored on secured networks with appropriately restricted access, not standalone PCs.
- Where access to notifiable conditions data through the NCIMS application is required externally (outside the usual work environment), individuals must ensure that information is not downloaded or saved to a PC.
- Network hardware and any back up or copies of notifiable conditions data must be password protected and stored in a secure location.
- Hard copies of identifiable notifiable conditions data related scheduled medical conditions should be stored in locked cabinets in a secure location.
- Secure document disposal facilities must be available.
- Secure printers and faxes must be available for confidential data management.

3.2.4 Workstation Security

- Care must be taken not to leave documents containing personal health information related to notifiable conditions data on work benches or anywhere they may be visible to unauthorised people.
- Personal health information should be unloaded from computer monitors (or the screen locked) if the monitor is to be left unattended.
- These requirements also apply where notifiable conditions data is handled externally (outside the physical confines of the usual work environment).

3.3 Acceptable use of notifiable conditions data

Notifiable conditions data must only be used for official NSW Health/Local Health District business related to notification or public health action, unless authorised in writing by an appropriate officer (see section 4 - Data and Information Release).

Notifiable conditions data should not be used for personal study. Use of the data for research purposes is subject to the NSW policy directive **PD2015_037**: 'Data Collections - Disclosure of Unit Record Data Held for Research or Management of Health Services' referred to in section 4 - Data and Information Release. Where an individual holds external organisation (e.g. academic) **and** NSW Health/Local Health District appointments, access to notifiable conditions data must not be used for any academic or teaching purposes without prior approval.

4. DATA AND INFORMATION RELEASE

4.1 Legal context for release of data

This section should be read in conjunction with 'Data Collections - Disclosure of Unit Record Data Held for Research or Management of Health Services' (**PD2015_037**).

NSW Health staff with access to notifiable conditions data must not release, pass on or otherwise make available to third parties (where the first party is NSW Health and the second party is the notifiable conditions data user) any data, subset of data or any tables, graphs or other aggregations or manipulations of data obtained or derived from notifiable conditions data where this data or information allows the identification of individual persons, institutions, communities or organisations by any means.

NSW Health staff with access to notifiable conditions data should note that identification of individuals, communities or organisations may occur through the release of specific identifying information such as addresses, or by inference from the combination of multiple non specific or less specific data items (such date of birth plus postcode).

The authority to disclose notifiable conditions data is vested in:

a) the Director General or his/her delegate (for identified unit record data) under the *Health Administration Act 1982* and the *Health Administration Regulation 2012* (subject to the conditions of that Act and Regulation).
b) The Chief Health Officer (for epidemiological data) under the *Public Health Act 2010* and Health Administration Act and *Health Administration Regulation* (subject to the conditions of those Acts and Regulation).

There are no delegations relating to the disclosure of identified unit record notifiable conditions data under the *Public Health Act*.

The delegations under the *Health Administration Act 1982* can be found in section 10 of the Combined Delegations Manual at http://www.health.nsw.gov.au/policies/manuals/Pages/combined-delegations.aspx

Other persons are not authorised to disclose notifiable conditions data.

4.2 Applications for release of data

Applications for release of notifiable conditions data should be made through the relevant data custodian using the appropriate form and will be assessed in accordance with PD2015_037 (Appendix 2).

Applications for the release of identified unit record notifiable conditions data for research or management of health service should be submitted to the NSW Population and Health Services Research Ethics Committee for consideration as per policy directive PD2010_055 *Ethical & Scientific Review of Human Research in NSW Public Health Organisations*. Available at: www.health.nsw.gov.au/policies/pd/2010/PD2010_055.html

Specific guidelines for the release of Aboriginal health information related to notifiable conditions data are required to protect Aboriginal people from the risk of identification as individuals or communities. Disclosure of Aboriginal health information must comply with the NSW Aboriginal Health Information Guidelines.

4.3 Exceptions for release of identifying data

Under the *Public Health Act 2010* (Section 130), it is an offence to disclose information obtained in connection with the Act unless the disclosure is made:

- with the consent of the person whom the information was obtained;
- in connection with the administration or execution of the Act or regulations;
- for the purposes of legal proceedings arising out of the Act or the regulations, of a report of any such legal proceedings;
- with the approval of the Chief Health Officer, or a person authorised by the Chief Health Officer, to a person specified in the approval and the information consists of epidemiological data specified in the approval;
- in any other prescribed circumstances; or
- with other lawful excuse.

4.4 Acknowledgement of use of data in publications

Where notifiable conditions data is approved for release in research or management of health services, all approvals must include a condition that data recipients agree to include a written acknowledgement of the role of NSW Health and the Centre for Health Protection in the fulfilment of any data requests and in the preparation of any report, scientific paper or on-line document (such as a World-Wide Web page). Typically the acknowledgement will appear in the covering letter, foreword or, in the case of electronic documents, as part of the introductory or top-level pages.

The source of notifiable conditions data should be attributed to the underlying data collection. For example, a graph which displays notifiable disease information derived from Notifiable conditions data should have the following attribution: “Source: Notifiable Conditions Information Management System, NSW Health”.

Where data is accessed via a secondary interface, such as SAPHaRI, the underlying data collection should be referenced along with the method of extraction: “Source: Notifiable Conditions Information Management System (Secure Analytics for Population Health Research and Intelligence), NSW Health”.

5. DURATION OF THIS AGREEMENT

The applicant agrees to be bound by the conditions of this Agreement indefinitely or until they sign a new Confidentiality and Data Security Agreement which supersedes this agreement.

The applicant is bound by this Agreement regardless of whether they continue to be an active user of the notifiable conditions data or database system and regardless of whether they remain an employee of or associated with the NSW Health or Local Health District.

6. LIST OF ATTACHMENTS

1. Notifiable conditions Confidentiality and Security Agreement
2. Data request template

Office Use Only
Application granted: Yes/No
Signed: _____
Date: _____

Appendix 1

Notifiable Conditions Data - Confidentiality and Security Agreement

I, (Full name of applicant) _____

(Work phone number)_____ (work e-mail address)_____

(Employed as Position)_____

By (Name of business unit employing the person)_____

Agree to abide by the confidentiality and data security conditions and procedures set out in this document.

By signing this document and each page of the Notifiable Conditions Data Security and Confidentiality Policy Directive, I confirm that I have read, understood and have agreed to comply with the policies, procedures and conditions set out in it.

I undertake not to knowingly access any personal health information unless such information is essential for me to properly and efficiently perform my duties. I undertake strictly to preserve the confidentiality of this information and I understand that a breach of this undertaking will result in disciplinary action.

I acknowledge my statutory duty under Section 22 and Section 23 of the NSW Health Administration Act 1982 and Section 130 of the NSW Public Health Act 2010, in relation to the disclosure of information. In order to fulfil this undertaking, I will not divulge any identifying, personal or health information regarding individual persons, except to authorised staff of the NSW Ministry of Health, Local Health District or other staff who require such information to carry out their medical or public health duties.

I further undertake to inform my supervisor immediately if I become aware of any breach of privacy or security relating to the information which I access in the course of my duties.

Signature of applicant _____ Date: _____

Position Title: _____

Witnessed by (Name of witness): _____

Signature of witness: _____ Date: _____

To be completed by Unit manager employing the applicant:

I confirm that, to properly fulfil the functions of their position, the above signed has reasonable need for access to notifiable conditions data. I also confirm that, in order to properly undertake the business of NSW Health or Local Health District, the business unit has a valid requirement for access to this data.

Manager's Name: _____

Signature: _____ Date: _____

Position Title: _____

Business Unit Name: _____ Local Health District_____

For access to notifiable conditions data through the NCIMS application - please tick all that apply

Applicant position:		Intended role:	
Administration	☐	Administration	☐
Immunisation staff	☐	Data entry	☐
Project Officer	☐	Data cleaning/analysis	☐
Public Health Nurse	☐	Epidemiological analysis	☐
Surveillance Officer	☐	Outbreak response	☐
Tuberculosis Nurse	☐	Surge Capacity	☐
Other *(describe)*	☐ _____	Other *(describe)*	☐ _____

End of Agreement

Appendix 2

TRIM REF:

Request for Release of Notifiable Conditions Data

Request for release of notifiable conditions data by requesters external to NSW Health or Local Health District.

To be completed by person making the request

1. **Person and/or agency making request:**

2. **Purpose for which data is sought:**

3. ☐ **Epidemiological/aggregate data** ☐ **Unit record data**
   Where unit record data are sought, please provide a copy of the NSW Population and Health Services Research Ethics Committee approval (according to PD 2012_010)

4. **Description of data requested** *(disease/condition, fields of interest, & time period of interest)*

5. **What (if any) publication of data is intended?**

6. **Date data requested by**: *(allow up to 6 weeks from the date of request)* _____ / _____ / _____

7. **Person taking responsibility for appropriate use of data:**

   Name: _____ Position: _____

   Organisation name: _____

   Phone: _____ Email: _____

   Signature: _____ Date: _____

Fax this form to the Surveillance Manager, Communicable Diseases Branch on 02 9391 9189

NSW Health reserves the right of comment on use of data and interpretation prior to publication.

Request Received: _____ **Request Approved:** _____

Date request completed: ___ ___ / ___ ___ / ___ ___ **Data prepared by:** _____

INTELLECTUAL PROPERTY ARISING FROM HEALTH RESEARCH

(PD2023_007)

PD2023_007 replaces PD2005_370

POLICY STATEMENT

NSW Health recognises that the acquisition and dissemination of knowledge and skills in the area of research and clinical practice is of major public benefit and a primary role of Public Health Organisations.

Public Health Organisations must establish a centralised system of managing their Intellectual Property, utilising an Intellectual Property Committee or other Committees which adhere to the requirements of this Policy Directive. They must also ensure that relevant agreements are in place with Clinical Academics, Visiting Practitioners, Visitors, Students, Independent Research Institutes and other third parties which appropriately deal with Intellectual Property.

SUMMARY OF POLICY REQUIREMENTS

Occasionally, the outcome of Health Research may have a significant commercial value. The objectives of this Policy are to:

- provide a framework for the use, generation, acquisition and management of Intellectual Property in NSW Health
- ensure that Intellectual Property owned by NSW Health is used to generate public value, knowledge transfer and innovation to the fullest extent possible
- encourage health research relating to the public health system and the acquisition and dissemination of knowledge and skills
- foster an environment within which the role of Intellectual Property in enabling clinical application of health research and realising commercial value is understood and recognised
- manage Intellectual Property with a potential commercial value in a manner which benefits the public health system as a whole
- foster an environment within which Intellectual Property issues can be identified and developed, and
- recognise and reward innovation by staff of NSW Health Organisations.

NSW Health provides an environment in which NSW Public Health Organisations are rewarded for the commercial exploitation of Intellectual Property.

The Office for Health and Medical Research will establish a Central Support Service offering assistance in commercialising intellectual property, which Public Health Organisations can delegate matters of that nature to if they are unable to establish or utilise a Committee. Employees of Public Health Organisations will be required to notify the Committee or Central Support Service (whichever is applicable within their Organisation) of Intellectual Property they develop or will imminently develop.

The Committee/ Central Support Service must examine and consider all notifications provided to it by Employees. Further, they will offer legal and commercialisation advice, and make recommendations to the Chief Executive of the relevant Public Health Organisation.

They will also act as a resource for staff on Intellectual Property matters, particularly in relation to the provision of advice on prior disclosure.

The full policy is available at:

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_007

STATE HEALTH FORMS (PD2009_072)

PURPOSE

This policy and attached procedures define the processes for the creation and management of State Health Record Forms incorporated in Health Care Records.

The scope of the policy is to have clinical statewide forms filed in the Health Care Record and the standardisation of the physical Health Care/Medical Record Cover as well as other health record documents such as labels and dividers. This policy includes but is not limited to Inpatient facilities, Community Health Centres and outpatient clinics/areas.

MANDATORY REQUIREMENTS

Health services are required to use standardised forms developed by the NSW Health State Forms Management Committee.

All State Health Record Forms for inclusion (or potential for inclusion) in the Health Care Record must be approved by the NSW Health State Forms Management Committee (SFMC) or Health Service forms for use only within the Health Service must be endorsed by the local forms committee. Health Services must establish:

- A functional health service Health Records Forms Committee.
- Processes to ensure all line managers are accountable for the effective implementation of standard health record forms across the health service, including Directors of Clinical Operations, Clinical Governance and Nursing and Midwifery Services, Health Information Management units and facility based Health Information services.

All NSW Health **State** Record forms can **only be obtained** from the State Print and Print Management contracted supplier.

IMPLEMENTATION

The Health Service Chief Executive is responsible for:

- Establishing a functional health service Health Records Forms Committee, a member of which must act as representative to the NSW Health State Forms Management Committee (SFMC).
- Establishing processes to ensure all line managers are accountable for the effective implementation of standard health record forms across the health service, including Directors of Clinical Operations, Clinical Governance and Nursing and Midwifery Services, Health Information Management units and facility based Health Information services.

The Health Service Records Forms Committee is responsible for:

- Reviewing clinical forms intended for statewide use.
- Approving all clinical forms to be used by its Health Service.
- Ensuring all clinical forms meet the requirements of relevant Australian Standards (e.g. AS2828), NSW Health Policy Directives, a Health Service and State Health Records Forms templates.
- Working with the NSW Health, appointed Print and Print Management Services contracted provider, to facilitate Statewide implementation of the Policy.
- To standardise clinical forms across their health service where possible.
- To provide a formalised communication network between Health Service forms users, Executive, the contracted Print Management Services provider and the SFMC.
- To make recommendations for ongoing introduction/amendment/deletion of forms.

- Ensuring that the terms of reference includes a requirement that direct clinical contribution is obtained as required.

The custodians and authors of Health Records Forms (including the NSW Department of Health) are responsible for:

- Ensuring all steps in the health record forms development processes adhere to policy.
- Submitting relevant forms through their health service representative to the SFMC for review and endorsement.
- If NSW Health Policy Directive or Guideline requires a Health Record form to be used or created in order to comply with that policy or guideline the form must be submitted directly to and processed through the NSW Health SFMC and form a part of that Policy Directive or Guideline before it is distributed for implementation.

Health Support is responsible for:

- Monitoring and Reporting:
  - Supplier (Print and Print Management Services) performance
  - Quality issues (product, artwork and supply)
  - Health Service usage and expenditure
  - Health Records Forms gallery
- Management and support of the SFMC.
- Implementation of a Communication Plan.
- Collaboration with Health Item Master File program.
- Maintenance of the State Health Record Forms and bar-code number allocation register.
- Management of print supplier contract and meeting costs associated with contract, (e.g. destruction of obsolete forms etc).

Persons undertaking the evaluation of forms are responsible for:

- Confirming that the form is compliant with the current Australian Standards on Hospital Medical Records (AS2828).
- Ensuring the form has a consistent format and template.
- Ensuring that the form meets the criteria as per stated throughout the Appendices to this policy.
- There is clear evaluation criteria against which the form is to be evaluated.
- A diverse group is selected to evaluate where applicable and possible and that consultation with any Health Service which is taking part in the evaluation has been consulted with at the highest level.
- Evaluation report is clearly documented and that any changes made to a form are within the boundaries of any policy directive which the form maybe written from.
- That any change which is outside a policy within which the form has been written from is referred back to the content owners for approval.
- That the form is in and remains in State Forms Management Committee State forms template.

BACKGROUND

About this document

In line with the strategic reform initiative, NSW Department of Health has instructed Health Support Services to include forms rationalisation and print management across NSW Health. This project will ultimately cover all forms however initially health records rationalisation is being addressed.

It is estimated that there are approximately 15,000 commercially printed health record forms being used across NSW Health. There is not a common Statewide process to develop or review health (clinical) record forms. Not all forms comply with current Australian standards (e.g. AS2828). NSW Department of Health develops policies and guidelines with health records forms incorporated for implementation across NSW Health without always making provision for:

- A co-coordinated implementation plan across all Health Services and agencies
- Compliance with the current Australian Standards (i.e. for paper-based health care records - AS2828)
- Review of the printing and distribution requirements and impact across all Health Services and agencies.

Key definitions

Health Record Form: A record of the provision of care, assessment, diagnosis, management and/or professional advice given to a person. This term is used inter-changeably with clinical form. A Health Record Form is a Clinical form that is endorsed by Health Service Forms Committee for use within the area/service.

State Health Record Form is considered to be a:

- Clinical Form that is mandated by NSW Department of Health for statewide usage. See appendix 3 for the Statewide forms templates.
- Clinical Form that Health Services have devised for health service or agency use.
- Clinical Form that has undergone a NSW Health State Forms Management Committee (SFMC) approval process.

Health Care Record: A Health Care Record is a documented account of a patient's/client's health evaluation, diagnosis, illness, treatment, care, progress and health outcome that provides a means of communication for all health care personnel during each visit or stay at a health service. It is the primary repository of all information regarding patient/client care.

The record is used to care for the patient/client during an episode of care but may also be used for future episodes of care, communication with external health care providers and regulatory bodies, planning, research, education, financial reimbursement, quality improvement and public health. The health care record may also become an important piece of evidence in protecting the legal interests of a patient/client, clinician or Health Service.

The health care record may be in hard copy, electronic or other form, and unless otherwise indicated, the provisions of this policy directive apply equally to all health care records regardless of the media in which they are kept.

Health Service: a Health Service within the boundaries of the *Health Service Act 1997* (which includes Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Public Hospitals)

SFMC: NSW Health State Forms Management Committee.

Site: Physical facility or service e.g. Hospital, Community Health Centre, Renal Service, Justice Health site.

Location: Ward, Oral Health, Clinic, Unit e.g. ICU, ED

Rationale

The introduction of statewide health records forms will assist in:

- Promoting quality processes through
  - Consistent business practices when designing and implementing clinical forms across NSW Health.
  - Statewide standardised document control for all Health Record Forms included in NSW Health Policies.
- Health Services and agencies transferring to electronic medical records systems.
- Streamlining the implementation of NSW Health Policy and forms at the Health Service and agency level.
- Supporting scanning of health care records, including a standardised bar-coding system and the maintenance of a State Health Record Forms Register.
- Promoting effective and efficient work practice by:
  - Decreasing the workload at Health Services and Agencies, who are currently responsible for the implementation of forms incorporated in NSW Health policies and guidelines.
  - Standardising information and formatting to assist staff across NSW Health to accurately and consistently collect patient information, regardless of the health care facility or service.

1. NSW Health State Forms Management Committee

1.1 Terms of Reference

The Committee has the following Terms of Reference:

- Co-ordinate the development of State Health Record Forms and documents.
- Standardise State Health Record Forms and documents and across the whole of NSW Health where possible.
- Ensure compliance with relevant Australian Standards where appropriate.
- Ensure liaison and co-ordination with the Electronic Medical Records Project (eMR) and other related electronic information systems.
- Provide a formalised communication network between form users, NSW Department of Health, Health Support and the contracted Print and Print Management Services Supplier.
- Disseminate forms and related information across NSW Health.
- Approve statewide health record forms and allocate a unique form number.
- Oversee the maintenance of the State Health Record Forms Register.
- Ensure actions and issues are assigned to the appropriate personnel either within Health Support, Health Services/Agencies, NSW Department of Health or the contracted Print and Print Management Services Supplier.
- Regularly review the statewide electronic forms web-site, when developed, for accuracy and initiate remedial action as required.
- Make recommendations for ongoing introduction/amendment/deletion of forms.
- To complement existing Health Service Forms Committees to ensure only endorsed approved (local or state) health record forms are produced for filing in the Health Care Record.

1.2 Governance

The Committee will be responsible to the Deputy Director-General, Health System Support.

1.3 Representation

NSW Health Services (NSCCAHS/HNEAHS/SESIAHS/SSWAHS/SWAHS/GSAHS/GWAHS/ NCAHS/CHW and Justice Health)

Health Support
By Invitation as required

- Standards Australia representative
- NSW Department of Health representative
- eMR Project Team representative
- Ambulance Service NSW representative
- MH-OAT representative
- Print and Print Management Services Contractor representative
- Other persons involved with special projects involving clinical forms and health records

3. Development of Statewide Health Record Forms

3.1 Identification of need for new or revised health record forms

Sources for identifying the need for the development or revision of a State Health record form include, but are not limited to:

- State executive sources including legislative requirements, NSW Health Policy Directives, Guidelines, Australian Standards and specific industry requirements, better practice or research evidence
- Service reviews, Incident Information Management System (IIMS), complaints, root cause analysis (RCAs) and peer review
- Internal and External audit reports

3.2 Development Stage

Custodians and authors of proposed State Health Record forms are required to:

- Search for an existing or similar form.
- Source relevant documentation where possible and ensure forms comply with Best Practice, both in forms design and clinical practice.
- Ensure compliance with NSW Health policy directives, guidelines and information bulletins.
- Ensure there is endorsement from Health Services and supply confirmation of this in writing to the SFMC.
- Ensure that the form utilises the SFMC Forms Template.
- Contact relevant Health Service Forms Committee to identify which form is to be replaced and provide reasons for replacement
- Through their SFMC representative, send an electronic version of the form and completed application package for approval to the SFMC – see appendix 7 for application checklist
- Consider usage when stock numbers are being established.
- Specify colour, print and other specifications at the time of form submission.
- Comply with relevant Australian Standards (e.g. AS2828)
- Ensure forms are developed in liaison with appropriate clinical representation at both State and Area level.
- Ensure forms meet medico-legal requirements.
- Ensure relevant stakeholders are alerted to form development.
- Ensure training and/or implementation guidelines and materials are developed and distributed to appropriate Area representatives prior to the introduction of the form.

- The AHS is to establish a single line of communication with the SFMC; and the process for submission to the SFMC should confirm the above has been undertaken and the proposal endorsed at an Area Health Service level, prior to submission.

3.3 Considerations

The impact of creating new Health Record forms is to be considered. This impact may include:

- Increased staff work load due to staff completing the form and Medical Record/Clinical/Health Information Department filing the form.
- Increased size of medical records, which may impact on storage space and have potential OH&S issues due to the weight
- Costs – for example the colour of form or print, NCR paper, A3 size and booklets.

Instructions/protocols/checklists should not, as a general rule, be included on the back of forms. Rather, alternate approaches should be explored to minimize interference with clinical documentation and unnecessary space requirements in the health care record. For example, instructions can be laminated and placed in an obvious area when introducing the form and/or be included in a procedure.

Only Health Record forms endorsed by the SFMC (or Health Service Forms endorsed by the local Forms Committee) will be filed in the Health Care Record. If a Health Record form is released for use without an authorized form number and bar-code identifier when one is required, then it will be deemed ineligible to be filed into the Health Care Record.

Revised forms, once approved, will be printed for use when the current supply is depleted. If a form is deemed to pose a clinical risk it is to be destroyed at the contracted printers and the artwork removed.

Photocopying of blank State Health Record forms for use and filing in the Health Care Record is not permitted.

3.4 Validation Stage

The NSW Health State Forms Management Committee (SFMC) will review the proposed Health Record form based on the following criteria:

- Form must comply with NSW Health State templates and current Health Record Standards (e.g. AS2828).
- A unique form number must be allocated from the State Forms Register.
- A bar code identifier must be allocated based on the determined state form number.
- Working with the NSW Health contracted Print and Print Management supplier, to manage printing of the form using the approved SFMC template.
- Informing author or custodian of approval or non-approval
- Managing the gallery of State Health Record Forms.
- Provide support to authors in design and concepts (e.g. colours of print, paper, scanning requirements).

3.5 Consultation Phase

A consultation phase will occur for a two week period from the time the form is released to the AHS's or relevant Health Bodies for comments to be received back.

3.6 Evaluation Criteria

All Health Record Forms will be evaluated on:

- best practice through
  - Consistent format and standardised template.
  - Compliance with current Australian Standards on Hospital Medical Records (AS2828)
- provision of supporting policy and guidelines
- current clinical policy
- clinical work flow
- financial resources
- implementation requirements and the provision of training materials
- decrease in duplication of data items
- decrease in space requirements of health records i.e. storage requirements.

The evaluation process shall include consultation with the Health Services.

3.7 Transition Period

Implementation

High usage clinical forms will be identified for standardisation into the NSW Health statewide template. It is expected that this is where the greatest impact should be gained for cost saving and standard work practice. Examples of these forms are; Medical record covers, Progress notes, Fluid Balance charts, etc.

Phased Transition

The SFMC will determine based on usage and/or clinical criteria the priority for the standardisation of Statewide forms. If more than one form exists then there will need to be consultation with the key stake holders via the members of the SFMC about the design of the most clinically functional and cost effective solution.

Once the SFMC has developed a new form the Print Management Services vendor will be advised not to replace current stock of previous old forms. When the stock is low or no longer available the "Flag" on the Print Management Services vendor's web site will direct users to the NSW Health Statewide standardised form that must be used.

The replacement Statewide form must be available on the Print Management Services vendor's web site before old stock is depleted to ensure continuity of supply.

If old stock is still available after 6 months the Print Management Services vendor will identify this issue with the SFMC for a decision to either:

- Contact the owner of the form and advise them of "The option to write off old stock"
- Make the stock redundant
- Discuss with the relevant Health Service to determine who will bear this cost.

The Option to Write Off Old Stock

If a Health Service or NSW Department of Health Division needs to write off excess "old" stock (in order to introduce "new" stock rapidly), they must be advised that:

a. The Service Level Agreement Contract allows that the Print Management Services vendor is responsible for the (write off) cost of the first 3 months of stock held,
b. The Health Service would be responsible for the cost of the remaining (unused) "old" stock, and the costs of destruction.
c. Where there is stock held which has not moved in the last 12 months, the Print Management Services contractor would notify the owner of the stock of their intent to write off and destroy (noting the above incurred costs), unless advised otherwise within 2 months time
d. If no response or advice is given after that period, then the stock will be written off and the entire cost of the stock and destruction costs will be invoiced to the initiating source.

State Mandated Forms (those included in a NSW Health Policy Directive)

a. If the form is Print on Demand (POD), it can be transitioned to the NSW State Forms Template immediately as there is no stock on hand.
b. If the form is warehoused existing stock will be run out and the form transitioned into the NSW State Forms Template ready to be printed on the next reprint.
c. New forms required by Policy Directives in the process of formulation will follow the requirements of this policy elsewhere described.

3.8 Health Record forms that require a trial

The following guidelines are to be followed for introduction of a new State Health Record Forms which are not available in the NSW Health Print and Print Management Contractor's State Health Record Forms Library:

a. Complete the request and forward it to the Health Service Forms Committee Representative advising of the need to develop/introduce a State Health Record Form. See Appendix 7 for the Application Checklist.
b. The Health Service or agency Forms Representative is to advise the NSW Health State Forms Management Committee (SFMC) Convenor of the proposed form.
c. The SFMC is to formulate the appropriate Working Party who will be responsible for co-ordinating, providing education and supervising the form trial.
d. The time period required for the trial of a form will be dependent on the usage of form. For forms that have a high usage, a minimum trial period of up to 3 months may be required, whilst forms that have a low usage may require up to a 12 month trial period.
e. During the trial period, stocks of the "old" form (if a revised form) must be withdrawn from circulation, to enable a true and accurate trial of the "new" form to occur.
f. All trial forms to adopt the State Forms Template and to be allocated a 'Trial State Forms Number category and bar code'.
g. At the end of the trial period, the outcome of the trial must be evaluated to determine whether the new form has been accepted by users (results of a compliance audit). If the trial is unsuccessful the current version should be deleted from the State Health Record Forms website as a State form or re-designed. If a local area wishes to continue using the trial form they must give it a local form number.
h. The final form to be registered with State Forms Number, category and barcode.

3.9 Low Usage Forms

Those forms that are identified by the SFMC as extremely low usage can be made available via the relevant website (primarily the NSW Health authorised Print and Print Management suppliers' website). These forms can be viewed and printed direct from the website. These forms must adhere to this policy including usage of the approved NSW Health clinical forms artwork and must be approved by the NSW Health SFMC. As identified by the SFMC by usage at the present time this is expected to be in the realm of 100 per annum per site.

4. REFERENCES

4.1 External

Australian Standard AS2828 - Paper Based Health Care Records

4.2 Internal

Electronic Information Security Policy – NSW Health (PD2013_033)
Health Care Records – Documentation and Management (PD2012_069)
NSW Health Patient Matters Manual
Privacy Manual for Health Information (March 2015)

4.3 Glossary

SFMC = NSW Health Statewide Forms Management Committee
HIMS = Health Information Managers
HS = Health Service
PD = NSW Health Policy Directive
POD = Print On Demand
HSS = Health Support
MHOAT = Mental Health Outcomes Assessment Tool

4.4 Appendices

Appendix 1 - Forms Committee Process and Procedure
- a – State Health Care Record Form Process – New Form Process
- b – State Health Care Record Form Process – Targeted Form standardisation

Appendix 2 - Health Forms Design
Appendix 3 - State Forms Templates
Appendix 4 - State Health Care Record Cover Artwork
Appendix 5 - Terminal Digit Colours for Health Care Record Covers
Appendix 6 - Strip Colours and Patterns
Appendix 7 - NSW Health State Health Record Form Design Checklist

ABORIGINAL AND TORRES STRAIT ISLANDER ORIGIN – RECORDING OF INFORMATION OF PATIENTS AND CLIENTS

(PD2012_042)

PD2012_042 rescinds PD2005_547.

PURPOSE

The policy directive and the associated procedures document outlines the requirements for collecting and recording accurate information on whether clients of NSW Health services are Aboriginal and/or Torres Strait Islander. Aboriginal and Torres Strait Islander people are under-reported in many health related data collections in NSW. Self-report in response to the standard Australian Bureau of Statistics question about a person's Aboriginality is the most accurate means of ascertaining whether a client is Aboriginal and/or Torres Strait islander. The standard question must be asked of all clients of NSW Health services, and the information needs to be recorded accurately according to national standards.

MANDATORY REQUIREMENTS

1. All NSW Health services are required to collect consistent and comprehensive data on Aboriginal and Torres Strait Islander health.

2. The *Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients: Procedures* document describes the standards required for the accurate collection and recording of data.

3. The standard question seeking information about a person's Aboriginality should be asked of all clients of NSW Health services to establish whether they are Aboriginal and/or Torres Strait Islander:
   'Are you (is the person) of Aboriginal or Torres Strait Islander origin?"

4. These standard response options should be provided to the clients to answer the questions (either verbally or on a written form):
   - ☐ No
   - ☐ Yes, Aboriginal
   - ☐ Yes, Torres Strait Islander
   - ☐ Yes, both Aboriginal and Torres Strait Islander

5. Asking the question:
   - Staff responsible for registering a client should ask the standard question when the client is first registered with the service.
   - The question should be asked of all clients irrespective of appearance, country of birth, or whether or not the staff know the client or their family background.
   - Clients may be asked the question directly, or asked to complete a form with the question included, and the client should answer this question themselves.
   - Specific situations related to asking the question are described in Section 2 and Section 4 of the Procedures document.

6. Recording the Information:
   - Information systems should record whether a client is Aboriginal or Torres Strait Islander using the standard categories, which are outlined in Section 3 in the Procedures document.
   - Responses to the standard questions should be coded as described in Section 3 in the Procedures document.

- A response to the standard question should be a mandatory requirement when registering or entering client details in electronic recording systems.
- Local data management systems must be able to identify those records that are coded as not stated/inadequately described which require follow-up.

7. Training in the correct and consistent recording of whether a client is Aboriginal and/or Torres Strait Islander must be delivered to all staff. See Section 5 in the Procedures document.

8. Data quality assurance and validation activities must be undertaken at the local level (Section 6 Procedures document) and by NSW Ministry of Health (Section 7 Procedures document).

IMPLEMENTATION

1. Roles and Responsibilities of NSW Health agencies:

- Chief Executives, Health Service Executives, and Managers are responsible for the implementation of this policy and procedures at the local level.
- All NSW Health employees are responsible for the accurate recording of Aboriginality when ever this is part of their role.

2. Roles and Responsibilities of NSW Ministry of Health:

- NSW Ministry of Health is responsible for providing the mandatory requirements and procedures, and to support the implementation and evaluation of this policy.

3. Activity Based Funding

With the implementation of activity based funding in July 2012, accurate and consistent recording of Aboriginality is essential for the effective application of associated weighting and will enable LHDs/SHNs to:

- Monitor expenditure on health care against funding for Aboriginal clients.
- Enable clinicians and managers to understand the factors contributing to cost variations including the extent to which these relate to patient complexity or differences in the way services are delivered to Aboriginal clients.
- Make decisions about where to invest additional resources to meet increasing demand in the most cost effective way for Aboriginal clients.
- Contribute information about costs to the national "price setter", the Independent Hospital Pricing Authority.
- Be appropriately funded according to the efficient pricing for treating Aboriginal patients.

1. BACKGROUND

1.1 About this document

This Policy Directive replaces Policy Directive PD2005_547 '*Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients'*. This policy directive revises and updates the previous policy.

1.2 Legal and legislative framework

The '*National best practice guidelines for collecting Indigenous status in health data sets'* (AIHW, 2010) documents the national approach for collecting and recording accurate information on whether a client is Aboriginal and/or Torres Strait Islander.

The Council of Australian Governments (COAG) National Indigenous Reform Agreement requires all jurisdictions, including NSW, to implement the National Best Practice Guidelines.

This policy and procedures document incorporate the activities outlined in the National Best Practice Guidelines. The implementation of these will ensure NSW meets their National Indigenous Reform Agreement obligations in relation to identification of Aboriginal and Torres Strait Islander people.

2. ASKING THE QUESTION

2.1 The Standard Aboriginal and Torres Strait Islander Origin Question

The following question should be asked of all clients to establish whether they are Aboriginal and/or Torres Strait Islander:

'Are you (is the person) of Aboriginal or Torres Strait Islander origin?"

2.2 The standard response options

2.2.1 Three standard response options should be provided to the clients to answer the questions (either verbally or on a written form):

- ☐ No
- ☐ Yes, Aboriginal
- ☐ Yes, Torres Strait Islander
- ☐ Yes, both Aboriginal and Torres Strait Islander

2.2.2 If the question has not been completed on a returned form, this should be followed up and confirmed with the client.

2.3 How to ask the question

2.3.1 Staff responsible for registering a client should ask the standard question seeking information about a person's Aboriginality when the client is first registered with the service.

2.3.2 The question should be asked of all clients irrespective of appearance, country of birth, or whether the staff know of the client or their family background

2.3.3 The question should be placed within the context of other questions related to cultural background, such as country of birth and main language spoken.

2.3.4 Clients may be asked the question directly, or asked to complete a form with the question included, and the client should answer this question themselves.

2.3.5 In some situations (such as in the case of birth and death registrations) the client will be unable to answer the question themselves. In this case it is acceptable for certain others (such as mother, father, close friend, relative, or household member) to be asked the question and to answer the question on the client's behalf if they feel confident to provide accurate information.

2.3.6 In instances where the client is temporarily unable to answer the question, it is also acceptable for certain others who know the client well to respond on their behalf; however this response should be verified with the client wherever possible.

3. RECORDING RESPONSES

3.1 How to record responses

3.1.1. Information systems should record information on whether a client is Aboriginal and/or Torres Strait Islander using the standard national categories, which are:

1. Aboriginal but not Torres Strait Islander origin
2. Torres Strait Islander but not Aboriginal origin
3. Both Aboriginal and Torres Strait Islander origin
4. Neither Aboriginal nor Torres Strait Islander origin
9. Not stated/inadequately described

In addition databases in NSW should use the following additional category:

8. Declines to respond

3.1.2 Responses to the standard questions should be coded to the following national standards.

Response	Coding Category
'Yes, Aboriginal' is ticked, but 'Yes, Torres Strait Islander' is not ticked.	1
'Yes, Torres Strait Islander' is ticked, but 'Yes, Aboriginal' is not ticked.	2
'Yes, Aboriginal' is ticked, and 'Yes, Torres Strait Islander' is ticked.	3
'Yes, both Aboriginal and Torres Strait Islander' is ticked	3
'No' is ticked	4
'No' is ticked and either/both 'Yes, Aboriginal', and 'Yes, Torres Strait Islander' is ticked.	1, 2 or 3
Client is capable of responding but declines to respond following prompting/follow-up	8
Where it is impossible for the question to be asked during the contact period	9
Response to the question has been left blank or is incomplete	9

(Note these categories represent national standards, with the addition of the code 8, used by NSW to identify clients who have declined to respond. In the national categories, the NSW Code 8 would be coded as 9. See Section 3.3 for further information).

3.2 Mandatory completion

A response to the standard question on a person's Aboriginality should be a mandatory requirement when registering or entering client details in electronic recording systems. Staff registering or entering details of a client should not be able to proceed with registration until a response has been completed.

3.3 Identifying records for follow up

3.3.1 Local data management systems should be able to identify those records that require follow up. In NSW the code 8 is used (as described in 3.1.2) to identify clients who have declined to answer, and therefore do not require follow up. Client's coded as 9 (not stated/inadequately described) because of situations where it was impossible for the question to be asked during the contact episode, and other situations where the response was left blank or incomplete, require follow up with the client, to determine the correct code.

3.3.2 Additional categories used by NSW or in local systems for the purposes of workflow management and follow-up must be mapped to the correct national category (Categories 1, 2, 3, 4, and 9) before the data are provided to the national data custodian. In NSW, data coded as category 8 (declined to respond) must be recoded to category 9 before submission to national data custodians.

4. IMPLEMENTING THE PROCEDURES IN SPECIFIC SITUATIONS

4.1 In the event of a birth

4.1.1 For perinatal data collections, the standard questions on whether a client is Aboriginal and/or Torres Strait Islander should be asked directly of the mother, regardless of the information separately recorded in the hospital database.

4.1.2 In NSW, information on whether the mother and the newborn baby are Aboriginal and/or Torres Strait Islander must be recorded in the NSW Perinatal Data Collection (See NSW Policy Directive **PD2015_025**).

4.1.3 The mother should be asked to provide the information on whether her baby is Aboriginal and/or Torres Strait Islander in addition to her own Aboriginality.

4.1.4 It should not be assumed that the baby will share the mother's origin. In particular, if the mother does not report her origin as Aboriginal and/or Torres Strait Islander, it should not be assumed that the newborn is therefore not Aboriginal or Torres Strait Islander.

4.2 If the client is a child under 15

4.2.1 Where the client is a child under 15 years of age, the parent or guardian is asked to declare whether the client is Aboriginal and/or Torres Strait Islander on their behalf.

4.2.2 If the parent or guardian is not available, certain others may be asked to provide this information (see 2.3.4).

4.2.3 If the accompanying adult is unable to provide this information, the child's parent/guardian should be contacted as follow-up to establish whether the child is Aboriginal and/or Torres Strait Islander.

4.3 If the client is too ill to be questioned or is unable to respond

4.3.1 When the client is unable to respond to the standard question because they are too ill, unconscious, or too ill due to psychiatric condition or dementia, in the first instance the staff member should ask the client's carer, relative, or any other person accompanying the client (see 2.3.4).

4.3.2 The response provided by this person should be verified with the client when they have recovered sufficiently to be able to answer the questions themselves.

4.3.3 If the person accompanying the client does not know whether the client is Aboriginal and/or Torres Strait Islander, the client should be asked the question directly when they are capable of responding.

4.3.4 In the event that the person accompanying the client does not know whether the client is Aboriginal and/or Torres Strait Islander and the client does not recover sufficiently to provide this information, the answer to the standard question on Aboriginality should be recorded as a non-response.

4.4 If the client does not speak English, or cannot read or write

4.4.1 If the client does not speak English, but is accompanied by someone who can interpret for them, it is recommended that the person accompanying them is asked to translate the question and their response.

4.4.2 If there is no-one with the client who can speak English, it is recommended that an interpreter, or Aboriginal or Torres Strait Islander liaison officer (who can interpret the relevant Aboriginal or Torres Strait Islander language spoken by the client) be called to assist.

4.4.3 If a form is to be provided and the client cannot read or write, it is recommended that an appropriate staff member (e.g. an interpreter, social worker, Aboriginal or Torres Strait Islander Liaison Officer) go through the questions with the client.

4.4.4 All clients' should be given the opportunity to respond to the standard Aboriginality question for themselves. While a client who speaks an Aboriginal language may be highly likely to be an Aboriginal person, their Aboriginality cannot be assumed; the client may be of both Aboriginal and Torres Strait Islander for example.

4.4.5 Non-English speaking clients from various cultural backgrounds should also be asked the question and given the opportunity to self-report in response to the standard question.

4.5 If the client is deceased

4.5.1 Funeral directors, undertakers, medical practitioners and coroners responsible for registering a death or assessing the cause of death must ask the next-of-kin about whether the deceased is Aboriginal and/or Torres Strait Islander. If no next-of-kin is available, then the question should be asked of the broader family. If this information is not able to be obtained from either of these sources, another person who knew the deceased well may be asked to provide this information.

4.5.2 If information on whether the deceased is Aboriginal and/or Torres Strait Islander is missing on the death registration form, the funeral director should follow up with the next-of-kin before the form is sent to the registry. Similarly, medical practitioners or the coroner responsible should attempt to complete this item before the deceased's information is sent to the registry.

4.6 If staff are reluctant to ask the question

4.6.1 Staff should be encouraged to collect information from all clients in a professional and respectful manner, without anticipating or making assumptions about the client's identity or about how the client is likely to react or respond to any given question. Staff should be encouraged to regard the standard question on a person's Aboriginality as no more or less sensitive or problematic than other items of personal data routinely collected from clients.

4.6.2 All client's, whether Aboriginal, Torres Strait Islander, or non-Aboriginal or Torres Strait Islander, have the right to self-report, rather than have their identity assumed and recorded on their behalf. To refrain from asking any client the standard question on a client's Aboriginality is an act of discrimination which infringes upon the client's right to respond to this question for themselves.

4.6.3 Staff should not modify the standard question in any way. The question should be asked correctly, consistently, and uniformly of all clients, using the wording precisely as stated in this policy and procedure.

4.7 If the client wants to know why they are being asked the question

4.7.1 The following provides several responses that may assist staff in explaining to clients the reasons for asking the standard question on a client's Aboriginality:

a. The question on whether a person is Aboriginal and/or Torres Strait Islander is one of several questions related to a client's identity and demographic characteristics that are asked of all clients who attend a health service, enrol with Medicare, or are involved in the registration of a birth or death.

b. The collection of information on whether a person is Aboriginal and Torres Strait Islander is necessary for government and other services to plan and deliver appropriate services for all Australians, to assess the impact of services on particular groups in the community, and to improve health care and to monitor changes in health and wellbeing over time.

c. The response to this question allows service providers to ensure that Aboriginal and Torres Strait Islander clients have an opportunity to access relevant services such as Aboriginal liaison officers and Aboriginal health workers, health checks, Aboriginal and Torres Strait Islander specific immunisation considerations and PBS listings if they choose.

d. Service providers cannot make assumptions about whether a person is Aboriginal, Torres Strait Islander, or non-Aboriginal and Torres Strait Islander, therefore this information can only be determined by asking the client the standard question.

e. All personal information is protected by privacy law. The Privacy Manual for Health Information (March 2015) provides operational guidance for health service staff to the legislative obligations imposed by the *Health Records and Information Privacy Act 2002*, and outlines procedures to support compliance with the Act in any activity that involves personal health information.

4.7.2 Should a client request a more detailed explanation of where the data go or the ways they are used, staff may wish to refer the client to the Australian Institute of Health and Welfare website **www.aihw.gov.au** or the Australian Bureau of Statistics website **www.abs.gov.au**.

4.8 If the client objects to the question or declines to answer

4.8.1 Where a client objects to the question or declines to answer they should be informed of their right to decline to answer the standard question on whether a client is a Aboriginal and/or Torres Strait Islander person and be advised that their level of care and access to services will not be affected if they choose not to answer the question.

4.8.2 While staff have a duty to collect and record information on whether a client is Aboriginal and/or Torres Strait Islander from all clients as correctly as possible, they are not obliged to convince a disgruntled, upset or unwilling client to respond to the question.

4.8.3 While staff have a duty, if queried, to explain to clients why this question is being asked, they are not obliged to justify the use of the standard question.

4.9 If the client chooses not to answer the question 'correctly'

4.9.1 There may be occasions where a client is known to staff as an Aboriginal or Torres Strait Islander person yet the client chooses not to report as such in response to the standard question. Conversely there may be occasions where a known non-Aboriginal or Torres Strait Islander person chooses to report themselves as Aboriginal or Torres Strait Islander in response to this question.

Clients have a right to self-report whether they are Aboriginal and/or Torres Strait Islander and staff should therefore always record the response that the client provides; they should not question or comment on the client's response.

4.9.2 The client's recorded response should not be altered or annotated in any way to reflect the views of the staff member collecting the information.

4.10 If a client identifies as Aboriginal and/ or Torres Strait Islander

4.10.1 Any client who self-reports as Aboriginal and/or Torres Strait Islander should be offered the services of Aboriginal liaison officers or Aboriginal health workers where available; however, the client's choice to engage or not engage with such services should be respected.

4.10.2 Information about a person's Aboriginality should be included on the client's discharge summary.

4.11 If the client wishes to change personal information on their record

4.11.1 All clients should have the opportunity to confirm or update any previously recorded personal information on a regular basis, including confirmation or alteration of a record that they are Aboriginal and/or Torres Strait Islander.

4.11.2 The NSW Health Client Registration Policy (PD2007_094) describes when to update client registration details. Client/patient details, including information on Aboriginal and Torres Strait Islander origin, should be checked and confirmed or updated, as appropriate each time a client presents for a new phase of treatment.

4.11.3 Any changes to the previously recorded information on whether a client is Aboriginal and/or Torres Strait Islander should be received without comment and clients should not be required to provide a reason for changing their record.

5. STAFF TRAINING

5.1 Training in the correct and consistent collection of information on whether clients are Aboriginal and/or Torres Strait Islander must be delivered to all staff.

5.2 This training may be delivered as part of a training that focuses on overall data collection and data quality.

5.3 While it is recommended that all staff receive training in cultural safety for Aboriginal and/or Torres Strait Islander clients, such training should not be considered a pre-requisite for the collection of information on whether a client is an Aboriginal and/or Torres Strait Islander person using the standard question.

5.4 All staff must complete training requirements as outlined in the *Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health* (PD2011_069).

5.5 All persons responsible for collecting, recording and validating information on whether clients are Aboriginal and/or Torres Strait Islander should be able to demonstrate the following competencies:

a. An ability to ask the standard questions *Are you of Aboriginal or Torres Strait islander origin?'* correctly, and to correctly record responses on paper forms and/or computer systems.

b. An ability to clearly explain to clients the reason for collecting this information.

c. An understanding of why it is important to collect and record information on whether all clients are Aboriginal and/or Torres Strait Islander.

d. An understanding of why it is important to collect this information correctly and consistently, using the standard question.

e. An understanding of the voluntary nature of self-reporting a client's Aboriginality, and of a client's right to decline to answer this question or to change the information recorded.

f. Knowledge of available information and services for Aboriginal and Torres Strait Islander clients, and ability to convey this to clients as required.

g. Knowledge of and ability to conduct follow-up procedures for obtaining missing information, including whether a client is Aboriginal and/or Torres Strait Islander.

6. DATA QUALITY ASSURANCE AND VALIDATION AT LOCAL SERVICE LEVEL

For data quality assurance and validation at the local service level, local service providers must:

6.1 Review all forms and data recording systems to ensure the standard question on whether a client is Aboriginal and/or Torres Strait Islander is included and that coding categories are consistent with this policy and procedure.

6.2 Provide appropriate training, supervision and support to staff in primary data collection and data management roles, to ensure data items such as the item recording a client's Aboriginality are collected correctly and consistently

6.3 Ensure data collection processes and systems are streamlined and user friendly for staff in data collection roles.

6.4 Review client intake procedures to ensure client privacy is maintained, particularly in areas where clients are interviewed to obtain personal information.

6.5 Ensure staff across various levels and disciplines within the service are prompted to check for and follow up on missing client registration details, including information on a client's Aboriginality, in their contact with clients.

6.6 Establish business rules for distinguishing between 'not stated/inadequately described' records that are a result of a client's inability to answer (and are therefore to be followed up) and 'not stated/inadequately described' records in which the client declined to answer (which do not require further follow up).

6.7 Establish policies and procedures for correctly following up and correctly coding records with incomplete information on whether a client is Aboriginal and/or Torres Strait Islander.

6.8 Establish business rules for checking information on a client's Aboriginality against other data items, particularly country of birth, language spoken, and Medicare eligibility.

6.9 Monitor trends in the number and proportion of Aboriginal and/or Torres Strait Islander clients by comparing with the previous year's data, to determine whether there have been any obvious errors in coding.

6.10 Conduct data quality surveys involving direct surveys or interviews with clients, to determine the consistency and accuracy of the collection of information on whether clients are Aboriginal and/or Torres Strait Islander and to develop estimates of under-reporting.

7. DATA QUALITY ASSURANCE AND VALIDATION AT NSW MINISTRY OF HEALTH

For data quality assurance and validation state-wide, NSW Ministry of Health must:

7.1 Ensure data providers are aware of the policy and procedure

7.2 Ensure the correct business rules are applied to cope with different identifications when there are two sources of data (e.g. cause of death forms and death registrations). For example, if one data source identifies the client as Aboriginal or Torres Strait Islander, the record relating to this client should be coded accordingly.

7.3 Regularly monitor information on whether clients are Aboriginal and/or Torres Strait Islander and provide continuing feedback on data quality to local services. In particular, monitor levels of 'not stated' reported from local service providers to determine whether further education or assistance is required.

7.4 Regularly check that codes used for recording a client's Aboriginality in local systems are consistent with the policy and procedures, in particular check that invalid or inappropriate codes are not being used.

7.5 Compare data for Aboriginal and Torres Strait Islander persons with variables such as country of birth, language spoken, and Medicare eligibility, and follow up with local service providers to ensure any issues are investigated.

7.6 Regularly check that local service providers have not set default values for the standard question seeking information on whether a client is Aboriginal and/or Torres Strait Islander. This would be evidenced by no reporting of records with a 'not stated' response to the standard question.

7.7 For each local service, compare the number and proportion of records with information indicating clients are Aboriginal and/or Torres Strait Islander with the previous year's data to determine whether there have been any probable errors in coding.

7.8 Establish a system of review and audit of data collection processes and data quality for local service providers, including review and audit of Aboriginal and Torres Strait Islander data.

7.9 Inform the national data custodian of any events or issues that may have affected the quality of data recording whether clients are Aboriginal and/or Torres Strait Islander for a given period.

7.10 Establish a procedure for the prompt investigation and response to data validation requests from the national data custodian.

8. MONITORING

Monitoring of the implementation and impact of this policy directive will be undertaken by NSW Ministry of Health and Local Health Districts:

8.1 In partnership with the Australian Institute of Health and Welfare, NSW Ministry of Health conducts a biannual survey which estimates the level of correct reporting of Aboriginal and Torres Strait Islander people in NSW public hospital data.

8.2 Local Health Districts will be required to determine appropriate indicators to monitor the adherence to this policy.

9. REFERENCES

- Australian Institute of Health and Welfare (2010). National best practice guidelines for collecting indigenous status in health data sets. Cat. No. IHW 29. Canberra: AIHW.
- Privacy Manual for Health Information (March 2015).
- NSW Health (2007) Client Registration Policy (PD2007_094)
- NSW Health (2011) Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health. Policy Directive PD2011_069.

FRONT SHEET/PRINCIPAL DIAGNOSIS

To be read in conjunction with the Health Care Records Documentation and Management Policy (PD2012_069).

The front sheet of the health record must contain the **principal diagnosis,** other diagnoses and any operation(s) performed. Other conditions of significant concern should also be recorded.

The condition to be selected as Principal Diagnosis is the diagnosis established, after study, to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility). For acute surgical hospitals this will generally be the condition or reason for the surgical procedure(s) performed. The principal diagnosis is the major collection item for hospital morbidity statistics and is an important factor in research, evaluation, planning and allocation of resources.

The front sheet must be signed and designated by the medical officer in charge of the patient's care. This responsibility may be delegated to another medical officer, however, the medical officer in charge of the patient's care remains responsible for ensuring that the delegated duty is performed.

The front sheet of the medical record should be completed within 14 days of the patient being discharged.

HEALTH CARE RECORDS – DOCUMENTATION AND MANAGEMENT
(PD2012_069)

PD2012_069 rescinds PD2005_004, PD2005_015 & PD2005_127.

PURPOSE
The purpose of this policy is to:
- Define the requirements for the documentation and management of health care records across public health organisations (PHOs) in the NSW public health system.
- Ensure that high standards for documentation and management of health care records are maintained consistent with common law, legislative, ethical and current best practice requirements.

MANDATORY REQUIREMENTS

Documentation in health care records must provide an accurate description of each patient/client's episodes of care or contact with health care personnel. The policy requires that a health care record is available for every patient/client to assist with assessment and treatment, continuity of care, clinical handover, patient safety and clinical quality improvement, education, research, evaluation, medico-legal, funding and statutory requirements.

Health care record management practices must comply with this policy.

IMPLEMENTATION
Chief Executives are responsible for:
- Establishing mechanisms to ensure compliance with the requirements of this policy.
- Ensuring health care personnel are advised that compliance with this policy is part of their patient/client care responsibilities.
- Ensuring line managers are advised that they are accountable for implementation of this policy.
- Ensuring implementation of a framework for auditing of health care records and reporting of results.
- Ensuring health care records are audited and results reported within the PHO.

Facility/service managers are responsible for:
- Ensuring the requirements of this policy are disseminated and implemented in their hospital/ department/service.
- Ensuring health care personnel within their facility/service have timely access to paper based and electronic health care records.
- Monitoring compliance with this policy, including health care record audit programs, and acting on the audit results.

Health care personnel are responsible for:
- Maintaining their knowledge, documentation and management of health care records consistent with the requirements of this policy.
- Ensuring they are aware of current information about the patient/client under their care including where appropriate reviewing entries in the health record.

1. OVERVIEW

1.1 Introduction

This standard sets out the requirements for documentation and management for all models of health care records within the NSW public health system. Health care records promote patient safety, continuity of care across time and care settings, and support the transfer of information when the care of a patient/client is transferred eg. at clinical handover, during escalation of care for a deteriorating patient and transfer of a patient/client between settings.

1.2 Key definitions

Attending medical practitioner	Visiting Medical Officer or Staff Specialist responsible for the clinical care of the patient for that episode of care.
Approved clinician	A clinician, other than a medical practitioner, approved to order tests eg Nurse Practitioner.
Health care personnel	A person authorised to provide assessment, diagnosis, treatment/care, observation, health evaluation or professional advice or those personnel who have access to the patient/client health care records on behalf of the NSW public health system to facilitate patient/client care. Health care personnel include clinicians (and students) and clinical support staff. Clinicians include registered health practitioners[83] and other including Assistants in Nursing, social workers, dieticians, occupational therapists and Aboriginal Health Workers. Clinical support staff include Health Information Managers, Clinical Governance and Patient Safety staff, ward clerks, health care interpreters and accredited chaplains.
Health care record	The main purpose of a health care record is to provide a means of communication to facilitate the safe care and treatment of a patient/client. A health care record is the primary repository of information including medical and therapeutic treatment and intervention for the health and wellbeing of the patient/client during an episode of care and informs care in future episodes. The health care record is a documented account of a patient/client's history of illness; health care plan/s; health investigation and evaluation; diagnosis; care; treatment; progress and health outcome for each health service intervention or interaction. The health care record may also be used for communication with external health care providers, and statutory and regulatory bodies, in addition to facilitating patient safety improvements; investigation of complaints; planning, audit activities; research (subject to ethics committee approval, as required); education; financial reimbursement and public health. The record may become an important piece of evidence in protecting the legal interests of the patient/client, health care personnel, other personnel or PHO. The health care record may be paper, electronic form or in both. Where a health care record exists in both paper and electronic form this is referred to as a hybrid record. Where PHOs maintain a hybrid record health care personnel must at all times have access to information that is included in each part. This policy applies to health care records that are the property if, and maintained by, PHOs, including health care records of private patients seen in the PHO. The policy does not apply to records that may be maintained by patients/clients and records that may be maintained by clinicians in respect of private patients seen in private rooms.

[83] Health practitioners registered under the following National Boards - Chiropractic, Dental, Medical, Nursing and Midwifery, Optometry, Osteopathy, Pharmacy, Physiotherapy, Podiatry and Psychology - are required to comply with the health care records section of their relevant code of conduct/guidelines/competency standards. On 1 July 2012 the following healthcare personnel will be represented by a national registration board - Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners, and occupational therapists http://www.ahpra.gov.au/.

Must	Indicates a mandatory action required by a NSW Health policy directive, law or industrial instrument.
Medical practitioner	A person registered under the Health Practitioner Regulation National Law (NSW) in the medical profession.
Public health organisation (PHO)	a) Local health district. b) Statutory health corporation that provides patient/client services. c) Affiliated health organisation in respect of its recognised establishment or recognised service that provides patient/client services, or d) Ambulance Service of NSW.
Should	Indicates an action that ought to be followed unless there are justifiable reasons for taking a different course of action.

1.3 Privacy and confidentiality

All information in a patient/client's health care record is confidential and subject to prevailing privacy laws and policies. Health care records contain health information which is protected under legislation.[84] The requirements of the legislation, including the Privacy Principles, are explained in plain English in the NSW Health Privacy Manual.[85] Health care personnel should only access a health care record and use or disclose information contained in the record when it is directly related to their duties and is essential for the fulfilment of those duties, or as provided for under relevant legislation.

1.4 Auditing

Health care records across all settings and clinical areas must be audited for compliance with this policy. PHOs must establish a framework and schedule for auditing of records and approve and designate audit tools and processes.

Clinical audits of documentation in health care records should involve a team based approach with the clinical team consisting of medical practitioners, nurses, midwives, allied health practitioners and other health care personnel, as appropriate.

Health care record audit results should be:
a) Provided to relevant clinical areas and health care personnel.
b) Included in PHO performance reports.
c) Referred to PHO quality committees to facilitate quality improvement.

1.5 Education

PHOs must establish a framework for the development and delivery of suitable education on documentation and management of health care records. All health care personnel who document or manage health care records must be provided with appropriate orientation and ongoing education on the documentation and management of health care records.

The content and delivery of education programs should be informed by health care record audits. The results of such audits should be used to target problem areas relating to particular health care personnel groups or facets of documentation and management.

Specific education must be conducted for the introduction of any new complex health care record forms and for changes in documentation models.

[84] Health Records and Information Privacy Act 2002 http://www.legislation.nsw.gov.au/maintop/view/inforce/act+71+2002+cd+0+N
[85] Privacy Manual for Health Information (March 2015)

2. DOCUMENTATION

2.1 Identification on every page/screen[86]

The following items must appear **on every page of the health care record**, or on each screen of an electronic record (with the exception of pop up screens where the identifying details remain visible behind):

a) Unique identifier (eg. Unique Patient Identifier, Medical Record Number).
b) Patient/client's family name and given name/s.
c) Date of birth (or gestational age/age if date of birth is estimated).
d) Sex. The exception is ObstetriX records where sex of the mother is not recorded.

2.2 Standards for documentation[87]

Documentation in health care records must comply with the following:

a) Be clear and accurate.

b) Legible and in English.

c) Use approved abbreviations and symbols.

d) Written in dark ink that is readily reproducible, legible, and difficult to erase and write over for paper based records.

e) Time of entry (using a 24-hour clock - hhmm).

f) Date of entry (using ddmmyy or ddmmyyyy).

g) Signed by the author, and include their printed name and designation. In a computerised system, this will require the use of an appropriate identification system eg. electronic signature.

h) Entries by students involved in the care and treatment of a patient/client must be co-signed by the student's supervising clinician.[88]

i) Entries by different professional groups are integrated ie. there are not separate sections for each professional group.

j) Be accurate statements of clinical interactions between the patient/client and their significant others, and the health service relating to assessment; diagnosis; care planning; management/ care/treatment/services provided and response/outcomes; professional advice sought and provided; observation/s taken and results.

k) Be sufficiently clear, structured and detailed to enable other members of the health care team to assume care of the patient/client or to provide ongoing service at any time.

l) Written in an objective way and not include demeaning or derogatory remarks.

m) Distinguish between what was observed or performed, what was reported by others as happening and/or professional opinion.

n) Made at the time of an event or as soon as possible afterwards. The time of writing must be distinguished from the time of an incident, event or observation being reported.

[86] PD2009_072 State Health Forms http://www.health.nsw.gov.au/policies/pd/2009/PD2009_072.html
[87] Each registered health practitioner is required to comply with the health care records section of the code of conduct/guidelines/competency standards under their relevant National Board
[88] PD2005_548 Student Training and Rights of Patients http://www.health.nsw.gov.au/policies/pd/2005/PD2005_548.html and GL2005_034 Reports - Countersigning Enrolled Nurse, Trainee Enrolled Nurse or Assistant in Nursing Patient Care http://www.health.nsw.gov.au/policies/GL/2005/GL2005_034.html

o) Sequential - where lines are left between entries they must be ruled across to indicate they are not left for later entries and to reflect the sequential and contemporaneous nature of all entries.

p) Be relevant to that patient/client.

q) Only include personal information about other people when relevant and necessary for the care and treatment of the patient/client.

r) **Addendum** - if an entry omits details any additional details must be documented next to the heading 'Addendum', including the date and time of the omitted event and the date and time of the addendum.

For hardcopy records, addendums must be appropriately integrated within the record and not documented on additional papers and/or attached to existing forms.

s) **Written in error** - all errors are must be appropriately corrected.
No alteration and correction of records is to render information in the records illegible.

An original incorrect entry must remain readable ie. do not overwrite incorrect entries, do not use correction fluid. An accepted method of correction is to draw a line through the incorrect entry or 'strikethrough' text in electronic records; document "written in error", followed by the author's printed name, signature, designation and date/time of correction.

For electronic records the history of audited changes must be retained and the replacement note linked to the note flagged as "written in error". This provides the viewer with both the erroneous record and the corrected record.

2.3 Documentation by medical practitioners

Documentation by medical practitioners must include the following:

a) Medical history, evidence of physical examination.

b) Diagnosis/es (as a minimum a provisional diagnosis), investigations, treatment, procedures/ interventions and progress for each treatment episode.

A principal diagnosis must be reported for every episode of admitted patient care.

c) Medical management plan.

d) Where an invasive procedure is performed and/or an anaesthetic is administered, a record of the procedure including completion of all required procedural checklists. Where a general anaesthetic is administered, a record of examination by a medical practitioner prior to the procedure is also required.

e) Comprehensive completion of all patient/client care forms.

f) A copy of certificates, such as Sick and Workers Compensation Certificates, provided to patients/clients must be retained in the patient/client's health care record.

2.3.1 Attending Medical Practitioner

The Attending Medical Practitioner (AMP) is responsible for the clinical care of the patient/client for that episode of care and is responsible for ensuring that adequate standards of medical documentation are maintained for each patient/client under their care.

When documentation is delegated to a medical practitioner e.g. Intern, Resident, Registrar, the AMP remains responsible for ensuring documentation is completed to an appropriate standard that would satisfy their professional obligations.

The AMP should review the preceding medical entries and make a written entry in the health care record (print name, signature, designation and date/time) to confirm they have been read at the same time as they are reviewing the medical management plan for the patient/client to ensure it remains current and clinically appropriate, consistent with the AMP's duty of care to the patient/client.

2.4 Documentation by nurses and midwives

Documentation by nurses and midwives must include the following:

a) Care/treatment plan, including risk assessments with associated interventions.

b) Comprehensive completion of all patient client care forms.

c) Any significant change in the patient/client's status with the onset of new signs and symptoms recorded.

d) If a change in the patient/client's status has been reported to the responsible medical practitioner documentation of the name of the medical practitioner and the date and time that the change was reported to him her.

e) Documentation of medication orders received verbally, by telephone/electronic communication including the prescriber's name, designation and date/time.

2.5 Frequency of documentation

The frequency of documentation entries should conform to the following as minimum requirements.

2.5.1 Acute Care Patient/clients

a) Registered Nurse/Midwife, Enrolled/Endorsed Nurse should make an entry in the patient/ client's health care record a minimum of once a shift. An entry by an Assistant in Nursing should **not** be the only entry for a shift.

Entries should reflect in a timely way the level of assessment and intervention. The results of significant diagnostic investigations and significant changes to the patient/client's condition and/or treatment should be documented as these occur.

b) Medical practitioners should make an entry in the health care record at the time of events, or as soon as possible afterwards, including when reviewing the patient/client.[89]

c) Other health care personnel should make entries to reflect their level of assessment and intervention consistent with the medical management plan.

2.5.2 Long Stay or Residential Patients/Clients

Depending on the health care setting and the length of stay (or expected length of stay) of the patient/ client, health care personnel should make an entry at least weekly in the health care record particularly when warranted by the patient's medical condition or frailty.

Additional entries should be made to reflect changes in the patient/client status, condition and/or treatment or care plan as these occur.

2.5.3 Non-Admitted Patient/Clients

An entry must be made in the health care record for each patient/client attendance (including video conference sessions) and for failures to attend.

[89] Medical Board of Australia. Good Medical Practice: A Code of Conduct http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

Entries should reflect the level of assessment and intervention. The results of significant diagnostic investigations and significant changes to the patient/client's condition and/or treatment should be documented.

Attendance of individual patient/clients at sessions of a formal multiple session group program should be noted. Such attendances may be documented in an attendance register or scheduling system rather than the patient/client's health care record. Where a patient/client receives specific individual care or treatment in addition to the group session interaction, this care or treatment should be documented in their health care record.

2.6 Alerts and allergies

Clinicians must flag issues that require particular attention or pose a threat to the patient/client, staff or others including:

a) Allergies/sensitivities or adverse reactions, and the known consequence.

b) Infection prevention and control risks.

c) Behaviour issues that may pose a risk to themselves or others.

d) Child protection/well being matters including

   i. alerts and flags for High Risk Birth Alerts or prenatal reports
   ii. children at risk of significant harm
   iii. where NSW Police or the Department of Family and Community Services have issued a general alert to a PHO.

e) Where patients/clients have similar names and other demographic details.

PHOs must implement systems for the identification of such alerts and allergies. If a label is used on the outside folder of a paper based health care record this does not negate the need for documentation in the health care record of the alert/allergy, and known consequence.

Any such issue should be 'flagged' or recorded conspicuously on appropriate forms, screens or locations within the health care record. Where alerts relate to behaviour issues or child protection matters the alert should be discreet to ensure the privacy and safety of the patient/client, staff or others.

These flags, especially where codes or abbreviations are used, must be apparent to and easily understood by health care personnel; must not be ambiguous; and should be standardised within the PHO.

A flag should be reviewed at each admission. When alerts and allergies are no longer current this must be reflected in the health care record and inactivated where possible.

2.7 Labels

Non-permanent adhesive labels should be avoided. Where considered essential the label must be relevant to the patient/client and placed so that all parts of the health care record are able to be read and patient/client privacy maintained. State approved labels must be used.

2.8 Tests - requests and results

The health care record must document pathology, radiology and other tests ordered, the indication and the result.

When tests are ordered the name of the ordering medical practitioner/approved clinician and their contact number must be clearly printed (if written) or entered (if computerised) on the request form.

Pathology, radiology and other test results must be followed up and reviewed with notation as to action required. The results must be endorsed by the receiving medical practitioner/approved clinician, with endorsement involving the name, signature, designation of the medical practitioner/ approved clinician, and date/time.

PHOs must develop local procedures, including steps to be taken, when:
a) Relevant details on the request form are incomplete or illegible.
b) The ordering medical practitioner/approved clinician is not on duty or contactable.

Critical/unexpected/abnormal results should be documented in the patient/client's health care record by the responsible medical practitioner/approved clinician as soon as practicable and any resultant change in care/treatment plans documented.

2.9 Patient/client clinical incidents

All actual clinical incidents must be documented in the patient/client's health care record.[90]

Staff must document in the health care record.
a) Incident Information Management System (IIMS) identification number.
b) Clinically relevant information about the incident.
c) Interactions related to open disclosure processes.[91]

2.10 Complaints

Complaint records are not to be kept with the patient's health care record.[92]

2.11 Emergency Department records

Emergency Department records must include the following:

a) Date and time triaged including triage score.

b) Presenting problem and triage assessment.

c) Date and time seen by a medical practitioner, other clinicians such as a Clinical Initiatives Nurse, Nurse Practitioner, nursing, midwifery and allied health staff.

d) Medical, nursing, midwifery and allied health assessment.

e) Pathology, radiology and other tests ordered. Pathology, radiology and other test results must be followed up and reviewed with notation as to action required.

f) Description of critical/unexpected/abnormal pathology, radiology and other test results. If the patient/client has left the Emergency Department and not been admitted, document the steps taken to contact the patient/client or their carer if the test results indicate that urgent treatment/ care is required.

[90] PD2014_004 Incident Management Policy http://www.health.nsw.gov.au/policies/pd/2014/PD2014_004.html
[91] PD2014_028 Open Disclosure Polocy http://www.health.nsw.gov.au/policies/pd/2014/PD2014_028.html
[92] Complaint Management Policy (section 7.9) http://www.health.nsw.gov.au/policies/pd/2006/PD2006_073.html

g) Details of treatment.

h) Follow up treatment where applicable.

i) Transfer of care date and time, destination (eg. home, other level of health care) method and whether accompanied.

2.12 Anaesthetic reports

Anaesthetic reports must include the following:

a) Pre-operative assessment, including patient anaesthetic history.

b) Risk-rating eg. American Society of Anaesthesiologists (ASA) score.

c) Date and time anaesthetic commenced and completed.

d) Anaesthesia information and management ie. medications, gases, type of anaesthetic.

e) NSW safety checklists including patient assessment and equipment checklists consistent with Australian and New Zealand College of Anaesthetists requirements.

f) Operative note/monitor results.

g) Post-operative notes/orders.

2.13 Operation/procedure reports

Operation/procedure reports must include the following:

a) Date of operation/procedure.

b) Pre-operative and post-operative diagnosis.

c) Indication for operation/procedure.

d) Procedure safety checklist.

e) Surgical operation/procedure performed.

f) Personnel involved in performing the operation/procedure.

g) Outline of the method of surgery/procedure.

h) Product/device inserted and batch number.

i) Changes to, or deviations from, the planned operation/procedure, including any adverse events that occurred.

k) Tissue removed.

l) Pathology ordered on specimens.

m) Post-operative orders.

2.14 Telephone/electronic consultation with patient/clients

When clinical information is provided to a patient/client, or their carer/guardian/advocate, the consultation must be documented in the health care record. The identification of the caller must be documented.

Where the caller is not the patient/client, or their carer/guardian/advocate obtain consent from the patient/client, or their carer/guardian/advocate prior to the consultation. Document the:

a) Caller's name,
b) Relationship to the patient/client, and
c) That the patient/client, or their carer/guardian/advocate has consented to the caller seeking clinical information about the patient/client

in the patient/client's health care record.

2.15 Telephone/electronic consultation between clinicians

Where a clinician involved in the care and treatment of a patient/client formally consults another clinician, via telephone/electronic means, about the patient/client and the consulted clinician provides advice, direction or action, that advice, direction or action must be documented in the health care record by the clinician seeking the advice. The name and designation of the consulted clinician, and the date/time of the consultation must also be documented as soon as practical following consultation with the other clinician and in a manner as to ensure continuity of care for patients.

2.16 Leave taken by patients/clients

Any leave taken by the patient/client should be documented in their health care record with the date/ time the patient/client left and returned. The patient/client should be assessed before proceeding on leave and the outcome of that assessment documented in the health care record, together with the documented approval of the AMP noting the assessment.

2.17 Leaving against medical advice

A patient/client who decides to leave the health service/program against medical advice must be asked to sign a form to that effect with the form filed in the patient/client's health care record. If the patient/client refuses to sign the form this must be documented in the health care record, including any advice provided.

Examples of advice that could be provided to the patient/client include:

a) The medical consequences of the patient's decision, including the potential consequences of no treatment.

b) The provision or offering of an outpatient management plan and follow-up that is acceptable and relevant to the patient.

c) Under what circumstances the patient should return, including an assurance that they can elect to receive treatment again without any prejudice.

3 MANAGEMENT

3.1 Responsibility and accountability

The Chief Executive of the PHO must comply with the State Records Act and its regulation in respect of health care records.[93]

Responsibility for the maintenance of appropriate health care records must be included in the terms and conditions of appointment (including position descriptions) for all health care personnel as defined in this policy.

Documentation must be included as a standing item in annual performance reviews of clinicians. Failure to maintain adequate health care records will be managed in accordance with current NSW Health policies and guidelines for managing potential misconduct.

3.2 Individual health care record

An individual health care record with a unique identifier (eg unique patient identifier, medical record number) must be created for each patient/client who receives health care. Every live or still born baby must be allocated a unique identifier that is different to the mother.

Where multiple patient identifiers exist for the same patient/client within a PHO there must be processes established for their reconciliation and linkage, with the ability to audit those processes.

A reference notation should be placed on the health care record to identify any relevant other documents that relate to the patient's health care. Index or patient administration systems must reference the existence of satellite/decentralised health care records that address a specific issue and that are kept separate from the principal health care record. Due to the nature of the information contained in sexual assault records these must be maintained separately from the principal health care record and be kept secure at all times; as should child protection/wellbeing and genetics records.

Staff screening and vaccination records are considered as personnel rather than health care records and must be maintained separately.

3.3 Access

Health care records should be available at the point of care or service delivery. Health care records must not be removed from the campus unless prior arrangements have been made with the PHO eg. required for a home visit, required under subpoena.

Health care records are only accessible to:[94]

b) Health care personnel currently providing care/treatment to the patient/client.
c) Staff involved in patient safety, the investigation of complaints, audit activities or research (subject to ethics committee approval, as required).
c) Staff involved in urgent public health investigations for protecting public/population health, consistent with relevant legislation.[95]

[93] State Records Act 1998 http://www.legislation.nsw.gov.au/maintop/view/inforce/act+17+1998+cd+0+N
[94] Privacy Manual for Health Information (March 2015)
Health Records and Information Privacy Act 2002 http://www.legislation.nsw.gov.au/maintop/view/inforce/act+71+2002+cd+0+N,
Government Information (Public Access) Act 2009 http://www.legislation.nsw.gov.au/maintop/view/inforce/act+52+2009+cd+0+N
[95] Public Health Act http://www.legislation.nsw.gov.au/

d) Patient/client to whom the record relates, or their authorised agent, based on a case by case basis in accordance with health service release of information policies and privacy laws.
e) Other personnel/organisations/individuals in accordance with a court subpoena, statutory authority, valid search warrant, coronial summons, or other lawful order authorised by legislation, common law or NSW Health policy.

All requests for information, that is contained in a patient/client's health care record, from a third/ external party should be handled by appropriately qualified and experienced health care personnel, such as Health Information Managers, due to the sensitive nature of health care records; the special terminology used within them; and regulatory requirements around access to, and disclosure of, information.

3.4 Ownership

The health care record is the property of the PHO providing care, and not individual health care personnel or the patient/client.

Where shared care models or arrangements exist for clinicians to treat private patient/clients within PHO facilities/settings, responsibility for the management of those health care records must be included in the terms of the arrangement between the PHO and the clinician.

3.5 Retention and durability

Health care records must be maintained in a retrievable and readable state for their minimum required retention period.[96]

Entries should not fade, be erased or deleted over time. The use of thermal papers, which fade over time, should be restricted to those clinical documents where no other suitable paper or electronic medium is available e.g. electrocardiographs, cardiotocographs.

Electronic records must be accessible over time, regardless of software or hardware changes, capable of being reproduced on paper where appropriate, and have regular adequate backups.

3.6 Storage and security

The *Health Records and Information Privacy Act 2002* establishes statutory requirements for the storage and security of health care records, which are also included in the NSW Health Privacy Manual. A summary of these requirements is provided below. However, the Privacy Manual should be consulted for further detail in this area.

Personal health information, including healthcare records, must have appropriate security safeguards in place to prevent unauthorised use, disclosure, loss or other misuse. For example, all records containing personal health information should be kept in lockable storage or secure access areas when not in use.

Control over the movement of paper based health care records is important. A tracking system is required to facilitate prompt retrieval to support patient/client care and treatment and to preserve privacy.

[96] Patient Matters Manual (http://www.health.nsw.gov.au/policies/manuals/Pages/patient-matters-manual.aspx) and patient/client records requirements at State Records (http://www.records.nsw.gov.au/recordkeeping/government-recordkeeping-manual/rules/general-retention-and-disposal-authorities/general-retention-and-disposal-authorities-1/?searchterm=GDA)

A secure physical and electronic environment should be maintained for all data held on computer systems by the use of authorised passwords, screen savers and audit trails. If left unattended, no personal health information should be left on the screen. Screen savers and passwords should be used where possible to reduce the chance of casual observation. Consideration may be given to providing staff with different levels of access to electronic records where appropriate (i.e. full, partial or no access).

Details of the roles and responsibilities of staff, including system administrators and IT technical and support staff, concerning the protection of health care records held on electronic information systems are given in the NSW Health Electronic Information Security Policy http://www.health.nsw.gov.au/policies/pd/2013/PD2013_033.html

3.7 Disposal[97]

Health care records, both paper based and electronic, must be disposed of in a manner that will preserve the privacy and confidentiality of any information they contain.

Disposal of data records should be done in such as way as to render them unreadable and leave them in a form from which they cannot be reconstructed in whole or in part.

Paper records containing personal health information should be disposed of by shredding, pulping or burning. Where large volumes of paper are involved, specialised services for the safe disposal of confidential material should be employed.

The disposal of health care records must be documented in the PHO's Patient Administration System and undertaken in accordance with the relevant State General Disposal Authority.

[97] Patient Matters Manual (**http://www.health.nsw.gov.au/policies/manuals/Pages/patient-matters-manual.aspx**) and patient/client records requirements at State Records (**http://www.records.nsw.gov.au/recordkeeping/government-recordkeeping-manual/rules/general-retention-and-disposal-authorities/general-retention-and-disposal-authorities-1/?searchterm=GDA**)

4 IMPLEMENTATION SELF ASSESSMENT CHECKLIST

An Implementation Self Assessment Checklist is provided to support implementation of this policy.

Requirement: Self Assessment:

	Nil	In development	Partial implementation	Mature
A. STRATEGIC FUNDAMENTALS				
PHO has documented processes to manage health care records				
PHO uses an approved abbreviation list				
There are resources and support to implement the Health Care Records policy and regular monitoring of progress by a responsible officer				
Key performance indicators are developed to monitor and measure implementation of the Health Care Records policy in the PHO Examples of performance measures: 1 Patient identification is on every page of the health care record or on each screen of the electronic record. 2 Handwritten entries are legible to a reader other than the author.				
B. INTEGRATION INTO NORMAL BUSINESS SYSTEMS				
Responsibility and accountability for documentation and management of health care records is clearly stated in position descriptions and incorporated into performance review for all relevant health care personnel.				
The design, approval and implementation of health care records forms (including electronic systems) is consistent with state policies and procedures.				

9. HEALTH RECORDS AND INFORMATION 9.161

Requirement: Self Assessment:

	Nil	In development	Partial implementation	Mature
C. ORGANISATIONAL IMPLEMENTATION				
A schedule is in place for auditing of health care records across clinical settings. This should include both record completeness and clinical audits.				
All clinical areas are audited for compliance with the Health Care Record policy according to the schedule noted above.				
Results and analysis of health care record audits are provided to clinicians and managers, and are used to inform remedial quality improvement activities.				
Results and analysis of health care record audits are used to inform education on clinical documentation.				
There is a process for recognition of excellence in the documentation and management of health care records.				
Health care records key performance indicators are monitored at ward/unit, hospital/service and PHO level and benchmarked with appropriate peers.				

NOTIFICATION OF ACUTE RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE – THE NSW PUBLIC HEALTH ACT 2010 (IB2015_057)

PURPOSE

This Information Bulletin provides guidance on the addition of Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) to the list of medical conditions in Schedule 1 of the *NSW Public Health Act*, and to the list of notifiable diseases in Schedule 2 of the Act.

Under the provisions of the *Public Health Act 2010* and the *Public Health Regulation 2012*, doctors, hospital chief executive officers (or general managers), pathology laboratories, directors of child care centres and school principals are required to notify certain medical conditions listed on the NSW Ministry of Health website.

KEY INFORMATION

On 2 October 2015 the *NSW Public Health Act 2010* was amended to add ARF and RHD in a person under the age of 35 to:

a) The list of medical conditions in Schedule 1 to that Act:
   i. That must be notified by medical practitioners to the Secretary of the NSW Ministry of Health,

and

b) The list of notifiable diseases in Schedule 2 to that Act:
   i. That must be notified by health practitioners providing care in hospitals to the chief executive officer of the hospital concerned,

and
   ii. That must be notified by the chief executive officer of a hospital to the Secretary of the NSW Ministry of Health.

NOTIFICATION MECHANISMS

Information on the notification of infectious diseases under the *Public Health Act 2010* is detailed in the Information Bulletin IB2013_010.

Infectious disease notifications should be directed to the local Public Health Unit, and should be initiated as soon as possible within 24 hours of diagnosis.

In order to protect patient confidentiality, notifications must not be made by facsimile machine except in exceptional circumstances and when confidentiality is ensured.

Disease notification guidelines and notification forms for notifiers are available at:
www.health.nsw.gov.au/Infectious/Pages/notification.aspx

NON-ADMITTED PATIENT DATA COLLECTION: CLASSIFICATION AND CODE STANDARDS FOR REPORTING SERVICES PROVIDED FROM 1 JULY 2016 IN A WEBNAP EXTRACT FORMAT (IB2016_039)

PURPOSE

The purpose of this Information Bulletin is to inform NSW Health service providers and source system administrators of changes to the classification and code set standard for reporting non-admitted patient service provided from 1 July 2016.

KEY INFORMATION

Due Dates for Reporting

Non-admitted patient activity data must be submitted and of acceptable quality by the 10th calendar day of the month after the month the service was delivered.

Patient or summary level non-admitted patient activity reporting

Patient level non-admitted patient activity is to be reported for in scope activity.

Where the requirement to report patient level activity data cannot be met summary level data must be reported.

The following services are only required to report non-admitted patient activity at the summary level.

1. Group immunisation services (Service Type 023 Immunisation – On Mass (no patient level data)
2. Group diagnostic screening services
3. Needle exchange services and supervised injecting room services (including service units classified to Service Unit Establishment Type 11.04 Needle Exchange Allied Health / CNS Unit).
4. Crisis line counselling telephone services.

This data is to be reported by WebNAP, or by mLoad when that capability is provided.

Summary level must not be reported for any service unit reporting activity at the patient level.

There is no longer a requirement to advise the Executive Director, Health System Information and Performance Reporting Branch of the Local Health Districts (LHDs) and Specialist Health Networks (SHNs) intention to decommission summary level reporting for those service units reporting at the patient level.

Reporting of Services with Multiple Providers

When reporting non-admitted patient services in a WebNAP extract via mLoad each individual service provider should be reported, even if two or more providers have the same provider type code.

Occasion of Service Record Identifier

Each occasion of service must be reported with a unique record identifier in the 'Service Event Record ID' field. When resubmitting an occasion of service record the same record identifier must be reported so that the original record is identified and updated.

Where a record identifier is not unique within a single submission to EDWARD, mLoad will prevent the entire file from loading.

Data element classifications subject to change

The requirements for reporting non-admitted patient activity to the Non-Admitted Patient Data

Collection will change for the following data elements:

1. Provider Type
2. Setting Type
3. Financial group.

The changes are of the following type:

1. Some new categories will become effective from 1 July 2016
2. Some existing categories will expire on 30 June 2016
3. Some continuing categories have descriptive label changes.

Implementation

The classification changes must be implemented for the reporting of non-admitted patient services provided on or after 1 July 2016 where they are reported via a WebNAP extract format.

These changes will require LHDs / SHNs to:

- Modify local source system classifications
- Map the local source system categories to the appropriate WebNAP alias code values
- Modify WebNAP Service Options for the service units reporting summary level data and impacted by the changed classifications

This involves:

  - End dating existing service options containing expired reference codes effective 30 June 2016
  - Establishment of new service options containing the new reference codes effective from 1 July 2016.

LHD / SHNs must advise and instruct their source system vendors of the changed requirements and any subsequent need to modify systems. Where a source system is shared between multiple LHDs / SHNs; are compliant with a State Based Build; and / or are subject to application support services provided by eHealth NSW, it is the responsibility of each LHD / SHN to ensure the technical implementation of the modified reporting requirements are raised through the appropriate application support mechanisms. This includes:

- The LHD / SHN Application Advisory Group (AAG) representative ensuring that the change requirements are on the AAG meeting agenda, discussed at the AAG meetings and are approved within a time frame that will enable the implementation due date to be met.
- Directing and authorising eHealth NSW to make the application build change by raising the request for change on the State-wide Service Desk and tracking the change through to its delivery.

Clarification Advice

The NSW Ministry of Health will provide clarification advice regarding the changed reporting requirements outlined in the attachments. Requests for advice should be directed to the Health System Information and Performance Reporting Branch, NSW Ministry of Health.

Primary Contact:

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Escalation Contact:

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LINK TO ATTACHMENTS:

http://www0.health.nsw.gov.au/policies/ib/2016/pdf/IB2016_039.pdf

ATTACHMENT 1

Non-admitted Patient Activity Reporting – Changes to Classification and Code Standards for Reporting Services Provided from 1 July 2016 via a WebNAP Extract Format.
This attachment outlines changes to Non-admitted Patient Data Collection (NAPDC) data elements domains, in scope of the existing WebNAP extract, for services provided on or after 1 July 2016.

The final classifications for each data element reported in a code format, incorporating the changes applicable from 1 July 2016, are provided Attachment 2.

The NAPDC WebNAP Data Dictionary in HIRD provides detailed information pertaining to the concepts and classification, including the new and changed category definitions. Links to this data dictionary are provided on the following NSW Ministry of Health Intranet page:

http://internal.health.nsw.gov.au/data/collections/webnap/webnap-data-dictionary-patient-v6.html

ATTACHMENT 2

Non-admitted Patient Activity Reporting – Classification and Code Standards for Reporting Services Provided from 1 July 2016 via a WebNAP Extract Format.

This document provides the NSW Health State classification and code standards applicable to services provided from 1 July 2016 for data elements in scope of the Non-admitted Patient Data Collection Core Minimum Data Set and reported via the legacy WebNAP patient level extract.

The NSW Health State classification and code standards applicable to services reported in the EDWARD extract format are provided at the following NSW Ministry of Health intranet page:

http://internal.health.nsw.gov.au/data/edward/edward-metadata-data-stream-service-event-nap-flat-file-format.html

NON-ADMITTED PATIENT DATA COLLECTION TRANSITION FROM WEBNAP TO EDWARD REPORTING (GL2015_012)

PURPOSE

The purpose of this Guideline is to advise NSW Health non-admitted patient service providers and non-admitted patient activity source system support staff of the changes in requirements involved in the transition from reporting via WebNAP to reporting via the EDWARD.

An understanding of these differences, and the three phases of implementation, is required to reconfigure source system builds and patient level activity extracts, and redesign non-admitted patient activity reporting business processes.

KEY PRINCIPLES

In line with NSW Health's strategic direction and the significantly increased volumes of non-admitted patient services being reported at the patient level by NSW Health services the Non-Admitted Patient Data Collection will transition to be reported via EDWARD rather than the interim system WebNAP.

The migration of the data collection to EDWARD will have significant benefits for Local Health Districts (LHDs) / Specialist Health Networks (SHNs) and other NSW Health agencies. LHDs / SHNs should expect higher data availability, more efficient data loading and resubmission processes, significantly improved data error reporting functionality and appropriately secured access to activity data.

When reported via EDWARD the non-admitted patient, admitted patient and emergency department activity data will be automatically allocated the appropriate National Weighed Activity Unit (NWAU) and integrated into a single data mart that supports full patient journey analysis utilising the Enterprise Patient Registry unique identifier.

USE OF THE GUIDELINE

In order to minimise the transition burden, requirements have been prioritised across three phases:

- **Phase 1**: Report current scope via EDWARD and decommission WebNAP
- **Phase 2**: Convert source system extracts and classifications to the EDWARD format
- **Phase 3**: Integrate additional reporting requirements for specific clinical streams

The EDWARD Business Implementation (EBI) Program collaborating with the NSW Ministry of Health's Health Systems Information and Performance Reporting (HSIPR) Branch will establish a small project team to support transition, testing and address queries as they arise during the migration period.

Phase 1

Implementation of phase 1 requires LHDs/SHNs to load WebNAP patient level and summary level extracts into EDWARD and to cease reporting to WebNAP.

To support the transition to EDWARD reporting during Phases 1 and 2, a file upload, conversion and transfer tool, the EDWARD mLoad Tool, will be available for LHDs/SHNs to upload patient level and summary level data extracts from source systems in either the WebNAP extract format, or the EDWARD extract format.

The tool will apply the necessary file format conversions to WebNAP extracts compliant with the 2015/16 WebNAP reporting requirements and file format. It will also produce a container header file (based on user inputs) for both WebNAP and EDWARD flat file formats, and transfer files to the EDWARD drop zone where they will be automatically loaded into EDWARD.

During this phase LHDs / SHNs:

1. Must build EDWARD extracts for non-admitted patient source systems that are not yet reporting at the patient level
2. Must commence the reconfiguration of WebNAP extracts such that the source system can report activity directly in the EDWARD extract format
3. May cease reporting summary level data for services reporting at the patient level once reporting through the EDWARD mLoad Tool
4. May commence (or fully implement any) transition steps outlined in later phases.

Phase 1 must be completed by **30 June 2016**, to enable the decommissioning of WebNAP.

Phase 2

Implementation of Phase 2 requires LHDs / SHNs to complete the reconfiguration of WebNAP source system extracts into the EDWARD extract format and source systems to be fully aligned with the EDWARD classification standards.

During this phase any changes effective from 1 July 2016 will also need to be incorporated into the EDWARD extracts.

During this phase LHDs/SHNs may implement Phase 3 implementation steps.

Phase 2 must be completed **by 30 June 2017**, to enable the decommissioning of the WebNAP patient level file conversion functionality, compliance with 2016/17 reporting requirements and to establish the foundations required for implementation of Phase 3.

Phase 3

Phase 3 involves reporting the additional data elements set aside in the EDWARD extract file format for the integration of other non-admitted patient data collections for specific clinical streams. It will involve decommissioning the legacy extracts and legacy data repositories (such as HIE and other disparate databases).

This phase may only impact selected source systems. For example, radiotherapy sources system would add data elements required for the integration of radiotherapy waiting times and non-admitted patient cancer notifications, while source systems used by Hepatitis, HIV/AIDS and sexually transmissible diseases services would add data elements pertaining to communicable diseases.

Phase 3 is expected to be completed **by 30 June 2018**, to enable the decommissioning of the HIE and other legacy data repositories and to establish a single comprehensive non-admitted patient data collection.

FURTHER INFORMATION

The NSW Ministry of Health will provide advice and clarifications regarding the requirements for reporting non-admitted patient activity via EDWARD. Requests for advice should be directed to the Health System Information & Performance Reporting Branch, NSW Ministry of Health.

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ATTACHMENT

1. "Non-Admitted Patient Data Collection Migration Strategy and Transition Details" -Guideline.

LINK TO COMPLETE GUIDELINE AND ATTACHMENT :

https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2015_012

RIGHT TO ACCESS MEDICAL RECORDS BY LEGAL REPRESENTATIVES – MENTAL HEALTH REVIEW TRIBUNAL HEARINGS (IB2018_019)

PURPOSE

The purpose of this information bulletin is to inform Local Health Districts/Specialty Networks of the right of a patient's legal representative to inspect and access the patient's medical records when the patient has a matter before the Mental Health Review Tribunal and the need to facilitate a legal representative's access to such records.

KEY INFORMATION

Under the Mental Health Act 2007, where the Mental Health Review Tribunal (Tribunal) holds a hearing or review in respect of a mental health patient, the patient has a right to be represented by a legal representative. In certain hearings, such as a mental health inquiry, the patient must be represented by a legal representative (or other person approved by the Tribunal). In most cases, a patient's legal representative will be a legal practitioner from LegalAid or a LegalAid panel firm.

In order to ensure that a patient's legal representative can appropriately represent the patient, the Mental Health Act gives a patient's legal representative the right to inspect or have access to any medical records in the possession of the mental health facility at the Local Health District/Specialty Network relating to a patient who has a hearing before the Tribunal.

A legal representative's right to access a patient's records is important in order to ensure that that the legal representative can understand the basis on which the patient has been detained and can properly and fully make submissions to the Tribunal in relation to the patient's detention.

A Local Health District/Specialty Network must facilitate a patient's legal representative's right to inspect or access information about a patient's detention, including admission documents, progress notes and relevant reports.

In advance of a hearing before the Tribunal, the relevant unit in a Local Health District/Specialty Network (such as a mental health facility or medical record unit) must provide the patient's legal representative with access to the medical records of patients who have a hearing before the Tribunal and who are represented by the legal representative. This should generally be done as follows:

- A list of all patients who will be seen by the Tribunal should be prepared by the relevant unit in the Local Health District/Specialty Network in advance of the Tribunal hearing.
- Two copies of the each patient's "relevant medical records" should be printed in advance of the Tribunal hearing - one copy for the Tribunal and one for the patients' legal representative.
- Where a legal practitioner from LegalAid, or a LegalAid panel firm, attends to represent patients, they should be asked to confirm they have been appointed by LegalAid to act as the patients' legal representative. Once they have confirmed they are acting for the patient/s that will be seen by the Tribunal and the practitioner's identification documents have been sighted, a copy of the relevant records should be provided to the legal representative. A form of Confirmation as Legal Representative is at Appendix 1.
- The relevant unit in a Local Health District/Specialty Network (such as a mental health facility or medical record unit) must keep a copy of the Confirmation as Legal Representative form. This could be kept in a separate file or register in the relevant unit and where reasonable a note should be included in each patient's file noting that the patient's legal representative has been given access to the records.

- In a small number of cases, a legal representative other than from LegalAid, or a LegalAid panel firm, will represent a patient. In such cases, written confirmation they act for the patient, and identification documents sighted, must be provided for inclusion in the patient's medical record before a copy of the relevant records is provided to the legal representative. A copy of the written confirmation should be placed in the patient's medical record.
- If a medical practitioner considers that there is information in the medical records that will be harmful for the patient's legal representative to share with the patient, the medical practitioner should warn the legal representative that it would be harmful to share the information with the patient. A legal representative is obliged to have due regard to the warning and not obliged to disclose the information to the patient. If the medical practitioner remains concerned, the practitioner can seek an order prohibiting the disclosure of information to the patient from the Tribunal.

This procedure can be adapted locally when giving access to electronic records.

Relevant medical records will include, at a minimum:

- For a mental health inquiry, all admission and detention documents relating to the current detention of the patient. This will include Assessment Form/s completed at the time of admission. If a person is transferred from another facility there may be more than one such form.
- For a mental health inquiry, a copy of the Statement of Rights, signed and dated by the patient where possible or, if refused, annotated copies recording the same and notations documenting later service.
- Nomination of Designated Carer form/s (including any exclusions) and, if nomination is refused, documentation of any determination by an authorised medical officer or Director of Community Treatment in relation to their appointment of a Principal Care Provider; evidence of further attempts to have the person nominate a Designated Carer.
- Documentation of any recent reviews carried out by a Consultant and/or Registrar or other member of the treating team.
- Documentation by the Consultant/Registrar of their final review prior to the Tribunal hearing, including any plan that specifies the order to be sought at the hearing.
- Recent progress notes.
- Any recent medical practitioner's report.
- Any recent social work or allied health report.
- Any other documents specifically requested by the Tribunal in relation to the matter.

If the patient's medical record contains details about a risk of significant harm under the Children and Young Persons (Care and Protection) Act, details about the mandatory reporter or the report must not be disclosed to the patient's legal representative.

In some circumstances, a patient's legal representative may request access to additional information about the patient. Where the request relates to the patient's mental health or detention, the information should be provided to the patient's legal representative.

Once the legal practitioner is given a copy of the records, the copy of the records is the responsibility of the legal practitioner and can be removed from the hospital. A patient's legal representative will have their own professional and privacy obligations to maintain the confidentiality of the patient's medical records.

Appendix 1: Confirmation as Legal Representative – LegalAid (including LegalAid Panel Firms) - for matters before the Mental Health Review Tribunal

Confirmation as Legal Representative

I,_____, of_____, confirm that I have been appointed by LegalAid to legally represent the patients below who have a hearing before the Mental Health Review Tribunal and who are detained at _____.
[Name of patients and their MRN to be included by the mental health facility]

Name of Patient	MRN

[Legal representative to delete any patient's name who they are not representing]

If a patient does not confirm the instructions, I undertake to inform the mental health facility and return all records provided to me by the facility.

_____
Signed this day of 20

Note: under the Mental Health Act 2007, if a medical practitioner warns the legal representative of that it may be harmful to communicate to the patient, or any other person, specified information contained in the medical records, the legal representative is to have full and proper regard to that warning and the legal representative is not obliged to disclose to the patient any information in the records.

THE GUARDIANSHIP APPLICATION PROCESS FOR ADULT INPATIENTS OF NSW HEALTH FACILITIES (GL2017_013)

GL2017_013 rescinds GL2016_026

PURPOSE

This Guideline will assist relevant professionals, including medical, allied health, nursing and midwifery staff in NSW Health facilities to understand their roles and responsibilities when making an application to the Guardianship Division of NCAT.

KEY PRINCIPLES

The Guideline aims to standardise practice across NSW Health facilities to improve the process for adult inpatients waiting for a guardianship hearing by ensuring that NSW

Health facilities are aware of:
1. When an application to the Guardianship Division of NCAT is necessary and appropriate.
2. Who is responsible for coordinating the application.
3. Who to consult for advice when considering making a guardianship/financial management application.
4. Making applications and providing reports to the Guardianship Division of NCAT within seven days.
5. What assessments and evidence is required when submitting an application to the Guardianship Division of NCAT.
6. How to record data for patients waiting for guardianship on the patient flow portal.

USE OF THE GUIDELINE

This document provides guidance to NSW Health inpatient facilities and their relevant staff when considering whether an application to the Guardianship division of NCAT is necessary. This document should be used as a practice guideline rather than a mandatory directive.

A full copy of the guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_013

318(26/06/17)

GUARDIANSHIP APPLICATION PROCESS FOR ADULT INPATIENTS OF NSW HEALTH FACILITIES (IB2017_001)

PURPOSE

The purpose of this Information Bulletin is to inform NSW Health staff:
1. How to obtain assistance in making submissions to NCAT arguing that Local Health Districts (LHDs) and Specialty Networks have legal standing to lodge applications for guardianship orders on behalf of inpatients, and
2. Of changes to NCAT's practice and procedures.

KEY INFORMATION

GL2016_026: The Guardianship Application Process for Adult inpatients of NSW Health Facilities, has been developed in collaboration with clinicians from across Local Health Districts and Pillar organisations.

1. Applications should now be made in the name of the LHD or Specialty Network and legal assistance is available to support this change

The Guideline recommends that applications to NCAT for guardianship orders be made in the name of the LHD or Specialty Network, rather than in the name of an individual health professional. This represents a change to the previous practice of health professionals, typically social workers, lodging

applicants in their own name. The primary purpose of this change is to protect individual health professionals from any adverse consequences of being named as a party to Tribunal proceedings.

Where applications are made in the name of the LHD, NCAT may hold a directions hearing, and request submissions on whether the organisation has standing to be an applicant.

Should this occur in respect of an application, please contact Legal and Regulatory Services at the NSW Ministry of Health (legalmail@doh.health.nsw.gov.au / telephone 9391 9606) so that assistance with preparing and lodging submissions can be provided.

2. Changes to practices and procedures in the Guardianship Division of NCAT

NCAT has advised that from 1 January 2017:
- The guardianship and financial management application forms will be separated into two forms
- The applicant will be directed to give (serve) a copy of the application and any attachments to the parties and the subject person
- The parties will be directed to give (serve) each other any material instead of the registry distributing it
- All parties will receive a notice of hearing, and
- Prior to the hearing the registry will send a list of the materials provided to the Tribunal to the parties and send the material to the subject person.

Service of a copy of the application and any attachments to the parties and the subject person may be done by providing it to the party, or by posting it to them. Service should be documented by the LHD (for example by making a file note stating that the document was handed to the party or keeping a copy of the covering letter, if service is by post).

318(09/01/17)

ADMISSION POLICY FOR NSW HEALTH (PD2017_015)

PURPOSE

The purpose of this policy is to provide guidance to health service staff in regard to the decision to admit, the admission of patients to hospital and associated business processes. This policy aims to ensure consistency in the way that admissions occur and applies to all NSW public hospitals and publically contracted care in other facilities in NSW.

MANDATORY REQUIREMENTS

This Policy Directive applies to all NSW public hospitals (and publically contracted care facilities), which are required to have local policies, protocols and procedures in place consistent with the attached Admission Policy for NSW Health procedures document.

This policy does not describe the data or reporting requirements for the Admitted (and Non-Admitted) Patient Data Collections, which are outlined in separate policies.

IMPLEMENTATION

Chief Executives are responsible for ensuring that this Policy Directive is brought to the attention of Clinical, Finance and Administrative staff who are involved in the admissions process.
Health System Information and Performance Reporting (HSIPR) branch will provide information to existing data governance groups and key established reference groups to assist with local implementation. HSIPR will arrange individual Local Health District/Speciality Health Network information sessions in 2017 to facilitate the introduction of the Admission Policy.

318(15/06/17)

ADMISSION POLICY FOR NSW HEALTH - Procedures

1 INTRODUCTION

The purpose of this document is to provide guidance to health service staff in regard to the decision to admit, the admission of patients to hospital and associated business processes. This policy provides principles and criteria to assist in the decision making process.

The condition, acuity and clinical needs of the patient, as well as the availability of appropriate clinical resources are to be the principal factors guiding treatment decisions and in determining the most appropriate setting for their care.

The decision to admit should not influence specific care and treatment decisions for individual patients. While the decision to admit is based on providing the most appropriate setting in which to treat the patient, it chiefly determines subsequent administrative processes including billing and data collection and reporting. The specification and requirements for those processes are provided separately rather than in this policy, e.g. resources for the Admitted Patient and other data collections are provided at the Data Collections page of the NSW Health Intranet.

1.1 Scope

This policy applies to all NSW public hospitals as well as publically contracted care in other facilities within NSW.
Decisions to admit and discharge patients are clinical decisions and should only be influenced by non-clinical factors as specifically outlined in the Criteria for Admission below.
Patients within residential aged care or community residential settings are out of the scope of this policy.

1.2 Admission Policy Principles

This policy is built on the following nine principles which must be read in conjunction with the *Criteria for Admission* (see 2.2):

1. The decision to admit a patient is primarily a clinical decision to be made by a clinician with admitting rights to the facility who must determine that the patient requires admission.
2. The decision to admit a patient is to be based on the patient's condition and clinical needs, the facility's ability to meet those needs, including the availability of appropriate clinical resources, and with reference to the *Criteria for Admission* listed below (2.2)
3. The decision to admit should be made when other care and treatment options have been considered and determined not to be optimal for that patient at that time.
4. The decision to admit a patient should not be influenced by the following factors;
    - the facility's key performance indicators;
    - the treatment location; or
    - the patient's financial status.
5. Once a patient has been discharged from admitted patient care, if a clinician with admitting rights determines that the patient again requires admitted patient care, this is to be a new admission; not a continuation of the previous admission.
6. An admission may be planned or unplanned. In the case of a planned admission, the decision to admit may be made prior to the patient's presentation at the facility.
7. The clinician with admitting rights to the facility is responsible for ensuring that the clinical decision to admit and the reason for admission are documented in the patient's health record.
8. Application of the Admission Policy should not restrict local innovation in clinical practice or development of alternative models of care.
9. Local governance will provide the strategic and operational direction through which this Admission Policy is implemented.

2 DEFINITION AND CRITERIA FOR ADMISSION

2.1 Admitted Patient

An admitted patient is a person: (i) for whom a clinician with admitting rights to the facility has determined meets the criteria for admission and requires a level of care provided in an inpatient setting, and (ii) who has undergone the admission process but has not yet been separated by the facility.
For each admission there must be documentation in the patient's health record by the admitting clinician, or another authorised clinician, that supports the need for admission.
An admission can occur in a hospital or, in the case of 'Hospital in the Home' programs, another setting such as the patient's residence.

2.2 Criteria for Admission

2.2.1 Emergency Department Patient

A patient treated solely within the emergency department is not to be an admitted patient.
A patient presenting to an emergency department can only be admitted if a clinician with admitting rights to the facility determines the patient requires admission and the patient is transferred to another appropriate treatment location within that facility.

This is to ensure compliance with national regulatory requirements and is the only non-clinical criterion that should direct the decision to admit or not. This provision should not impact or restrict the care and treatment provided to any emergency department patient.
For further information see 3.1 Patients in Emergency Departments

2.2.2 Intended Medical Care or Clinical Management

- The patient requires observation in order to be assessed or diagnosed, this may constitute:
  - Active, skilled observation for assessment, diagnosis or treatment.
  - Initiation or stabilisation of therapy or palliation.
  - Structured therapeutic contact in a rehabilitation or mental health program.
- The patient requires, at a minimum, daily management of their treatment and/or medication, this may constitute:
  - Observation of vital, physiological, behavioural or neurological signs.
  - Parenteral medications and/or fluid replacement.
  - Structured therapeutic contact with appropriately trained and qualified health professionals in one-to-one counselling sessions or group therapy sessions that have clearly defined clinical outcomes.
- The patient's condition requires clinical management and/or facilities not available at their usual residential environment or other non-admitted setting.

2.2.3 Intended Procedure

The patient requires a procedure/s that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available. Intended procedures are defined as the following:

- **Type A** procedure as specified in the *Private Health Insurance (Benefit Requirements) Rules 2011.*

  Note: This should be read in conjunction with the *Private Health Insurance Act 2007 (Cth)* and the *National Health Act 1953 (Cth)*; or

- **Type B** procedure is a procedure specified as a Band 1, 2, 3, or 4 as described in the Private Health Insurance (Benefit Requirements) Rules 2011; or
- **Type C** procedure is a procedure specified in reference to Medical Benefits Schedule (MBS) items as detailed in the Private Health Insurance (Benefit Requirements) Rules 2011 general medical services tables. These procedures normally do not require hospital treatment.

Special circumstances that may warrant an admission for a Type C Professional Attention Procedure are:

- The patient's residence is in a remote location
- There is insufficient support available in the patient's usual residence
- The patient requires general anaesthesia so that a Type C procedure can be performed (e.g. child requiring a CT scan).

Note: A patient may remain an admitted patient even if the procedure for which they are admitted is cancelled.

2.2.4 Newborns

A patient aged 9 days or less must be admitted under the following additional scenarios:

- When born in the hospital;
- When a patient was intended to be born in the hospital and the birth occurs within 24 hours of the mother's arrival at the hospital; and
- When a newborn baby born at home or another facility presents to hospital and requires specialist care.

A still born baby (of 20 weeks gestation or more, or if the gestation cannot be determined, with a body mass of 400 grams or more) is not admitted but must be registered in the patient administration system.

2.2.5 Other

Where there is a legal requirement for admission (e.g. under child protection legislation) or involuntary admission of patients under certain legislation, such as the *Mental Health Act 2007 (NSW)*, the *Drug and Alcohol Treatment Act 2007 (NSW)*, and the *Mental Health (Forensic Provisions) Act 1990 (NSW).*

Community Residential services are out of scope for this admission policy as the patients receiving this care are not admitted.

3 ADMISSION GUIDELINES

3.1 Patients in Emergency Departments

A patient treated in and discharged from an emergency department only is not an admitted patient and must not be recorded as such. These patients must be recorded and counted as emergency department non-admitted attendees.
A patient who presents to an emergency department and whose clinical condition meets the criteria for admission, may be formally admitted to the hospital but must be transferred to another appropriate treatment location within the same facility. Such locations may include inpatient wards, operating theatres, short stay units and other treatment locations appropriate to the care required.
When the decision is made to admit a patient from the emergency department, but the patient is discharged, transferred or dies before they proceed to an admitted patient location in that facility, the admission is to be retracted.

The admission date and time are the date and time that the clinical decision to admit the patient is made. The length of time a patient spends in ED is not a criterion for admission; admission is determined by clinical need.

Patients being transferred to another hospital or facility do not require admission before being transferred. Admissions to short stay units must comply with the '*Emergency Department Short Stay Units*' Policy Directive (PD2014_040; 13 Nov., 2014).

3.2 Boarders

A boarder is a person receiving food and/or overnight accommodation from the hospital but does not require clinical treatment or care. For example, a mother accompanies an admitted child or a child staying with an admitted mother.

Patients who turn 10 days of age and do not require clinical care are to be separated and, if they remain in the hospital, are designated as a boarder.

A boarder is not an admitted patient. The hospital may register a boarder in its patient administration system.
A boarder in the Justice Health and Forensic Mental Health Network is defined as a patient who has been medically discharged and is no longer receiving medical treatment. They are however receiving food and/ or accommodation whilst awaiting placement elsewhere.

3.3 Organ Donation

Posthumous organ procurement is the harvesting of human tissue for the purpose of transplantation from a donor who has been declared dead.
Posthumous organ procurement episodes are not reported as admitted patient episodes but must be recorded by the hospital on their patient administration system.
A live organ donor may be admitted to hospital if they meet the criteria for admission.

3.4 Collaborative Care

Collaborative Care is care provided to a patient under an agreement between a purchaser or requestor of admitted patient services and a provider of admitted patient services. Collaborative Care includes:

- contracted care, between a private sector admitted patient facility and a public sector admitted patient facility or two public facilities where a financial or other agreement is in place; AND

- arrangements between two public hospitals where both sites provide part of the continuous care, and where at least one provides only a same-day service, regardless of financial arrangements.

Where a patient is admitted to the purchasing hospital for intended overnight admission and is transferred to and returns from the provider hospital on the same day, the patient must be placed on leave from the first (purchasing) hospital while they are under the care of the second (provider) hospital.
If the patient remains overnight at the second (provider) hospital, they must be discharged from first (purchasing) hospital and admitted to second hospital.

Further information is available in the Admitted Patient Data Dictionary

3.5 Leave from Hospital

An admitted patient may be granted leave with the approval of their Admitting Medical Officer, or other authorised clinician, for a designated period of up to and including seven consecutive days.

The episode of care is continuous while the patient is on leave.

A patient on approved leave may be discharged while on leave.

A voluntary patient on approved leave who does not return by their nominated leave return date, is to be discharged and their discharge date recorded as the earlier of the nominated leave return date or the date which the patient notified the hospital that they were not returning from leave.

A patient that does not return from leave at the conclusion of seven days must be discharged.

For patients who are absent without leave (AWOL), if they do not return within seven days, record the discharge date and time as the date and time at which the patient was first noted to be absent. Involuntary Mental Health patients may be granted a longer period of leave (see section 3.5.2).

Where a patient is on a treatment program that requires admitted patient care each day, but not overnight care, they are to be admitted and discharged each day rather than remaining as a single admission with periods of overnight leave.

Same day patients are not generally granted leave.

3.5.1 Patients on Leave Presenting to an Emergency Department

A patient on leave that presents to the emergency department of the hospital to which they are currently admitted is not to be discharged and then readmitted. The patient should have an ED Type of Visit of 'Current Admitted Patient Presentation' and, if required, a care type change.

A patient on leave from one hospital who presents to the emergency department of another hospital and is admitted to that hospital must be discharged from the first hospital. The second hospital must inform the first that they have admitted the patient.

3.5.2 Involuntary Mental Health Patients

An authorised medical officer may only grant an involuntary patient leave in accordance with the provisions of the *Mental Health Act 2007*.

The period of leave for an involuntary mental health patient may exceed seven days.

An involuntary patient should only be discharged whilst on leave if an authorised medical officer from the admitting facility authorises it, having satisfied themselves that the patient either no longer requires involuntary care under the *Mental Health Act 2007*, or their involuntary care has been transferred to another treating facility or clinician. Under such circumstances, the date of discharge is the date the medical officer authorises the discharge or transfer of the patient. This also applies to involuntary mental health patients who are absent without leave (AWOL).

An involuntary mental health patient on leave from one hospital who presents to another hospital should not be discharged from the first hospital unless an authorised medical officer from that hospital authorises the discharge or transfer of the patient to the second hospital. In the absence of such a discharge or transfer, the patient must remain admitted to both facilities simultaneously.

For further information see Patient Leave Procedures Manual and *Mental Health Act 2007*.

3.6 Care Delivered in an Outpatient Setting

An admission occurs when a clinician with admitting rights to the facility determines that a patient meets the clinical criteria for admission and requires admitted patient care. This does not preclude admitted patients being treated in an outpatient setting.

For procedures and interventions that may be delivered as either admitted or non-admitted care, the decision to admit must be based on the condition, acuity and specific clinical and support needs of that patient.

3.7 Inter-Facility Transfers

A patient that is to be transferred to another facility does not need to be admitted before transfer. Admission to the initial facility may occur if a clinician with admitting rights at that facility determines that the patient meets the clinical criteria for admission and requires admission to the facility prior to transfer.

All inter-facility transfers must comply with '*Inter-facility Transfer Process for Adults Requiring Specialist Care Policy Directive*' (PD2011_031).or *Children and Adolescents – Inter Facility Transfers (PD2010_031).*

3.8 Hospital in the Home

Hospital in the Home (HITH) is a supported model of care and admissions under the HITH program must comply with the provisions of this policy. For specific details around the definitions and eligibility for HITH, refer to the HITH Guidelines and the Admitted Patient Data Collection Data Dictionary.

3.9 Admissions When No Clinician With Admitting Rights is Present

In most circumstances a clinician with admitting rights will be physically present to admit a patient, however there are certain circumstances where this is not the case, such as in small, rural or remote facilities.

In the circumstances where a clinician with admitting rights is not physically present but can be contacted, a decision to admit may be made and conveyed to on-site staff who must clearly document this in the patient's health record.

Where a clinician with admitting rights cannot be contacted to make the decision to admit, an admission cannot proceed. The care provided will be either an ED attendance or a non-admitted service.

4 DISCHARGE

A patient is discharged if:

- the treating clinician has decided that they no longer require admitted patient care, the patient has been advised they can leave and has left the treatment location; or
- the patient signs a "discharge against medical advice form" and leaves the treatment location; or
- the patient is declared deceased.

For patients who are being transferred to another facility for ongoing clinical care, discharge occurs when either (i) the patient is under the care of the transporting authority, if the transporting authority is a separate entity to the treating facility (e.g. NSW Ambulance Service), or (ii) the patient is admitted to the receiving facility, if the original treating facility is providing the transportation.
For Hospital in the Home patients, discharge occurs when the treating clinician has decided that they no longer require admitted patient care and the patient has been advised that they are to be discharged.

5 FURTHER INFORMATION

5.1 Residential Care Clients

For the purposes of this admission policy, residential aged care clients and community residential clients are out of scope.

A residential aged care client is a person who receives care in a wholly or partially Commonwealth funded residential aged care bed.

A community residential client is a person who receives care in a designated mental health or drug and alcohol community residential bed.
While these patients must be registered on a local patient administration system, for reporting purposes these patients are not considered to be admitted patients. Rules surrounding residential aged care and community residential client reporting can be found in the Admitted Patient Data Dictionary.

5.2 Admission Documentation

The documentation in the patient's health record must be sufficient to support their need for admission. For all patients admitted from the elective surgery waiting list, 'Recommendation For Admission' documentation must be completed. See the '*Waiting Time and Elective Surgery Policy*' (PD2012_011) section 2.4.

5.3 Client Registration

The requirement to register patients is separate and additional to admission and the documentation required for an admission. Requirements for patient / client registration are detailed in the following:

- '*Client Registration Policy*' (PD2007_094; 19 December, 2007)
- '*Client Registration Guideline*' (GL2007_024; 19 December, 2007)
- '*Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients*' (PD2012_042; 25 July, 2012).
- '*Health Care Records – Documentation and Management*' (PD2012_069; 21 December, 2012)

6 GLOSSARY

Absent Without Leave (AWOL)
A patient who is absent without leave is a current patient of that facility who has left care without permission to do so.

Admitted Patient
An admitted patient is a person: (i) for whom a clinician with admitting rights to the facility has determined meets the criteria for admission and requires a level of care provided in an inpatient setting, and (ii) who has undergone the admission process but has not yet been separated by the facility.

Episode of Care
Each admission is comprised of one or more episodes of care which represent a period of care with a common clinical focus as reflected by the "care type".

For example, a patient who is receiving acute intervention for a stroke will have a care type change to rehabilitation if and when the main focus of care changes from acute management to functional improvement.

For further details see the '*Care Type Policy for Acute, Sub-Acute and Non-Acute Patient Care*' (PD2014_010).

Hospital in the Home (HITH)
Hospital in the Home (HITH) services provide daily care to children and adults with acute conditions who reside outside hospital, as a substitution of in-hospital care.
A person may receive their care at home (including Residential Aged Care Facilities), in a hospital clinic, community setting, at school or in the workplace. The place of residence may be permanent or temporary.

Inpatient Ward
An inpatient ward is a physical location where admitted patients are accommodated or treated for their care and treatment

Non-Admitted Patient
A person who receives care or treatment but has not undergone the hospital's admission process. This includes patients treated entirely within the Emergency Department.

Overnight Admission
An overnight admission is where the admission date and separation date occur on different calendar days.

Same Day Admission
A same day admission is where the admission date and separation date occur on the same calendar day, irrespective of the intended length of stay.

7 FURTHER RESOURCES

NSW Health Policies, Guidelines or Information Bulletins

- '*Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients*' (PD2012_042; 25 July, 2012)
- '*Admitted Patient Election Processes for NSW Public Hospitals – Revised*'(PD2005_221; 27 January, 2005)
- '*Care Type Policy for Acute, Sub-Acute and Non-Acute Patient Care*' (PD2016_039)
- '*Children and Adolescent – Inter-Facility Transfers*' (PD2010_031; 2 June, 2010)
- '*Client Registration Guideline*' (GL2007_024; 19 December, 2007)
- '*Client Registration Policy*' (PD2007_094; 19 December, 2007)
- '*Clinical Handover – Standard Key Principles*' ([PD2009_060; 28 September, 2009)
- '*Departure of Emergency Department Patients*' (PD2014_025; 17 July, 2014)
- '*Emergency Department – Direct Admission to Inpatients Wards*' (PD2009_055; 7 September, 2009)
- 'Emergency Department Short Stay Units' (PD2014_040; 13 November, 2014)
- '*Fees Procedures Manual for Public Health Organisations*' (http://www.health.nsw.gov.au/policies/manuals/Documents/fees.pdf)
- '*Health Care Records – Documentation and Management*' (PD2012_069; 21 December, 2012)
- 'Inter-facility Transfer Process for Adults Requiring Specialist Care' (PD2011_031; 1 June, 2011)
- '*Non-Admitted Patient Activity Reporting Requirements*' (PD2013_010; 4 June, 2-13)
- '*NSW Hospital in the Home (HITH) Guideline*' (GL2013_006; 20 August, 2013)
- '*Waiting Time and Elective Surgery Policy*' (PD2012_011; 1 February, 2012)
- NSW Health Fees Procedures Manual.

Legislative or Regulatory Instruments

- *Drug and Alcohol Treatment Act 2007 (NSW)*
- *Mental Health Act 2007 (NSW)*
- *Mental Health (Forensic Provisions) Act 1990 (NSW)*
- *National Health Act 1953 (Cth)*
- *Private Health Insurance Act 2007 (Cth)*
- *Private Health insurance (Benefit Requirements) Rules 2011*
- National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services

PRIVACY INTERNAL REVIEW GUIDELINES (GL2019_015)

GL2019_015 rescinds GL2006_007

PRPOSE

NSW privacy law establishes a process of internal review for handling a privacy complaint, in certain circumstances. These Guidelines help staff navigate and comply with all legislative requirements in conducting a privacy internal review. Guidance is provided on undertaking an appropriate investigation into the privacy complaint, including conducting interviews and consultation requirements. The Appendices include template letters and reports to provide practical assistance to staff, and a consistent approach to privacy complaint handling for NSW Health agencies.

KEY PRINCIPLES

60-day time limit

A privacy internal review must be completed as soon as practicable, and a time limit of 60 calendar days applies. The 60-day time limit starts from the receipt of the first written privacy complaint or request for privacy internal review. In exceptional circumstances, the agency may ask the applicant for an extension of time. (*Sections 5.3 and 5.4*)

NSW Privacy Commissioner

The NSW Privacy Commissioner must be notified of all applications for privacy internal review, provided with a draft investigation report for comment, and provided with the final report and covering letter to the applicant. (*Sections 5.7 and 7.3*)

NSW Civil and Administrative Tribunal

An individual who is dissatisfied with the outcome of the agency's privacy internal review, can lodge an application for administrative review with the NSW Civil and Administrative Tribunal (NCAT). This must be lodged within 28 calendar days of receipt of the privacy internal review report from the NSW Health agency. (*Section 7.1*)

USE OF THE GUIDELINE

Chief Executive

The Chief Executive, or their Senior Executive delegate, is ultimately responsible for the privacy internal review process and outcome. The Chief Executive, or their Senior Executive delegate, should approve the final internal review report and letter to the applicant. (*Section 3.4*)

Privacy Contact Officer, NSW Health agency

Privacy internal review is normally undertaken by the Privacy Contact Officer for the NSW Health agency. Privacy internal review must be undertaken without bias, and by an officer who is neutral to the circumstances relating to the complaint. If an officer was substantially involved in the matter relating to the complaint, including attempts to informally resolve the complaint, they are unable to undertake the privacy internal review. In such case, an alternative review officer must be appointed. (*Section 3.4 & 5.1)*

Ministry of Health

The Privacy Contact Officer, Ministry of Health and legal officers within the Legal and Regulatory Services Branch, may assist agency staff with matters of privacy internal review.
NSW Health agencies should:

- notify relevant privacy internal review matters to the Ministry, (*Section 5.5*)
- seek advice and clarification from the Ministry as necessary, (*throughout*)
- provide the draft internal review report to the Ministry for comment, (*Section 6.2*)
- provide final letter and internal review report to the Ministry, (*Section 6.4*)
- report statistical data on privacy internal reviews in the agency's privacy annual report (*Section 7.2*)

A full copy of the guideline is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2019_015

USE OF EXCHANGE OF INFORMATION PART 13A CRIMES (DOMESTIC AND FAMILY VIOLENCE) ACT 2007 FORM (IB2016_056)

PURPOSE

The purpose of this Information Bulletin is to inform NSW Health service providers and Health Information Management staff of the publication of the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act 2007* Form. This Information Bulletin also provides guidelines for the use of the form.

The Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act 2007* Form is a paper form **ONLY** and is **NOT** to be scanned into any electronic medical records systems.

KEY INFORMATION

Reducing domestic violence is a NSW Premier's Priority. Safer Pathway is a whole-of government response designed to provide accessible and effective domestic violence support services to victims, with a focus on victims at serious threat. Under Safer Pathway, police, justice, health, education, child protection and victim service agencies work in an integrated manner to reduce threat to adult and children victims of domestic violence. This is to ensure that a seamless response can meet the individual needs of victims and children, and service providers jointly manage threats of further violence.

NSW Health has a key role as an interagency partner in fortnightly Safety Action Meetings, which are a component of Safer Pathway. Participation in Safety Action Meetings includes file searches for relevant health information, participation in fortnightly meetings and follow up actions resulting from Safety Action Plans. NSW Health is represented by up to three clinicians / healthcare professionals at a Safety Action Meeting, including Mental Health and Drug and Alcohol services wherever possible.

Please note that the information contained in this document is to be read in conjunction with the NSW Government guidelines listed below, and attached to this Information Bulletin. Information and records relating to Safety Action Meetings must be managed and stored in accordance with these documents:
- Safer Pathway Domestic Violence Information Sharing Protocol
- Safety Action Meeting Manual
- Domestic Violence and Child Protection Guidelines

Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form

The NSW Health Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form is a state form that assists NSW Health workers to comply with requirements under the NSW *Crimes (Domestic and Family Violence) Act 2007*.
This legislation governs information sharing related to Safety Action Meetings, and other victims of domestic and family violence at Serious Threat.

The form is available for download as an interactive PDF or to print on demand via Stream Solutions.

A number of key principles underlie information exchange at Safety Action Meetings.
These include:

- The threshold of *serious threat* under which information exchange at Safety Action Meetings takes place, means that there is a reasonable belief that there is serious threat to a victim's life, health or safety, or other person's life, health or safety, due to domestic violence, and action is necessary to prevent or lessen this threat. A threat does not have to be imminent to be serious.

- Information sharing at Safety Action Meetings is limited to that which is necessary to prevent or lessen a serious threat to the life, health or safety of victims, their children or other persons. Each member is responsible for decisions about what information it considers reasonably necessary to share.
- Consent to share information is preferable, but in instances of Serious Threat, not necessary. The Local Coordination Point which is staffed by the Women's Domestic Violence Court Advocacy Support Service, or Victim's Services, are usually responsible for seeking consent from a victim for information sharing at a Safety Action Meeting.
- Consent to share information is NEVER requested from a person listed on a Safety Action Meeting agenda as a perpetrator of violence. Information about Safety Action Meetings and Safety Action Plans must likewise NOT be shared with alleged perpetrators of violence. This could be vital to ensuring the safety of a victim.

The Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form is to be used with the following guidelines:

- Use in preparation for Safety Action Meetings, and other information exchange that takes place under Part 13A of the NSW *Crimes (Domestic and Family Violence) Act 2007*
- A new form is to be used per client and per client file system reviewed:
  - Information from other service areas are **NOT** to be compiled on a single form
  - Information from other clients' files are **NOT** to be compiled on a single form
- Store in the client file reviewed. This must be in paper form **ONLY** and is **NOT** to be scanned into electronic systems.
- Actions from a Safety Action Meeting are to form part of the contemporaneous client notes in the appropriate client file.

The Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form intersects with other healthcare privacy considerations and information exchange processes including:

1. Sexual Assault Communications Privilege

It is vital that staff are aware that information sharing at Safety Action Meetings is limited to that which is necessary. In the case of information which may be subject to the Sexual Assault Communications Privilege, it is recommended that advice from Local Health District legal services, or the Domestic and Family Violence team at the Ministry of Health be sought *prior* to information exchange under 13A.

Sexual assault communications are made in the course of a confidential relationship between a victim of sexual assault and a counsellor. The sexual assault communications privilege provides an absolute prohibition, in NSW courts, against requiring the production of documents recording counselling communications in preliminary criminal proceedings. Once the main criminal proceedings have started, the privilege will also apply unless the court specifically grants leave and requires the documents be provided. Documents that are the subject of this privilege in any criminal proceedings continue to be privileged in subsequent civil proceedings. A sexual assault privilege also applies in ADVO proceedings.

The purpose of this privilege is to give victims a confidential and safe place to talk about, or disclose, information about their traumatic experience, personal or sensitive issues and concerns. It includes counselling communications made by, to or about a victim. In NSW, an objection may be made to produce a protected confidence on the ground that it is privileged; but the victim of the sexual assault can consent to disclosure.

2. Child Protection

In cases of domestic violence where children are victims, or are affected by domestic violence in the home (including when listed on a SAM agenda as a perpetrator of violence), prescribed bodies should exchange information under Chapter 16A in the first instance. Both Part 13A and Chapter 16A prioritises the safety, welfare, and wellbeing of a child or young person over an individual's right to privacy.

Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998 (CYPCP Act)* overrides other laws that prohibit or restrict the disclosure of personal information such as the *Privacy and Personal Information Protection Act 1998* (*PIPP Act)* and the *Health Records and Information Privacy Act 2002 (HRIP Act)*. The focus of the exchange of information is on the safety, welfare and wellbeing of children, and facilitating the provision of services to these children and their families.

Service providers who are prescribed bodies under the *CYPCP Act* may exchange information that relates to a child or young person's safety, welfare or wellbeing, whether or not the child or young person is known to the Department of Family and Community Services (FACS).

Where Chapter 16A does not apply, information may be shared under Part 13A and the Safer Pathway Domestic Violence Information Sharing Protocol.

NSW Health staff should also be aware that information sharing under 13A *does not replace* mandatory reporting obligations for children and young people at risk of significant harm. Where information exchange processes identify risk of harm to a child or young person, NSW Health staff are required to apply usual clinical practice, including application of the Mandatory Reporter's Guide, and reports to FACs where indicated. This occurs within the normal timeframe for any risk of harm identification and is *not* dependent on Safety Action Meeting dates or processes.

3. Health Information Access

The *Health Records and Information Privacy Act 2002*; the *Government Information (Public Access) Act 2009* and the *Privacy and Personal Information Protection Act 1998* govern access to information held in health records. As a general rule, a victim's personal and health information must never be disclosed to an alleged perpetrator or any other person acting on behalf of the alleged perpetrator, such as the alleged perpetrator's legal representative. Part 13A and the Protocol seek to ensure that the victim's safety is not compromised by individuals' right to access their information under NSW privacy laws. For this reason, Part 13A and the Protocol override the *PPIP Act* and the *HRIP Act* in when the applicant is the alleged perpetrator.

In domestic violence situations it can be important for the victim's safety that the alleged perpetrator remains unaware of impending interventions. If the alleged perpetrator is aware, this may result in an escalation of violence. Service providers must also consider the potential for placing the victim at increased risk of violence where the attempt to reduce or prevent the serious threat was not successful and the alleged perpetrator becomes aware that the victim has reached out for support.

Requests for any file containing the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form and other related file notes, where the applicant is the alleged perpetrator, **could reasonably be expected to expose a person to a risk of harm**. For information relating to this see the NSW Health *Privacy Manual for Health Information*, section 12. Where any doubt exists about the release of information relating to Safety Action Meetings, consult Local Health District legal advice.

4. Subpoenas

A service provider that has used or disclosed information may be subpoenaed to produce the information held, including the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form. If a Local Health District or Specialty Health Network receives a subpoena to produce information about a victim or an alleged perpetrator, that service provider must seek legal advice before producing any information. A subpoena may be challenged on a number of different grounds, including abuse of process, oppression and/or on the basis of a privilege at law over the information.

All subpoenaed files containing the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form, where privilege at law does not exist, should be subject to a Sensitive Information Claim. See NSW Health Subpoenas Policy (PD2010_065) for how to make these claims.

ELECTRONIC MEDICAL RECORDS OF INFORMATION EXCHANGE TO REDUCE DOMESTIC AND FAMILY VIOLENCE THREAT

(IB2020_022)

PURPOSE

This Information Bulletin clarifies the requirements around notations made within electronic medical records of information exchange under Part 13A Crimes (Domestic and Personal Violence) Act 2007.

It contains information for health services which supplements the NSW Health Information Bulletin *Use of Exchange of Information Part 13A Crimes (Domestic and Personal Violence) Act 2007 Form* (IB2016_056).

KEY INFORMATION

The *NSW Health Exchange of Information Part 13A Crimes (Domestic and Personal Violence) Act 2007 Form* is a state form that assists NSW Health workers to comply with requirements under the *NSW Crimes (Domestic and Personal Violence) Act 2007*.

This legislation governs information sharing related to Safety Action Meetings, and other victims of domestic and family violence at Serious Threat.

Health workers are to continue to follow the NSW Health Information Bulletin *Use of Exchange of Information Part 13A Crimes (Domestic and Personal Violence) Act 2007 Form* (IB2016_056), including the guidance around use of the State Form.

Health services may include minimal information in the progress notes of the electronic medical record indicating that information exchange has occurred to reduce a serious domestic violence threat to a person. Standard statements are included below for use in the progress notes. The statements include a prompt on how to respond where clinicians have ongoing concerns regarding a domestic violence threat.

Information *shared* under Part 13A about a client who is the alleged perpetrator

Staff may include a brief statement in the progress notes of the electronic medical record when information is shared under Part 13A about a client who is the alleged perpetrator and a Safety Action Meeting is held that identifies actions for Health pertaining to the perpetrator.

- Any such statement should be labelled *'VAN Progress Note: Strictly Confidential - **not** to be shared with client'* and indicate that:

  "This client's file has been reviewed and relevant information shared for the express purpose of reducing a serious domestic violence threat to another person/s including children.

  The client must not be informed that this has occurred.

  Any inappropriate disclosure of the information to [insert client's name] has potential harmful consequences for the safety of a victim/s.

  To discuss concerns about an ongoing or escalating domestic violence threat, contact [LHD service/contact]. Where a clinician has reasonable grounds to suspect that there is a serious and imminent risk to the victim/s or others' safety, Police should be contacted."

Information shared under Part 13A about a client who is a victim

Staff may include a brief statement in the progress notes of the electronic medical record when information is shared under Part 13A about a client who is a victim, and a Safety Action Meeting is held which identifies actions for Health.

- Any such statement should be labelled '*VAN Progress Note: Strictly Confidential – not to be shared before contacting the nominated clinician/service below*' and indicate that:

  "*This client's file has been reviewed and relevant information about the client shared for the express purpose of reducing a serious domestic violence threat to the client or another person, including a child.*

  Any inappropriate disclosure of the information has potential harmful consequences for the victims' safety.

  To discuss the above information and/or concerns about an ongoing or escalating domestic violence threat, contact [LHD service/contact]. Where a clinician has reasonable grounds to suspect that there is a serious and imminent risk to the victim/s or others' safety, Police should be contacted."

The suggested statements for progress notes above can also be applied where information is shared at Safety Action Meetings using Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*.

For further relevant information on information sharing and documentation please refer to the *NSW Government Domestic Violence Information Sharing Protocol* and, where sharing information under Chapter 16A, the *NSW Health Policy Directive* Child Wellbeing and Child Protection Policies and Procedures for NSW Health *(PD2013_007).*

The complete Information Bulletin is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2020_022

LOOKBACK (PD2023_003)

POLICY STATEMENT

NSW Health Services are to implement lookback processes consistent with the requirements of this Policy Directive to ensure the timely notification and coordinated tracking of affected or potentially affected groups of patients.

SUMMARY OF POLICY REQUIREMENTS

Health Services are to initiate a lookback process when a clinical incident or concern has affected or may affect a group of patients.

Health Services are to undertake the four-step lookback process to identify, track, communicate and provide ongoing advice to these patients. The scope and scale of a lookback process can vary, so Health Services are to use an initial risk assessment to determine whether each element within a step is required.

The lookback process is to align to incident management, open disclosure, critical response and privacy processes.

Health Services are to notify appropriate internal and external bodies and regulators.

In keeping with a risk management approach, Health Services are to escalate as required to the NSW Ministry of Health and/ or the Clinical Excellence Commission.

The lookback process may involve a system wide communication strategy and/ or notifying the wider community. In such circumstances, the Clinical Excellence Commission and/ or NSW Ministry of Health will provide guidance.

The complete Policy is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2023_003