

9. Risk management and clinical governance

This Chapter incorporates the terms of reference and issues relating to existing administrative systems and improvements to support health service delivery, focusing on:

- risk management
- quality and safety and
- clinical audit and governance.

These issues are central to improving patient care and clinical outcomes. We know that many people are harmed while receiving care in hospitals. This chapter recommends system changes to maximise the quality and safety of clinical services. Risk management, quality and safety, clinical audit and governance are closely related and are therefore addressed together in this chapter.

The chapter addresses some of the significant risks faced by Queensland Health that have attracted recent media attention. The overall approach to risk management for Queensland Health is described followed by the management of clinical risk through a system of clinical governance. The latter includes quality and safety, clinical audit and feedback on patient experiences. Consideration is also given to the internal and external reporting requirements on the systems to support clinical governance and quality and safety of health services. The greater emphasis given to clinical risk as opposed to other aspects of risk management is because this is where the majority of gains for patient outcomes can be made.

Summary of the reforms recommended in this Chapter are:

- Clinician led quality and safety improvement in the delivery of clinical care, through benchmarking, development of clinical pathways and open disclosure
- Increased access and dedicated resources to training in service improvement techniques
- A more informed public through a number of reporting strategies
- An improved complaints recording and resolution process with external monitoring by a Health Commission with oversight by a Parliamentary Committee.

The reforms recommended in this chapter will:

- improve the quality of healthcare for patients and other healthcare consumers
- ensure that patients using Queensland public health services will be treated by competent and well trained clinicians
- have a health system that is responsive to public input and patient concerns
- report more accurately and regularly to the public on the state of health care.

9.1 Risk management

The concept of risk combines the probability of an adverse event occurring with the seriousness of the consequences of that event. The identification and management of risk is an integral obligation for any organisation. In Queensland Health's case there are a

wide range of risks that must be considered. Examples include adverse outcomes for individual patients, workforce shortages, the ability to deal with pandemics or large numbers of people injured in the event of a natural disaster, loss of supply of electricity and clean water to hospitals and inability to maintain budget integrity.

The features of a good risk management system most of which are set out in the Australian and New Zealand Standard on risk management are:

- the risk management process provides for identification, analysis, evaluation and treatment of risks as well as mechanisms to monitor and review risks
- risk management is applied at facility, district, area and corporate levels (which would include assigning accountabilities for key corporate risks and risk categories)
- risk management is a part of “how we do business” and there is a risk management ethos throughout the organisation
- employees are supported with initial and ongoing training and assistance in risk management
- the risk management process is customised to the organisation, its policies, procedures and culture and
- adequate resources are provided.

A culture of understanding risk in this way has not been achieved in Queensland Health and in the main risk management in districts is a reactive process. Risk registers identifying potential risks have been established in all districts but to some extent are seen as a legislative compliance issue rather than a useful approach to ensuring the quality, safety and sustainability of health services. The effort that has gone into recording and categorising risks has not been followed up with a systematic process of prioritisation and action to prevent or manage the risks concerned. While many risks are most appropriately managed at the district level, some risks are more effectively managed corporately. Systems to identify and manage these corporate risks are not in place.

Risk management should be a standing agenda item at all executive management meetings to enable prioritisation of risks and appropriate allocation of the resources required to address those that are most significant. Risk registers should be used as a tool to inform this process.

Risk management is one of those matters addressed in the report where the options are few and the way forward very clear. As the implementation of risk management in the Queensland public sector is a legislative requirement and the risk management standard AS/NZS 4360:2004 is regarded as world’s best practice, the implementation of a risk management system adhering to the Australian and New Zealand Standard should continue without delay.

Recommendation 9.1

Queensland Health should establish risk registers at all levels in the organisation (District, Area and Central Office) and identify the individuals who are accountable for the management of those risks.

Recommendation 9.2

The importance of the risk management function needs to be recognised by providing recurrent funding for this activity.

9.2 Clinical Governance

9.2.1 What is clinical governance?

Historically the individual clinician has been held accountable for the clinical outcomes of their patients including clinical risks. However this paradigm has been challenged in recent years and the concept of a system of clinical governance has been developed. This has largely been in response to:

- major health system failures (most notably the inquiry into paediatric cardiac surgical deaths at the Bristol Royal Infirmary)
- national and international reports which estimate that one in ten patients admitted to hospitals are harmed as a result of the health care they receive and
- the increasing complexity of the delivery of health services.

Clinical Governance is defined as...*“The system through which health services are accountable for continuously improving the quality of services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish”*⁷⁹.

It seems from the investigation into events in Bundaberg that systems of clinical governance to manage a range of clinical risks were either not in place or were not working effectively.

The Adverse Clinical Outcomes at Bundaberg Health Service District

This Review does not address the specific circumstances that led to concerns about adverse clinical outcomes in Bundaberg but rather considers the systemic issues. However to assist in understanding the interrelationships of the elements of clinical governance, the system failures at Bundaberg Hospital with respect to clinical governance are briefly explored below. This exploration is not intended to pre-empt any findings of the Queensland Public Hospital's Commission of Inquiry.

- Arguably, the world wide shortage of doctors, changes in societal expectations and decreasing competitiveness of medical remuneration were significant factors leading to the need to employ overseas trained doctors in Bundaberg.
- It appears that a single point weakness in the Queensland registration process led to a failure to identify restrictions to registration in the United States.
- It appears that the process of checking credentials did not involve the College of Surgeons and no written clinical privileges appeared to have been granted on appointment. The current process for granting clinical privileges is not specific to a procedural level.
- The prevailing system focused executive attention on budget and production targets rather than clinical outcomes.
- There appears to have been no decision support system in place to support clinical executives and managers in managing individual clinician performance issues.
- Clinical pathways, clinical auditing and open disclosure are only in the early stages of development in Queensland Health. They are not mandated, and are not subject to internal compliance auditing. It is up to the individual clinician and local leadership to implement and sustain.
- Incident reporting and management appeared to receive little leadership support. There appeared to be a culture of not reporting incidents. There was inadequate capacity and resources to develop effective multi-disciplinary root cause analysis processes.
- There appeared to be confusion, and no clear and transparent process for the management of concerns about an individual clinician's performance.

⁷⁹ Based on the definition of clinical governance in the British National Health Service (NHS).

- There appeared to be diffuse accountabilities for monitoring the clinical performance of services, with multiple committees involved.
- An appendix in the Interim Report contained the list of sentinel type events (severe adverse clinical events), in relation to which mandatory reporting and investigation is required. Certainly some of the poor clinical outcomes could have been classified as sentinel events.

Simply developing policy and procedures around clinical governance has not been enough to achieve the reform needed in this area. Clinical professional groups have retained old models of care which have an individual focus rather than a focus on teams and systems of care. At the same time, changes in health service delivery, increased demand and politicisation have significantly increased the production focus of public health services. This has led to immense pressure on clinicians and executives to do 'more with less' at the expense of a focus on improving safety and quality and managing clinical risks.

There has been a national focus on improving Quality and Safety since the release of the 1995 report on the "Quality in Australian Health Care Study" which identified an adverse event rate of 16.6 percent in hospitalised patients (this was later revised to 10.6 percent following a comparison with a similar US study). The first large investment in quality and safety was made under the Australian Health Care Agreement 1998-2003. Until recently national leadership has been provided by The Australian Council for Safety and Quality in Health Care. A new Australian Commission for Safety and Quality in Health Care is currently being established which will take forward implementation of initiatives and extend the quality improvement focus across the continuum of care including the private sector.

9.2.2 Guiding principles of clinical governance

It is instructive to clearly articulate a set of overarching principles to underpin the development of effective clinical governance. The following principles are adapted from the New South Wales Patient Safety and Clinical Quality Program⁸⁰.

1. **Openness about failures:** errors are reported and acknowledged without fear of inappropriate blame, and patients and their families are told what went wrong and why.
2. **Emphasis on learning and support:** the system is orientated towards learning from its mistakes and staff are supported to participate in improvement activities.
3. **Obligation to act:** the obligation to take action to remedy problems is clearly accepted and the allocation of this responsibility is unambiguous and explicit.
4. **Accountability:** the limits of individual accountability are clear. Individuals understand when they may be held accountable for their actions.
5. **Just culture:** individuals are treated fairly by the organisation and are not blamed for failures of the system. "Blameworthy" acts are clearly defined.
6. **Appropriate prioritisation of action:** action to address problems is prioritised according to the available resources and directed to those areas where the greatest improvements are possible; and

⁸⁰ Patient Safety and Clinical Quality Program, First report on incident management in the NSW public health system, 2003-04, NSW Health

7. **Teamwork:** teamwork is recognised as the best defence against any system failures and is explicitly encouraged and fostered within a culture of mutual respect.

Guided by principles such as these other jurisdictions have taken a stepwise approach to introducing clinical governance into health services. The key steps in all of these examples have been the:

1. development of a quality and safety policy
2. development of a clinical governance framework
3. provision of supporting infrastructure
4. establishment of standards and
5. establishment of performance monitoring.

9.2.3 Implementation issues

The clinical governance approach aims to bring the often fragmented, risk management, quality and safety, clinical audit and patient complaints and feedback activities together into the one system. The rationale behind this is that a structured organisational wide approach will be able to address barriers and make it easier for clinicians to provide high quality and safe health services.

The danger in establishing an organisation wide approach to clinical governance is that it becomes very “top down”. However, as clearly identified in recent research and in the Interim Report, the engagement of clinical staff is essential for effective clinical governance. As stated by Degeling et al 2004 “Clinicians are at the core of clinical work, so they must be at the heart of clinical governance”. Many clinicians consulted in this Review argue that clinical governance must employ “bottom-up” approaches and be supported at the unit level with training and resources. Clinicians recognise the need for some “top down” requirements such as setting corporate performance targets, monitoring and reporting but have strong views that this should not be the overarching theme of the clinical governance approach.

Clinical governance must be established at the clinical unit level and be built into the culture, structure and reporting arrangements at all levels of the organisation. If the clinical governance model is ‘top down’ it will be a process of external surveillance and retrospective governance. If however, the process is established at the clinical unit level and is “bottom up” it is necessarily a process of internal development, self government and prospective clinical management.

Source: Submission to the Queensland Health Systems Review

The two key issues that need to be considered in deciding the best way forward for effective implementation of clinical governance in Queensland Health are therefore:

- the need for a “bottom-up” approach to engage clinicians which indicates the need for internal education and training, performance monitoring and identification of emerging issues and best practice and
- the need to be open and transparent with the community about the quality and safety of health services which, if provided by an external mechanism, would provide greater independence, be seen as having more ‘credibility’ by the public and greater accountability for providers. Given the level of community concern about the quality and safety of health services following the recent events at Bundaberg, the

community is justifiably likely to have an expectation of some formal external review of the quality and safety of health services.

Separation of the roles and responsibilities for education and training from monitoring is one way of achieving the balance between the “bottom up” and “top down” approaches and facilitating greater clinical involvement (as recently recommended by the NHS)⁸¹.

Professional bodies have provided for all health professional groups avenues to identify and maintain professional standards. Therefore consideration must also be given to the role of these bodies in the overall approach to clinical governance taken by Queensland Health.

Consideration must also be given to the scope of clinical governance approaches in Queensland ie. that it be applied to public and private hospitals.

In Queensland private hospitals are licensed under the *Private Health Facilities Act 1999*. This Act requires that private hospitals meet a number of standards that relate to clinical governance which include having in place:

- external accreditation
- credentials and clinical privileges
- adverse clinical event monitoring, evaluation and improvement strategy implementation
- patient complaints and
- infection control.

Currently, the performance of private hospitals against these standards is audited by the Office of the Chief Health Officer.

As clinical governance is an emerging area and as new approaches are further developed it is important that implementation occurs right across the health sector. This is in line with the directions being taken nationally. Consumers and patients have the right to expect the highest quality and safety of care in all health services whether public or private. This is reflected in Chapter 13 with a Health Commission progressively monitoring implementation of clinical governance in private hospitals.

9.2.4 A framework for clinical governance

Clinical governance is a system with many elements: people, procedures, structures, information and standards. As an aid to understanding the overall concept of clinical governance and the inter-relationships between these elements a framework is helpful. For the purposes of this report a very simple framework is used.

This model is premised on effective clinical governance requiring:

- the *right person*, doing the *right job*
- with the *right skills*
- working in *high-functioning teams*
- supported by *effective organisational systems*⁸².

⁸¹ Robinson M, O'Rourke I and Braithwaite J. 2003 Report on a study tour of the Clinical Governance Support Team of the English National Health System NSW Health, Institute for Clinical Governance, Centre for Clinical Governance Research, UNSW.

The system must

- give careful consideration to the patient's experience, and
- be accountable to the community with regular public reporting against standards and performance indicators.

The following sections use these headings to describe various aspects of clinical governance, what is currently happening in Queensland Health and recommended directions for change.

9.3 The right person doing the right job

Clinicians (doctors, nurses and allied health staff) require appropriate training, experience and ongoing skills development to ensure the delivery of safe and effective health care. This section describes the processes required to ensure appropriately trained and experienced staff are employed and that their ongoing clinical work is performed to the standards required. The specific processes discussed are recruitment and selection, credentialing and clinical privileging, and assessment, development and management of individual clinician performance.

9.3.1 Recruitment and selection

Obviously Queenslanders only want well trained and competent clinicians to be registered and working here. While the following section is specifically about the recruitment of doctors, it is also imperative that all clinicians employed by Queensland Health have appropriate professional registration and that during the process of recruitment and selection their ability to meet the clinical competencies required for the particular job is carefully assessed.

In the context of clinical governance, the recruitment process must have safeguards around professional standards. In the usual context this is achieved through the provision of qualifications recognised by the various registration boards resulting in registration to practice as a professional. The current workforce shortage in medical practitioners has caused a change to this process with doctors receiving special purpose registration based on overseas qualifications not recognised as equivalent to Australian qualifications. This special purpose registration is granted with conditions.

As an employer under pressure to fill medical vacancies, Queensland Health faces a conflict of interest in making objective and transparent determinations of an "area of need" which would allow special purpose registration of Overseas Trained Doctors (OTDs). This registration category is not subject to the same requirements as apply to locally trained doctors. The review supports the recent transfer to the Medical Board of Queensland of responsibility for making area of need determinations. Determination of an area of need should only be made where there is evidence of a genuine shortage of medical practitioners. Area of need determination should be based on transparent criteria and cannot be "portable" across locations or positions.

⁸² Dr Michael Ward, Queensland Health, 2005

Even if recruitment campaigns succeed in attracting doctors from countries such as the United Kingdom, it is likely that Queensland Health will continue to be reliant in the short term on attracting doctors trained in other countries which may not have equivalent teaching standards.

A number of the current concerns in Queensland are based on the rigour and safety associated with the special purpose registration process. For example, the issue of Dr Patel and Bundaberg has created a great deal of concern and some heightened tensions within the medical profession generally. This doctor is reported to have submitted false credentials to the Medical Board which resulted in his appointment. Another specialist from overseas is believed to have been appointed on the basis of falsified credentials. However, it has been Queensland Health that has been most significantly admonished in the media for failure to manage consequent clinical performance.

Recent changes to the Medical Board process are aimed at improving the rigour and validity of the process of special purpose registration for doctors. They include:

- verification of credentials via the Educational Commission of Foreign Medical Graduates International Credentials Service (EICS)
- computer administered screening exam
- English language proficiency
- curriculum vitae review and
- clinical interview.

There will be a need to evaluate whether these changes are sufficient to provide confidence to the Queensland public that all doctors being registered in Queensland are adequately skilled in the absence of recognised equivalence in qualifications and “full registration”.

OTDs seeking special purpose registration may come from different cultural, language and health care backgrounds. It is therefore relevant to have a process for OTDs which assesses language, culture and clinical competence and provides education on the specific issues relevant to working as a medical practitioner in Queensland.

While the recent Medical Board changes will improve the registration process specific resources both for the Medical Board and the relevant employer will be required to address all concerns around clinical competence.

Essentially there are two broad categories of special purpose registration, senior doctors employed in specialist roles and more junior doctors employed in generalist roles.

Special purpose registration processes

Deemed Specialists

Assessment of an OTD for practice at specialist level should be performed via the established Australian Medical Council (AMC)/Specialist College (College) pathway. No OTD should commence employment in a senior position intended to be filled by a specialist prior to this assessment occurring. An OTD deemed not to be at specialist level by the relevant College should then be assessed by the Medical Board of Queensland as for other non-specialist grade doctors.

Non-Specialists

The assessment of non-specialists would focus on four major areas:

- formal written application for a specified vacancy
- performance at clinical interview
- referee checks and
- further on shore assessment including clinical skills laboratory assessment for those going in to positions of high responsibility and low supervision.

The assessment tools used at interview should include:

- specific questions to determine experience and usual practice (eg patient mix; cases seen)
- specific questioning regarding the current facility that the applicant is working in, its capabilities and support structures (ie allied health, nursing; medical imaging, and pathology)
- clinical scenarios (eg patient presentations, requirement to transfer a patient from one facility to another and a description of how this would be undertaken and enacting this over the telephone)
- role plays using particularly Australian situations to make an estimation regarding the applicants ability to communicate and their cultural safety (eg whilst it could not be expected that an applicant from overseas would understand Australian slang, it would be expected that they would indicate that they did not know and ask what something meant)
- questions relating to specific selection criteria and requirements of the position.

There are a group of non-specialist OTDs with special purpose registration who will apply for positions with the requirement for significant procedural skills. These doctors will require additional assessment. This could occur by these doctors spending time in a large hospital (preferably the referral centre to which they will be sending patients) and having an assessment made and/or formal assessment in a simulation environment.

OTDs should not be subjected to unduly intensive critique of their work. The expectations around ability to fulfil the requirements of the position should be those that are used for any medical graduate in the position.

The implementation of these screening processes has the potential to significantly prolong the recruiting process. Efforts must be directed at measures to streamline these processes without affecting the quality of the recruiting process. The Medical Board of Queensland is a key decision maker and should be encouraged to review existing and proposed processes to maximize efficiency whilst safeguarding standards of practice.

Review of special purpose registration for current medical practitioners

In the context of clinical governance it is important to consider those OTDs who are currently working in Queensland who were not subject to the proposed requirements. The two categories of OTD again are deemed specialists and generalists.

Current Deemed Specialists

This group should participate in the usual clinical performance management processes applicable to all doctors (clinical audit etc).

Current Non-specialists

There are many non-specialists currently practicing in Queensland (both in the public and private sector) who have not been through a clinical assessment process as part of registration. At the time of reappointment or re-registration (this group is employed on twelve month contracts) the full recruitment assessment process should occur. This would include the clinical interview, language and cultural assessment and appropriate clinical skills assessment. This process would be informed by the knowledge available from existing supervisors.

The processes outlined focus on special purpose registration requirements in the context of clinical governance. It is obvious that ideally Queensland Health should be growing its medical workforce locally to minimise the need for special purpose registration. Initiatives in this area are described in Chapter 10 on Workforce.

There are obligations on employers of OTDs with special purpose registration to ensure that this group, who are making an important contribution to the Queensland Health workforce are appropriately treated. This should include dedicating funding to assist OTDs professionally, socially and culturally. The employer should commit to appropriate training support to assist OTDs with specialist registration to successfully complete appropriate requirements to achieve full registration.

These processes are more fully detailed in Appendix 9.1 which is a summary of a project proposal for recruitment, assessment, placement, training and support (RAPTS) of OTDs. Queensland Health should consider this proposal to reform the current management of OTDs.

As a matter of principle, the practice of wealthy nations like Australia actively recruiting doctors from developing nations should not be encouraged. In the longer term and in the interests of good global citizenship, Australia must aim to achieve national self-sufficiency in respect of its clinical workforce. This is best achieved through bilateral government action and is identified as a principle in the National Health Workforce Strategic Framework released by Australian Health Ministers in April 2004.

Recommendation 9.3

The Medical Board of Queensland should be encouraged to:

- ensure that registration processes (current and future) provide a high quality assessment and are implemented in a timely and efficient manner
- conduct clinical assessments of non-specialist grade OTDs with special purpose registration
- conduct the assessment of OTDs for practice at specialist level via the established Australian Medical College/College pathway.

That Queensland Health implements the Recruitment, Assessment, Placement Training and Support (RAPTS) program for OTDs.

9.3.2 Credentialing and clinical privileging

The credentials and clinical privileging process is to ensure that only those practitioners who are appropriately qualified, trained and experienced will undertake clinical care within the constraints imposed by the available resources, including staff and equipment, and the physical facilities available within the healthcare facility concerned.

Currently, this process is generally undertaken by the local hospital employing the doctor. In an environment of workforce shortage, this may mean that the local clinical leaders and managers have a conflict between credentialing someone about whom they are uncertain or having no one to deliver the service. It appears that these issues may have been relevant at Bundaberg.

It is therefore important that credentialing is performed by an appropriately constituted group removed from the specific service delivery area. The Clinical Governance Units of the Area Health Service should be responsible for the credentialing of all medical practitioners in the Area Health Service using an appropriately constituted committee (National Guidelines are available).

A doctor, once credentialed, should only work in areas that are appropriate given the support services that are available. The Service Capability Framework provides standards on the complexity of support services required in clinical situations. This process is clinical privileging.

Recommendation 9.4

Credentialing of medical practitioners should occur at Area Health Service level facilitated by the Clinical Governance Unit using National Guidelines.

Clinical privileging (the specific services that are suitable for the local health service) should also be performed by the Clinical Governance Unit and should include on the committee a representative of the District Manager of the specific employing health service. Privileging decisions should be based on the Service Capability Framework.

9.3.3 Assessment, development and management of individual clinician performance

Performance assessment and development

The public service Performance, Appraisal and Development (PAD) process is mandated for all staff. In general, the evidence is that Queensland Health public servants, staff in support roles, allied health staff and nurses comply with this requirement however most do not see PAD as a useful process due to the lack of linkage to training and development opportunities. Chapter 4 makes a recommendation about effective performance appraisal and development processes. These processes are most likely to be meaningful if managers and team leaders engage with their staff in ongoing informal discussion about performance in a supportive environment.

Medical practitioners and medical administrators currently view the generic performance management framework within Queensland Health as unsuitable for the following reasons:

- Medical professionals often consider (rightly or wrongly) that review of their clinical performance as a function of their professional peers (College) and not their employer.
- Seniority is also a factor; it is often the case that younger and less experienced specialists occupy clinical director positions, with senior visiting medical officers officially reporting to them as subordinates which creates genuine difficulty for full-time directors in successfully managing performance.

- There is no clear and transparent process for managing concerns about individual clinician performance.
- The current PAD framework makes it difficult to separate the concepts of human error (due to systems issues), knowledge and skill-based deficits and intentional harm.

According to the current Queensland Health policy each medical practitioner is required to submit an application for credentials and clinical privileging review at least every 3 years. Requirements for credentials and clinical privileging include that medical practitioners subject their clinical performance to quality assurance mechanisms such as clinical audit. They must also demonstrate a commitment to past and continuing professional education, an important part of the PAD framework. The effectiveness of the implementation of credentials and clinical privileging and various other elements of clinical governance will impact significantly on the effectiveness of this process, however it does have potential to be part of a PAD process for medical professionals.

Identifying performance issues

Identification of clinician performance issues using existing clinical indicator monitoring and information systems is rarely of any benefit. This is due to relatively small frequency of adverse outcomes and small overall numbers of procedures. The statistical rigour of such approaches is poor and usually, it would take several years of data to identify with confidence, a significant trend.

The use of statistical process control methodology and CUSUM (cumulative sum control chart) can be applied to individual clinical performance. This can allow clinicians and their supervisors to better self-assess performance in key clinical areas and identify any concerns earlier. However caution is required and this should primarily be used as a tool for self evaluation and peer review for improvement rather than for routine organisation monitoring of individual performance.

Managing concerns regarding individual clinician performance

Concerns regarding the performance of an individual clinician, either as a result of an increased frequency of adverse patient outcomes, complaints from staff/ patients or from the PAD processes must be appropriately and transparently managed. Whilst it is essential that the clinician concerned is afforded natural justice and confidentiality, patient safety must be the basis for decisions.

The Credentials and Clinical Privileging Guidelines enable specified clinicians or relevant professional groups to request a review of a clinician when there are indicators of decreasing clinical competence. This is not intended as a mechanism for initiating disciplinary matters, but findings of the Credentials and Clinical Privileging committee may be a consideration in such matters. However there is currently no established process to provide decision-support to administrators and clinicians in addressing these difficult and complex issues.

The National Health Service in the United Kingdom and New South Wales Medical Board have progressed the issues of performance assessment and development and the management of concerns about an individual clinicians performances. Their work could inform the development of similar processes in Queensland.

Recommendation 9.5

Policy, guidelines and training should be developed to support a consistent statewide approach to:

- Conduct individual clinician performance assessment and development
- manage concerns about an individual clinician's performance.

Where there are concerns about an individual clinician's performance:

- the Area Clinical Governance Units should take responsibility for the assessment of the clinician and recommendations regarding remediation
- the District Manager will be responsible for decisions regarding the management of an individual clinician.

The Medical Board of Queensland be encouraged to:

- develop a performance evaluation program that is non-punitive and provides a framework for ongoing demonstration of professional competence. This will require new legislation.
- develop guidelines regarding its expectations of medical practitioners to participate in continuing professional development.

9.4 The right skills

Safe and effective health care not only requires the maintenance and development of good clinical knowledge and skills but a range of other skills. In our complex health care environment the ability to work well with a team of health professionals and to communicate with respect, openness and transparency must be developed. A more informed community also requires clinicians to be able to communicate with patients about the status of their health condition including adverse clinical incidents. Specific skills are also required to undertake a range of clinical governance processes such as root cause analysis and benchmarking.

While ongoing training and development for clinicians is a life long process which must be supported by Queensland Health this section describes skills that are very specific to clinical governance, open disclosure and service improvement processes.

9.4.1 Open disclosure

Open Disclosure is the practice of timely and accurate communication with patients and relatives following an adverse clinical incident or event. There is evidence that specific use of open disclosure processes can significantly improve patient satisfaction after such an event. Failure to practice open disclosure often leads individuals to explore other avenues of redress via complaints mechanisms or through litigation.

The elements of Open Disclosure are:

- an expression of regret
- a factual explanation of what happened and the potential consequences
- the steps being taken to manage the event and
- prevent recurrence without implication of liability or blame of any individual.

The person providing the disclosure must be someone who:

- the patient and their family or carer are comfortable with and can talk easily

- has been involved in the care of the patient and knows the facts and most importantly
- has enough seniority in the clinical area to be able to raise the issue/s with the hospital executive to begin action to stop the problem from happening again and
- has been trained and is competent to disclose appropriately.

A national Open Disclosure Standard has been developed based on international best practice and a national pilot has been endorsed by Australian Health Ministers. Queensland Health is progressing the pilot in seven Health Service Districts with initial training due to commence in late October 2005.

Recommendation 9.6

Queensland Health through the Patient Safety and Clinical Improvement Service should proceed to implement the national Open Disclosure Standard for communication with patients and relatives following an adverse clinical incident or event.

9.4.2 Training in service improvement techniques

Clinical governance is an emerging area and the skills and capacity to undertake specific techniques to identify and manage clinical risk is variable among the current clinical workforce. Some of these techniques include incident investigation, root cause analysis, clinical audit, benchmarking and clinical pathway implementation and variance analysis⁸³.

Therefore to advance quality and safety initiatives access to education and training will be essential and clinicians will need to be supported to undertake and implement this training. Clinical leaders should be involved in both the development and delivery of training and training approaches should be relevant to the health service delivery environment.

As training modules in relation to quality and safety in health services are developed they should also be incorporated into the undergraduate, post-graduate and leadership curricula for patient safety.

Recommendation 9.7

Appropriate training in the use of specific service improvement techniques such as incident investigation, clinical audit, benchmarking and clinical pathway variance analysis should be developed and implemented with the support of the Patient Safety and Clinical Improvement Service and involvement of clinical leaders.

9.5 Effective organisational systems

Many systems have been developed to assist in the identification and management of clinical risks. These include proactive and reactive processes, the effective coordination of which is an integral part of clinical governance. This section describes a number of the key individual systems.

⁸³ The specifics about each of these processes are addressed in the section on effective organisational systems.

9.5.1 Clinical pathways

It is generally accepted that health care should be delivered using evidence based clinical pathways. Health departments interstate and internationally promote the use of pathways and are working on systems to facilitate this such as electronic records and variance analysis. Various incentive programs are in place to encourage uptake of pathways (eg in the United States insurers favour facilities that use pathways and in New South Wales funding was provided to service networks to develop pathways). Pathway development is generally prioritised to areas of high impact (high frequency, high mortality/morbidity, high cost).

Currently, there is no systematic use of clinical pathways in Queensland Health. The clinical collaboratives have been an important vehicle for facilitating the use of pathways by showing that standard practice can improve patient outcomes (see Interim Report for examples). However, it is not common practice for clinicians statewide to use pathways and analyse variances.

There are few statewide pathways available and some of those that have been developed have been reported to be 25 page documents and not practical for implementation. The Mater Hospital has distilled pathways into a one page document which also acts as a data collection tool, an approach that clinicians have embraced.

Queensland Health should work towards more systematic use of clinical pathways. The focus should be on adopting already developed pathways (eg the Mater hospitals use Millimans in the United States) but the process must be led by clinical networks.

Clinicians need to be supported to implement clinical pathways and provided with tools that facilitate easy adoption (eg information systems that conduct variance analysis, statistical expertise). Clinical networks will be an important means through which clinicians can be supported.

The use of endorsed pathways needs to be monitored by Area Health Services and represents a potential indicator of the quality of health service delivery for reporting. Clinical pathways should take into account the size of the facilities, including the skills and environment within which services are delivered eg rural and remote practice is different to metropolitan practice.

Recommendation 9.8

Evidence based clinical pathways targeting high volume services (where standardisation will improve safety and quality) should be developed (or purchased) and implemented by clinical networks with the support of the Patient Safety and Clinical Improvement Service.

9.5.2 Benchmarking

The Measured Quality Program was the first corporate attempt to introduce statewide benchmarking across a number of domains including clinical outcomes, efficiency, patient satisfaction and system change and integration. This program has reported against these indicators for 60 hospitals since 2002. Health Service Districts have been advised of any significant variation in their performance against these indicators, when compared with their peer hospitals.

Generally speaking clinicians perceive the Measured Quality Program as a corporately driven initiative developed with little clinical input, not timely, using indicators that are not robust, and in a shroud of secrecy that is counterproductive. The Health Round Tables are thought to be a much better example of a useful quality benchmarking exercise where similar hospitals can compare performance and share information while remaining de-identified in the process.

The most difficult aspect of benchmarking is determining the measures. Due to the difficulties of varied casemix and risk adjustment, it is generally much more useful to benchmark key *process indicators* against best practice/evidence based rates. If the measures are clinically relevant, then there is a greater chance of clinician ownership and resulting improvement activity.

It is a requirement of most medical professional bodies that members participate in continuing professional education and development activities including benchmarking. It is also a requirement for ongoing credentialing and clinical privileging for specialist staff. Queensland Health should work with professional bodies to introduce more systemic benchmarking participation. A first step, could be the development of standard processes for evaluating the appropriateness of staff participation in benchmarking activities required by colleges and to include this in performance appraisal processes.

For other clinical streams, participation in benchmarking processes should be pursued through the service networks and the use of incentives for data collection. This process must be led by credible clinicians. Clinicians participating in clinical networks should be encouraged to involve local clinical staff/teams in the analysis of performance compared to other facilities.

As the clinical networks mature and benchmarking becomes routine practice for various health conditions, the performance indicators used by networks for benchmarking should be incorporated into Area Health Service reporting. An example of this is the inclusion of “use of Beta Blockers in eligible patients with congestive heart failure” as a performance indicator in outputs reporting to the Queensland Government. This performance indicator was developed through the Collaborative process.

Recommendation 9.9

Effective quality and safety benchmarking processes should be developed by Clinical Networks facilitated by the Patient Safety and Clinical Performance Service.

Clinicians participating in clinical networks should involve local clinical teams in the discussion and interpretation of benchmarking data.

9.5.3 Clinical audit and death review

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria followed by the implementation of change at an individual team or service level. Further monitoring is used to confirm improvement in healthcare delivery⁸⁴. The clinical areas audited should be high risk, high volume or high cost.

⁸⁴ A Practical Handbook for Clinical Audit, NHS 2005

⁸⁷ Australian Institute of Health and Welfare, Australian Hospital Statistics 2003-04, 2005

While clinical audits are being undertaken in Queensland public hospitals, there is no systematic approach, no formal requirement for districts to perform audits and no formal reporting and monitoring mechanisms. A major barrier to effective implementation of clinical audit at a local level has been the lack of clinical information systems to support the process.

In 2003 a Clinical Quality Unit was established in the Office of the Chief Health Officer with a view to conducting and supervising a statewide program of clinical audit and training clinicians in clinical audit processes. This work has not been substantially progressed to date.

This unit also supports the work of the three Quality Councils - the Queensland Paediatric Quality Council, the Queensland Maternal and Perinatal Quality Council and the Queensland Committee to Enquire into Peri-operative Deaths. These Councils were established under the *Health Services Act 1991* to provide advice to the Minister and the Director-General on benchmarks, and comparative data across regions and populations on morbidity and mortality. The Councils provide legislative protection to the Council members to undertake confidential enquiries.

While the intent of the Councils has merit, the current processes are not effective, due mainly to the lack of timely information and connectedness to change processes within Queensland Health. The councils have recently begun a new three year term and are seeking to address some of these issues.

The Clinical Practice Improvement Centre is currently developing plans to support patient outcome audits that will be clinician driven at the local level.

Death review is a clinical audit process whereby all deaths in a particular hospital are reviewed on a regular basis. Some hospitals already have processes in place to undertake death review but systematic approaches across the state are not in place. Best practice approaches include a multi-level, multi-disciplinary, systems review of deaths led by the clinical service, but oversighted by administration.

Recommendation 9.10

Clinical audit (including routine death review) should be a routine activity for all clinicians, clinical networks and services. The necessary tools, resources, information systems and support should be developed and made available to facilitate this activity.

9.5.4 Incident monitoring and analysis (including sentinel events)

Queensland Health has had an Incident Management Policy in place since June 2004. This policy defines incidents and outlines the processes and accountabilities for the management of incidents. Ten sentinel event types have been specified for investigation by Queensland Health and these are included in the policy. Root Cause Analysis and central reporting of sentinel events is mandated to enable state-wide learning and the development and implementation of statewide safety improvement initiatives.

The effectiveness of the incident management policy has been variable to date due to a range of business processes being used across districts, no comprehensive information system for incident reporting, lack of tools for incident analysis, limited training for staff in analysis techniques and limited resources and capacity in districts to set up and maintain systems. The Patient Safety Centre was established to address these issues.

There is a requirement that all deaths that are not reasonably expected to be an outcome of a health care procedure be reported to the State Coroner for investigation. Queensland Health in conjunction with the State Coroner should develop a policy and process to provide clarification and consistency in the reporting.

Incident reporting

A web based electronic incident reporting system (PRIME) is currently being rolled out across the state (in use in 35 percent of Districts). This system aims to:

- improve the reporting and management of clinical incidents including sentinel events and near misses
- facilitate appropriate action for individual incidents,
- enable the analysis of incident trends, and
- evaluate local and statewide initiatives aimed at reducing adverse events.

The system is consistent with the Australian Standard and uses a risk matrix to prioritise risk of adverse events. This allows a focus on the most serious clinical risks and prioritised resources for analysis and intervention.

There has been a mixed response to PRIME particularly in districts which already had an incident monitoring system in place. Key factors in this dissatisfaction appear to be the length of the incident forms, limited computer access and low computer literacy skills among staff. Middle managers in many districts which had an existing system in place before PRIME have reported receiving fewer incident reports after PRIME was introduced.

PRIME was developed as an interim solution pending progress on a national database, however it is critical that staff have a system for reporting incidents which enables incident analysis to be conducted. The roll out of PRIME therefore must be progressed as a priority and concerns raised in the Interim Report addressed. This will require:

- an evaluation of the implementation to date and improvements implemented in response to findings
- consideration of the overlap with the STOCCA reporting system for adverse drug events and IMS for Workplace Health and Safety events and determination of whether these systems should be migrated to PRIME.

In recognition that PRIME was an interim measure, work needs to commence now on a permanent solution. The AIMS system should be one of the potential systems considered for a permanent solution as it is being used in a number of health systems in other states.

Incident analysis

In many areas, medical and nursing staff advised that they are not reporting incidents (let alone near misses) because they receive no feedback on how the information is used. Many staff considered that there are no clearly defined responsibilities for follow-up and reporting on actions taken. An exception was the Northern Zonal Clinical Review Committee which provides an opportunity to examine critical incident reports from the various districts to assess common themes and share learning/information.

There is a need to standardise the business processes and governance of clinical incidents. The Incident Management Policy is currently being reviewed and as a part of this process will develop standard documentation to assist districts in this regard. This includes the reporting of unexpected deaths to the coroner. Staff need to be educated on the policy and their responsibilities and managers need to promote a just culture to encourage reporting.

There should be area and statewide level analysis of incidents. Staff need to be trained in investigation techniques for serious incidents and sentinel events (root cause analysis). Training commenced in July 2005 and the Patient Safety Centre has recently put a process in place to obtain copies of the incident analysis relating to sentinel events. The development of solutions needs to be done in consultation with clinicians particularly the relevant clinical networks.

The analysis of aggregated incident data to identify trends should be supported with appropriate statistical expertise but interpreted and acted on by clinical leaders.

Area Health Services should monitor incident reporting and analysis and be required to report on the processes in place (eg % serious incidents investigated) to identify and manage clinical risks through this process.

There should be an annual public report on sentinel events as per New South Wales and Victoria. This report should provide a de-identified state wide summary and be available publicly.

Recommendation 9.11

- Review and implement the incident management policy.
- Address the current issues with PRIME before continuing implementation across the state including improved training for staff. Develop a strategy for future system enhancement (including a review of national progress on the development of incident monitoring systems and potential benefits of national standardisation).
- Queensland Health in conjunction with the State Coroner should develop a policy and process to enable reporting to the State Coroner of all deaths that are not reasonably expected to be an outcome of a health care procedure.
- Analyse serious and sentinel events at an area health service and state level (and contribute to national reporting) with a focus on preventing and minimising harm.
- Based on incident analysis develop and implement state-wide safety initiatives using clinician led networks.
- Measure and report on safety culture within health services to promote attitudes and behaviours associated with safe practice.
- Provide an annual public report on sentinel events.

9.5.5 Programs targeting high-risk areas of patient safety

Medication safety, hospital acquired infections, falls, pressure ulcers and procedural practice have been identified nationally as quality and safety priorities. These issues represent areas where major gains in quality and safety can be achieved and have received Ministerial commitments. Queensland Health has developed programs for these areas, some of which are recognised nationally as best practice (eg safe medication practice). These programs should continue to be supported, led by clinical leaders, with appropriate resourcing.

Further work is required to address and prevent the key safety risks associated with mental health adverse patient events. This should be given priority.

Recommendation 9.12

Endorsed priority programs in medication safety, infection prevention and control, falls, correct site surgery and pressure ulcers should continue to be developed and implemented.

9.5.6 Enabling legislation

Within the context of clinical governance there are two areas that require legislation to enable the effective implementation of processes. These are the use of patient data and indemnity issues for clinicians.

Use of patient data

Prior to 2004 confidentiality provisions within the *Health Services Act 1991* placed limits on the use of individual patient medical records for the assessment of the quality and safety of health services. Amendments regarding confidentiality provisions were made to the *Health Services Act 1991* which came into force in early 2005 that now enable use of these records within the Department for the purposes of evaluating, managing, monitoring or planning health services.

The relevant sections of the legislation: 62G (Disclosure for data collection and public health monitoring), 62H (Disclosure for purposes relating to health services) and 62M (Disclosure to approved quality assurance committee) should be broad enough in their scope to enable effective sharing of information by clinicians to ensure there is proper monitoring of the quality and safety of services. However this should be reviewed in June 2006 to assess whether the operation of the confidentiality provision is inhibiting the work of quality and safety processes within Queensland Health.

Indemnity issues

Open disclosure (to patients) and open discussion and learning among clinical teams have also been hampered by the lack of legislation indemnifying clinicians when they are frank and open about adverse clinical incidents. Clinicians need clear advice about how they will be treated when they are involved in an adverse patient event. This requires consistent and coordinated legislation and policy which is primarily focused on:

- defining ‘blameworthy behaviour’ (established in other jurisdictions as intentionally unsafe acts, criminal acts, acting under the influence of alcohol and illicit drugs, and patient abuse)

- focusing on learning from adverse events by taking a systems approach to the analysis and subsequent action to prevent recurrence
- providing privilege to the root cause analysis process so that staff can feel free to speak openly and honestly about what happened without fear that this could be used against them in a court of law
- providing protection to staff from action by their employer in the event of an adverse event occurring as the result of systems failure
- protection for analysis teams against civil actions, privilege of working documents arising from a root cause analysis and from giving evidence associated with the root cause analysis.

Legislation currently operating in New South Wales, protecting Root Cause Analysis of clinical incidents, has been seen to be effective in engaging clinicians in trying to learn from adverse clinical outcomes. Specific legislation granting complete privilege is the most effective way of protecting the Root Cause Analysis outputs. The Legislative Projects Unit in Queensland Health has commenced a project to address this with the advice of the Patient Safety Centre. In the future it would be the role of a Health Commission to recommend to government legislative changes associated with health service improvement.

The review is obliged to sound a note of caution that legislative provision backed by formal policy will not be sufficient to achieve unconditional support of clinicians for the clinical governance systems recommended. Complete open reporting and reconciling of errors, omission and incidents will only occur in a just culture or workplace environment. Clinicians throughout Queensland, especially doctors, expressed very strong reservations to the Review, and in some cases anger, that there was evidence that their employer had not honoured commitments to indemnify staff in undertaking their normal clinical duties where they have acted in good faith but where procedures have resulted in adverse outcomes for patients or their families. The clinical workforce cites several instances where their employer (both Queensland Health and Government) has not been supportive of their actions taken in good faith, but instead, in their view taken a line of least resistance to minimise adverse publicity often at the expense on an individual staff member receiving fair and just treatment.

It is strongly emphasised that the system of clinical governance recommended will only come to fruition with full clinician support which in turn depends on whether the clinicians' employer in fact demonstrates, as opportunities arise, that it does presume professional conduct in good faith by its clinicians until fair and just process prove otherwise.

Clinical staff need to be confident that they have the support of the organisation. This is an essential underpinning for improving the confidence of the community in Queensland Health.

Recommendation 9.13

Development of legislation encouraging and protecting good quality and safety assurance analysis should proceed and be submitted to the Health Minister to progress.

Review of the recent confidentiality provisions of the *Health Services Act 1991* should be conducted during 2006 to determine the impact on the effective sharing of information by clinicians for quality assurance purposes.

9.5.7 Health service accreditation

External accreditation is sought by health services through the Australian Council on Healthcare Standards or the Institute for Health Communities Australia. Health Services Districts are now moving towards ‘whole of district’ accreditation (including primary care, aged care and mental health services). Ninety percent of Health Service Districts have ‘whole of district’ accreditation and districts not currently accredited are progressing towards accreditation. The proportion of public hospitals accredited in Queensland is higher than the national average⁸⁷.

There is doubt about the effectiveness of the current accreditation process in providing assurance of safe healthcare services. Most of the high-profile health system failures in Australia have occurred in facilities that were fully accredited and there is little evidence that accreditation leads to improved safety or outcomes of care. Accreditation agencies are aware of these issues and are seeking to review their accreditation processes accordingly.

Recommendation 9.14

Queensland Health should work with health service accreditation agencies to establish more meaningful quality and safety measures for accreditation assessments.

9.6 The patient experience

Health services have much to gain from listening to feedback from patients and their carers on their experiences with the service provided. This can be achieved through proactively working with consumers to gain feedback and input into how services actually work for them and through effective reactive processes such as patient complaints systems. Western Australia’s model for clinical governance has consumer liaison and participation as one of four critical pillars. Canadian health services also explicitly identify this dimension in their clinical governance frameworks.

9.6.1 Consumer feedback

“Hearing the voices of consumers is an effective way for hospitals to get good information about what needs to be done to improve the quality of their services”⁸⁸

Feedback from patients on their experience of Queensland Health’s services has been recognised as a significant component of monitoring quality and has largely been addressed through complaints resolution processes and patient satisfaction surveys. Statewide patient satisfaction surveys have been conducted by Queensland Health in 2001 and 2005. Individual districts have also undertaken patient surveys in an ad hoc manner. The latter surveys were more likely to be at the clinical unit level which provided staff with more practical feedback in terms of implementing change to improve services.

⁸⁸Mary Draper, *Involving Consumers in improving hospital care: lessons from Australian hospitals*, Department of Health and Family Services, 1997

Patient satisfaction surveys have been a common method for gaining feedback on health services but have largely focused on hotel services, helpfulness of staff and provision of information. A major criticism of the statewide survey currently in use is that it does not evaluate whether the patient's health improved as a result of their interaction with the health service. There are suggestions that patient surveys should add more specific questions about clinical quality (such as whether a person felt safe during hospitalisations) or clinical outcomes. However there is a concern that there are fundamental barriers to integrating perceptions of service and clinical quality.

Health services need to use a range of methods in getting effective feedback from consumers. Some alternative approaches to using surveys include focus groups, workshops, community forums, submissions and hotlines. These approaches provide a rich source of information of the patient's experience that may better inform the improvement of services. Use of these methods requires considerable commitment from senior management, adequate resources and specific skill sets. The latter have been identified as lacking in many Australian Hospitals. The District and Area Health Councils proposed within this report would provide another avenue for consumer feedback on services.

An important element in engaging with consumers is establishing and communicating consumer rights. In 2002 Queensland Health developed a public patient's charter which explains patients' rights and responsibilities.

Recommendation 9.15

Revise the Patient Charter to incorporate changes resulting from this Review and communicate patients' rights and responsibilities to patients and their carers.

Establish District Health Council and Area Health Council processes for consumer and community input into service planning and evaluation.

Establish a strategy for consumer feedback (including but not limited to patient satisfaction surveys) at the District and Area Health Service levels. This should be developed in the context of a statewide framework for consumer and community engagement and supported through the development of appropriate tools and methodologies and appropriate resourcing.

9.6.2 Patient complaints

Queensland Health's complaints policy reflects contemporary best practice but its implementation has been poor and there is a lack of uniformity and quality in complaints systems across the State. Patients are unsure how to progress their concerns about healthcare and who to approach in the health system. District staff advise that they do not feel empowered or confident in handling complaints and Queensland Health has no system to be adequately informed about patient complaints and concerns (or compliments).

Features of an effective complaints and compliments system

A good complaints model should promote "frontline complaints handling"⁸⁹ which advocates timely resolution of complaints at the local level, whilst providing for further internal and external review.

⁸⁹ Queensland Ombudsman "Developing Effective Complaints Management Policy And Procedures", March 2004, p. 4

According to the International Standard (ISO 10002) on complaints management a complaint system should⁹⁰:

- “provide a complainant with access to an open and responsive complaints-handling process
- enhance the ability of the organisation to resolve complaints in a consistent, systematic and responsive manner, to the satisfaction of the complainant and the organisation
- enhance the ability of an organisation to identify trends and eliminate causes of complaints, and improve the organisation’s operations
- help the organisation create a customer-focused approach to resolving complaints, and encourage personnel to improve their skills in working with customers
- provide a basis for continual review and analysis of the complaints-handling process, the resolution of complaints, and process improvements made”.

The complaints model should promote and enable open disclosure. Patients need to be informed of their involvement in clinical incidents, and this should happen in a way that is immediate, open and honest⁹¹.

Further as stated in the Interim Report, the complaints system should adhere to the Australian Health Care Agreement 2003-08 which requires the existence of an independent complaints body (in Queensland this is currently the Health Rights Commission).

The proposed complaints model

Three complaints model options have been considered based on initiatives from other jurisdictions, as well as suggestions from the submissions to the Review, public consultations and meetings with stakeholder groups.

The first option is that all initial complaints should be filtered through an external body which would subsequently pass the matter onto the appropriate body to deal with (whether that is the local district or the mandated statutory body where relevant).

A second similar option is that all initial complaints should be filtered through a single internal body. The concern with both of these options is the potential delays in being able to address complaints in a timely manner locally (as per best practice).

The third option is that all complaints be dealt with by local resolution initially with the ability to be escalated to an external body at any time.

Under this model, if complaints about patient care (other than suspected official misconduct which would be referred to the Crime and Misconduct Commission) are not resolved to the patient’s/complaint initiator’s satisfaction within 30 days, they are to be escalated to a Health Commission with the powers to investigate such complaints. This model is the most conducive to timely local resolution but also provides for external accountability. Every complaint written or oral must be recorded and contact must be

⁹⁰ International Standard ISO 10002:2004 Quality management - Customer satisfaction - Guidelines for complaints handling in organisations

⁹¹ Open Disclosure Standard: A National Standard For Open Communication In Public And Private Hospitals, Following An Adverse Event In Health Care, July 2003, Australian Council For Safety and Quality In Health Care

made with patient/staff member within 72 hours of the date of lodgement. Local resolution is facilitated by open disclosure. Further details of this preferred model are found in Figure 9.1.

A designated District Complaints Coordinator should be responsible for resolving as many complaints as possible themselves. The Complaints Coordinator must be highly skilled in conflict resolution and be given authorisation to engage all district staff in the effective resolution of complaints. In the event that they are unable to resolve the issue the Complaints Coordinator should escalate the matter to the relevant member of the District Executive (for example a complaint involving a nurse should be followed up by the Director of Nursing). Where a complaint is made against a doctor the Complaints Coordinator should also immediately notify the Director of the Area Clinical Governance Unit.

Complaints Coordinators will require on-going training particularly on the *Whistleblowers Protection Act 1994* and how to better support Whistleblowers. The training on complaints handling would be conducted via a partnering arrangement between Queensland Health, a Health Commission, the Crime and Misconduct Commission with significant input from the Ombudsman's Office. A network should also be established for coordinators to support each other and share experiences.

Area Complaints Managers (within the Area Clinical Governance Unit) must ensure that actions taken are appropriate for all complaints and that unresolved matters are escalated within the timeframes.

One statewide complaints and compliments database

Queensland Health should treat complaints and compliments as a data source to improve service delivery but there is currently a lack of uniformity and quality in complaints systems across the Department. Consideration should be given to developing one statewide complaints data base, with a number of security access levels, which would record all complaints and compliments about Queensland Health's provision of healthcare as well as complaints and compliments about other Queensland Health services. To facilitate data analysis Queensland Health should consider recording on this same complaints and compliments database, complaints made to the Minister and Director-General, misconduct complaints, level 2 and 3 grievances, email misuse and if possible suspected official misconduct.

Some work has commenced on a patients complaints module for the incident management system PRIME. This initiative should be evaluated and if it meets Queensland Health's needs be progressed as soon as possible.

Analysis of complaints data to identify systemic issues should be undertaken centrally and feedback provided to Area and District Complaints Coordinators. They would also provide regular reports to Area and District Managers on the status of complaints.

A complaints system in which patients/consumers of healthcare have confidence

The public needs to have confidence that complaints are being actioned and any systemic matters addressed. The role of an independent body such as a Health Commission is impartial adjudication with timely complaints resolution the required outcome. The most transparent way of ensuring this takes place is for this independent body to have closer

involvement in complaints handling involving Queensland Health. This could mean having access to the complaints data base and complaints data for independent monitoring of individual cases and having the power to investigate or to take over the investigation of a complaint at any time. This would provide one source of checks and balances missing in the current system of complaint handling within Queensland Health.

In recognition that consumers of health services sometimes need support to guide them through the health maze, other jurisdictions have introduced the concept of advocacy services whose role it is to support health consumers in reaching clear decisions and taking action as a result of those decisions, with the aim of resolving complaints.

The Western Australian health system has a Health Consumers' Council, an independent community based organisation, which advocates on behalf of consumers to government, doctors and other health professionals. In New South Wales the Health Care Complaints Commission (HCCC) provides a Patient Support Service with officers located in Area Health Services. This service is repositioning itself from what has been perceived as a consumer advocacy service to supplying an impartial complaints resolution service.

In reviewing services to assist patients in other jurisdictions, the Review has concluded that patients/health service consumers would benefit from receiving independent assistance if they should need this. This may be particularly the case with respect to culturally and linguistically diverse groups (often referred to as CALD). Therefore an independent patient support officer service offered by the non-government sector and managed through a Health Commission should be considered.

Numerous non-government organisations provide support and assistance to health care consumers. While complaints management is not their primary role, if these organisations have a clear understanding of the complaints management model they can more effectively work with consumers and communities when they have concerns about the provision of health services. It is therefore important for Queensland Health to make information about complaints management widely available to such organisations.

Interstate experience also shows that a network of locally based Health Commission staff in regional areas can also assist in timely complaints resolution. It is suggested that placing Health Commission officers in centres such as Cairns, Townsville and Rockhampton should be considered. Placing a Health Commission officer in Bundaberg to service the Bundaberg/Fraser Coast Health Service Districts for a period of approximately two years would assist the local communities in regaining confidence that health care concerns will be addressed promptly. Additional Health Commission officers should be considered to improve the service to high growth areas such as Gold Coast, Logan City and Sunshine Coast as well as rural/remote areas of Queensland.

This strategy would help to promote resolution of complaints in a timely way and better meet the patient/consumer of health services' needs in terms of accessibility and understanding of local issues.

Criminal history checking

One strategy to reduce the risk of complaints of a serious nature involving employees is to ensure that the workforce has undergone a prudent degree of screening prior to employment. With that in mind Queensland Health has been working towards a general Criminal History Check policy and process in accordance with the provisions of the

Public Service Act 1996. The Review team was advised that a specific submission is currently with the Office of Public Sector Merit & Equity for consideration. This followed changes to the Public Service Act in 2004 enabling Queensland Health to conduct broad based checks on potential and existing staff - no legislative provision existed prior to that time.

At this point in time Criminal History checks are conducted on certain staff employed within Queensland Health in accordance with the *Commission for Children, Young People and Child Guardian Act 2000* and the *Aged Care Act 1997*.

The “Working with Children Check” or Blue Card is only required in Queensland Health for those staff working predominately with children and young people in a school or school based environment. This includes staff working in school based youth health programs and oral health programs and some Alcohol Tobacco and other Drugs programs. All other Queensland Health staff, including Medical Practitioners and Nurses, are not required to hold Blue Cards at this time.

It is in the interests of patients and other staff, that all current and prospective Queensland Health employees undergo a criminal history check. It should be noted that a prospective employee with a criminal history is not prevented from being appointed to a position for which they apply, provided the conviction is not deemed relevant. As this is a large organisation staff working with the most vulnerable patients/consumers should be considered first.

Whistleblowers

During the review of the complaint systems and having regard to Bundaberg issues generally it is clear that the *Whistleblowers Protection Act 1994* (the Act) could be enhanced. Based on the consultations held and submissions received four changes to the Act have been considered:

- One submission has proposed that just as agencies must refer allegations of suspected official misconduct to the Crime and Misconduct Commission so too agencies should have an obligation to refer disclosures involving serious maladministration to the Ombudsman’s Office and that the Ombudsman should be empowered to investigate these disclosures of maladministration. One concern with this suggestion relates to the possible extension of time to investigate issues. The constant theme repeated by healthcare consumers and past complainants during the Review’s consultation process and in submissions, is the time delays in resolving matters by external complaint bodies such as the Ombudsman’s Office and the Health Rights Commission. Secondly, this proposal does not appear to represent a significant gain for Whistleblowers as maladministration is only one of four types of conduct that constitute a public interest disclosure. No proposal is put forward for two of the four types of conduct:
 - danger to the public health or safety or the environment
 - negligent or improper management affecting public funds

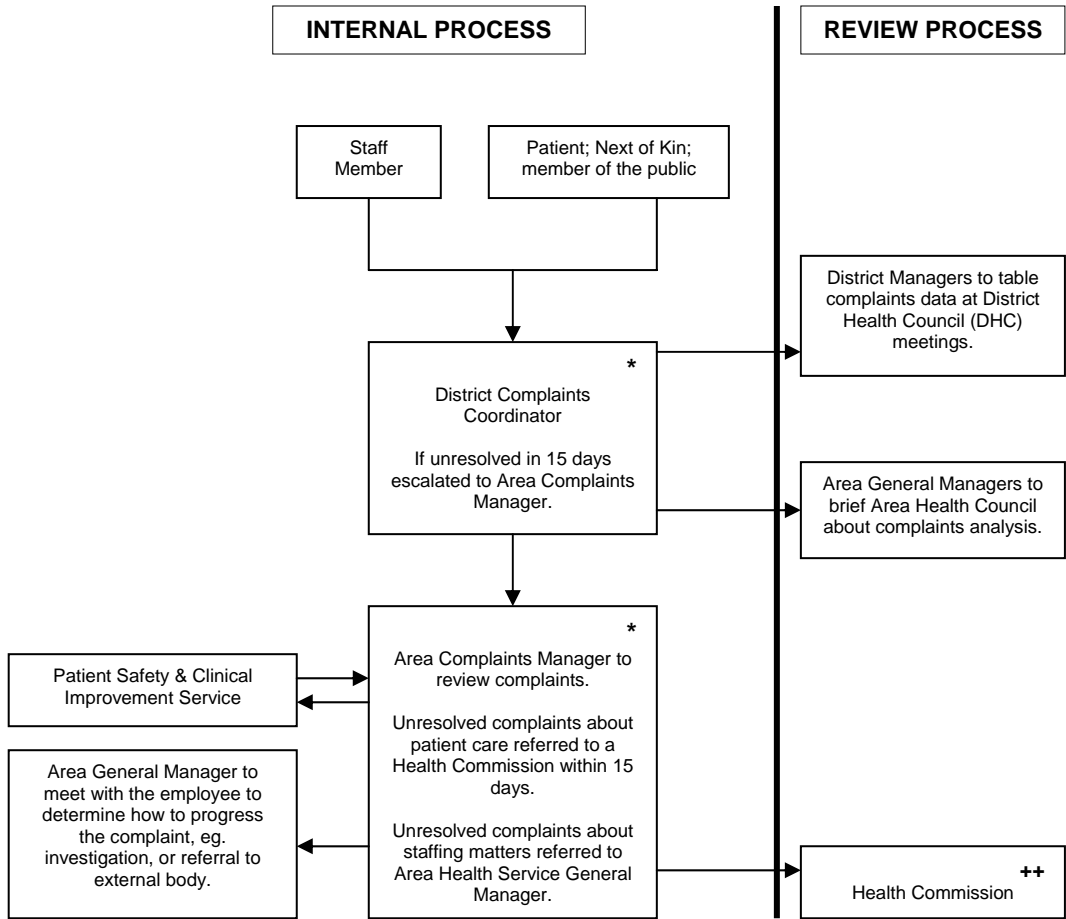
If the proposal was to be endorsed the definition of “Maladministration” under Schedule 6 of the Act would need to be more specific. Public Interest Disclosures could also relate to more than simply maladministration which may cause confusion as to which external body has carriage of the Disclosure. For the above mentioned reasons this proposal is not supported.

- That Whistleblowers should be able to lodge Public Interest Disclosures with Members of Parliament and have protection under the Act. This proposal is supported.
- That Whistleblowers should be able to lodge Public Interest Disclosures with the media and have protection under the Act. This proposal is not supported as there are already a number of options available to Whistleblowers and such a move could allow untested allegations being made public that unjustly impugn those against whom allegations have been made.
- That any person not just a public officer should be afforded protection for disclosing danger to public health and safety. Such a change to the Act would protect for example patients from reprisals, particularly defamation proceedings. This proposal is supported.

Statements have been made that Queensland Health's culture is not conducive to disclosing clinical incidents and treating complaints as learning opportunities. Undertaking a re-education program on the *Whistleblowers Protection Act 1994* is one of the strategies Queensland Health should implement to help to ensure situations like Bundaberg do not occur again. Queensland Health also needs to create an open and responsive complaints system. Several of the strategies considered in developing the proposed complaints model address this concern. The key strategies are:

- rewriting the Code of Conduct so it is not used as a tool to bully or intimidate but rather focuses on a new set of organisational values which are patient/consumer centric
- Queensland Health partnering with external complaints bodies to train Complaints Co-ordinators in complaints handling with a particular focus on how to support Whistleblowers
- a Health Commission should have access to Queensland Health complaints data about patient care and the complaints database, at all times and should be able to take over the carriage of a complaint at any time
- staff of a Health Commission be appointed to have a local presence and improve service to regional Queensland as well as high growth areas and
- there are timeframes for investigation of complaints after which there is mandatory reporting to a Health Commission.

FIGURE 9.1 - RECOMMENDED COMPLAINTS MANAGEMENT & RESOLUTION MODEL



++ Additional Health Commission staff may be located in regional centres
 * Area Complaints Managers and District Complaints Coordinators may need to consult with Human Resource Manager/SSP in resolving staff complaints

Director-General/Ministerial complaints would be forwarded to the Area Health Service General Manager for attention.

The Complaints model above in no way overrides statutory/mandatory reporting requirements.

Recommendation 9.16

A complaints model be adopted that provides for local resolution first whilst requiring escalation to an independent complaints body, a Health Commission, if the complaint is not resolved in 30 days.

District Complaints Coordinators with the skills and the delegation required be employed to take primary responsibility for complaint resolution and be supported through appropriate training and networks.

A Complaints Manager position be created for each of the Area Health Services to support District Complaints Coordinators and ensure all complaints about health care in the Area Health Service are resolved or escalated to a Health Commission and that actions taken in response to such complaints are appropriate.

Recommendation 9.17

District Managers will table regularly at District Health Council meetings de-identified district complaints and compliments data and any Health Service District and Area Health Service trends and learnings to keep community representatives informed.

Recommendation 9.18

Consideration should be given to developing one statewide complaints data base with a number of security access levels which would record all complaints and compliments about Queensland Health's services.

Recommendation 9.19

A Health Commission should have access to Queensland Health complaints data about patient care and the complaints database, and should be able to take over the management of a complaint at any time.

An independent patient support officer service be arranged with the non-government sector and managed through the Health Commission.

Some Health Commission staff be located around the state to assist healthcare consumers in resolving complaints.

Recommendation 9.20

All current and prospective employees should undergo criminal history checks in the interests of patients and staff. Staff working with the most vulnerable patients/consumers should be targeted first.

Recommendation 9.21

Changes considered to the *Whistleblowers Protection Act 1994*

Whistleblowers should be able to lodge Public Interest Disclosures with Members of Parliament and have protection under the Act.

The media should not be approved as one of the bodies to whom Whistleblowers can lodge Public Interest Disclosures and have protection under the Act.

Any person not just a public officer should be afforded protection for disclosing danger to public health and safety.

Complaint oversight bodies

Several external oversight bodies have varying degrees of involvement with healthcare complaints about Queensland Health. The bodies with most involvement are the Health Rights Commission which addresses approximately 1500 complaints annually and the Crime and Misconduct Commission which receives approximately 200 complaints annually. The Health Practitioner Registration Boards and the Queensland Nursing Council also receive a large number of complaints annually but numbers are not currently available.

There are also a number of other bodies that may become involved to a lesser extent in healthcare complaints. These are the Professional Conduct Review Panel, the Queensland Ombudsman, the Coroner, the Adult Guardian, the Public Trustee, the Commission for Children and Young People and the Child Guardian.

The terms of reference for this review are limited to systems within Queensland Health. However, in making findings and recommendations regarding the effectiveness of complaints systems within Queensland Health, it is important to also make comment about the broader system of complaints management faced by health consumers and individuals seeking to raise concerns or have complaints addressed. There are several organisations potentially involved:

The Health Rights Commission

The Health Rights Commission can only undertake a formal investigation about a non-registered provider and is the only Commission in Australia that does not have jurisdiction to investigate a complaint about a registered provider. An effective Commission will keep procedures as informal as possible and focus on resolution via mediation rather than investigation. It should be noted that there are already recommendations contained in the report on the Health Rights Commission Review conducted in 2002, which would make the Commission more effective. Some of these recommendations have not been implemented, one of which relates to the legislative changes which are still required.

Health Practitioner Registration Boards (some 14 in total)

Where a board receives a complaint about a registrant from a user of a service provided by the registrant, it must then refer the complaint to the Health Rights Commissioner. Consultation then takes place to determine whether the relevant board will investigate the matter.

While the registration bodies have the power to investigate the actions of individual registrants, they do not have the power to investigate systemic issues – which comes under the responsibility of the Health Rights Commission. This creates difficulties if an event raises both professional standard issues and systemic issues.

The Crime and Misconduct Commission (CMC)

This role is well established within the Public Sector. Many complaints regarding misconduct made to the CMC are referred back to the agency concerned for investigation. The CMC investigates the most serious matters.

The State Coroner

The Coroner has jurisdiction to inquire into the cause and circumstances of a reportable death. There is no consistent approach within Queensland Health to supporting the role of the Coroner in the investigation of deaths that are not reasonably expected to be an outcome of a health care procedure.

These investigations are performed by police officers. It may be preferable for such investigations to be lead by clinicians.

The Queensland Ombudsman

The Ombudsman is empowered to deal with complaints about the administrative actions of Queensland Government departments including Queensland Health.

The submissions received and feedback from public meetings indicate that complainants are looking for better coordination of the work of these external bodies in resolving their issues. The Review concurs with the above view that interaction of the external bodies needs to work better. For this to occur the working arrangements between external complaint bodies should be the subject of further legislative review.

Recommendation 9.22

A separate and short review needs to be undertaken of the legislation and working arrangements between existing external complaint bodies nominated in the report.

9.7 Clinical Governance – external oversight

The clinical governance system, described in the last section of this chapter, will only be effective if it is embraced by the clinical workforce and most importantly, if it enjoys the trust and confidence of the community.

The Review has concluded that significant effort will be required by the employer, Queensland Health, to restore public and internal faith and trust in its clinical workforce. Comparable effort will also be required by Government to regain the confidence of the community following matters about the Bundaberg Hospital and other hospitals revealed at the former Bundaberg Commission of Inquiry and the Public Hospitals Commission of Inquiry and which have been widely reported.

The Review is also mindful from its statewide consultation that some community members have misgivings about the role and effectiveness of the current Health Rights Commission, even though the Review is aware that there have been recent improvements in the way the Commission operates. However, a number of previously recommended legislative changes have not occurred in respect to this body. There is also a need to review the interface arrangements between the Health Rights Commission and registration boards.

The Review has also considered Commissions that exist in other jurisdictions to oversee issues such as quality and safety and clinical practice improvements and enhancements in acute hospitals. Commissions of this kind can provide independent, expert oversight of clinical practice and set evidence based practice standards for, and monitor compliance by, all health facilities whether public or private.

Independent commissions are well positioned to report honestly to the community about progress being made in developing clinical governance systems and standards, and comment specifically upon performance of such systems and the outcomes. Queensland would be well served by establishing an independent body of this kind.

A commission, called the Health Commission, should be established and have the following functions:

- Oversee the development and implementation of quality, safety and clinical practice standards throughout the State's public and private health facilities
- Monitor the compliance of all public and private health facilities with the above agreed standards including regularly publishing reports on a comparative basis relating to these standards

- Encourage hospitals to ensure that clinical governance systems are in place throughout the public and private hospital network and perform as intended
- Investigate on its own initiative and where necessary report on systemic failures within the State's public and private health facilities
- Investigate matters referred by the Minister or the Committee (see below) where there is a suspicion of systemic weakness or failure
- Receive, investigate and manage complaints about the State's public and private health facilities and health services raised by individuals, patients, clinicians and consumers of services
- To undertake complementary research to inform its other functions
- To report generally to the Parliament or Minister and Committee as deemed appropriate by the Commission on its functions and research.

A Commission of this kind in the Queensland context could assume within its functions the role of the current Health Rights Commission to manage a broad range of complaints and undertake certain investigations.

It is recommended that the Health Commission has the following structure:

- A Commissioner and a small team of Assistant Commissioners to act as the governing board of the organisation
- An Executive Director who would assume the role of accountable officer and the administrator of the organisation
- The current envisaged functional requirements of the Commission would require three Directors, not necessarily all at the same level, each Division being responsible for:
 - existing Health Rights Commission functions including complaints
 - oversight of quality, safety and systemic clinical practice issues (including standards and compliance) and
 - the appointment of District Health Council members throughout Queensland and for community consultation and liaison generally. The Commission will advertise and interview for applicants. Two Commission representatives and a Ministerial representative will form the selection panel with nominations to the Minister for appointment.

The selection, qualification and tenure of Commissioners and Directors will be vital.

- In the first years of the Health Commission, the Commissioner and some of the Assistant Commissioners may need to be full time appointees.
- The Commissioner and Assistant Commissioners would be appointed on a full and part time basis for staggered periods with a maximum tenure of five years but a usual term of service of three years. (This is to ensure retention of corporate knowledge and at the same time, renewal in the organisation.)
- As the Health Commission will have a multi-disciplinary mix, Commissioners will need to reflect this mix and should have the following specific backgrounds:
 - The Commissioner – an eminent medical practitioner not concurrently involved in hospital clinical practice with demonstrated leadership qualities
 - A lawyer with medico-legal experience
 - Two people with extensive clinical background in nursing or allied health not currently involved in delivering health services in Queensland
 - A well respected community representative not previously involved in the delivery of healthcare services

- An industry representative with extensive background experience in systemic quality and safety functions in a large human resource environment.
- Directors would have a tenure limited to between three and five years.

The Commission would require access to source information from:

- Incident management systems
- Coroner's findings and recommendations
- Expert committees' reports
- Quality system assessments
- Complaints database
- Literature and research.

The Commission must have specific expertise to ensure that data provided is managed and interpreted using valid statistical analysis and independent expert interpretation. This is vital for both clinician and public confidence in the Commission's reports.

To ensure this Commission is accountable and has the level of independence necessary to restore the community's trust and faith in healthcare systems within Queensland, it should report to both the Minister and a statutory committee established under the *Parliament of Queensland Act 2001*.

The role and functions of this Committee should include:

- To monitor and review the operations of the Commission to ensure that the Commission is performing its functions as intended
- To receive reports of the Commission, together with the Minister, that it is determined should not be tabled in the Parliament.
- To monitor the outcomes of reports by the Commission.
- To refer matters to the Commission by its own initiative
- To refer complaints to the Commission for investigation in its normal processes
- To oversee the appointment process of Commissioners. (Appointments to the Commission should be on the nomination of the Minister, after extensive advertising, but will require a majority of the Parliamentary Committee to support the appointment of the Commissioner and Assistant Commissioners with that majority including both Government and non-Government members)
- The Parliamentary Committee should expressly not have jurisdiction to investigate particular individual complaints against health facilities or system issues per se (in order to avoid duplication) but would inform itself of its monitoring and review role by consulting more broadly with the community on a range of relevant issues and paying attention to systemic trends and or failures and the effectiveness of remedial and supportive follow-up action being instigated by the Commission
- To liaise generally with the Minister about the operation of the Health Commission and matters under its jurisdiction.

No member of the Parliament with executive functions or non-government spokesperson responsibility for health issues should be a member of the Committee. It is, however, envisaged that the Committee and the Minister liaise closely on the operation of the Commission.

Both the Commission and the Parliamentary Committee would need to be appropriately resourced and funded.

New enabling legislation to establish the Health Commission and the Committee, and reform other bodies mentioned in this report and effect other recommendations will be required.

Recommendation 9.23

The Health Commission recommended in this report, with functions that include the coordination of health care complaints, be established.

A Parliamentary Committee with the role and functions described in this report, be established to provide external oversight.

9.8 Public reporting

Much has been said publicly and in submissions that the general public has the right to be informed about the standard of healthcare that it is being provided. Information should be available to the public at the local district, area health service and statewide level. Just as the public has the right to be informed, Area and District Managers and departmental media personnel must be able to respond to media requests and make factual comments publicly on the circumstance of their respective health service, whilst protecting patient confidentiality.

District and Area Health Councils should be a part of this process so they can report to communities.

In external reporting, health service accreditation status continues to be used by the Queensland and Commonwealth Governments as the key measure for the quality of health services, despite evidence that this is not a particularly robust measure. Chapter 13 addresses this issue and details the suite of indicators for reporting.

In other jurisdictions, the first stage in improved public reporting has been to focus on the implementation of clinical governance functions using a set of standards. These are detailed in the New South Wales Implementation Plan, Western Australian audit tool and Victorian checklist and could be used as starting points for Queensland Health.

Once these structural arrangements are bedded down reporting should transition to the use of indicators to monitor the performance of the various processes of clinical governance. These indicators should be developed by clinicians with leadership roles in the various clinical governance activities.

Reporting on the quality and safety of health services should be included in the public reporting of the performance of Queensland Health as also detailed chapter 13 of this report. These reports would be derived from monitoring activities undertaken by the Area Clinical Governance Units and District Health Services.

Recommendation 9.24

There needs to be public reporting on the performance of health services, as described in Chapter 13. This would include an enhanced role for Area and District Health Councils.

9.9 Proposed roles and responsibilities for clinical governance in Queensland

For clinical governance to be effective it is essential that the roles and responsibilities for the development and implementation of the various elements described in this chapter be clearly articulated. Considerable variation exists in the delegation of these roles and responsibilities in other jurisdictions however all of those examined have some degree of independent external involvement in clinical governance.

The proposed roles and responsibilities outlined below takes into account the implementation issues discussed in section 9.2.3 and the lessons learnt from other jurisdictions.

Clinicians

Function: Implementation of clinical governance processes
 Activities: Participation in local quality and safety initiatives such as using clinical pathways, open disclosure, clinical audit, and incident investigation.
 Participation in clinical networks

District Managers

Function: Local accountability for all clinical governance processes
 Activities: Provide the resources necessary to support clinical governance activities and have accountability for ensuring local responsibilities are met

District Health Councils

Function: Consumer feedback on clinical performance
 Activities: Receives monthly performance information and six monthly performance review reports
 Providing an annual public report on performance.

Area Clinical Governance Units

Function: Area implementation and performance monitoring
 Activities: Based at hub hospitals in each Area Health Service, these units would be responsible for:

- implementation of policy supporting clinical governance
- performance monitoring of the implementation of statewide clinical policies and initiatives
- provision of support, education and training to staff
- operationalising the credentialing and clinical privileging process
- assessing performance of individual clinicians and acting as an escalation point for individual clinician performance issues.

Area Health Councils

Function: Consumer feedback
 Activities: Receives monthly performance information and six monthly performance review reports
 Providing an annual public report on performance.

Patient Safety and Clinical Improvement Service

- Function: Statewide support for clinical governance problems and enablers
- Activities: A state-wide service working collaboratively with clinicians and Area Health Services across a range of clinical content areas to:
- develop clinical governance policy
 - develop the necessary tools, resources, information systems and support to facilitate the implementation of policy and quality and safety initiatives
 - set standards
 - develop and implement measurement systems
 - analyse data
 - identify and advise on priorities
 - develop and trial improvements
 - develop and support the provision of training and education
 - assist Area Clinical Governance Units and clinical networks to implement safety initiatives
 - coordinate the Coroner's recommendations.

Performance Directorate, Central Office

- Function: Performance reporting
- Activities: Development of performance indicators to monitor the implementation of clinical governance and the quality and safety of health services
Coordination of quality and safety of health services reporting in overall health service performance reporting arrangements.

Health Commission

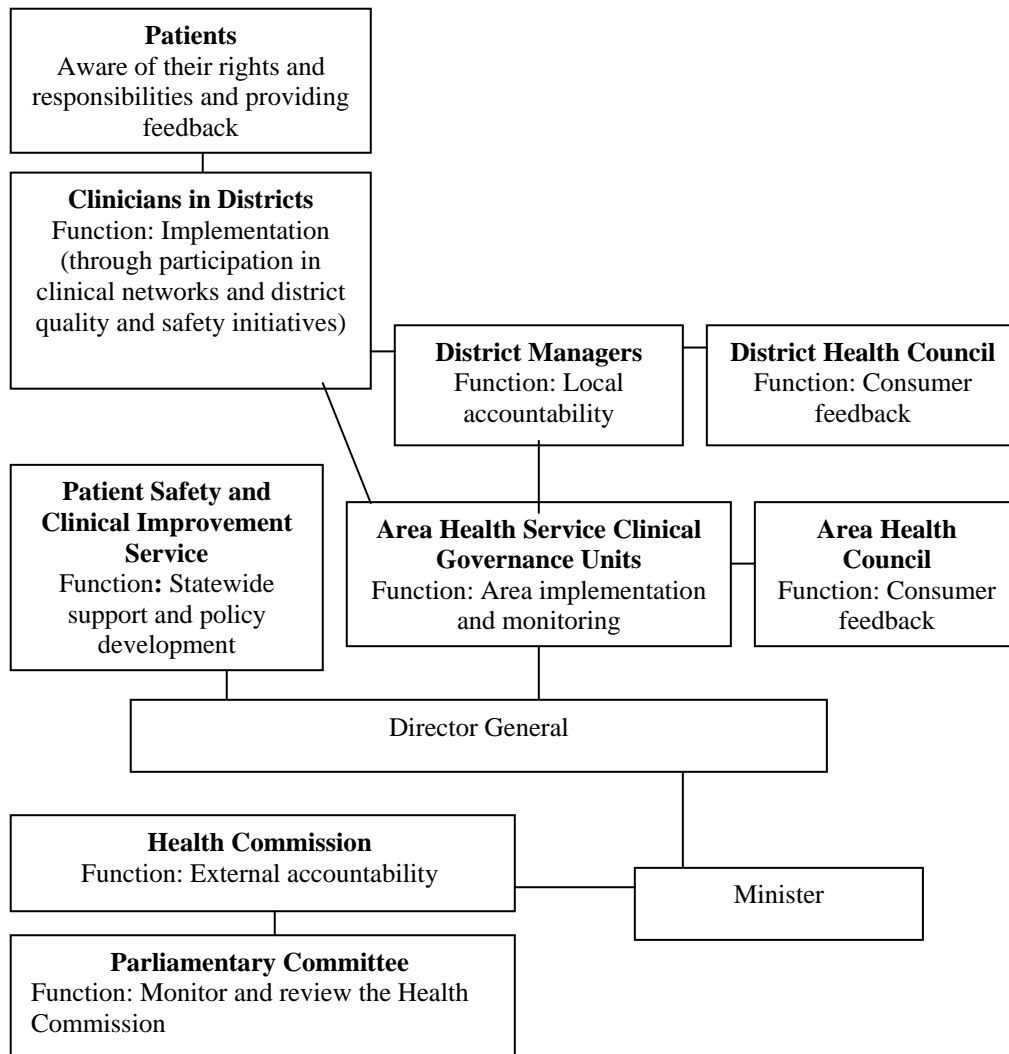
- Function: External accountability
- Activities: An independent external body that would undertake:
- assessment of the quality and safety of health services
 - auditing compliance with clinical governance systems and standards
 - public reporting on systems to support clinical governance and the quality and safety of health services
 - independent investigation of quality and safety issues when required.

Parliamentary Committee

A Parliamentary Committee will ensure that the Health Commission is accountable and has the level of independence necessary to fulfil its role.

- Function: External accountability and Parliamentary oversight
- Activities: The Parliamentary Committee would:
- monitor and review the operations of the Health Commission
 - monitor the outcomes of reports by the Commission
 - refer matters to the Commission by its own initiative
 - refer complaints to the Commission for investigation.

While not incorporated into the structural arrangements for clinical governance, the involvement of professional bodies in implementing the processes and enablers is critical.



Recommendation 9.25

A clinical governance structure be established that is clinician and patient focused with functions as outlined in this section and the following components.

- Safety and quality committees in all districts, chaired by senior clinicians (who are involved in clinical networks)
- Area Clinical Governance Units in each Area Health Service led by a senior medical officer with experience in systems improvement
- A statewide Patient Safety and Clinical Improvement Service
- An independent Health Commission with responsibility to monitor the implementation of clinical governance and the safety and quality of health services and report publicly
- A Parliamentary Committee to provide external oversight.

Professional bodies must be involved in implementing the clinical governance processes and enablers.

The District Manager is accountable for the local implementation of clinical governance.

District Health Councils and Area Health Councils will be provided with performance reports on quality and safety in their monthly performance information and a six monthly performance review report and will be provided with annual public reports on performance for the District and Area respectively (as detailed in Chapter 13).