Improving the notifications process

How we are implementing the KPMG recommendations

January 2017

AHPRA

Aboriginal and Torres Strait Islander health practice
Chinese medicine
Chiropractic
Dental
Medical
Medical radiation practice
Nursing and Midwifery
Occupational therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

About this report

In late 2015, AHPRA commissioned KPMG to review how notifications (aka. complaints and concerns) about registered health practitioners are assessed and managed in Victoria by AHPRA and Boards.

AHPRA accepted all the recommendations for improvement in the KPMG review.

This report provides an update on how we are implementing the KPMG recommendations and follows our response to the KPMG review which was released in March 2016.

Further information about our work in Victoria is also outlined in the Victorian summary of our Annual Report.

Why was this review commissioned by AHPRA?

In 2015 the Department of Health and Human Services (the Department) in Victoria was alerted to a cluster of potentially avoidable newborn and stillborn deaths at Djerriwarrh Health Services (Djerriwarrh). As a result, the Department made sweeping changes to the management and governance at Djerriwarrh.

At the time, AHPRA was also the subject of significant media comment and community interest. This was because of the 28-month timeframe to investigate a notification relating to one of the long serving doctors at the health service. In October 2015, AHPRA made a public statement acknowledging that it took longer than it should have to investigate that complaint, which related to a single case about the standard of care provided to a mother after birth.

In March 2016, the Department commissioned Dr Stephen Duckett to conduct a review of hospital safety and quality assurance in Victoria in response to the events at Djerriwarrh. His report[i], released in October 2016, identified the need for system-wide improvements in clinical governance, including the need for clinical leaders, hospital managers, the Department and AHPRA to escalate concerns and share information earlier and more routinely where there may be concerns for harm. He also noted that mandatory reporting rates in Victoria have been lower than in other states and territories and identified a need to strengthen the reporting culture.

This report provides an update of the work undertaken to improve the way we work and includes response to the recommendations of the KPMG review and some issues raised in the Duckett report.

Summary of KPMG recommendations

The KPMG review recommended that AHPRA and National Boards:

1. develop a better framework for risk assessment, that is more systematic, exhaustive and data informed
2. develop and apply different strategies for managing cases based on risk-rating, including intensive resourcing of higher risk notifications, so these cases don't take the longest time to manage
3. interpret and use the National Law flexibly, not narrowly, to support information sharing in the public interest and promote transparency about what we do
4. are perceived as pro-practitioner and need to shift this perception through cultural change, with a greater emphasis on service, and
5. should continue to critically evaluate the causes of delays, especially for high risk and complex cases.

What we've done

Better management of risk

We have made a number of changes to the way we work to enable early and effective assessment of risks to the public when we receive a notification.

- **Senior AHPRA staff as first responders to notifiers:** Calls from new notifiers are now managed directly by an experienced investigation officer. These staff apply their knowledge and skill from managing notifications to identify risk factors and ensure that cases with a high risk profile are flagged early and managed through the assessment stage (including considering whether immediate regulatory action may be recommended).
- **New ways to identify risks to patient safety:** Through analysis of past cases, the review of research evidence and the workshopping of ideas with boards and committees, we are developing a broader set of factors which can be used by staff to gather relevant information and better assess risks, beyond the information we receive from the notifier. This includes factors such as past history of notifications, nature and source of the notification and practice context.
- **New specialised investigation teams:** Notifications which may represent a serious risk are diverted to a specialised immediate action team for further assessment. This allows for prompt response without drawing the focus of investigation officers away from ongoing management of other notification work.

  Higher risk cases are managed by experienced investigations teams. Moderate risk cases with lower complexity but that need more information to be gathered are referred from assessment to a 'fast-track' investigation team.

  A special investigations team is investigating a number of notifications which we received about practitioners associated with Djerriwarrh. The number and complexity of these investigations has required varied investigative approaches.
- **Making it easier for people to provide the right information when they raise concerns:** In January 2017, we launched a new online portal that enables members of the public, practitioners and employers to lodge notifications online and to make it easier to get the information we need to quickly assess the concerns.
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- **Building the evidence base for understanding risk:** We have established a national unit to bring the best of research and data analysis to better identify, understand and manage risk. This includes a research partnership with Melbourne University with funding support from the National Health and Medical Research Council.[1]

  A number of National Boards, and our regulatory partners in the NSW Health Professional Councils, have undertaken project to analyse the patterns of conduct and performance issues in the management and assessment of notifications.
- **Setting up a National Restrictions Library:** A collection of conditions and other restrictions that decision-makers can use to ensure that any restrictions they impose on practitioners' registration to manage risks to patients are consistent, enforceable and able to be monitored.

[1] Notifications to the Australian Health Practitioner Regulation Agency: Identifying 'hot spots' of risk. This three year research partnership between the University of Melbourne and AHPRA and the National Boards is jointly funded with the National Health and Medical Research Council.

Greater transparency and collaboration to share information earlier

- **Recommending legislative amendments:** We have recommended to health ministers that the National Law be amended in a number of ways to improve our ability to share and receive more information where it is necessary to take action concerning a practitioner's health, conduct or performance.

- **Established regulatory compact with the Department of Health and Human Services:** We have established a memorandum of understanding with the Department which sets out the ways we will share and manage information in the public interest and within the National Law. We are more frequently disclosing information to the Department and individual health services where we believe they may need to assess and respond to safety concerns we have identified through a notification.

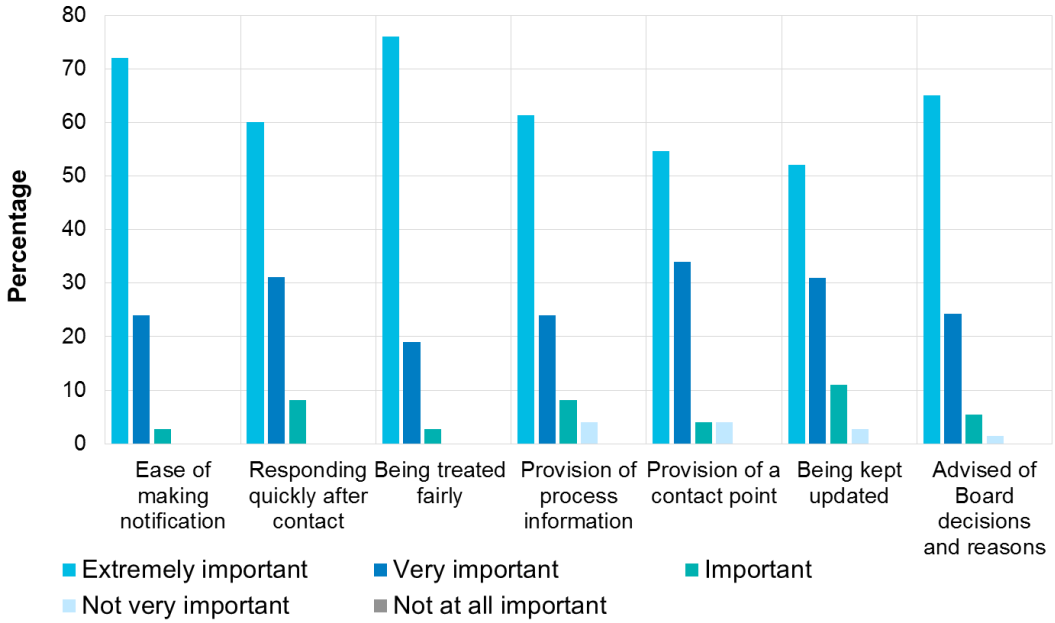
- **Outreach to health services:** The AHPRA State Manager Victoria has established a program of visits to health services and employers to develop awareness of the mandatory requirement to notify AHPRA if they are concerned about the health, conduct or performance of a practitioner they work with or employ, as well as looking at ways we can work together in response to concerns about standards and safety.

Culture change with a greater focus on service

- **Improving notifier and practitioner experience:** We have established a specialist role within AHPRA to improve liaison and communication with notifiers and practitioners while a notification is being assessed and managed. We have also worked closely with our Community Reference Group and professional bodies such as the AMA and indemnity organisations on ways to improve the information we provide about how we deal with notifications and what to expect.

- **Surveying notifier experience:** We have introduced regular surveys of notifiers and practitioners in Victoria asking them to rate our performance against: accessibility, responsiveness, transparency, timeliness and fairness. This feedback helps us to improve our services and will be reported each year as part of our Annual Report.

What matters to our notifiers



- **Making it easier for people to provide the right information when they raise concerns:** We have updated the AHPRA website to make it easier to understand and use. For example, we've replaced the word 'notification' with 'complaint or concern' and added an online form so that notifications can now be lodged online and to make it easier to get the information we need to quickly assess the concerns.

Reducing investigation timeframes

We continue to work towards reducing the length of time it takes to investigate a complaint or concern.

- **New training:** A National Manager Investigations was appointed on 1 July 2016 specifically to work with notification staff in Victoria and elsewhere to overcome 'barriers' to resolving investigations, with an emphasis on older investigations. We have also engaged a training specialist to help us improve our investigator training more generally.

- **Additional resources:** We have developed additional resources for our investigators to help them in conducting investigations under the specific provisions of the National Law.

- **Regular quality assurance:** We have embedded a quality review process in both our assessment and management of notifications to help us identify causes of delays and to address these. For example, we have worked with Medicare to reduce the time it takes to get information from them; we have worked with medical colleges and others to streamline our processes for identifying experts who can provide clinical opinions as part of the investigation of complaints.

Supporting work to improve governance and safety in Victoria

In 2016 the Department asked Dr Stephen Duckett to review safety and quality assurance in Victoria. While the work of AHPRA and the Boards were not the focus of the Duckett report, we are committed to supporting the implementation of those recommendations wherever we can.

- The Duckett review identified the importance of sharing information to identify potential failings in safety of care. As outlined above, we've implemented a number of changes to facilitate greater sharing of information in the public interest.
- The review also recommended strengthening the reporting culture and governance arrangements to ensure timely escalation and management of risks. We will continue to work with the Department, health services and other organisations to ensure practitioners and employers are aware of their reporting obligations.
- In 2016 we ran a national public awareness campaign on mandatory reporting obligations for employers and practitioners. The campaign which had a reach of nearly 8 million Australians included online and print advertisements across the 14 professions, information brochures, community newspapers and a social media campaign.
- In 2015/16, there was a 23.9% increase in mandatory notifications to AHPRA compared with 2014/15. Of the mandatory notifications received by AHPRA, 71.3% related to professional standards, while a further 20.9% relate to impairment. The proportion of mandatory notifications that resulted in regulatory action taken by a National Board was 49.2%. These data suggest that notifiers are making more appropriate notifications having reasonably assessed that the risk to the public warrants the notification being made. In Victoria mandatory notifications increased from 171 in 2014/15 to 224 in 2015/16, representing 22.9% of mandatory notifications nationally in 2015/16.

Further information

We continue to report regularly on our work to improve the notifications process, both within Victoria and nationally. Our quarterly performance reports provide regular updates on our core regulatory work across each state and territory. Our Annual Report provides more detailed analysis of our performance in our core functions with a report for Victoria and each state and territory breaking down the information by jurisdiction and profession.

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[i] Executive Summary Targeting zero. Supporting the Victorian hospital system to eliminate and avoid harm and strengthen quality of care. Report of the Review of Hospital Safety and Quality Assurance in Victoria. 2016. Duckett, S, Cuddihy, M & Newnham, H. https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review