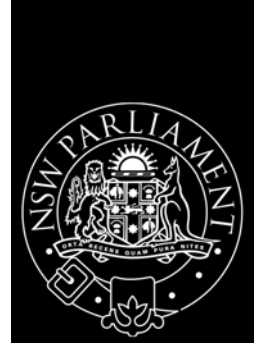


PARLIAMENT OF NEW SOUTH WALES



Committee on the Health Care Complaints Commission

Review of the 2006-2007 Annual Report of the Health Care Complaints Commission

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Terms of Reference

The Committee on the Health Care Complaints Commission is a current Joint Statutory Committee, established on 27 June 2007. The Committee was established under the *Health Care Complaints Act 1993*. The Committee monitors and reviews the Commission's functions, Annual Reports and other reports it makes to Parliament. The Committee is not authorised to re-investigate a particular complaint or to reconsider a decision to investigate; is not to investigate or to discontinue investigation of a particular complaint or to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

The Terms of Reference for the Committee are set out in Part 4, sections 64 - 74 of the *Health Care Complaints Act 1993*. Section 65 of the Act sets out the following functions of the Committee:

- (1) The functions of the Joint Committee are as follows:
 - (a) to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act,
 - (a1) without limiting paragraph (a), to monitor and review the exercise of functions by the Health Conciliation Registry,
 - (b) to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed,
 - (c) to examine each annual and other report made by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report,
 - (d) to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Commission,
 - (e) to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

- (2) Nothing in this Part authorises the Joint Committee:
 - (a) to re-investigate a particular complaint, or
 - (b) to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint, or
 - (c) to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

- (3) The functions of the Joint Committee may be exercised in respect of matters occurring before or after the commencement of this section.

Chair's Foreword

It is with pleasure that I present the Committee's review of the Health Care Complaints Commission's Annual Report 2006-2007, pursuant to the Committee's responsibilities under the *Health Care Complaints Act 1993* to examine all reports of the Commission. This is the Committee's second such report in the 54th Parliament.

This particular review has been conducted in exceptional circumstances when considered in the context of the wider health system. At the time of the Committee's examination the State Government had already set in train major processes of inquiry and reform in the operation of the NSW health system. Public misgivings have been expressed regarding the effectiveness of the Commission's complaints-handling methods in fully exploring each and every complaint. The Committee acknowledges that the Commission's complaint-handling work is high volume and stressful, as complainants have often suffered catastrophic losses in their lives and experienced the death of loved ones. When misfortune occurs with the delivery of health services, they rely on the Commission to find out 'what went wrong'.

Having regard to this, in its review the Committee was particularly concerned to ensure that the Commission's investigations of individual complaints are as responsive, thorough, and transparent as possible, and that the Commission does its utmost for complainants who may have suffered traumatic experiences as a result of their interactions with the health system in NSW.

The Committee will continue to monitor the contribution made by the Commission to the effective operation of the health care system as a whole. I would like to take this opportunity to thank the Commissioner, Mr Kieran Pehm, and the staff of the Commission, for providing their full assistance to the Committee in its conduct of this review.



Hon Helen Westwood AM MLC
Chair

Chapter One - The Year In Review

THE COMMISSION IN 2006-2007

Pursuant to the *Health Care Complaints Act 1993* [the Act], the NSW Health Care Complaints Commission has the important role of primary independent statutory body investigating health care complaints in NSW. Under s 3 of the Act, the Commission's fundamental responsibilities are to:

- receive and assess complaints relating to health service providers in NSW;
- resolve or assist in the resolution of complaints;
- investigate serious complaints that raise questions of public health and safety and
- prosecute serious complaints.

The Committee's oversight responsibilities under s 65 of the Act are largely exercised by the review of the Commission's reports. The Committee does this by forwarding questions to the Commissioner based on the contents of the report in question; examining him under oath at a public hearing; and then giving the Commissioner further written questions to take 'on notice' and forward his responses to the Committee. The information obtained by the Committee in this process forms the basis of this chapter.

Executive Summary of 2006-07 Annual Report

Complaints-Handling

- strong focus on complaints-handling with continued redesign of processes and systems;
- improved procedures for making recommendations to other organisations to improve the health system;
- first full year of centralised restructured enquiry service; and
- increased number of enquiries.

Assessments

- 2722 written complaints received during the year and 2710 finalised assessments;
- Implementation of redesigned assessment process;
- staffing establishment finalised for assessments;
- 83.7 per cent of complaints assessed in statutory time frame of 60 days;
- average time for assessment fell from 61 to 39 days; and
- increase in the number of complaints assessed as suitable for alternative dispute resolution.

Investigations

- 307 complaints referred for investigation;
- 381 investigations completed;
- average time for an investigation fell from 353 to 318 days;
- nearly 70 per cent of investigations were completed in 12 months;
- investigation outcomes suggest fewer matters result in adverse findings;

The Year In Review

- improved procedures for monitoring implementation of recommendations to other organisations; and
- new Director of Investigation, Mr Bret Coman, appointed.

Legal

- 112 complaints about individual health practitioners referred for investigation to the Director of Proceedings;
- 97 matters finalised by the Legal Division;
- Legal Division restructured into two teams under team managers reporting to the Director of Proceedings; and
- Casemate system to support legal processes adopted.

Legislative

- the *Health Legislation Amendment (Unregistered Health Practitioners) Act 2006* came into operation on 4 December 2006, amending the *Health Care Complaints Act 1993*, the *Public Health Act 1991* and various Acts governing the registration of health professionals with the purpose of increasing the Commission's powers regarding unregistered health service providers, and preventing practitioners de-registered in one area of practice setting up elsewhere.

The Year in Review

Access to the Commission

The ability of all potential complainants to access the Commission's services, regardless of background, language skills, disability, etc., has been a recurrent matter of concern to the Committee. Accordingly, the Committee is pleased to note that during 2006-07 the Commission has been actively engaged in raising the awareness of its role in the community generally, and specifically in those groups who may have faced additional access difficulties.

The Commission is targeting disadvantaged complainants through its Consumer Consultative Committee, and taking steps to ensure that this Committee includes as broad a representation as possible. The Commission has also appointed an Aboriginal Designated Officer to provide information to Aboriginal communities. Stationed in Dubbo, the Officer will work specifically on the project of delivering Commission information to Aboriginal communities in NSW.

The Commission has recently 'rebadged' all its promotional literature, with a range of pamphlets and posters to be distributed through the public hospital system by the Department of Health, and a private organisation contracted to distribute information through general practices. The Commission now undertakes public presentations, talks and addresses various public interest and practitioner groups, with Resolution Officers conducting 6-8 community presentations per year. The Commission has also reviewed all its publications and there will be a specific multilingual distribution to culturally and linguistically diverse communities.

From 1 July 2008, the Commission will have a new process in place to analyse the demographics of complaints received, to determine what groups are under or over-represented in those attempting to access its health care complaints services. The Committee considers that this has the potential to be an important means of focussing

promotion of the Commission, particularly given the evidence from the 2007 Inquiry into the Royal North Shore Hospital that many complaints go 'under the radar', unless there has been publicity to bring the Commission's services to the public attention. The Committee looks forward to being advised by the Commission of the outcomes of this demographic analysis.

Importantly, the Commission now has in place a customer survey process, and sends out survey forms to all complainants and service providers. The Commissioner has assured the Committee that in respect of all complaints against a health practitioner which are investigated but not referred to prosecution, a complainant will receive a detailed final letter advising of the outcome, specifically:

- the context of the complaint;
- the conduct of the investigation,
- the evidence gathered;
- any expert opinion on the practitioner's conduct; and
- the reasons for the Commission's decision.

Investigations Officers also maintain regular monthly phone contact with complainants during the course of an investigation. The Committee considers that these changes are positive steps towards more fully integrating complainants into the Commission's assessment and investigation process.

Assessment and Investigation Processes

Previously, the Chair noted that the Committee looked forward to an improvement in assessment time frames in 2006-07 to more fully comply with the Commission's statutory obligations. The proportion of sustained findings against organisations and practitioners has been steadily increasing in the past three years. According to the Commissioner, as procedures are more systematic, and investigations are becoming much more rigorous, the Commission is handling a greater number of matters as a result of the improved processes.

The Commission's assessment process and procedures consist of the following:

- complaint received;
- complaint subjected to initial assessment by the Director of Assessment and Resolution Division and Manager of Assessments;
- complaint allocated to Assessment Officer¹ with instructions;
- Assessment Officer invites a response to complaint from health provider(s) and requests relevant medical records where serious clinical treatment issues are involved;
- Assessment Officer examines the material;
- Assessment Officer seeks advice from an internal medical adviser if necessary;
- Assessment Officer prepares an assessment brief summarising
 - issues raised by complaint;
 - the content of material gathered in assessment process; and
 - a recommendation having regard to criteria under s 23 of the Act;
- Assessment brief is considered by team leader and Manager of Assessments who may amend the brief having regard to s 23 criteria;

¹ Assessment Officers process assessment of individual complaints, and have a caseload of 45 to 55 complaint files, to be assessed within the statutory timeframe of 60 days. The Casemate system identifies overdue tasks, and team leaders audit files after 21, 40 and 55 days, to ensure that the assessment process is on schedule.

The Year In Review

- the final version of the brief is considered by the Director of Assessment and Resolution² and the Commissioner;
- the Commissioner determines as to whether the complaint will be investigated by reference to the statutory criteria.
If the complaint is about an individual practitioner, the Commission must consult with the registration authority, e.g. the NSW Medical Board, before the final determination. If that authority decides the matter should be investigated, the complaint must be investigated even if the Commissioner holds a contrary view;
- if the Commissioner decides not to investigate, he determines the most appropriate option, e.g., discontinuance, referral for assisted resolution, referral for conciliation or referral to the appropriate registration authority or to some other suitable agency.

The Commission has strived to professionalise the Investigations area, with an improved Investigations Procedures Manual introduced under the new Director of Investigations, Mr Bret Coman. Investigations procedures are now multi-lateral, unlike the previous linear, paper-based approach. The Commission now uses an electronic case management system enabling more active monitoring of cases by management. The Commissioner has also advised the Committee that powers to compel production of information, introduced in March 2005, will be used more frequently.

However, the Commissioner admits that assessments cannot be done within the required 60 days for complex matters, e.g., hospital care complaints which may involve a consider number of medical practitioners and nursing staff. Accordingly, 30 per cent of investigations are not finalised within 12 months. Moreover, despite the Commission's aim of persuading as many complainants as possible, there is not a significant take-up of the offer of conciliation. The Committee will continue to monitor these important areas of the Commission's operations.

In the course of the Commissioner's public examination, the Director of Proceedings, Ms Karen Mobbs, highlighted the difficulties in determining the levels of seriousness of a matter and the appropriate prosecution or disciplinary action, due to inconsistencies in the powers of tribunals under the various registration Acts. Specifically, she noted that not all registration bodies have a Professional Standards Committee, but may only have a Tribunal or Boards of Inquiry. She suggested that the Commission would like to see consistent disciplinary legislation across all the jurisdictions. The Committee agrees that there is potential for these inconsistencies to inhibit proper investigation of health care complaints, and has recently resolved to issue a Discussion Paper on the oversight of Registration Authorities in NSW generally.

Staffing Issues

The Committee is pleased to note that staff attrition in Assessment, Resolutions and Investigation Divisions is down on the levels of 2005-06. The Commission has adopted exit interviews as recommended by the Committee in its 2005-2006 Review, and consultants have been engaged to conduct a climate survey by the end of June 2008.

² Resolution Officers arrange assisted resolution of complaints which the Commission has assessed as not warranting investigation. They handle telephone enquiries, conduct reviews of files when the complainant requests a review of the assessment decision. They have a caseload of 15 to 20 files for assisted resolution and handle 3-5 review files at any given time.

Code of Conduct and Ethical Standards

In order to maintain public confidence in the integrity of the Commission, the Code provides that officers of the Commission must avoid conflicts of interest between their personal interests and professional duties. Officers should avoid any personal activity, association or financial dealing that could directly or indirectly compromise the performance of their duties. Thus, s 30(2) of the Act provides that the Commission may not obtain an expert report from a person who has a financial connection with the health practitioner against whom the complaint is made.

The Committee notes that the Code of Conduct has recently been reviewed. The Code of Conduct is separate from the Code of Practice which is designed to explain to the public and external stakeholders the way in which the Commission performs its role (see below).

Complaints Analysis

In 2006-07 there was an average of 227 complaints per month about health service providers (2,722 in total) and 508 complaints about public hospitals (18.7 per cent of the total).³ The Commission is currently reviewing its complaints classification system to make it more specific, so that it can better communicate the information in dialogues with health practitioners about how to better manage complaints. The new classifications will be introduced from 1 July 2008, although the Commissioner notes that they may be slightly altered to better co-ordinate with the Commission's interstate counterparts. The categories also will assist in better identifying complaints trends in relation to individual practitioners and health organisations.

Information-sharing relationships between key organisations in the health care system are, in the Committee's view, crucial to ensuring an even greater measure of effectiveness in preventing failures in the delivery of health services in NSW. The Committee is therefore pleased to note that the Commission is exploring improved data analysis methodologies with the Director-General of the Health Department and the CEOs of Area Health Services, due to the fact that the Department receives a broad range of complaints, whereas the Commission's own samples are often too small to identify trends. The Commissioner has also advised the Committee that he will also liaise with the Clinical Excellence Commission [CEC] to establish whether data can be shared between the CEC and the Commission.

The Commission is now analysing complaints, classifying them according to the type of practitioner and taking the proactive step of approaching the various Colleges to discuss complaint handling and outcomes in respect of the various areas of medical practice. Commission staff are also going out to Area Health Services and speaking with clinicians directly.

Code of Practice

In March 2008 the Commission issued a Draft Code of Practice, under s 80(1) of the Act, which requires the Commission to develop, after appropriate consultation, a Code of Practice to provide guidance on the way in which the Commission intends to carry out some or all of its functions. The Code has now been finalised and is attached to the Committee's Report (see Appendix 4).

³ In the ten months from July 2007 to April 2008 there was an average of 251 complaints per month (total 2,514 complaints); and 603 complaints about public hospitals (24 per cent of the total).

The Commission plans to incorporate the Code into the regulations under s 80(3) of the Act.⁴ The Committee acknowledges the thoroughness of the consultation process, and recommends the Code as a good practical step to informing potential complainants about what exactly the Commission does, and how they can expect the Commission to go about doing it.

Impact of developments in the wider health care system

As noted in the Chair's Foreword, at the time of the Commissioner's public examination the Government had already set in train major processes of inquiry and reform within the NSW health system. In December 2007, the Joint Select Committee on the Royal North Shore Hospital tabled its Report; in January 2008 the Governor established the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, under Commissioner Peter Garling SC; and in May 2008 Ms Deirdre O'Connor, retired Federal Court Justice, presented her *Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system* to the Minister for Health, Hon Reba Meagher MP. The Terms of Reference for both the Royal North Shore Inquiry and the Garling Inquiry contained specific provisions for referring individual complaints to the Health Care Complaints Commission.

The Commissioner advised the Committee that there has been an increase in complaints about the Royal North Shore Hospital and the Royal Prince Alfred Hospital, Camperdown, in the period July 2007 to April 2008, although the sample is too small to draw conclusions. Nonetheless, three temporary staff have been appointed in the Commission's Assessment Division until the end of June 2008 to deal with the increase in complaints in recent months. The Commission is monitoring the situation to see whether a permanent increase in the numbers of Assessment staff is warranted.

There has also been a substantial increase in complaints following publicity generated by the case of ex-Dr Graeme Reeves, and the Commissioner expects the number of investigations into public hospitals to increase in the short term as a result of the Garling Inquiry. The Commission has established a liaison point and conferred with Commissioner Garling and is receiving transcripts regularly. The Commissioner noted that 79 complaints have been referred to the Commission, complainants are being contacted and each complaint is being put through the Commission's usual assessment process. The Committee is closely monitoring all these developments.

Conclusion

In exercising its functions under the Act, the Commission is required to have as its primary object the protection of the health and safety of the public. During 2008, the Commission has been subjected to sustained criticism of its failure to do just that, especially in the case of de-registered medical practitioner, Graeme Reeves.

However, without making any judgment on the Commission's conduct prior to the year in review, the Committee considers that, on the evidence before it, in 2006-07 the Commission has undergone a process of considerable improvement in the manner in which it exercises its functions under the Act, and particularly how it engages with both health care complainants and others involved in the provision of health care in NSW. The Committee is

⁴ Section 80(3) of the *Health Care Complaints Act 1993* provides that a code of practice developed by the Commission under s 80(1)(i) has no effect unless it is incorporated in, or adopted by, the regulations.

not suggesting that there is not room for improvement, but it does acknowledge the efforts of the Commission to address operational areas which the Committee has previously noted as deficient.

In the Foreword to the Committee's *Review of the 2005-2006 Annual Report of the Health Care Complaints Commission*, the Chair noted that there were a number of areas in which the Commission had 'real need for performance improvement, both in terms of change and in the pace of that change'. The Committee considers that in 2006-07 the Commission has genuinely picked up that pace, in the important areas of internal operations and its external 'outreach' to raise public awareness of its services, and the Committee looks forward to working with the Commission to ensure that the pace and process of positive change is maintained.

Chapter Two - Questions on Notice

2006-2007 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

EXECUTIVE SUMMARY

Question 1

The Report notes as follows:

'Although the number of inquiries increased from the previous year, the restructure included the handling of inquiries at one central point, so a comparison with figures from previous years cannot readily be made. The improvement in the quality of advice given by the Inquiry Service has contributed to the Commission receiving fewer written complaints in 2006-07.'

Could you please clarify these statements?

RESPONSE:

The first statement is explained in more detail at page 32 of the Annual Report under the heading 'Inquiries received' as follows:

'In 2006-07, the Inquiry Service dealt with 7927 inquiries. Chart 9.1 shows the number of inquiries dealt with by the Commission during the last three years [4577 in 2004-05, 6003 in 2005-06, and 7927 in 2006-07].

The apparent increase in the number of inquiries is partly explained by a change in counting methods. Chart 9.2 shows the numbers of both inquiries and resolution matters that were received during the last three years. The increase in inquiries corresponds with a decrease in matters that were previously handled by the Resolution Service when it was called the Patient Support Service. Until March 2005, the inquiries handled by the Patient Support Service were counted separately from the inquiries handled by the Inquiry Service. They are now counted together.'

The second statement is also explained in more detail at page 32 of the Annual Report under the heading 'Inquiry Service' as follows (emphasis added):

'The Inquiry Service in its current form has operated since April 2006.

The Inquiry Service, staffed by Resolution Officers, helps potential complainants by providing information and answers to questions. The Service can also provide advice on various approaches to resolve the concerns in question. This may include discussing strategies to deal with those concerns, and in some cases referring callers to a more appropriate agency.'

By way of elaboration on the matters referred to in the sentence underlined:

- Strategies to deal with a caller's concerns can include encouraging the caller to raise their concerns directly with the health service provider, and providing guidance on how to do so, with a view to a prompt resolution of the concerns directly between the

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caller and the practitioner or health service organisation. If the matter can be resolved in this way, it obviates the need for a written complaint to the Commission.

- Staff of the Inquiries Service have met with and clarified the role of other relevant agencies, such as Medicare, the Aged Care Complaint Scheme, and the Office of Fair Trading. This has enabled the Inquiry Service, where appropriate, to refer the caller to another agency more suited to dealing with their concerns.

In addition, the Commission has introduced a process called 'assisted referral'. Where a caller raises a concern which should only take a quick telephone call to resolve, the matter will be promptly dealt with by an officer of the Inquiry Service in this manner – again obviating the need for the caller to write a letter of complaint to the Commission.

IMPROVING THE HEALTH SYSTEM

Question 2

The report notes that Commission staff made a total of 62 presentations to health service and community groups during the reporting period, and that Resolution Officers also participated in various community events to promote the Commission's services. Did the Commission seek feedback from participants, or seek input as to how to increase community awareness of the role of the Commission?

RESPONSE:

The Commission did not seek formal feedback from the groups that attended the presentations. The Commission is in the process of developing a formal feedback process which it proposes to implement from 1 July 2008.

The answer to Question 3 below also goes to the issue of increasing community awareness of the role of the Commission.

Question 3

The Commission plans to develop information packages, including brochures and posters, to support health service providers in informing patients and the public about how to use the services of the Commission. Could you please advise of the progress of these plans?

RESPONSE:

The Commission provided its existing information material to all Area Health Services between September and November 2007. The Commission also advised the Area Health Services that it was reviewing the content and presentation of this material, and sought feedback from the Area Health Services to assist with this review. The Commission subsequently finalised its review of the content and design of its various publications, and consulted with the representatives of the key consumer bodies through its Consumer Consultative Committee in doing so. The new brochures and posters will be available for distribution to the Area Health Services in April 2008.

LEGISLATIVE CHANGES

Question 4

The report notes that legislative amendments strengthened provisions against de-registered health practitioners? Having regard to the recent tragic cases involving ex-doctor Graeme Reeves, does the Commission intend to review its internal practices with regards to referring practitioners to the Office of the Director of Public Prosecutions?

RESPONSE:

Following an investigation, the Commission can refer the conduct of a practitioner to the Office of the Director of Public Prosecutions if there is evidence that an offence has been committed. The Commission's Investigation Division manual makes this clear.

The Commission will also refer allegations of criminal conduct to the police where it has obtained the consent of the complainant to do so – as has occurred with the Commission's referral of certain complaints about Dr Graeme Reeves to the NSW Police Force Strike Force 'Tarella', which is investigating the issue of possible criminal conduct by Dr Reeves.

The *Health Care Complaints Act* provides for the referral of evidence of possible criminal conduct to the Director of Public Prosecutions at the end of an investigation. In December 2007 (some months before the publicity surrounding Dr Reeves), the Commission sought a legislative amendment to the *Health Care Complaints Act*, which enacted, will give the Commission the power to disclose information to law enforcement, investigative and prosecuting agencies at any time.

Question 5

Does the Commission have an ongoing plan for recommending further legislative changes in the immediate future?

RESPONSE:

Yes. The Commission has recently made 29 recommendations for amendments to the *Health Care Complaints Act* and the legislation governing registered health service providers. The desirability of many of the proposed changes has been reinforced by various concerns raised by the case of Dr Graeme Reeves.

TRENDS IN COMPLAINTS

Question 6

With respect to complaints made about nurses, in the category 'communication', the proportion increased by 4.2 per cent in 2005-06 to 9.1 per cent in 2006-07, the main issue in relation to communication being attitude. Whilst these are small figures, has the Commission examined why this figure has more than doubled?

RESPONSE:

In terms of actual complaint numbers, the 4.2 per cent of complaints about communication by nurses in 2005-06 represents eight complaints, while the 9.1 per cent of complaints about

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the same issue in 2006-07 represents 18 complaints. Accordingly, the increase in the actual number of complaints is very small in real terms.

It should also be noted that, in 2004-05, the number of complaints about communication by nurses was 12 – higher than the figure of eight complaints the following year.

All of these complaint numbers are set out in Table 18.6 of the Annual Report at page 129.

Question 7

With respect to dentists, there was a significant increase from 6.5 per cent in 2005-06 to 15 per cent in 2006-07, in relation to issues of professional conduct, most commonly relating to competence and illegal practices. The Report notes further that complaints about dentists are generally referred to the NSW Dental Board, which has 'robust processes' for managing them. Has the Commission had any feedback from the Board on the cause/s of this increase?

RESPONSE:

In terms of actual complaint numbers, the 6.5 per cent of complaints about professional conduct by dentists in 2005-06 represents 12 complaints, while the 15 per cent of complaints about the same issue in 2006-07 represents 28 complaints. Accordingly, the increase in the actual number of complaints is relatively small in real terms.

It should also be noted that, in 2004-05, the number of complaints about professional conduct by dentists was 20 – higher than the figure of 12 complaints the following year.

All of these complaint numbers are set out in Table 18.6 of the Annual Report at page 129.

In light of the above discussion, there has been no occasion for the Commission to seek feedback from the Dental Board on these matters.

Question 8

Access to Justice Health services has been the subject of a number of complaints to the Commission. What types of issues have been raised, and how are they being resolved? Does the Commission liaise with the Ombudsman in relation to Justice Health?

RESPONSE:

As illustrated in Chart 8.15 of the Annual Report at page 26, a total of 119 issues were raised in complaints about Justice Health.

As noted in Table 18.11 of the Annual Report on page 135, these 119 issues consisted of:

- 69 about treatment;
- 31 about access;
- 10 about professional conduct;
- seven about communication;
- one about privacy/discrimination;
- one about grievance.

As noted in Table 18.23 of the Annual Report at page 142, the Commission assessed 98 complaints about Justice Health in 2006-07. The outcomes of these assessments were as follows:

- 62 were discontinued;
- 23 were referred for assisted resolution;
- five were referred for investigation;
- three were referred to another body;
- three were referred to a registration board;
- two were resolved during assessment.

The Commission liaises with the Ombudsman in relation to the handling of particular complaints.

INQUIRY SERVICE

Question 9

The Report notes that only one in seven people who have contact with the Inquiry Service see the need to request a complaint form to make a formal complaint to the Commission. Do you have any concerns that members of the public – especially those from non-English speaking backgrounds, or people with mental illness or intellectual disability - may be discouraged from making valid complaints by this process? What is the Commission doing to ensure that this does not happen?

RESPONSE:

Inquiry Service staff use interpreter services when dealing with people who do not use English as their first language. They have also attended training about providing support to people with a mental illness or developmental disability.

Inquiry Service staff can provide support in the writing of a complaint, by drafting the complaint and sending it to the complainant to sign and return to the Commission

To assist people from a non-English speaking background, the Commission is having its current publications translated into 20 community languages; having signs in these languages displayed in its reception area; and having details of the telephone interpreter service placed on the back of its letterhead.

The Commission uses the Consumer Consultative Committee to ensure that its publications are accessible to the various groups who are potential users of the Commission's services, including people with a mental illness or developmental disability.

ASSESSING COMPLAINTS

Question 10

The Commission must advise the parties to a complaint about its assessment decision within 14 days. In 2006-07, 87.8 per cent of decision letters were completed within this timeframe. While this is a significant level of compliance, what is the average timeframe for the remaining 12.2 per cent, and for what reasons are they not sent out within this period?

RESPONSE:

The average time for the despatch of letters not sent within 14 days was 25.1 days.

There are various reasons (individually or in combination) for assessment decision letters not being finalised within the 14-day timeframe:

- The Commission has been training its staff to write in plain English, with a view to more effective communication between the Commission and complainants. In supervisors ensuring that letters use plain English, there are times when a draft letter will require considerable redrafting, meaning that the final version of the letter is produced beyond the 14-day timeline.
- Some complaints raise complex medical issues which require particularly careful drafting of the assessment decision letter, and therefore liaison between the Commission assessment staff and the Commission's internal medical advisers to discuss appropriate terminology for the assessment letter.
- Commission officers telephone complainants to discuss the assessment decision before sending the decision letter. In some cases, the complainant will provide further information relevant to the matter that should be, and is, referred to the internal medical adviser for consideration, in order to determine whether the original decision should be adhered to. The need for the internal medical adviser to consider the additional information and provide further advice, and for this advice to be reflected in the final decision letter, necessarily extends the time taken to finalise the decision-making process and the preparation of appropriate correspondence.

Since the publication of the 2006-2007 Annual Report, the Commission has introduced a process to track the drafting and despatch of assessment decision letters.

CONCILIATING COMPLAINTS

Question 11

The Report notes the positive feedback received by the Health Conciliation Registry. How does/will the Registry act upon any unfavourable feedback, especially if the feedback is related to the process generally?

RESPONSE:

The brochure provided by the Registry to all parties referred for conciliation includes information about making a complaint with respect to the conciliation process.

If unfavourable feedback relates to the staff and/or processes of the Health Conciliation Registry – the Registrar contacts the person to see if the concerns in question can be resolved. Resolution can involve a change to the Registry's processes. There are instances where this has occurred – for example, as a result of feedback in an evaluation form, the Registry has included in its correspondence additional information explaining the role of support people in conciliations.

If the Registrar cannot resolve a complaint about a staff member, or the complaint is about the Registrar herself – the matter is referred to the Director of the Assessments and Resolution Division to manage.

If a complaint is made about a conciliator's conduct – the Registrar contacts the complainant and then refers the complaint to the conciliator for comment. The Registrar considers the complaint in the light of the conciliator's comments and the Commission's code of conduct, and reports on the outcome of the investigation to both the complainant and the conciliator.

INVESTIGATING COMPLAINTS

Question 12

In 2006-07 two matters were re-opened for re-assessment. What was the basis for re-opening these matters?

RESPONSE:

In substance, the two matters arose out of one investigation and concerned the conduct of two doctors.

The parents of a person with a mental disability complained about many issues relating to the treatment of their daughter, including whether they had given consent to a surgical procedure. The Commission investigated the complaint and found that informed consent had been given. The parents requested a general review of the outcome of the investigation. The investigation was re-opened to investigate the specific issue of whether the appropriate current consent form under the *Guardianship Act* had been used.

PROSECUTING COMPLAINTS

Question 13

In 11 cases referred by the Commission, the Director of Proceedings made a determination not to prosecute the matter. What were the types of matters for which this determination was made?

RESPONSE:

Five matters related to complaints about nurses. Of these, four related to clinical practice, while one concerned alleged criminal conduct which could not be substantiated. Four of the five matters were referred back to the Commissioner for the consideration of further action, such as referral to the Board for counselling. In the remaining matter, no further action was taken.

A further five matters related to complaints about medical practitioners. Of these, two related to clinical practice, and two involved allegations of the crossing of professional boundaries – one was referred back to the Commissioner for the consideration of further action, and no further action was taken in relation to the other three matters. The remaining matter related to a breach of conditions – no further action was taken in relation to this matter because the practitioner had died.

The remaining matter related to a podiatrist. Whilst the Director of Proceedings was of the view that the matter warranted further action, she did not consider it was sufficiently serious to warrant prosecution before a Tribunal. In the absence of a Professional Standards Committee in this jurisdiction, the matter was referred back to the Commissioner with a recommendation that it be referred to the relevant Board for a Board of Inquiry.

ACCESS TO SERVICES

Question 14

The Report notes that the Commission has attempted to ensure representation of people from culturally and linguistically diverse backgrounds on the Commission's Consumer Consultative Committee. How has the Commission gone about this?

RESPONSE:

The Ethnic Communities Council represented the interest of culturally and linguistically diverse community groups on the Commission's Consumer Consultative Committee. As the Council has ceased to exist, the Commission is currently arranging for a suitable replacement.

In addition, the other consumer bodies on the Consumer Consultative Committee have CALD strategies in place to reach their members from culturally and linguistically diverse backgrounds. The bodies represented on the Committee are:

- Aboriginal Health & Medical Research Council
- Alzheimers Association
- Association for the Wellbeing of Children in Healthcare
- Carers NSW Inc
- Combined Pensioners and Superannuants Association
- Council on the Ageing
- Ethnic Communities Council
- NSW Consumer Advisory Group – Mental Health
- Mental Health Coordinating Council
- NCOSS
- NSW Council of Intellectual Disability
- People with Disability Australia Incorporated (PWD)
- Positive Life NSW
- Rural & Remote Health Consumers of Australia
- Women's Health NSW

Question 15

Given the Commission's current low percentage of staff with a disability, has the Commission considered specifically targeting people with disabilities in future recruitment processes?

RESPONSE:

The Commission developed a three year Disability Action Plan in 2006, which identified a range of strategies to assist the Commission in increasing the number of employees with a disability within its workforce. These strategies have been successful in increasing the percentage of staff recorded as having a disability within the workforce, as demonstrated by the increase of 67 per cent in the percentage of employees that have been recorded as having a disability from the 2004 figures. The current figure of 9 per cent is 3 per cent below the NSW Government Benchmark.

It should be noted that the data collected on whether an employee has a disability is completely voluntary. There are a number of employees who have a known disability, and, in particular, a disability that has required a work-related adjustment, who have declined to identify as having a disability when recording their data. As a result, and similar to the data of other agencies in this category, the Commission's data is not a one hundred per cent reflection of the true representation of people with a disability within its workforce.

The Commission already has one employee who was employed under an affirmative action strategy for people with a disability. No further targeted recruitment programs are planned at this stage.

Question 16

Information on the Commission's services was to have been made available on the Commission's web page in 20 community languages by the end of 2007. This has not occurred. Could you advise how this is progressing?

RESPONSE:

Information on the Commission's services has been part of the overall review of the Commission's information material, as described in the response to question 3, and is currently being translated. The translated information will be available in April 2008.

ORGANISATION AND MANAGEMENT

Question 17

Could you please advise the Committee on the status of the Commission's implementation of the online, self-paced corporate induction program for new staff and completion of the training competencies for positions?

RESPONSE:

The Commission is proceeding with the development and implementation of the online induction program. The modules on OHS for managers and staff are complete and will be established by April 2008; the general modules will be in place by June 2008.

The Assessment and Resolution Division and the Investigation Division have had competencies developed for all of their positions. The competencies for positions in the Legal Division, Corporate Services and the Executive Unit will be completed by June 2008.

Question 18

What has been the impact upon the operations of the Commission of the introduction of performance management?

RESPONSE:

The introduction of performance management has established clear expectations for all staff about their performance, resulting in improved overall performance for the Commission, as demonstrated by the key performance indicators in the Annual Report.

Question 19

How is the Commission's planned review of its Code of Conduct progressing?

RESPONSE:

A revised version of the Code of Conduct is being prepared, and should be finalised by the end of June 2008.

Question 20

At what stage is the new development project aimed at extending Casemate's capabilities to the Legal Division and re-engineering legal processes in accordance with its business requirements?

RESPONSE:

A number of significant changes were made to the Casemate Legal Division processes in November/December 2007. This involved streamlining the existing processes to better reflect the work carried out by the Legal Division, and allows for compliance with external timeframes (such as those imposed by Tribunal directions) to be captured and reported upon in the Casemate system. Information will be captured in relation to all Legal Division processes that were opened after the changes were introduced.

Casemate now has the capacity to record non-prosecution work carried out by the Legal Division, such as FOI applications.

Question 21

Has the Commission achieved accreditation to ISO 27001 *Standards for Information Security*?

RESPONSE:

Yes – the final audit certification from SAI Global was obtained on 13 December 2007.

Question 22

Could you tell the Committee in detail about the audits of the Commission's Assessment of Complaints Service and its Resolution Service?

RESPONSE:

The reports by SAI Global on its audit of Assessments (dated March 2007) and its audit of Resolution Services (dated August 2007) are attached (see Appendix 2 and Appendix 3 respectively).

Question 23

The Commission's Executive Assistant now has responsibility for developing and implementing a CALD promotion strategy for the Commission over the next twelve months. How will the promotion of the Commission's services to people from culturally and linguistically diverse backgrounds take place?

RESPONSE:

The Commission's Executive Assistant – who herself is from a culturally and linguistically diverse background – recently took over the responsibility of developing and implementing a promotion and education strategy to all external stakeholders of the Commission. The role has now been broadened to the full-time position of Communications and Stakeholder Relations Officer.

In relation to the promotion of the Commission to people from a culturally and linguistically diverse background, the Commission has displayed signs in its reception area and in its regional offices to allow people to indicate the type of language assistance that they would like an officer of the Commission to arrange for them.

The Commission has printed on the back of its letterhead advice in 20 languages on how to seek help in translating correspondence from the Commission by contacting the Translating and Interpreting Service. The advice on how to seek language assistance is now being made part of all Commission publications as part of the review.

As mentioned in the answer to question 16, the information about services offered by the Commission will be available online in April 2008.

The Commission is also arranging presentations about its functions and services that will specifically target CALD communities. In the coming year, the Commission plans to contact community radio stations to arrange for the Commission to be present in programmes targeting members of the various communities of NSW.

Question 24

What supports does the Commission have in place to assist the staff member in the Aboriginal and Torres Strait Islander position?

RESPONSE:

The officer in this position is located in Dubbo – an area where there is a large Aboriginal population. The officer is well connected to the community, and is encouraged to participate in appropriate cultural events to strengthen their connection to the community and to improve networks. The officer attends monthly meetings at the Commission's main office, and has supervision meetings with their supervisor on a six weekly schedule. The Commission engaged this officer during February and March 2008 to work on a project to identify key elements for effective service delivery to Aboriginal communities.

Chapter Three - Transcript of Proceedings

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE 2006-2007 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

—

At Sydney on Thursday 1 May 2008

—

The Committee met at 2.00 p.m.

—

PRESENT

Hon Helen Westwood (Chair)

Legislative Council

Hon. D. J. Clarke

Legislative Assembly

Hon K. A. Hickey
Ms J. Hopwood
Dr A. D. McDonald

CHAIR: I declare the hearing open. It is the function of the Joint Parliamentary Committee on the Health Care Complaints Commission to examine each Annual Report of the Commission and report to the Parliament upon it in accordance with s 65 (1) (c) of the Health Care Complaints Act 1993. I note that two members of the Committee, Reverend the Hon Fred Nile, MLC, and Mr Matthew Morris, MP, are unable to attend today's hearing due to longstanding commitments with other Parliamentary Committees. The Committee welcomes the Commissioner and senior officers of the Health Care Complaints Commission to the table for the purpose of giving evidence on matters relating to the 2006-2007 Annual Report of the Health Care Complaints Commission. I thank the Commissioner and staff for their appearance before the Committee today.

KIERAN TIBOR PEHM, Commissioner, Health Care Complaints Commission, Level 13, 323 Castlereagh Street, Sydney, sworn and examined, and

BRET COMAN, Director of Investigations, Health Care Complaints Commission, Level 13, 323 Castlereagh Street, Sydney, sworn and examined:

KAREN BERNADETTE MOBBS, Director of Proceedings, Health Care Complaints Commission, Level 12, 323 Castlereagh Street, Sydney, affirmed and examined:

CHAIR: I am advised that you have been issued with a copy of the Committee's Terms of Reference and a copy of the Legislative Assembly's Standing Orders 291, 292 and 293 that relate to the examination of witnesses, is that correct?

Mr PEHM: Yes, that is right.

CHAIR: The Committee has received a detailed submission from the Health Care Complaints Commission in response to a number of Questions on Notice relating to the Commission's 2006-2007 Annual Report. Commissioner, do you wish this submission to form part of your evidence here today and to be made public?

Mr PEHM: Yes, that is no problem.

CHAIR: I direct that these materials be attached to the evidence of the witness to form part of the evidence. Do Committee members concur with authorising the publication of the submission?

Dr ANDREW McDONALD: Yes.

CHAIR: For the record, in what capacity are you appearing before the Committee today?

Mr PEHM: I am appearing as Commissioner of the Health Care Complaints Commission.

CHAIR: Commissioner, would you like to make an opening statement before the commencement of questions?

Mr PEHM: No, I am happy to proceed and answer any questions you may have.

CHAIR: On page 5 of the Annual Report, the Foreword notes that the Commission brings a valuable perspective to the health reform process because the information from complaints helps to inform health providers about concerns of patients. What processes does the Commission have in place to ensure that this takes place?

Mr PEHM: The complaints process itself obviously informs health and service providers of individual complaints. The process is to provide respondent health practitioners with the complaint and to ask them for a response. Our complaints resolution processes often involve both conciliation and assisted resolution. They involve complainants meeting with health service providers and, hopefully, in many cases reaching agreement as to changes that might occur as a result of the complaints. The investigations of complaints against health organisations can result in the making of comments and recommendations. Those are copied to the Director General of the Department of Health. The Director General has set up a central clinical governance unit, which looks at the applicability of the Commission's recommendations across the health system. We have regular meetings with the Area Health Services Chief Executives. I have three monthly meetings with the Director General that go to the implementation of the Health Care Complaints Commission's recommendations. There is a whole range of activity outside the complaints process, such as, addressing practitioner groups, speaking to colleges and doing public talks that inform people about the Commission's processes and the way we work and how we contribute to the improvement of the health system.

CHAIR: Generally, does the Commission use the statistical information it compiles to assist the various registration Boards to provide the most appropriate professional training—for example, by focussing on clinical issues, which frequently form the basis of complaints?

Mr PEHM: We have begun to do that. We provided a report to the New South Wales Medical Board fairly recently which looked at the types of complaints made and the kind of practitioner the complaints were made against. The Board has all of this information itself because we are required to consult with them on complaints as we get them, each and every complaint. I am not aware of the activity the Board has taken in response to the report. I do not think the Board has a very strong education role. I could be corrected by the Board, but I am not aware of that. To address that side of the issue, we are approaching the colleges, which provide regular training for their practitioners, and we are breaking down complaints data in terms of the types of complaints against particular kinds of practitioners - whether it is obstetricians, gynaecologists, surgeons, emergency department practitioners - and speaking to them about the nature of those complaints, how they are handled and outcomes and discussing with them what they can do to address complaints and prevent complaints from being made.

Hon KERRY HICKEY: Has the Commission ever given consideration as to the way it might work with other complaints handling bodies to look at ways of cross-promotion of services?

Mr PEHM: No is the short answer to that. We meet nationally with all the complaints handling bodies in the health area every six months. This year we are developing a public promotion and education strategy. That is quite extensive. We are involved, as I said, in talks to colleges and practitioners and also going out to the Area Health Services and speaking with clinicians. I have not thought of cross-promotion, but it is not a bad idea. I

think the Ombudsman may still do country visits and we were planning to do that in our own right, but it may well be worth linking up with them. That is something we could look into.

Dr ANDREW McDONALD: The Terms of Reference of the Garling Inquiry into the New South Wales health system requires the special Commission to refer individual complainants to the Health Care Complaints Commission. How has the Health Care Complaints Commission been assisting the special Commission? Roughly how many complaints have been received?

Mr PEHM: We met with Mr Garling quite early in the piece and discussed the Terms of Reference and we set up a liaison point between us and the Commission. We have been referred, I think, about 40 complaints so far. We might have to come back to you with a particular figure. That Inquiry has gotten quite an impetus up and it is holding public hearings almost daily. The Commission refers the transcripts of its hearings to us. In some cases the matters have been dealt with previously by the Commission. In those cases we contact the complainant to see if they have outstanding concerns. Many of them have said, 'No, I am not making another complaint. I am happy with all this. I just wanted Mr Garling to hear my concerns.' There are a substantial number of new matters coming in and we are treating them as new complaints, getting in touch with the complainant, clarifying the issues and putting them through our assessment process.

Dr ANDREW McDONALD: Are you able to give us on notice information as to the exact number?

Mr PEHM: Yes, we will come back to you with the exact number.

Hon DAVID CLARKE: On page 31 of the Annual Report it is noted that treatment issues accounted for 86.3 per cent of all issues and investigations of health organisations. Given that these issues would necessarily involve individual medical practitioners and the health care providers, does the Commission undertake any further breakdown or use these figures to investigate individuals?

Mr PEHM: There is a breakdown of the sub-categories under the treatment category in the appendices at the back of the report. It is on page 125, Table 18.2. The issues are inadequate treatment, medication, diagnosis, infection control. The largest category by far is inadequate treatment. We actually think these categories are very broad and not particularly helpful in terms of describing them. As I said earlier, we are going out to health practitioners, looking at what our data tells us and trying to have a dialogue with them about how to manage complaints better. We are redoing all of the issue categories, hopefully, with a much greater degree of specificity so that we can be clearer and give a breakdown that speaks more accurately to people.

Hon DAVID CLARKE: What is the time frame on that?

Mr PEHM: We will be introducing it from 1 July this year. We have been working on it for about nine months. We are trying to have it done as a national system. So we have been meeting with the other Health Care Complaints Commissioners and the New Zealand Commissioner as well and trying to get a joint adoption of the new issues.

Hon DAVID CLARKE: Does that look likely?

Mr PEHM: I think it is unlikely. We will proceed with it anyway because we think it is an improvement. I think New Zealand will almost certainly follow us. Queensland, I think, has adopted it. Others have various technical issues. Their database capacity is not as strong as ours. We are having another meeting, I think on 14 May. That will be the last meeting. The discussion will be finalised and people will decide whether they will come on board. The present indication is that I do not think it will be adopted nationally. The other complication is that other States have different legislation. Some of them cover privacy and some cover health and disability complaints. The smaller jurisdictions have a much broader range of issues to deal with apart from health care complaints.

CHAIR: I refer to the New South Wales State Plan. There does not appear to be a reference to the Commission in the State Plan for 2007. Did the Commission play any role in the preparation of the plan?

Mr PEHM: We were aware that it was being developed and as the Chief Executive I went to some of the initial meetings with Chief Executive Officers. However, I was not on any of the working parties that developed the State Plan in particular areas. We are too small and our function is so particular that we probably did not rate a specific mention. The State Plan is a very broad-ranging plan.

CHAIR: Did the Commission have any role in the development of the New South Wales State Health Plan?

Mr PEHM: No.

CHAIR: Is there a reason for that?

Mr PEHM: I did go to a presentation on the development of the plan and I had a look at the draft plan, but I had no particular input. I was invited to have input. Again, our role is very particular. There is an issue around the handling of the complaints by the Health Department itself. We are getting very interested in that this year. It has come out of analysing our own data. The Committee has asked what conclusions we can draw from our data. The answer is often 'not many', because our sample is so small. The department has a much broader pool of complaints.

The Clinical Excellence Commission just published a six-monthly report that showed 7,000 complaints in six months as well as 51,000 incidents of clinical management. At the moment I am talking to the Chief Executives of all the Area Health Services and the director general. I will be meeting with Cliff Hughes from the Clinical Excellence Commission shortly to see whether we can get greater access to that data. I do not think there is a problem with our getting access generally and, of course, the Commission publishes those six-monthly reports. However, again, they are at a very high level and we need to drill down—to use the common term—to get more individual and particular data.

Dr ANDREW McDONALD: I refer to page 31 of the report and figures 824 and 825. A significant percentage of complaints about health organisations and practitioners have no further action. Is that because your threshold for investigation is quite low in that you tend to investigate a lot and that is why you do not find much? Is it a case of if in doubt you tend to investigate?

Mr PEHM: No. If you go back over previous years' Annual Reports you will see that the proportion of complaints found to have no substance at the end of investigation has been steadily decreasing. So the number and proportion of matters where we do make findings of wrong treatment is increasing. The criteria for us to investigate a complaint are in s 23 of our Act. It states that a significant issue of public health or safety may warrant disciplinary proceedings against a practitioner or may involve gross negligence. So the Act sets a very high threshold. One category raises a question of doubt. It states that if at the end of an assessment a significant question remains about whether adequate care was provided, we must investigate.

Our assessment has become much more thorough over the past couple of years. We still strive to do it within 60 days. With complex matters that is very difficult, if not impossible. At the end of the assessment process we are obliged by force of the statutory mechanism to investigate matters that ultimately may not have anything in them. We cannot always predict at the start after an assessment process. We make our best judgement as to whether there is substance or whether it is a serious issue. On closer and further investigation, that may turn out not to be the case. However, the general answer is that, if anything, the proportion of sustained findings against both organisations and practitioners has been steadily increasing over the past three years.

Table 18.33 on page 150 of the Annual Report indicates that in 2003-04, 78 per cent of investigations into health organisations were terminated without any further action. This year - 2006-07 - that figure is 45 per cent. The same trend occurs with individual practitioners as well. Terminated by the Commission has gone from 49 per cent, to 42 per cent to 34 per cent over the three years.

Dr ANDREW McDONALD: The figures in 2005-06 and 2006-07 for health organisations are identical.

Mr PEHM: Yes, and that is not a mistake. I noted that when we were doing the report and we double-checked it. It is simply a coincidence.

Dr ANDREW McDONALD: I refer back to chart 823. Page 30 refers to conciliations finalised in 2006-07. A large number are not resolved. What does that mean in effect?

Mr PEHM: It means that the parties cannot reach an agreement in the conciliation process.

Dr ANDREW McDONALD: What is the usual consequence of that?

Mr PEHM: That is the end of the matter if the parties cannot reach an agreement. Matters are sent to conciliation and resolution processes where they do not reach that threshold for investigation. It is a completely voluntary process on both sides. If agreement cannot be reached there is no compulsion that the Commission can exercise to take further action. That is the end of it.

Dr ANDREW McDONALD: So these cases are not being investigated because they do not fulfil the criteria in the Act.

Mr PEHM: If the decision at the end of the assessment process is that they do not fulfil the criteria of the Act, complainants can always request a review of the assessment decision. A substantial number of complainants refuse to participate in the resolution processes. If they believe that their matter is more serious and that it warrants investigation, they can request a review and a review will be conducted. That may vary the assessment decision, and occasionally those matters are looked at in more detail or the complainant might provide more evidence and matters can be investigated.

Mrs JUDY HOPWOOD: I note that there were fewer investigations into public hospitals in 2006-07 than in 2005-06. Do you consider that there is any correlation between the Commission's failure to use its coercive powers and the apparent failure to identify the very serious complaints that have come to the attention of the public in the past 12 months?

Mr PEHM: There is quite a lot in that question and I am not sure where to start in breaking it down. I was not aware that there was a failure to use coercive powers. Coercive powers are used where we consider it necessary and appropriate. Each complaint is judged on its merits and a fair assessment is made of whether it reaches the criteria for investigation. Can you point out the part of the report where that reduction is stated?

Mrs JUDY HOPWOOD: It is on page 151 of the Annual Report and relates to fewer investigations finalised into health practitioners and health organisations.

Mr PEHM: Do you mean that the numbers were going down?

Mrs JUDY HOPWOOD: Yes.

Mr PEHM: There are a number of reasons. The 2004-05 figure of 675 investigations finalised represents action taken to deal with the accumulated backlog of complaints in the Commission and all the matters that came out of the Macarthur period. There were 139 investigations solely related to Macarthur. More generally, part of the problem and the reason the Commission accumulated the backlog of complaints and investigations—when I arrived 1,000 matters were under investigation, some of them years old—was that it was not applying the statutory threshold we referred to earlier for the seriousness of the matters that were going through to investigation. The assessment process was not as thorough as it is now. By doing a more careful assessment we are referring fewer matters through to investigation. However, I would say the investigations are also becoming much more rigorous and thorough than they were then, simply as a function of the resources can be applied to a greater number of matters.

Hon DAVID CLARKE: Do you foresee an increase in the number of investigations into public hospitals in the future?

Mr PEHM: It is hard to judge. In the past two months there has been a substantial increase in the number of complaints received.

Hon DAVID CLARKE: How substantial has that increase been?

Mr PEHM: I will have to get back with actual numbers, but it is a significant increase. It is a factor of the publicity generated by the Graham Reeves, 'Butcher of Bega' matter. Many people are reminded of poor health care—not specifically in relation to that

individual—when they see publicity about such cases. They are reminded of poor health care they may have experienced. We get the same when a particular factor has brought the matter to mind and they complain. The Garling Special Commission of Inquiry, as well as referring particular complaints to us is also generating a lot of publicity. As a result of that I would expect the number of investigations into public hospitals to increase in the short term. Whether that becomes sustained is difficult to say.

Hon DAVID CLARKE: So, there are a whole lot of complaints out there that do not even hit the radar unless there is publicity to stir them up, as it were?

Mr PEHM: Yes, it would seem so. That is one of the reasons why we are going on what will be quite an extensive public promotion campaign over the next year. I think I said last time I was here the Commission has been focusing on its internal problems and making sure it was in a position to deal properly with complaints. Yes, I think the more publicity and the more awareness there is of the Commission the more complaints should be received. I can elaborate on what we are doing there. We just completed a rebranding, I think it is called, of all of our promotional literature. We have a range of pamphlets and posters now. We have agreed with the Department of Health to have those distributed through our public hospital system. We are entering into an arrangement with a private organisation to have all that information distributed through general practices in New South Wales—practices that are members of this organisation—along with the public presentations and talks and addressing various public interest groups and practitioner groups.

Dr ANDREW McDONALD: Can I ask you about the North Shore Inquiry? At that Inquiry there seemed to be, as you mentioned, the underreporting of health care complaints. The North Shore Inquiry certainly found there was this significant underreporting. Has that Inquiry had any impact on the work of the Commission?

Mr PEHM: Possibly in the general sense that I mentioned earlier in that it has heightened public awareness of delivery of public health services. I have not done an analysis more recently of the rate of complaints out of North Shore compared to Prince of Wales or Prince Alfred, the big teaching hospitals. I did that at the time of the Parliamentary Inquiry, and our complaint data did not show any larger number of complaints about Royal North Shore than it did for comparable teaching hospitals in Sydney.

Dr ANDREW McDONALD: Now that it has been some months, are you able to take that on notice for us?

Mr PEHM: We can do that. We will have to go to the Department for that information so it might take a bit of time, but I am happy to do that.

CHAIR: As a result of the 2003-04 reforms at the Commission, positions previously concerned with partnership development and education were deleted or realigned to the Commission's principal function of complaint handling. Given the evidence of the general lack of community awareness of the role of the Commission, do you consider that an education position ought to be re-established?

Mr PEHM: We have. We have established a promotions and stakeholder relations position, which I think is in our papers there that we advised you on.

CHAIR: When was that position re-established?

Mr PEHM: Probably from early this year, January or February this year. I can give you the exact dates if you like. It may well be in the answers we have already given you.

Mrs JUDY HOPWOOD: You have answered this in part but what further measures will the Commission include in his Annual Report to allow assessment of the success of its promotions strategies, particularly strategies to reach people with a mental illness, persons with a disability, an Aboriginal person and a person from a culturally and linguistically diverse background? Just some specifics, if you are able to answer that, apart from the brochures and other measures you have indicated?

Mr PEHM: We have a Consumer Consultative Committee as part of our legislation. We meet with it quarterly, and all of the groups you mentioned are represented on that. We have written pieces for all of their newsletters that we transmitted to them—I do not have the exact details of those who have printed them, but we are collecting all of that information. Our Resolution Officers are also going out and speaking to meetings of those organisations. So, there is some targeted action, if you like, of those relatively disadvantaged areas, specialised areas of patient complaint. We have also reviewed the Commission's collection of demographic data from complainants to try to get an idea of who is complaining and whether particular groups are underrepresented or overrepresented. We are starting that from 1 July. We have been doing all the preparatory work for that.

This is not directly related to your question, but it is part of the same process. We are doing customer survey processes with every complaint we handle, so everyone who makes a complaint and any health service provider we deal with we send a form to fill in about how they evaluate the Commission's processes and service. So, we are getting quite a range of strategies and we should be able to produce, I hope, fairly detailed data on that for our Annual Report—not for 2007-08 but for 2008-09 it should all be in place.

CHAIR: So, those demographics would include ethnicity, language group—

Mr PEHM: Yes, Aboriginality—

CHAIR: Mental illness?

Mr PEHM: Yes. We can give you a copy of those forms, if you like.

Hon DAVID CLARKE: According to the report, over 30 per cent of investigations are not finalised within 12 months. Are you concerned about that? What types of matters take more than 12 months to complete?

Mr PEHM: I do have a concern about that because change is not instant in public sector organisations, or probably anywhere for that matter. There has been a process of continuing improvement to improve those times. I will not dwell on how bad things were in the past, lest I be seen to be making excuses, but I might ask Bret Coman, our Director of Investigations, to explain to you some of the measures we are putting in place which we think will result in significant improvement to investigation time frames.

Mr COMAN: Part of that involves the Procedures Manual, so a change of our policy and practice. Part of it is cultural too, to instil an urgency into investigations.

Hon DAVID CLARKE: When you say a change in culture, does that mean there were people dragging their feet in doing these investigations?

Mr COMAN: I suspect so, yes.

Mr PEHM: The Commission had a very linear process of investigation which involved sending the matter to the respondent and waiting for a response. If the response took longer than the 28 days requested, they might wait a bit more and then send a reminder letter. So, that might blow out to two months and they would still be waiting for that response. The essence of the new Procedures Manual is that a multiplicity of lines of enquiry is pursued from the outset. So, we are not waiting on one response before we proceed with other lines of enquiry. Sometimes you do have to wait because there is particular information that will be the source and the foundation of the enquiry without which you cannot proceed, but the Commission's investigation process traditionally has been very linear, and the second step was not taken until the first step had been completed.

Do not forget, the Commission did not have any powers to compel the production of information until post-Macarthur. So, that came in, in March 2005 and I do not think the culture of the Commission geared up very quickly to the availability and the use of those powers. It is all very well for me to say we have them and to tell people to use them and address staff meetings, but it is not part of their everyday practice and it is not how they think about investigations. It takes time for those sorts of messages to get through. Previously, if a health practitioner did not respond to the Commission there was nothing the Commission could do about it, short of executing a search warrant on their premises, which is completely out of proportion to the nature of the complaints.

The new procedures manual integrates the powers in the investigation process and it is just a much more active approach. Our investigation team structure - we have introduced a lot closer supervision. Previously the culture was that individuals were responsible for their files. They were given to them and no one asked for anything back until they had finished their investigation. So there was very little supervision of the complaints process. We have much tighter control of that now. There is a lot more monitoring, a lot more reporting back, and the new manual will introduce default reports, so that if certain steps are not taken within certain time frames, managers will be notified through the case management system, electronically, and they will be obliged to follow it up. So, the process will be much more active and inevitably it will get quicker.

Hon DAVID CLARKE: What types of matters genuinely take more than 12 months to complete?

Mr PEHM: Complex ones, generally.

Hon DAVID CLARKE: Can you give some examples of that?

Mr PEHM: The classic ones are the complex hospital care matters. Things can be complicated by external processes, by coronial inquiries, and so on, and police and criminal inquiries. So, that can be a contributing factor, or criminal charges being laid. The most

complex investigations are those provided in big hospitals where the patient has been in care for a significant period of time, many weeks. Medicine in those contexts is very much a team delivery of service. A classic one would be a post-operative infection where, during an operation, something is nicked and the contents of one organ leak into other areas and peritonitis develops and infection. That can be picked up early or it can be picked up later. So, you have to look at the nurses doing the monitoring during that time, you have to look at the Registrars and the Career Medical Officers reviewing that patient and you have to look at the surgeon and the post-operative follow-up. So, even in a two-week period, if you include the shifts and looking at when the critical deterioration occurred, you are looking at 15 or 20 or more health practitioners.

You then decide how many of those are critical and what level of evidence you need from them. Traditionally the Commission wrote out and waited for responses. I guess it was easy when you had that many people but in a complex care situation the level of individual responsibility for the deterioration of a patient, say, is often very diffuse amongst a lot of practitioners. It is a question of balancing up and weighing up the contribution of one compared to the other. That can require you to go back when you get responses from one practitioner to double check with others. Those other matters do take a long time.

CHAIR: Mr Coman, I was not sure that you had completed your answer?

Mr COMAN: Yes. In essence, Kieran answered it. It was just the management and the ongoing management of those investigations and setting milestones and making sure those milestones are met, and if they are not, taking corrective action to make sure they are met.

Hon KERRY HICKEY: Does the Commission experience any delay going from the assessment stage to the investigative stage?

Mr PEHM: There is a service level agreement between our Assessments Branch and our Investigations Branch. I do not think there are any significant delays but Bret can probably tell you the time that takes.

Mr COMAN: There have not been any significant delays that I can recall at this stage. We have our own time frames and we follow up on them fairly quickly.

Hon KERRY HICKEY: So, you are saying there is no delay from the assessment to the investigative stage?

Mr PEHM: There are administrative things that have to be done. At the end of the assessment process the parties have to be advised of the outcome of the assessment decision, their right to request a review, and the file has to be transferred to investigations. So, letters have to be written by the Assessment Officer, the Case Officer, but I think the transfer rate is three or four days at the moment.

Mr COMAN: Or even less than that.

Mr PEHM: We have an actual number of days specified. I cannot recall what it is at the moment.

Mrs JUDY HOPWOOD: The report notes that unsatisfied complainants have the right to take their matters to the Ombudsman or the Independent Commission Against Corruption. Do you think it would be appropriate to also note in the Annual Report that the Committee has an oversight role with respect to systemic issues at the Commission?

Mr PEHM: I am happy to do that. I think people find it difficult to distinguish between systemic issues and how their particular complaint was handled, but I absolutely have no problem with doing that at all.

CHAIR: The staff attrition at the Commission is certainly down on the levels of 2005-06, but it remains not inconsiderable, particularly in the Assessment and Resolutions and the Investigation Divisions. Has the Commission adopted the process of exit interviews and staff satisfaction surveys recommended by the Committee in its report of the Commission's 2005-2006 report?

Mr PEHM: Yes. Last time we met I was unsure as to whether we did exit interviews. We do, or at least staff are given a form to fill out and they are offered the opportunity for an exit interview. That has been in place for some time. We are also conducting what is known as a climate survey. We have consultants in to undertake that process. At our last staff meeting about three weeks ago all the staff were addressed on that process. A working group will frame the questions and we expect that to be finished by the end of June and have the results of that.

Hon DAVID CLARKE: What did those exit interviews show? Did they show a pattern of complaints or concern as to why people left?

Mr PEHM: No. Since that matter was raised I actually talk to staff that are leaving. It is very stressful work actually and not a lot of people have the right temperament for it. That has been the main reason in the assessments area particularly and there has been a lot of pressure on the assessments area with the number of complaints and I think I have explained to the Committee that we have put in place procedures that require our staff to talk much more directly with people than has been the case in the past. Everything used to be done in writing and led to a lot of alienation of the complainants from the Commission.

It is high volume work and it is very stressful because a lot of the complainants have suffered catastrophic losses in their lives, the deaths of loved ones and so on. They are grieving, and they want to tell their story and people have to deal with that. That has certainly been expressed to me by a few staff who have not had the temperament for it. They have to deal with a fair bit of conflict, if not aggression, and not a lot of people have the right temperament for that either.

Hon KERRY HICKEY: Is the exit level up or down?

Mr PEHM: It is down in the 2006-07 year on the previous year, and I think I went into the reasons for that. I do not inherently see staff turnover as a bad thing and if the idea of staff stability is an inherent good in itself, I just disagree with that.

Hon KERRY HICKEY: It is just that you said that the assessment of the complaint is up, yet the investigative level is down because of the strong assessment.

Mr PEHM: Yes.

Hon KERRY HICKEY: Are staff doing the assessments leaving quicker than they were before?

Mr PEHM: Staff is fairly stable now. I am just responding to the Chair's comment, if I was hearing you right that there has been a high turnover in assessments.

CHAIR: Yes.

Mr PEHM: Assessments is fairly stable now. It is very important to pick the right sort of staff. We put a lot of effort into promotion, recruitment and induction of staff, but it is a stressful job.

Hon DAVID CLARKE: Would more staff relieve the pressure?

Mr PEHM: More staff will relieve the pressure.

Hon DAVID CLARKE: Do you need more staff?

Mr PEHM: We have put on three temporary staff until the end of June to see how this load that I have explained from the increase in complaints in the last couple of months to deal with that and we will monitor it again at the end of June to see whether we need to make some more longer term increase in assessments staff numbers.

I should make the point that I do not think staff turnover is inherently a bad thing. Staff at the Commission since I have been there have probably been under a lot more pressure than they have been prior to that. Although they had significant backlogs, we did not have the sorts of process I have been describing in assessments and in investigations where staff were monitored, supervised and directed, and a lot of staff, particularly in the early days, reacted very badly to that because they had been given complete independence to run their own race. Now when you are going through a cultural change process and trying to get a teamwork environment developed where everyone is working together towards the same ends, I do not think it is a bad thing that people who do not see their future working in that environment decide to go and I do not think that we should be bending over backwards to try to keep people like that either.

Dr ANDREW McDONALD: You talked about the stressful job. I would like you to enlarge on that. You talked about the anguish of the families, the conflict and aggression. Can you expand on the main stresses for the staff who work there?

Mr PEHM: Every complaint that comes in now, assessments staff will call the complainant and discuss the complaint with them, clarify that their written complaint fully expresses their complaint and if not add to it and make sure we have a comprehensive complaint before we go to the respondent. They do deal with a lot of angry people and a lot of people who are grieving. Health is very high risk - not high risk, but people are ill and they die and emotions are involved.

I had to do a lot on the grieving process and the first stage is denial and then anger. People want to look for external causes outside the inherent nature of the situation and they

want to look for people to blame. That is one of the main reasons why the level of refusal by complainants to accept the conciliation process is still high and we are working hard to try to get that down. They can become frustrated when they start to realise that the more extreme actions they might have wanted or anticipated do not take place.

If a loved one is in a hospital situation or paid care and they are dying over a period of time, the complainant or member of the family will build up a relationship; they will be visiting them, they will see the conditions or they might have a run-in with a nurse about how long they took to get there. Personalities come into it and all those human factors. You cannot cut those out of the complaint process. Most staff try to be as professional and dispassionate as possible in the interests of fairness and impartiality, but it is unfair and inhuman not to allow those people to express their grief and frustration at the system, and I think that takes a toll.

The officer I am thinking of in particular is a lovely fellow with a very nice temperament but he likes to be liked. He does not like getting yelled at or being told, 'You are useless; why can't you do anything. What use are you?' and this sort of thing. You do have to put up with a certain amount of conflict. The foreword to this Annual Report - generally the level of public trust in the health service providers is very high, but when something goes wrong it is fractured in a really emotional and often a very bitter way. Staff have to deal with a lot of human situations that are not particularly pleasant.

Dr ANDREW McDONALD: The next question relates to reaction from health providers because after you have taken the information, you then ring the health provider, is that right? Is there stress between the HCCC staff and the health providers?

Mr PEHM: It is the same thing. The Commission is in the most difficult position. It is in the middle of what is often a really fractured relationship. I went to a talk and there is a psychiatrist in Melbourne who works for the college there and he counsels practitioners who have complaints made against them and he described it as the same stages of grieving as Kubler-Ross; their first reaction is anger and denial as well. How dare they? They are biting the hand that feeds them. I am just there to help and look at the thanks I get. There is also unfortunately a culture in the health services, and the medical profession in particular, that sees complaints as an attack against character, standing and reputation. People pride themselves on never having complaints made.

There is not the appreciation that I think there needs to be that it is really a part of doing business of any sort, that when you are dealing with consumers you will always have interactions, and particularly in medicine where the issues are so complex and the treatment can have side-effects and complications that may not necessarily have been foreseen. Even if the consent process has been good, people want to hear the good outcomes. We get a lot of complaints around informed consent where the practitioner will even produce signed consent forms about the side-effects and complications and explaining them and the complainant will swear that they were never told about those adverse side-effects. I am wandering a bit there but does that answer your question?

Dr ANDREW McDONALD: Very much so, thank you.

CHAIR: Earlier in one of your answers you talked about the increase in staffing and that you have created some temporary positions to deal with the increased load of complaints since the publicity following Royal North Shore Hospital and the Mr Reeves

matter. Is it only in the area of assessment resolution that you see that you need additional staff?

Mr PEHM: At the moment, yes, but with management everything is constantly under review and you are always monitoring and measuring where the workload is, but certainly that is the big influx of complaints, and until we process those matters and determine the proportion that will go through to investigation or other areas, it is difficult to say whether the increase will be sustained and whether it will flow through to substantially increased work in other areas.

CHAIR: I was thinking of the investigations. You are not expecting that on assessment there would be an increase in the number of investigations?

Mr PEHM: It is on the radar and we have talked about the possibility of that and, if necessary, we will seek supplementation and see whether we can reorganise resources from other parts of the Commission. It is a bit early to say yet.

CHAIR: Do you foresee any difficulty in acquiring people with the skills you need as investigators, if you find you need them very soon?

Mr PEHM: That is another thing, where it is a sort of constant management problem. Bret is a former Chief Inspector of the New South Wales Police Service. We have had a very strong push to professionalise our investigations area. My impression is that the more the Commission is improving its performance and reputation in the health system, the more we are getting applications. We just did a recruitment process in assessments and there was something like 90 applications. Bret is keeping the staffing of the investigations area under review continually.

Mr COMAN: From time to time we get expressions of interest as well and we call for their curricula vitae to identify people who could be good at the Commission. We are looking at one detective who is interested in secondment and we are trying to work through that. We do have a few people in mind, even just for the short term.

Dr ANDREW McDONALD: Thank you very much for providing the draft code of conduct, which is very good. What is the progress of the code because it still has 'draft' on it?

Mr COMAN: Is that our code of conduct or the code of practice? There are two documents.

Dr ANDREW McDONALD: The one you gave us?

Mr PEHM: That is the code of practice under section 80 of our Act. We are also drafting a code of conduct, which is why I asked, so it could well have been the other one. We just sat down yesterday and went through the responses we received from both the health profession and the community stakeholders with the draft code of practice and we will finalise that in the next couple of weeks I think. All the responses have been very good, constructive and useful. They have all practically said it is a good initiative to produce the document. There will be some pretty substantial revision. There will be a bit more detail in it

than there is now and the format will be changed slightly but that is all under way and we will have that finished by the end of the year.

Dr ANDREW McDONALD: Shorter is better.

Mr PEHM: Yes but there are people that feel particular things need to be said and that has got to be respected as well so it will get longer. We are trying to keep lawyers language out of it and keep it in plain English.

Mrs JUDY HOPWOOD: With the proposed national registration and accreditation scheme for health professions which will establish new partnerships between the Federal and State registration and education accreditation bodies governing medical professions, what impact, if any, do you consider a national scheme will have upon the operations of the Commission?

Mr PEHM: That is a really interesting question. I do not know what the answer to it will be. I went to a consultative meeting while the national accreditation registration scheme was being drafted and raised that very issue of what impact it will have on the complaints and disciplinary side. The response broadly was that the Commonwealth recognises that is all very difficult and all of the States have different legislation and complaint-handling procedures. They had given it some thought but they had not put in a great deal of work to the process of harmonising those processes nationally. The national registration scheme is aimed at workforce deployment. It came out of the Productivity Commission originally and it is a good thing. The idea is if you register in one State you are registered nationally.

At the moment if you are in Tweed Heads or Coolangatta you have to be registered in both States, you have got two sets of registration fees and you would be subject to a different disciplinary process in Queensland than you would in New South Wales. Also for overseas trained doctors to be accredited by one central authority and be able to work rather than go to each State and go through a different accreditation process. That is the primary objective. There will inevitably be a flow-on effect from it and it is conceivable in a rational world all of the complaint-handling procedures would be made consistent because the ultimate outcome of a complaint will affect registration. If you are registered you can have conditions placed on registration. I think it will take some time and a lot of negotiation as to precisely the form it takes. It may not become urgent until there is an anomalous case where a practitioner is dealt with differently under one jurisdiction that has impacts in another that really highlights the problem. So there will be an impact but it is very difficult to say what it will be at the moment.

CHAIR: Can you please give the Committee a more detailed account of the Commission's interactions with Justice Health?

Mr PEHM: I was just out at Justice Health this week, on Monday I think. We interact with them in the everyday complaint handling sense, of course. I went out to see them about some particular issues where I suppose the security considerations in the prison had affected the conditions of the patients in the forensic hospital and we had a complaint about that so I wanted to talk about that. We have interaction at a lot of different levels. Our Resolution Officers deal with them quite a bit.

Our complaints follow the normal process. We generally get a response from Justice Health if it can be resolved there or we feel that the matter has no substance at the end of it, but we do refer a lot of matters to our Resolution Service because the complainants are in a vulnerable position and often need representation. So our Resolution Officers deal with them a lot. I will say that Justice Health are very responsive and professional in the way they deliver their services and are very responsive to us.

The other reason for our meeting was that they are also going through a bit of cultural change themselves and perhaps introducing some more strict discipline in their ranks than has been the case in the past. So they are also referring complaints to us against some of their health practitioners.

CHAIR: Just to refer to some of the responses that you gave to the questions that we asked on notice. In answer to one of the questions you said in some instances the Director of Proceedings does not agree with the level of seriousness of the matters referred to her by the Commission, although this was only on a small number of occasions. Do you consider there is any basic divergence in the concept of 'serious' between the Director and the Commission staff?

Mr PEHM: No. Complaints can be referred to the Director of Proceedings for a number of reasons. A very common one, and one where the Director might decide not to take action, is where there are allegations of sexual boundary violation—sexual misconduct basically. The matter might go to a criminal prosecution and the magistrate might say they do not find it proved to the criminal standing: beyond reasonable doubt. Now a different standard is applied in a protective jurisdiction before a disciplinary tribunal. I would feel safer referring that to the Director of Proceedings with a prosecutor who can go through the evidence and make her own independent assessment of the prospects of success of a prosecution than making that decision myself at the end of an investigation. There will inevitably be cases referred through to Karen really for safety in the public interest so that a person whose skills are better suited to looking at the prospects of prosecution can make the decision. Do you want to add anything to that Karen?

Ms MOBBS: I think that is all true. The other aspect of it is that when it comes through to the Legal Division we are really looking at it with a view to whether there is sufficient evidence to prosecute. The criteria actually set out the likelihood of proving the complaint. Obviously before the Professional Standard Committees, the tribunals that we deal with, certain views have been taken in relation to types of matters and how they have to be proved. So with the same set of facts that may constitute a departure from the standards, it may well be that in other similar cases a tribunal or Professional Standards Committee has taken a particular view that it will not amount to the legal definition of unsatisfactory professional conduct. So in those cases it may be that whilst there is a departure, it is not worth pursuing it in the disciplinary sense because we are not going to get a finding, and may well incur costs in doing so, and that matter is best dealt with by referral back to the Commission to be dealt with by the Board's comments or counselling or some other disciplinary outcome rather than prosecution.

Another one of the matters that is sometimes a difficulty is that not all of the registration Acts have a Professional Standards Committee. A number of them only have tribunals and what they call Boards of Inquiry. A tribunal will generally deal with those matters requiring de-registration or suspension. In those jurisdictions such as for doctors and nurses there is a Professional Standards Committee that can deal with less serious

unsatisfactory professional conduct. In matters such as psychology and podiatry there is not a second lower prosecuting body, which means I do not really have any jurisdiction to prosecute unless it is dealt with in the more serious jurisdiction. So on those occasions I do not have any choice but to refer it back to the Commissioner for him to refer to a Board of Inquiry. So even though there will be a disciplinary outcome it is actually counted as me making a determination not to prosecute just because of the framing of those bodies.

CHAIR: Do you think that it should be standard across the Professional Boards? Have you made any recommendations to Government about a change of legislation that would address that anomaly?

Ms MOBBS: We have made a number of recommendations in trying to have commonality amongst the various registration Acts. I do not know that so much attention has been focused on Boards of Inquiry. We have certainly raised that with the individual Boards.

Mr PEHM: It has always been our position that there should be consistent discipline legislation across all of the jurisdictions. It is moving slowly that way. The pharmacists and I think that dentists now are going into the same scheme as the doctors and nurses.

Ms MOBBS: The Pharmacy Act was a new Act that came in very recently—in February. So it is slowly changing and certainly we would support, and have made a number of recommendations that any changes made, for example, to the Medical Practice Act be reiterated across all of the registration bodies, because it makes it very difficult. We also have to work with the interface between the Health Care Complaints Act and the other registration Acts. The more differences there are between those Acts, the more difficult it is to work them in with our Act. Certainly our recommendation is that at some time, and the sooner the better, all of those Acts be reviewed together to make sure there are as few inconsistencies between them as possible.

CHAIR: I note that the Commission is currently arranging for a suitable replacement for the Commission's Consumer Consultative Committee. Can you inform the Committee on how that is progressing?

Mr PEHM: We might be trying to recruit new members to the Committee. I do not know that we are looking at replacing the Committee. The Committee is actually a statutory creature so I do not think we can replace it without amending the statutes. Is there a particular answer there?

CHAIR: There was an answer that we received.

Mr PEHM: We are reviewing the membership of the Committee and trying to make sure that we have as broad a representation as possible. We put that to the Committee and at the next meeting they will be suggesting other potential members and so –

CHAIR: It relates specifically to a representative from the Ethnic Communities Council?

Mr PEHM: Yes. We are actually consulting with the Community Relations Commission about a suitable member from that area.

CHAIR: It is just progressing. The report notes that the Commission plans to undertake a full review of its publications which are specifically focused on providing information to the Aboriginal community regarding its services. Can you tell me how that is progressing?

Mr PEHM: We have reviewed all of our publications. We have just sent the proofs to the printers to have all of our pamphlets done. The answer I was going to give was really concerned with the multilingual distribution to the ethnic community. We have our Aboriginal Designated Officer as part of this program we have to develop senior management. She is doing a project specifically on the delivery of Commission information to Aboriginal communities. She is stationed in Dubbo and I think she is on leave at the moment working with Charles Sturt University. Her supervisor is not here today but she will be delivering a proposal to us about how we would best do that. It is a difficult and sensitive area and she is best placed to do it but we do not have the outcome of that yet.

My adviser informs me that she has been released from her duties by the Commission to work specifically on the project of delivering Commission information to Aboriginal communities in New South Wales. I am pretty sure she is working with Charles Sturt University on that.

Mrs JUDY HOPWOOD: I seek further clarification in relation to a complaint that covers both a system failure and a health practitioner failure, and the reporting mechanism or communication between the Commission and the family members in relation to the complaint or incident that occurred and is causing concerns. I know that systemic failures are looked at in a different way as opposed to dealing with health practitioners. In relation to the health practitioners, how much information does the family or the significant members of the community –

Mr PEHM: The complainants.

Mrs JUDY HOPWOOD: Yes, the complainants.

Mr PEHM: With every complaint against a health practitioner that is investigated but does not get referred for prosecution the final letter to the complainant telling of the outcome is a fairly full investigation report that sets out the context of the complaint, the conduct the subject of the investigation, all the evidence gathered, the expert opinion on the practitioner's conduct and the reasons for the outcome. They get fairly full explanations. Our Investigation Officers are charged with keeping regular phone contact - at least once a month - with complainants and family, so there is fairly close communication and we believe reasonably full advice of the outcomes at the end.

It can be very difficult for people to distinguish. Often the complaint is about the whole of care and there are reactions on all sides. Some will take a particular dislike to a practitioner and want them deregistered for whatever reason - their interaction with them has not been very constructive during the illness. Others will say when we prosecute individual practitioners, 'Oh, they're just being made a scapegoat. It's all the system's fault.' You get reactions on all sides. Some will want us to take stronger action against individuals; others will say, 'No, I'm not concerned with individuals. I want the system changed.' We do advise people fairly fully of the outcomes.

With matters that are being prosecuted we do not, because potentially people can be called as witnesses for the prosecution. You do not want them to know the evidence of other parties in case even unconsciously they change their version of events. It just complicates things. They will be party to the disciplinary proceedings if they are witnesses. Tribunal proceedings, of course, are in public; Professional Standards Committees are in private. There is a problem there with the parties knowing the outcome. I think that has been pretty well addressed by the legislative amendments that will be made as a result of the Reeves matter, which require Medical Practice Act Professional Standards Committees to be in public unless there is a good reason for them not to be. Again, on the consistency point, that will apply only to medical practitioners because that is the circumstance that gave rise to it.

Mrs JUDY HOPWOOD: In relation to a Coroner's finding when there is no reference or recommendation for a prosecution relating to a practitioner arising from the evidence and the HCCC finds there should be a prosecution, is there any discrepancy between the fact that the Coroner did not make that finding and you did?

Mr PEHM: It is a question of the different standard of proof. The Coroner is looking at a criminal standard: should a practitioner be prosecuted for manslaughter or criminal negligence? That is a higher standard of proof than we might be required to prove before a Committee. There are also the outcomes of our proceedings, leaving dismissal and suspension aside. There is often a case where it is appropriate for a Professional Standards Committee to impose conditions on a practice. That is a circumstance you want expert panels to judge. They can make finer judgments than the Coroner. The Coroner certainly gets expert witnesses who give opinions, but the proceedings are different.

CHAIR: Commissioner, we may have some more Questions on Notice following the evidence today. I am sure Committee members will go away and consider those. If we have more questions we will forward them to you. I thank you for the very timely way in which you have responded to our Questions on Notice to date. We certainly have appreciated that. It has made the Committee's work a lot easier. Thank you and Ms Mobbs and Mr Coman for appearing before us today.

(The witnesses withdrew)

(The Committee adjourned at 3.20 p.m.)

Chapter Four - Answers to Questions Taken on Notice

QUESTIONS TAKEN ON NOTICE DURING THE HEARING

The Commission responded to several questions taken on notice during the public hearing held on Thursday 1 May 2008.

Question 1

Dr Andrew McDonald MP asked in relation to the requirement in the Terms of Reference of the Garling Inquiry into the New South Wales health system for the Special Commission to refer individual complainants to the Health Care Complaints Commission: 'How has the Health Care Complaints Commission been assisting the Special Commission? Roughly how many complaints have been received?'

You undertook to give the Committee a particular figure as to how many complaints had been referred.

RESPONSE:

As at 30 April 2008, the Commission had received 79 complaints from the Garling Special Commission of Inquiry.

Question 2

The Hon. David Clarke MLC referred to page 31 of the Annual Report which states that treatment issues accounted for 86.3 per cent of all issues and investigations of health organisations. He asked: 'Given that these issues would necessarily involve individual medical practitioners and the health care providers, does the Commission undertake any further breakdown or use these figures to investigate individuals?'

As part of your reply, you stated the Commission was redoing all of the issue categories with a much greater degree of specificity so that it can be clearer and give a breakdown that speaks more accurately to people. The Committee would appreciate receiving further details about that.

RESPONSE:

Enclosed is the current version of the revised complaint issue categories that the Commission has developed following both internal consultation with Commission staff, and external consultation with the Department of Health and the Commission's counterparts in other Australian jurisdictions (see Appendix 5).

The Commission will again be discussing these categories with its counterparts at a conference later this month – the purpose being to bring as much consistency as possible to the complaint issues used throughout Australia, in order to compare and contrast relevant statistics and trends between and among the various Australian jurisdictions.

Subject to any minor alterations or additions agreed to at the agency conference, the Commission will be using the revised issue categories as from 1 July 2008.

The Commission anticipates that the use of the revised issue categories will assist in better identifying complaint trends generally, in relation to both individual health practitioners and health organisations.

Question 3

The Hon. David Clarke MLC asked in relation to complaints received about hospitals in the past two months: ‘How substantial has that increase been?’

You undertook to give the Committee actual numbers of complaints, noting that the increase was significant.

RESPONSE:

The figures and trends in relation to the number of complaints about health service providers generally, and about public hospitals in particular, are as follows:

Complaints generally

In 2006-07, the Commission received a total of 2,722 complaints – an average of about 227 complaints per month.

For the following ten-month period, from July 2007 to April 2008, the Commission received 2,514 complaints – an average of 251 complaints per month.

The last three months of this ten-month period – February, March and April 2008 – have seen a steady increase in the number of complaints received by the Commission.

Complaints about public hospitals

In 2006-07, 508 of the 2,722 complaints (18.7 per cent) were about public hospitals.

For the following ten-month period, from July 2007 to April 2008, 603 of the 2,514 complaints (24 per cent) were about public hospitals.

The relatively high and increasing number of complaints about public hospitals in the last three months reflects the fact that the Garling Special Commission of Inquiry is required by its Terms of Reference to refer any complaints that it receives to the Commission, and has been doing so during that period (see also the Commission’s response to Question 1 above).

Table: Number of complaints received from 1 July 2007 to 30 April 2008

(calculated by reference to the number of health service providers the subject of complaint)

	2007						2008				Total
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
Complaints received about health service providers	237	257	219	278	233	194	215	268	277	336	2514
Complaints received about public hospitals	53	62	44	72	53	38	47	58	70	106	603
% of complaints about public hospitals	22.4%	24.1%	20.1%	25.9%	22.7%	19.6%	21.9%	21.6%	25.3%	31.5%	24.0%

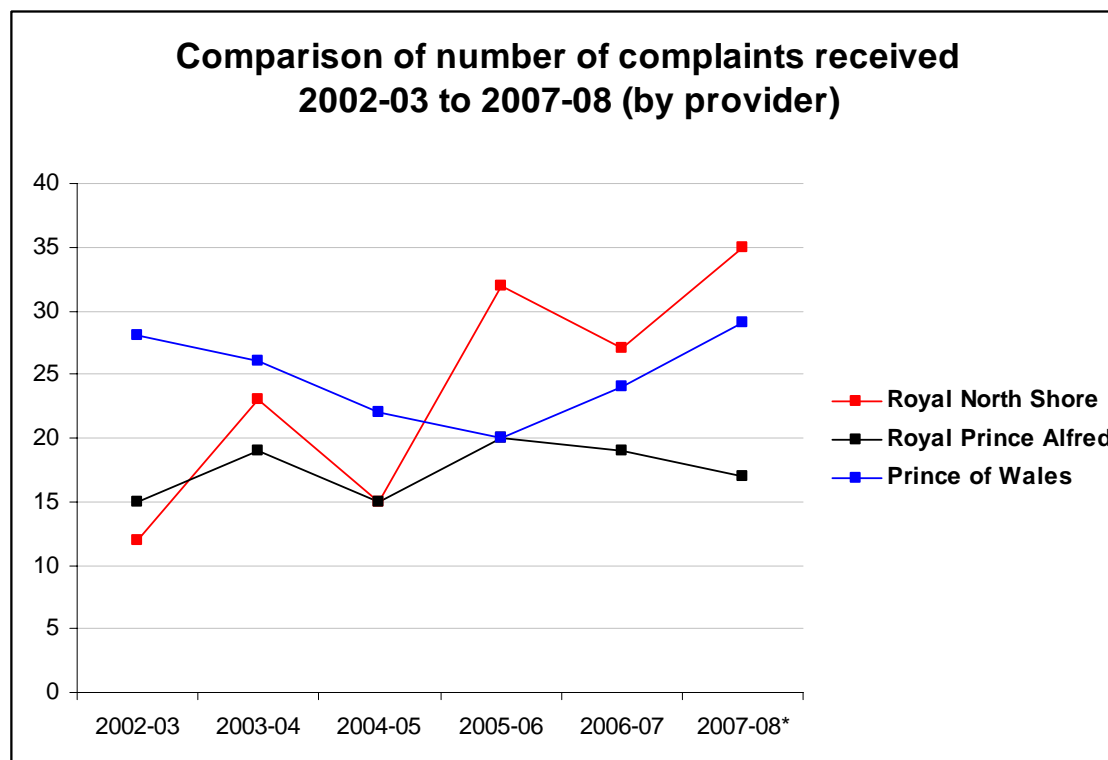
Question 4

Dr Andrew McDonald MP asked about the North Shore Inquiry and the underreporting of health care complaints. The North Shore Inquiry found there was significant underreporting. He asked: ‘Has that Inquiry had any impact on the work of the Commission?’ and ‘Now that it has been some months, are you able to take that on notice for us?’

You undertook to obtain an analysis of the rate of complaints from the North Shore compared to other big teaching hospitals from the Department of Health.

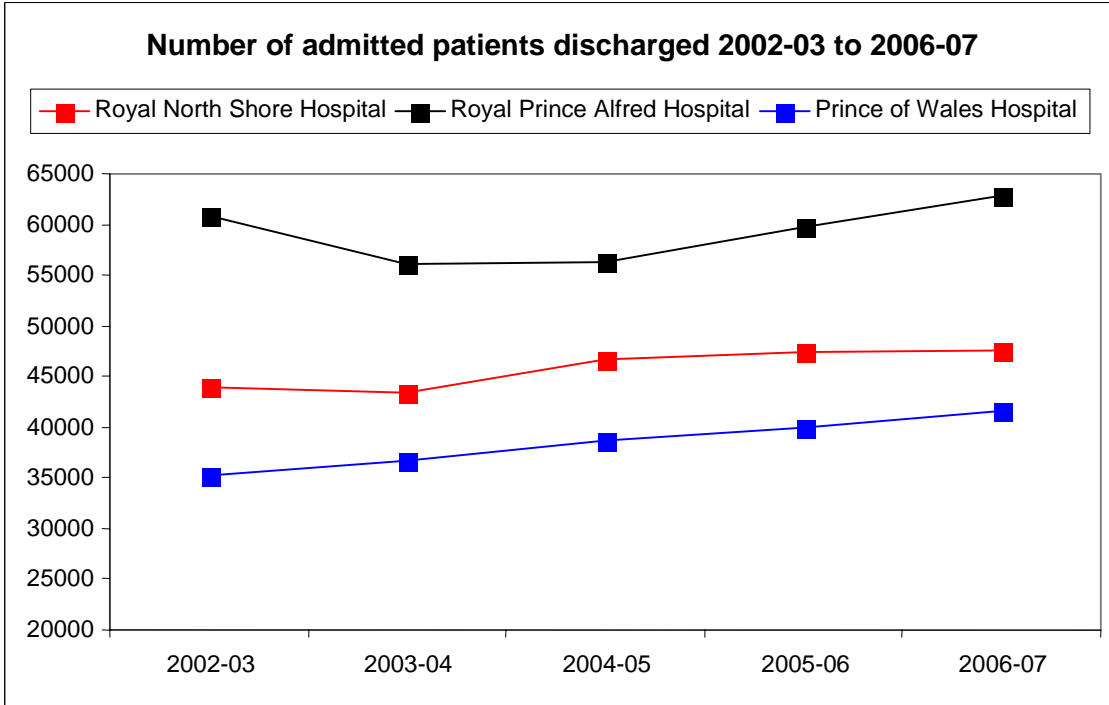
RESPONSE:

The following graph shows the actual number of complaints that were received about Royal North Shore Hospital, compared to other comparable hospitals – Royal Prince Alfred and Prince of Wales – over the years from 2002-03 to 2007-08.

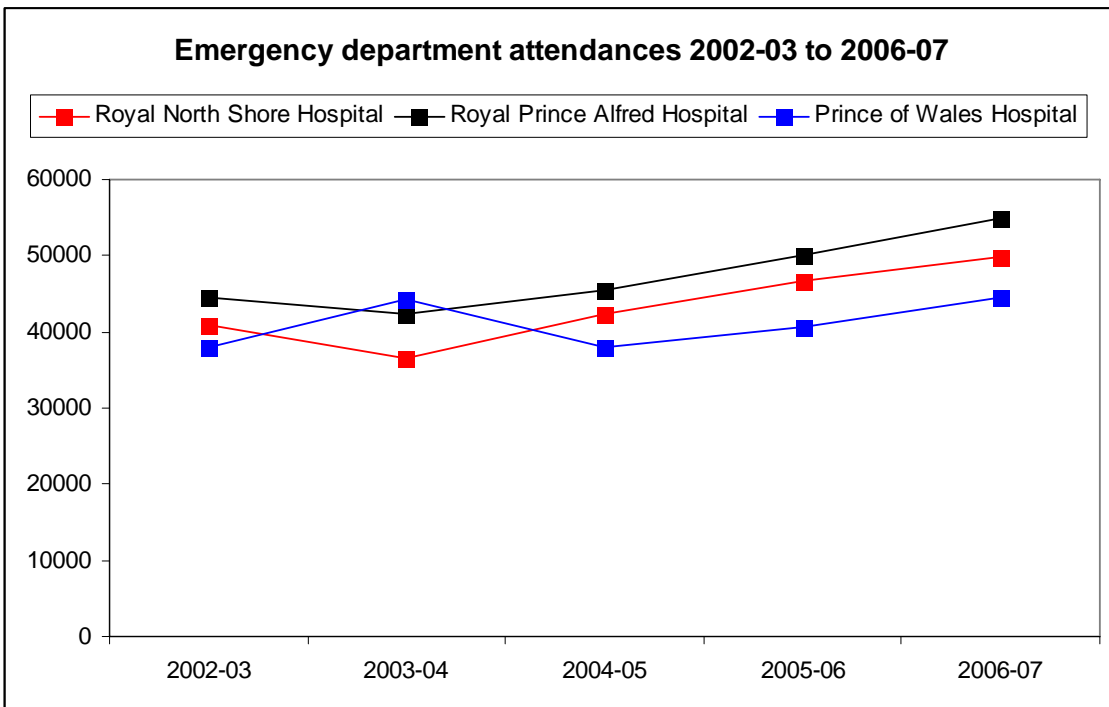


* Estimate based on data for the ten-month period from July 2007 to April 2008

It is unsafe to draw any conclusions from these numbers in light of the small number of complaints compared to the vast number of admissions and emergency attendances for each of the hospitals, as set out in the graphs below:



Data provided by the Department of Health



Data provided by the Department of Health

OTHER QUESTIONS TAKEN ON NOTICE

The Commission responded to an additional list of questions that were provided to the Commissioner following the hearing on Thursday 1 May 2008.

Question 1

How does the Commission see its main priority and goal in the receipt and handling of patient complaints?

Has the Commission taken into account any over-arching duty of care considerations in setting these?

RESPONSE:

The Commission's main priority and goal in the receipt and handling of complaints about health service providers – both individual health practitioners and health organisations – is specifically defined and mandated by the provisions of the *Health Care Complaints 1993*, as amended over the years.

The Commission's objects

Section 3 of the Act – 'Objects of this Act' – provides (emphasis added):

- (1) *The primary object of this Act is to establish the Health Care Complaints Commission as an independent body for the purposes of:*
 - (a) *receiving and assessing complaints ... relating to health services and health service providers in New South Wales, and*
 - (b) *investigating and assessing whether any such complaint is serious and if so, whether it should be prosecuted, and*
 - (c) *prosecuting serious complaints, and*
 - (d) *resolving or overseeing the resolution of complaints.*

- (2) *In exercising its functions under this Act, the Commission is to have as its primary object the protection of the health and safety of the public.*

Section 3A(2) of the Act – 'Outline of role of Commission and related government agencies in health care system' – also says the following in relation to the role of the Commission:

The Commission is an independent body with responsibility for dealing with complaints under this Act, with particular emphasis on the investigation and prosecution of serious complaints [about individual health practitioners] in consultation with relevant registration authorities.

Section 3A also outlines the respective complementary roles of a number of other specific individuals and bodies in the health care system – namely:

- the various registration authorities,
- the Director-General of the Department of Health, and
- public health organisations.

Criteria for the investigation of complaints

The statutory criteria for the determination by the Commission of whether or not any particular complaint about a health service provider should be investigated are set out in s 23(1) of the Act, which provides as follows:

The Commission must investigate a complaint:

- (a) if ... the appropriate registration authority is of the opinion that the complaint should be investigated, or*
- (b) if, following assessment of the complaint, it appears to the Commission that the complaint:*
 - (i) raises a significant issue of public health, or*
 - (ii) raises a significant question as to the appropriate care or treatment of a client by a health service provider, or*
 - (iii) if substantiated, would provide ground for disciplinary action against a health practitioner, or*
 - (iv) if substantiated, would involve gross negligence on the part of a health practitioner, or*
 - (v) if substantiated, would result in the health practitioner being found guilty of an offence under Division 3 of Part 2A of the Public Health Act 1991.⁵*

Section 18 of the *Health Care Complaints Act* specifically provides that, even though a complainant has withdrawn their complaint, the Commission must still continue to deal with the matter the subject of the complaint if it appears to the Commission that the matter satisfies one or more of the criteria for investigation set out above.

Furthermore, s 23(4) of the Act specifically provides that the Commission may investigate a complaint despite any agreement which the parties to the complaint may have reached concerning the complaint.

⁵ Division 3 of Part 2A of the *Public Health Act* creates the following scheme of statutory obligations and related criminal offences:

De-registered practitioners

There is a requirement that any advertising of health services by a de-registered practitioner specify that the practitioner has been de-registered – a breach of this requirement is a criminal offence.

A de-registered practitioner must also inform any potential client (or, where appropriate, their parent or guardian) and the practitioner's employer that their registration has been cancelled or suspended – any breach of this obligation is a criminal offence.

Persons subject to a prohibition order

The Commission, registration boards, courts and relevant tribunals have the power to issue orders prohibiting individual health practitioners from providing all or some health services, either permanently or for a specified period. It is an offence to provide a health service in contravention of a prohibition order.

There is also a requirement that any advertising of health services by a person the subject of a prohibition order specify the existence and nature of the prohibition order – a breach of this requirement is a criminal offence.

Furthermore, a person the subject of a prohibition order must inform any potential client (or, where appropriate, their parent or guardian) and any employer of the existence and nature of the prohibition order – again, a breach of this obligation is a criminal offence.

Against the background of the above discussion, it will be appreciated that, under the statutory regime, the Commission's overarching duty in dealing with, investigating and prosecuting complaints must be – and is – the protection of the health and safety of the public.

Question 2

With respect to the draft Code of Practice's value of 'High professional and ethical standards', what protocols exist within the Commission for the socialising (professional or otherwise) of Complaints and Resolution officers with members of the NSW medical profession and its associated professional bodies?

Question 3

With respect to the draft Code of Practice's value of 'Impartiality', what protocols exist for Liaison, Complaints and Resolution Officers to declare any conflict of interest before speaking to complainants and handling complaints?

RESPONSE:

Section 80(1) of the *Health Care Complaints Act* provides that one of the Commission's functions is to develop a 'code of practice' to provide guidance on the way in which the Commission intends to carry out all or some of its functions, after consultation with clients, health service providers and other persons who, in the Commission's opinion, have an appropriate interest.

Accordingly, the Commission's Code of Practice is largely designed to explain to the public and external stakeholders the way in which the Commission performs its role.

The Commission also has a Code of Conduct, which explains to the Commission's staff the requirements and expectations of staff in relation to the performance of their professional duties.

The Commission's current Code of Conduct contains the following information and advice about the issue of conflicts of interest (emphasis added):

Officers must avoid conflicts of interest between their personal interests and their official duties.

A conflict of interest arises where there is a likelihood that an officer with a particular personal interest could be influenced, or appear to be influenced, in the performance of his or her official duties. Officers should avoid any personal activity, association or financial dealing that could directly or indirectly compromise the performance of their duties, or be seen to do so.

Some examples of situations that may give rise to a conflict of interest include:

- having a financial interest in a health organisation or in the provision of health services, or having friends or relatives with such interests,
- having or developing personal associations with a complainant or a health practitioner involved in a complaint to the Commission, that goes beyond the level of a professional work relationship,

- *accepting outside employment that may, or may appear to, compromise the integrity of the officer or the Commission,*
- *participation in political matters that may relate to the affairs of the Commission.*

In many cases only the individual officer will be aware of the potential for conflict. Therefore, the onus is on the officer to consult with an appropriate senior officer if a potential or actual conflict of interest arises.

Where officers are uncertain whether any conflict of interest exists, as a general rule disclosure of a possible conflict of interest is always preferable. Consultation about a possible conflict of interest can be conducted on a confidential basis. Such consultation can do no harm, whereas a great deal of harm may be done if officers do not disclose interests, associations or activities which may embarrass the Commission.

After consultation, officers should abide by decisions made by the appropriate senior officer in relation to a conflict of interest. Some of the options available for resolving a conflict of interest are recording the details of the disclosure, requesting the officer to relinquish the personal interest, or removing the officer from duties in which the conflict arises.

Under s 30(2) of the Act, the Commission may not obtain an expert report from a person who has a financial connection with the health practitioner against whom the complaint is made.

The current Code of Code of Conduct has recently been the subject of review by the Commissioner and the other executive officers of the Commission – a draft of the revised Code has recently been provided to the staff of the Commission for consultation, discussion and feedback, and the terms of the Code will be finalised following the consultation process. The revised Code of Conduct will substantially reiterate the requirements of the current version of the Code of Conduct in relation to the issue of conflicts of interest.

Question 4

What guidelines are used or followed by Liaison/Resolution or Complaints Officers in the handling of complaints? Specifically, how does the Commission guide Officers in deciding whether or not they ought to progress matters to investigation?

RESPONSE:

In order to answer this question, it is necessary to outline the Commission's assessment process and procedures.

Following the receipt of a complaint, the complaint is subject to an initial assessment by the Director of the Assessment and Resolution Division and the Manager of Assessments. In the vast majority of cases, the complaint is allocated to an Assessment Officer with some instructions.

The Assessment Officer responsible for the file invites a response to the complaint from the health provider(s) the subject of complaint, and – where serious issues of clinical treatment are involved – also requests the provision of all relevant medical records. Following an examination of all of this material, the Assessment Officer may, if appropriate, seek advice from one of the Commission's internal medical advisers on the adequacy of the care and treatment of the patient.

The Assessment Officer then prepares an 'assessment brief' summarising the issues raised by the complaint; the nature and content of the material obtained through the assessment process; and their recommendation as to how the matter should be appropriately dealt with. Importantly, the Assessment Officer's recommendation as to whether or not the complaint should be investigated must have regard to the statutory criteria set out in s 23 of the *Health Care Complaints Act* for determining whether a complaint must be investigated (these criteria have already been set out above, in the response to Question 1).

The assessment brief is then considered by the officer's team leader and, following any necessary amendments to the brief, by the Manager of Assessments, who may also require amendments to the brief. Again, the team leader and Manager of Assessments will have regard to the statutory criteria for determining whether a complaint should be investigated.

The final version of the assessment brief is considered by the Director of Assessment and Resolution and the Commissioner. The Commissioner makes a determination as to whether the complaint should be investigated by reference to the statutory criteria for investigation. If the Commissioner decides that the matter should not be investigated, he then considers the most appropriate option available for dealing with the complaint – these options being no further action ('discontinuance' of the complaint); referral for assisted resolution; referral for conciliation; or referral to the appropriate registration authority or to some other suitable agency.

It should also be noted that, in the case of complaints about individual registered practitioners, the Commission is required to consult with the relevant registration authority before making a final determination as how the complaint should be dealt with. Where the registration authority is of the opinion that the complaint should be investigated – and notwithstanding a contrary view on the part of the Commissioner – the complaint must be investigated (ss 23(1) and 13 of the *Health Care Complaints Act*).

Question 5

What internal management systems exist to monitor complaints caseload management by Liaison or Resolution Officers?

Question 6

What is the current average caseload for individual Complaints and Resolution Officers, and how is this monitored?

Are officers rotated throughout the Commission?

RESPONSE:

The Commission's Assessment and Resolution Division is staffed by:

- Assessment Officers – who are responsible for the handling of the assessment of individual complaints,
- Resolution Officers – who are responsible for the assisted resolution of complaints where the Commission has, following assessment, determined that the complaint does not warrant investigation, and that assisted resolution is the appropriate option for the handling of the complaint.

Resolution officers are also responsible for:

- handling telephone inquiries to the Commission, and
- conducting reviews of files where the complainant has requested a review of the Commission's assessment decision.

Assessment Officers

The general process for the assessment of complaints has already been outlined above, in the response to Question 4.

The caseload for an Assessment Officer at any one time is about 45 to 55 complaint files.

Upon registration of the complaint in Casemate (which involves the allocation of a reference number for the complaint), a number of key steps for the handling of the file, and accompanying timelines within the statutory timeframe of 60 days for assessment, are created in the Casemate system as follows:

- file set-up,
- acknowledgement letter to the complainant,
- notification letter to the health service provider(s) the subject of complaint,
- assessment decision,
- assessment letters to complainant and health service provider(s).

On this basis, Casemate has the capacity to inform Assessment Officers – and their supervisors – as to when tasks are due to be completed and of overdue tasks.

Each team leader within the Assessment Branch audits the handling of the files being handled by the Assessment Officers within their team at days 21, 40, and 55 after the initiation of the assessment process, in order to check whether the tasks to be completed for the file within the relevant timeframes have been completed, and – if not – of the reasons for that.

Resolution Officers

The caseload for Resolution Officers is as follows:

- about 15 to 20 files at any one time for assisted resolution,
- two rostered four-hour shifts each week to respond to telephone inquiries, plus one or two four-shifts each week as 'back-up' for telephone inquiries,
- handling three to five 'review' files at any one time,
- conducting six to eight community presentations each year.

In relation to matters allocated to Resolution Officers for assisted resolution, the Commission monitors the handling of the relevant files as follows:

- A 'resolution management plan' is developed. On this basis, various key steps for the resolution process, and timelines for completion of those steps, are created in Casemate.
- Casemate generates reports about the timelines involved in the handling of particular files, and in relation to overdue tasks.
- The Manager of the Resolution Service conducts supervision sessions every six weeks to review of the handling of all files being dealt with by the Resolution Officers. This session focuses on whether the resolution management plan has been followed; whether there has been compliance with the timelines for the completion of the tasks required; and the quality of the officer's work. As part of the supervision session, the Manager also checks the accuracy and quality of five randomly audited inquiry calls recorded in Casemate.
- Following completion of the assisted resolution process (whether or not there has been a successful resolution of the matter), the Manager of the Resolution Service conducts a final audit of the file to ensure that all relevant data entry has been completed; that all relevant tasks have been completed; and that the outcome of the resolution process has been confirmed in writing to the parties to the complaint.

Rotation of officers

Staff within the various divisions of the Commission are not rotated throughout the Commission. Staff are recruited to fill particular positions on the basis that they are the most suitable applicant for that position, and have the particular knowledge and skills required of the position in question.

Nevertheless, where vacancies for positions become available, the Commission will seek expressions of interest from staff within the Commission who are at the appropriate grade and/or able to 'act' in the position in question. A number of Commission staff have been able to 'rotate' within or among the divisions of the Commission on this basis.

Question 7

With respect to the draft Code of Practice's value of 'Timeliness and responsiveness', does the Commission have Key Performance Indicators for Complaints and Resolution Officers for the handling, resolution and/or ending of complaints?

RESPONSE:

The Commission does have key performance indicators for the handling, resolution and finalisation of complaints.

The performance indicators for all divisions of the Commission are set out in 'Appendix A – Performance Report' to the Commission's 2006-07 Annual Report (at pages 118-121). The Commission's performance for the year 2006-07, as measured against those indicators, is also set out in detail in that Appendix.

With respect to Resolution Officers, the performance indicators are as follows:

- Percentage of matters resolved or partially resolved by the Resolution Service,

- Timeliness of the resolution process,
(Please note that the performance of the Resolution Service against this key performance indicator for 2006-07 is set out at page 41 of the Annual Report.)
- Percentage of Resolution Service clients satisfied with service.

Question 8

What, if any, reward or recognition is given to Complaints and Resolution Officers for the expedient closure of complaint files?

RESPONSE:

Recognition for good performance generally – including the timely handling of complaint files – can be and is given to officers by their supervisors through the Commission’s performance management program. There is and can be no monetary ‘reward’ for the expedient closure of complaint files – this would, of course, be contrary to the principles underlying the payment of the salary commensurate with the duties of the particular officer’s position.

Question 9

What is the average level of medical training and/or health care service expertise of complaint officers employed at the Commission? Although it is not necessary for the Commission’s Complaints Officers to have clinical experience, what training opportunities are available for staff to ensure that they are able to effectively and appropriately assess complaints?

RESPONSE:

It is – appropriately – the Commission’s internal medical advisers and experts that provide advice with respect to clinical issues and the adequacy of a health service provider’s care and treatment of the patient. The skills required of the Commission’s Assessment Officers, Resolution Officers, Investigation Officers and Legal Officers are necessarily analytical, resolution, investigative and legal skills respectively. Indeed, risks have been identified with Commission staff having a medical or some other care health care background that clouds the officer’s assessment and judgment in relation to particular matters. There can be a tendency for such officers to act on their own, less qualified, experience, and to not appreciate the weight of qualified expert advice. Of course, such officers cannot be called as expert witnesses in any prosecution.

Nevertheless, I would observe that some officers do have a health service background which may be of value in exercising the skills appropriate to their position. For example, one of the Commission’s investigation officers has had experience as a solicitor involved in litigation concerning alleged medical negligence/malpractice. Another investigation officer is on secondment from her position as a registered nurse.

Furthermore, there are opportunities for staff of the Commission to undertake training that will enhance the knowledge and skills required for their particular position. For example, the Commission recently approved the attendance of one of its officers at a course on medical terminology and forensic medicine.

Question 10

How many complaints reported by the Commission as closed or resolved are subsequently the subject of litigation?

RESPONSE:

The Commission is unable to provide any comprehensive response to this question, because the Commission has no statutory obligation to monitor, nor does it in practice monitor, whether complainants institute civil proceedings against health service providers and/or others in relation to their treatment by health service providers.

I should also note the following historical developments in this context:

In November 2000, a previous Committee on the Health Care Complaints Commission prepared a report entitled 'Report on mandatory reporting of medical negligence'. The Committee noted by way of background to its report that s 80(1)(j) of the *Health Care Complaints Act* required the Commission to 'investigate the frequency, type and nature of allegations made in legal proceedings of malpractice by health care providers', but that the Commission was unable to perform this function because there were no legal obligations on individuals and organisations which held the relevant information to report it to the Commission (see page 10 of the Committee's report).

Section 80(1)(j) of the *Health Care Complaints Act* was repealed in 2004 with the New South Wales Parliament's passing of the *Health Legislation Amendment (Complaints) Act 2004*.

Appendix 1 – Committee Minutes

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No 6)

Thursday 6 March 2008 at 1.10 pm
Parliament House

Members Present

Hon Helen Westwood MLC (Chair); Dr Andrew McDonald MP (Deputy Chair); Hon David Clarke MLC; Mrs Judy Hopwood MP, Hon Fred Nile MLC.

In Attendance

Mr Mel Keenan (Committee Manager), Ms Jo Alley (Senior Research Officer), Ms Jacqui Isles (Committee Officer), Mr John Miller (Assistant Committee Officer)

The Chair opened the meeting at 1.05 pm.

1. Apologies

Hon Kerry Hickey MP, Mr Matthew Morris MP

7 (i) Review of the 2006-2007 Annual Report of the Health Care Complaints Commission – Terms of Reference

Resolved on the motion of Mrs Judy Hopwood MP, seconded by Hon Fred Nile MLC:

‘That in relation to the review of the 2006-2007 Annual Report of the Health Care Complaints Commission:

(a) The Committee’s report shall consist of:

- The questions on notice to the Commissioner;
- The corrected transcript of the evidence given by the Commission during the public hearing;
- Answers to the questions on notice, not provided during the hearing by the Commissioner but taken on notice;
- Relevant information (that is not confidential) as provided by the Commissioner in response to matters taken on notice during the hearing.

(b) The report, so comprised, be adopted as the report of the Committee and that it be signed by the Chair and presented to the House, together with the minutes of evidence;

(c) The Chair and Committee Manager be permitted to correct stylistic, typographical and grammatical errors.

7(ii) Date and Time of Examination:

‘That a public examination of the Commissioner be conducted by the Committee on a date to be confirmed after consultation by the Secretariat with Members.’

7(iii) Request and deadline for Commissioner’s responses:

‘That the Committee write to the Commissioner and request a written response to the questions by 1 April 2008’.

7(iv) Publication on website

‘That the Committee publish a notice and all relevant details concerning the Review of the 2006-2007 HCCC Annual Report on the website.’

8. Draft Questions on Notice concerning the 2006-2007 Annual Report:

Resolved on the motion of Mrs Judy Hopwood MP, seconded by Hon David Clarke MLC:

‘That the draft questions be considered *in globo* and adopted without amendment’.

**Minutes of Proceedings of the Committee on the Health Care Complaints Commission
(No 7)**

Friday 11 April 2008 at 8.30 a.m.
Parliament House

Members Present

Hon Helen Westwood MLC (Chair), Dr Andrew McDonald MP (Deputy Chair), Hon Kerry Hickey MP, Mrs Judy Hopwood MP, Mr Matthew Morris MP, Hon Fred Nile MLC.

In Attendance

Mr Mel Keenan (Committee Manager), Ms Jacqui Isles (Committee Officer), Mr John Miller (Assistant Committee Officer)

The Chair opened the meeting at 8.30 a.m.

1. Apologies

The Hon David Clarke MLC.

5. Review of the 2006-2007 Annual Report of the Health Care Complaints Commission.

The Committee noted the Commissioner's response to the Committee's Questions on Notice dated 1 April 2008, copies of which were distributed.

The meeting closed at 9.00 a.m.

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 9)

Thursday 1 May 2008 at 1.15 p.m.

Parliament House

Members Present

Hon Helen Westwood MLC (Chair), Dr Andrew McDonald MP (Deputy Chair), Hon David Clarke MLC, Hon Kerry Hickey MP, Mrs Judy Hopwood MP.

In Attendance

Mr Mel Keenan (Committee Manager), Ms Jacqui Isles (Research Officer), Mr John Miller (Committee Officer), Ms Kristie Matthews (Assistant Committee Officer)

The Chair opened the meeting at 1.15 pm

1. Apologies

Mr Matthew Morris MP and Hon Fred Nile MLC.

12. Public Hearing - Review of the 2006-2007 Annual Report of the Health Care Complaints Commission

The Chair declared the hearing open at 2.00 p.m. and welcomed the witnesses, Mr Kieran Pehm, Commissioner, Mr Bret Coman, Director of Investigations and Ms Karen Mobbs, Director of Proceedings. Mr Kimber Swan, Executive Officer, and Ms Katja Beitat were also in attendance.

The Chair asked the Commissioner whether he wished his submission to form part of the evidence to be given on the day and to be made public.

The Commissioner stated that he agreed. The Chair directed that the written responses to the questions on notice be attached to the evidence of the witness to form part of the evidence.

The Chair asked the Commissioner whether he agreed that his written responses be placed on the Committee website. Mr Pehm agreed. The Chair asked Committee Members whether they concurred with authorising publication of the submission. The Members agreed.

Mr Kieran Pehm, Commissioner, Mr Bret Coman, Director of Investigations, were sworn and Ms Karen Mobbs was affirmed. The Chair asked Mr Pehm whether he would like to make an opening statement. Mr Pehm did not wish to make a statement. The witnesses were examined.

Evidence concluded, the witnesses withdrew.

The Chair declared the public hearing closed at 3.20 pm

**Minutes of Proceedings of the Committee on the Health Care Complaints Commission
(No. 10)**

Friday 6 June 2008 at 8.30 a.m.

Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Dr Andrew McDonald MP (Deputy Chair), Hon David Clarke MLC, Mrs Judy Hopwood MP, Hon Fred Nile MLC.

In Attendance

Mr Mel Keenan (Committee Manager), Ms Jo Alley (Senior Committee Officer), Mr Jude Devesi (Committee and Research Officer on secondment), Ms Jacqui Isles (Research Officer), Mr John Miller (Committee Officer), Ms Lisa Kroesche (Assistant Committee Officer)

The Chair opened the meeting at 8.32 a.m.

3. Apologies

Hon Kerry Hickey MP; Mr Matthew Morris MP.

5. Review of the 2006-2007 Annual Report of the Health Care Complaints Commission

Moved by Dr Andrew McDonald MP, seconded by Hon Fred Nile MLC:

‘That the corrected transcript from the Public Hearing on 1 May 2008 be placed on the Committee’s website; and

‘That the Commissioner’s Answers to Questions Taken on Notice from the Public Hearing be placed on the Committee’s website.’

The Chair adjourned the deliberative meeting at 9.00 am.

**Minutes of Proceedings of the Committee on the Health Care Complaints Commission
(No. 11)**

Tuesday 24 June 2008 at 8.30 a.m.

Waratah Room, Parliament House.

**4. Review of the 2006-07 Annual Report of the Health Care Complaints Commission.
Consideration of Chair's Draft Report**

Moved Judy Hopwood MP, seconded by Andrew McDonald MP

‘That the draft Report be adopted *in globo* as the Report of the Committee and that it be signed by the Chair and presented to the House and that the Chair and the Secretariat be permitted to correct stylistic, typographical and grammatical errors’.

Publication of the Report

Moved Hon Fred Nile MLC, seconded by Judy Hopwood MP:

‘That, once tabled, the Report be placed on the Committee’s website.’

Appendix 2 – Internal Audit of Assessments, March 2007

1 Executive Summary

Introduction

As part of the internal audit services provided to the Health Care Complaints Commission ("HCCC" or "the Commission"), Deloitte Touche Tohmatsu ("Deloitte") has conducted an internal audit of the assessments process. The internal audit involved assessing the adequacy and effectiveness of the controls in place to mitigate the associated business risks relating to the assessment of complaints.

The engagement was performed in accordance with Australian Auditing Standard AUS 110, "Assurance Engagements Other than Audits or Reviews of Historical Financial Information." Further information in relation to the extent of the procedures performed and the scope of our engagement is detailed in Section 2, Terms of Reference and Section 6, Statement of Responsibility, respectively.

Background

The HCCC, established by the Health Care Complaints Act 1993 ("the Act"), is responsible for receiving and dealing with the following complaints:

- complaints relating to the professional conduct of health practitioners
- complaints concerning the clinical management or care of individual clients by health service providers, and
- complaints referred by a registration authority under a health registration Act.

During 2005/06 HCCC implemented major reforms following amendments to the Act which came into effect 1 March 2005. These included substantial organisational change, new internal processes and appointment of a new Director Assessments and Resolutions, as well as the introduction of an electronic case management system (CaseMate).

The volume and composition of complaints received in 2004/05 and 2005/06 have been summarised below.

Financial Year	Number of Complaints	Category								
		Access	Communication	Consent	Corporate Services	Cost	Grievances	Privacy/ Discrimination	Professional Conduct	Treatment
2004/05	2816	6.1%	9.2%	2.4%	3.6%	5.3%	0.5%	3.4%	23.6%	43.3%
2005/06	3023	6.8%	7.8%	1.7%	0.7%	5.2%	0.3%	3.4%	17.5%	56.8%

Source: 2004/05 and 2005/06 HCCC Annual Report

Complaints are assessed by the Assessment Team through a series of readings, analysis, discussion and consultation. The main stages through the assessment process include:

- Receiving and considering new complaints
- Recording and acknowledging complaints
- Collecting and considering information
- Assessment and consultation with Registration Boards
- Post assessment activities.

Assessment decisions are made by a committee consisting of the Commissioner, Director of Assessments and Resolution, Manager Assessment Team, Manager Resolutions, Health Complaints Registrar and the relevant Assessment Officer.

The outcomes of assessment decisions are outlined in the Act to include:

- Discontinuation (section 27)
- Assisted resolution (division 9)
- Referred to a registration authority (section 26)
- Investigation (section 23)
- Conciliation (division 8)

Under the Act, the Commission must carry out an assessment within 60 days of receiving a complaint. Complainants are also entitled to request a review of the assessment decision if they are not satisfied with the outcome. If the request for review is lodged within 28 days of the notification of the decision the Commission must review the decision, if it is received after 28 days the Commissioner has the discretion to refuse to review the decision.

The Assessments Team reports to the Director, Assessments and Resolution and consists of:

- Manager, Complaint Assessment Team
- Two Team Leaders
- Eight Assessment Officers
- Three Clerical Support Officers

Key Issues

Our Internal Audit found several key controls were in place over the assessments process during the internal audit period (April 2006 - October 2006) such as:

- Assistance to complainants in filing a written complaint through the HCCC Telephone Inquiry Service
- Complaint procedures available on the HCCC website
- Electronic case management tool- CaseMate
- Decision outcomes determined by the Assessment Committee
- Key Performance Indicators (KPI's) resulting from legislative requirements and internal benchmarks
- Monthly KPI monitoring
- Staff training on assessment criteria and procedures.

New control developments arising after October 2006 include:

- Finalisation of the Complaint Assessment Procedures Manual (the procedures manual)
- Development of an audit functionality in CaseMate
- Development of mail system and CaseMate exception interface.

During our internal audit period (April 2006 - October 2006), procedural changes were also implemented including:

- Trialling of post assessment phone calls to complainants prior to issuing a decision letter
- Requirement for an assessment brief to be drafted for all complaints received directly through HCCC

These new procedures were partially implemented during the audit period, potentially skewing the internal audit results. Management should take this into account whilst reviewing these results.

During our audit, the level of compliance to legislative requirement timeframes was assessed to be:

- 83% of our sample (12) were assessed within 60 days
- 100% of decision letters to complainants and providers were sent within 14 days. In addition, we note the HCCC has adopted the Plain English Style Guide for decision letters with a tone scale between Formal, Official and Officialese. Review of ten assessment decision letters identified the tone of letters ranged from Official to Officialese.

However, several areas were identified where there was opportunity for improvement and or enhancement of existing processes or controls. The key issues and improvement opportunities are summarised below and detailed further in Section 3 Business Issues.

Assessment Period (Important)

Sample testing of 12 complaints identified two which were not completed in the stipulated 60 day timeframe as required by the Act. We note HCCC has made substantial progress toward achieving assessment timeframes. Initiatives have been implemented to monitor the progress of complaints against the 60 day target including:

- Audit procedures to be conducted at 14 days, 42 days, 56 days and over 60 days.
- Individual employee performance indicators linked to timely completion

We support the initiatives HCCC have implemented to reduce the assessment period of complaints. We recommend management continue to actively monitor and manage the achievement of this KPI.

Assessment Briefs (Important)

Sample testing of 12 complaints identified nine which required assessment briefs to be generated. Of these nine, five (55%) assessment briefs were not evidenced. The four assessment briefs sighted were a combination of three text briefs and one electronic CaseMate generated briefs.

We understand brief preparation has undergone a series of continuous improvement stages to arrive at this current process in a relatively short period of time. We recommend HCCC now enforce the use of electronic system briefs for all complaints in the future.

Contacting the Complainant (Important)

Under section 20 of the Act, the Commission is to use its best endeavours to confirm with complainants the matters identified. Of the nine complaints sampled which were received directly through HCCC:

- Four (44%) lacked evidence of complainants being contacted by phone to clarify issues
- Seven (77%) lacked evidence of Assessment Officers contacting the complainant by phone post assessment.

Although it is not a requirement to contact complaints by phone after an outcome is decided, we understand this procedure was trialled as a response to a high level of requests for review of assessment decisions being processed.

We recommend management re-enforce the use of CaseMate file notes and process markers to document any communication with the complainant. Any attempts to contact the complainant or specific reasons as to why the complainant was not contacted should be documented.

HCCC should also review the correlation between post assessment contact and the level of requests for reviews of assessment decisions. If there is no correlation found between post assessment contact and the number of reviews, management should consider revising the procedure manual to make it optional to contact the complainant when an assessment is decided.

Internal Timeframes: Complaint Readings and Acknowledgement Letters (Important)

From a sample of nine complaints tested, the following exceptions from established timelines were noted:

- Six (66%) complaints were not initially assessed within two days of receipt (average period of three days, ranging between three to four days)
- Two (22%) complaints did not have a date of assessment on the Assessment Plan
- Five (55%) complaints were not acknowledged within five days of receipt (average period of 14 days, ranging from six to 25 days)
- Six (66%) complaints were not sent to the provider for notification within nine days of receiving complaint (average period of 16 days, ranging from 11 to 25 days).

Management should continue to actively monitor and manage the achievement of these KPIs. We note that a lack in compliance to internal procedures requiring initial assessment in two calendar days may not be feasible as a result of letters received on Fridays. We recommend HCCC consider the revision of the procedures manual to reflect a more realistic KPI of three days.

Engagement Rating System

Based on the scope of our engagement, HCCC's performance relevant to the assessment process is outlined below. This rating is based on observations made during the engagement, and in some areas these observations may have been limited by the scope of the work performed. The rating is intended to assist HCCC's senior management and the Audit and Risk Committee to focus on areas of greatest concern, and does not form part of our opinion.

5	Minimal opportunities for improvement identified.
4	A small number of minor control weaknesses / opportunities for improvement identified.
3	Several control weaknesses of concern identified.
	Significant control weaknesses found in a number of areas.
	Poorly controlled. Pervasive, significant weaknesses in controls identified.

Further, each issue within the report has been assigned a suggested priority of action as follows:

Priority Ranking	Explanation	No. of issues raised
Significant	A control weakness or an issue that exposes the organisation to an unacceptable level of risk and requires management's resolution within one month.	-
Important	A control weakness or an issue that exposes the organisation to risk, requires improvement and management's resolution within three months.	4
Minor	An issue which if unresolved may expose the organisation to risk or a recommendation that may be of benefit to the organisation's control environment.	2

Acknowledgements

We wish to place on record our appreciation of the assistance and co-operation received from various HCCC staff during the engagement.

Report Clearance

This report has been discussed with Mr Ian Thurgood, Director of Assessments and Resolutions.

Conclusion

Based on the work program described and the evaluation criteria set out in the Terms of Reference in Section 2 of this report, and except for the matters noted in Section 3 of our report nothing has come to our attention which causes us to believe the HCCC did not maintain in all material respects, effective control procedures in relation to the assessments process.

DELOITTE TOUCHE TOHMATSU



Rory O'Connor
Partner

2 Terms of Reference

Scope

The engagement involved an assessment of the adequacy and effectiveness of the controls in relation to the assessments process conducted by HCCC staff.

Our procedures were designed to provide limited assurance, as defined by AUS 110. Our procedures were limited primarily to inquiries of relevant personnel, inspection of evidence, and observation of, and enquiry about, the operation of procedures for a small number of transactions or events.

The engagement focused on complaints received 1 April 2006 – 30 September 2006.

Objectives

The objectives of the engagement were to:

- Assess the adequacy of existing controls and procedures to mitigate the associated business risks focusing on the following areas:
 - Compliance to established criteria and procedures for assessing complaints and making assessment decisions
 - Timeliness of assessing information
 - Management review and oversight of complaints assessed
 - Quality assurance processes
 - Efficiency and effectiveness of assessment processes
 - Records management for assessments and referral processes.

As part of our engagement, we also provided commentary, where applicable, on the efficiency of process and/or control design. Such commentary does not however provide assurance.

Methodology

The following procedures were completed during the engagement:

- Developed an understanding of the assessment process and determined the associated risks through discussion with relevant officers and reviewing policy and procedures and performing walkthroughs;
- Documented key processes and control procedures applicable to assessments;
- Developed and implemented a test plan and an appropriate sample sufficient to support the required level of assurance;
- Prepared recommendations to improve controls where required.

3 Business Issues

3.1 Assessment Period [Important]

Criteria

Section 22 of the Health Care Complaints Act 1993 stipulates all assessments are to be carried out within 60 days of receiving the complaint or 60 days from the receipt of further particulars (e.g. medical records, authorisation from subject of complaint).

Observation

Sample testing of 12 complaints identified two which were not completed in the stipulated 60 day timeframe. We note HCCC has made substantial progress toward achieving assessment timeframes. Initiatives have been implemented to monitor the progress of complaints against the 60 day target, including:

- Audit procedures to be conducted at 14 days, 42 days, 56 days and over 60 days.
- Individual employee performance indicators linked to timely completion.

Review of quarterly KPI reports for the first two quarters of 2006 indicates 85% of all complaints have met the 60 day target.

Cause

Cases allocated to Assessment Officers may be delayed as a result of complaints awaiting action from other parties such as advice from specialists or responses from the Health Service Provider. These are often outside the control of HCCC.

Business Implication

If complaints are not assessed within 60 days, HCCC is in breach of its required duties under the Act.

Recommendation

We support the initiatives HCCC have implemented to reduce the assessment period of complaints. We recommend management continue to actively monitor and manage the achievement of this KPI.

Management Response

Agreed

Responsible Officer

Director Assessments & Resolution

Timeframe

Ongoing

3.2 Assessment Briefs |Important|

Criteria

The procedures manual Function 3.9 requires the Assessment Officer to prepare an assessment brief using CaseMate.

Observation

Sample testing of 12 complaints identified nine complaints which required assessment briefs. Of these nine, five (55%) assessment briefs were not evidenced. These exceptions have been identified in Section 4.

The assessment briefs sighted were a combination of text briefs and electronic CaseMate generated briefs (three text briefs and one CaseMate brief).

Cause

Discussion with management has indicated the procedures for the creation of an assessment brief have been an evolving process. The generation of electronic briefs through CaseMate has only been implemented from approximately September 2006. Prior to this, Assessment Officers were asked to write narrative briefs. It is also noted in some cases, briefs are not completed if:

- It is clear through the second reading that the complaint does not have any underlying issues and should be discontinued
- The complaint is brought to the HCCC via a registration authority board consultation and immediately assessed as a discontinue or investigation.

Business Implication

Generation of a brief allows the issues to be clearly stipulated and analysed. Without a brief, all issues may not be identified and sufficiently explored. Attendees at the Assessment Committee or Registration Board consultations may not get a clear understanding of the issues arising.

Lack of documentation reduces the amount of evidence supporting a transparent and appropriate assessment process.

Recommendation

We understand brief preparation has undergone a series of continuous improvement stages to arrive at this current process in a relatively short period of time. We recommend HCCC now enforce the use of electronic system briefs for all complaints in the future.

Management Response

All complaints now need an electronic brief before they are assessed.

Responsible Officer

Director Assessments & Resolution

Manager Assessments

Timeframe

Implemented and completed

3.3 Contacting the Complainant [Important]

Criteria

Under section 20 of the Act, the Commission is to use its best endeavours to confirm with the complainant the matters identified. Function 3.1 of the procedures manual requires the Assessment Officer to liaise with the complainant within eight days of receipt of the complaint to clarify any issues.

The procedures manual in Function 5.3.2 also requires the Assessment Officer to inform the complainant of the assessment decision by phone.

Observation

Of the nine complaints sampled which were received directly through HCCC:

- Four (44%) lacked evidence of complainants being contacted by phone to clarify issues
- Seven (77%) lacked evidence of Assessment Officers contacting the complainant by phone post assessment.

These exceptions have been outlined in Section 4.

Discussion with management have identified the procedure to call all complainants after an outcome has been decided is a new procedure which was trialled as a response to a high level of requests for review of assessment decisions being processed.

Cause

There are certain instances where it is not possible to contact complainants directly eg lack of contact details. However, the exceptions noted above did not have any documented reason on file why the complainant was not contacted by phone.

Management believe not all complainants should be contacted by phone after an outcome is decided as some complainants may be aggravated by the call, exposing Assessment Officers to increased risk of unnecessary verbal abuse.

Business Implication

If the complainant is not initially contacted, there is an increased risk of misinterpreting facts and issues when assessing the complaint. Keeping the complainant informed of the progress of their complaint may also assist in a faster resolution of complaints.

The lack of communication between HCCC and complainants may result in the complainant being unsatisfied with the outcome as they may not respond as well to written responses. A greater amount of resources may be required to address the situation through increased number of reviews requested.

Recommendation

We recommend management re-enforce the use of CaseMate file notes and process markers to document any communication and attempts at contacting the complainant. Any attempts to contact the complainant or specific reasons as to why the complainant was not contacted should be documented.

HCCC should also review the correlation between post assessment contact and the level of requests for review of assessment decision. If there is no correlation found between post assessment contact and the number of review requests, management should consider revising the procedure manual to make it optional to contact the complainant when an assessment is decided.

Management Response

Casemate has been enhanced to capture if the complainant has been contacted to clarify issues, procedures manual has been updated, Manager to reinforce with Assessment officers.

Contacting the complainant to explain the decision has now been introduced to casemate with reasons being recorded why the complaint was not contacted. This is being monitored by Team leaders and the Manager.

Early indications are that this strategy of contacting the complainant is reducing the review of decision requests. This will continue to be monitored by the Director.

Responsible Officer

Team leaders

Manager Assessments

Director Assessments & Resolution

Timeframe

Completed and implemented, needs ongoing review

3.4 Internal Timeframes: Complaint Readings and Acknowledgement Letters [Important]

Criteria

HCCC has implemented a series of internal timeframes surrounding the front end of the assessment process to allow for the 60 day legislative timeframe to be met. These include:

- initial and second reading be conducted within two days of complaint receipt. (Procedures manual function 1.3 and 1.4)
- acknowledgement to be sent out to the complainant within five days of receipt. (Procedures manual function 2.6)
- notification letter be sent to the health service provider within nine days of receipt of the complaint. (Procedures manual function 3.1)

Observation

From a sample of nine complaints received directly through HCCC it was noted:

- Six (66%) complaints were not initially assessed within two days of receipt (average period of three days, ranging between three to four days)
- Two (22%) complaints did not have a date of assessment on the Assessment Plan
- Five (55%) complaints were not acknowledged within five days of receiving complaint (average period of 14 days, ranging from six to 25 days)
- Six (66%) complaints were not sent to the provider for notification within nine days of receiving complaint (average period of 16 days, ranging from 11 to 25 days).

Cause

HCCC have implemented internally generated KPIs within the procedures manual to ensure complaints are assessed and acknowledged as soon as possible to enable assessment a more flexible time frame.

Business Implication

HCCC may not meet the 60 day timeframe for assessment decisions as required by the Health Care Complaints Act 1993 if the internal process deadlines are not achieved.

Recommendation

Management should continue to actively monitor and manage the achievement of these KPIs. We note that a lack in compliance to internal procedures requiring readings in two calendar days may not be feasible as a result of letters received on Fridays. We recommend HCCC consider the revision of the procedures manual to reflect a more realistic KPI of three days.

Management Response

This KPI has now been increased to the recommendation of three days.

Responsible Officer

KPI to be monitored by Manager Assessments

Timeframe

Completed and implemented

3.5 Quality Assurance and Review [Minor]

Criteria

The procedures manual Function 3.6 identifies audit processes to be completed on a regular basis. A final quality assurance review is also conducted by the Manager Complaint Assessment Team as a post assessment activity as per Function 6.1.

Observation

Through discussion with management and review of complaint files, a lack of evidence of file review within assessments was noted for files which are sent to other teams within HCCC (e.g. files sent to investigation or conciliation/assisted resolution).

We understand a new audit procedure checklist is currently being implemented for audits at 14 days, 42 days, 56 days and over 60 days. However, this does not provide assurance of a final review at the completion of an assessment.

Cause

Evidence of a file review by the Manager Complaint Assessment Team is only captured for the files which are closed within the Assessments team. For complaints which are referred to other teams within the Commission no sign off is required by the Manager Complaint Assessment Team as evidence of file review.

Business Implication

Although management has identified that as part of the procedure, all files are reviewed by the Manager Complaint Assessment Team before being either closed or referred on, a lack of evidence supporting this review provides for an incomplete audit trail.

Recommendation

HCCC should continue the implementation of this quality assurance/audit process. Management should also consider the implementation of a final audit checklist to be completed by the Manager Complaint Assessment Team when the file review is conducted.

Management Response

The Manager Assessments has now developed a final audit checklist with each file receiving a final audit prior to being placed in storage or being referred to another part of the Commission. The Procedures manual has also been update to reflect this new practice.

Responsible Officer

Manager Assessments

Timeframe

Completed and implemented.

3.6 Policies and Procedures [Minor]

Criteria

Consistent and accurate documented policies and procedures are essential to maintaining a controlled environment surrounding any business process. Clearly documented policies and procedures provide guidance to staff in performing their responsibilities, reduce the risk of errors and minimise the occurrence of unaccepted practices.

Observation

We note the procedures manual has been under development from April 2006 till November 2006. It has been drafted to reflect the current practices employed throughout the assessment process.

Through review of this document, we have identified small areas for improvement to the procedures manual including:

- Inclusion of assessment criteria in the procedures manual
- Fine tuning internal KPIs to reflect attainable targets
- Increased explanation of the new audit process including sample audit checklists
- Increased guidance on the type of information required to be obtained whilst liaising with the complainant
- Inclusion or references to style guides and information requirements for letter writing.

Cause

The procedures manual was finalised during our internal audit fieldwork. As the manual is put into practice, refinements to the manual may be required.

Business Implication

Comprehensive policies and procedures are fundamental to the development of a strong control environment. If procedures manuals do not reflect the entire process, controls in particular areas may be less effective as a result of poor knowledge of the required procedures.

Recommendation

The procedure manual should be updated to include:

- assessment criteria
- internal KPI's reflecting attainable targets
- increased explanation of the new audit process including sample audit checklists
- increased guidance on the type of information required to be obtained whilst liaising with the complainant
- guidance on construction, tone and mandatory information (eg private and confidential markings, assessment review clause) in writing decision letters.

Management Response

To be addressed in the next update of the manual

Responsible Officer

Manager Assessments

Timeframe

June 2007

4 Documentation Exceptions

The table below lists complaint files examined that did not contain all relevant documentation.

Complaint ID	Exceptions			
	Assessment Brief	Pre-assessment contact with complainant	Post Assessment Instruction Sheet	Evidence complainant was contacted by phone post assessment
06/01823	x	x	x	x
06/01103	x	x		x
06/01518				x
06/01005	x	x	x	
06/01725				x
06/00497	x			x
06/01274	x	x		x
06/02164				x

5 Implementation Table

Please find below an action plan template, which is to be used for follow-up by HCCC. The purpose of this summarised action plan is to provide a reference and timeframe for the implementation of agreed management responses to the recommendations made by Deloitte in this report. In this regard, HCCC should ensure that the action plan is specifically based on each management response task identified in this report.

Ref	Recommendation	Proposed Action by Management	Officer Responsible	Target Date	Completion Date
3.1	We support the initiatives HCCC have implemented to reduce the assessment period of complaints. We recommend management continue to actively monitor and manage the achievement of this KPI.	Continued monitoring and three monthly reporting on the 60 day and 14 day timelines. Three monthly performance reviews with Assessment officer, team leader and the Manager Assessments.	Director Assessments & Resolution Team leader Manager Assessment	Ongoing next report end of March 2007 Three monthly next due end March 2007	Ongoing
3.2	We understand brief preparation has undergone a series of continuous improvement stages to arrive at this current process in a relatively short period of time. We recommend HCCC now enforce the use of electronic system briefs for all complaints in the future.	All complaints now require and electronic brief to be prepared before assessment.	Manager Assessment	March 2007	Feb 2007

Ref	Recommendation	Proposed Action by Management	Officer Responsible	Target Date	Completion Date
3.3	<p>We recommend management re-enforce the use of CaseMate file notes and process markers to document any communication with the complainant. Any attempts to contact the complainant or specific reasons as to why the complainant was not contacted should be documented.</p> <p>HCCC should also review the correlation between post assessment contact and the level of requests for review of assessment decision. If there is no correlation found between post assessment contact and the number of review requests, management should consider revising the procedure manual to make it optional to contact the complainant when an assessment is decided.</p>	<p>Case mate to be upgraded to capture this date and action reinforced with staff.</p> <p>Case mate to be upgraded to capture this date and action reinforced with staff.</p>	<p>Manager Assessment</p> <p>Director Assessment & Resolution</p>	<p>Mar 2007</p> <p>May 2007</p>	<p>Feb 2007</p>
3.4	<p>Management should continue to actively monitor and manage the achievement of these KPIs. We note that a lack in compliance to internal procedures requiring initial assessment in two calendar days may not be feasible as a result of letters received on Fridays. We recommend HCCC consider the revision of the procedures manual to reflect a more realistic KPI of three days.</p>	<p>Procedures manual to be updated to reflect the three days suggested by the review. KPI will be monitored on a three monthly basis.</p>	<p>Manager Assessments</p>	<p>Mar 207</p>	<p>Feb 2007</p>
3.5	<p>HCCC should continue the implementation of this quality assurance/audit process. Management should also consider the implementation of a final audit checklist to be completed by the Manager of Assessments when the file review is conducted.</p>	<p>Checklist to be developed.</p> <p>Procedures manual to be updated.</p>	<p>Manager Assessments</p>	<p>Jun 2007</p>	<p>Feb 2007</p>

Implementation Table

Ref	Recommendation	Proposed Action by Management	Officer Responsible	Target Date	Completion Date
3.6	<p>The procedure manual should be updated to include:</p> <ul style="list-style-type: none"> ▪ assessment criteria ▪ internal KPI's reflecting attainable targets ▪ increased explanation of the new audit process including sample audit checklists ▪ increased guidance on the type of information required to be obtained whilst liaising with the complainant ▪ guidance on construction, tone and mandatory information (eg private and confidential markings, assessment review clause) in writing decision letters. 	Manual to be reviewed.	Manager assessments	June 2007	

6 Statement of Responsibility

This report has been prepared in accordance with the terms contained in our agreement with the Health Care Complaints Commission dated 22 September 2006 and with Australian Auditing Standard AUS 110, "Assurance Engagements other than Audits or Reviews of Historical Financial Information" and subject to the following limitations:

- Our procedures were designed to provide limited assurance as defined by AUS 110, which recognises the fact that absolute assurance is rarely attainable due to such factors as the use of judgment in gathering and evaluating evidence and forming conclusions, and the use of selective testing, and because much of the evidence available to the auditor is persuasive rather than conclusive in nature.
- Because of the inherent limitations of any internal control structure, it is possible that errors or irregularities may occur and not be detected. Our procedures were not designed to detect all weaknesses in control procedures as they were not performed continuously throughout the period and the tests performed are on a sample basis.
- Any projection of the evaluation of the control procedures to future periods is subject to the risk that the systems may become inadequate because of changes in conditions, or that the degree of compliance with them may deteriorate.
- The matters raised in this report are only those which came to our attention during the course of performing our procedures and are not necessarily a comprehensive statement of all the weaknesses that exist or improvements that might be made. We cannot, in practice, examine every activity and procedure, nor can we be a substitute for management's responsibility to maintain adequate controls over all levels of operations and their responsibility to prevent and detect irregularities, including fraud. Accordingly, management should not rely on our report to identify all weaknesses that may exist in the systems and procedures under examination, or potential instances of non-compliance that may exist.
- This report has been prepared for distribution to HCCC only. We disclaim any assumption of responsibility for any reliance on this report to any other persons or users, or for any purpose other than that for which it was prepared.

Suggestions for improvement should be assessed by management for their full commercial impact before they are implemented.

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Appendix 3 – Internal Audit of Resolution Services, August 2007

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1 Executive Summary

Introduction

As part of the internal audit services provided to the Health Care Complaints Commission (HCCC or Commission), Deloitte Touche Tohmatsu (Deloitte) has conducted an internal audit of the Resolution Service. The internal audit involved assessing the adequacy and effectiveness of the controls in place to mitigate the associated business risks relating to the processes performed by the Resolution Service, specifically assisted resolution and review of assessment decisions.

The engagement was performed in accordance with Australian Auditing Standard AUS 110, "Assurance Engagements Other than Audits or Reviews of Historical Financial Information." Further information in relation to the extent of the procedures performed and the scope of our engagement is detailed in Section 2, Terms of Reference and Section 5, Statement of Responsibility, respectively.

Background

Resolution Service was formed in March 2005 resulting from the restructure of the HCCC. Prior to the restructure, informal resolution services were being provided by Patient Support Officers located within various Area Health Services.

The Resolution Service is responsible for:

- Assisted resolution services
- Review of assessment decisions
- Inquiry services
- Community promotion workshops

The volume of cases handled by Resolutions Service July 2006- April 2007 is summarised below:

Case Type	Cases Received	Cases Finalised
Assisted Resolution	356	371
Review of Assessment Decisions	192	253

Based on these statistics for 2006/07 provided by the Director, Assessments and Resolutions, cases received have declined from prior years. Discussion with management have identified the following reasons for the decline:

- Development of the inquiry service
- Use of assisted referrals
- Resolution of some cases during the assessment process

The scope of the audit focussed on assisted resolution and review of assessment decisions.

Assisted Resolution

Assisted resolution is a fluid process for which specified outcomes are not legislated. The main objectives of the process as set out in Division 9 of the *Health Care Complaints Act 1993* (Act) are to:

- Provide an alternate and neutral means of resolving complaints that is independent of the investigative process of the Commission
- Facilitate the resolution of complaints, including determining the most appropriate means of resolution having regard to the nature of the complaint and the expectations of the parties to the complaint
- Provide information to health service providers and members of the public on the complaints resolution functions of the Commission under the Act.

The HCC Act does not outline a timeframe for the completion of assisted resolution activities. It is at the discretion of the Resolution Officer and Manager to determine if all necessary action has been taken to resolve the matter. In 2005-06, 28.3% of cases were completed in 30 days, 73% within 90 days and 100% within a year[†].

Review of Assessment Decisions

Under Section 28 of the HCC Act, complainants are entitled to a right of appeal of an assessment decision. For an automatic review, an appeal must be lodged within 28 days of the notification. If the request is received after 28 days of notification, it is at the discretion of the Commissioner to grant a review.

The Resolution Service is independent to the assessment process and is responsible for review of assessment decisions. All requests for reviews of assessment decisions are considered by the Director, Assessments and Resolutions to ensure the requests are within the scope of legislation before being allocated to an officer for re-assessment.

Although the review process does not have a statutory timeframe, the Commission endeavours to complete reviews within 45 days.

Resolution Service consists of:

- Director, Assessments and Resolution
- Manager, Resolution Service
- Eleven Resolution Officers[†]
- One Clerical Support Officer (0.5 FTE)

The Resolution Service is the only part of the Commission which currently requests feedback surveys from participants. In the financial year 2006/07, approximately 335 surveys were sent with 163 responses as of May 2007. Survey results are published in HCCC Annual Reports and are also used as a performance management tool to improve HCCC services.

Key Issues

Our Internal Audit found several key controls were in place during 2006/07 such as:

- Resolution Management Plan (RMP) template
- Use of system Quality Assurance function for review of RMP
- Updated Resolution Service Procedures Manual
- Development of Review of Decision Procedures Manual
- Electronic case management tool - Casemate
- Casemate and Crystal Reporting tools

New controls arising from May 2007 include:

- Closure letters sent to all parties when resolution process is closed
- Formalisation of internal timeframe performance indicators
- Quality audit checklist to be completed in finalising reviews of assessment decisions.

However, some minor issues were identified where there was opportunity for improving the existing processes and controls. The areas noted for improvement relate to:

- Process timelines and monitoring compliance
- Surveying parties involved in the assisted resolution process
- Procedural consistency

[†] HCCC Annual Report 2005-06

[†] Only nine positions were filled at the time of the audit
Deloitte: Internal Audit of Resolution Services

- Finalisation and availability of procedures manuals.

The above issues are discussed in detail in Section 3 of our report.

Engagement Rating System

Based on the scope of our engagement, HCCC's performance relevant to the resolutions process is outlined below. This rating is based on observations made during the engagement, and in some areas these observations may have been limited by the scope of the work performed. The rating is intended to assist HCCC's senior management and the Audit and Risk Committee to focus on areas of greatest concern, and does not form part of our opinion.

5	Minimal opportunities for improvement identified.
4	A small number of minor control weaknesses / opportunities for improvement identified.
3	Several control weaknesses of concern identified.
	Significant control weaknesses found in a number of areas.
	Poorly controlled. Pervasive, significant weaknesses in controls identified.

Further, each issue within the report has been assigned a suggested priority of action as follows:

Priority Ranking	Explanation	No. of issues raised
Significant	A control weakness or an issue that exposes the organisation to an unacceptable level of risk and requires management's resolution within one month.	-
Important	A control weakness or an issue that exposes the organisation to risk, requires improvement and management's resolution within three months.	-
Minor	An issue which if unresolved may expose the organisation to risk or a recommendation that may be of benefit to the organisation's control environment.	4

Acknowledgements

We wish to place on record our appreciation of the assistance and co-operation received from various HCCC staff during the engagement.

Report Clearance

This report has been discussed with Mr Ian Thurgood, Director, Assessments and Resolution.

Conclusion

Based on the work program described and the evaluation criteria set out in the Terms of Reference in Section 2 of this report, and except for the matters noted in Section 3 of our report nothing has come to our attention which causes us to believe the HCCC did not maintain in all material respects, effective control procedures in relation to the resolution service processes.

DELOITTE TOUCHE TOHMATSU



Rory O'Connor, Partner

2 Terms of Reference

Scope

The engagement involved an assessment of the adequacy and effectiveness of the controls in relation to the management of the Resolution Service.

Our procedures were designed to provide limited assurance, as defined by AUS 110. Our procedures were limited primarily to inquiries of relevant personnel, inspection of evidence, and observation of, and enquiry about, the operation of procedures for a small number of transactions or events.

The engagement encompassed referrals to the Resolution Service 1 July 2006 to 30 April 2007.

Objectives

The objectives of the engagement were to:

- Assess the adequacy of existing controls and procedures to mitigate the associated business risks relating to resolving complaints and reviewing assessment decisions referred to the Resolution Service; specifically giving focus to the following areas:
 - Compliance to the HCC Act 1993 and established procedures for assisting with resolution of complaints and determining resolution strategies
 - Timeliness of processing and finalising complaints and assessment review requests referred to the resolution service
 - Management review and oversight of referrals received and resolution outcomes and assessment review results
 - Quality assurance processes
 - Efficiency and effectiveness of the Resolution Service processes
 - Records management for the resolution and assessment review processes.

As part of our engagement, we also provided commentary, where applicable, on the efficiency of process and/or control design. Such commentary does not however provide assurance.

Methodology

The following procedures were completed during the engagement:

- Developed an understanding of the assisted resolutions process and determined the associated risks through discussion with relevant officers and reviewing policy and procedures and performing walkthroughs;
- Documented key processes and control procedures applicable to resolution services processes;
- Developed and implemented a test plan and an appropriate sample sufficient to support the required level of assurance;
- Prepared recommendations to improve controls where required.

3 Business Issues

3.1 Process Timeliness [Minor]

Criteria

HCCC Resolution Service Procedures Manual outlines specific timeframes for completion of tasks:

- **Function 2.2** “Contact with each party must be attempted within seven days of receipt of the case information”

The HCCC Review of Decision Procedures Manual also proposes a timeframe of 45 days to complete reviews.

Observation

Sample testing of ten resolution cases and five review files identified the following exceptions:

- Three of ten cases reviewed did not contact parties within seven days

Case Number	Process Start Date	Contact Made with provider (date)	Contact made with complainant (date)	Time taken to contact
06/02238	2-Mar-07	16/03/07	16/03/07	11 days
07/00419	7-May-07	22/05/07	22/05/07	14 days
07/00006	22-Mar-07	22/03/07	2/04/07	8 days

Review of the Resolution Service Timeline Analysis report identified approximately 40% of cases were completed within two months. The average completion time for the cases selected in our sample was 48 days.

- Two of four closed review files were not completed within 45 days

Case Number	Process Start Date	Process End Date	Time taken to complete
06/01572	01-Sep-06	02-Nov-06	48 days
06/02339	24-Jan-07	30-Mar-07	66 days

Cause

Specific timeframes were only identified and enforced as part of the procedure manual update in May 2007.

Business Implication

Without sufficient monitoring and enforcement of timeframes, HCCC service targets may not be met.

Recommendation

We recommend management monitor compliance to the defined timeframes as part of performance management of Resolution Officers.

Management Response

Casemate key performance indicator (KPI) reports will be developed to monitor the resolution process through its various stages.

Responsible Officer

Director Assessments and Resolutions, Manager Resolution Services and Manager IT

Timeframe: December 2007

* Process start date has been based on casemate note completed dates
Deloitte: Internal Audit of Resolution Services

3.2 Use of Surveys [Minor]

Criteria

Resolution Service surveys each party (Consumers and Providers) once the assisted resolution process has been closed.

Observation

Currently, satisfaction surveys are sent to parties involved in the resolution process in a separate request. A Resolution Officer may elect not to send a survey if:

- Complainant is unwell or a reminder of the incident may significantly interfere with their well being
- Provider has received one or more surveys in the last six months
- A party has declined involvement in the assisted resolution process.

Testing of eight completed resolution cases identified four marked to not receive a survey form. From reviewing the case files, reasons supplied for not sending a survey were not in line with accepted reasons in the procedures manual.

Cause

Although a review of file is conducted to ensure survey requests are sent in accordance with HCCC policies there remains a level of subjectivity placed on surveys requested.

Business Implication

Subjectivity in obtaining feedback from participants may skew results. It reduces the integrity of analysis outcomes and may limit the effectiveness of surveys as a feedback mechanism for performance management and future process improvements.

Recommendation

We recommend HCCC consider sending surveys in conjunction with closure letters to each party to remove subjectivity in selection of survey participants and streamline the process.

Management Response

Agreed. Management actions include:

- Survey forms to be redesigned
- Results of Survey forms to be available via Casemate reports.

Responsible Officer

Director Assessments and Resolutions, Manager Resolution Services and Manager IT

Timeframe

December 2007

3.3 Procedural Consistency [Minor]

Criteria

The HCCC Resolution Service Procedures Manual outlines specific actions to be undertaken throughout the resolution process:

- *Function 3.2.1* "Resolution Management Plan (RMP) is drafted and attached to case file as a linked document"
- *Function 6.1.4* "Write to both parties to confirm the resolution process is being closed"

The HCCC Review of Decision Procedures Manual states:

- *Function 1.4.1* "A Review Plan is developed which outlines the timeline for the review. The Review Plan is linked in Casemate and a hard copy attached to the file. Each section of the Review Plan is to be signed off and the KPI recorded."

Observation

Sample testing of ten resolution cases and five review files have highlighted several areas of procedural inconsistency including:

- Use of RMP linked document
Three of ten resolution cases did not use a linked RMP document. However, it was noted a shortened RMP was written in the case notes within Casemate. All cases however did have an RMP prepared. The requirement for a linked RMP has only been recently enforced.
- Preparation of a resolution closure letter
Four of ten resolution cases were identified where a closure letter was not sent. We do note in every case all parties were contacted by phone. We understand this is a new procedure and thus some exceptions were expected as the new process is rolled out.
- Development of a Review Plan
One of five review files did not have a Review Plan prepared. Discussion with management identified a lapse in control procedures during staff absence. We also note the hard copy of the Review Plan requires date draft is completed; however this stage is not captured in Casemate.

Cause

Discussion with management has identified the process for writing closure letters as well as generating linked RMP documents was not made mandatory until the release of the procedures manual in May 2007. The review procedures are still to be fine tuned.

Business Implication

Inconsistency in documentation reduces transparency in the process. Consistent procedures form a solid basis to support that due process was undertaken through the complaints resolution and review processes. Casemate is not being effectively used for capturing all stages of the Review Plan to assist in reporting and monitoring the performance.

Recommendation

We recommend HCCC re-enforce new procedures to staff involved and concentrate on monitoring compliance during the transition period. Management should consider aligning Casemate with all stages of the manual Review Plan to assist in capturing and monitoring key performance indicators.

Management Response

Agreed. The Casemate resolution processes to be reviewed. Procedures are also discussed during team meetings.

Responsible Officer

Director Assessments and Resolutions, Manager Resolution Services and Manager IT

Timeframe

March 2008

3.4 Policies and Procedures [Minor]

Criteria

Latest versions of policies and procedures should be readily available to all staff members.

All personnel involved in the re-assessment of cases should be independent from the original decision process to prevent a perceived conflict of interest.

Observation

During the internal audit, it was noted both the Resolution Service Procedures Manual and the Review of Decision Procedures Manual are currently being updated. As a result, the procedure manuals were not available on the intranet for staff to access. However it was noted hardcopy manuals were provided to all staff as well as being available on the shared drive.

The process of reviewing decisions is being re-assessed. The current procedure is for the Director, Resolutions and Assessments to conduct the first reading to grant or deny a review. If a review is granted, the Director sends a notification of review to the complainant. This may be viewed as a conflict of interest as the Director was involved with and signed the original decision.

Examination of the Review of Decision Procedure Manual also identified limited guidance on letter writing style and structure. A letter template is provided as an attachment to the procedure manual; however there is no reference to letter writing structure and style in the body of the manual. In addition, we note the HCCC has adopted a tone scale for review letters between Formal, Official and Officialese. Analysis of four review closure letters identified the tone was Officialese which indicate HCCC may need to look at lightening the tone.

Cause

We note the Review of Decision Procedures Manual is a work in progress.

Business Implication

Without finalised policies and procedures to adhere to, consistency in the process may not be achieved.

The current procedure for starting a review process may be perceived as a conflict of interest. Complainants may believe their case is not being reassessed fairly and without bias.

Recommendation

1. We recommend management finalise and approve both procedures manuals as soon as practical. These should be uploaded to the HCCC intranet for staff to access. Development of guidance on writing style and editorial standards should also be considered.
2. Management may also consider moving the role of the first reading and review from the Director, Assessments and Resolution to the Manager, Resolution Service. This will eliminate any perceived conflict of interest.

Management Response

1. Agreed. A style guide has been developed to provide further guidance when writing HCCC correspondence. Procedure manual for review of assessments will be finalised after the casemate process for review has been reviewed.
2. Management has considered the recommendation and decided no further action will be taken as the Director of Assessments only performs an administrative role. Any decision to decline a review is made by the Commissioner.

Responsible Officer

Director Assessments and Resolutions

Timeframe

December 2007

4 Implementation Table

Please find below an action plan template, which is to be used for follow-up by HCCC. The purpose of this summarised action plan is to provide a reference and timeframe for the implementation of agreed management responses to the recommendations made by Deloitte in this report. In this regard, HCCC should ensure that the action plan is specifically based on each management response task identified in this report.

Ref	Recommendation	Proposed Action by Management	Officer Responsible	Target Date	Completion Date
3.1	We recommend management monitor compliance to the defined timeframes as part of performance management of officers.	Casemate key performance indicator (KPI) reports will be developed to monitor the resolution process through its various stages.	Director Assessments and Resolutions, Manager Resolution Services and Manager IT	December 2007	
3.2	We recommend HCCC consider sending surveys in conjunction with closure letters to each party to remove subjectivity in selection of survey participants and streamline the process.	Agreed. Management actions include: <ul style="list-style-type: none"> ▪ Survey forms to be redesigned ▪ Results of Survey forms to be available via Casemate reports. 	Director Assessments and Resolutions, Manager Resolution Services and Manager IT	December 2007	
3.3	We recommend HCCC re-enforce new procedures to staff involved and concentrate on monitoring compliance during the transition period. Management should consider aligning Casemate with all stages of the manual Review Plan to assist in capturing and monitoring key performance indicators.	Agreed. The Casemate resolution processes to be reviewed. Procedures are also discussed during team meetings.	Director Assessments and Resolutions, Manager Resolution Services and Manager IT	March 2008	

Ref	Recommendation	Proposed Action by Management	Officer Responsible	Target Date	Completion Date
3.4	<p>We recommend management finalise and approve both procedures manuals as soon as practical. These should be uploaded to the HCCC intranet for staff to access. Development of guidance on writing style and editorial standards should also be considered.</p> <p>Management may also consider moving the role of the first reading and review from the Director, Assessment and Resolutions to the Manager, Resolution Services. This will eliminate any perceived conflict of interest.</p>	<p>1. Agreed. A style guide has been developed to provide further guidance when writing HCCC correspondence. Procedure manual for review of assessments will be finalised after the casemate process for review has been reviewed.</p> <p>2. Management has considered the recommendation and decided no further action will be taken as the Director of Assessments only performs an administrative role. Any decision to decline a review is made by the Commissioner.</p>	Director Assessments and Resolutions	December 2007	

5 Statement of Responsibility

This report has been prepared in accordance with the terms contained in our agreement with the Health Care Complaints Commission dated 22 September 2006 and with Australian Auditing Standard AUS 110, "Assurance Engagements other than Audits or Reviews of Historical Financial Information" and subject to the following limitations:

- Our procedures were designed to provide limited assurance as defined by AUS 110, which recognises the fact that absolute assurance is rarely attainable due to such factors as the use of judgment in gathering and evaluating evidence and forming conclusions, and the use of selective testing, and because much of the evidence available to the auditor is persuasive rather than conclusive in nature.
- Because of the inherent limitations of any internal control structure, it is possible that errors or irregularities may occur and not be detected. Our procedures were not designed to detect all weaknesses in control procedures as they were not performed continuously throughout the period and the tests performed are on a sample basis.
- Any projection of the evaluation of the control procedures to future periods is subject to the risk that the systems may become inadequate because of changes in conditions, or that the degree of compliance with them may deteriorate.
- The matters raised in this report are only those which came to our attention during the course of performing our procedures and are not necessarily a comprehensive statement of all the weaknesses that exist or improvements that might be made. We cannot, in practice, examine every activity and procedure, nor can we be a substitute for management's responsibility to maintain adequate controls over all levels of operations and their responsibility to prevent and detect irregularities, including fraud. Accordingly, management should not rely on our report to identify all weaknesses that may exist in the systems and procedures under examination, or potential instances of non-compliance that may exist.
- This report has been prepared for distribution to HCCC only. We disclaim any assumption of responsibility for any reliance on this report to any other persons or users, or for any purpose other than that for which it was prepared.

Suggestions for improvement should be assessed by management for their full commercial impact before they are implemented.

Deloitte Touche Tohmatsu is a Swiss Verein (association), and, as such, neither Deloitte Touche Tohmatsu nor any of its member firms has any liability for each other's acts or omissions. Each member firm is a separate and independent legal entity operating under the names "Deloitte," "Deloitte & Touche," "Deloitte Touche Tohmatsu," or other, related names. The services described herein are provided by the member firms and not by the Deloitte Touche Tohmatsu Verein.

Appendix 4 – HCCC Code of Practice

HEALTH CARE COMPLAINTS COMMISSION CODE OF PRACTICE



About the Commission

The Health Care Complaints Commission was established in 1994 as an independent body to deal with complaints about health service providers in NSW.

The scope of our work is governed by the *Health Care Complaints Act* (the Act). We strictly comply with the provisions of the Act.

Why have a Code of Practice

The Code of Practice provides practical guidance on the way we carry out our functions. The Code of Practice has been developed through consultation with representatives from consumer organisations, health services, employees of health employers and other government agencies.

The Code of Practice does not replace the provisions of the Act nor any other current legislation.

The Code of Practice will be modified periodically to reflect changes in experience and public interest.

To whom the code applies

The Code of Practice applies to all staff of the Commission, including the Commissioner, the Directors and Managers, the Health Conciliation Registrar and the Director of Proceedings.

The Code of Practice also applies to all consultants engaged by the Commission.

Objective

The Commission independently deals with complaints about health service providers in NSW by assessing and resolving complaints when possible. We also investigate and prosecute serious complaints.

We consult closely with the health registration boards when handling complaints to ensure the best possible protection of the public health and safety.

In exercising our functions as an independent body, our primary objective is the protection of the health and safety of the public.

The services of the Commission

Responding to inquiries

We respond to inquiries by people concerned about health service provision by an individual health practitioner or health service organisation.

Our Inquiry Service provides information to potential complainants and discusses strategies on how to resolve their concerns without the need to lodge a formal complaint.

The Inquiry Service may suggest more appropriate avenues to address concerns.

The Inquiry Service may assist a person to lodge a complaint with the Commission.

Assessing complaints

We assess complaints about health service provision in order to determine the most appropriate way to deal with the concerns.

We clarify the issues with the complainant, explain the complaint process and obtain all relevant information needed to determine the most appropriate action, if any, to take in order to deal with the complaint.

Resolving complaints

We aim to resolve those complaints that do not raise significant issues of public health and safety that would warrant investigation.

We may be able to resolve complaints during the assessment phase by providing the response of the health service provider to the complainant and thus satisfy their need for clarification.

We may also refer complaints for conciliation by the Health Conciliation Registry, or for assisted resolution by Resolution Officers of the Commission.

Investigating complaints

The Commission must investigate complaints that raise significant issues of public health and safety or significant questions about the care provided.

In relation to individual practitioners, we must investigate complaints that, if substantiated, would provide grounds for disciplinary action or involve gross negligence.

When we investigate serious complaints against health organisations, we may finalise the investigation by making recommendations to the provider. Recommendations are aimed to instigate long-term improvements in health services. In such cases, the

critical issue is of systemic nature and not the conduct of an individual practitioner.

Investigations are conducted in a timely, independent, impartial manner. We respect the rules of procedural fairness and provide a fair opportunity to respond to any proposed adverse outcomes.

Reviewing complaints

We respect the right of complainants to request a review of the decision regarding their complaint.

We review our assessment of a complaint while dealing with it.

We may also review and amend both the issues raised in a complaint and the persons involved in a complaint, whenever this is supported by new relevant facts.

Prosecuting serious complaints

The Commission prosecutes complaints against individual practitioners where the Director of Proceedings has made a determination in accordance with statutory criteria that a complaint should be prosecuted before a disciplinary body.

The Director of Proceedings determines the most appropriate forum for disciplinary proceedings taking into account

- ▶ the evidence gathered during the investigation
- ▶ the nature of the complaint
- ▶ the likely outcomes.

In conducting all prosecutions and other legal proceedings, the Commission acts with complete propriety, fairness and in accordance with the highest professional standards.

Our Values

We acknowledge that the trust and confidence of the public are essential to our role. We therefore set for ourselves a high standard of professionalism and place ethical conduct at the core of our operations.

Our work is based on the following core values:

Independence

The Commission acts independently by handling complaints without direction from any person or body.

Accountability

We are accountable for our work. We regularly report to the Minister for Health, the Joint Parliamentary Committee on the Health Care Complaints Commission, and professional and key consumer bodies.

We report annually to the general public about our work and trends in complaints in our Annual Report.

The Joint Parliamentary Committee on the Health Care Complaints Commission oversees the management of our processes. The Commissioner is responsible to the Minister for Health for the management of the Commission.

Impartiality

We handle complaints impartially. In the process of determining the most appropriate action in dealing with a complaint, we act on all relevant evidence.

We deal with the parties to complaints, as well as other persons and organisations, without bias and in a fair, co-operative and respectful manner.

Accessibility

People from all parts of the community should feel confident that they have a complaints body that is accessible, impartial and available. We ensure the accessibility of our services to everyone, and will act with flexibility in order to accommodate special needs. This includes:

- ▶ Assisting people with disabilities (accessibility of the building, TTY access).
- ▶ Providing information about the Commission in 20 community languages for people from non-English speaking backgrounds, and arranging interpreting and translation services when required.
- ▶ Helping people to lodge a complaint, when required.

Timeliness and responsiveness

We perform our work in a timely manner and adhere to the statutory timeframes set out in the Act; this includes usually assessing a complaint within 60 days.

We explain our processes and the reasons for our decisions.

We also keep all persons who are involved in a current complaint updated about the progress of the complaint.

Confidentiality

We observe and respect the privacy of parties to complaints and others and act strictly within the framework of relevant legislation.

Comments on our service

We encourage comment on our services from those involved in a complaint process by surveying their satisfaction when finalising a complaint.

We also invite you to provide your general feedback, by sending your compliments or complaints to hccc@hccc.nsw.gov.au or LMB 18, STRAWBERRY HILLS NSW 2012. You can also call us on 9219 7444 or toll free on 1800 043 159.

If you are dissatisfied with the outcome of your complaint

As a complainant, you may request in writing a review of the Commission's assessment decision on your complaint. The request should be made within 28 days of receiving the letter notifying you of the assessment decision. Please address your request for review to the Director of Assessment or the Commissioner.

If your complaint was investigated and you are dissatisfied with the outcome of the investigation into an individual health practitioner, you may request a review of the Commission's decision. Please address your request for review to the Director of Investigation or the Commissioner.

If you are dissatisfied with the Commission or its staff

Please write your complaint to the Commissioner, if you:

- ▶ are dissatisfied with way the Commission handled your complaint
- ▶ are dissatisfied with the conduct of a Commission staff member
- ▶ believe that this Code of Practice has been breached.

We will properly investigate your complaint and take appropriate action. If we cannot satisfy your concerns, we will advise you of other ways to pursue your complaint.

Appendix 5 – Draft Complaint Issue Categories

Draft Issues Categorisation

status: 19/2/2008

New Category	New Sub category	Definition	Old category
Communications & Information			
	Attitude	Provider's manner is rude; discourteous; negative; lacks sensitivity; or is patronising or overbearing. (Excludes 'Discriminatory conduct').	Communication
	Special needs not accommodated	Interpretative or special needs services not provided eg. spoken language, sign language, disability support.	Communication
	Inadequate information provided	Information is inadequate; incomprehensible; difficult to understand due to jargon, or other barriers; or is incomplete or information was not provided.	Communication
	Incorrect/misleading information provided	Information is wrong; incorrect; misleading; or conflicting. (Excludes 'Consent not Informed/Failure to Warn' and 'Information on Costs').	Communication
Consent			
	Involuntary admission or treatment	Where concerns are raised about the way a community order was obtained or issues relating to the treatment provided under the order. The admission or treatment of a patient when not indicated or required. Also detained, scheduled under a Mental Health Act.	Consent
	Consent not obtained or inadequate	The consumer was not involved in decision-making in relation to any aspect of treatment or care. Treatment provided or action taken without the consent of the patient or the patient's legal representative. The patient was not competent to consent; did not understand the information; was coerced; or the consent was not specific to the treatment performed. (For inadequate consent which would be required from a professional body, please see 'Treatment' -> 'Unauthorised treatment').	New
	Uninformed consent	Includes lack to warn about complication risks associated with the procedure or treatment when obtaining consent. Not enough information was given for the patient to make an informed choice regarding treatment options. (Excludes 'Inadequate Information').	Consent
Discharge & Transfer Arrangements			
	Delay	Delays occurred in the transfer or discharge of the patient.	New
	Patient not reviewed	Patient discharged or transfer from facility without review; discharged without appropriate discharge summary; the patient's VMO or GP was not advised of the discharge.	New
	Inadequate discharge	Premature discharge or transfer; refusal to discharge or transfer, inadequate discharge planning; or transfer to unsuitable facility.	Access
	Mode of transport	Where the facility used inappropriate transport to transfer the patient.	New

Medical Records			
Access to/transfer of records	The provider does not provide access to medical records or does not provide them in the format requested. Includes where records have been disposed of in an incorrect manner e.g. left at a dump, left by a provider who has left a practice or the provider has died without proper arrangements being made for the transfer or disposal of the records	Privacy/Discrimination	New
Record keeping	Poor quality or inadequacy of record keeping or information not recorded in the patient medical record. (Where records have been tampered with see 'Professional conduct' under illegal practices).	Professional Conduct	

Medication		part of Treatment	
Administering medication	Where a medication is delivered in the incorrect way eg IV -v- IM injection or where the wrong drug is administered or to the wrong patient. Medicine was not received	New	
Dispensing medication	Where a pharmacist dispenses the wrong medication or the wrong dose of medication or to the wrong patient	New	
Prescribing medication	Where a doctor prescribes the wrong medication. Inadequate knowledge of medication prescribed. Over prescribing of medication. Includes adverse reactions if they were the result of a prescribing error. Practitioner refuses to prescribe medication. Practitioner does not seek/have authorisation to prescribe medication. (For drug misuse by a practitioner, see 'Professional conduct' -> 'Drug misuse')	New	
Supply/security/storage of medication	Where medication is not supplied or stored appropriately and secure. Where the labelling of the medication is insufficient, wrong or misleading.	New	

Reports/Certificates		part of Professional Conduct	
Cost of report/certificate.	Issues relating to the cost of a report or certificate.	New	
Accuracy of report/certificate.	The quality of the report/certificate does not meet an acceptable standard and is not addressing the request. (For false fraudulent reports/certificates, see 'Professional conduct' -> 'Issuing falsified certificated/reports').	New	
Timeliness of report/certificate.	Delays in providing the report or certificate.	New	
Refusal to provide report/certificate	The provider refuses to provide a report or certificate	New	

Privacy / Confidentiality			
Inappropriate disclosure of information	Where private health information was released without the consent of the patient. Where private health information was disclosed to another party who was not authorised to receive the information. Where information was deliberately released without consent.	New	
Refusal to release information	Where the provider refuses to release information although consent is valid	New	

Environment/Management of the Facility		Corporate Services
Access to facility	Physical access to the facility is not appropriate.	New
Cleanliness/hygiene of facility	Hazards in physical environment; unclean or unsanitary conditions; unsafe storage of sharps. (Excludes 'Infection Control').	Corporate Services
Administrative processes	Relates to issues such as loss of records (excluding medical records), staff not following correct procedures regarding making of appointments, follow-ups, results and complaints.	Corporate Services
Statutory obligations/accreditation standards not met	Where a facility does not meet statutory, regulatory, OH&S or prescribed standards. Where a safe environment for patients, staff and/or visitors is not provided.	New
Physical environment of facility	Services and physical environment provided during a patient's visit or stay. Includes car parking; cleaning; catering; grounds; laundry; maintenance; security and accommodation; noise and lighting; signage.	Corporate Services
Staffing and rostering	Where the staffing is inadequate to provide appropriate care. Staff is not qualified to provide the required level of care.	New

Fees, Costs & Rebates		Cost
Billing Practices	Fee or account is too high including unnecessary provision of services. Unfair/unsatisfactory billing practices including item numbers used to disadvantage; insufficient or wrong information on bill; extra fees for services normally included in a global fee; unreasonable penalties for late payment; refusal to consider financial circumstances; etc. issues with bulk billing, payment schedules and fees related to public/private election fall within this category	Cost
Access to Government rebate	Government subsidies for treatment or services are unavailable or inadequate. For example, schedule fee, availability of drugs under PBS, travel and accommodation subsidy.	Cost
Financial consent	Information about costs was not offered prior to treatment; or the information was partial, misleading or incorrect.	Cost

Grievance Processes		Grievances
Information about complaints procedures not provided	Where the provider fails to provide information about their complaints procedure or denies access to the procedure.	New
No response to complaint/s lodged	Where there has been no response to the complaint raised.	New
Inadequate response to complaint	Inadequate response to a complaint made directly to a provider by a patient.	Grievances
Reprisal/retaliation as result of complaint lodged	Any direct or indirect action or threat of action against a patient, or detrimental change in treatment or care as a result of the complaint; or disadvantage in employment for staff who lodge a complaint or report or who give information about a complaint.	Grievances

Professional Conduct		Professional Conduct
Assault	Where a provider is alleged to have verbally or physically assaulted a patient.	Professional Conduct
Boundary violation	Where a provider has entered into an inappropriate personal relationship with a patient, which exceeds the bounds of professional practice. (Any sexual offences are covered by 'Sexual misconduct'. Physical abuse is covered under 'Assault')	New
Breach of condition	Where a registered provider fails to comply with any conditions on their practice and/or fails to advise of any such conditions where relevant e.g. to employers, registration boards, accreditation and privileges bodies and professional partners.	Professional Conduct
Competence	A standard of practice is not met because of the lack or note using of clinical knowledge; skills; judgement or care.	New
Discriminatory conduct	Conduct, which would constitute discrimination under anti-discrimination legislation and similar statutes.	Privacy/Discrimination
Annual declaration not completed	To be used when nurses or other practitioners have not completed their annual declaration at time of re-registration.	Professional Conduct
Financial fraud	Where a provider obtains a financial benefit by fraud, or uses their position to exploit a benefit from their patient	Professional Conduct
Impairment	A standard of practice is not met due to mental or physical conditions related to drug or alcohol additions; mental illnesses; physical impairment; or illness to a degree where it impinges on a provider's ability to practise safely.	New
Illegal practice	Alleged breaches of trade practices law; deceptive claims; extortion; criminal actions; fraudulent claims of curative properties; or dishonesty. (Excludes "Financial Fraud"). Where the provider is making false and misleading claims in their advertising	Professional Conduct
Issuing falsified certificated/reports	The provision of a report without an appropriate consultation being conducted or the medical history reviewed, backdating of sick certificates or issuing a certificate which is false. (For delayed/ inadequate reports, see 'Reports/certificates').	Professional Conduct
Misrepresentation of qualifications	Where a provider misrepresents their qualification or provides a service, which they are not qualified to provide. Assuming bogus qualifications.	New
Scientific fraud	Where a provider falsifies or misrepresents their scientific findings	New
Drug misuse	The inappropriate prescribing and administration of scheduled drugs or drugs of addiction to self or others for purposes other than treatment. (For prescribing errors, see 'Medication' -> 'Prescribing').	New
Sexual misconduct	Any touching of a sexual nature or any sexual relationship with a consumer whether or not initiated by the consumer; or behaviour such as gestures or comments that are sexually demeaning to a consumer.	Professional Conduct

Treatment		Treatment
Attendance	An appointment was not kept.	Access
Unexpected treatment outcome	Where treatment results in an adverse outcome for the patient which was unexpected. Excludes adverse outcomes due to prescribing errors (see 'Medication' -> 'Prescribing')	New
Coordination of treatment	Uncertainty about who is managing the patient; no one taking overall responsibility for the patient; conflicting decisions; or poor communication between providers about treatment or care. Where there is no advice from a more senior person sought regarding the proposed treatment from a supervisor/peer before the commencement of the treatment or where it was not attempted to seek advice or contact the on call supervisor when it would have been reasonable to do so. Includes also cases where advice was not provided or refused.	Treatment
Delay in treatment	Delays in treatment or admission including delay in attending. For example, long waits in emergency department or waiting rooms. (Excludes 'Waiting Lists')	Access
Diagnosis	Missed, wrong or inadequate diagnosis; or investigation not adequate.	Treatment
Unauthorised treatment	Where the treatment provided was not appropriately authorised. For example where treatment requiring the consent of the Ethics Committee was delivered without such consent. (For cases where the patient's consent was not obtained, see 'Consent' -> 'Consent not obtained or inadequate').	New
Appropriate referral not made	Where there is no referral made to an appropriate provider or service or when the referral is not made in a timely manner.	Access
Emergency treatment not provided	No treatment in an emergency situation was provided.	Access
Inadequate consultation	Where the length of time or location for the consultation was inadequate. Where the provider performs an examination which does not appear to be related to the condition the patient presented with. (For attitude or communications issues see "Communication")	Privacy/Discrimination
Inadequate treatment	Where the treatment is incomplete or the treatment falls below the standard expected of a competent practitioner.	Treatment
Inappropriate care	Where the care (not treatment) provided by nursing or other staff was below standards reasonable expected, for example in relation to changing bed sheets, washing, provide assistance to use the toilet.	New
Incorrect treatment	The incorrect or inappropriate choice of therapy has been made (but not where proper therapies are performed wrongly).	Treatment
Infection control	Inadequate measures taken to control sources of infection; sterilise equipment; or to adhere to standard (universal) precautions.	Treatment
Excessive treatment	Where treatment, test or consultations are in excess of those that should be reasonably provided for the condition.	New

Public/private election	Where the treatment is affected by the type of election made, whether the patient had an opportunity to make an informed choice about that election. (For cases where no financial consent to public or private election was obtained, see 'Consent' -> 'Financial consent').	Cost
Refusal to treat	Refusal by an institution or health provider to accept a person as a client, or refusal to provide a service where a service is available.	Access
Rough and painful treatment	Rough treatment or unnecessary pain inflicted during an examination or treatment.	Treatment
Waiting lists	Unreasonable wait for elective surgery, other treatment or service; or further postponement after a date has been set. (Excludes 'Delay in Admission or Treatment').	Access
Withdrawal of treatment	Removal of treatment; or denial of additional treatment or service perceived to have a therapeutic benefit. (Excludes 'Refusal to treat').	Treatment