

PARLIAMENT OF NEW SOUTH WALES



Committee on the Health Care Complaints Commission

8TH MEETING ON THE ANNUAL REPORT OF THE
HEALTH CARE COMPLAINTS COMMISSION

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FUNCTIONS OF THE COMMITTEE

The Joint Committee on the Health Care Complaints Commission was appointed in 1994. Its functions under Section 65 of the *Health Care Complaints Act 1993* are:

- a. to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act;
- 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.

The Joint Committee is not authorised:

- 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.

CHAIRMAN'S FOREWORD

I present this report of the 8th Meeting on the Annual Report of the Commissioner of the Health Care Complaints Commission as required by Section 65(1)(c) of the *Health Care Complaints Act 1993*.

This is the fifth Meeting on the Annual report produced while I have been Chairman of the Committee. Following the March 2003 election there has been a significant change in the Committee membership. I welcome new members: the Hon David Clark MLC; Ms Tanya Gadiel MP; the Hon Christine Robertson MLC; Mr Allan Shearan MP and Mr Russell Turner MP. I also welcome back the Hon Dr Peter Wong MLC, a member of the previous Committee. Appearing before the Committee for the 8th Meeting were both the Commissioner Amanda Adrian and Assistant Commissioner Julie Kinross.

This report covers the key issues raised during the meeting this year: interactions with both complainants and respondents; delays in investigation of complaints; conciliation of complaints; patterns in types of complaints received; benchmarking of performance; organisational changes within the HCCC; and improvements in performance reporting.

There were a number of significant improvements in reported outcomes of the Health Care Complaints Commission in the Annual Report for the 2001/2002 year and these are discussed within this report. However, in regard to three important areas: delays in investigation times; achieving a greater degree of field based investigations; and better performance reporting the record of the Commission is once again disappointing.

The "Moving Forward" project commenced in January 2001 and was discussed with the Commissioner at the annual general meetings held in 2001, 2002 and again this year. At each meeting the Commissioner repeated assurances that investigation timeframes would be addressed (see Summary of Key Issues – Delays in Investigation, page 3).

The "Moving Forward" project aimed to cut investigation timeframes however it seems so far to have had no discernable result. Unacceptable investigation timeframes have been an ongoing concern of this Committee since its establishment and in light of the large funding increase the Commission has received the failure of the Commission to produce any improvement in this area is disappointing.

It has also been frustrating that the Committee has not been able to discern whether the Commission has actually increased its degree of direct contact with both complainants and respondents. The Committee has received many complaints over the years from health professionals under investigation whose only contact with the Commission has been by way of written letter. Factual misunderstandings and further delays have often been the result.

Supplementary information supplied by the Commissioner after the meeting indicated that in 2001-2002 some 58 per cent of complainants were interviewed and 36 per cent of respondents. However, there is no indication given as to whether these interviews were merely done over the telephone or even what the definition of an "interview" actually is.

The Committee has requested that the Commission provide clarification of this issue as well as up to date statistics on the number of complaints and timeframes for investigations. It can only be hoped that this supplementary information, which will also be included in the HCCC 2002-2003 Annual Report which is soon to be tabled in Parliament, will show some significant improvement in the areas of concern.

In relation to the measuring and reporting of performance the Committee's ongoing concern is that the Commission's current approach to annual reporting does not present a clear picture of whether the Commission actually achieved what it projected it would for the year.

The Committee engaged expert consultant to the Public Bodies Review Committee, Mr John Chan Sew, to analyse the HCCC Annual Report in terms of accountability reporting. His analysis and recommendations for improvement have been forwarded to the Commission and are included within the body of this report.

Reported outcomes which the Commissioner noted in particular include: a levelling out of formal complaints and telephone enquiries received by the HCCC during the year, a trend consistent with other Australian and New Zealand jurisdictions; a significant reduction in the number of complaints assessed for investigation; and implementation of organisational change arrangements as per the Commission's Strategic Directions 2002-2005 model.

The Committee was pleased to note these improvements and others responding to the Committee's previous suggestions. However it urges the need for:

- strengthened reporting in relation to current legislative requirements
- improving the current approach to performance measurement (benchmarking) and reporting
- addressing ongoing deficiencies in the Report; and
- restructuring the form and content of the Report to provide for better accountability.

Overall, once again the Commission's failure to address many of its ongoing problems during the reporting year has been disappointing. The explanations put forward at the Annual General Meeting for this are familiar. Assurances have been made in previous years that changes at the Commission are being implemented and that these would result in improvements. It is clear that there is need for major change to the Commission's operations. The Committee's report into Investigations and Prosecutions undertaken by the Commission which is due to be finalised soon will be commenting in more detail about this and making recommendations for reform.

Mr Jeff Hunter MP
Chairman

SUMMARY OF KEY ISSUES

Delays in Investigations

The Committee noted that, as part of its “Moving Forward” project which commenced in early 2001, the HCCC sought additional funds to address as a priority the backlog in investigations along with other administrative changes.

In June 2002, the Commissioner commented that the HCCC had been successful in receiving an increase of \$1.4m on the recurrent budget for 2002-2003. The Committee noted that the HCCC also received additional *pro rata* funds of \$800,000 in 2001/2002.

The Committee had previously indicated that it anticipated as a matter of priority and as a result of the additional resources secured by the Commission a lifting of the Commission’s performance in addressing the backlog of investigation of complaints.

In this regard, the Committee was pleased to note the Commissioner’s comments at the annual general meeting about a significant reduction in the number of complaints assessed for investigation, down from 335 in 2000-2001 to 212 in 2001-2002. However the Committee believes that, contrary to the Commissioner’s view, the targeting of investigations does need to be regarded as the primary task of the Commission. The Committee bases this belief upon the statutory role of the Commission and a backlog of complaints for investigation that continues to remain high. In 2001-2002, the Commissioner reported that the ‘disposal rate’ for complaints was 107, which she noted was an “improvement rate over the last two years where the disposal rate was 103 in 2000-2001 and 54 in 1999-00”.

The Committee is concerned that, cognisant of its concern about the investigation of complaints as a primary focus, the Commissioner was unable to quantify the component of additional resources which have been directed into the investigation of complaints. The Commissioner indicated at the annual general meeting that resources had been invested in skill development and recruitment of investigation officers; in case management; the patient support service and in the Commission’s new database, but that there was no breakdown into specific allocations for the investigations area.

In supplementary information supplied to the Committee by the Commissioner following the Annual General Meeting via a letter dated 20 October 2003 the Commissioner said that an additional \$267,000 had been directed into investigations.

The Committee would expect that a breakdown of allocated expenditure, addressing in particular the investigation of complaints, should be provided in the future as an indication of the Commission’s prioritisation of activities. The Committee notes that such a breakdown is provided, for example, in the Annual Report of the New South Wales’ Ombudsman.

However the Committee was pleased to note that there are now no unallocated investigations, where there were 250 unallocated investigations in the previous financial year.

Last year, the Committee indicated concern at the high number of investigations open (328) which had remained open for more than eighteen months. These matters involved some 510 practitioners. At this meeting, the Commissioner indicated that the number of practitioners and services under investigation had fallen to 347, although the Committee was unable to

ascertain the date at which this figure was representative. Further, no figure was available for the number of investigations remaining open after eighteen months. The Committee notes that it would like to review this figure as a comparative indicator of performance and has written to the Commissioner seeking more information.

The “Moving Forward” project which commenced in January 2001 aimed to cut investigation timeframes. The project was discussed with the Commissioner at the Annual General Meeting in 2001, again in 2002 and at this year’s meeting.

In 2001 the Commissioner told the Committee that the Commission was *...currently realigning and investigating a lot of (their) resources into trying to bring down the investigations that have been going on for some years.* The Commissioner also said that: *I think there is a point in the (annual) report where we actually do talk about the timelines in relation to investigations. Your point is well made and I think that it is not a secret and I have given the Committee an assurance on a number of occasions that I am taking active steps to try to bring down the number of old investigations. We have currently a major strategy in place where we are actively wrestling down the older investigations while at the same time managing the current ones....*

At the 2002 meeting, the Commissioner repeated the assurance that she would *confront some of the particular challenges confronting the Commission, including reducing the significant backlog of investigations that had built up over the years [and] shortening the length of time that investigations take.* The Commissioner also said that: *by my estimation we should be seeing some significant rewards, not necessarily dramatically at the end of the 2001-2002 reporting year, but definitely by the end of the 2002-2003 year.*

It was further noted that this year the organisational structure identified to best deliver the key elements of the strategic directions has been progressively implemented. However, at this year’s meeting the Commissioner also commented: *I am pre-empting the next Annual Report that the survey results around our investigations are not wonderful. They do highlight issues around delays and things like that.*

The Commission’s Annual Report indicated that only one investigation of a health service and 33 investigations of health practitioners were completed within the seven to twelve month time standard. In response to a query about this, the Commissioner noted that achievement of the one-year turnaround was unlikely in the immediate future – *until we get the back log of investigations and those unallocated investigations out of the way, these figures will probably not change substantially for a year or two.*

The Committee believes that the HCCC should be attempting to establish performance targets for investigations, that is, nominating a percentage of investigations it aims to complete within a given period and report annually against the anticipated performance.

The Committee was similarly concerned that the Commissioner could provide no figure for the number of field-based investigations undertaken by the Commission during the year. The Commission had been previously criticised for largely undertaking desk-based inquiries, leading to delays and avoidable errors in the investigation process.

The Commissioner indicated to the meeting that the Commission is conducting 'more and more active' inspection, visiting of sites, working more actively with clinicians and with respondents. However the Committee was concerned that in the absence of any estimate by the Commission of the extent to which this is occurring, the Committee cannot form a view as to the extent more active investigations are taking place.

The Commissioner subsequently provided supplementary information after the meeting to indicate that in the 2001-2002 financial year 58 per cent of complainants and 36 per cent of respondents were interviewed by the Commission. There has been no indication as to whether these interviews were actually done face to face or merely over the telephone. The Committee is still also unclear what an "interview" actually consists of.

The Committee has requested that the Commission provide clarification of this issue as well as up to date statistics on the number of complaints and timeframes for investigations.

Conciliation of Complaints

The Commissioner outlined for the Committee examples of the HCCC's role in the direct resolution of complaints, indicating that this enabled a flexible and immediate response in complaints assessment and referral to patient support officers within a day or so.

Increasing numbers of complaints are being referred to the Health Conciliation Registry. The ongoing challenge is obtaining the consent from the parties to participate in that conciliation. The Commissioner indicated that one reason for this is "the way our *Act* is structured in that there is such importance placed on investigation within it as a means of resolving complaints which I would like to see addressed in the future ..."

The Commissioner noted that staff within the Commission are being encouraged to understand the importance of conciliation and work with the Health Conciliation Registry to try and engage the parties. The Commissioner commented that improvement to the number of referrals to the Health Conciliation Registry is welcome. The Commissioner particularly noted the increased flexibility of the Health Conciliation Registry to meet parties' needs, including going out to the place where the conciliation needs to occur and developing a greater range of conciliators from multicultural backgrounds and regional areas. The role of the Commission in assisting with the selection of these conciliators was also indicated.

Types of Complaints

When the HCCC receives and assesses written complaints these are categorised. The HCCC received 7% fewer complaints in the reporting period than in the previous year. Clinical standards was again the category with by far the greatest number of complaints at 1,404 or 52.5% of total. Quality of care was the next highest category at 337 or 12.9% of total (down from 16.2% on the previous year); followed by business practices 248 or 9.3% of total; prescribing drugs 124 (4.6%); patient rights 104 (3.6%); provider-consumer relationship 95 (3.6%) and impairment 91 (3.4%).

The HCCC reports a large increase in complaints about inadequate treatment, from 221 in 2000/01 to 340 in 2001/02. The number of complaints about hospital admission on mental health grounds reportedly doubled from 16 to 27. Complaints concerning inappropriate discharge, premature discharge or refusal to admit decreased, according to the report.

Complaints about fees reportedly increased from 69 to 84.

The number of complaints received about health services increased marginally by 23 or 3%. Complaints about public hospitals fell by 45 or 9%. The HCCC notes that this is the first time for many years that complaints about public hospitals has fallen below 50% of all health services complaints.

The Committee sought the Commissioner's comments on the trends indicated by these figures. The Commissioner suggested that the trend for complaints in the category of clinical standards is indicative of consumers willing to remark upon clinical standards and quality of care provided to them by health providers. She indicated that there is nothing in these trends that surprises in any way.

An increase in complaints about fees is attributed to changes within the health system such as shortened length of stays, people coming into hospital on the day of surgery or for day surgery, etc. The Commissioner believes that in these circumstances anaesthetists may not have the opportunity to discuss fees with patients, or hospitals do not coordinate the information for patients with surgeons and anaesthetists. While the increase in complaints about fees is small, the HCCC is in discussion about the issue with the Australian Competition and Consumer Commission, which is noticing a similar trend.

Communications with Parties to Complaints

The Commissioner noted that the HCCC is now conducting interviews with both respondents and complainants at the end of an investigation. Although it is not clear whether this is routine in every case. The information being currently gathered will be reported by the Commission in the coming year.

The HCCC engaged external assistance to provide advice about the reliability of questions to be included in the two surveys. There is currently no external review of the survey.

The Committee noted that it is considering producing a report on the HCCC's consumer/stakeholder satisfaction rating. It sought assistance from the Commission in terms of access to survey participants under the same arrangements as it did for a previous Health Conciliation Registry satisfaction survey. For that survey, participant details remained confidential and de-identified. The Commissioner indicated that, provided privacy considerations were addressed, the Commission would be pleased to cooperate in such an exercise.

The Commissioner noted that a formal review process within the Commission provides qualitative information about health service investigations.

The Committee indicated that the reported percentage in the Annual Report of written complaints about the HCCC was incorrect. The Commissioner later agreed with this. There were 49 written complaints out of a total of 2673 written complaints, 1.8 per cent of the total.

Patient Support Officers

The Committee was pleased to note the achievement of additional funding for three new Patient Support Officer positions around the State and the aim to establish those positions in 2002/03. The Commissioner reported that the Patient Support Officers have now been appointed. They are based at Lismore, Dubbo and Wollongong and serving the surrounding areas.

The Committee indicated that it had previously expressed a need to see more detailed information on the performance assessment of Patient Support Officers, preferably against benchmarked objectives. The Committee discussed with the Commissioner the potential for formalising a performance reporting process with CEOs of Area Health Services about the patient support service. This is seen to be important because of the differential performance of PSOs reported to the Committee in past inquiries.

HCCC Organisational Changes

The Committee noted that the Annual Report referred to expenditure of effort in staff training, review of organisational values and on piloting strategies. It asked the Commissioner whether there was any breakdown of staff time expended on these areas. However, the Commissioner indicated that information was unavailable. The Committee believes that undertaking such an analysis would be valuable as an effectiveness indicator of available work hours for core duties. It might also assist in providing a balance against the perception reported to the Committee of lengthy staff absences within the Commission. The Committee notes that the Victorian Health Services Commission's Annual Report provides a detailed breakdown of the amount spent on staff training and seminars.

The Committee expressed its disappointment that the development and implementation of the computerised case management system was not achieved during the year. The Committee had previously indicated that errors, tracking problems and inefficiencies within the Commission identified in a current Committee Inquiry could be addressed by an improved case management system. The Commissioner indicated that she shares the Committee's disappointment in this regard. She noted that the Commission stands ready to act with the partners to the project, the Tasmanian Health Complaints Commissioner and the ACT Community and Health Services Complaints Commissioner. Expressions of interest for the project have now been received and a tender was expected to be issued within days. The Commissioner anticipates a further six months of developmental work with the successful tenderer in order to achieve responsiveness to the user specifications for the system.

The Committee discussed with the Commissioner its belief that benchmarking of the HCCC's activities should occur to ensure operational transparency, and to remark upon the effects of organisational change now under way.

The Commissioner indicated that there have been difficulties in achieving this, because of different practices in different jurisdictions, but she assured the Committee that the Council of Health Complaints Commissioners is examining the issue, and that the New Zealand jurisdiction may be the most closely aligned in terms of activities with which to benchmark.

However, the Committee believes that there may be opportunities for the HCCC to undertake benchmarking around components of its activities with other complaints-handling organisations within the Australian jurisdiction.

Consultant to the Committee, Mr John Chan Sew, noted that most performance indicators in the Annual Report relate to quantities and timeliness of outputs. The Committee expressed concern that there is limited coverage in the Annual Report of outcomes achieved or quality and effectiveness aspects of performance. Mr Chan Sew's report to the Committee is attached at Appendix 2.

The Commissioner noted the HCCC's intent to report on formal satisfaction surveys for the Patient Support Service and investigations in the next Annual Report.

The Committee notes that other Australian Health Complaints Commissioners do include qualitative and quantitative performance reporting and benchmarking in their annual reports. For example, the Northern Territory and Western Australia report on the time taken to finalise a complaint; the number of improvements or actions taken by agencies as a result of the Commissioner's recommendations; the cost per enquiry/complaint, etc.

The HCCC has previously indicated that, apart from the differences between jurisdictions, a complicating factor for establishing performance indicators and benchmarking occurs around the differing degrees of complexity of complaints. The Committee notes that both the Australian Capital Territory and Victoria categorise complaints according to the seriousness of matters, which it believes may present opportunities for comparison/contrast. Similar opportunities may exist and could be explored by the HCCC with other complaints bodies within the State of New South Wales.

The Committee also noted the Commissioner's assurance that the HCCC will be reporting against goals in its next Annual Report. The Annual Report will also be modified in terms of case studies, which will be largely contained in a special purpose case study booklet as a supplement to the Report.

Additional Information

Supplementary information to the Committee, provided by Commissioner Adrian is attached at Appendix 1.

The technical review of the Annual Report undertaken by Mr John Chan Sew is attached at Appendix 2.

TRANSCRIPT OF PROCEEDINGS

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

INQUIRY INTO HEALTH CARE COMPLAINTS COMMISSION

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At Sydney on Thursday 18 September 2003

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The Committee met at 10.00 a.m.

—

PRESENT

Mr J. Hunter (Chair)

Legislative Assembly

Mr A. F. Shearan
The Hon. T. Gadiel

Mr R. W. Turner

Legislative Council

The Hon. Dr P. Wong
The Hon. C. Robertson

CHAIR: I will declare the public hearing open. Today we have the Commissioner of the Health Care Complaints Commission, Amanda Adrian, with us, and Assistant Commissioner Julie Kinross. Before we get under way I will have to get both the Commissioner and the Assistant Commissioner to take the oath or make the affirmation. Commissioner, we will start with you. Will you now take the oath or make the affirmation?

AMANDA MARY ADRIAN, Commissioner of the Health Care Complaints Commission, 323 Castlereagh Street, Sydney

JULIE KINROSS, Assistant Commissioner, Health Care Complaints Commission, 323 Castlereagh Street, Sydney, sworn and examined:

CHAIR: Today's hearing is in relation to the Health Care Complaints Commission's Annual Report of 2001-02, which was tabled in the Parliament late at the end of 2002. With the election intervening, and the Committee not being reformed until the end of May-early June, this is the first opportunity that we have had to meet with the Commissioner. Today I would remind members that we are reviewing that Annual Report, so I will not be allowing leeway for members to be asking questions on other issues. We stick to the Annual Report, which is the 2001-02 year. Commissioner, is there an opening statement you would like to make before we move into questioning?

Ms ADRIAN: There is indeed, Mr Hunter, if I may commence with that?

CHAIR: Certainly.

Ms ADRIAN: Mr Chair and members of the Committee, I welcome the opportunity to make an opening statement today. As was the case last year, I have invited Commission staff to attend and actively observe the Commission's review of the 2001-02 Annual Report of the Health Care Complaints Commission, because I think it is important that they understand the accountability mechanisms that exist for the Commission.

You will notice significant changes to the content of the Commission's 2001-02 Annual Report. A number of these have been in response to the review commissioned by this Committee, of the 2000-01 Annual Report; and I would like to take the opportunity to point out some of those changes.

The first is the reduced reliance on narrative as the key means of performance reporting. Performance information is now presented in a table format that clearly shows the links between what the Commission set out to achieve, and what was achieved; and also the planned achievements for the next reporting year. The performance table also sets out future plans. Further improvements are planned for the 2002-03 Annual Report, and in fact it has been quite difficult, as we are currently preparing that report at the moment, to unpick this report from what we are reporting on today. However, the areas that we are planning further improvement is on the reporting of performance by specific goals outlined in the Commission's Strategic Directions Plan.

Comparative data has been provided in the Performance Indicators Table where possible, and will be improved and continued to be provided in the future. Short explanations

for any performance shortfall is provided. However, it is also a section that we are moving on to improve. We have included an Executive Summary for the first time, which provides an overview of the contents of the Report. There is a Financial Summary included; Table 42 on page 100, which I know was a request of the Committee last year. There is also a narrative preface to the audited financial statements included this reporting year. An Index of Statutory Compliance has been included on page 125.

In relation to the Commission's case studies, the Commission has conducted a survey and consulted some stakeholders—both provider and consumer groups—who feel that the Annual Report case studies have been an important tool to highlight the work of the Commission, the value of the complaints in quality improvement, and have offered insights of value to the health system. While the review of the 2001-02 Annual Report recommended a reduction in the number of case studies, the feedback from stakeholders noted above indicates that they have a valuable role to play.

This reporting year we are trialing a different approach. The 2002-03 Annual Report will contain some case studies, but the majority will be contained in a special purpose case study booklet that will be included as a supplement to the Annual Report and available for separate distribution.

The Committee may have noted a levelling out of the numbers of patient support service clients' formal complaints and telephone inquiries received by the Commission during the reporting year, as compared with previous years. It appears that 2000-01 was a peak year for all health complaints agencies in both Australia and New Zealand. No one valid reason has been identified for why this has occurred. However, overall the number of written complaints and patient service matters has continued to show an upward trend when compared with previous years.

Trends to remark on are that there has been a significant reduction in the number of complaints assessed for investigation. In 2000-01 there were 335. There were 212 in 2001-02, and this trend is in keeping with the Commission's commitment and strategy to reduce the longstanding backlog of investigations to a manageable load that matches the Commission's capacity. The targeting of investigations is only part of this. Strengthening local complaint resolution and management by providing education and training is another key strategy as is strengthening the other complaint resolution mechanisms used by the Commission. The disposal rate of complaints was 107 for this reporting year, which is an improvement over the last two years where the disposal rate was 103 in 2001 and 54 in 1999-00. This shows that the Commission closed more complaints than were received, and is a heartening indication of the bite into the backlog.

As outlined at the Review Committee Meeting last year, when introducing the then Commission's Strategic Directions 2002-05, the organisational structure identified to best deliver the key elements of the strategic directions has been progressively implemented. Teams are working in two divisions: the Complaint Resolution Division and the Organisational Development and Support Division. Legal Services continues to remain outside the divisional structure and reports directly to the Commissioner. Improved links with Area Health Services and other regionally based health services are of critical importance to the development of good complaints management and underpinning relationships. To help achieve this goal, the

Commission's complaint resolution teams within the reporting year have been organised on a regional basis around the geographic boundaries of the Area Health Services.

Feedback from external stakeholders and staff internally indicate that this has been a very positive change and as all the new permanent positions are recruited and appointed, it is hoped that this will position the Commission well to conduct its business better in the future. I am particularly pleased that the Commission has developed and published a Streetwise brochure for Aboriginal people and communities, in partnership with the New South Wales Aboriginal Health and Medical Research Council. This has proved to be a very important tool for our Aboriginal liaison officer working with Aboriginal communities across New South Wales. Other key HCCC brochures were reviewed and published during the reporting period and the Commission's Consumer Consultative Committee has provided important ideas and feedback in all cases, using their constituencies as a sounding board. These brochures would have been in the packages provided to each of the Committee members when the new Committee was constituted after the last election.

Building on our track record of providing effective training and development opportunities for the health system, we introduced two additional courses: one of which is Resolution Training for Mainstream Health Workers; and the second is Resolution Training for Aboriginal Health Workers. Two full-time education and training development officers were employed to meet the Commission's commitments. This program is an example of the Commission's commitment to establishing productive partnerships within the health system to support consumer and quality focused complaints management.

As mentioned previously, our current complaints database has significant limitations necessitating investment to create a case management system that will support timely and consistent resolution of complaints.

We have made substantial progress during the 2001-02 reporting year. A full-time project manager was engaged in October 2001 to direct the project and to coordinate the requirements of the three partners, who are Tasmania, New South Wales and the ACT. The project parameters were defined, together with the necessary structure, such as the steering committee and user groups. Considerable time was also invested to refine the user specifications with staff within the Commission, as well as with our project partners.

As I said at the review meeting last year, I have made a commitment to seek solutions to the challenges facing the Commission that are sustainable and not quick-fix. I stand by that commitment and again ask the Committee to recognise that building in sustainability requires very close scrutiny of the causes of the problems, and addressing those, before one can hope to reform and effect change.

I remain of the view that the Commission is undergoing a transition that will show the benefits to stakeholders, particularly the community, in upcoming reporting years.

Significant improvements in workplace relations within the Commission and relations with other stakeholders last year are continuing. The review and improvement of internal processes is also continuing and remains a priority.

The skills, experience and professionalism and commitment of the Commission staff, and their preparedness to develop and change, remain one of the organisation's great strengths, and I wish to acknowledge that today. I also look forward to the appointment of the Assistant Commissioner for Organisational Development and Support in the next few weeks. Recruitment is now complete and negotiations are being finalised with a strong candidate who will, I have no doubt, bring a new dimension to the roll out of the Commission's strategic directions.

Finally, I would welcome the opportunity to invite the Committee to visit us in our new premises. Much is happening in the Commission and the members of the Committee may find an informal briefing around our strategic directions and progress to date will assist them in their work. It is pleasing to report ongoing improvement in the performance of the Commission in a number of areas, in a climate of continuing high levels of activity and workload. I look forward to the next phase of the Commission's development and improvement, expanding our horizons, and I welcome your questions. Thank you.

CHAIR: Thank you very much. The Committee is pleased to note a range of improvements to the report, including those which respond to the Committee's previous suggestions, and some of those you have outlined that you will be making further changes in the coming report. However, the Committee notes a number of areas that are still to be addressed, and I am going to go through those. As I said, some of those you have already touched on in your opening statement. One of them is the need to strengthen reporting in relation to the current legislative requirements; secondly, the need to improve the existing approach to performance measurement and reporting; the need to overcome a range of deficiencies noted in the report, and these will be detailed when we follow up with some questions; and finally, the perceived need for restructuring of the form and content of the report.

My first question—I have a bit of preamble to it—as part of the Moving Forward Project, which commenced in early 2001, the Commission sought additional funds to address the backlog of investigations and other administrative changes. In June 2002, at the meeting you held with us regarding the 2000-01 Annual Report, the Commissioner commented that the Commission had been successful in receiving an additional increase of \$1.4 million on the recurrent budget. That was at page 19 of the transcripts, and I notice that you mention in the Annual Report we are discussing today, on page 101, that in the new financial year this \$1.4 million will flow through. You also mention on the previous page of the report, page 100 in the second—it is Finance, Budget. It is on page 100 on the second column, the second paragraph you talk about transfer of \$800,000 from the Department of Health to the Commission. I was wondering, that \$800,000 came through before the end of the 2001-02 financial year. Was there any additional funding to come through to make up the \$1.4 million, or did you then gain in the next financial year a \$1.4 million increase?

Ms ADRIAN: The \$1.4 million was in the following financial year. The \$800,000 was a pro rata for this particular year.

CHAIR: In the last financial year and in this financial year you have had a \$1.4 million recurrent increase.

Ms ADRIAN: Yes.

The Hon. CHRISTINE ROBERTSON: The literacy level in these questions is very high. What is the quantum of additional resources received in the 2001-02 financial year directed into the investigation of complaints?

Ms ADRIAN: Our primary focus was on increasing the number of investigation staff, or staff with investigation skills, to undertake the investigations. As we are finding, investigation officers do not grow on trees and sadly there is only a small pocket of them, and we are having to invest in development of skills in this area as well as recruiting people with those skills. I think probably that would be borne out by any of the other investigative agencies. It is not as easy as it sounds, to go out and bring on board X number of investigation officers. Certainly we have an ongoing recruitment drive, and also an ongoing training and development drive, to make sure that we can build up our skills in that area.

That has been the primary investment. Obviously the investment in our case management scheme has been another key investment as far as the investigations go, so that we can manage and monitor the progress of investigations much better than we have been able to in the past, with a very old MS-DOS Paradox database, so we have seconded somebody into the Commission to work with us in developing a case management project and that is currently being rolled out across the Commission. The other area of investment is obviously in making sure that we have sufficient resources to invest in the new database when we purchase it, and we have engaged with other partners with similar business to do that in a much more rational way than if we were going out into the marketplace ourselves. Clearly, Health Complaints Commissions in other states and territories have a similar interest in having a good database that we can benchmark with each other is the other challenge.

The Hon. CHRISTINE ROBERTSON: This was the 2001-02 financial year, of course, so we cannot work through the exact resources that went directly into investigations.

Ms ADRIAN: At this stage we do not have that broken down into specific allocations. As with most of our allocation, our primary resources are in people and certainly the two areas that we have invested in, and are continuing to invest in, are the patient support service and the complaint resolution investigations area, along with my commitment from last year.

The Hon. CHRISTINE ROBERTSON: I feel the next question has been answered. In its performance indicators on 20 and 21, the HCCC notes that it closed 363 investigations in 2001-02, and 284 were closed in 2000-01. The HCCC aims in 2002-03 to continue to increase closed investigation numbers, which you talked about in your earlier—table 25 on 46 indicates 952 open complaints, a reduction by 150 in the number of open investigations. Table 25 on page 46 indicates 952 open complaints, a reduction by 150 in the number of open investigations and the report notes that increased resources secured by the HCCC were only received late in the year—that is on page 100—so additional improvements should be expected next year. What steps is the HCCC taking to close investigations expeditiously?

Ms ADRIAN: If I could point out, the difference in those numbers is complaints opened and investigations opened are counted separately and those are other complaints. The strategies that we have to close investigations expeditiously are firstly by developing the skills of existing investigation officers, employing more; and, as I said, that is not as easy as

we would have liked it to have been. It has been quite challenging. We have invested very much in developing the case management tool that we can use for individual investigation officers to manage and monitor, as well as their managers, and the Assistant Commissioner and I, in monitoring progress with investigations.

We are working towards an average investigation time of 12 months in the long term. We had at our meeting last year approximately 250 investigations that were unallocated, because of our inability to be able to allocate those to the existing staff numbers. At the moment we have no unallocated investigations, other than one case load of a person who has recently left, that is being shared out at the moment. That is a significant change from where we were this time last year in that we have no unallocated investigations. We have now been able to share those out amongst all the investigation officers that we have. We are certainly getting closer to being able to meet that 12-month average time frame for any investigation conducted by the Commission, which has been a long-term objective of the Commission's.

The Hon. Dr PETER WONG: To start with may I congratulate you and the Commission for the many improvements you have made.

Ms ADRIAN: Thank you.

The Hon. Dr PETER WONG: Some of them are quite impressive. I am sure we would like to know, when you are talking about employing additional investigators, can you tell us what qualifications are needed to be an investigator, and the second point is, we also questioned you a while ago about medical experts in the Commission, do you allow any funding to be used for additional medical experts?

Ms ADRIAN: The first of your questions about body of skills and knowledge and experience that we would require of investigators. It is essentially a mix of skills we need, and the mix of skills would be similar in many cases to what the Ombudsman or other investigation agencies would require. Obviously an understanding of the system in which we are working. It is most useful if people have some knowledge and understanding of both the legal system as well as the health system. The critical overlay on that is having an understanding of investigation as a skill and certainly: staff that have public health backgrounds; staff who have legal, investigative or police backgrounds, mixed with their health professional or legal skills. It is not one bundle of things. It is a mix of skills that we need to be able to enable people to conduct an investigation within the health system, and understand the health system and also the legal infrastructure in which we work.

The Hon. Dr PETER WONG: The second part of the question.

Ms ADRIAN: The second part of the question?

The Hon. Dr PETER WONG: Yes.

Ms ADRIAN: Remind me, sorry; it was about the—

The Hon. Dr PETER WONG: About the medical experts acting on the Committee.

Ms ADRIAN: —medical experts. We have increased our number of internal medical officers so that we have others to call upon when we have particularly heavy loads, and we have been doing that over the last couple of months. We also have continued to develop our panel of professional reviewers, and we have also been using them much more adventurously than we have in the past. I think I mentioned at the Committee last year, we were starting to look at having for major investigations a panel of experts, rather than having a single expert or going back and forth to one or two.

We have used that and are continuing to use that more and more for the major investigations and that has certainly been a very successful mechanism and we are working on developing that further.

The Hon. Dr PETER WONG: My next question is how many investigation matters currently open have been open for more than 18 months, and how does it compare to—I know you mentioned some figure earlier on—how does it compare to say last year and the year before?

CHAIR: I think on page 14 of your report, you listed 328 investigations involving 510 practitioners were open for more than 18 months, so we would like to know whether you could tell us what it is currently.

Ms ADRIAN: The current state. I have only the individual numbers so the match for the 514, which is 347, which is going down quite considerably.

The Hon. CHRISTINE ROBERTSON: I understand that the Committee previously suggested the critical importance of the HCCC developing a suite of benchmarks for activities with other similar jurisdictions. What steps has the Commissioner taken to develop these benchmarks for its complaints handling times with other jurisdictions?

Ms ADRIAN: The Commission sits on the Council of the Australia and New Zealand Health Complaints Commissioners and Ombudsmen and that Council has been working together to work out what would be a suite of benchmarks for that group. The challenge is that the only Commission that shares probably the breadth of role that this Commission does is the New Zealand Commission, and to that end we have been working quite closely with the New Zealand Commission to try and particularly get a set of benchmarks that would be comparable, because they do have the broader prosecution and investigation functions that we have, which many of the other commissions do not have. I am hoping, Ms Robertson, that we will have some benchmarks that we can—I mean, I am concerned at this stage that we do not start publishing them until we have tested their reliability, because at the moment we are comparing chalk with cheese, and we are trying to make sure that we have comparable data that we are measuring.

The Hon. CHRISTINE ROBERTSON: So you and New Zealand are using the same?

Ms ADRIAN: At the moment our data definitions are slightly different, which is why we cannot publish against them, so we are trying to align those.

The Hon. CHRISTINE ROBERTSON: In 2002 the Commissioner indicated the draft investigation time frames with the proposed standard of 12 months per investigation have been developed.

Ms ADRIAN: Yes.

The Hon. CHRISTINE ROBERTSON: Page 56 indicates that only one investigation of the health service and 33 investigations of health practitioners were completed within the seven to 12 months time standard. Nine investigations of health services and 54 of health practitioners took 37 months or more to investigate, a situation echoed by concerns expressed to the current Committee inquiry. Could the Commissioner comment on the application of the time standard of 12 months and whether it is realistic or it requires adjustment.

Ms ADRIAN: My statement to this Committee was that we were working towards that. We had some significant barriers to achieving that. However, I did not and will not resile from that 12 months as a goal. Those barriers that we have been working through are, certainly in the first instance, the unallocated investigations that we have now wrestled into some level of control. The number of staff to be able to manage the case loads and then actually having manageable case loads for those staff has been another challenge. When I put that goal up to the Committee in the first instance, I did make it clear that it was not a one-year turnaround for us to achieve that. It was within our Strategic Directions which is 2002-05 goal. My commitment remains, and certainly I have no reason at this stage to amend that goal. I will, if I need to, once we have been able to sort out the other distracters and barriers to that, but we are certainly working towards it. I am concerned that until we get the back log of investigations and those unallocated investigations out of the way, these figures probably will not change substantially for a year or two.

CHAIR: Allan Shearan, could you ask question number 9.

Mr SHEARAN: Commissioner, it is observed on page 9 of the report that the trend for the number of complaints received is levelling, and that this is a common trend and you made mention of that earlier. Among the reasons being explored for this downward trend in the number of complaints received, has there been consideration given to the possibility of discouraged complaints? In other words, those who simply give up on a complaint because the process seems to onerous or slow.

Ms ADRIAN: If I could clarify; in my opening remarks I mentioned that the 2000-01 rise was a rise that was dramatic and experienced across Australia and New Zealand with complaints. If you look at the complaint trends in each of those organisations, a similar glitch has occurred. What has happened is that—in fact taking out 2000-01—the number of complaints has continued to rise in a steady way rather than going down, or even levelling out too much, when you take that particular blip out. I would hope that we are not discouraging the bringing forward of complaints. We have an active process of getting information out about local complaints resolution to health services, because one of our major investigations strategies with our move to reduce investigation backlogs and things is to enable the health system to do it better at the front end, and that is a major commitment that we have continued to have. But the other commitment we have is by making our information, both

electronic and paper, and by having staff available to talk to community groups through our Patient Support Service, all of the other parts of the Commission, we are actively informing and encouraging through the means we have available to us. I do admit and recognise that our lengthy investigations that we have conducted probably could be seen to have an obstructive effect. However, we have been working on that, as I hope I have explained, to try and reduce that in the longer term.

Mr SHEARAN: As a supplementary to that, I do not suppose there is any follow-up mechanism to see whether people withdrew because of the process?

Ms ADRIAN: We certainly routinely survey people involved after the end of an investigation, both respondents and complainants, to actually seek their information around that, and also Patient Support Service clients. Generally I can report that the Patient Support Service clients are very satisfied because it is a flexible, timely, on-the-spot service that we are certainly investing more in. Our investigation survey forms do highlight the difficulties we have in there for delays.

Mr SHEARAN: The explanations for the results from some activities would appear to be barely adequate. For example, the outcome of 22 out of 43 health services investigations on page 50 is dealt with by one brief sentence:

The Commission made comments or recommendations at the end of 22 investigations in relation to policies, guidelines, procedures and training.

About half of these investigations—21—were terminated by the Commission. Can the Commissioner comment on the adequacy of explanations in general. In the specific example given, would a further explanation have been more informative?

Ms ADRIAN: I guess this is where we have used a case study particularly, because the difference in the types of investigations about health services are so dramatic that we have used the narrative to describe those. I think you will find within the case studies, a number of those health service investigations have been described in some depth. It is quite difficult when, for instance, a complaint about a health service might relate to one very specific issue, or it might relate to 300 different issues or incidents or things. It is quite difficult in a table of numbers to try and unpick the complexity of those health service investigations. As you can probably appreciate, that if we receive a general complaint about standards of care, failure to provide care, then the investigation in that sort of situation would be very different from a particular patient issue around an adverse outcome for instance. I would be keen for the Committee, if they had some suggestion as to how we could report that better, we would be delighted to hear it, but certainly we have used the case-study mechanism as one way of highlighting the differences in those sort of health service investigations as well as others.

The Hon. CHRISTINE ROBERTSON: In 2002 the Commissioner indicated to the Committee a greater role for the HCCC in the direct resolution of complaints. This approach is again reported on at pages 41 to 43 of the report. How do matters assessed as suitable for direct or assisted resolution differ from matters assessed as suitable for conciliation?

Ms ADRIAN: In some cases they might be a secondary recommendation from—in the first instance, we seek consent for conciliation. Then our secondary decision is, if we cannot obtain the consent for conciliation, then they will be referred for direct resolution. Very often that is our secondary recommendation if we are unable to obtain consent. So those cases, there will be no difference whatsoever.

Other matters where we might seek direct resolution, as opposed to conciliation, is there might be no ongoing relationship; that the person might have absolutely adamantly said they never want to see that person again, they do not want to sit in the same room with them; there is absolutely no way the conversation, even with a mediator or a conciliator would occur. The other level is where sometimes on the face of the complaint, we can see that it really is about explaining something to somebody, sitting down with them and talking them through a medical report, a record, something like that, where a formal process of conciliation, where a doctor might have to leave work for half a day, a person might have to come into the city from the country area to sit down in the conciliation process, is not necessary for the issue or problem that we have found. Yes, there may be a difference in those matters where we would see a direct resolution.

Other examples are where somebody writes to us and tells us their doctor will not release their medical records, and it is really about a patient support officer going and approaching the doctor and saying, "You really have an obligation to provide this. Let's work out how we can do it best," and things like that. It is an active intervention, if you like. There will be a difference there.

The Hon. CHRISTINE ROBERTSON: I guess you have touched on this next question, which is: what is the benefit for the HCCC's involvement in direct or assisted consultative resolution matters?

Ms ADRIAN: It enables a flexible and immediate response, in that we can get the complaints, assess for direct resolution, refer them straight out to our patient support officers within a day or so, and they can pick those up and begin the activity. And that is a very important feature of our business, that we have not always had the strength in before. Increasingly that is a critical feature. If I could make one other point around the difference between the conciliation and the direct resolution, we certainly recognise that the conciliation process is a legal framework for enabling a safe resolution to occur, and also there is the opportunity for some compensation to be negotiated, which is a very important aspect of that resolution. Certainly any matters that highlight the need for that will be referred there.

The Hon. CHRISTINE ROBERTSON: Yes, and that touches on this. The next question is: could, or possibly should, all of these resolution matters be handled by the Health Conciliation Registry?

Ms. ADRIAN: No, and I think I have given you some examples where it would be a waste of the Conciliation Registry's time and the stake of the other parties' time to engage in a formal process of conciliation, where it might be an explanation or a phone call that can achieve the outcome.

The Hon. CHRISTINE ROBERTSON: Your part of the process is to evaluate the appropriate place?

Ms. ADRIAN: Yes. You will see that we have been recommending for conciliation many more matters than have been in the past, and that the challenge remains in obtaining the consent from the parties to participate in that conciliation. We have certainly invested a lot of effort in trying to improve people's understanding of the benefits of attending conciliation, and we have been working with the Health Conciliation Registry in relation to that.

CHAIR: The question I am going to pose to you next has a preamble and some of the issues I raise in that you have already touched on, such as the spike in complaints.

Ms. ADRIAN: Yes.

CHAIR: However, there is an ongoing trend, but nevertheless I will proceed with this because it details some of the increases and decreases in complaints. When the HCCC receives an assesses written complaints, these are categorised.

Ms. ADRIAN: Yes.

CHAIR: The HCCC received 7 per cent fewer complaints in the reporting period than in the previous year. Clinical standards was again the category by far the greatest number of complaints at 1,404, or 52.5 per cent of the total. Quality of care was the next highest category, at 337, or 12.9 per cent of the total—that was down from 16.2 per cent on the previous year—followed by business practices, 248, or 9.3 per cent of the total; prescribing drugs, 124, or 4.6 per cent; patient rights, 104, 3.6 per cent; provider/consumer relationship, 95, 3.6 per cent, and impairment, 91, at 3.4 per cent. The HCCC reports a large increase in complaints about inadequate treatment, from 221 in 2000-01 to 340 in 2001-02. The number of complaints about hospital admission on mental health grounds reported doubled from 16 to 27.

Complaints concerning inappropriate discharge, premature discharge or refusal to admit decreased according to the report. Complaints about fees reportedly increased from 69 to 84. That is on page 30. The number of complaints received about health services increased marginally by 23, or 3 per cent. Complaints about public hospitals fell by 45, or 9 per cent. The HCCC notes that this is the first time for many years that complaints about public hospitals has fallen below 50 per cent of all health service complaints. Does the Commissioner have any view as to the indications behind these trends? As I said, you have given some indications before. That [bell] means that the Lower House members have to go and vote. As far as I know, under the conditions we operate, we can continue and I would call on the Deputy Chair to take the chair.

DEPUTY CHAIR: Did you complete that?

CHAIR: I did, and it is just that the Commissioner may wish to comment to elaborate on those trends.

Ms. ADRIAN: You still want me to comment on those trends?. I would be delighted.

CHAIR: Then you may want to ask a few more questions. But we will be at least 10 minutes, if you wish to stop and have some refreshments before we come back.

Ms. ADRIAN: If I could pick up the issue around clinical standards. I think that this is one of the rebuttals for one of the furphies within the health system, that consumers do not comment on the quality of care and the clinical standards that are provided to them by health providers. Certainly our statistics over many years have shown that the area of clinical standards and quality of care remain the highest areas for complaints. Certainly there is nothing in those trends that surprises in any way. I guess one thing, just to make a comment on: we are seeing an increase in complaints about informed financial consent in relation to fees.

This I think is reflected in what is happening in the health system: shortened length of stays; people not coming into hospital until the day of their surgery or coming in for day surgery; anaesthetists not having the opportunity to perhaps discuss with patients their fees; the fact that hospitals do not coordinate that information for patients with their surgeons and anaesthetists so that it is available to them; and things like that. I think that while that is not a huge rise, we are seeing it as a real trend, that particular issue. And in discussions with the ACCC, they are also seeing a similar increase in relation to this. That is certainly something to bear in mind, that is worth commenting on.

In relation to the public system complaints reducing somewhat, I think statistically it is not hugely significant and probably is in keeping with that glitch in relation to the 2000-01 statistics. However, that said, we have been investing very heavily in education and training at the front end for staff in the Area Health Services. It has been a considered and major strategy of the Commission, the education and training program around investigation resolution, and while I think it has a long way to go, I think we are seeing some of the benefits of it. The other thing I think we are seeing the benefits of is the reorganisation within the Commission around the geographic areas, where each of the complaints resolution teams has a focus on working with Area Health Services.

We are certainly referring a lot more matters now that we can be a little more confident about their capacity to investigate and manage complaints themselves, to them. That is very much in line with a quality improvement strategy. People will often own and recognise problems in their own system if they have the opportunity to unpick themselves and provide us with information back. So that has been another really important strategy. We have consciously referred more complaints to the health services and provided them with support and advice in how they investigate and manage those complaints.

The Hon. Dr PETER WONG: I ask for some elaboration on the clinical standards of 725 at page 36. Assuming half are from the public system, the other half would be from the private system what type of doctors are they who you receive complaints about—GPs, specialists—and what particular ratio? Do we have any data on that?

Ms ADRIAN: Page 34 does break down the public hospital area particularly, and certainly I think we do break it down into general practice, and on page 36 it is a crude break

down; medical practitioner, nurse. It really is a cross-reference between those tables; 34 and the one on 36 will give you that picture. We certainly have data on where we can get it on specialties of practitioners. Unfortunately, we are not always able to obtain it. It is one of the difficulties; particularly specialties of practitioners in hospitals and things like that.

The Hon. CHRISTINE ROBERTSON: I am sorry to divert. I know that the time is short, but I am wondering, the investigations that you receive and send back to the health services to try and negotiate, they get recorded in this preliminary—

Ms ADRIAN: They do. They are reported—if I can lead you to pages 48 and 49, it describes the—

The Hon. CHRISTINE ROBERTSON: They are not inclusive on 30 and 31. Is that right?

Ms ADRIAN: Yes, they are in the number of complaints overall.

The Hon. CHRISTINE ROBERTSON: That was my question.

Ms ADRIAN: Because they are what come through the door to the Commission and we disperse them different ways.

The Hon. CHRISTINE ROBERTSON: My next question again has a little preamble. In 2002 the Committee suggested the need for a more active approach to be taken in the investigation of complaints. In particular the Committee was concerned at the lack of definitive information on the number of field based investigations. The HCCC report still does not provide any definitive information in this regard, although it discusses pilot strategies to improve investigations, including presenting cases to an expert clinical panel, the appointment of independent experts and peers to conduct reviews and report to the Commission, and working with health providers to identify causes of potential problems and possible solutions. In what number of instances did HCCC investigators go out into the field and meet with respondents regarding the particulars of a complaint?

Ms ADRIAN: Our difficulty is finding a data element or item to count these, because it is about a philosophy change, rather than an action change, and I have given the Committee a commitment that as we take control of the investigations, and wrestle the number down, that we are doing more and more active—out there statement taking, inspection, visiting of the sites of areas where necessary, and certainly that commitment remains. I have not yet been able to work out a way to actually count it in a meaningful way to provide the Committee with the information on how many site visits and things.

Certainly the protocol and policy is that we are going out much more than we have in the past. We are not relying on paper based investigations to the extent that we did before. We are engaging much more actively with clinicians and with the complainants as well in relation to that, and I think that will become much easier as the number of investigations and each person's case load becomes more manageable, and I would invite the Committee, if they can work out how we can count it in a way that is meaningful, to provide us with some advice.

The Hon. Dr PETER WONG: I would like to congratulate you first on your achievements in this field. As you know, there had been the complaint from us in the past.

Ms ADRIAN: Yes, there was.

The Hon. Dr PETER WONG: I think you have done rather well.

Ms ADRIAN: The counting of it remains a challenge, and I am not sure how I can report on that but, as I say, I would welcome some ideas.

The Hon. Dr PETER WONG: What are the strategies of preliminary inquiry prior to assessment used by HCCC in page 42, and how effective do these strategies seem to be? I also would like to make a comment that I notice that the complaints are 123 complaints fewer than the previous financial year. It dropped from 12 per cent and 8 per cent. Are you using a new strategy of preliminary inquiry which is different from the previous practice?

Ms ADRIAN: We are doing a number of things. Obviously the referral of more serious matters out to the Area Health Services and providing advice and support and supervision for them to do the investigations has been one strategy. The reduction in investigations has been, while building up our skills in other resolution mechanisms—and I am sorry, Dr Wong, I have forgotten the first part of your question which was about the—

The Hon. Dr PETER WONG: Let me repeat it.

Ms ADRIAN: I am sorry; I beg your pardon.

The Hon. Dr PETER WONG: Are there strategies of preliminary inquiry, prior to assessment, used by HCCC? My question was how does it compare to previous practice.

Ms ADRIAN: A difficulty with preliminary investigation is the time requirements on our assessment and notification. We do do preliminary inquiries where we can; where we have not enough information to make an assessment in the first instance, where we have perhaps some conflicting information, or not enough to follow-up. However, under the current legislative requirements around assessment and notification, we have to assess within 14 days and notify within 60. It does pose a bit of a challenge for us to do preliminary investigations in a meaningful way. That said, we do attempt to do them where we can. We are also—and doing many more—seeking responses from respondents in that preliminary period than we have done in the past.

The Hon. Dr PETER WONG: I am still not clear. Do you have a standard format of certain guidelines for preliminary assessment? For example, in your preliminary inquiries—private assessment—are there certain formats that you would follow?

Ms ADRIAN: It is a decision of the Assessment Committee that if there is not enough information to make an assessment decision, or there is some dispute or conflict around the information that the Assessment Committee has before it, then they will seek the relevant information. They might get hold of the records. They might obtain a response from the respondent in the first instance; advice from a health practitioner or specialist or one of our

professional reviewers about the information that has been furnished to us. Certainly we do do that and my interest would be in being able to do that more flexibly without the time constraints that we currently have under our present legislation. But certainly we do that, and do it regularly.

The Hon. Dr PETER WONG: In 2002, you have indicated to the Committee the intent to conduct client satisfaction surveys about whether their complaint is resolved. This, and satisfaction of the service in general, are reported at page 63 and page 64. However, the consumer satisfaction survey refers only to complainants. Are the respondents regarded as the clients of HCCC and, if so, how is it proposed that their views of client satisfaction are taken into account?

Ms ADRIAN: We are now formally—I think I mentioned earlier—surveying people at the end of an investigation; respondents and complainants. We are certainly receiving that information and will report on that in the coming year. Also, the Patient Support Service clients are surveyed routinely in relation to their satisfaction with the service. Those are two routine surveys that are ongoing, that are part of our normal daily business. I also collect, as a normal part of the Commission's daily business, any incidental or unsolicited correspondence where people are critical of the Commission. For instance, a person might write to this Committee and forward a copy to us. We count that in the data in relation to the feedback from the clients. We are certainly scrutinising that. We have a routine reporting mechanism to all staff where action is identified and a review and follow up is also identified. That we began about 18 months ago routinely, and we are starting to really perfect that and get some meaningful data out of that because, as you will appreciate from the correspondence the Committee gets, we do, in the course of other correspondence get feedback on our performance, both positive and negative. It is about collecting and having the means of collecting that well.

The Hon. CHRISTINE ROBERTSON: Are there any quality measures on the health service investigations, or do you just use the consumer feedback?

Ms ADRIAN: We have in fact—and if I can go to the section 26, there is a formal review. Some of the matters are referred to the health service without asking for a report back for them to manage because they are to fix and not to come back to us. A number of them, we seek a report back from the health service because we are concerned about an issue that perhaps we are seeing all over the State, or we are still not convinced that they are able to manage the investigations adequately. There is a formal process. There are several staff in the Commission who have a role in reviewing those investigations and looking at those. We do not seek feedback other than through incidental means at this stage. We do not survey complainants about that. We certainly get feedback from people when they write to us and say they were not satisfied what happened at the health service level, and we collect that data.

The Hon. CHRISTINE ROBERTSON: So there is no real consistent quality measure? It may be very difficult to create such a measure anyway. There is a quality framework, I understand that, but I also understand how they work.

Ms ADRIAN: We do have a very stringent process for reviewing those that we have sought reports back from, and we will often go back and negotiate around them. We will often contact the complainant and ask if they are satisfied with it. Complainants will often

seek a review if they are not, so we have got a mechanism for following that up. Certainly the Area Health Services are generally relatively cooperative in providing those reports to us. Sometimes their timeliness is as challenging as ours in relation to that.

Mr TURNER: Commissioner, the number of written complaints received about the Commission totalling 49 as a proportion of the number of written health care complaints totalling 2673 is 1.8 per cent, not the 0.01 per cent as claimed on page 63. If this discrepancy is to be explained in terms of total complaints, can the HCCC provide figures for complaints made verbally about its services?

Ms ADRIAN: Mr Turner, what we are trying to do is develop a much better collection mechanism for those verbal complaints as well as for the other complaints that we receive about the Commission because, as I said to you before, a number of those complaints come in incidental—correspondence about other things, and it is about us having the mechanisms in place. And certainly over the last 18 months, staff have been encouraged to recognise that feedback and provide it to me, and that is certainly information that I analyse personally and look at what actions and what strategies we need to do to try and improve matters.

I take your point about the statistics—I am sorry, can I take that on notice, because I really do not have the capacity to be able to report on that here at this stage? If I can reply to the Committee in writing around that.

Mr TURNER: That is all right.

Ms ADRIAN: And if it is a mistake, I will happily acknowledge it.

Mr TURNER: Further, the Committee previously suggested the need for external scrutiny of the exit survey process in order to ensure that the information obtained does critically inform complaints, handling and communications processes. Could the Commissioner comment on why this process has not been adopted?

Ms ADRIAN: I am sorry, I am not quite sure what you are referring to.

Mr TURNER: Being new on the Committee, I am not either.

Ms ADRIAN: Maybe you could elaborate.

Mr TURNER: Modesty on both sides.

CHAIR: You have talked about that you survey people.

Ms ADRIAN: Sure, yes.

CHAIR: All we are saying is that it should have some kind of external scrutiny, rather than you just assessing this.

Ms ADRIAN: Right. Sure.

CHAIR: Have you brought someone else in who is an expert in this field, maybe to give you some advice on what questions are asked and the feedback that you are getting? Because you may remember that we had the same situation when we did the Conciliation Registry Inquiry, that the Conciliation Registrar had wonderful figures of people walking out of a conciliation and the figures showing wonderful results, yet with your assistance we surveyed all those people who had into conciliation and our survey got totally different results.

Ms ADRIAN: I am pre-empting the next Annual Report that the survey results around our investigations are not wonderful. They do highlight the issues around delays and things like that. We do certainly—our processes within the Commission are that those survey forms do not go back to the people that were investigating it; they go to a separate data and information section where they de-identified and collated separately and they are not available to the individual investigators, unless the person particularly wants the investigator to see it, or the patient support officer to see it. But certainly the address and means for them to provide it back to the Commission is a separate part of the Commission.

I take your point about the development of the surveys. We did seek some independent advice about what are reliable questions that need to be asked in the development of those two surveys. We certainly will be collating to those and looking at those and testing those with interest this year. As far as having an external review from outside, at this stage we do not, but I hear the Committee's concerns around that. That said, our climate survey of staff that was commissioned during this year—and if I can, just as a supplementary, it was evaluated by an external group outside the organisation. It may be that we can use them to evaluate our satisfaction surveys in the future.

The Hon. TANYA GADIEL: Does the Commissioner propose to ensure that consumer feedback surveys are extended?

Ms ADRIAN: Absolutely. I would very much like to extend the opportunity for consumer feedback across all of the activities of the Commission, including where we refer matters that people were satisfied that we referred them appropriately and things like that.

The Hon. TANYA GADIEL: Will the Commissioner give consideration as to how a better survey design can take into account suggestions for service improvement and increasing response rates?

Ms ADRIAN: Yes. Certainly our Consumer Consultative Committee have been very active in this -- we have been inviting them to go back to their constituencies to provide us with feedback on how we can do that better. That includes also the actual complaint form that we are improving at the moment.

The Hon. TANYA GADIEL: The Committee is considering producing a report on the Commission's consumer stakeholder satisfaction rating. Would the Commission provide the Committee with access to survey participants under the same arrangements as it did for the Health Conciliation Registry Satisfaction Survey?

Ms ADRIAN: I will certainly give every consideration to it. I will obviously have to examine the privacy problems around that, but certainly I would be delighted, if I can.

CHAIR: And I will point out that that was de-identified.

Ms ADRIAN: Yes. Yes, we could probably do that.

CHAIR: We produced a survey, you sent it out to people, so we did not know who you sent it to, and then they had—if they wished to return it to us, they did, and, as I said, we got starkly different results to what the Conciliation Registrar had got.

Ms ADRIAN: If I could take that on notice, but certainly I will give every consideration to it, yes; absolutely.

CHAIR: In relation to Patient Support Officers, the report details the achievement of additional funding for three new Patient Support Officer positions around the State, and the aim to establish those positions in 2002-03, and that is mentioned on page 21 of the report. The report also comments on the new arrangement whereby complaint resolution teams are given responsibility for specific areas of the State. The Patient Support Service provided assistance to 3,842 people in the 2001-02 year—that is on page 24 of the report—a small decrease over the previous year, which had previously seen a strong uptake of the service the year before. The committee has previously expressed a need to see more detailed information on the performance assessment of Patient Support Officers, preferably against benchmarked objectives.

There is a great deal of information provided in the Annual Report on how clients found out about the Patient Support Service—69 per cent through the Commission itself—the types of concerns clients raised, outcomes and concerns by location. However, there is no inclusion of information on PSO performance against standards, or even a comparison about how the new arrangements for complaint resolution teams are performing against the old arrangements. The committee finds this disappointing. Have new Patient Support Officers been appointed, and where are they located?

Ms ADRIAN: There is a number of questions in that which I will try and unpick and remember.

CHAIR: I think statements and one question.

Ms ADRIAN: From the last one first, the Commission in this most recent reporting year has appointed three new Patient Support Officers, as it undertook to do. Those Patient Support Officers are located in the regions around the Northern Rivers area, around the Illawarra area and around the Macquarie-Orana area, based at Dubbo. The Patient Support Officers are based in Lismore, Dubbo and Wollongong in relation to that.

CHAIR: The next question I was going to ask you related back to the introduction which was, given the considerable resourcing which has gone into new arrangements, how can the Commissioner explain the lack of performance assessment information on PSOs in the Annual Report?

Ms ADRIAN: In relation to the Patient Support Service—the consumer satisfaction surveys that are done assiduously for that service report on satisfaction of well over

85 per cent, as I understand it, in relation to consumer satisfaction around that. In the accountability review of the Patient Support Service, table 4 on page 26 does give some indication of the outcomes of Patient Support Service activities, which I would regard as a fair measure of the work they are doing, in that it shows up that 36 per cent of all matters are resolved; 21.4 per cent, where there was information provided and the person went off to pursue it themselves. And I would like to remind the Committee that one of the roles of the Patient Support Service is to provide information and enable people to resolve their own complaints, and that in itself is regarded as an achievement.

Partial resolution was achieved in 19.3 per cent of cases, and 10.6 per cent of cases, where we referred somebody to the patient support service, they declined to use the service. I am keen to find out if the Committee has—certainly there are the essential criteria and the job statements and the performance requirements internally against the Patient Support Service officers' requirements, and they have performance review as part of their normal day-to-day work.

CHAIR: After today's hearing, we might discuss that with you and come up with some suggestions.

Ms ADRIAN: Sure. No, I would be happy to pursue that further, because I am not sure—certainly the patient support service was one of the first services within the Commission that we actively and routinely surveyed for satisfaction. We certainly unpicked their outcomes and have for some years assiduously. I am interested in what the Committee has in mind there, because I am not sure we share—

CHAIR: Basically, before Allan asked the question, we were talking about some external scrutiny of the satisfaction surveys. Again, you might want to—

Mr SHEARAN: Yes, 26, sorry.

CHAIR: We will leave 25, because that is what we are talking about. We will go onto 26.

Ms ADRIAN: Talking numbers.

Mr SHEARAN: Would regular independent surveys of CEOs within the Area Health Services similarly inform improvements of the Patient Support Service?

Ms ADRIAN: We certainly provide each of the CEOs with a report each year. A number of those CEOs respond to that report and provide us with some feedback. But at this stage, it is not a formal process. In fact, I was reading one only the other day, which is included in the data for this year's feedback that I will be reporting on for next financial year, where a CEO had done an analysis and report back and a commentary on the performance of the patient support service in their area. That is not formal. Routinely we meet with the CEOs and discuss issues around the patient support service. As this Committee knows, we have in a past committee—we respond to concerns about patient service support service and have taken steps in response to CEO concerns in several situations.

Mr SHEARAN: I suppose the question there is, do you think it should be formalised?

Ms ADRIAN: Certainly the infrastructure is there now, that could easily be formalised. Certainly there is the report that goes out. There is the invitation to respond. Yes, we could certainly make it more mandatory.

CHAIR: The reason why we ask these questions, we go back to the Conciliation Inquiry we had where a number of concerns—not a great number, but a number of concerns—were raised when with Area Health Services, about different aspects of the performance of PSOs. Maybe if there is some way we could formally get their responses; try to encourage them to respond.

Ms ADRIAN: If I could comment on that, because one of the concerns that was raised by one of the two people from the Area Health Service we did deal with, and responded to and took some action. The other one we continued discussions around and were able to resolve that. Yes, from an informal point of view, we certainly do, but I take your point and I am happy to explore a more formal performance reporting process with the CEOs about the Patient Support Service.

CHAIR: The Lower House members again will have to leave. I will hand over to the Deputy-Chair. We are going to move onto the Conciliation Registry and I wish I was here to hear this.

DEPUTY-CHAIR: The Annual Report noted that 381 complaints were assessed suitable for conciliation. This represents 10 per cent of the total complaints, which is comparable with last year. The report goes on to comment that the HCCC was able to obtain consents for only 169 of these complaints to proceed to conciliation. That is on pages 39 and 40, it says here. While this is disappointing, the number of consents thus referred to the Health Conciliation Registry, 212, is a significant increase over referrals for the previous year, when only 106 consents were obtained and referred, which I think you spoke to earlier. Does the discrepancy relate to consents carried over from the previous year?

Ms ADRIAN: Some of them will, because obviously this is data that, if a process of seeking consent begins in one reporting year, we cannot actually isolate it by reporting year. As I said earlier, we have made a concerted effort to attempt to explain the process of conciliation much more appropriately; make sure that people know that it is an important complaint resolution strategy of the Commission and that we value it. We will certainly be working on building those figures up and increasing them over the years. I have not really, other than to say that we are delighted with the increase and are committed to trying to improve it even further, I have no further—

The Hon. Dr. PETER WONG: Commissioner, I noticed that other States—I am not saying this because you are doing the wrong thing—I am only saying that in other States somehow they are pushing a lot more for conciliation, as you know anyway, more than I do. How does our figure compare to, say, Victoria, Western Australia?

Ms ADRIAN: When we looked at Victoria—and I think we have provided that to the Committee for the inquiry—in a numeric sense we conciliated more matters than certainly Victoria did.

The Hon. Dr PETER WONG: What about percentage-wise?

Ms ADRIAN: A bigger percentage, I am informed. The challenge for us is that we have a diverse range of resolution strategies, investigation being one of them, and certainly people's expectation that a matter will be investigated is something that is quite hard to talk them through, because they see that their complaint is very serious and do not necessarily share the Commission's view that the best way to deal with it would be through a conciliation process rather than a forensic investigation.

The Hon. Dr PETER WONG: Is it because the community overall has become more litigious; in your personal opinion?

Ms ADRIAN: To some extent it is the way our Act is structured in that there is such importance placed on investigation within it as a means of resolving complaints, which I would like to see addressed in the future. That rather than a hierarchy of mechanisms to deal with complaints, that there is in fact a range of mechanisms that make it much clearer that we do not value a complaint because we do not refer it for investigation.

The Hon. CHRISTINE ROBERTSON: We have two more questions on this particular segment, and then we might have 10 minutes break so that you can recuperate. The Committee notes that the Health Conciliation Registry has in fact implemented most of the recommendations of the Committee in its report: *“Seeking closure; improving conciliation of health care complaints,”* et cetera. These include the recent recruitment of new conciliators from a broader community spectrum, including multicultural conciliators and conciliators from regional areas. What improvements in conciliation has the Commissioner noted since the changes implemented in the Health Conciliation Registry?

Ms ADRIAN: I think there are some major achievements I would like to comment on. Firstly, the increased flexibility of the Conciliation Registry to meet parties' needs to go to the place where they need the conciliation to occur, rather than the only mechanism for people in rural and regional areas having telephone conciliation, and I think that is to be applauded; absolutely applauded. I think we are really only starting to see the real benefits for the long term, but certainly the more flexible approach by the Conciliation Registry is a major achievement for that organisation.

I look forward to having the range of conciliators, who can reflect the different groups in our society, being part of the process, and certainly the Commission has been an active participant and one of our staff has spent many hours being part of the recruitment and selection of those panels, and it is certainly a commitment we have made to participate in that to ensure that the Registry gets the best people for the job—yes, we applaud that. We have started to see some major changes. We have been working closely with the Registry in achieving those and look forward to continuing that in the future.

Can I make a point about that. We are getting fewer complaints about the conciliation process and I think that is worth noting.

The Hon. Dr PETER WONG: Can I ask a very quick question. If you do not have the information, tell us afterwards. When you talk about multicultural conciliators, and we notice that the biggest group—apart from the Anglo-Celtic speaking very good English—would be from Arabic-speaking community and Chinese and Vietnamese. How many multicultural conciliators do we have?

Ms ADRIAN: That is something where I would have to ask the Conciliation Registry for that information. As you know they are part of the Department of Health. I am happy to take that on notice and provide that to the Committee.

The Hon. CHRISTINE ROBERTSON: Maybe what would be good too to provide with that is the interpretation facilities that they are able to utilise, because the health service of course has them, but whether or not they get access is another issue. Improvement in the number of referrals to the Health Conciliation Registry is welcome. The Committee would like to see an ongoing lifting of the rate of consents and thus referrals to the Health Conciliation Registry. Does the Commission have any comment on additional strategies to improve the number of consents obtained for complaints assessed for conciliation and referral to the Registry?

Ms ADRIAN: We are certainly working with our staff in the Commission to help them understand the importance of conciliation and being able to work with the Registry in trying to engage the parties. As I said before, one of the difficulties we have is that people see that they are being shrugged off to a second level resolution strategy, and I think that is going to be one of our challenges when we review our Act, is to make sure that we show equal value for all the resolution strategies and not create a hierarchy of expectation.

(Short adjournment)

CHAIR: I will reconvene the hearing. I will turn question 31, Mr Turner. We are deleting question 30 and moving to 31.

Mr TURNER: Commissioner, the Annual Report details expenditure of effort in staff training, review of organisational values and on piloting strategies. Is there a breakdown of staff time expended on these areas?

Ms ADRIAN: Probably the most evident is in the impact it had on our closure of investigations in the figures for the year before; in that we did have to pull staff in to look at what we were doing, what we needed to do better, where we could improve and things like that—I think probably in last year's figures, the investigation figures. But as far as a staff breakdown, a work based analysis, we do not have that detail of information, I am sorry.

Mr TURNER: As an addition to that, as a result, if the investment of time spent in staff training, review of organisational values and vision and piloting strategies, what is the Commissioner's assessment of staff readiness for task orientation?

Ms ADRIAN: I think we are seeing a very important improvement and change in the way that we are doing our business. I think some of the figures are evident in this Annual Report. My expectation is that they will be reflected in upcoming Annual Reports more and more. As you may be aware, the strategic directions process was around looking at how we could do that over the three years from 2002-05. It was not a one-year cyclical process because the challenges that face the Commission, I believe, need both the investment of time and effort that is more than a year or even two years can provide. It is a long-term investment of strategy and time. It did have an impact, I believe, most manifestly in our last reporting year. However, I think we are starting to see the benefits and improvements for the future.

Mr TURNER: I think you have answered the next one.

The Hon. TANYA GADIEL: Table 44 on page 102 of the Annual Report details workers compensation for the Commission. How many staff were on stress leave during last year?

Ms ADRIAN: Minimal.

The Hon. TANYA GADIEL: One on mental stress leave in that report.

Ms ADRIAN: One on mental stress leave in that report.

CHAIR: This table says "types of claims", "top types of claims". I thought that meant by number 1 was that mental stress was the top type of claim. Body stress was the—

Ms ADRIAN: No, there was one person.

CHAIR: That clarifies that.

The Hon. TANYA GADIEL: The Committee notes the organisational separation of legal services, including prosecutions from complaint resolution services—including investigations—and organisational development and support. The need for a structural separation of these areas was previously noted by the Committee. The Committee is disappointed to note the development and implementation of new computerised case management system for complaints was not achieved during the year. The HCCC secured significant resources for this process. The Committee believes that a great number of errors tracking problems and inefficiencies of the HCCC, identified through the course of the inquiry into investigations and prosecutions, could be overcome by timely implementation of the computerised case management system. What is the current time line for implementation of the computerised case management system?

Ms ADRIAN: I totally agree with you about our dinosaur of a database, absolutely. One of the challenges is, as you would appreciate we are working with other partners in this project—the ACT and Tasmania. In fact, some of the negotiations around the user specifications involved in that partnership have been some of the—our Commission has been

ready since late last year to go to tender. It has been the hold-up in the negotiation around the development of those user specifications with the other partners in the project that have held it up. We have reissued the expressions of interest because we were advised by the Office of Information Technology that has now become part of the Department of Finance that as the time gap—I think it is nine months—was such that we have had to reissue it, so we have had to add that to our processes. Those expressions of interest have now been received. The partners' Steering Committee meets on Friday to consider those. The day after, I hope we can put out the tender because, like you, I am totally dissatisfied with the system we are working with at the moment.

It has been a major investment. We did look at existing products to see if there was something there we could buy off the shelf. There was not, which is why the other two partners have joined us, because they had a similar need and had identified a similar problem. Certainly as far as wanting to go, and go tomorrow, that is our hope; that we will be able to issue a tender in the very near future, which will mean—I think there is probably six months while we work with the tenderer to develop the system. We have spent a lot of time investing in and making sure that the user specifications that we need are there, that they drive the technology, not the technology driving the user, which is a problem that we identified with a number of other agencies that had bought technology in this area; that ultimately they were beaten over the head with the technology rather than vice versa.

Mr SHEARAN: The summary of performance indicators on pages 20 and 21 refers to performance measures implemented. The Committee is concerned that although there are references to a case-made partnership in the benchmarking of one specific task, on page 15:, there is no detail of performance measures or evidence to suggest the HCCC is moving actively to introduce a set of benchmarks against similar organisations as per the Committee's previous suggestions. The Committee maintains that the HCCC should attempt benchmarking—and sooner rather than later—to ensure transparency and to remark upon the effects of organisational changes now under way.

I note earlier that you made references to benchmarking and difficulties with other jurisdictions, and you referred to New Zealand, but I am sure there must be some certain factors that are common to all jurisdictions. I was wondering whether there might be more

stringent efforts made by the Commission to institute performance review and benchmarking with other Australian jurisdictions, particularly where factors are common.

Ms ADRIAN: As I said to you, the Council is actively working towards that, the Council of Health Complaints Commission and Ombudsman are trying to work towards getting a set of benchmarks. Our difficulty is our products and our processes are so different, and while we might be able to say on the face of it that we are all conciliating and doing things like that, when you unpick what conciliation is for say Victoria as opposed to New South Wales, it is different. We have to be very careful, because they are very crude indicators if we pick them up and use them as they were. I know that my fellow Commissioners and Ombudsmen share my misgivings about doing that at this stage, without spending some time looking at the data definitions around what it is we do. I can only give the Committee an assurance that the Council is actively pursuing this. We will hopefully be

able to—all of us, the eight jurisdictions involved—have some benchmarkable data in the future. I am not sure when it will be.

The difficulty we have, for instance in New Zealand is that what they call an investigation sits across three or four of our processes: conciliation; investigation; direct resolution. It is quite a difficult challenge. It, on the face of it, seems an easy one but once we—I hear the Committee's request and certainly I will pass that on to the next Council meeting which is in November. We do have a session scheduled for that, at that Council meeting to continue that work.

CHAIR: Can I come in for the next question and say that the six States in Australia, two Territories and New Zealand all attend the six-monthly Commissioner or Ombudsmen's meetings. Three of those nine jurisdictions would have similar type processes: New Zealand, yourself and the ACT because they are both the conciliation and investigation organisations, even though it is very small.

Ms ADRIAN: When you unpick what they do and how they do it, it is different. Yes, we are—

CHAIR: Or similar to them.

Ms ADRIAN: Yes, we have been doing some work around it. Certainly the New Zealand and New South Wales match is closer than any of the others at this stage. Certainly the Commissioner in New Zealand and I have been starting to—I mean we have been benchmarking. It is just that the data is as yet unreliable. It is not reliable enough to publish.

CHAIR: My next question then is—there are two questions coming up: one is Medical Boards in other States undertaking what you are doing—investigations and prosecutions, in a sense. How often do the Commissioners group meet with maybe Registrars and Chairmen of other Medical Boards in other States to get some cross-fertilisations and ideas?

Ms ADRIAN: It is my understanding that each of the States meets with their Health Professional Registration Boards relatively regularly because they are colliding with complaints that involve the health professionals there.

CHAIR: So that individual State Commissioner then would bring that information along?

Ms ADRIAN: Yes, and certainly New South Wales is the only one that has a co-regulatory process. None of the others have that. New Zealand go the closest to it, but it is not quite the same and this is where the counting makes it difficult, because we are counting different things.

CHAIR: Then again, apart from yourself and New Zealand, most of the other jurisdictions around Australia are doing conciliation, and that is why it was suggested in the past that the Conciliation Registrar be invited to those meetings—the New South Wales Registrar. Has that happened, do you know? Was that agreed to?

Ms ADRIAN: It has been discussed at previous meetings. Certainly the Council at the meeting last time wanted to consider it further because they felt that it was a very different

role to the level and scope of business that each of the Commissioners were dealing with, and they certainly wanted to explore it further at the next meeting. But it was certainly put up on the table at the last meeting. One of the options was that the heads of the conciliation sections of each of the Commissions have some sort of network established.

Mr SHEARAN: Indicators are always difficult, but the consultant to the Committee, Mr John Chan Sew, notes that the performance indicators presented in the report relate to quantities and timeliness of outputs. There is limited coverage of outcomes achieved for quality and effectiveness aspects of performance. How does that the Commissioner believe the development of relevant and meaningful performance indicators can be addressed by the HCCC?

Ms ADRIAN: I have already indicated to the Committee that we are hoping to report on formal satisfaction surveys for patient support service and investigations in the next report. I am hoping as far as stakeholder satisfaction in relation to that, that will be evident. We are exploring other qualitative indicators to be able to report on. Once again, if the Committee has any ideas on what they would like to see in that area, we would welcome that. The difficulty we have in selecting those is their meaningfulness to our business. Certainly the performance indicators that we do report on are the ones that are required under the Act. We are looking at having a better qualitative framework of performance to be able to report against in the future as well.

CHAIR: Some of the things that I am going to raise now you have addressed, so do not think that I did not hear you earlier. The section on performance indicators, page 20-21, details aims but not performance measures, and does not indicate the degree of satisfactory performance with achievements. In the case of performance shortfalls, the explanation of the actions taken to address those shortfalls is expressed only in the terms of for the forthcoming year. There is still no provision of an organisational plan for the year.

The report refers—on page 14—to a strategic direction statement for 2002-05. We presume that is the value strategic directions and organisational model. But this document is neither appended, nor does it appear on the HCCC's web site.

The Annual Report continues to be weighed down in our belief with case studies, and I know that you have addressed this. These occupy 15 pages in addition to the almost four and a half pages of illustrative case studies throughout the text. The Committee had previously suggested that because the Annual Report is an accountability document, it was more appropriate for the HCCC to present such information through other communication mediums, and this remains the Committee's advice. How might these matters be addressed in the next Annual Report? And I know that that last point you have said you will address.

Ms ADRIAN: In relation to the strategic directions, at the review meeting of the Committee last year we tabled this document which is our strategic directions. It was my understanding that this was on our Internet web site. Certainly it has been there. If it has dropped off, I need to know about it and I will certainly go back and explore that because certainly—and I have recently finished the interviews for the Assistant Commissioner, and most of them picked it off the web site. I will check that.

CHAIR: Maybe we did not find it.

Ms ADRIAN: That is a question in itself too, and if it is too hard to find, then that is a problem, but certainly that has been available in the 18 months since we developed it on the web site. In my opening statement I also gave an assurance that we would be reporting against the goals in the next Annual Report, and I stand by that.

CHAIR: It may be in the report. I am not sure, I cannot see it, but you could highlight that that document is available on the web site in the report—direct people to it.

Ms ADRIAN: Yes, absolutely. As far as the case studies, I hope I have adequately addressed that in my opening statement.

CHAIR: I am checking some of the questions we prepared, and you have answered thoroughly.

The Hon. TANYA GADIEL: The report provides much information on completed initiatives or projects, but no details on what the Commission planned to achieve for 2001-02. It is therefore difficult for the Committee to determine the Commission's degree of success in what it had planned. Does the Commissioner propose to address the inclusion of planned targets in future Annual Reports in line with Treasury guidelines.

Ms ADRIAN: Yes. I think I did allude to that in my opening statement that that was a strategy for the next Annual Report.

The Hon. TANYA GADIEL: The Committee is pleased to note the addition of an Executive Summary in the report. However, in the Committee's view this needs to include current new targets for key performance indicators, financial information, plans and targets for the following year, future directions and developments, as previously suggested by the Committee. Will these deficiencies be picked up in the next Annual Report?

Ms ADRIAN: Certainly most of the them have, and if I could ask the Committee if I could have a list perhaps be provide, and I will make sure that we attempt to meet all of those requests. I know that a number of them we have picked up already, but I want to make sure that we have a match against each of them.

CHAIR: I am quite happy to give you a copy of our consultant's report.

Ms ADRIAN: That would be great.

CHAIR: I think you have spoken with him previously.

Ms ADRIAN: Yes, I have.

The Hon. TANYA GADIEL: The Committee also notes that the report lacks a statement on performance of the Commissioner. Clause 11 of the Annual Report, statutory bodies regulations, requires such a statement at the end of each reporting year. The

Committee is concerned that the HCCC's Annual Report should comply with the guidelines. Can the Commissioner explain this omission?

Ms ADRIAN: Certainly. Each year we request from the Minister a statement on performance, and we have not yet been furnished with one. The Minister last year in this annual reporting period—we have on record a letter to him requesting he furnish us with it, so that we could meet our reporting requirements. We did not receive one from him, despite following it up. Sorry, it is a horse-to-water situation unfortunately. We have attempted to obtain that because we are very cognisant of the requirement.

CHAIR: That is good. We will follow that up.

The Hon. Dr PETER WONG: No comment.

Mr SHEARAN: Back to indicators again. We have touched on this a number times. But the Committee is pleased to note the achievements in relation to outreach to Aboriginal communities, as detailed in Performance Indicators at page 66. In line with its other suggestions in this regard, the Committee proposes a need to benchmark performance with similar organisations in other jurisdictions. Does the Commission have any thoughts on ways that this might be achieved?

Ms ADRIAN: Certainly some of the Committee may be aware that there is a joint initiatives group across the other Ombudsmen—are you talking about within Health, or were you talking about across watchdog agencies within the State? I am not sure. I think I have addressed the question around Health jurisdictions that we do—

Mr SHEARAN: I am simply talking about outreaching to indigenous communities, other organisations that do—

Ms ADRIAN: Yes. The joint initiatives group that the Commission works with—for instance the Legal Services Commissioner, the Ombudsmen—those groups have been looking at outreach services and having joint initiatives. For instance, if the Ombudsman goes out to Broken Hill, then there is a package of goodies that he takes with them to give out to—when they are handing out Ombudsman brochures and things like that. There has been some work done around promotion and making sure that we take up opportunities like that.

The Commission has also committed to be part of that because, needless to say, particularly with our patient support services being out in more regional areas now we have more and more opportunity to do that, we have a commitment to be able to use, I guess, the limited resources of all the watchdog agencies to better effect, and make sure that we can get to other communities. It is not just Aboriginal communities that we have identified. There are other minority people in the community that we do not necessarily serve well. We need to attempt to do much better. Our promotions and consultation process has identified a number of those that we will be working much more actively—to engaging with—in the next two years.

Mr SHEARAN: Do you have a formal liaison with some of these other jurisdictions? You mentioned the Ombudsman.

Ms ADRIAN: Yes, there is. There is what we call a joint initiatives group, where all the Ombudsmen and Commissioners meet regularly. But there is also another level below that of high level officers that are working on projects together: education and training projects; using manuals; developing manuals. For instance, one common theme for all of us is that we do investigations, so rather than reinventing the wheel over and over again, making sure that we utilise the resources across those organisations. We call them the watchdog group. Most of the watchdog agencies are represented at that meeting. Sorry, I do not think I have answered your question adequately.

Mr SHEARAN: I am still wondering about that benchmarking. I know it is difficult with indicators, but if you have a formal liaison, is there a benchmarking process with those other organisations then?

Ms ADRIAN: Certainly there is, around investigations. There has been some joint and other work done in what is the best way to investigate—what are the processes and protocols. It is around process more than around numbers. What we have been looking at are things like what are the procedures that the Ombudsman uses, the Commission uses, the Legal Services Commission uses. What are the obligations under our legislation? I am still not answering your question, I can see.

Mr SHEARAN: I am a bit uncomfortable with it, but anyway, I might follow that up later.

Ms ADRIAN: No, please.

CHAIR: We will move on and that can form part of our next meeting with you on the investigations across submissions.

Ms ADRIAN: Yes.

The Hon. Dr PETER WONG: Commissioner, the Committee notes that there were few complaints in table 11—it is page 35—received about traditional medicine, which is alternative health provider with number seven cases, I think. I would like to add my personal comment. This is really—there are very few in number—in contrast to the view of many doctors, some politicians and Prof John Dwyer, the question is, are there any commonalities of the type of complaint received about this area? Furthermore, is this a true picture or have we missed a lot of complaints we did not pick up?

Ms ADRIAN: About the question as to the commonalities, no. They range from the extreme, such that we have seen recently prosecuted by the Director of Public Prosecutions in Newcastle around a naturopath—that was referred by the Commission to the Director of Public Prosecutions—to simple matters of informed financial consent. But there is no commonality. As far as is there a bigger iceberg under the bit that we are seeing, I would not like to comment on that.

Certainly one of the things that we have been doing is working with, for instance, the ACCC and Fair Trading around these sorts of issues, because the difficulty in this area is who gets the complaints. We have been working closely with ACCC and Fair Trading to try and

make sure that we have some capacity—and this might go to your question about benchmarking. What is the whole, what is the quantum of these, or are we dependent on people making a decision on which organisation it goes to? Certainly the issues around impotence clinics and some of the alternative health practitioners are things that we know go to both Fair Trading and ACCC as well as to us. We have a policy of making sure we refer matters like that, where possible, to those organisations so we know what the whole picture is as much as we can.

The Hon. Dr PETER WONG: I will ask an additional question to supplement. Does that mean clinical standards are somehow less important when applied to alternative medicine practitioners or they do not complain—or nobody complains.

Ms ADRIAN: I think the complaints in many cases can be similar: adverse treatment outcomes, inadequate treatment. I have no direct correlation between those factors here, but certainly the variety—I would not like to draw a conclusion on one thing being the main thing.

DEPUTY-CHAIR: I think a research study to see—

Ms ADRIAN: It is a research study in itself.

The Hon. Dr PETER WONG: Yes, a research study—

CHAIR: The Committee has been going around for some time doing an investigation into traditional medicine, alternative medicine, registration of Chinese medicine, such as in Victoria and overseas, so we will probably pursue that in the coming years.

Ms ADRIAN: The Commission would be pleased, and notes the report that was done by the Committee in the past, and supports most of those recommendations absolutely, because it is an area where, other than referral to the Director of Public Prosecutions or to a professional association, we are hamstrung in taking any real action. Indeed the matter that went to the DPP, while extraordinary, there needs to be a mechanism to protect the public that is less than a criminal—

The Hon. Dr PETER WONG: Do we share the feeling that is much better that alternative medicine be managed and registered rather than to let everyone go their own way?

Ms ADRIAN: Sorry, I am not—

The Hon. Dr PETER WONG: Do we have the impression that you agree that it is better for them to be registered and therefore under supervision, to have continuing education and under the proper complaints system rather than have no control whatsoever?

Ms ADRIAN: I think there is a such a range of different therapies that there has to be some recognition. I support the AHMAC process of looking at the level of potential harm. And yes, those who have the potential to harm people, there needs to be stringent regulation around.

Mr SHEARAN: Some of your comments might even overlap a little bit on this, but as the source of complaints, the report identifies a significant increase in the number of complaints from consumers. It quotes 752 or 65 and a half per cent compared with 1,443 or 50 per cent in the previous year, and a significant decrease in the number of complaints from Registration Boards; 409 or 15.3 per cent compared with 595 or 20.6 per cent in the previous year—I think it is outlined on page 37. Does the Commissioner have a view as to what may have affected these changes?

Ms ADRIAN: No, we do not. It is something we have been asking ourselves; is there any evidence to support a cause for this. I hope one of the causes is that we have been much more successful in getting good information out to people and many of you know that we have contacted each of the Members of Parliament after the election this year and provided them with a full package of information, and we have been trying much more strategically to get information out to the community about how they can make complaints themselves; that has been a commitment of ours. But the reason why there has been such a change in that profile is not evident to us.

As far as the Registration Board complaints, a complaint of the Registration Board is a deemed complaint of the Commission, so I am not sure—perhaps people have been writing on their own behalf. Certainly the counting has not changed in any way in that area.

Mr TURNER: Thanks, Mr Chairman. Commissioner, given that you have a significant decrease in the number of complaints from Registration Boards, you also have fewer complaints from the Commission going to Registration Boards; from 402—after assessment, somewhat fewer complaints 402 or 33.1 per cent were referred to Registration Boards in 2001-02 than in the previous year, 625 or 43.3 per cent. What factors might have affected the changes in the number of complaints referred to registration boards—that was on page 39?

Ms ADRIAN: I think there are a couple of factors that we would be able to identify. One is the increasing transfer of complaints to the Area Health Services, recognising that an individual professional may not be individually responsible for a problem; that in fact a hospital health service might have more overt responsibility as a whole. I think there has been a change in the way we refer those matters, and with our education and training for the Area Health Services, we are developing a confidence in their capacity to be able to manage those. The other comments I would make in relation to that is that our patient support service and the conciliation processes are picking up more and more of the timely flexible matters around, particularly communication, access to records, those sorts of things, that might have gone to the health Registration Boards in the past.

Mr TURNER: You have partly answered my next question. Similarly, figures for the referral of complaints to other bodies—a total of 16—have doubled. What trends might affect an increase in referral of complaints to other bodies, and what are the types of bodies referred to—and you have already mentioned the Area Health Services—

Ms ADRIAN: Yes, the Area Health Services certainly, and to the, for instance, Department of Health branches that have regulatory responsibility for investigating particular matters such as the pharmaceutical services area. The Private Health Care Branch has

responsibility for regulation of private hospitals, day procedure centres and nursing homes. But also we refer matters to other jurisdictions that might be more effective or have a stronger regulatory response to dealing with a problem. For instance, Fair Trading, where a matter really goes to the heart of a commercial issue to the Anti-Discrimination Board on matters of discrimination, and other areas like that. I guess we are looking at complaints much more carefully and looking at where the best resolution mechanism is available for people.

Mr TURNER: What might affect the doubling on the previous year of complaints awaiting processing? Again, in table 16, I do note the large figure there for 1999-00, then there is a dramatic drop and then it is now starting to increase.

Ms ADRIAN: I think that it really is the point of reporting. There is usually between 50 and 100 matters that we have in process because we probably get between 50 and 100 matters a week to process so it really is— at 30 June, that is how many we had received in the last week that we perhaps had not processed. That is probably a reasonably traditional figure, and I would say it probably always sits between 50 and 100 on average.

The Hon. Dr PETER WONG: Your report indicates that the HCCC reviewed—on page 44 by the way—193 assessment decisions, an increase of 26 per cent on the previous year. What might be the reason for such a significant increase in requests for assessment reviews?

Ms ADRIAN: I think that goes to the nub of what we were discussing earlier about people having a perception that there was a hierarchy of resolution strategies, and if we do not assess them for investigation then we are devaluing their complaint and, as you have remarked during the course of the meeting, we are referring more matters for conciliation. We are referring more matters for direct resolution and to the health services for action and investigation, and my own sense is that because our legislation says if it is serious you have to investigate it, and that is the paramount thing, then the people feel that we have not valued their complaint adequately, which I totally disagree with.

The Hon. Dr PETER WONG: In your view, is the Independent Complaints Review Committee operating effectively?

Ms ADRIAN: It is a very useful mechanism for providing a means by which a panel of people who are not Commission staff can look at the way the Commission has assessed and managed a complaint. They are appointed by the Minister. They are selected by their health professional and consumer organisations, appointed by the Minister. They have a role to look at with new eyes, de novo, from the beginning, what the Commission has done with the complaint, make comment on that and certainly the feedback they give is important to us, and recommend to me whether a matter should be reopened or dealt with differently.

Given that there is no statutory basis for it, my sense is that it is not a bad mechanism at the moment. The matters that they look at, I cannot think of a situation where we have not taken up their recommendation.

The Hon. CHRISTINE ROBERTSON: The report indicates, on page 50, a number of investigation reviews in which preliminary reports—it is the second paragraph on page 50 under "Information, Resolution and Complaints"—obtained during the last year either

contained inadequate information 68 per cent; revealed inadequate methodology, 14; or made inadequate findings, 18. Can you tell us what numbers of investigation reviews were involved in such particular percentage figures, and what reasons might underpin the inadequacy of the original investigation reports? I think it is a problem with the way it is written.

Ms ADRIAN: It may well be.

The Hon. CHRISTINE ROBERTSON: It looks like 100 per cent have been evaluated and they all failed.

Ms ADRIAN: No, not at all.

The Hon. CHRISTINE ROBERTSON: No, I know they did not. It is just that if it does not have the base line figure, it does not make any sense.

Ms ADRIAN: No, you are right. We reviewed 279 which is 82 per cent of 262 which is the figure on the bottom on page 48 which is the investigation by other agencies. We reviewed 82 per cent of—

The Hon. CHRISTINE ROBERTSON: Yes, but these figures about how many were found no good. So you reviewed 82 per cent which is a pretty good way of evaluating the work, but this discusses how many were not any good. It is 100 per cent according to the figures here, but there is no—

Ms ADRIAN: It is 68 per cent of the 18 per cent of the ones that we found were flawed. The thing that we found was the problem was the inadequate information in 68 per cent of that 18 per cent, inadequate in methodology in 14 of that 18 per cent, and inadequate findings in 18.

The Hon. CHRISTINE ROBERTSON: It is one of those times numbers might have been more useful.

Ms ADRIAN: Yes, and we probably needed an "and equals". Point taken.

The Hon. TANYA GADIEL: Table 30 on page 55 summarises the outcome of finalising investigations about health practitioners. One line indicates an outcome of "make comments to the practitioner about the complaint". What is meant by "make comments to the practitioner about the complaint"? That is at table 30 line 4.

Ms ADRIAN: Essentially it is in the past they used to be referred to as "adverse comments", but the legislation says "make comments about a complaint". It is a critical comment about a finding in relation to a finding in an investigation that something went wrong or their conduct was a problem. So on their record at the Health Professional Registration Board and in the Commission, that comment is there.

CHAIR: It is listed.

Ms ADRIAN: It is there. For instance, it might be that Nurse X failed to adequately check medications before giving them a patient according to the requirements under the schedule 8 Medication Guidelines. It basically is a criticism of the conduct of that person that is an outcome of an investigation.

The Hon. TANYA GADIEL: Similarly, what is meant by "terminated by the Commission", table 30, line 5? Does this mean that the practitioner is advised no further action will be taken by the HCCC against them in the matter?

Ms ADRIAN: Yes, it is.

The Hon. Dr PETER WONG: Can I say something—I am sure, I may be totally wrong—in the past my impression was some practitioners found it a threat of the HCCC that that person has to apologise or the HCCC will take further action. That is different from making comments to the practitioner about the complaint. What is your philosophy on that? There has been complaints to the Committee that the doctors on this list that the HCCC has said to them, "You either apologise to the patient or we take the steps further." Perhaps not under you, I am not saying that.

Ms ADRIAN: Certainly that is not my *modus operandi*. We would negotiate around an apology in a very different way to that. I mean, really with the open disclosure work that has been done by the National Council on quality and safety and things like that, it would be under that philosophical—and certainly an apology has no meaning unless it is well meant. The criticism might be that they failed to provide information to a person, and most people will recognise that an outcome of that might be to apologise to the complainant.

The Hon. CHRISTINE ROBERTSON: The report indicates the number of FOI requests received by the HCCC, and they came off a low of 33 requests in 2000-01 to 56 in 2001-02. The report notes the tendency for these to increase each year, but the 1999-2000 Annual Report shows a figure of 53 for FOI, so there appear to be more of a variable trend. Does the Commissioner have any comment to make on the trend or handling of FOI requests?

Ms ADRIAN: The Commission's position in relation to FOI is to release information on request. It only exercises a discretion to withhold if it raises personal information that a person is not entitled to receive. Our presumption we work from is to provide information, and then we evaluate it and see if there is personal information being given to a third party that they are not entitled to receive; in which case, we then go to the person usually and say, "Can we release it?" If they say "Yes", we do, and if not, then we do not. As far as the trends, I have no view. I think it is probably a trend that is seen across all agencies that it is variable, that is depends on what is happening politically and in the media and things like that. There is certainly no observable causation for it that we have been able to note.

CHAIR: On page 101 of the report, it contains a reference to adverse costs totalling \$295,000. Could the Commissioner provide details of adverse costs by case, including HCCC's costs to contest each case, and the costs awarded against the HCCC. If you do not have it readily available, I am quite happy for you to take that on notice and provide us with the details.

Ms ADRIAN: I think it would be more useful to do that than provide it off the top of my head here. I have some figures, but it is not the complete set of figures.

CHAIR: Maybe for that financial year, and seeing the last financial year is closed, it might help our current investigation, Commissioner.

Ms ADRIAN: Right, that is fine. However, I would note that the costs owed to the Commission and the costs outstanding are much higher than the adverse costs, and I am happy to provide that. Mr Swain, could you make sure that we have that available to the Committee.

CHAIR: The final formal question from myself, although I will open it up to Committee members who may have some other questions, the Committee's report on Mandatory Reporting of Medical Negligence, which we tabled in November 2000, recommended the development of pilot project using de-identified data regarding medical negligence litigation actions relating to gross negligence, professional misconduct, unsatisfactory professional conduct and consistent substandard performance. United Medical Protection, the New South Wales Medical Board and the HCCC had some discussions about moving the concept forward. Could the Commissioner comment on the process in this regard?

Ms ADRIAN: The Commission totally supports the recommendation made by the Committee because it is our view that there may be some connection in relation to matters that have been dealt with in the insurance claims area that would raise questions about the performance or conduct of individual practitioners. Our understanding is that the Medical Board has not yet received that information from the medical protection organisations for them to be able to pass it on to us. There are some, as I understand it, misgivings of the medical protection organisations in providing that information, particularly to the Commission. However, the Commission would be of the view that it would be very valuable information for us to have, but it is certainly very valuable information for the Medical Board to have. And with that information in their hands, they would be, I believe, obliged to review it and refer matters that they felt raised questions of professional conduct, performance or health to the Commission. But we totally support the spirit of recommendation.

CHAIR: Before Dr Wong asks his questions, I will clarify for the members, the report said that UMP and other insurers—you could say—of doctors should hand de-identified information to the Commission. That was agreed to by UMP who is the major insurer. I believe even the AMA in New South Wales agreed that it could be done if it was de-identified. That would allow the Commission to show in Annual Reports trends in different areas. I believe agreement was given that identified information would only be given to the Medical Board, and I think they were hoping that there would be some legislative or regulations put in place to allow them to do that.

I think the Health Care Liability Act that was put in place by the previous Minister for Health allowed him to make regulations, and I am not sure whether a regulation was made, but that regulation would have then directed that UMP and other insurers provide the information in two streams. de-identified to the Commission so they could report on trends in medical negligence litigation, identified to the Medical Board for them to examine in more detail to see whether a doctor or any practitioner needed some further investigation if that

name was reappearing regularly and it is not related to the type of practice. But that may need some more investigation, Dr Wong.

Ms ADRIAN: It is my understanding those regulations have not been made.

CHAIR: That is okay.

The Hon. Dr PETER WONG: Commissioner, I will slightly digress from that question. We asked the Medical Board of New South Wales a similar question, whether the doctor who sits on a tribunal or committee ought to have medico-legal and cross-cultural training. I understand your investigators that you mentioned earlier on to have a medico-legal training background, and you believe that it is appropriate also that your investigators will go through a similar process on cross-cultural understanding and training.

Ms ADRIAN: Absolutely, and in fact we have invested in cross-training both with Aboriginal cultural awareness and with other cross-cultures, and we will continue that.

The Hon. Dr PETER WONG: Very good.

CHAIR: That is the end of the formal questions. I would ask either the Commissioner or the Assistant Commissioner if they would like to make a closing comment and then I will close the hearing.

Ms ADRIAN: The Committee has identified a number of areas that they obviously have ongoing concerns about in relation to our annual reporting. I would welcome the opportunity of having those collated and provided to me, because we have worked very closely—I hope you can see some of the evidence of, in relation to the last review. We have also sought a review by the Annual Report awards group that do the Annual Report awards all over Australia, because we wanted to also pick up what it was that made Annual Reports awardable; not that we want an award, but we want to improve our reporting. I would welcome the information about the other areas: (a) that we have not perhaps succeeded to meet your needs in relation to the last review; but also the review that has obviously been conducted on this report. I give you an undertaking that we will endeavour to move towards meeting those requirements. Sometimes there is a tension between meeting different stakeholder needs, as we found with the case studies, that we probably need to be a bit strategic and lateral about.

CHAIR: I would like to thank the Commissioner and the Assistant Commissioner and the staff of the Commission who have come along today. It has been very informative for the Committee, particularly the new members of the Committee. We look forward to working with you over the coming months on completing our current inquiry into investigations and prosecutions. We will be contacting you over the next few weeks about probably sitting down and having a round-table meeting rather than a hearing to discuss some of the discussion points we put forward in our discussion paper last year on that inquiry.

Ms ADRIAN: That would be great.

CHAIR: Thank you very much. I declare the hearing closed.

(The Committee adjourned at 12.55 p.m.)

APPENDICES

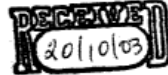
Appendix 1 – Letter from Commissioner Amanda Adrian dated
20 October 2003

Appendix 2 - Review of the 2001-2002 Annual Report of the Health Care
Complaints Commission by consultant to the Committee,
Mr John Chan Sew



HEALTH CARE
COMPLAINTS
COMMISSION

Appendix 1



Ms Catherine Watson
Committee Member
Committee on the Health Care
Complaints Commission
Parliament of New South Wales
Macquarie Street
SYDNEY NSW 2000

Dear Ms Watson

Please find enclosed the transcript of the proceeding of the meeting with the Committee of Thursday 18 September 2003. I have made some minor suggestions for your consideration.

Thank you for the extension of time, several staff members who are responsible for the provision of information have been on leave, which has prevented us from getting the data you requested. However, I am now able to provide the following, which I hope will help the Commission.

1. The quantum of additional resources directed into the investigation of complaints: I am informed a reasonable estimate will be \$267,000 at this stage. This expenditure has been directed at recruitment of 3 new Investigation and Resolution Officers (IRO), case review and ongoing education and development for less experienced IROs. As I stated to the Commission recruitment and selection of experienced Investigation Officers is never easy, despite our best efforts. It is the experience of most investigation agencies such as the Commission.
2. Active investigation and field visits by field officers during an investigation: The HCCC began collecting data from C & R during 2002/03 using its investigation surveys. The HCCC did not receive a statistically significant numbers of surveys. This information is therefore of no use, of those who did reply 70% reported five or more contacts by the investigation resolution officer.

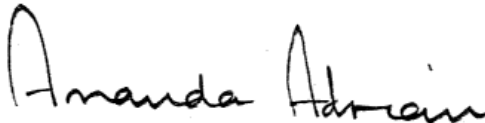
The HCCC also began a secondary process of collecting information from IRO's. In 2001-02, the information indicated that 58% of complainants were interviewed and 36% of respondents were interviewed. The information collected does not provide the number of patients who were offered an interview who refused. The data was also collected in 2002-03, however the data was lost due to operator error. This data is not highly useful in itself as other contextual information is not available eg. the number of complaints involving deceased patients; the number of complaints involving incompetent complaints (dementia etc); the number of complaints where the nature of the investigation does not require a complainant interview, and the number of respondents who elect to make no response to HCCC at all, or where it would be an inefficient use of Commission resources where a complaint or response is sufficiently particularised to proceed.

It would not be a good use of Commission resources to collect this data, particularly when other sources of information eg. the car log books indicate more field work is being undertaken. Perhaps more important to the achievement of the Commission's strategy are the process measures being put in place. These include a revision of the Commission's letters to invited every party for an interview with the Commission and training for the IRO's to improve their confidence in interviewing and statement taking.

3. Reporting error in a number of written complaints about the Commission: In its Annual Report 2001-02 the Commission noted an error in the percentage number of written complaints as percentage of the total number of complaints on page 63. The Commission Annual Report 2001-02 reported the proportion of .01 as a percentage of (.01%). This error will be corrected in the 2002-03 report.
4. The number of open investigations concerning individual health practitioners has reduced from 510 (not 514 as stated by the Commission) to 347.
5. Legal costs, see the attached table headed Legal Services Team, Legal Costs.

Should the Committee require any further information I will be pleased to provide this.

Yours sincerely



Amanda Adrian
Commissioner

20 October 2003

Appendix 2

Review of the 2001-2002 Annual Report of the Health Care Complaints Commission

The Health Care Complaints Commission has been given a number of specific statutory responsibilities to promote quality health care in the state of New South Wales. Therefore, it is critical for the annual report each year to provide a "clear and concise 'snapshot' of the vital work" that was carried out during the year under review. This was, in fact, stated as the aim of the 2001-2002 report in the "Commissioner's Observations" section (see page 12).

To be an effective instrument of accountability, the Committee is of the view that the report must contain a strong outcomes focus with clear linkages to the objectives, strategies and outputs. In reading the report, the stakeholders should be able to assess the extent to which the Commission has succeeded in promoting quality health care (including contribution to the final impact on health care consumers).

The Committee is pleased to note that there have been a number of improvements made to the annual report as a result of the adoption of some of the Committee's previous recommendations. However, the Committee's view is that the desired aim of good accountability reporting still has not yet been fully achieved. To attain an "exemplary" status in terms of future reporting, a number of important issues would need to be addressed by the Commission. The comments below are focussed on those issues which include:

- improvements to the existing performance measurement and reporting approach;
- overcoming other deficiencies noted in the 2001-2002 report;
- a complete restructuring of the form and content of the report; and
- further strengthening of the current legislative framework.

Improvements to Performance Measurement and Reporting

In relation to the measurement and reporting of performance, the Committee's major concern is that the Commission's current approach does not enable a clear picture to be provided of what the Commission set out to achieve; what it did achieve (as compared to plans) during the year; and what it plans to achieve in the following year. The Committee's finding is that the past reports did not provide sufficient and relevant information to the readers to enable a proper assessment of the extent of the achievement of the Commission's vision and aims.

The major deficiencies of the current approach that need to be addressed are detailed below:

- The aims of the Commission as currently drafted (see page 18) are mainly related to the processes rather than the outcomes of performance. The outcomes that the Commission seeks to achieve (as identified in the Vision Statement on page 18) are to improve health standards and the quality of health care services in New South Wales. Therefore, it is necessary as part of the review to revisit the aims of the organisation.
- Most of the performance indicators presented in the report are related to the quantities and timeliness of the outputs and there is limited coverage on the outcomes achieved and the quality and effectiveness aspects of the performance. In the Committee's view, more work still needs to be done in developing relevant and meaningful indicators of performance outcomes. For example, further improvement is required in the conduct of consumer feedback surveys in relation to the patient support service and the investigation and prosecution processes. Changes that are considered necessary include:
 - ensuring that the survey methods (e.g. questionnaires) are properly designed to obtain meaningful responses to issues that are reflective of the different aspects of the Commission's performance (including suggestions for service improvement);
 - increasing the response rates to survey requests to enable valid conclusions to be drawn; and
 - subjecting the survey processes to periodic independent reviews.

The feedback surveys should be extended to cover other stakeholders as identified on page 18 of the report e.g. staff members and interest groups. In addition, it would be helpful to also publish the results of all internal reviews of the Commission's operations in the annual report together with details of remedial actions.

- Details of the survey methodologies, findings and actions taken or proposed to be taken to improve services should be fully documented in the report. This is not the case at present.
- Only some performance targets for the current year have been provided in the report and generally the explanations given for under/over performance (in comparison with last year's results or targets) are not adequate. In addition, there is limited information disclosed on the lessons learned and specific actions taken to address under performance.
- Although there is a lot of information given throughout the report on completed initiatives and projects, it is difficult to determine whether the Commission was in fact successful in delivering what it planned to achieve as the details relating to initiatives and projects planned for the 2001-2002 year have not been provided.
- At present, there is an absence of a benchmarking comparison with the performance results of similar agencies in the State and in other Australian jurisdictions.

- The Committee is also concerned about the adequacy of the explanations given for the results of various activities. By way of an example, it has been noted that only limited comments have been provided in the report about the high percentages (about 50%) of the investigations of health service organisations and health practitioners being terminated by the Commission and also about the results of investigations. In the case of health service investigations, there is only a one-sentence explanation for the results of 22 (out of a total of 43) investigations completed in 2001-2002 which reads:

“The Commission made comments or recommendations at the end of 22 investigations in relation to policies, guidelines, procedures and training”.

Other Issues Relating to the 2001-2002 Report

There are a number of other disclosure issues identified by the Committee in the Report. They should also be taken into account in the restructuring of the report, as explained in the next Section.

The inclusion of an Executive Summary is a positive feature of the report. However, the coverage of the Summary is inadequate in the following respects:

- The key performance indicators disclosed are mainly related to volumes of activities and there is no information given on effectiveness and outcome indicators.
- Current year's targets for the key performance indicators have not been provided and generally the Summary only gives a very limited discussion and analysis of the challenges and achievements.
- The survey of consumers and the review of service planning and delivery conducted during the year are mentioned but the results have not been provided.
- There is an absence of financial information for the year and also there is no mention of the plans and targets for the following year nor any commentary on future directions and developments.

The “Performance Indicators” Section only presents a list of projects and initiatives planned for the current year and brief details of achievements as well as another list of projects and initiatives for the following year. The heading of this particular Section is misleading as it does not contain any of the quantitative measures of performance that are disclosed throughout the report.

In the "Review of Operations" Section of the report, the Committee has noted that the presentation of the key performance indicators is intermingled with a large number of tables of other non performance-based statistical data. The Committee believes that the prominence of the performance-based indicators can be increased by presenting them together at the beginning of the Section and they should be accompanied by a detailed discussion and analysis.

Restructuring of the Report

To be an effective accountability document, it is the view of the Committee that the form and content of the annual report would need to be substantially changed. In addition, the large amount of low level details relating to, for example, functions, activities and minor initiatives and projects should be removed as previously recommended by the Committee. Detailed information relating to the functions and activities of the Commission (which may be of interest to specific stakeholder groups) should be provided on the Commission's website and/or through other forms of communication (e.g. information brochures).

The focus of the report should be on explaining, in simple terms, what the Commission set out to achieve; what it has in fact achieved in terms of outcomes for the stakeholders and improvements in the services provided. At present, the reporting on the critical success factors is not sufficiently comprehensive and it has also been somewhat detracted by the vast amount of non performance-based information presented throughout the report. Future reports should seek to clearly delineate the causal links between the key drivers of performance (for which the Commission is responsible) and the outcomes achieved.

The Committee believes that the following changes to the form and content of the report would be appropriate:

- A short "Foreword" by the Commissioner (not 8 pages as in the 2001-2002 report).
- A statement on the vision, charter, aims and objectives, major strategies and stakeholders of the organisation.
- An "Overview" or "Executive Summary" Section at the beginning of the report commenting briefly on:
 - significant issues and developments which had an impact on the performance during the current year and future directions and outlook for the following year (including both positive and negative factors);
 - key performance targets and results achieved (including explanations for any major variances);
 - trend data on performance for the key result areas;

- significant projects/initiatives completed against plans as well as key projects/initiatives identified for the following year; and
- financial results and position for the current year as compared to budgets and past trends.

[Note : The Sections on "Year at a Glance" (page 5), "Executive Summary" (pages 6 & 7) and "Performance Indicators" (pages 20 & 21) in the 2001-2002 annual report can all be deleted]

- An Organisation Chart accompanied by a brief explanation of the corporate governance arrangements and decision making processes.
- A "Review of Operations" Section providing a balanced discussion and analysis of the performance results achieved during the year in relation to the major areas of activities. Emphasis should be given to the reporting of performance outcomes and effectiveness (rather than types and volumes of activities) e.g. consumer feedback, results of conciliations, investigations and prosecutions and time intervals involved in the complaints and investigation processes. To assist the stakeholders in assessing the performance of the Commission, the following information must be provided:
 - A comprehensive set of key performance indicators relating to all major aspects of the operations together with a commentary on the meaning and background contexts of the indicators.
 - Performance targets for the current year as stated in the Strategic and Corporate Plans.
 - A comparison of the actual performance achieved during the year with the targets set.
 - Explanations for instances of major under and over performance and, in the case of under performance, details of lessons learned and actions taken to improve services.
 - Trend data (preferably over a five year period) accompanied by a detailed commentary on the changes over time. (The aim is to give a "continuing story" on the performance of the organisation).
 - A benchmarking comparison with the performance results of similar agencies in the State and in other Australian jurisdictions.
 - An outline of the major initiatives and projects planned for the current year and details of the results achieved (together with an explanation for any delay and the revised target date for completion).
- A separate Section on "Future Directions and Developments" providing forward-looking information and comments such as:
 - a discussion of the future outlook for the Commission including issues and events that are likely to have a significant impact on the following year's performance;

- details of expected future changes and trends within the Commission's operating environment; and
 - an outline of what the Commission aims to achieve in future years (particularly the next 12 months) e.g. planned key projects and initiatives and quantitative measures of performance.
- A "Finance" Section presenting summarised Statements of Financial Position and Statements of Financial Performance over a five year period and a detailed commentary on all major variances from last year and budgets as well as on significant changes over time. This Section should also address all important financial management and accounting issues faced by the Commission during the year.
 - All case studies should be transferred to the Appendices Section with only the major issues identified in the studies being discussed in the relevant parts of the "Review of Operations" Section of the report.

It should be noted that the performance-based disclosures recommended above are consistent with the intent of the existing annual reporting legislation and the guidance provided by Treasury from time to time.

Strengthening of the Current Legislative Framework

At present, section 95 of the Health Care Complaints Act 1993 prescribes the following information for inclusion in the annual report:

- the numbers and types of complaints received, assessed, referred for conciliation and investigated.
- the results of conciliation, investigation and prosecution; and
- the time intervals involved in the complaints process.

To ensure a comprehensive and robust performance reporting approach, the Committee believes that it is important to expand the current legislative framework to specifically require the inclusion of other additional information such as:

- performance targets for the current year;
- performance results achieved particularly the outcomes of the conciliation, investigation and prosecution processes in terms of their impact on health standards and the quality of health care in the State;
- explanations for under/over performance relative to targets and details of actions taken to address performance deficiencies;
- a commentary on the trend data relating to key aspects of the Commission's performance;

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- timeliness of the processes relating to complaints handling, investigation and prosecution;
- feedback surveys of consumers and other stakeholders conducted during the year including details of survey methodologies, major findings and actions taken to improve services;
- a summary of major projects and initiatives planned for the current year and the results achieved; and
- a summary of major projects and initiatives planned for the following year.

Non-Compliance with Annual Reporting Requirements

From the review of the report, the Committee has also noted that the Commission has not included "A Statement on the performance of each executive officer of or above Level 5 holding office at the end of the reporting year." The Commissioner's position is at Level 5 of the Senior Executive Service. According to Clause 11 of the Annual Reports (Statutory Bodies) Regulations, this Statement is required to be made by a person responsible by law for reviewing the Commissioner's performance and is to indicate the Commissioner's performance having regard to the agreed performance criteria.