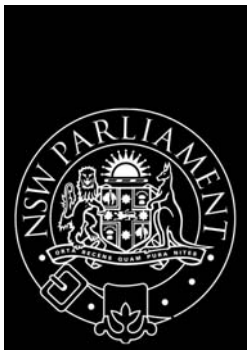

PARLIAMENT OF NEW SOUTH WALES

Committee on the Health Care Complaints Commission

INQUIRY INTO INTERNAL COMPLAINT HANDLING IN PRIVATE HEALTH PRACTICES

November 2006

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Terms of Reference

The Committee on the Health Care Complaints Commission is to inquire into and report on the following:

- The adequacy of existing models and methods of resolving health complaints in private practices and clinics other than those required to be formally investigated by the Health Care Complaints Commission under Section 23 of the Health Care Complaints Act 1993;

- Alternative models and methods of resolving health complaints in private practices and clinics other than those required to be formally investigated by the Health Care Complaints Commission under Section 23 of the Health Care Complaints Act 1993;

- Models and methods of resolving health complaints in private practices and clinics in comparative jurisdictions;

- Any other related matters.

Chairman's Foreword

Recent trends in the resolution of health complaints in Australia, and indeed New South Wales, have seen health complaints Commissions nation-wide commit to referring low-level complaints against health facilities back to the point of service for early resolution before providing external intervention.

With the resources of the NSW Health Care Complaints Commission now largely being directed into the investigation and prosecution of more serious complaints, it became evident to the Committee that it was even more important to assist private practices and clinics to more effectively resolve low-level complaints internally.

In general, the Committee has found that public health facilities have access to greater resources to assist with the internal resolution of low-level complaints than do private health facilities. Private health facilities are not directly comparable to public health services, as they differ substantially in characteristics such as size, staffing levels and operating budget. As such, the complaints protocols and systems of private health services cannot be expected to reflect those present in larger public health facilities.

Not a great deal of work specifically relating to equipping private practices and clinics to manage low-level complaints internally is being done in most Australian jurisdictions.

At a basic level, several state health complaints Commissions are involved in the provision of education and training to health practitioners and clinics around effective complaints management. Although not extensive, this training does expose practitioners to the essential elements of a successful complaints management approach and can educate them about the services the relevant state Commission can provide to assist their practice when a complaint has been received.

During the course of this Inquiry the Committee became aware that a Victorian Division of General Practice had joined together with the Medical Defense Association of Victoria and the Victorian Health Services Commission to develop protocols and systems to assist General Practitioners and their staff to both reduce the incidence of and adequately respond to consumer complaints.

Known as the Conflict and Litigation Management (CALM) pilot, this project involves the following: training general practitioners and other frontline staff in communication and complaints management, developing a complaints coding system and database to enable the consistent recording and reporting of complaints across Divisions and training independent mediators to assist in the resolution of consumer complaints.

The project is based on three levels of intervention: internal complaint handling, local complaint handling, and mediation, with each level being attempted prior to increasing the level of involvement.

The Committee was particularly impressed with the CALM model. Consequently, a Roundtable event was hosted by the Committee at NSW Parliament House on Thursday 28

September 2006. This event brought together key organisations involved in private health complaints management in NSW and developers of the pilot program.

Reponses to the CALM project from NSW representatives was positive, with participants agreeing that the Pilot provides an excellent opportunity for General Practices to link in with other members of the community involved in alternative dispute resolution processes. All participants expressed support for the trial of a similar project in NSW, and tentatively offered the involvement of their organisation provided certain conditions were first met.

Without a formal evaluation of the project, which has yet to be completed, no conclusions can be drawn about the effectiveness of the CALM project in reducing the number of consumer complaints and claims, or in increasing the effectiveness of General Practitioners in responding to consumer concerns when they arise. Nevertheless, the Committee believes that the processes and strategies employed by the project are worth exploring in NSW.

Giving careful consideration to the qualities of a practice that are likely to assist in the success of the pilot, the Committee has recommended that discussions be held between NSW Divisions of General Practice, the Central Highlands Divisions of General Practice (Victoria), the Medical Defense Associations of Victoria and NSW, United Medical Protection and the Royal Australian College of General Practitioners to determine the feasibility of two or three NSW Divisions of General Practice participating in the CALM trial.

The Committee has been informed that much of the CALM methodology could be easily transferred to other health settings with minimal modifications. Pending the outcome of the CALM pilot evaluation, the Committee also recommends that the transferability of components of the CALM model to other health service providers be explored.

Evidence received to the Committee Inquiry suggests that there is both a practitioner and consumer component to effective complaints resolution. Consequently, the Committee strongly believes that a multifaceted approach to internal complaints management is needed that focuses on both equipping health service providers and assisting health consumers.

The Committee would therefore like to see a comprehensive approach to improved low-level resolution of complaints adopted that incorporates the following: improved access to the Complaints Resolution Service for both providers and consumers, improved access to conciliation (through the Health Conciliation Registry) and mediation services, NSW involvement in the CALM pilot, improved training in complaints management for practitioners and their staff and the introduction of measures to regularly monitor patient satisfaction.

The Committee has made a number of detailed recommendations that it believes, if implemented, will dramatically improve the handling of low-level patient complaints in private practices and clinics. These recommendations will also benefit health care consumers and substantially reduce the number of low-level complaints flowing to the NSW Health Care Complaints Commission.

I would like to thank all those who made submissions to the Inquiry and in particular those who provided evidence before the Committee. Members of the Committee greatly appreciate their participation in the Inquiry.

I would also like to thank my fellow Committee Members for their contribution, as well as the secretariat Ms Catherine Watson, Ms Samantha Ngui, Ms Belinda Groves and Ms Glendora Magno for their assistance in the preparation of the Report.

As this will be my final Inquiry report as Chairman of the Committee during the 53rd Parliament, I would also like to thank all current and previous members of the Committee and secretariats who have served with me on the Committee during the 52nd Parliament (1999-2003) and the 53rd Parliament (from 2003). It has been a pleasure to work with them in an effort to improve the operation of the Health Care Complaints Commission.

JEFF HUNTER MP
Chairman

List of Recommendations

Chapter One - Background

1.1 Generic complaint research shows that for every complaint made there are likely to be 26 dissatisfied consumers who do not lodge a complaint.[1]

1.2 Research conducted in South Australia suggests that consumers may not complain about a health service for the following reasons (in order of frequency):[2]

- Lack of trust and/or confidence that the service would respond;
- Did not know how to complain;
- Fear of retribution;
- Personal difficulty.

1.3 Nevertheless, a substantial number of complaints are received daily by practices and clinics across NSW, as well as by patient representatives, registration boards, professional associations, indemnity insurers and the Health Care Complaints Commission. Figures on the number of complaints received in NSW are included in Chapter Nine.

1.4 The reasons that consumers complain about health services vary. Data collected by the NSW Health Care Complaints Commission (HCCC) suggest that concerns about treatment and communication are the most frequently recorded consumer complaints.[3] The significance of interpersonal behaviours as a source of complaint has strong support in the literature:

> Interpersonal aspects of care appear to be extremely important to the health consumer. Consumers expect health professionals to be competent, but they are also increasingly demanding quality of process, a key part of which is the interpersonal aspect of care… There is evidence that good interpersonal patient-centered care results in better health outcomes providing a good link between process and outcomes.[4]

1.5 A 1998 study by the Singapore Ministry of Health examined all reported reasons for complaints against general practitioners in a one-year period, determining practitioner attitude/conduct to be the number one reason for complaints (28.8% of all complaints received). Other frequently cited reasons for complaints included:

- Professional skills;
- Waiting times;
- Patient expectations; and
- Communication.[5]

1.6 The major sources of consumer complaint in other private health facilities are not as well researched, however it would be reasonable to expect substantial similarity to those observed in general practice complaints data and in overall data collected by the HCCC.

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[1] Denham, J. (1998). *Handling consumer complaints: turning challenges into opportunities.* Prentice Hall: Syd.
[2] Consumers Association of South Australia. (2002). *Survey of consumers' experiences regarding health complaints.*
[3] Annual Report of the Health Care Complaints Commission (2004/2005)
[4] Brand, D., & Wright, D. (2004) *General Practice in Australia*. Australian Department of Health and Ageing.
[5] Lim, H.C., Tan, C.B., Goh, L.G. & Ling, S.L. *Why do patients complain? A primary health care study.* Singapore Medical Journal, 39(9), 390-395.

1.7 The importance of clinics and practices responding effectively to a consumer complaint cannot be underestimated, particularly with research showing that up to 43% of unsatisfactory encounters with a service may stem from employees' inability or unwillingness to respond to service failure.[6]

1.8 It is not surprising, then, that much evidence exists to support the benefits of handling complaints quickly, at the local level, and close to the source of concern. Failure to do so can often serve to exacerbate the initial concern or irritation, which may otherwise have been easily resolved.

1.9 Advantages of prompt local resolution for the service provider include fewer resource strains, reduced financial cost and, potentially, a reduction in litigation. Through giving consideration to a consumer's concern and providing a detailed explanation or resolution, service providers are also given the opportunity to prevent future dissatisfaction with the service and any negative word-of-mouth that may have otherwise resulted from an unresolved concern or grievance.

1.10 Research has also shown that an effective response to a consumer complaint can increase the likelihood of consumer retention and loyalty, promote positive word-of-mouth advertising and result in an enhanced relationship with the patient (in many cases more so than if the complaint had not been received in the first place):

> Well-handled complaints can create loyal patients and increase profits. There is always something positive that can be done about a complaint. The focus of an organization is to create and keep patients - and effectively addressing a complaint is really an opportunity to create a positive experience with customers - in addition to preventing them from going to a competing clinic or hospital. At the very least, a complaint is an opportunity to strengthen your relationship with the complaining patient.[7]

1.11 This finding has been replicated in other settings, with a study conducted by Coca-Cola and IBM showing that resolution of a consumer complaint on first contact achieved 10% higher satisfaction and loyalty than resolution via multiple contacts.[8]

1.12 For the consumer, a prompt and adequate response from the service provider can prevent further frustration, distrust and scepticism, and can assist the consumer to understand the circumstances surrounding the event that disturbed them. They can then make an informed decision as to their next course of action.

Complaints as a Mechanism for Continuous Quality Improvement

1.13 Over the last decade there has been a trend in the health setting away from viewing consumer complaints as something to be discouraged and/or avoided and towards consumer complaints as a vital source of information to feed continuous quality improvement activities:

> …different types of patient feedback on healthcare received derived from surveys, patient groups, or complaint procedures… can be used for continuing education and service improvements.[9]

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[6] Bitner, M. J., Booms, B. H., & Tetreault, M. (1990). *The service encounter: diagnosing favourable and unfavourable incidents.* Journal of Marketing, 54(1), 71-84.

[7] *The complaint prescription: finding hidden wisdom in consumer complaints*. Shaw Resources. (October 2006).

[8] Goodman, J. (1999). *Basic facts on customer complaint behaviour and the impact of service on the bottom line*. Competitive Advantage, June, 1-5.

[9] Wensing, M., & Elwyn, G. (2002). *Research on patient's views in the evaluation and improvement of quality of care*. Quality and Safety in Health Care, 11, 153-157

1.14 Whilst complaints requiring critical systemic change tend to be of a more serious nature, low-level complaints can also reflect a broader problem with the culture and/or approach of a service.[10]

1.15 For the purposes of this inquiry, it is the low-level management of consumer complaints that is of most interest to the Committee.

1.16 In March 2005, the role of the NSW Health Care Complaints Commission was refocused to centre on the investigation and prosecution of serious complaints.

1.17 Previously, the Commission's role was to:

- Facilitate the maintenance of standards of health services in NSW;
- Promote the rights of clients in the NSW health system by providing clear and easily accessible mechanisms for the resolution of complaints;
- Facilitate the dissemination of information about clients' rights throughout the health system; and
- Provide and independent mechanism for assessing whether the prosecution of disciplinary action should be taken against health practitioners who are registered under health registration Acts.

1.18 Under the amended legislation, the role of the Commission was changed to:

- Receive and assess complaints relating to health services and health service providers in NSW;
- Investigate and assess whether any such complaint is serious and if so, whether it should be prosecuted;
- Prosecute serious complaints; and
- Resolve or oversee the resolution of complaints.[11]

1.19 With the Commission's resources now largely being directed into the investigation and prosecution of more serious complaints, it becomes even more important to assist organisations to more effectively resolve low-level complaints internally.

1.20 Generally speaking, public health facilities are often better equipped to respond to consumer complaints made against their organisation than are private health facilities. Public facilities (particularly public hospitals) will have designated complaints managers (or even complaints teams) as well as patient representatives, and have established protocols and systems for the reporting and monitoring of consumer complaints and the implementation of resulting actions.

1.21 Private health facilities cannot be directly compared to public health services, as they differ substantially in characteristics such as size, staffing levels and operating budget. Accordingly, the complaints protocols and systems of private health services cannot be expected to reflect those present in larger public health facilities.

1.22 As a basis for understanding the makeup of private health facilities in NSW, characteristics of medical facilities in Australia are provided below.

[10] Briefing with Ms Leena Sudano, South Australian Health and Community Services Complaints Commissioner
[11] Annual report of the Health Care Complaints Commission 2004/2005

Private Health Facilities in Australia

1.23 The Private Medical Practices Survey (2001/02), conducted by the Australian Bureau of Statistics, provides data on the number and characteristics of General Practices and specialist medical facilities in Australia.

General Practices

1.24 As at June 2002, there were 9,600 private General Practices in Australia, 4,857 of which were located in NSW. Single practitioner practices accounted for 68.5% of these. Only 100 practices consisted of more than 10 general practitioners (1% of total General Practices).

1.25 A breakdown of practices sizes across Australia can be found in the following table:

1 Practitioner	2-5 Practitioners	6-10 Practitioners	>10 Practitioners	Total
6,579	2,429	492	100*	9,600
68.5%	25.3%	5.1%	1.0%	100%

*Estimate has a relative standard error of between 10% and 25% and should be used with caution

1.26 On average, General Practices employed approximately 2.9 persons. Large practices (those with >10 practitioners) employed an average of 91.9 persons each.

1.27 Over 83% of all General Practices were based in capital cities or other metropolitan centres, followed by 14.6% in rural areas and 1.5% in remote areas.

Specialist Medical Practices

1.28 Private specialist medical practices included in the ABS survey were:

- Anaesthesia;
- Dermatology;
- Diagnostic imaging;
- Internal medicine;
- Obstetrics and gynaecology;
- Ophthalmology;
- Paediatrics;
- Psychiatry; and
- Surgery.

1.29 In June 2002 there were 9,864 specialist medical practices in Australia. 5,696 (34.3%) of these were located in NSW. Surgery had the highest number of practices, followed by internal medicine, psychiatry and anaesthesia.

1.30 Specialist medical practice sizes are shown in the following table.

1 Practitioner	2-5 Practitioners	6-10 Practitioners	>10 Practitioners	Total

8,845	871	92*	56*	9,864
89.7%	8.8%	0.9%	0.6%	100%

*Estimate has a relative standard error of between 10% and 25% and should be used with caution

1.31 As can be seen from this table, single practitioner clinics accounted for 89.7% of specialist practices as at June 2002.

1.32 On average, 3.2 persons were employed in each specialist practice.

Other Private Health Facilities

1.33 Whilst General Practices and other specialist health facilities comprise the bulk of private practices and clinics in NSW, a number of other health professions practice predominantly in the private sector.

1.34 For the purposes of this inquiry, the Committee has focused on registered health professions whose workforce largely practises in the private setting. These include: chiropractors, psychologists, optometrists, dentists, osteopaths, physiotherapists and podiatrists.

1.35 No data is specifically available to confirm the number of these registered professionals working in a private health clinic, and there will certainly be a proportion that are employed in the public sector.

1.36 Nevertheless, to provide an estimate of the potential extent of professionals practicing in the private health setting the number of registrations with each of the respective NSW registration boards are presented below:

Profession	Number
Chiropractors	1305
Psychologist	8636
Optometrist	1654
Dental Technician/Prosthetist	723/419
Osteopath	508
Physiotherapist	423
Podiatrist	783
Total	14,451

Chapter Two - Private Practice Internal Complaints Handling in NSW

Patient Support Office/Complaints Resolution Service

2.1 The NSW Health Care Complaints Commission established the Patient Support Service in 1996 as a localised support service for consumers with concerns about both public and private health services:

> "The assistance provided… is available regardless of whether the complaints relates to a public health service provider or a private health service provider. Factors that are relevant to determining whether referral to a CRO is appropriate are generally not affected by the nature of the ownership or control of the provider. The outcomes that can be achieved through the involvement of CROs are also generally not affected by the nature of the ownership or control of the provider."[12]

2.2 The role of the Patient Support Service was:

- To promote and protect the rights of health consumers;
- To assist in the timely, efficient and effective resolution of health concerns;
- To empower people to have a positive and active role in their health care and to resolve their own concerns in the future;
- To facilitate access to appropriate health care;
- To assist consumers and health providers to understand approaches to local resolution of health concerns.[13]

2.3 Several different types of services were made available to patients through the Patient Support Service, including information, support and assisted advocacy. Examples of services provided include assisting the client to draft a letter of complaint, advising consumers on where to obtain further medical advice, assisting them to find avenues for formal complaints, arranging and/or attending meetings between the complainant and service provider, locating appropriate health services for the client, and acting as an advocate for the consumer throughout the complaints process.

2.4 Patient Support Officers could respond directly to requests for assistance from consumers or health services, and also received referrals from the Health Care Complaints Commission when a consumer did not wish to lodge a formal complaint. In 2003/04, 32.9% of complaints managed by the Patient Support Service were received through sources other than the Health Care Complaints Commission.

2.5 Patient Support Officers, although located within Area Health Service facilities, were designed to operate independently of the Area Health Services. The independence of the service was regarded as especially important given that a large part of the role of the Service focuses on providing assistance to the patient, which would be undermined by perceived connections to the health services.

2.6 The number and location of Patient Support Officers employed by the Health Care Complaints Commission between 2000/01 and 2004/05 were as follows:

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[12] Submission Number 6 from the NSW Health Care Complaints Commission

[13] Health Care Complaints Commission, 2003, Health Care Complaints Commission- Annual Report 2002-2003, page 19.

Year	Number of PSO's	Location of PSO's
2000/01	8 + Manager	Liverpool, Penrith, Mount Druitt, Pagewood, St Leonards, Balmain, Newcastle and City (Head Office)
2001/02	8 + Manager	Liverpool, Penrith, Mount Druitt, Pagewood, St Leonards, Balmain, Newcastle and City (Head Office)
2002/03	8 + Manager	Liverpool, Penrith, Mount Druitt, Pagewood, St Leonards, Balmain, Newcastle and City (Head Office)
2003/04	11 + Manager	Central Sydney, Northern Sydney, Penrith, South Eastern Sydney, South Western Sydney, Western Sydney, Newcastle, Dubbo, Wollongong and Lismore
2004/05	11 + Manager	Central Sydney, Northern Sydney, Penrith, South Eastern Sydney, South Western Sydney, Western Sydney, Newcastle, Dubbo, Wollongong and Lismore

Amendments to the Role of the Patient Support Office

2.7 In March 2005, amendments were made to the *Health Care Complaints Act 1993* to recognise and further clarify the role of the Patient Support Service:

> "Under the amendments to the HCCA that took effect on 1 March 2005 the Commission's role in the assisted resolution of complaints has for the first time been recognised in the legislation, Division 9 of Part 2. The Commission provides an alternate and neutral means of resolving complaints that is independent of the Commission's investigative functions, section 58B. As with conciliation… participation in assisted resolution is voluntary".[14]

2.8 The role of the Service, defined by Division 9 Part 2 of the amended Act, is to:

(a) provide an alternate and neutral means of resolving complaints that is independent of the investigative processes of the Commission;

(b) facilitate the resolution of complaints, including determining the most appropriate means of resolution having regard to the nature of the complaint and the expectations of the parties to the complaint;

(c) provide information to health service providers and members of the public on the complaints resolution functions of the Commission under this Part.

2.9 The definition of the Service under the amended Act differs slightly from that of the previous role (which emphasised the promotion of patient rights and interests). The Patient Support Service was therefore renamed the 'Complaints Resolution Service' to reflect the more neutral role now played in assisted resolution. All staff retained their positions and service locations.

2.10 Legal advice obtained by the HCCC advised that, by incorporating the Complaints Resolution Service under the *Health Care Complaints Act 1993*, the Service was subject to the same conditions placed on other functions of the Commission.

[14] Submission Number 6 from the NSW Health Care Complaints Commission

2.11 Significantly, a complaint to the Service must now be received in writing and assessed by the Commission before assistance can be offered by the CRS.

2.12 This enables the Commission to determine the suitability of the complaint for referral, and to identify any issues of potential seriousness that should be referred for investigation. In general, complaints meeting the following criteria are most likely to be referred to the Complaints Resolution Service:

> "Complaints or parts of complaints are appropriate for referral to CRS for resolution where the complainant may require assistance from a party not connected to the provider (and not directly connected to the health system) to express their concerns and identify what outcomes they would like to achieve as a result of meeting, or otherwise dealing, with the health service provider. CRO involvement can be of particular value where there is high emotional content, complex grief issues, where it is desirable to maintain (or re-establish_ the therapeutic relationship, in cases where there has been a breakdown in communication or where the complainant is vulnerable or has special needs.[15]

2.13 On the other hand, the Committee has concerns that requiring a written complaint could potentially dissuade private practitioners and their patients looking to access assistance to resolve low-level complaints.

2.14 Practitioners may be reluctant to refer a client to the CRS or request assistance of their own if this was guaranteed to generate a formal complaint with the Commission.

2.15 Patients may also be less inclined to utilise the Service if it means taking extra effort to record and send a complaint and potentially waiting weeks for a resolution. This is especially the case if the issue involved is relatively minor or the client requires an immediate remedy by the provider.

2.16 In support of the Committee's concerns, amendments to the Act appear to have had a negative impact on the number of concerns being managed through the Complaints Resolution Service.

2.17 The Health Care Complaints Commission's Annual Report 2004-2005 shows a marked decrease in the number of clients accessing the Complaints Resolution Service in 2004-2005 compared to the previous two reporting years.[16]

2.18 In 2002-2003, 3883 clients were serviced by the Patient Support Service, increasing to 4149 in 2003-2004. In 2004-2005 the Complaints Resolution Service assisted a total of 2657 clients with health care concerns. The Annual Report attributes this decrease to the change in referral requirements that accompanied amendments to the *Health Care Complaints Act 1993* in March 2005.

2.19 At a briefing with the Committee in November 2006, Commissioner Kieran Pehm provided an explanation as to why the number of concerns being received by the CRS are significantly fewer than under the previous PSO system:

> The way inquiries were previously dealt with was that assessments staff would handle simple inquiries but anything complex would be referred to the PSOs/CROs. These inquiries, although they may have only involved one telephone call giving advice, were recorded as clients of the PSOs/CROs. The increase in inquiries since central handling of

[15] Submission Number 6 from the Health Care Complaints Commission
[16] Health Care Complaints Commission, 2005, Health Care Complaints Commission Annual Report 2004-2005, page 25.

them began on 1 April 2006 indicates that a substantial proportion of the PSO/CRO "clients" were in fact merely inquiries.

2.20 The Committee accepts that recording of complaints data may be contributing to the low rate of concerns that appear to be handled by the CROs. Nevertheless, as one of the few mechanisms for assistance with low-level complaints resolution available to the private sector, the Committee believes that this resource could be better utilised. This is discussed further in Chapter 13.

NSW Health Conciliation Registry

2.21 The NSW Health Conciliation Registry provides a formal conciliation process for both public and private health facilities. Conciliation involves a meeting between parties to a complaint, facilitated by an independent and impartial conciliator. Conciliation is only available for complaints that do not warrant investigation by the Commission.

2.22 As of March 2005, administrative responsibility for the Health Conciliation Registry was transferred from the NSW Department of Health to the NSW Health Care Complaints Commission:

> "With effect from 1 March 2005 the Health Conciliation Registry was transferred from the Department of Health to the HCCC. Part 6 of the HCCA establishes the Health Conciliation Registry and the position of Registrar and sets out the functions of conciliators."[17]

2.23 Currently, the Commission is responsible for assessing a complaint as suitable for conciliation. A complaint will not be assessed as suitable for conciliation if:

- The complainant has made it clear that they do not want to meet or interact with the provider again, and do not see conciliation as a means to resolve the complaint;
- It is apparent that the issue may be resolved more efficiently or less formally by another process;
- A complainant has a particular support need which may require a more tailored form of resolution (e.g. a person with ongoing mental health issues or major unresolved grief).[18]

2.24 The conciliation process is voluntary and the results of conciliation are expected to be binding. Nevertheless, resolution through this means depends on the goodwill of both parties, as the agreements entered into in conciliation are not enforceable in any court or tribunal:

> "Conciliation is a voluntary process and all parties have consented to it. It is to be expected that as part of this voluntary participation parties will honour the agreements they enter into in the conciliation.
>
> The Commission's experience is that most matters referred for conciliation are successfully resolved and the providers honour their obligations under conciliation agreements."[19]

2.25 Both practitioners and patients are permitted to bring support people to conciliation, provided the person is not a lawyer:

[17] Submission Number 6 from the NSW Health Care Complaints Commission
[18] Annual Report of the NSW Health Care Complaints Commission 2004/2005.
[19] Submission Number 6 from the NSW Health Care Complaints Commission

> "Complainants are entitled to assistance from a person, who is not a legal practitioner, as of right. Any other arty to a conciliation may have assistance if the Registrar or the conciliator agrees because the party would otherwise be disadvantaged. Where a party to a complaint that is being conciliated is a corporation it is entitled to be represented at the conciliation by an officer of the corporation."[20]

2.26 All conciliation proceedings are confidential, and admissions made within conciliation cannot be used as evidence in any disciplinary proceedings:

> "Section 52 provides that conciliation is confidential. Evidence of things said or of admissions made during a conciliation is not admissible in any proceedings before a court, tribunal or body. Documents prepared for, or in the course of, a conciliation are not admissible in any proceedings before a court, tribunal or body. A person cannot be compelled by subpoena or other process to produce evidence or documents in evidence if the evidence or documents are inadmissible because of section 51."[21]

2.27 In 2004/2005, 164 complaints were assessed by the Commission for suitability for conciliation, 101 of which proceeded to the conciliation stage. Like concerns referred to the CROs, the nature of these complaints centred on issues with treatment, communication and access to services.

2.28 In the previous two reporting years however, 'Corporate Services' issues out-ranked 'Access' as the third most frequently reported consumer concern. The number and proportion of complaints in these categories are provided below.

Category	2002/2003	2003/2004	2004/2005
Treatment	239 (55.8%)	177 (47.6%)	90 (54.9%)
Communication	58 (13.0%)	62 (16.7%)	26 (15.9%)
Access	33 (7.4%)	32 (8.6%)	15 (9.1%)
Corporate Services	48 (10.8%)	39 (10.5%)	11 (6.7%)

2.29 There has been a small but steady increase in the success rate of conciliation over the past three years. In 2004/05 over 84% of conciliations reached either full or partial agreement between parties. This is compared to 83.7% in 2003/2004 and 78.7% in 2002/2003. The number of conciliations conducted has decreased over this time, from 133 in 2002/2003 to 85 in 2004/2005.

2.30 At present, a formal complaint must be received and assessed by the HCCC before access to conciliation is given. Essentially, then, the Registry is not currently a feasible option for health facilities looking to resolve low-level complaints in a timely manner.

2.31 In the past, the Committee has explored the possibility of the Registry playing a more active role in local complaints resolution. In 1997 the Committee conducted an inquiry into localised health complaint resolution procedures, with one component of this inquiry being procedures in private practice.[22]

[20] Ibid
[21] Ibid
[22] Committee on the Health Care Complaints Commission. (1997). *Report on Localised Health Complaint Resolution Procedures*. NSW Parliament.

2.32 The subsequent report by the Committee recommended that the role of the Health Conciliation Registry be amended to allow it to provide education to health services about the effective handling of complaints at a local level:

> The Committee recommends that the Minister for Health, as part of the current review of the Health Care Complaints Act 1993, consider expanding the role and powers of the Health Conciliation Registry by amending Part 6 and Section 57 of the Act in order that the Registry may perform a more educative role to facilitate the better handling of complaints at the local level.

2.33 The Committee also recommended that the Registry be made more accessible to health facilities by permitting direct access by practitioners to conciliation services:

> The Committee recommends that the Minister for Health, as part of the current review of the *Health Care Complaints Act 1993*, consider expanding the role and powers of the Health Conciliation Registry by amending Part 6 and Section 57 of the *Act* in order to provide direct access to the Health Conciliation Registry, in prescribed circumstances, by bodies other than the Commission in order to facilitate the better handling of complaints at the local level.

Royal Australian College of General Practitioners (RACGP)

2.34 The Royal Australian College of General Practitioners (RACGP) makes training available to Registrars across various topics related to complaints management.

2.35 Included as one of the five practice areas in the training Curriculum is *'Communication Skills and the Patient-Doctor Relationship'*, covering topics such as effective communication, patient centeredness, health promotion and whole person care. It is expected that upon completion of this section of the curriculum the practitioner will be able to:

- Outline the principles of conflict resolution, and demonstrate an ability to resolve conflict through negotiation;
- Communicate effectively with patients, staff, the community, and other health professionals in providing quality health care;
- Understand the need for, and importance of, working as part of a team in providing a professional service;
- Outline the principles of quality management;
- Identify employment issues relating to financial arrangements (e.g. agreements between colleagues; employees; taxation, and legal issues);
- Demonstrate skills in negotiation regarding terms and conditions of employment;
- Understand the importance of, and undertake, a practice management audit;
- Discuss the concept of financial service management (e.g. service theory, areas of cost);
- Outline how to achieve an effective practice environment, and the resources and equipment required for efficient service delivery (e.g. for an adolescent-friendly practice);
- Understand ethical issues in medical practice and business practice;
- Discuss how different practice models contribute to health care (e.g. associateships, partnerships, and solo practice).[23]

[23] Royal Australian College of General Practitioners, *Curriculum Statement: Practice Management*

2.36 Workshops are often conducted using guest speakers, including GP's who are principals in their practice and medical educators with experience in the area. The aim is to facilitate discussion about the practical aspects of practice management and to guide group discussion.

NSW Ombudsman

2.37 NSW Ombudsman provides training workshops on a number of aspects of effective complaints management, including:

- Complaint handling for front line staff;
- Dealing with difficult complainants;
- Art of negotiation;
- Resolving consumer complaints;
- Towards best practice in complaints management;
- Rights;
- Responding to allegations against employees;
- Child protection policy development;
- Risk management.

2.38 Workshops are available to both public sector and private sector organisations at a cost of $95 per participant. Specially tailored presentations are available if sufficient numbers are met.

Complaint Handling for Front Line Staff

2.39 This workshop provides staff with skills and strategies for managing customers effectively and efficiently, while being aware of the possible underlying needs of the customer. It is designed specifically for those coming into regular/high-volume contact with customers either by telephone or in person. Participants will have a better appreciation of the obstacles to customer satisfaction and what they can do to overcome them.

2.40 The workshop should equip participants to:

- Understand the customer's perspective;
- Learn a step-by-step model for dealing with customer complaints and apply this model in the workplace;
- Analyse the customer's needs;
- Identify common, yet perhaps surprising, reasons for expression of anger;
- Deal with anger in a constructive and positive manner;
- Employ skills and strategies for communicating successfully with various types of 'challenging' behaviours;
- Appreciate the importance of de-stressing and debriefing.

Dealing with Difficult Complainants

2.41 This workshop enable participants to practice the essential skills for dealing with difficult customer scenarios and discuss:

- Communication styles and habits and the part played by staff in every interaction;

- Great communicators – skills that enable staff to manage difficult customer situations successfully;
- Shifting attention – to enable staff to see things from other perspectives;
- Expressing personal points of view in a non-provocative way;
- Responding to aggression/persistence;
- Limiting access – the rights of the public and the legislative responsibility of the service provider;
- Debriefing and de-stressing – the importance of looking after oneself.

Act of Negotiation

2.42 This workshop provides a thorough grounding in negotiation skills and strategies, and participants are provided with ample opportunities to practise these. The workshop focuses on interest-based negotiation. The day is structured around a series of trainer inputs followed by group exercises and discussions. Participants are provided with a framework within which they can plan and successfully carry out negotiations. Participants in the workshop will examine:

- The 'why' and the 'how' of preparing for a negotiation;
- How to consider a negotiation from many angles;
- How to avoid feeling disempowered;
- The importance of the opening statement;
- Getting personal needs clear as well as taking into account the other party's needs;
- Successful communication in negotiation;
- Relationship building;
- Rapport building;
- Closing a negotiation successfully;
- Effectively managing unexpected negotiations.

Resolving Consumer Complaints

2.43 This one-day workshop is for those who work directly with clients in community service settings. This workshop looks at:

- Why complaints are an important issue for human services;
- The value of complaints and service quality;
- Your own attitudes to complaints and complainants;
- Communication strategies for developing better customer service skills;
- How to advocate on behalf of, and support, customers who want to make a complaint.

Towards Best Practice Complaints Management

2.44 This one-day workshop is for managers and coordinators of community services, staff responsible for complaint systems, and management committee members.

2.45 The workshop covers:

- Best practice models for handling complaints;

- Organisational culture and quality management;
- Involving staff and consumers;
- Implementing, reviewing and monitoring your system;
- Practice issues and implications.

Responding to Allegations Against Employees

2.46 This workshop is for heads of agencies, managers or supervisors who are responsible for responding to and/or investigating a reportable allegation or conviction against an employee.

2.47 The workshop covers:

- Principles for responding to an allegation;
- Preparing to investigate the allegation;
- Steps in the investigation process;
- Risk assessment and risk management;
- Record keeping;

Risk Management

2.48 This workshop is for heads of agencies, managers or supervisors who are responsible for responding to and/or investigating a reportable allegation or conviction against an employee. It includes information covered in the briefing session as well as the following topics:

- What is risk management?;
- Stages of risk management;
- Assessing and evaluating risk;
- Managing risk;
- Monitoring and reviewing risk.

2.49 In 2005/06 NSW Ombudsman delivered over 70 training sessions to more than 4,000 people including staff of agencies providing services to the public and customers of those services. These presentations covered a range of issues including the role of the Ombudsman, protected disclosures, conflicts of interest, access to information laws, the role of official community visitors, complaint-handling and alternative dispute resolution.

Chapter Three - Mechanisms for the Low-Level Handling of Complaints in Other Jurisdictions

Australian Jurisdictions

3.1 Very little work specifically relating to equipping private health services to manage low-level complaints internally is being done in Australian jurisdictions.

3.2 At a basic level, several state health Complaints Commissions are involved in educating and training health practitioners and clinics in effective complaints management. Although not extensive (often totalling one day or less), this training does expose practitioners to the essential elements of a successful complaints management approach, and can educate them about services the Commission can provide to assist their practice when a complaint has been received. The Commissions of Victoria, Queensland, South Australia and the ACT all currently offer this training.

3.3 Some additional services for both consumers and practitioners are provided by the non-Government sector in several Australian jurisdictions.

Conflict and Litigation Management (CALM) Pilot Victoria

3.4 A number of Victorian Divisions of General Practice have joined together with the Medical Defense Association of Victoria and the Victorian Health Services Commission to develop protocols and systems to assist General Practitioners and their staff to both reduce the incidence of and adequately respond to consumer complaints.

3.5 This project is discussed in greater detail in Chapter Nine.

Western Australian Health Consumers Council

3.6 The Western Australian Health Consumers Council is an independent, non-Government advocacy service for health consumers. The Council advocates on behalf of consumers to government, doctors, other health professionals, hospitals and the wider health system.

3.7 The Council has five main objectives:

- Helping consumers understand health issues;
- Encouraging consumer participation in decisions that affect the health system;
- Encouraging accountability in the health system to ensure that money is spent wisely and productively;
- Giving people who use the health system access to advocacy, information, training and support;
- Helping the community understand the health system.

3.8 Health Consumers' Council staff will assist consumers to define and clarify the issues within their complaint, for the purposes of addressing the complaint to the most appropriate respondent. In doing this, staff will visit consumers in their home when mobility or access to the Council office is difficult for the consumer.

3.9 Staff will assist consumers to draft letters, Statutory Declarations and Statements of Claim, Freedom of Information applications or will draft these on behalf of the consumer, subject to editing by the complainant.

3.10 The Council also maintains a toll free phone line and a reply paid mail facility to enable affordable access to the Health Consumer's Council office for consumers outside the metropolitan area.

3.11 The Council will assist a consumer or groups of consumers with a complaint when they are unable or unwilling to do it themselves.

3.12 Staff will attend meetings or consultations with health consumers, adopting the role of advocate or independent third party. Consumers have identified this as a useful role in presenting their grievance or perspective on health issues. Where staff adopt the role of advocate and become a participant in proceedings, this will be to assist the consumer achieve agreed objectives of the meeting.

3.13 The Council does not, however, possess statutory authority to effect change or require responses from health service providers.

3.14 According to the 2005/06 Annual Report of the Council, 477 health consumers were assisted with complex complaints and provided with advocacy services in that year.

3.15 The Council also provided 447 consumers with pamphlets on how to make a complaint about a health service.

Northern Territory Health and Community Services Commission

3.16 In 2003, the Northern Territory Health and Community Services Commission undertook a review of the *Health and Community Services Complaints Act*.

3.17 In its final report the Commission concluded that there was a need for the Government to provide health consumers with greater assistance and advice when making a health complaint. Specifically, the need for an advocacy system was identified:[24]

> "The failure to provide an advocacy/community visitor scheme represents a major flaw in the Northern Territory's current complaints model and I believe that the absence of such a function within the complaints model is significanlty compromising the rights of a major proportion of the Northern Territory population."

3.18 The Report found that documented low levels of complaints from the aged and disability sector and from Aboriginal people signified systemic barriers to accessing the existing complaints model. It was concluded that an advocacy/community visitor scheme could address some of these concerns.

3.19 When addressing the issue of an appropriate location and type of service, the paper went on to say:

> "…such a service (advocacy/visitor) need not necessarily be within the Commission, and might be best located within the community…. I am particulary supportative of the approach taken in New Zealand…"

3.20 Information on the New Zealand model is provided below.

[24] Northern Territory Health and Community Services Complaints Commission. (2003). *Establishment of a Community Visitor/Advocacy Service for Users of Health and Community Services*

New Zealand

3.21 The *Health and Disability Commissioner Act* was enacted in October 1994, creating the Office of the Health and Disability Commissioner (HDC), a national network of independent advocates (under the Director of Advocacy) and an independent prosecutor (the Director of Proceedings).

3.22 Together, these units are designed to promote and protect the rights of health and disability services consumers.

3.23 Specifically, the duties of the Commission are:

(a) To secure the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights; and

(b) To provide for the appointment of a Health and Disability Commissioner to investigate complaints against persons or bodies who provide health care or disability services; and to define the Commissioner's functions and powers; and

(c) To provide for the establishment of a Health and Disability Services Consumer Advocacy Service; and

(d) To provide for the promulgation of a Code of Health and Disability Services Consumers' Rights; and

(e) To provide for matters incidental thereto.

3.24 Customised training is developed and implemented with individual providers and group providers to address their specific needs in relation to better meeting their obligations under the Code, whether it is changes to their practice or their systems.

3.25 Consumer education sessions are also conducted to help members of the public understand their rights and responsibilities when using the health system.

3.26 In June 2006 the HDC released a Statement of Intent for the following year, outlining specific outputs to be achieved in that timeframe. A number of these outputs centred on assisting providers to adopt a more effective approach to managing consumer complaints.[25]

3.27 Firstly, the HDC have committed to conducting education sessions with health service providers:

> "Conduct education workshops, presentations and seminars for three types of providers based on frequency of complaints and rarity of complaints received targeted to raise awareness about their responsibilities and the use of complaints as a quality improvement tool making good use of HDC opinions and recommendations."

3.28 The HDC has also planned to engage health registration boards in discussions around potentially incorporating standards on observing patient rights as a requirement for registration with the board:

> "Work with registration Authorities to promote the inclusion of rights-based practice as a core competency for maintaining registration of providers."

3.29 The Commission also provides information on complaints trends to Health Boards and other professional bodies twice a year. Whilst this clearly does not reach

[25] Office of the Health and Disability Commissioner. (2006). *Statement of Intent 2006/07*.

practice level directly, it does assist peak bodies in implementing systemic change based on an analysis of complaint trends.

3.30 The Nationwide Health and Disability Service provides a free advocacy service for consumers. The duties of advocates include:[26]

- Clarify issues and identify the desired outcome in relation to the complaint;
- Make a complaint;
- Meet with or communicate with the health or disability service provider;
- Assert the concerns;
- Increase the confidence of the consumer in speaking up;
- Achieve direct resolution of the complaint at a local/low level;
- Resolve complaints effectively between the parties;
- Understand the various ways to make a complaint, including how to contact the Health and Disability Commissioner;
- Give information and provide education about rights to consumers and providers;
- Encourage providers to view complaints as opportunities for learning and improving the quality of their service;
- Network assertively within their local communities to maintain contact with vulnerable populations and keep abreast of local issues.

3.31 The volume of work handled by advocacy services is considerable with an estimated 7640 enquiries responded to by June 2006 and an estimated 4680 complaints managed in that time.

3.32 The practice guidelines of the service include: consumer empowerment, protecting the wider body of consumers, priorities (in relation to targeting consumers least able to self advocate), consumer interdependence, advocates maintaining their role and confidentiality.

United Kingdom

3.33 The National Health Service (NHS) is the major source of health services in the UK and is funded by Government.

3.34 The NHS provides both primary and secondary health services, including mental health and social care services.

3.35 The majority of NHS services are commissioned or purchased on behalf of patients by Trusts, including the services of consultants, doctors, nurses, hospital dentists, pharmacists, midwives and health visitors, physiotherapists, radiographers, podiatrists, speech and language therapists, dieticians, counsellors, occupational therapists and psychologists.

3.36 The NHS treats a population of 60 million and employs one million staff including approximately 45,000 GPs.

3.37 In this way, the system of health service provision in the UK differs significantly to the way in which health services are delivered in NSW, where private health services comprise a much greater proportion of health services.

[26] New Zealand Health and Disability Commissioner. *Statement of Aims*

3.38 Unlike Australian patients, health consumers in the UK have little say as to which general practitioner they consult, as they are required to attend a particular practice within the NHS.

3.39 The NHS handles all of its own complaints unless there is a need to refer a complaint about a practitioner to a registration board or council.

General Medical Council

3.40 The General Medical Council (GMC) is the United Kingdom equivalent of Australian state Medical Boards.

3.41 Established under the *Medical Practice Act 1958*, the GMC is responsible for:

- Registering and keeping an up-to-date register of qualified doctors;
- Maintaining a high standard of medical practice;
- Promoting high standards of medical education;
- Handling complaints against medical practitioners in the UK.

Good Medical Practice Guidance

3.42 In October 2006 the General Medical Council released a revised *Good Medical Practice* guide, which has been sent to 240,000 doctors nationwide. The Guide sets out the principles on which good practice is founded, and comes into effect as of 13 November 2006.

3.43 Wide ranging consultation with doctors, patients and the general public was undertaken during the development of the Guide, which offers guidance for doctors and patients on issues such as standards of care, good communication, relationships with patients and colleagues, probity, conscientious objection, responsibilities towards children and young people, and dealing with relatives, carers and partners.

3.44 The principles in the new *Good Medical Practice* guide apply to all doctors at all levels and is to be a core part of the curriculum for medical students across the United Kingdom. Serious or persistent failures to meet the standards outlined in the guide will jeopardise a doctor's registration with the GMC.

3.45 Adherence to the Guide is expected to improve doctor-patient relations and ultimately decrease adverse incidents, complaints and claims within practices.

Patient Advice and Liaison Service (PALS)

3.46 The Patient Advice and Liaison Service (PALS) was established by the UK Department of Health provides a number of services for patients, families and their carers free of charge, including:

- Confidential advice and support;
- Information on the NHS and health related matters;
- Confidential assistance in resolving problems and concerns quickly;
- Explanations of NHS complaints procedures and how to get in touch with someone that can help;
- Information on how to get more involved in health care and the NHS locally;

- Information about local health services; and
- Acts as an early warning system by monitoring trends, highlighting gaps in service and making reports for action to Trust managers.

3.47 PALS staff liaise with staff of health services, managers and (where appropriate) other relevant organisations to negotiate solutions for health consumers and to help bring about changes to the way services are delivered.

3.48 Staff provide information and advice by which patients and families can make an informed decision, but do not facilitate financial compensation.

3.49 The UK Department of Health first began funding a trial of PALS in April 2001.

3.50 The evaluation of this trial contributed to the development of a resource pack: *Supporting the Implementation of Patient Advice and Liaison Services: A Resource Pack 2002* which contained national core service standards and was designed to support UK trusts with the implementation of PALS.

3.51 By 2002 it became apparant that implementation of PALS was not as widespread as had been anticipated and that the target of establishing PALS in all trusts by April 2002 would not be met.

3.52 Consequently, the Department of Health facilitated representation from each Strategic Health Authority (SHA) area to work together to identify and prioritise a national PALS development agenda. This group formed the basis of the National PALS Development Group (NPDG).

3.53 Since this time PALS have been implemented in all trusts and its effectiveness continues to be evaluated against the National Core Standards. National Core Standards are issued by the Department of Health and set out the minimum service to be delivered by PALS.

3.54 These Standards include:

- The PALS service is identifiable and accessible to the community served by the Trust;
- PALS will be seamless across health and social care;
- PALS will be sensitive and provide a confidential service that meets individual needs;
- PALS will have systems that make their findings known as part of routine monitoring in order to facilitate change;
- PALS enables people to access information about Trust services and information about health and social care issues;
- PALS plays a key role in bringing about culture change in the NHS, placing patients at the heart of service planning and delivery;
- PALS will actively seek the views of service users, carers and the public to ensure effective services.

3.55 Evidence for these standards will include surveying clients and other stakeholders, reviewing of data, staff questionnaires, interviews and focus groups.

3.56 Trusts are also encouraged to set additional standards for themselves (such as target response times).

Evaluation of PALS

3.57 An evaluation of the PALS system has been conducted over the past two years.

3.58 Dr David Evans (Reader in Applied Health Policy and Principal Investigator) and Sarah Booker (Research Fellow) conducted the evaluation on behalf of the UK Department of Health.

3.59 The Department of Health released a summary of the evaluation findings in September 2006.

3.60 Of relevance to the current inquiry is the evaluation of the impact of the PALS system on the efficiency and effectiveness of complaints resolution within Trusts.

3.61 Early investigations suggest the following:

> It is clear from our case studies that PALS are overwhelmingly effective in filtering potential complaints and enabling patients who wish to persist in raising issues to do so in an effective, focused way that is most useful to the organisation.
>
> The emerging context of higher expectations, less deference and a loss of public trust in professionals will have an impact on the number of complaints received by Trusts in recent years. There is an anecdotal belief that PALS effects and reduces the number of complaints. No formal research investigation has been carried out and there was no conclusive evidence from the Trusts involved in our first three case studies that PALS have reduced the number of complaints. [27]

3.62 The evaluation then looked at the consumer experience and acceptance of the PALS system, with preliminary results suggesting that PALS has increased communication between consumers and the health system and is largely received positively by consumers:

> Preliminary results from our case studies strongly suggest that PALS enable and empower patients and others to use Trust services effectively, appropriately and usefully address the issues they have. Where PALS have done their own user evaluations, the results have been very positive.
>
> Evidence from user input to our action inquiry events suggest that PALS provide a conduit between sometimes uncommunicative Trust systems, are occasionally the last source of hope for people who access them and offer people vital support in that they offer someone to talk to and explore their issues with.
>
> There can be little doubt that PALS improve individual patients' and other service users' experiences.

3.63 The evaluation also identified several characteristics of successful PALS programs, including:

- A history of support for the involvement of patients and the public and Board-level support for PALS;
- A senior manager with change management skills, giving strategic management to PALS;
- Integration with other policies and programs, including the *Policy for Patient and Public Involvement*, clinical governance, partnerships and risk management;
- Good information systems for sharing and integrating PALS intelligence across the organisation;

[27] UK Department of Health & University of the West of England. (2006). *Developing the Patient Advice and Liaison Service: Key Messages for NHS organisations from the National Evaluation of PALS*

- Engagement with trust staff;
- Networking across the health community.

Independent Complaints Advocacy Service (ICAS)

3.64 The United Kingdom Independent Complaints Advocacy Service (ICAS) provides support for people who want to make a complaint about their NHS care or treatment. This support ranges from advice to advocacy, and is provided by experienced caseworkers.

3.65 ICAS services are not available for complaints about treatment in a private facility unless these services have been contracted to the NHS.

3.66 The services offered by ICAS include:

- An information pack for consumers to manage a complaint on their own;
- A contact point for face-to-face questions;
- Assistance in drafting a letter of complaint;
- Advice about the process and what to do next;
- A supporter or advocate at meetings or hearings;
- A route to other specialist help if needed;
- Outreach and home visits.

3.67 All ICAS services are free.

3.68 Trained advocates with knowledge of the NHS complaints procedure help clients to understand whether they wish to pursue a complaint and, where needed, advocates provide support to clients in doing so. The support offered ranges from helping the client with initial preparation in ordering their thoughts and thinking about what a good resolution would look like to them, through to attendance at resolution meetings and helping people with correspondence.

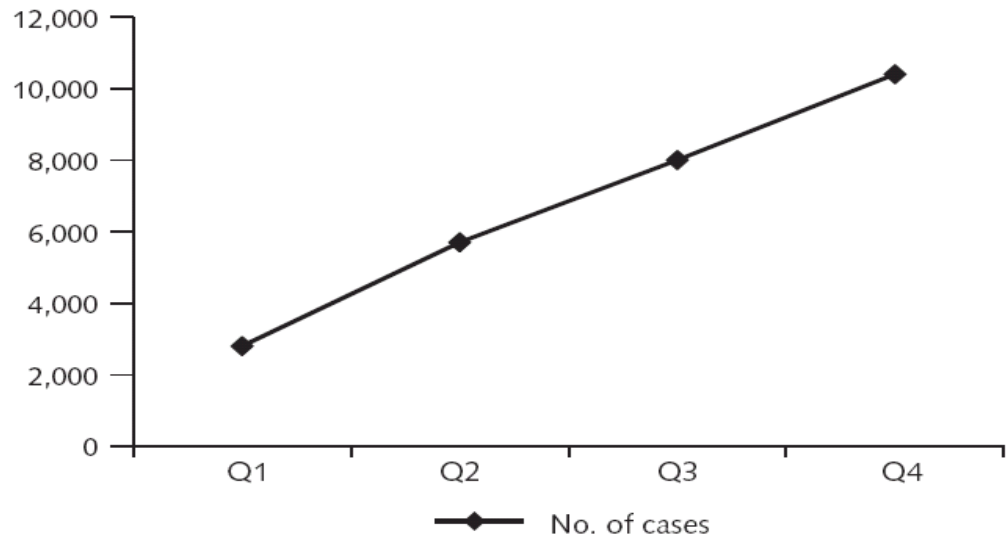
3.69 Section 12 of the Health and Social Care Act 2001 provides the legislative basis for the Independent Complaints Advocacy Service [ICAS], placing a statutory responsibility on the Secretary of State for Health to make appropriate arrangements for the delivery of independent advocacy services to support people in making complaints about the NHS.

3.70 The Department of Health funds and manages contracts for the delivery of ICAS, setting quality standards and supporting its development. Four voluntary sector organisations deliver ICAS services. ICAS services are organised on a regional basis, with each of the four voluntary sector organisations having responsibility for one or more of the nine English Government Office Regions.

3.71 This statutory service was launched on 1 September 2003 and provides for the first time a national service delivered to agreed quality standards. The core principles of the service include: empowerment, independence, confidentiality, inclusion, resolution and partnership.[28]

3.72 The first year of operation resulted in the following volume of complaints:[29]

[28] The First Year of ICAS,
[29] Ibid



Q = quarterly reporting periods (Q1: 1 Sept 03 – 30 Nov 03, Q2: 1 Dec 03 – 28 Feb 04, Q3: 1 March 04 – 31 May 04, Q4: 1 June 04 – 31 Aug 04)

3.73 The areas most frequently resulting in complaints were:[30]

- Aspects of their clinical treatment;
- The attitude of staff; and
- Communication/information to patients

3.74 An assessment of the service lead to some changes in the model employed. A dual model of self and supported advocacy will now be employed:[31]

1. Self advocacy model – designed to empower those clients who want and are able to raise their own concerns
    - Information and support via local rate telephone numbers, staffed by advocates, with extended opening times;
    - Support via any form of written correspondence (fax, e-mail, letter);
    - Support via specially designed Self Help Information which is available in hard copy, from the web and is reproduced in all of the major community languages;
    - 'Third party', professional support for other advocacy, support or advice workers already supporting clients with complex needs locally.
2. Supported advocacy model – designed to empower and support those clients with more complex needs:
    - With resources directed towards the most disadvantaged and vulnerable groups in each region, this model will ensure clients with more complex needs have access to specialist advocates who can support them through the complaints process.

[30] Ibid
[31] ICAS website http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/ComplaintsPolicy/NHSComplaintsProcedure/NHSComplaintsProcedureArticle/fs/en?CONTENT_ID=4127482&chk=/Upod%2B date accessed 2 November 2006

3.75 The start up cost for ICAS was £1 million, with an additional £7 million spent on operating costs in the first year. The total ICAS service encompasses 172 staff ranging from caseworkers to support worker in both central and regional areas.[32]

Healthcare Commission

3.76 The Healthcare Commission promotes improvement in the quality of the NHS and independent health care.

3.77 It has a wide range of responsibilities all aimed at improving the quality of healthcare, including a statutory duty to assess the performance of healthcare organisations, award annual performance ratings for the NHS and to coordinate reviews of health care.

3.78 Each year, the Healthcare Commission intends to conduct a check of NHS services (of interest to this Inquiry, Primary Care trusts) to evaluate their compliance with several policies and standards in the areas of:

- Adult community mental health services;
- Existing national targets;
- Meeting core standards;
- New national targets;
- Quality of services;
- Services for children in hospitals;
- Substance misuse services;
- Tobacco control; and
- Use of resources.

3.79 The first such audit was conducted in 2005/06.

3.80 The UK Healthcare Commission website publishes the results of each trust's performance in each key health check area.

3.81 Of note, the website publishes the performance of each primary care trust in meeting four minimum standards relating to complaints management:

1. Information about how to make complaints and give feedback;
2. People are not discriminated against after making a complaint;
3. Concerns are acted on appropriately and improvements are made;
4. The views of patients and others are taken into account.

3.82 Compliance is coded into three categories:

- Met: The Trust has shown clearly how they have met the given criterion;
- Insufficient assurance: The Trust has provided insufficient evidence to support a claim to have met a given criterion;
- Not met: The Trust has stated outright that they have not met the core criterion.

[32] Citizens Advice ICAS Central Team. (2005). *Annual Report: second year of ICAS (September 2004-September 2005)*.

3.83 A summary of Trust compliance with the minimum standards in 2005/06 is provided below.

Information about how to make complaints and give feedback

3.84 In 2005/06, two Trusts did not meet the required standard for providing information about making complaints and giving feedback.

3.85 An additional two Trusts could not provide the evaluators with sufficient evidence that they have complied with this standard.

3.86 The remaining 299 Trusts complied sufficiently with the standard.

People are not discriminated against after making a complaint

3.87 Four primary care Trusts did not meet the agreed criterion for ensuring a person is not discriminated against after having made a complaint. All remaining Trusts were found to be compliant.

Concerns are acted on appropriately and improvements are made

3.88 Three Trusts reported not meeting the set criteria for ensuring that patient concerns are appropriately responded to and the relevant improvements made.

3.89 Three Trusts were rated as providing 'insufficient assurance' against this criterion.

3.90 All other primary care Trusts were rated as 'compliant'.

The views of patients and others are taken into account

3.91 Four Trusts did not meet the criterion of ensuring that the views of patients and others are taken into account, with an additional eight Trusts providing insufficient assurance of meeting this standard.

3.92 In cases where a core standard has not been met or insufficient assurance has been given, Trusts are required to provide a statement of intent showing how they will implement changes to improve their compliance with the standard over the coming year.

United States- Sorry Works!

3.93 The Sorry Works! Coalition is an organisation of doctors, lawyers, insurers and patient advocates in the United States that are working together to promote full disclosure and apologies for medical errors in the healthcare setting.

3.94 The Coalition has developed a protocol to assist healthcare organisations looking to pursue a similar goal. In essence, the Coalition encourages providers (and their insurer) to conduct a root cause analysis after a bad outcome or adverse event and determine whether or not a standard of care had been met.

3.95 If it is determined that the standard has not been met, the providers and their insurer should:

- Apologise to the patient/family;
- Provide and explanation of what happened and how the hospital/organisation will ensure that the error is not repeated; and
- Make a fair offer of up-front compensation.

3.96 Any determination of appropriate compensation should be done by an actuary or other qualified party.

3.97 In the event that a root cause analysis reveals that the standard of care was sufficiently met, the providers and their legal counsel should still meet with the patient/family (and their solicitor, if desired) and explain what happened, apologise and offer empathy but do not admit fault or provide upfront compensation. All subsequent charges should be fought by the organisation and insurer.[33]

3.98 In addition to a reduction in the costs of litigation, it is anticipated that the Sorry Works! program will have the following benefits for both the practitioner and the consumer:

- Restores the doctor-patient relationship and improves communication and trust between parties;
- Repairs the reputation of doctors and hospitals as they can begin to be believed when they say a death or injury wasn't their fault.
- A culture of honesty and openness leads to improved systems and processes to reduce medical errors- particularly repeat medical errors.

3.99 The inclusion of up-front compensation is considered to be an essential part of the program, as an apology alone can often be perceived as flippant or not meaningful, potentially increasing the risk of litigation.

3.100 The program was initially piloted in the Department of Veterans Affairs Hospital in Kentucky, and has been replicated in other hospitals across the United States (including Vermont and Colorado). However, the Sorry Works! Coalition emphasise the transferability of the principles to the private health sector and even to individual practitioners.

3.101 Some implementation in private health facilities has been done with similar successes to those seen in public hospitals. The program was adopted by the private Kaiser Permanente hospitals and promoted by the insurance fund Catholic Healthcare West for their independently contracted doctors.

3.102 Statistics on the costs of litigation for those practices that have adopted the program strongly suggest that open disclosure principles are having a significant impact.[34]

3.103 Implementation of a full-disclosure program is said to have almost halved medical litigation costs in the University of Michigan hospital system. Moreover, the average payout for Lexington Veterans Affairs was $16,000 per settlement, compared to the national Veterans Affairs average of $98,000 per settlement.

3.104 Other research findings are yet to substantiate that full disclosure and an apology coupled with compensation substantially reduces medical litigation.

United States- Patient Advocacy Inc

3.105 The Committee understands that there are a variety of advocacy services which focus exclusively on the rights of people living with a mental illness. These rights often intersect with the health services sector.

[33] Wojcieszak, D., Banja, J., & Houk, C. (2006). *The Sorry Works! Coalition: making the case for full disclosure*. Journal on Quality and Patient Safety, 32 (6), 344-350.
[34] Wojcieszak, D., Banja, J., & Houk, C. (2006). *The Sorry Works! Coalition: making the case for full disclosure*. Journal on Quality and Patient Safety, 32 (6), 344-350.

3.106 An example of such a service is the Protection and Advocacy Inc. (hereafter PAI) in the United States of America. PAI provides legal protection and advocacy services to Californians identified as mentally ill who are or have been residents of facilities providing treatment or care. It is a federally mandated system.

3.107 In addition, the USA has set up a state-mandated patients' rights advocacy system (called Patients' Rights Advocacy Services) comprising three parts:

- County patients' rights advocates;
- State hospital patients' rights advocates; and
- The State Office of Patients Rights.

3.108 The services offered by the Patient's Rights Advocacy Services include both individual and systems advocacy:

Individual Advocacy

3.109 Individual Advocacy services provided include:

- Investigate and resolve complaints received from mental health recipients about violations or abuse of their rights in licensed health or community care facilities;
- Educate recipients regarding their legal rights under the California Welfare and Institutions Code;
- Advocate for mental health recipients who are unable or afraid to register a complaint, and/or help in -negotiating a solution to a problem;
- Representation of a client in a Certification Review Hearing, Administrative Fair Hearing or other dispute resolution process;
- Assist clients with problems in the health care system related to licensed board and care facilities, mental health clinics and psychiatric hospitals.

System Advocacy

3.110 Patients' Rights Advocacy Services works to improve the mental health system by:

- Regular monitoring of Orange County hospitals, skilled nursing facilities with specialized programs, licensed board and care facilities, county mental health clinics and contracted mental health clinics for compliance with patients' rights laws;
- Assist staff in ensuring that the information about patients' rights is posted in all facilities providing mental services, and that all incoming clients are informed of their rights, including the right to contact Patients' Rights Advocacy Services or the State Office of Patients' Rights;
- Reviewing and commenting on policies and practices which affect recipients of mental health services;
- Providing consultation and generating policy questions for the State Office of Patients' Rights;
- Coordinating with other advocates for system reform;
- Analysing state and federal legislation and regulatory developments;

- Representing clients' interests in public forums.[35]

3.111 A strong emphasis is also placed on self-advocacy as an essential part of the advocacy system. Consequently, the Office assists mental health recipients to establish self-advocacy organisations.

[35] *www.pai-ca.org*

Chapter Four - Prevalence of Consumer Complaints Against Private Health Practitioners in NSW

NSW Health Care Complaints Commission

4.1 The Annual Report of the NSW HCCC provides some data on the number of complaints received against health practitioners in private practice.

4.2 The following table shows that number of complaints received against all health services between 2002 and 2005. Whilst a significant number of these complaints were against public hospitals (519 in 2004/05), there were approximately 418 complaints that appear to be made against a private health service or practitioner in 2004/05.

TABLE 50 - COMPLAINTS RECEIVED ABOUT HEALTH SERVICES 2002-03 TO 2004-05

Facility	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Public hospital	396	43.9%	484	51.4%	519	45.8%
Other*	82	9.1%	83	8.8%	93	8.2%
Private hospital	71	7.9%	59	6.3%	83	7.3%
Corrections Health Service	32	3.5%	29	3.1%	58	5.1%
Nursing home	47	5.2%	40	4.2%	50	4.4%
Community Health Service	32	3.5%	32	3.4%	49	4.3%
Pharmacy	14	1.6%	36	3.8%	46	4.1%
Medical centre	35	3.9%	41	4.4%	43	3.8%
Area Health Service	25	2.8%	20	2.1%	40	3.5%
Private medical practice	10	1.1%	7	0.7%	31	2.7%
Dental unit - public	8	0.9%	7	0.7%	20	1.8%
Optometrist Practice	5	0.6%	3	0.3%	18	1.6%
Ambulance Service	17	1.9%	15	1.6%	15	1.3%
Radiology practice	17	1.9%	14	1.5%	14	1.2%
Dental surgery - private	1	0.1%	4	0.4%	12	1.1%
Psychiatric hospital	62	6.9%	34	3.6%	10	0.9%
Health Fund - Private	1	0.1%	3	0.3%	6	0.5%
Drug & alcohol service	1	0.1%	2	0.2%	7	0.6%
Pathology centres/labs	19	2.1%	13	1.4%	6	0.5%
Nursing Agency - District/Community	4	0.4%	0	0.0%	5	0.4%
Women's health centre	2	0.2%	1	0.1%	4	0.4%
Day procedure centre	13	1.4%	9	1.0%	3	0.3%
Hostel - aged	8	0.9%	6	0.6%	1	0.1%
Total	**902**	**100.0%**	**942**	**100.0%**	**1133**	**100.0%**

* **Other: 2004-2005:** Alternative health service 2; Blood Bank 2; Sexual Assault 2, Group home - mental health 2; Hostel - other 2; Methadone clinic 2; Physiotherapy clinic - private 2; Public Development Disability Hospital 2; Boarding house 1; Chiropractic practice 1; DD Hospital 1; Early childhood clinic 1; Family planning clinic 1; Group Home - Development Disability 1; Health Fund - Public; Multi Purpose Service 1; Other, no code available 69.

4.3 Until March 2005, concerns and complaints raised with the Complaints Resolution Service (formally the Patient Support Service) were not included in the total complaint count above.

Patient Support Service/Complaints Resolution Service

4.4 As discussed in Chapter Two, the Complaints Resolution Service (formally the Patient Support Office) can assist consumers and practitioners to resolve low-level complaints not requiring a formal investigation. Consequently, concerns raised with the Service are another important source of data. Importantly, concerns managed by the CRS are likely to be of a less-serious nature, making them of particular interest to the Committee in this inquiry.

4.5 Between 2000 and 2005 the Patient Support Office assisted 18,587 clients. A breakdown of these clients by year is provided below:

2000/01	2001/02	2002/03	2003/04	2004/05	Total
4056	3842	3883	4149	2657	18,587

4.6 The 2004/05 Annual Report of the NSW Health Care Complaints Commission provides details on the service sector to which CRS concerns relate. A public/private breakdown is provided for 2004/05:

TABLE 13 - CRS CONCERNS BY LOCATION AND SERVICE SECTOR 2002-03 TO 2004-05

AHS	2002-2003 Total No.	2003-2004 Total No.	2004-2005 Public[1]	Private[2]	Other[3]	Total No.
Central Coast AHS	135	143	42	45	2	89
Central Sydney AHS	329	316	95	77	11	183
Corrections HS	158	286	233	2		235
Far West AHS	23	28	9	4	1	14
Greater Murray AHS	85	90	25	16	2	43
Hunter AHS	331	316	83	105	3	191
Illawarra AHS	147	298	138	64	12	214
Interstate/Out of State	4	9	3	6		9
Macquarie AHS	44	141	65	15	1	81
Mid North Coast AHS	146	144	39	40	4	83
Mid Western AHS	57	52	32	24	1	57
New England AHS	52	41	14	14		28
Northern Rivers AHS	129	207	66	57		123
Northern Sydney AHS	458	448	123	166	16	305
Not known	100	65	7	17	9	33
South Eastern Sydney AHS	612	556	158	188	12	358
South Western Sydney AHS	416	506	139	133	3	275
Southern AHS	80	69	21	12		33
Wentworth AHS	131	127	41	36	3	80
Western Sydney AHS	504	461	119	130	23	272
Total *	**3,941**	**4,303**	**1,452**	**1,151**	**103**	**2,706**

* This total is based on the 2657 files opened in the financial year. It differs from the total number of clients because some clients raised concerns about more than one health provider.

[1] Public: all public health services including public hospitals, public nursing homes and community health services.

[2] Private: all private health services including private hospitals and nursing homes, private practitioners e.g. GPs, specialists, dentists etc.

[3] Other: all Non Government Organisation (NGO) health services and concerns about system wide issues, access to services that involve all sectors.

Note: Private and NGO health services are located within the geographical boundaries of an Area Health Service but are not under its control.

4.7 This data can then be compared to the proportion of private sector PSO/CRS concerns in the five years previous. The following Table shows the proportion of concerns reported to the former Patient Support Office that related to professionals in private practice (which includes private hospitals and nursing homes, GPs, specialists, dentists and all other private practitioners):

Year	% Private Practitioners
2000/01	48.1
2001/02	49.5
2002/03	48.6
2003/04	44.5
2004/05	42.5

4.8 Overall, then, the HCCC deals with approximately 1500 complaints against private health facilities per year.

4.9 It is interesting to note the types of concerns raised by members of the community to the former Patient Support Service. Concerns about treatment and communication consistently ranked among the top three client concerns between

2000 and 2005, accounting for approximately 50% of all concerns raised during this time.

4.10 The following table illustrates the three most frequently reported concerns received by the former Patient Support Office in the years 2000-2005.

Year	Concern (1)	Concern (2)	Concern (3)
2000/01	Clinical Standards (Treatment) (38.9%)	Communication (16.2%)	Quality of Care (15.3%)
2001/02	Clinical Standards (Treatment) (29.2%)	Clinical Standards (Communication) (15.7%)	Quality of Care (14%)
2002/03	Clinical Standards (Treatment) (33.6%)	Communication (15.3%)	Access (12.4%)
2003/04	Clinical Standards (Treatment) (36.3%)	Communication (13.9%)	Access (12.5%)
2004/05	Treatment (34.9%)	Communication (14.5%)	Access (13.6%)

#Clinical standards are those complaints relating to inadequate or incorrect diagnosis, inadequate or incorrect treatment, infection control or the quality of medical records.
^Communication concerns involve perceived rude or insensitive comments, provision of incorrect or misleading information, or lack of information.

4.11 A separate category of 'Corporate Services' is listed as the fifth ranked consumer concern between 2002 and 2005. At a Public Hearing on 8 March 2006, Commissioner Kieran Pehm informed the Committee that this category of concern included issues such as:

> Corporate services include things like hotel services, car parking, cleaning, catering, grounds, laundry, maintenance, security, hygiene, environmental standards and administrative services like clerical process, admissions and those sorts of things, so bits and pieces like that.

4.12 Between 2002 and 2005, 1123 concerns of this nature were received by the Patient Support Office, approximately 7.8% of all Patient Support Office matters.

4.13 It is the Committee's view that the nature of these issues means they are most likely to benefit from assisted low-level resolution.

Health Registration Boards

4.14 NSW Health Registration Boards also receive complaints about member practitioners. With the exception of nurses and midwives (and some medical practitioners), the majority of these professionals practise in the private health industry.

4.15 The following table identifies that 1266 complaints were received by health registration bodies in the year 2004/05:

Profession	Complaints in 2004/05
Psychologists	67
Dental Technicians	20

Optometrists	18
Chiropractors	37
Osteopaths	4
Physiotherapists	27
Podiatrists	13
Medical Practitioners	1080
	Total = 1266

United Medical Protection

4.16 The 2004/05 Annual Review of UMP reports that 2,676 claims/incidents were reported in that time.

4.17 Approximately 45.8% of these (1,226) could potentially relate to practitioners in private practice (this includes categories of complaint such as patient's letter, Solicitor's letter of inquiry, civil/unlitigated claim, and disciplinary hearing).

Health Professional Associations

4.18 Evidence to a previous Committee inquiry[36] suggests that health professional associations, many of whom represent professionals that largely practise in the private health sector, are consistently receiving and responding to consumer complaints.

4.19 The overall number of these reported complaints is relatively small, averaging around a dozen a year.

[36] Committee on the Health Care Complaints Commission. (September 2006). *Review of the 1998 report into unregistered health practitioners: the adequacy and appropriateness of current mechanisms for resolving complaints*. NSW Parliament.

Chapter Five - Turning Wrongs into Rights

5.1 In 2003, the Council on Quality and Safety in Health Care (now the Australian Commission on Quality and Safety in Health Care) funded the Turning Wrongs into Rights project.

5.2 This project aimed to use information gained from consumer reported incidents to improve the safety and quality of health care services. It was hoped the project would improve the way consumer complaints are managed by health services and to ensure they are linked to quality improvement.

5.3 The NSW Health Care Complaints Commission undertook the project on behalf of the Australasian Council of Health Care Complaints Commissioners, and worked in collaboration with representatives from the Royal Australasian College of Physicians and the Health Issues Centre.

5.4 The project reviewed and researched complaints management, surveyed fifty-three health care organisations, conducted consultations and drew upon existing policies, standards and laws.

5.5 The final product comprised three components:

- A comprehensive literature review to research and identify information on innovation and better practice in complaints management;
- *Better Practice Guidelines on Complaints Management for Health Care Services;*
- *Complaints Management Handbook for Health Care Services.*

Literature Review

5.6 The literature search focused on locating information published within the previous five years, and used a combination of database, library and website searches, as well as contacting key people working in the area of health care complaints (including expert authors both within Australia and internationally).

5.7 The review focused on current knowledge about consumer complaints management processes, in particular:

- Principles of good practice in complaints management; and
- Effective use of complaints to drive organisational or systemic improvement.

5.8 The Literature Review was to answer the following questions:

- What are the key principles in nationally significant consumer complaints handling standards and policies?
- What evidence is there of processes that directly link consumer complaints to systems for organisational or service improvement?
- What are the models of 'better practice'?
- What are the key elements of those 'better practice' systems?
- What difference have these better practice complaints management system made to the way that organisations do their business?
- What performance indicators are used to measure success?

- What research is there on the staff competencies in complaints management and the position of front line complaints management staff within organisations (perceived and actual)?
- What information is there of effective strategies to implement complaints management processes, such as staff training, information technology tools and other initiatives?

Key Findings

5.9 Whilst the literature review largely contained summaries of relevant articles, guidelines and standards, some key themes were identified and reported by the researchers.

5.10 Firstly, the researchers concluded that there was very little literature that suggests complaints practice had started to systematically and effectively inform service improvement processes. There was, however, significant weight in the literature given to consumers' and relatives' responses to complaints, the interaction between provider and complainant, and resolution of the consumer's concerns.

5.11 The researchers also found numerous guidelines and standards providing recommendations on complaints handling and identifying what constitutes better practice in the handling of complaints. They also found a number of toolkits to support and inform health managers and clinicians in the establishment and maintenance of structures and processes for managing complaints.

5.12 While using complaints to improve quality and safety was generally seen as 'a good idea', the review found very little evaluation of such practice is evident. Similarly, very little literature was found on the development of performance indicators.

5.13 The general approach to complaints management in health care was one that individualised the grievance and minimised the impact on the organisation, its protocols and procedures.

5.14 However the review found some evidence to suggest a shift towards a 'systems' approach, which regards complaints as central to organisational learning and emphasizes the documentation and reporting of complaints as well as ensuring that necessary changes are implemented.

Better Practice Guidelines on Complaints Management for Health Care Services

5.15 The *Better Practice Guidelines* were designed to assist health care services when developing or improving their complaints management system.

5.16 The Guidelines take into account relevant policies of Australian governments; the standards of leading accreditation programs in the health sector; the national Open Disclosure Standard 2003; and relevant Australian and International Standards.

5.17 The 'better practice' approach used in the Guidelines supports health care services to continue improving their performance over time.

5.18 Underpinning the Guidelines is a focus on a quality improvement cycle, which involves the organisation in stages beginning with identifying and reporting incidents through to making sure the necessary changes occur.

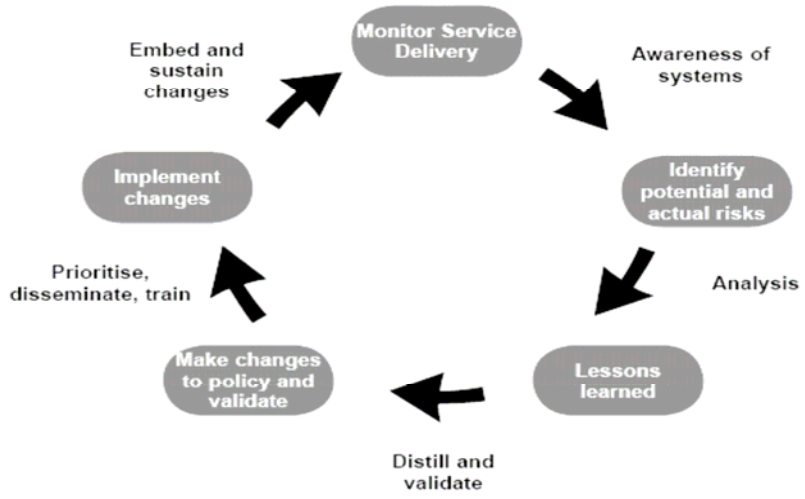
5.19 The quality improvement approach to handling complaints has a number of elements:

- Actively encouraging feedback from consumers about the service;

- Negotiating with consumers about outcomes and not just 'telling them';
- Managing complaints as part of risk management, enabling appropriate reporting, assessment and follow up action; and
- Learning from complaints and consumer feedback, enabling improvements to the systems of care.

5.20 This cycle is illustrated below:

Figure 1 – The learning cycle



Source: An organisation with a memory, NHS (UK)

5.21 The *Guidelines* address issues such as complaints and incident monitoring, dispute resolution and attitudinal change.

5.22 Eight guidelines are contained, each with better practice performance indicators against which an organisation can assess their own performance.

5.23 These guidelines are:

1. **Commitment to consumers and quality improvement:** Leaders in the health care service promote a consumer-focused approach to complaints as part of a continuous quality improvement program.
2. **Accessible:** The service encourages consumers to provide feedback about the service, including concerns and complaints, and makes it easy to do so.
3. **Responsive:** The service acknowledges all complaints and concerns and responds promptly and sensitively.
4. **Effective assessment:** The service assesses complaints to determine appropriate responses by considering risk factors, the wishes of the complainant and accountability.
5. **Appropriate resolution:** The service deals with complaints in a manner that is complete, fair to all parties and provides just outcomes.
6. **Privacy and open disclosure:** The service manages information in a fair manner, allowing relevant facts and decisions to be openly communicated while protecting confidentiality and personal privacy.
7. **Gathering and using information:** The service records all complaints to enable review of individual cases, to identify trends and risks, and report on how complaints have led to improvements.

8. **Making improvements:** The service uses complaints to improve the service, and regularly evaluate the complaints management policy and practice

Complaints Management Handbook for Health Care Services

5.24 The *Complaints Management Handbook for Health Care Services* was subsequently developed to assist organisations in implementing the *Guidelines*.

5.25 It is intended to provide practical assistance to organisations wanting to implement the Guidelines and to promote positive attitudes to complaints as part of a wider consumer feedback strategy.

5.26 The *Handbook* outlines the role of good complaints management in quality and safety improvement, and emphasises the benefits that taking an active approach to consumer complaints can have for health practice. Benefits identified include:

- Improved safety and quality of the service, by providing information about the experiences of consumers and carers;
- Restoration of the trust and confidence of a consumer or carer;
- Saving management time by the quick and simple resolution of complaints, thus avoiding escalation;
- Promote a culture of reporting and accountability;
- Prevent wasteful practices and reduce the costs, such as insurance;
- Create a more satisfactory working environment for clinicians and staff; and
- Enhance the reputation of the service and prevent negative comments or publicity.

5.27 There are four main sections to the *Handbook,* including:

- Information on the policy basis for the quality improvement approach to complaints management, based on fairness, risk management and partnerships with consumers.
- A discussion of each guideline and the indicators. Topics include: learning from errors, recording complaints, fairness, privacy and confidentiality, risk assessment and evaluation.
- Tools for use by practitioners, including a sample complaint follow up record, sample letters, a sample consumer feedback brochure and a *Self Assessment Guide*.
- Case studies illustrating how health care services in different settings manage complaints and describing the experiences of consumers who have lodged complaints.

5.28 Particularly important for the Committee's Inquiry is the inclusion of a supplement for use in General Practices and other specialist clinics (included below).

Supplement for General Practices and other Specialists

5.29 The *Handbook* includes a supplement for use in general practices and by other specialists. The supplement outlines key elements of complaints management that are particularly appropriate for private practice:

Key elements of complaints management

General practices and other specialist practices are often small services, run by the doctors who own the business. The system for managing consumer complaints and other feedback needs to be simple and easy to administer, incorporating the following:

- be open to consumer feedback, including complaints;
- show your willingness to listen through signage, brochures, general publicity and the attitudes of doctors and staff;
- provide information to consumers about how to give feedback and about health care complaints commissioners;
- be fair and thorough when investigating a complaint;
- keep personal information confidential and secure;
- resolve complaints promptly and keep in touch with the complainant if resolution is delayed;
- capture information about all kinds of consumer concerns as well as formal complaints;
- analyze information about concerns and formal complaints to identify trends and causes;
- assess the seriousness of complaints as part of a risk management strategy, and consult with regulatory agencies when serious issues arise;
- provide a regular forum for doctors and staff to discuss complaints and other incidents;
- implement improvements to the service following analysis of complaints and other feedback; and
- regularly review how well the complaints management system is working.

Everyone's responsibility

Resolving complaints and concerns needs to be the responsibility of everyone in the practice, consistent with their role and responsibilities. Everyone needs to understand what is expected of them. Training is important to support doctor's and staff dealing with complaints and understanding procedures. It is valuable for doctors and staff to discuss complaints regularly. A summary report of complaints and suggestions is a useful starting point for discussions about performance and improvements at clinical review and staff meetings.

Capturing comments

Information about the informal day-to-day concerns raised by consumers is just as valuable for quality improvement purposes as information from formal complaints. Keep an exercise book in reception where doctors and other staff can make a note of comments and observations, or use a computer-based system if that is more in line with the way the practice works.

Consumers should be encouraged to offer comments and suggestions by using a simple photocopied Consumer feedback brochure or Suggestion for improvement form. Doctors and staff can also use the Suggestion for improvement form. Once a problem is fixed, contact the consumer by telephone to check if they are satisfied and to confirm the agreed outcomes.

To ensure complaints receive the attention they need, a senior person needs to have designated responsibility for managing the practice's Complaints Management Policy, such as the practice manager or principal partner.

5.30 A sample complaints policy is also included, and encompasses the following:

1. An overarching statement of the policy aims:

- we aim to provide a service that meets our consumers' needs and we strive for a high standard of care.
- we welcome suggestions from consumers, their family members, and from our doctors and staff about the safety and quality of care, because it helps us identify problems and improve the care we provide.
- we are committed to an effective and fair system for resolving complaints.

2. Information on procedures:

Consumers and their families are encouraged to provide suggestions, compliments, concerns, complaints about their clinical care directly with the treating doctor. We also provide a Suggestion for Improvement Form and Consumer feedback brochure [or alternative] to encourage consumers to put their views in writing.

Our doctors and staff can also use the Suggestion for Improvement Form to note complaints or concerns about the quality of service to consumers.

The forms can be lodged anonymously, and will be acted on to the extent possible based on the information provided.

Our practice provides information about the complaints policy through its general publicity, the practice information sheet and on our website [where applicable]. We also provide information about [health care complaints commission], where consumers, their families, clinicians and staff can go to with a complaint about our service at any time.

Our practice conducts an annual consumer satisfaction survey to obtain information about levels of satisfaction with standard of care and aspects of the service [or other regular activity].

3. Statement of respect and sensitivity:

Consumers, their families, doctors and staff can raise concerns or make complaints on a confidential basis if they wish, and be assured that their identity will be protected.
No-one will be discriminated against or suffer any adverse consequences as a result of making a complaint.

Our doctors and staff are expected to provide assistance to consumers with special needs, such as those who do not speak English or people with a disability, so that they can provide feedback and follow up a complaint.

4. Statement of responsibility:

Our doctors and all staff are expected to encourage consumers and their families to provide feedback on the quality of care and services, including complaints and concerns.

Our doctors and staff are expected to resolve complaints directly with consumers, within the scope of their responsibilities. Generally, the process of resolving a complaint will follow the steps outlined below:

Step 1: Express regret for the distress or inconvenience caused, and an explanation or further information, if requested.

Step 2: Clarify the consumer's concerns and find out what they want to be done.

Step 3: Consult with the practice manager or principal partner about the possibilities for agreeing to the consumer's request. For example, a fee waiver or reduction may be offered if there has been inadequate information about fees or charges.

Step 4: Confirm with the consumer that they are satisfied with what is proposed, or if not resolved, confirm that it will be referred to the [practice manager/ principal partner].

Step 5: Make a record of the complaint in the Consumer Feedback book at reception, or by completing the Suggestion for improvement form."

5. Procedures for when a complaint is not resolved:

Complaints not resolved at the point of service, or received in writing, that require follow up are treated as formal complaints.

Our doctors and staff refer complaints to the practice manager or practice partner if they do not feel confident in dealing with the complainant, or if they believe, or the complainant believes, the matter should be brought to the attention of someone more senior. Complaints raising matters of clinical care are dealt with in close liaison with the treating doctor.

6. Rights to training and discussion

All doctors and staff need to have skills in handling complaints. The practice provides training in dispute management, complaints management procedures and patient safety as part of induction and through regular updates. Staff meetings and clinical review meetings are used to promote discussion and understanding of how complaints are managed and how they lead to improvements.

7. Requirements for risk assessment

The practice manager ensures all complaints are assessed for risk to identify high-risk complaints that require urgent notification to the principal partner and a specific action plan, different from the usual process for managing complaints. A designated practice partner assesses complaints concerning clinical care and the practice manager assesses complaints concerning office systems and administrative issues.

A complaint is assessed as high risk if:

- a consumer has died or suffered serious harm as a result of receiving health care, unrelated to the natural course of illness or expected outcomes of treatment, but resulting in hospital admission or emergency care;
- a health professional appears to lack knowledge, skill, care or judgment, or appears to have behaved in an inappropriate manner for a health care professional, such as committing a criminal act (for example, fraud or assault);
- there is a significant failure in practice systems for patient management; and
- there is a high likelihood of a consumer leaving the practice.

An important factor in assessing risk is to consider whether the nature of the issues raised by the complaint indicate that the incident is likely to happen again.

8. Guidelines for external notification:

The principal partner will consult with external agencies where a complaint raises:

Issue	External agency
Complaint cannot be resolved directly with consumer	Relevant health care complaints commissioner (see page 93)
Serious breach of consumer privacy	Office of the Federal Privacy Commissioner [and state or territory privacy commissioner or health care complaints commissioner if applicable]
	Professional registration body, if conduct is breach of professional standards
Unsatisfactory professional conduct of practitioner	Health professional registration [eg. in NSW, Health Care Complaints Commission]
Circumstances giving rise to the possibility of a legal claim	[medical indemnity provider and insurers]

All reportable deaths under the Coroners Act [insert relevant statutory provision] will be notified to the Coroner as required by law.

9. Timeframes for complaints handling:

"Formal complaints are acknowledged in writing or in person within 48 hours, and will usually be investigated and resolved within 10 days.

If the complaint is not resolved within 10 days the complainant and doctors or staff directly affected will be provided with an update.

If a complaint raises issues that require notification to an external body, the notification will occur within three days of those issues being identified. The people directly affected will be advised when this occurs."

10. Records and privacy provisions:

"Our practice manager [or alternate person responsible] maintains a complaints register. Our complaints register contains:

- summary records of informal complaints; and
- a complete record of formal complaints

Complaint records are kept in confidential files, separate from patient medical records. Information is only disclosed to those who need the information to manage the complaint."

11. Procedures for investigation and resolution:

Individual formal complaints are investigated to identify the events that took place, the causes of the complaint, remedial action that should be taken and improvements that might be made.

Where a complainant names an individual doctor or staff member, the person will be told the nature of the claims made against them. The principal partner or practice manager will conduct the investigation, depending on the position held by the relevant doctor or staff member.

The investigation will be conducted in accordance with the principles of natural justice.

The views of the complainant and doctors or staff directly involved will be considered along with other relevant information.

At the conclusion of an investigation, the complainant and any doctors or staff directly affected are provided with the agreed facts, reasons for decisions, the underlying causes of the complaint and recommended improvements.

The conclusions of the investigation are discussed with the complainant and action that will be taken by the practice agreed. The practice strives to achieve the outcomes that are fair and reasonable in the circumstances. If no agreement is reached, the complainant is provided with information about the Health Care Complaints Commissioner.

12. Complaints reporting and discussion:

The [practice manager/principal partner] provide reports on informal consumer feedback, formal complaints and any recommended changes to policies and procedures for discussion at staff meetings. Information in the reports is de-identified.

The [principal partner] provides a report for discussion at monthly clinical review meetings on informal and formal complaints, the causes, outcomes and recommendations for improvement.

Doctors and staff are encouraged to discuss complaints and the performance of the practice at staff meetings and clinical review meetings.

13. Policy oversight and evaluation

The [practice manager/principal partner] is responsible for coordinating the complaints policy, assessment of risk, investigation and action on formal complaints, regular reporting on complaints, and monitoring the effectiveness of the complaints procedure.

The [practice manager] continuously monitors whether complaints management practices are consistent with this complaints policy. The [practice manager/principal partner] annually evaluate the complaints management practices to measure whether we comply with the Royal Australian College of General Practitioners Standards for General Practices, and the *Better Practice Guidelines on Complaints Management for Health Care Services*.

Chapter Six - Guide to Complaints Handling in Health Care Services

6.1 In 2005, the Health Services Review Council developed the *'Guide to Complaint Handling in Health Care Services'*, funded by the Victorian Department of Human Services and designed for use in both public and private health facilities.

6.2 The *Guide* is based on the assumption that consumer complaints are inevitable in any health system and that, when handled in a prompt and efficient manner, many adverse consequences of complaints can be avoided:

> "…dealing promptly and effectively with complaints has considerable benefits for health organisations, including better quality health care, reduced likelihood of litigation, and substantial savings in the direct and indirect costs arising from adverse incidents, complaints and claims."[37]

6.3 The Council also believed that effective complaints handling reduces stress on staff, and is also in the interests of the patient's health and wellbeing.

6.4 Overall, a successful complaints handling system can lead to:

"
- Prompt and speedy resolution of complaints,
- Reduced costs (direct and indirect) involved with the complaint handling,
- Better risk management, potentially limiting the number of complaints that may become formal legal claims,
- Promotion of better health outcomes
- Better quality assurance, by providing feedback on service delivery,
- More satisfied consumers."

6.5 The objectives of any complaints management system should be to provide consumers with an efficient, fair and accessible complaints mechanism, to ensure that the rights of consumers are recognised, promoted and protected, and to collect data and monitor complaints for the purpose of improving the quality of health service delivery.

6.6 The *Guide* addresses complaints management issues in five sections:

1. Principles;
2. Organisational Foundations;
3. Process;
4. Skills;
5. Seriousness Assessment.

Guiding Principles for Effective Complaints Management

6.7 Seven guiding principles characterise the Guide:

1. Quality Improvement: Complaints management is an integral part of the quality improvement process that has been adopted by the health service.
2. Open Disclosure: The health service has a policy of open disclosure in relation to adverse events and complaints.

[37] Health Services Review Council. (2005). *Guide to Complaint Handling in Health Care Services.*

3. Commitment: The health service and its senior management are fully committed to an integrated complaints management system and will provide the necessary support for it to operate effectively.
4. Accessibility: The health service encourages consumers and staff to give feedback about the service and makes it easier for them to do so.
5. Responsiveness: The health service has a consumer-focused approach, being receptive to complaints and treating complaints seriously.
6. Transparency and Accountability: The complaints process is clearly articulated, open and accountable to both staff and consumers.
7. Privacy and Confidentiality: The health service respects the privacy and confidentiality of consumers and the information received during the complaints process, while at the same time making its decisions open and accountable.

Organisational Foundations

6.8 Each organisation should have policies on how complaints will be handled, including clear protocols for dealing with major incidents. The organisation should actively promote its complaints mechanisms to consumers, advertising processes widely and clearly.

6.9 Staff of an organisation should regard complaints management as an everyday part of their responsibilities. All staff should be trained to handle complaints themselves:

> "Dealing with complaints promptly at the point where they arise should be seen as a priority throughout the organisation."

6.10 The environment within an organisation should be such that staff can communicate freely with other staff and with senior management.

6.11 Organisations should have a designated complaints manager who is sufficiently senior to do the job effectively. These responsibilities can either be issued to one person, or aspects shared amongst several staff members within the organisation.

6.12 The job of complaints manager will usually involve co-ordinating complaints handling and ensuring that complaints are acted on, including providing backup and support for other staff to encourage them to resolve complaints themselves.

6.13 All complaints need to be recorded in some way. The same tool can also be used for staff to record informal comments and observations. Such a system will not only facilitate accountability but will also enable complaints to be tracked.

6.14 Recording systems should be simple and not too time consuming, and should be filled in by staff members, not consumers (as they are likely to have already filled in a complaints form, and should not have to repeat the process).

6.15 Once a complaint is recorded, organisations should ensure that a system is in place with which complaints may be tracked.

6.16 Organisations should have adequate data collection tools that not only enable data to be aggregated and analysed to identify trends but are linked into whatever system the organisations uses for its risk management.

6.17 Systems must also be in place to report on the outcomes of complaints. This reporting should be three-fold:

1. Reporting to the complainant;

2. Reporting to the quality systems of the organisation and to senior management;
3. Reporting to staff.

Complaints Process

6.18 The *Guide* provides information on three categories of complaints that are often encountered by practitioners and staff at health service facilities:

- Point-of-service complaints: These are straightforward complaints, which can be dealt with promptly and to the health consumer's satisfaction at the point of service.
- Complaints needing investigation: More serious or complex matters or unresolved complaints may need to be referred to more senior staff or the complaints manager. There is a need for investigation and a clear outcome identified, possibly involving different levels within the organisation.
- External complaints: Complaints that are unresolved by the organisation. They need to be referred to external bodies or insurers to deal with. Some complaints first come to the organisation from the Health Services Commissioner.

Point of Service Complaints

6.19 The *Guide* emphasises the importance of resolving complaints at the point-of-service. Immediate follow-up and feedback to the consumer can avoid the escalation of the complaint. The need to acknowledge the consumer's perception and provide an explanation is also highlighted.

6.20 Staff need to be clear about what they can and cannot do in response to a complaint, and should be encouraged to record information about complaints and any action taken. As a general rule, it is recommended that complaints are referred to the complaints manager if they:

- Are unresolved;
- Involve serious consequences;
- Involve complex medical issues or a number of different staff;
- Need action that is beyond the responsibility of the staff at point of service; or
- Need to be dealt with by someone with more authority.

Complaints Needing Investigation

6.21 This section outlines the four steps involved in complaint handling:

- Step 1: Assessment;
- Step 2: Information Gathering;
- Step 3: Resolution/Outcome;
- Step 4: Implementation.

Step One- Assessment

6.22 A decision should be made by the organisation as to who is to do the assessment, and under what circumstances.

6.23 It is recommended that assessment be undertaken using a seriousness assessment matrix. The outcomes of the seriousness assessment will determine who will deal with the complaint and who needs to be notified.

Step Two- Information Gathering

6.24 When analysing what went wrong or why there is a problem, systems should be examined to see how changes can be made and how individuals can be supported to prevent recurrence.

6.25 A complaint/feedback form should be completed for each complaint, which can be done by the staff member if necessary. Regardless of who records the information, it must reflect the story of the consumer without being filtered or interpreted.

6.26 The complainant should be kept informed at all stages of the investigation.

6.27 All relevant people should be consulted and accurate records kept at all times.

Step Three- Resolution/Outcome

6.28 Options for resolution should be discussed with the consumer after all evidence has been gathered. Options may include:

- Meetings between the patient, their family and staff;
- Provision of an explanation;
- An apology;
- An undertaking to review policies and procedures relating to the incident.

6.29 Although the focus of investigations is usually on systemic issues, the role of individual staff should also be considered.

Step Four- Implementation

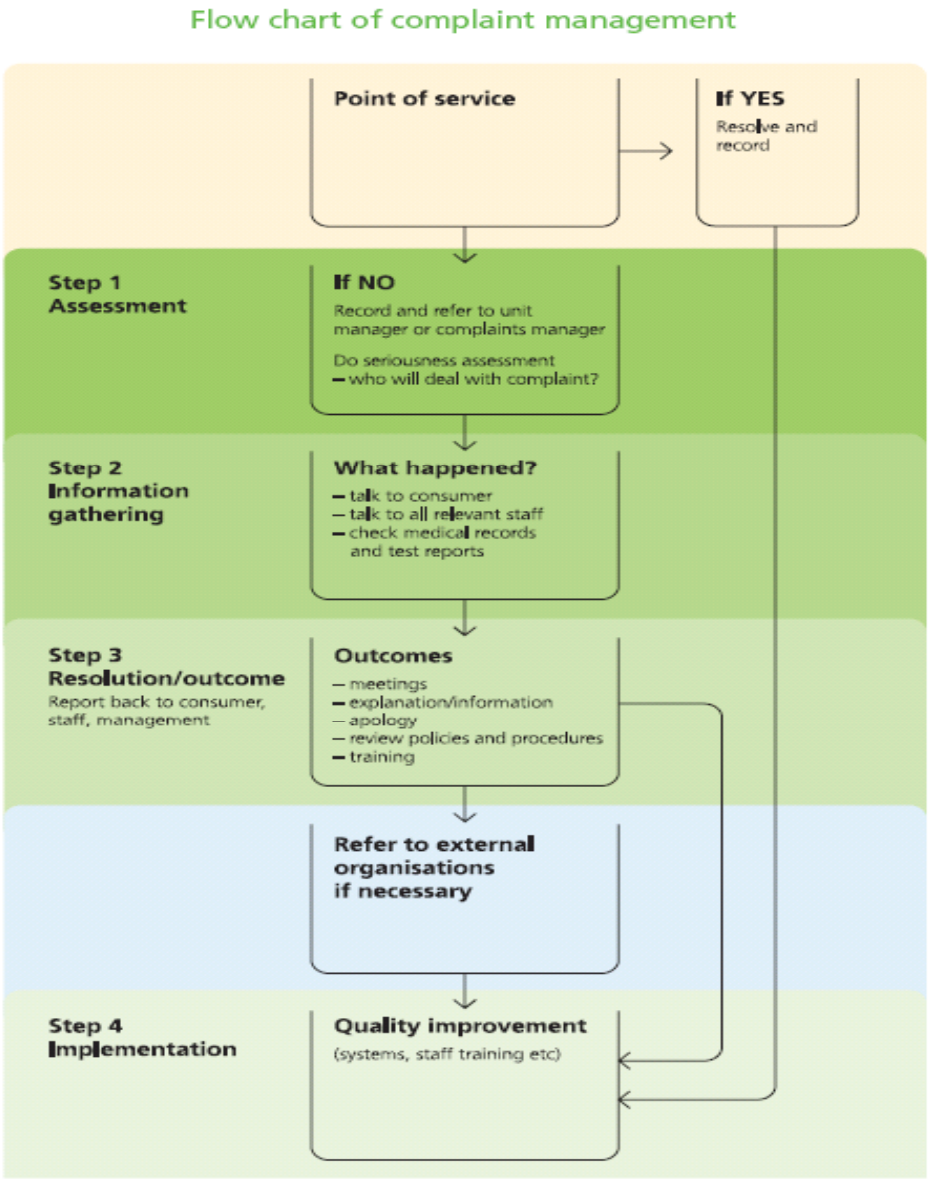
6.30 The resolution or outcome should be included in the relevant complaints data collection tool, and the actions implemented.

6.31 The outcome must be clearly communicated to the consumer, staff and management, and integrated into quality improvement systems.

6.32 The effectiveness of the outcome should also be monitored.

6.33 When a complaint cannot be resolved adequately internally, consumers should be referred to the relevant external complaints organisation.

6.34 The following flow chart of complaint management is provided in the *Guide*, and summarises the steps to be taken to ensure that an appropriate response to a complaint is given.



Complaints Handling Skills

6.35 The *Guide* outlines skills relevant to the effective handling of consumer complaints, including communication techniques and other tips for responding to difficult situations.

6.36 Staff are encouraged to employ active listening techniques and are given examples of the appropriate use of open and closed questions.

6.37 Factors impacting on emotional responses by both staff and consumers are described in the manual, providing alternative explanations for why some reactions to situations can appear unreasonable. Language difficulties and other situational frustrations are also discussed.

6.38 Appropriate uses of empathy and assertive language are outlined, and staff are encouraged to obtain help from other staff as necessary.

6.39 A list of patient circumstances requiring particular attention is provided, and includes:

- When a patient dies;

- Children;
- Persons with a mental illness;
- Persons with cognitive impairment;
- Patients who do not agree with the information provided;
- Language or cultural diversity;
- Aboriginal and Torres Strait Islander patients;
- Patients with other communication requirements (e.g. hearing impairment).

6.40 Information on conducting an effective meeting is provided, and the need for debriefing between colleagues emphasised.

System Tools

6.41 The *Guide* provides examples of system tools that can be used to assist the complaints process, but emphasises that each organisation should decide on a system that will work most effectively within their current management structure.

6.42 Essential elements of a complaints system are:

- A recording method for tracking complaints;
- Complaints are assessed in order to generate action from the appropriate level;
- Staff are aware of their responsibilities in the system and understand their role;
- Issues raised by complaints are reviewed and fed back into the work of the organisation.

6.43 A sample Audit Tool is provided in the *Guide* to enable organisations to assess their own performance with regards to the various areas of complaints handling. The tool allows comparisons to be made between current practice and desired practice indicators.

6.44 A summary section to record areas where action is required as well as priorities for improvement over the next 12 months is also included.

Seriousness Assessment Matrix

6.45 The Seriousness Assessment Matrix (SAM) was developed to enable health care providers to implement effective and consistent risk management strategies.

6.46 The SAM allows staff to categorise a complaint or incident according to the likelihood of it occurring again and the severity of any potential consequences.

6.47 Probability of occurrence and severity of consequences are given a score of 1 to 4, with 1 being the most serious.

6.48 The SAM is provided below:

Seriousness Assessment Matrix

Figure 1: SAM

PROBABILITY	SERIOUSNESS			
	Catastrophic	Major	Moderate	Minor
Frequent	1	1	2	3
Occasional	1	2	2	3
Uncommon	1	2	3	4
Remote	2	3	3	4

6.49 The SAM can be employed manually, but can also be used as an electronic tool, which has the added benefit of automatically generating 'flags' to designated staff for information or action.

Chapter Seven - International Best Practice Standard for Complaints Management

7.1 The International Standard *(ISO 10002:2004)* provides guidance for the design and implementation of an effective and efficient complaints-handling process for all types of commercial or non-commercial activities.

7.2 In 2006 an Australian equivalent Standard *(AS ISO 10002:2006)* was created by tailoring the International Standard to reflect national considerations.

7.3 Titled *Customer Satisfaction- Guideline for Complaints Handling in Organizations,* the Standard recognises that information obtained through the complaints-handling process can lead to improvements in products and processes and, where the complaints are properly handled, can improve the reputation of the organisation regardless of its size, location or sector.

7.4 Implementation of the processes described in Standard are expected to:

- Provide complainants with access to an open and responsive complaints-handling process;
- Enhance the ability of the organisation to resolve complaints in a consistent, systematic and responsive manner, to the satisfaction of both the complainant and the organisation;
- Enhance the ability of an organisation to identify trends and eliminate causes of complaints, and improve the organisation's overall operations;
- Help an organisation create a customer-focused approach to resolving complaints, and encourage personnel to improve their skills in working with customers; and
- Provide a basis for continual review and analysis of the complaints-handling process, the resolution of complaints, and the improvements made.

7.5 Organisations can use the complaints-handling process in conjunction with customer satisfaction codes of conduct and external dispute resolution processes.

Customer Satisfaction- Guidelines for Complaints Handling in Organizations (AS ISO 10002:2006)

Complaints Policy

7.6 General principles for effective complaints management included in the Standard cover:

- Visibility: Information about how and where to complain should be well publicized to customers, personnel and other interested parties.
- Accessibility: A complaints-handling process should be easily accessible to all complainants. The characteristics of an accessible complaints-handling process include the provision of readily accessible information about the process, flexibility in the methods of making complaints, free or local call fee facilities for making complaints and special arrangements and/or support should be made available for complainants with specific needs (including availability of interpreters and cross-culturally trained staff).

- Information should be made available on the details of making and resolving complaints. The complaints-handling process and supporting information should be easy to understand and use. The information should be in clear language. Information and assistance in making a complaint should be made available in whatever languages or formats that the products were offered or provided in, including alternative formats, such as large print, Braille or audiotape, so that no complainants are disadvantaged.
- Responsiveness: Receipt of each complaint should be acknowledged to the complainant immediately. Complaints should be addressed promptly in accordance with their urgency. The complainants should be treated courteously and be kept informed of the progress of their complaint through the complaints-handling process.
- Objectivity: Each complaint should be addressed in an equitable, objective and unbiased manner through the complaints-handling process.
- Charges: Access to the complaints-handling process should be free of charge to the complainant.
- Confidentiality: Personal information concerning the complainant should be available where needed, but only for the purposes of addressing the complaint within the organisation and should be actively protected from disclosure, unless the customer or complainant expressly consents to its disclosure.
- Customer-focused Approach: The organisation should adopt a customer-focused approach, should be open to feedback including complaints, and should show commitment to resolving complaints by its actions.
- Accountability: The organisation should ensure that accountability for and reporting on the actions and decisions of the organisation with respect to complaints handling is clearly established.
- Continual Improvement: The continual improvement of the complaints-handling process and the quality of products should be a permanent objective of the organisation.

Complaints-Handling Framework

7.7 The organisation should be actively committed to effective and efficient complaints handling. This commitment should be reflected in the adoption and dissemination of policy and procedures for the resolution of complaints. Commitment from management should be shown by the provision of adequate resources, including training. The policy should be supported by procedures and objectives for each function and personnel role included in the process.

7.8 When establishing the policy and objectives for the complaints-handling process, the following factors should be taken into account:

- Any relevant statutory and regulatory requirements; financial, operational and organisational requirements;
- The input of customers, personnel and other interested parties.

7.9 Additionally, the policies related to quality and complaints handling should be aligned.

7.10 Management should also take responsibility for the following:

- Ensuring that the complaints-handling process and objectives are established within the organisation;
- Ensuring that the complaints-handling process is planned, designed, implemented, maintained and continually improved in accordance with the complaints-handling policy of the organisation;
- Identifying and allocating the management resources needed for an effective and an efficient complaints-handling process;
- Ensuring the promotion of awareness of the complaints-handling process and the need for a customer focus throughout the organisation;
- Ensuring that information about the complaints-handling process is communicated to customers, complainants, and, where applicable, other parties directly concerned in an easily accessible manner;
- Appointing a complaints-handling management representative and clearly defining his or her responsibilities and authority;
- Ensuring that there is a process for rapid and effective notification to management of any significant complaints;
- Periodically reviewing the complaints-handling process to ensure that it is effectively and efficiently maintained and continually improved.

7.11 The complaints-handling management representative should be responsible for the following:

- Establishing a process of performance monitoring, evaluation and reporting;
- Reporting to senior management on the complaints-handling process, with recommendations for improvement;
- Maintaining the effective and efficient operation of the complaints-handling process, including the recruitment and training of appropriate personnel, technology requirements, documentation, setting and meeting target time limits and other requirements, and process reviews.

7.12 Other managers involved in the complaints-handling process should, as applicable within their area of responsibility, be responsible for the following:

- Ensuring that the complaints-handling process is implemented;
- Liaising with the complaints-handling management representative;
- Ensuring the promotion of awareness of the complaints-handling process and of the need for a customer focus;
- Ensuring that information about the complaints-handling process is easily accessible;
- Reporting on actions and decisions with respect to complaints handling;
- Ensuring that monitoring of the complaints-handling process is undertaken and recorded;
- Ensuring that action is taken to correct a problem, prevent it happening in the future, and that the event is recorded; and
- Ensuring that complaints-handling data are available for senior management review.

7.13 All personnel in contact with customers and complainants should be trained in complaints handling.

7.14 All personnel should also be aware of their roles, responsibilities and authorities in respect of complaints, be aware of what procedures to follow and what information to give to complainants, and report complaints which have a significant impact on the organisation.

Planning and Design

7.15 Management should take responsibility for ensuring that ensure that complaints-handling objectives are established for relevant functions and levels within the organisation, and that these are measurable and consistent with the complaints-handling policy.

7.16 Management should also ensure that the planning of the complaints-handling process is carried out in order to maintain and increase customer satisfaction. The complaints-handling process may be linked to and aligned with other processes of the quality management system of the organisation.

7.17 In order to ensure that the complaints-handling process operates effectively and efficiently, senior management should assess the needs for resources and provide them. These include resources such as personnel, training, procedures, documentation, specialist support, materials and equipment, computer hardware and software, and finances.

Communication

7.18 Information concerning the complaints-handling process should be made readily available to the consumer, complainants and other interested parties, including where and how complaints can be made, the process for handling a complaint, timeframes for complaints resolution and alternative options for remedy available.

7.19 Such information should be provided in clear language and, so far as is reasonable, in formats accessible to all, so that no complainants are disadvantaged.

Complaints Process

7.20 Upon reporting of the initial complaint, the complaint should be recorded with supporting information and a unique identifier code.

7.21 The record of the initial complaint should identify the remedy sought by the complainant and any other information necessary for the effective handling of the complaint including the following:

- A description of the complaint and relevant supporting data; the requested remedy;
- The products or related organisation practices complained about; the due date for a response;
- Data on people, department, branch, organisation and market segment; immediate action taken (if any).

7.22 The complaint should be tracked from initial receipt through the entire process until the complainant is satisfied or the final decision is made. An up-to-date status should be made available to the complainant upon request and at regular intervals throughout the process.

7.23 Receipt of each complaint should be acknowledged to the complainant immediately. After receipt, each complaint should be initially assessed in terms of criteria such as severity, safety implication, complexity, impact, and the need and possibility of immediate action.

7.24 Every reasonable effort should be made to investigate all the relevant circumstances and information surrounding a complaint. The level of investigation should be commensurate with the seriousness, frequency of occurrence and severity of the complaint.

7.25 Following an appropriate investigation, the organisation should offer a response. If the complaint cannot be immediately resolved, then it should be dealt with in a manner intended to lead to its effective resolution as soon as possible.

7.26 The decision or any action taken regarding the complaint, which is relevant to the complainant or to the personnel involved, should be communicated to them as soon as the decision or action is taken.

7.27 If the complainant accepts the proposed decision or action, then the decision or action should be carried out and recorded.

7.28 If the complainant rejects the proposed decision or action, then the complaint should remain open. This should be recorded and the complainant should be informed of alternative forms of internal and external recourse available.

7.29 The organisation should continue to monitor the progress of the complaint until all reasonable internal and external options of recourse are exhausted or the complainant is satisfied.

Continuous Improvement

7.30 The organisation should record the performance of its complaints-handling process. The organisation should establish and implement procedures for recording complaints and responses and for using these records and managing them, while protecting any personal information and ensuring the confidentiality of complainants. This should include the following:

- Specifying steps for identifying, gathering, classifying, maintaining, storing and disposing of records;
- Recording its handling of a complaint and maintaining these records, taking utmost care to preserve such items as electronic files and magnetic recording media, since records in these media can be lost as a result of mishandling or obsolescence;
- Keeping records of the type of training and instruction that individuals involved in the complaints-handling process have received;
- Specifying the organisation's criteria for responding to requests for record presentation and record submissions made by a complainant or his or her agent; this may include time limits, what kind of information will be provided, to whom, or in what format;
- Specifying how and when statistical non-personally identifiable complaints data are disclosed to the public.

7.31 All complaints should be classified and then analysed to identify systematic, recurring and single incident problems and trends, and to help eliminate the underlying causes of complaints.

7.32 There should be regular action taken to determine the levels of satisfaction of complainants with the complaints-handling process.

7.33 Continual monitoring of the complaints-handling process, the resources required (including personnel) and the data to be collected should be undertaken. The performance of the complaints-handling process should be measured against predetermined criteria.

7.34 The organisation should regularly perform or provide for audits in order to evaluate the performance of the complaints-handling process. The complaints-handling audit may be conducted as part of the quality management system audit. The audit results should be taken into account in the management review to identify problems and introduce improvements in the complaints-handling process. The audit should be carried out by competent individuals independent of the activity being audited.

7.35 Senior management of the organisation should review the complaints-handling process on a regular basis in order:

- To ensure its continuing suitability, adequacy, effectiveness and efficiency;
- To identify and address instances of nonconformity with health, safety, environmental, customer, regulatory and other legal requirements;
- To identify and correct product deficiencies;
- To identify and correct process deficiencies;
- To assess opportunities for improvement and the need for changes to the complaints handling process and products offered; and
- To evaluate potential changes to the complaints-handling policy and objectives.

7.36 The input to management review should include information on:

- Internal factors such as changes in the policy, objectives, organisational structure, resources available, and products offered or provided;
- External factors such as changes in legislation, competitive practices or technological innovations;
- The overall performance of the complaints-handling process, including customer satisfaction surveys and the results of the continual monitoring of the process;
- The results of audits;
- The status of corrective and preventive actions;
    - Follow up actions from previous management reviews, and recommendations for improvement.

7.37 The output from the management review should include:

- Decisions and actions related to improvement of the effectiveness and efficiency of the complaints-handling process;
- Proposals on product improvement; and

- Decisions and actions related to identified resource needs.

7.38 Records from the management review should be maintained and used to identify opportunities for improvement.

7.39 The organisation should take action to eliminate the causes of existing and potential problems leading to complaints in order to prevent recurrence and occurrence, respectively.

7.40 The organisation should explore, identify and apply best practices in complaints handling, foster a customer-focused approach within the organisation, encourage innovation in complaints-handling development, and recognize exemplary complaints-handling behaviour

Chapter Eight - Education and Training

8.1 The Committee is interested in the extent to which the education and training provided to existing and potential health practitioners who either currently practise or in the future will practise in the private health care sector prepares them to adequately respond to complaints made by patients.

8.2 An important reason for the inclusion of complaint handling training for health practitioners is that in the current complaints handling field there is a clear and identifiable trend towards encouraging patients to attempt to resolve conflicts directly with health practitioners prior to approaching third parties. The NSW Health Care Complaints Commission is no exception to this trend. Under the section entitled "Before Making a Complaint to the HCCC" the following instruction is given:[38]

> "Experience indicates that complaints are best resolved locally. This helps people to maintain a good relationship with their health service provider. If you have a concern or a complaint we suggest that in the first instance you should discuss the problem with the health service provider - either in person or on the telephone."

8.3 It would be unreasonable to expect health practitioners to be able to undertake complaints handling practices without appropriate training in the area.

8.4 For registered health professions, qualifying courses to be used for registration purposes are either stipulated in the relevant Act or Regulations or, alternatively, powers are given in the legislation for the registration board to determine the qualifying courses.

8.5 There is significant diversity amongst providers of education and training programs. Universities dominate the provision of courses used as qualifying degrees for many registered health professions, while private educational institutions feature heavily in the provision of courses for other currently unregistered health professions which are, most often, practised in the private health care sector.

8.6 With regards to the unregistered professions, the Community Services and Health Industry Council Ltd have developed national competency standards for complementary medicine. These standards cover topics related to complaints handling but do not exclusively cover the area. The standards include:

UNIT HLTCOM1A Provide specific information to clients/patients

Performance Criteria

1.3 Effective communication is used with clients/patients;

2.1 Clients/patients are encouraged to voice queries;

2.2 Client/patient are asked about information needs;

2.3 Client/patients are assisted to identify their information needs if necessary;

2.4 Client/patient information needs are confirmed;

4.4 Communication difficulties are *managed appropriately;*

4.5 Problems relating to providing information about services are referred to supervisor.

UNIT HLTCOM4A Communicate effectively with clients/patients

[38] New South Wales Health Care Complaints Commission website http://www.hccc.nsw.gov.au/html/how%20to%20comp.htm#1 date accessed 10 November 2006

Performance Criteria

1.3 *Effective communication* is used with clients/patients;

1.4 Clients/patients are encouraged to voice queries and/or fears and these are addressed appropriately;

1.5 *Cultural and personal factors* are taken into consideration when consulting or interacting with clients/patients;

1.6 Discretion and confidentiality are exercised appropriately and boundaries of; confidentiality are outlined and explained to clients/patients whenever appropriate or required

2.4 Any unresolved concerns or issues are discussed with enquirers.

8.7 The Committee is of the view that the inclusion of standards explicitly addressing effective complaints handling as a competency for complementary medicine courses would be most beneficial.

8.8 Relevant to the area of medicine are the provisions of the Australian Medical Council's accreditation standards for medical courses. The revised standards (as at 27 July 2006) make reference to the following relevant skills:

Graduates completing basic medical education should have developed the following skills and attributes:

Communication skills, including being able to listen and respond, as well as being able to convey information clearly, considerately and sensitively to patients and their families, doctors, nurses, other health professionals and the general public.

The medical curriculum of an accredited medical school must meet the following relevant standard:

- Communication skills;
- Law and ethics;
- Patient safety and quality of healthcare.

8.9 Notes on the standards listed above discuss the following:

Communication skills – to listen, reflect understanding, provide information and advice and give feedback – are of key importance in medical practice. Health care environments are complex communication environments, involving a wide range of health professionals and administrators, and patients who will have their own social, emotional and cultural communication needs. The beginning doctor must be able to negotiate these environments and communicate effectively.

Law and ethics – medical students should have a good grounding in the principles necessary to prepare them for a profession that requires ethical decision-making within the context of an appreciation of the complexity of ethical issues related to human life and death. Similarly, students need to be aware that law and codes of ethical practice will regulate their professional practice. Professionalism and ethical conduct are important components in patient safety.

Quality and safety research in Australia, New Zealand and other countries has documented considerable variability in the quality of health care and a lack of alignment between the actual outcomes of care and what is considered to be ideal care. As a consequence, there is an emphasis in health care institutions and health care policy on defining, measuring and

publicising both the quality of care and the performance of doctors and organisations. Doctors work increasingly in health care systems that give significant attention to enhancing service to patients by assessing and managing risk, improving quality, and reducing errors and inefficiency. Accordingly, they need to know both how the health care system affects them and how they can improve the elements within their control. Medical courses need to address issues relating to quality assurance in health care, including systems management and best practice guidelines. Medical students need to understand how errors can happen in medical practice and the principles of managing risks.

8.10 The following registered health professions are often practised privately:

- Chiropractors;
- Osteopaths;
- Dentists;
- General Practitioners;
- Optometrists;
- Physiotherapists;
- Podiatrists;
- Psychologists.

8.11 As the most common registered health professions largely being practised in the private sector, the qualifying degrees offered by universities in New South Wales in each of these areas was reviewed. Post-graduate qualifications were not examined because the entry conditions could not be determined. While the review acts as a good overview, information could not be found for some degrees.[39]

8.12 The results of the review are discussed below by professional group. Each University either offering a complaint handling specific course or a related course is listed. A complete list can be found at Appendix Three.

Dentistry

8.13 The qualifying degree for dentistry offered by the University of Sydney includes the following two subjects: 'Foundations of Total Patient Care' which aims to develop the necessary communication and reasoning skills for effective dental diagnosis, and 'Professional and Personal Development' which addresses ethical behaviours and self evaluation.

Medicine

8.14 The University of Newcastle's Bachelor of Medicine program includes a course entitled 'Introduction to Professional Practice' which aims to develop the interviewing skills of students.

8.15 The University of New South Wales Bachelor of Medicine/Bachelor of Surgery offers a foundations course which is described as: "*The teaching and learning methods are designed to incorporate issues such as information management, and written and oral communication."* The society and health subjects make reference to: *"A series of learning activities focusing on communication skills and clinical communication*

[39] Information sourced from online course guides from individual university websites in November 2006

operates throughout phase 1 of the Medicine program." The health maintenance subjects make reference to the extension of the student's capabilities in communication.

Optometry

8.16 The Bachelor of Optometry/Bachelor of Science program includes a subject on optometry which aims to: *"To produce a student with a professional attitude and good communication skills who can integrate scientific and clinical aspects of optometry."*

8.17 The professional optometry course aims to: *"to develop an awareness of professional and ethical action in optometric practice".*

Physiotherapy

8.18 'Foundation Skills for Allied Health Professionals' is offered by Charles Sturt University under the Bachelor of Physiotherapy which aims to develop the professional skills of students. 'Professional Issues in Physiotherapy' is a subject that covers health law, professional ethics and the role of the professional body.

8.19 The University of Sydney Bachelor of Applied Science (Physiotherapy) includes a professional practise subject which:

> " … includes the roles and responsibilities of physiotherapists and other health professionals in the context of the changing health care environment. Students will explore the Australian Physiotherapy Association Professional Code of Conduct and learn to apply this code in ethical and clinical decision-making. The importance of communication and respect for cultural differences in professional conduct will be addressed. Communication will include interviewing and the principles and process of professional documentation. The responsibility associated with being a member of a regulated profession, regulation of physiotherapy practice by the Physiotherapists Registration Act of NSW 2001 and by other health acts and the meaning of professional misconduct and other associated behaviours are explored in both lecture and tutorial format."

Podiatry

8.20 The Bachelor of Health Science (Podiatry) offered by Charles Sturt University includes the same two subjects for podiatry students as those previously listed under the Bachelor of Physiotherapy at the same university.

Psychology

8.21 Charles Sturt University offers an "Ethics and Current Issues in Psychology" subject as part of a Bachelor of Psychology. The subject examines the ethical context of psychological work by examining current laws, codes and standards pertaining to professional conduct.

8.22 Southern Cross University offers two courses relating to complaints handling. They include 'Contemporary Issues in Psychology' and 'Ethics and Professional Issues'. Between them the subjects cover ethical principles, professional issues, legal matters, confidentiality and relationships with clients.

8.23 The University of Sydney offers a course on communication and counselling as part of the Bachelor of Psychology. The communication component of the subject is concerned with understanding how interpersonal communication occurs in a face-to-face context.

8.24 The University of Western Sydney's Bachelor of Psychology includes a subject called 'Consulting in Applied Psychology', which aims to develop effective communication skills.

Discussion

8.25 From the review conducted it can be argued that while the qualifying degrees of many registered health professions in NSW do address legal and communication issues there does not appear to be a dedicated complaint handling subject on offer.

8.26 An awareness of ethical obligations and conduct and legal issues will be of inevitable benefit to a practising health professional, as would effective communication skills. Such subjects are ideally placed to then develop the foundations of effective complaint handling practices.

8.27 The Committee recognises the importance of communication to the ability of an individual to respond to a complaint and the potential for poor communication to contribute to the development of a complaint.

8.28 Recognition of the importance of communication at an international level is found in the World Health Organisation framework for assessing health system performance. Developed in the year 2000 the framework makes reference to communication as an element of responsiveness, the dimensions include:

- Respect for autonomy;
- Choice of care provider;
- Respect for confidentiality;
- Communication;
- Respect for dignity;
- Access to prompt attention;
- Quality of basic amenities; and
- Access to family and community support.

8.29 On a national level, TQA Research conducts a biennial survey on a broad range of health related issues. The survey is supported/purchased by Australian, State and Territory government health departments, private health insurance organisations, hospital operators and health related industry associations. In 2003 there were 1434 respondents from NSW, all of whom were randomly selected.[40]

8.30 The TQA results indicate that of those who were dissatisfied with their health service (10% of respondents) 15% of them nominated poor information/communication as the reason why.[41]

8.31 In a further testament to the importance of communication:

> "An Australian study found that communication; care and reassurance; professional attitudes and behaviours; and the physician as personal confidante to the patient, each significantly correlated with patient satisfaction. Also tested was technical competence, however factors related to professional interpersonal skills were found to be more

[40] Jim Pearse, Health Policy Analysis Pty Ltd, June 2005, Review of Patient Satisfaction and Experience Surveys Conducted for Public Hospitals in Australia, page 10

[41] Jim Pearse, Health Policy Analysis Pty Ltd, June 2005, Review of Patient Satisfaction and Experience Surveys Conducted for Public Hospitals in Australia, page 11

> significantly correlated with patient satisfaction. This is supported in nearly all studies, providing evidence that improving patient satisfaction requires a change in attitude on the part of professional staff" [42]

8.32 The importance of communication is reflected in its ability to deter potential liability claims:[43]

> "Communication skills have also been shown to be important in limiting patient dissatisfaction, so preventing liability claims."

8.33 The Committee encourages universities and other educational institutions to further develop the existing range of subjects related to compliant handling. Coverage of complaint handling practices would be highly beneficial to new health professionals and the Committee would like to see complaint handling covered in the subjects offered as part of health practitioner courses.

Continuing Professional Development

8.34 Another way in which practitioners in private practice have access to training in interpersonal communication and complaints management is through Continuing Professional Development courses.

8.35 Continuing Professional Development is not mandatory for the majority of registered health professions, although it is for medical practitioners. The minimum point requirement to maintain GP recognition status with Medicare Australia is 130 points over 3 years. Points are accrued through participation in activities across five general domains:

- Communication skills and the doctor-patient relationship;
- Applied professional knowledge and skills;
- Population health and the context of general practice;
- Professional and ethical roles; and
- Organisation and legal dimensions.

8.36 Continuing Professional Development is divided into two categories. GPs are required to undertake a minimum of two different activities from Category 1 during the triennium, which are worth 30 points each. There is no minimum point requirement in Category 2.

Category 1 Activities:

- 'Active Learning Modules', which are to replace the old 5 point per hour activities. These are held over 6 hours, or 6 x 1 sessions, of which not more than one third are taken up by didactic lectures or presentations. If the participant does not complete all activities in the Active Learning Module, 2 points per hour can be awarded from Category 2 for completed sessions;
- Clinical Audits;
- Supervised Clinical Attachments;
- A Learning Plan and Portfolio Module, where GPs develop an individual learning plan and submit it to the RACGP before the end of the first year;

[42] Victorian Department of Human Services – Acute Health Division, June 1997, Non Admitted Patient Services – A Literature Review and Analysis, DHS website http://www.dhs.vic.gov.au/ahs/archive/nap/contents.htm date accessed 6 November 2006

[43] P.R.H Newsome and G.H Wright, February 27 1999, British Dental Journal, Volume 186, Number 4

- Small Group Learning, where a group of GPs or GPs and practice nurses, specialists or psychologists etc take a minimum of 8 hours education under a theme such as women's health or childhood illness;
- General Practitioner Research, either as a Principal Investigator or Research Participant;
- Higher Education or College Courses;
- RACGP Assessment, either the examination format or a Practice Based Assessment, as an alternative to the examination;
- Write an article for a Peer Reviewed Journal.

Category 2 Activities

Category 2 activities are capped at 30 points for the triennium for each group of activities. Unlike Category 1, there is no minimum point requirement in category 2. Category 2 activity groups include:

- Attendance at workshops, seminars, presentations and short courses. Activities in this group are still 2 points per hour but are capped at 30 points for the triennium.

10 point activity groups include:

- Presentation of original papers to peers;
- Teaching medical students;
- Training supervision;
- External clinical teaching visits;
- Participating in sentinel surveillance;
- Writing a community article of at least 500 words;
- Editing or reviewing articles for refereed journals in general practice;
- A book review;
- Hospital in the home;
- RACGP examiner.

Other activity groups include letters to the editor (5 points per letter) and conference attendance (up to 15 points per topic). There is a maximum of 30 points for each of the category 2 activity groups.

8.37 The Committee encourages providers of continuing professional education programs to include options related to effective complaint handling as a means of up-skilling practising health care professionals.

Chapter Nine - General Practice Accreditation

9.1 The Royal Australian College of General Practitioners (RACGP) '*Standards for General Practices'* and the associated accreditation process were developed in the 1990s with the aim of engaging General Practices in an ongoing process of quality improvement.

9.2 The RACGP Standards are not a minimum standard of practise. Rather, they reflect good general practice in the areas of:

- The services practices provide;
- The rights and needs of patients;
- Quality improvement and education processes;
- Practice management; and
- The physical aspects of a practice.

9.3 The Standards concentrate on the principles of quality and safety rather than prescribing exactly how a practice should provide care, and are written in such a way that they can be applied to the diverse forms of General Practice in Australia, regardless of size or location.

9.4 Where possible, the Standards are based on evidence of improvements in quality and safety in practice and patient care from clinical trials or large-scale research, and where there is no other evidence, from current professional consensus. The Standards intend to concentrate on those areas of a practice that are considered critical by the profession in supporting quality and safety.

9.5 The Standards contain indicators that must be demonstrated by the Practice in order to meet the criteria for accreditation.

9.6 Since the early 1990s the RACGP has written three editions of the RACGP Standards for General Practices.

9.7 In the current RACGP Standards (3rd Edition), the requirements for General Practices are made more explicit. Importantly, the current Standards reflect a move away from the GP as the person solely responsible for the structures, systems and processes that deliver quality and safety, and a move toward recognising that each member of the practice team – and the team as a whole – contributes to quality improvements within a practice.

9.8 Practices are required to have complaint handling standards in place, and they are to make a complaints contact available. Practices must actively seek patient feedback. GPs and staff must also demonstrate that they can identify the person who coordinates feedback and complaints.

> "Standards relating to complaints handling can be found in two areas:
>
> 1. Having a complaints handling process in place and knowing about the process, plus responses to patient feedback. The practice must have a process for collecting feedback from the client.
> 2. The way HR is managed. The practice needs to be able to identify the person/people who manage the exploration and resolution of complaints."[44]

9.9 These criteria and their associated performance indicators are provided below.

[44] Briefing from Mr Ian Watts, National Manager, GP Advocacy and Support (RACGP)

Criterion 2.1.1 Respectful and culturally appropriate care

Our practice provides respectful and culturally appropriate care to patients.

Explanation

Patients have the right to respectful care, which promotes their dignity, privacy and safety. Patients have a corresponding responsibility to give respect and consideration to their GPs, practice staff and other patients. The GPs and staff need to have appropriate interpersonal skills to work with patients and others in the practice. Much of the success of a practice depends on the positive, friendly, attentive, empathetic and helpful behaviour of staff at the reception desk. This criterion requires that both GPs and staff deal with patients in a respectful, polite and friendly manner. Demonstrating respect for patients extends beyond the face-to-face interaction between the practice staff and the patient, to the recording of patient's health information. Making or recording derogatory, prejudiced, prejudicial, or irrelevant statements about patients has serious consequences for treatment, compensation and other legal matters, and may contravene antidiscrimination legislation. Such remarks are also prone to misinterpretation when records are used by other GPs and will result in differential treatment for such patients. Practices need to be aware that the Federal Disability Discrimination Act (1992), as well as the various state and territory Disability Services Acts and Equal Opportunity Acts, prohibit the discriminatory treatment of people based on their personal characteristics (such as gender or religion).

Further information is provided by the Human Rights and Equal Opportunities Commission (www.humanrights.gov.au). This website has guides to the relevant legislation, and links to state and territory agencies with similar responsibilities.

The ideal GP-patient partnership is a collaboration based on mutual respect and a mutual responsibility for the health of the patient. The GP's duty of care is to explain the benefits and potential harm of specific medical treatments and to clearly and unambiguously explain the consequences of not adhering to a recommended management plan. Patients have the right to seek further clinical opinions from other health care providers. Practices are encouraged to document in the patient's health record any indication by the patient that they intend to seek a further clinical opinion. Patients need to be encouraged to notify their GP when they are choosing to follow another health care provider's management advice. This allows the GP the opportunity to reinforce any potential risks of this decision. Where patients do seek further clinical opinions, an appropriate risk management strategy for practices includes documenting this decision in the patient's health record. In addition, the GP is encouraged to document in the patient's health record an explanation of the actions taken when a patient seeks a further clinical opinion, including referral to other care providers if arranged.

Where patients refuse advice, procedures or treatments, an appropriate risk management strategy for practices needs to include recording of such refusals in the patient's health record, including referrals to other care providers, if arranged. General practitioners are encouraged to document in the patient health record an explanation of the action taken.

When a patient requests to be transferred to the care of another GP (in another practice), a copy of patient health information needs to be transferred to the other practice in a timely manner to help facilitate care of the patient. Practice staff need to comply with the requirements of the state or territory legislation governing the transfer of patient health information. Where the practice produces a summary for transfer to another practice, it is useful to keep a copy of the summary in the patient's health record.

It is recommended that a copy of the patient health information be transferred and that the practice retain the original health information.

There may be patients whom the GP(s) no longer consider it appropriate to treat (when a patient has behaved in a threatening or violent manner or where there has been some other cause for a significant breakdown in the therapeutic relationship). The GP has the right to discontinue treatment of that patient, especially when the GP thinks they can no longer give the patient their best care. Concerns about violence in general practice were raised by people within and outside general practice during the consultations that formed a part of the RACGP's review of its Standards for general practices. In order to deal with these uncommon but distressing situations, the practice is encouraged to have a risk management strategy which details the steps taken to protect doctors and staff of the practice and to assist patients with ongoing care, including referral to other health care providers. Some states and territories have specific legislation governing the cessation of treatment (such as when a practice closes down) and practices need to be aware of their obligations.

A patient in distress may feel more comfortable in a private area than in a public waiting area. Practices - even those with limited facilities - need to attempt to provide privacy for such patients (eg. by allowing them to sit in an unused room, staff room or other area). This does not mean that a practice needs to have a room permanently set aside for such patients, but needs to have a plan that can be implemented as the need arises to ensure the patient is treated respectfully. The RACGP supports the choice of general practices to favour or specifically 'target' people and communities with high needs for comprehensive primary care, where choices need to be made about the allocation of limited resources.

This is one way of addressing the health inequalities of some individuals, families and communities by providing culturally appropriate care to these patients. In these cases the RACGP believes the general practice is still providing initial, continuing, comprehensive and coordinated medical care to individuals, families and communities, despite targeting a specific patient group. For these practices it remains important that the practice has clear systems to deal with requests for care by patients outside the target population.

Indicators

- Our practice does not discriminate against patients on the basis of their gender, race, disability, Aboriginality, age, sexual preference, beliefs or medical condition (interview).
- Our GP(s) and staff who provide clinical care can describe how they provide care for a patient who refuses a specific treatment, advice or procedure (interview).
- Our GP(s) can describe what they do when a patient informs them that they intend to seek a further clinical opinion (interview).
- Our GP(s) can describe what they do to transfer care to another GP in our practice or in another practice when a patient wants to leave the GP's care (interview).
- Our GP(s) can describe arrangements for managing the transfer of care of a patient whom a GP within our practice no longer wishes to treat (interview).
- Our GP(s) and staff can describe how our practice provides privacy for patients and others in distress (interview).
- Our practice has used patient feedback to establish whether patients of our practice are treated respectfully by our GP(s) and staff (patient feedback).
- Our GP(s) and staff can identify important/significant cultural groups within our practice, and outline the strategies we have to meet their needs (interview).

Criterion 2.1.2 Patient feedback

Our practice provides opportunities for, and responds to, patient feedback.

Explanation

Unique information about patient needs and the quality of care provided by a general practice can be gained from patients. Discussing consumer feedback and concerns openly helps people within the general practice to understand strengths in their practice, potential problems, and how to improve. It is helpful to know what patients think about a practice and what they are likely to tell other people. The more feedback a practice receives - whether it be complaints, compliments or suggestions - the better it will be able to provide care.

The 'Turning wrongs into rights: learning from consumer reported incidents project', a national project funded under the auspices of the Australian Council for Safety and Quality in Health Care (ACSQHC), has undertaken research on Australian health care services practices in complaints management, and has developed guidelines on complaints management in health care.

The importance and value of effective complaints management was expressed by the ACSQHC in its publication Better practice guidelines on complaints management for healthcare services: 'Customers (including patients and carers) have a unique expertise in relation to their own health and their perspective on how care is actually provided. Consumer complaints are therefore a unique source of information for health care services on how and why adverse events occur and how to prevent them.

As well as reducing future harm to patients, better management of complaints should restore trust and reduce the risk of litigation, through open communication and a commitment to learn from the problem and prevent its recurrence'.

Indicators

- Our practice has a process for receiving and responding to feedback and complaints from patients and other people (document review).
- Our GP(s) and staff can describe the processes for receiving and responding to feedback and complaints from patients and other people (interview).
- Our practice makes contact information for the state/territory health complaints agency readily available to patients on request (interview, document review).
- Our practice has used patient feedback to establish whether patients of our practice are confident that any feedback and complaints they make to our practice would be handled appropriately (patient feedback).
- Our practice can describe an improvement we have made in response to patient feedback or complaints (interview).

Australian General Practice Accreditation Limited (AGPAL)

9.10 Australian General Practice Accreditation Limited (AGPAL) is one body responsible for accrediting General Practices against RACGP standards. Currently, approximately 85% of General Practices are accredited with AGPAL Australia-wide.

9.11 The table on the following page shows the number of General Practices registered within NSW Divisions that are fully accredited by AGPAL.

Division Statistics as of November 15 2006	No. Registered	Full Accreditation
Bankstown Division of General Practice	46	41
Barrier Division of General Practice	4	3
Barwon Division of General Practice	13	12
Blue Mountains Division of General Practice	20	19

Canterbury Division of General Practice	62	60
Central Coast Division of General Practice	55	50
Central Sydney Division of GP	114	101
Dubbo Plains Division of General Practice	25	17
Eastern Sydney Division of General Practice	37	32
Fairfield Division of General Practice	51	46
Hastings Macleay Division of General Practice Ltd	31	30
Hawkesbury Hills Division of General Practice	20	18
Hornsby Ku-ring-gai Ryde DGP	87	83
Hunter Rural Division of General Practice	50	46
Hunter Urban Division of General Practice	84	83
Illawarra Division of General Practice	51	49
Liverpool Division of General Practice	28	27
Macarthur Division of General Practice	53	47
Manly Warringah Division of General Practice	41	38
Mid North Coast Division of General Practice	36	32
Murrumbidgee Division of General Practice	19	16
Nepean Division of General Practice	45	39
New England Division of General Practice	22	21
North West Slopes (NSW) DGP	18	14
Northern Rivers Division of General Practice	46	45
Northern Sydney Division of General Practice	44	42
NSW Central West Division of General Practice	35	33
NSW Outback Division of General Practice	6	5
Riverina Division of General Practice	28	24
Shoalhaven Division of General Practice	26	24
South East NSW Division of General Practice	27	26
South Eastern Sydney Division of General Practice	33	31
Southern Highlands Division of General Practice	15	14
St George Division of General Practice	67	61
Sutherland Division of General Practice	51	47
Tweed Valley Division of General Practice	23	23
Wentwest Limited	137	123

9.12 In all, 91.4% of registered practices in NSW Divisions of General Practice are accredited through AGPAL. This is the second lowest rate of any Australian state or territory. Rates of accreditation in all Australian states and territories are shown below.

State/Territory	Accreditation Rate %
New South Wales	91.4
Victoria	95.3
South Australia	95.9
Queensland	91.9
Western Australia	91.5

Northern Territory	73.9
Australian Capital Territory	94.5
Tasmania	99.2

9.13 Annual costs for a General Practitioner to participate in the accreditation process are as follows:

Cycle	Surveyor Team	Type	Rate
Accreditation 1st	GP/GP	Per FTE	$1,495.00 + GST
Accreditation 1st	GP/Non GP	Per FTE	$1,295.00 + GST
Reaccreditation	GP/GP	PER FTE	$1,495.00 + GST
Reaccreditation	GP/Non GP	PER FTE	$1,095.00 + GST

9.14 Accreditation for a range of primary care providers (including optometry and physiotherapy) is provided by Quality in Practice (QIP), a subsidiary of AGPAL. QIP also provides consultancy on quality accreditation frameworks for other health care organisations and providers.

9.15 The AGPAL website provides numerous resources for practitioners and their staff to assist them in meeting the accreditation requirements. A number of these requirements relate to complaints and patient feedback:

Handling Patient Complaints

9.16 Information on handling consumer complaints is offered, encouraging practices to embrace consumer feedback as a means of learning and adapting current practice. Use of a complaints register is promoted:

> A complaint register is a good way to document any complaints and should cover the complaint, the actions taken and the outcomes of the complaint. Ideally the practice manager or other nominated person should investigate each incident and record them in the register.[45]

9.17 Practices are encouraged to ask a number of questions of themselves and their systems in response to a complaint. Suggested questions include:

- What did we do wrong?
- What system, procedure or individuals contributed to the problem?
- How can we learn from the mistake and avoid future problems?
- What may be done to rectify the situation?
- Should further assistance be required, e.g. referred to the GP;
- How and when should you give feedback to the complainant?

9.18 The outcomes of a complaint should then be documented and, if any systemic areas are identified as being at fault, the fault should be rectified immediately and documented in the register.

9.19 Complaint registers should be reviewed regularly and be included in staff meetings so that all staff have the ability to discuss the situation and be able to learn from the outcomes. Focus should be placed on the complaint, how it was resolved and how it might have been better handled.

[45] www.qip.com.au

9.20 AGPAL also promotes the adoption of a practice complaints policy, of which all staff should be aware. This will ensure a consistent response to a consumer complaint regardless of who receives it. The policy includes a draft process that can be followed by staff when a complaint is received.

9.21 To assist organisations in the complaints handling process, the AGPAL website provides a draft complaint acknowledgement letter which can be downloaded and adapted by practices.

9.22 Additional information is provided by AGPAL on:

- Respectful care (example respectful care policy included);
- Patients' health rights;
- Patient feedback (discussed in greater detail in Chapter Ten).

Continuing Quality Improvement Developments in Other Markets

9.23 At present, AGPAL accreditation is only offered to particular health professions (namely, general practice, optometry and physiotherapy). Opportunities for expansion, product development and entry into new markets is assessed by AGPAL/QIP on a case-by-case basis. If there is an opportunity to utilise a quality improvement framework to improve the patient experience then AGPAL/QIP has expressed commitment to offering its services

Australian Council on Healthcare Standards

9.24 Australian Healthcare Standards Council (AHSC) utilise a program for accreditation purposes called the Evaluation and Quality Improvement Program (EQUIP). EQUIP operates on a four year cycle involving self-assessment, organisation-wide survey and periodic review.

9.25 In August of this year the fourth version of EQUIP was released. It contains 14 mandatory criteria which strengthen clinical care and consumer participation. EQUIP standards are found over the page:

Australian Council on Healthcare Standards
Evaluation and Quality Improvement Program Version 4[46]
(Mandatory criteria appear in italics)

Clinical Criteria

1.1 Consumers/patients are provided with high quality care throughout the care delivery process

[46] Australian Council on Healthcare Standards website http://surveyor.achs.org.au/pdf/E4A3_poster.mandcriteria.pdf date accessed 16 November 2006

1.1.1 The assessment system ensures current and ongoing needs of the consumer/patient are identified

1.1.2 Care is planned and delivered in partnership with the consumer/patient and when relevant, the carer, to achieve the best possible outcomes

1.1.3 Consumers/patients are informed of the consent process, understand and provide consent for their health care

1.1.4 Care is evaluated by health care providers and when appropriate with the consumer/patient and carer

1.1.5 *Processes for discharge/transfer address the needs of the consumer/patient for ongoing care*

1.1.6 Systems for ongoing care of the consumer/patient are coordinated and effective

1.1.7 Systems exist to ensure that the care of dying and deceased consumers/patients is managed with dignity and comfort

1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery

1.2 Consumers/patients/communities have access to health services and care appropriate to their needs

1.2.1 The community has information on, and access to, health services and care appropriate to their needs

1.2.2 Access and admission to the system of care is prioritised according to clinical need

1.3 Appropriate care and services are provided to consumers/patients

1.3.1 Health care and services are appropriate and delivered in the most appropriate setting

1.4 The organisation provides care and services that achieve expected outcomes

1.4.1 Care and services are planned, developed and delivered based on the best available evidence and in the most effective way

1.5 The organisation provides safe care and services

1.5.1 Medications are managed to ensure safe and effective practice

1.5.2 The infection control system supports safe practice and ensures a safe environment for consumers/patients and health care workers

1.5.3 The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy

1.5.4 The incidence of falls and fall injuries is minimised through a falls management strategy

1.5.5 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice

1.5.6 The organisation ensures that the correct patient receives the correct procedure on the correct site

1.6 The governing body is committed to consumer participation

1.6.1 Input is sought from consumers, carers and the community in planning, deliver and evaluation of the health service

1.6.2 Consumers/patients are informed of their rights and responsibilities

1.6.3 The organisation makes provision for consumers/patients from culturally and linguistically diverse backgrounds and consumers/patients with special needs

Support Criteria

2.1 The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks

2.1.1 The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery

2.1.2 The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed

2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the system of care

2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff

2.2.1 Human resources planning supports the organisation's current and future ability to address needs

2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meets the needs of the organisation

2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers

2.2.4 The learning and development system ensures the skill and competence of staff and volunteers

2.2.5 Employee support systems and workplace relations assist the organisation to achieve its goals

2.3 Information management systems enable the organisation's goals to be met

2.3.1 Records management systems support the collection of information and meet the organisation's needs

2.3.2 Information and data management and collection systems are used to assist in meeting the strategic and operational needs of the organisation

2.3.3 Data and information are used effectively to support and improve care and services

2.3.4 The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT)

2.4 The organisation promotes the health of the population

2.4.1 Better health and wellbeing for consumers/patients, staff and the broader community are promoted by the organisation

2.5 The organisation encourages and adequately governs the conduct of health and medica research to improve the safety and quality of health care

2.5.1 The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers/patients and manages organisational risks associated with research

Corporate Criteria

3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services

3.1.1 The organisation provides quality, safe care through strategic and operational planning and development

3.1.2 Governance is assisted by formal structures and delegation practices within the organisation

3.1.3 Processes for credentialing and defining the scope of clinical practice support safe, quality health care

3.1.4 External services providers are managed to maximise quality care and service delivery

3.1.5 Documented clinical and corporate policies assist the organisation to provide quality care

3.2 The organisation maintains a safe environment for employees, consumers/patients and visitors

3.2.1 Safety management systems ensure safety and wellbeing for consumers/patients, staff, visitors and contractors

3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively

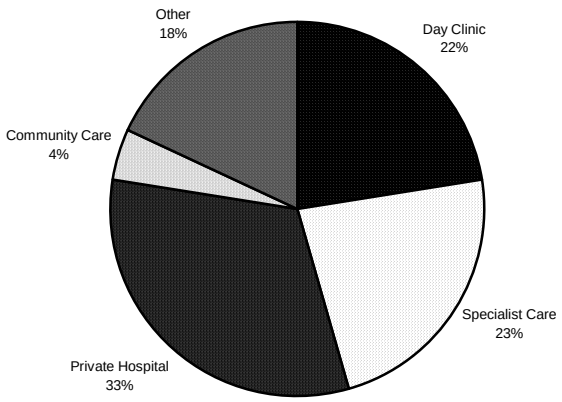
3.2.3 Waste and environmental management supports safe practice and a safe environment

3.2.4 Emergency and disaster management supports safe practice and a safe environment

3.2.5 Security management supports safe practice and a safe environment

9.26 At present in New South Wales there are over 100 private health care providers accredited with ACHS (based on figures from the ACHS website November 2006):

Types of ACHS Accredited Private Practices



Chapter Ten - Consumer Satisfaction

10.1 Assessing the nature and degree of patient satisfaction is an important means of establishing a dialogue between patients and health care providers on quality improvement, patient rights and other aspects of care. One of the key advantages to assessing patient satisfaction is the impact that it can have on health outcomes:

> " …there is growing evidence that, when healthcare services involve the consumer in their delivery and evaluation, the service is more patient-centred and more likely to produce better health outcomes."[47]

10.2 The definition of patient satisfaction is a topic that attracts much attention and debate. Among the definitions on offer are the following:[48]

> "Satisfaction consists of both a cognitive evaluation and emotional reaction to the components of care delivery and service. It is an individual subjective perception and is closely tied to an individual's expectations regarding the care and services."

10.3 The next definition is less conceptual and outlines the components of patient satisfaction as:[49]

> "Overall satisfaction, access, cost, overall quality, humaneness, competence, informativeness, bureaucratic procedures, physical facilities, the handling of psychosocial problems, continuity of care and the outcome of care."

10.4 The purpose of most patient satisfaction surveys is to do one of the following:[50]

> "…to measure the quality of care, identify problems, and to measure the outcome of care from patients' perspectives."

10.5 The range of consumer satisfaction assessment tools available to both organisations (including health facilities) are provided below:[51]

Literature reviews	Suggestion boxes/wish lists
Attentive listening	Personal interviews
Managerial observation	Submissions
Consultations and needs studies	Complaints handling
Consumer reference groups/advisory committees	Focus groups
Observation	Critical incident analysis
Telephone interviews	Comment cards
Delphi technique	Hotlines and phone ins
Public meetings and forums	

10.6 For the purpose of this inquiry the Committee will focus on periodic consultation, ongoing consumer representation and analysis of complaints data.

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[47] Michael Greco, Raising the Bar on Consumer Feedback – Improving Health Services, The Australian Health Consumer, Number Three, 2005-2006, Page 11

[48] Linda Urden, Patient Satisfaction Measurement – Current Issues and Implications, Lippincott's Case Management, September/October 2002, Volume 7, Number 5, page 194-200

[49] Hall.J and Dornan.M, What Patients Like About Their Medical Care and How Often They Are Asked: A Meta Analysis of the Satisfaction Literature, Social Science and Medicine, Volume 27, Number 9, 1988, Page 935-939

[50] Jonathan Spear, September 2003, A new measure of consumer expectations, perceptions and satisfaction for patients and carers of older people with mental health problems, Australasian Psychiatry, Volume 11, Number 3, page 1

[51] Draper 1997, p35-37; Cooper & Je Collaboration, 2000, pp 18-22

Periodic Consultation

10.7 Periodic consultation with health consumers can be undertaken by a facility as standard practice at predetermined timeframes. Often, consumer consultation is also required for specific purposes such as the design and implementation of a new service or policy, or to evaluate the success of a project trial.

10.8 Periodic consultation provides consumers with some input into the planning or delivery of a health service, although this input can often be quite restricted.

Consumer Representation

10.9 Ensuring that patients are represented on bodies that fulfill either an oversight or consultative function is another means of gauging the level of patient satisfaction. Consumer representation allows for patient representatives to raise issues of concern and to have regular input into health service delivery.

Analysis of Complaints Data

10.10 The analysis of complaints data is a means of identifying areas of dissatisfaction for patients in the health care that they have received in the past. Through the identification of any trends in the complaints data health care services are able to make modifications to decrease the likelihood of the problem being repeated in the future.

10.11 In the assessment of patient satisfaction there is an underlying assumption that patients are consumers of health services and this is in keeping with private sector oriented principles.

10.12 The historical basis for the measurement of consumer satisfaction in the health field comes from a need to improve clinical outcomes through ascertaining both overall and specific levels of consumer satisfaction.[52]

10.13 Rising consumer expectations and a necessity for efficiencies in the management of health care services have been identified as a driving force behind the increasing interest in patient satisfaction surveys. Health care providers are said to rely on patient feedback to increase competitiveness and to reform service delivery:[53]

> "It is therefore incumbent upon healthcare providers to seek input from their customers and to use that information to improve services and create innovative strategies that meet and exceed expectations.

10.14 NSW Health identifies three drivers for the increasing popularity of consumer satisfaction measures and evaluation:[54]

1. The emergence of an explicit consumer voice in health, and the resulting need to incorporate consumer perspectives into the development and evaluation of health services.
2. The influence of market ideas on health, which has seen patient satisfaction included in evaluations for the purposes of quality assurance and allocating resources.

[52] Dr Graeme Hawthorne and Cath Harmer, Centre for Health Program Evaluation, December 2000, Working Paper 117, The Genito-Urinary Treatment Satisfaction Scale Study, page 3

[53] Linda Urden, Patient Satisfaction Measurement – Current Issues and Implications, Lippincott's Case Management, September/October 2002, Volume 7, Number 5, page 194-200

[54] NSW Health, NSW Health Surveys 1997 and 1998, Health Services Utilisation – Difficulties Getting Health Care

3. The desire to improve compliance with treatment, since patient satisfaction is a strong a predictor of subsequent health behaviour (Williams, 1994; Draper, et al., 1995).

10.15 It has been argued, however, that the market based approach to consumer satisfaction in health is not always the most appropriate, as patients do not always have choice like other types of consumers and the unique relationship between doctors and patients make expressions of dissatisfaction problematic:

> "Part of the reason for this is that patients build up relationships with their doctors; i.e. Dependency may invoke a reluctance to criticise, especially where the relationship is continued through ongoing treatment. Often the patient cannot easily request services elsewhere and may be highly dependent on health care workers (Hardy, West et al. 1996). This dependency suggests that patients are not market consumers in the usual sense of the term, and that they do not make critical evaluations (Drummond, O'Brien et al. 1997; Williams 1997), especially where they are older and have chronic health care needs (Owens and Batchelor 1996). In addition, dependency may be stronger where the patient feels he/she has imperfect information about his/her health state and health needs (Drummond, O'Brien et al. 1997)."[55]

10.16 The work of Draper was referred to by Health Policy Analysis in their work on the review of patient satisfaction and experience surveys conducted for public hospitals in Australia. Criticisms raised in the 1990s related to:[56]

- Satisfaction is a multi-dimensional construct: There is limited agreement on what are the dimensions of satisfaction, and a poor understanding of what overall ratings actually mean;
- Surveys typically report high levels of overall satisfaction (rates that are similar across a broad range of industries), but often there is some disparity between the overall satisfaction ratings, and the same patients' opinions of specific aspects of their care process;
- Survey approaches have often reflected the concerns of administrators and clinicians rather than reflecting what is most important to patients;
- Satisfaction ratings are affected by: the personal preferences of the patient; the patient's expectations; and the care received;
- Systematic biases have been noted in survey results – for example, older patients are generally more satisfied than wealthier patients.

10.17 Part of the response to these criticisms included the assessment of patient expectations in consumer satisfaction surveys.

10.18 This practice is supported by the following source which argues that the practice increases the accuracy of the outcomes: [57]

> "Before and after questionnaires are seen as one of the most accurate measures of the degree of patient satisfaction with the service they have received, as satisfaction has been found to be confounded by the expectations patients bring to the service."

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[55] Dr Graeme Hawthorne and Cath Harmer, Centre for Health Program Evaluation, December 2000, Working Paper 117, The Genito-Urinary Treatment Satisfaction Scale Study, page 5

[56] Jim Pearse, Health Policy Analysis Pty Ltd, June 2005, Review of Patient Satisfaction and Experience Surveys Conducted for Public Hospitals in Australia, page 6

[57] Victorian Department of Human Services – Acute Health Division, June 1997, Non Admitted Patient Services – A Literature Review and Analysis, DHS website http://www.dhs.vic.gov.au/ahs/archive/nap/contents.htm date accessed 6 November 2006

10.19 Other researchers, however, have argued that, despite certain criticisms being levelled at patient satisfaction surveys, these measures continue to fulfil an important function:

> "Despite these criticisms, patient satisfaction is important because satisfaction enhances help-seeking behaviour, improves compliance with treatment and maintains relationships with health professionals."[58]

10.20 Given the ongoing relationship that many patients have with their health care providers it is important that a feature of this relationship includes an opportunity for the patient to be able to have input into future service delivery, to comment on service quality and to raise issues of concern.

10.21 Affirming the place of consumer satisfaction assessment tools is the direction being taken by NSW Health in future Continuous Health Surveys. NSW Health conducts the large-scale continuous health survey using random sampling. In 2003 a total of 15,837 interviews were conducted in NSW with a response rate of 67.9%.[59] NSW Health has informed the Committee that, from 2007, patient satisfaction will be comprehensively assessed in the survey.

10.22 The Committee learnt that the United Kingdom is moving to a system in which the fitness of a doctor to practice will be in part determined by a demonstration of the doctor's commitment to the assessment of the quality of the relationship with the patient. The Committee also learnt that both New Zealand and Alberta, Canada are moving to a similar system albeit without the possibility of deregistration for doctors who do not demonstrate that they have assessed the quality of the relationship with their patients.

10.23 This significant international development will place patient satisfaction methods high on the agenda of doctors and will ensure wide spread take up of patient satisfaction services, assessment tools and education and training programs on the topic.

Accreditation Programs

10.24 Some accreditation programs within Australia include a patient satisfaction component. The Australian Council on Healthcare Standards (ACHS) Evaluation and Quality Improvement Program (EQuIP) process places a mandatory requirement on health care providers evaluating the care they provide. Many private health care providers are accredited by ACHS.

10.25 As discussed in earlier, the revised 3rd Edition Standards from the Royal Australian College of General Practitioner's require that practices demonstrate that they have sought patient feedback in a robust manner. Examples of the kinds of activities that demonstrate that a practice has sought patient feedback include: focus groups, telephone interviews and face-to-face interviews.[60]

10.26 The Client Focused Evaluation Program is designed to assist health care services in assessing patient satisfaction. The Committee learnt that in NSW approximately 600

[58] Jonathan Spear, September 2003, A new measure of consumer expectations, perceptions and satisfaction for patients and carers of older people with mental health problems, Australasian Psychiatry, Volume 11, Number 3, page 1

[59] Jim Pearse, Health Policy Analysis Pty Ltd, June 2005, Review of Patient Satisfaction and Experience Surveys Conducted for Public Hospitals in Australia, page 12

[60] Greco, M. (2005/06). *Raising the Bar on Consumer Feedback- Improving Health Services*, The Australian Health Consumer, 3, p11

general practitioners participated in the program involving the surveying of 24,000 patients. This indicates a high rate of employment of patient satisfaction tools in this particular area of private practice.

10.27 A sub-group who are not typically captured through patient satisfaction measures includes patients from culturally and linguistically diverse backgrounds. A Queensland Health report acknowledged this problem:[61]

> "Queensland Health collects limited information relating to people from CALD communities through routine hospital-based information collections or the Statewide Patient Satisfaction Survey. This presents a significant barrier to planning effective and appropriate health services that adequately meet the needs of CALD communities."

10.28 As trends identified by past studies of patient satisfaction indicate that specific demographic groups tend to prioritise different aspects of patient care, it is necessary to identify and to respond to groups that may not be captured in the more common methods for assessing patient satisfaction:

> "Many studies reviewed showed that the elderly tend to have higher satisfaction with care than young, with different priorities in care, for example seeing the same doctor and being recognised by staff is important for elderly patients, and more attention to preventive measures (child immunisation and health checks) is important for younger patients. Higher satisfaction levels were also experienced by patients who had a higher severity of illness, or who felt they had least entitlement (such as the homeless), perhaps reflecting the lower expectations of these groups."[62]

10.29 Being aware of trends in the outcomes of reviews of patient satisfaction is only possible when data is benchmarked and shared between like services. Once trends have been identified results can then be interpreted with greater confidence adding to their level of usefulness.

[61] Queensland Health. (February 2005). *Report on the review of the implementation of the Queensland Health Multicultural Policy Statement and the Queensland Health Language Services Policy Statement,* P 11
[62] Victorian Department of Human Services, Acute Health Division. (June 1997). *Non-admitted patient services: A literature review and analysis*

Chapter Eleven - Conflict and Litigation Management Pilot

Background

11.1 A number of key events contributed to the establishment of the Conflict and Litigation Management (CALM) project in Victoria.[63]

11.2 Firstly, there was the perceived indemnity crisis in 2002, whereby GPs became increasingly concerned that very high medical indemnity premiums may impact on their capacity to practice effectively, particularly in specialty areas such as obstetrics and surgery. A proactive approach to risk management was called for.

11.3 In September 2002 a resolution was passed at a Central Highlands Division of General Practice (CHDGP) meeting to develop alternative dispute resolution processes which might mitigate unnecessary litigation and associated costs. Consultation with stakeholders began almost immediately.

11.4 In 2003, the CHDGP combined with two other Victorian Divisions of General Practice and the Medical Defense Association of Victoria (MDAV) to initiate a pilot program aimed at improving complaints management within General Practices and preventing litigation.

11.5 One of the hypotheses of the project was that good communication leads to a reduction in legal action. Evidence from Harvard research, from the Sorry Works! program in the US and from research conducted in Colorado supports this hypothesis. There is currently very little Australian research in this area.

11.6 It was agreed that the project would involve the following:

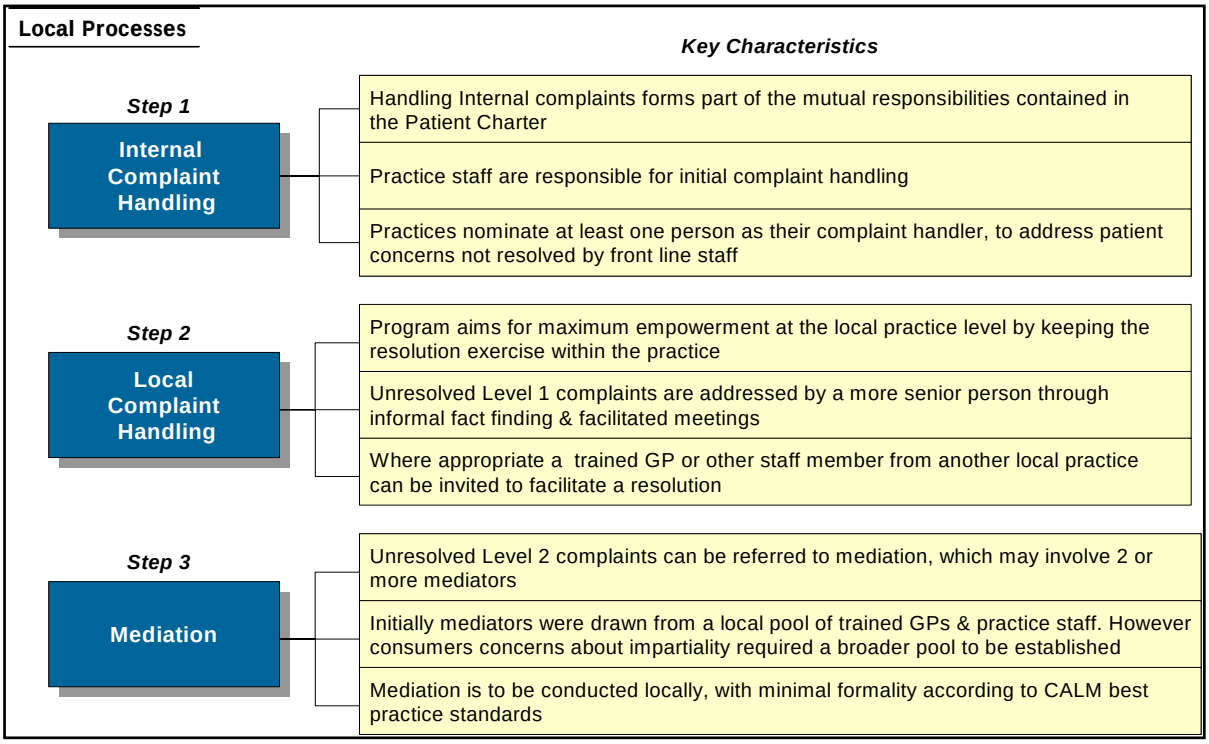
- Training general practitioners in communication and complaints management, as well as one frontline staff member from each practice, who would then take initial responsibility for receiving all complaints;
- Developing a complaints coding system and database to enable the consistent recording and reporting of complaints across divisions;
- Training independent mediators to assist in the resolution of consumer complaints.

11.7 The project was to be based on three levels of intervention, with each level being attempted prior to increasing the level of involvement:

1. Internal Complaint Handling;
2. Local Complaint Handling;
3. Mediation.

11.8 The characteristics of these processes are shown below:

[63] Presentation to the Committee and other stakeholders by the Central Highlands Division of General Practice, September 2006.



Stakeholder Consultation

11.9 A process of stakeholder consultation was undertaken at the commencement of the project. As part of this, a series of risk management forums were held with general practitioners across the division. During these forums, MDAV provided practitioners with data on the nature of complaints litigation received by MDAV over the past five years. This was the first time these GPs had been given concrete information on the types of complaints that result in increased insurance costs.

11.10 MDAV also provided de-identified case studies to forum participants, who were involved in activities aimed at helping them identify alternative processes that may not have led to litigation.

11.11 Workshops were also held with frontline staff including nurses and practice managers.

11.12 The aims of all the workshops were to encourage a culture of valuing and inviting consumer complaints, documenting them and monitoring outcomes.

Training and Mediation

11.13 The developers of the CALM project recognised that few registrars or medical students were currently receiving training in risk management. Consequently, training in effective communication and conflict management was considered an essential part of the project.

11.14 Training frontline staff was also identified as crucial to facilitating the effective resolution of low-level complaints internally. As such, one person from each participating practice was nominated to undertake the training. This person is to then take responsibility for overseeing all complaints received by that practice.

11.15 The Central Highlands Division of General Practice developed the systems, tools and processes to be used in the project, ensuring that they aligned with Royal Australian College of General Practitioners (RACGP) standards. Training modules were then

trialled in the three participating divisions. The divisions involved differed substantially on a number of characteristics. For example, divisions differed in terms of their makeup (in that some were predominantly sole practices whilst others comprised larger clinics with a number of practitioners) as well as the average age of their workforces. There was also a significant variation in the ethnicity of divisions involved.

11.16 Some aspects of the training modules were validated by the trials, however a number of potential issues were also uncovered.

11.17 Firstly, it was found that the training was too lengthy and was too time consuming for GPs in particular. As a result the modules were refined to enable them to be completed in approximately 3-4 hours.

11.18 There was also mixed feedback from consumers, with some consumers perceiving that having GPs mediate the complaints of other GPs would lead to bias towards the practitioner. Consequently, it was decided that the pool of mediators would be widened to include mediators from all different professional backgrounds as well as to GPs. To do this, the divisions decided to access existing pools of mediators from their local community. Costs of accessing mediation are borne by the practice involved.

Coding System and Complaints Database

11.19 Generally the systems developed for the CALM project were understood and supported by medical staff. However, even with an adequate understanding of the modules, without adequate systems GPs would be unable to implement the changes effectively.

11.20 It was decided that a system for coding complaints was needed, as well as a database to support the coding system.

11.21 A complaints coding system consistent with MDAV claims analysis was developed by Clinical Epidemiologist, Dr Richard Clark, to enable all participating practices to record complaints in a consistent manner.

11.22 A complaints database was also developed by the Victorian Health Services Commission. All practices involved in the pilot are required to maintain complaint registers.

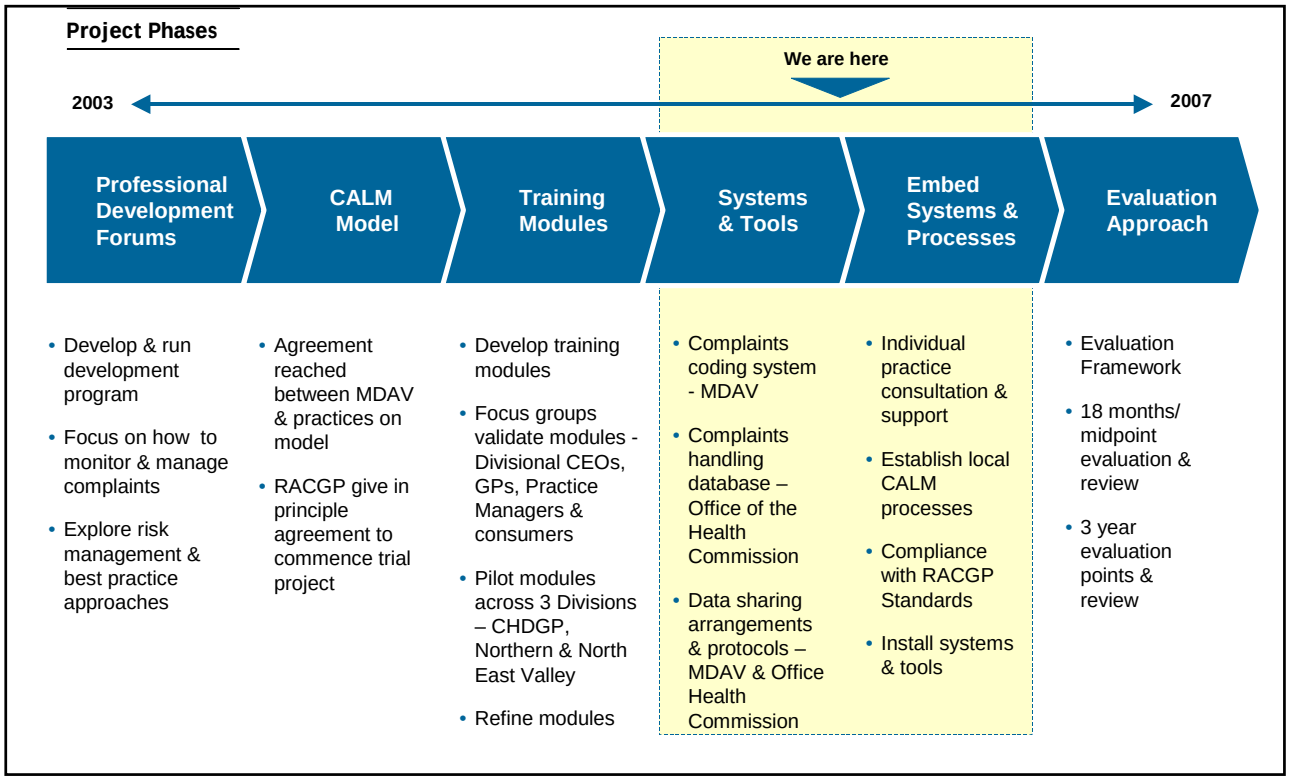
Evaluation of the Project

11.23 The Project will be evaluated after three years of its implementation, and several indicators of success will be used.

11.24 Firstly, it is expected that insurers will compare outcomes after the trial with either outcomes before the trial or averages of claims against GPs in similar areas.

11.25 Complaints data from the Victorian Health Services Commission will also be analysed to determine what, if any, impact the pilot has had on the number of complaints against GPs reported to the Commission.

Overview of Project Phases



Discussion

11.26 The project has focused on several aspects of complaints management that are imperative to the quality improvement process.

11.27 Firstly, the project recognises that a high level of communication between the patient and the doctor is required. Training in communication, negotiation and risk management was considered particularly important given that practitioners often find themselves in situations of high stress, and also because few practitioners entering the profession have been exposed to such training. Consequently, a significant upskilling of general practitioners and their staff is being undertaken. Recently, pharmacists have also begun training in the modules.

11.28 Secondly, the project recognises that adequate recording and reporting of consumer complaints is needed to enable the appropriate monitoring of trends as well as to evaluate the effectiveness of interventions. A complaints coding system enables data to be compared across participating divisions, and reported to a central database within the Victorian Health Services Commission. It also links complaints data to a broader quality improvement program.

11.29 Thirdly, the availability of trained mediators to assist in the resolution of complaints at a local level means that both practitioners and complainant have access to an independent third party skilled in the satisfactory early resolution of a complaint.

11.30 Whilst practitioners seem open to the use of mediation services, the project team are particularly interested in how well received mediation services are by consumers. This will form part of the overall evaluation of the project.

11.31 Currently, GPs or mediators are not permitted to settle a complaint by financial means.

Chapter Twelve - Roundtable Event

12.1 A roundtable event was hosted by the Committee at Parliament House on Thursday 28 September 2006.

12.2 The event featured presentations from five representatives involved in the development of the Conflict and Litigation Management Pilot (CALM) being trialled in Victoria:

Presenter Name	Position	Organisation
Ms Lynda Vamvoukis	Chief Executive Officer	Central Highlands Division of General Practice
Dr Chris Atkins	Chair Director	CALM Project Working Group Central Highlands Division of General Practice
Dr Mark Valena	Chief Executive Officer	Medical Defense Association of Victoria
Ms Therese Carroll	Clinical Risk Manager	Medical Defense Association of Victoria
Dr Richard Clark	Clinical Epidemiologist	

12.3 Representatives from NSW organisations involved in complaints management in general practice also attended the Roundtable. The following table shows the names and organisations of Roundtable participants:

Name	Position	Organisation
Dr Rod McMahon	Member	NSW Medical Board
Mr Anthony Johnson	Legal Director	NSW Medical Board
Mr Kieran Pehm	Commissioner	NSW Health Care Complaints Commission
Mr Michael Smith		NSW Health
Dr Graham Catt	State Manager	Royal Australian College of General Practitioners (NSW Branch)
Ms Helen Turnbull	Legal Officer	United Medical Protection
Ms Elizabeth Van-Ekert		United Medical Protection
Ms Deborah Jackson	Claims Manager	Medical Defense Association (NSW Branch)

12.4 Presenters provided participants with information on the process of developing, trialling and refining elements of the CALM project over the past three years. Participants were then given the opportunity to ask questions of the presenters.

12.5 At present when a complaint goes into a complaints system both the patient and the doctor lose some control over the process. As a result, the major players involved in

the complaint immediately become disempowered. Those involved in the development of CALM pilot strongly believed that the project would enable both the patient and the doctor to more effectively handle a complaint at the point-of-service.

12.6 Presenters emphasised that success of the pilot depends on general practitioners taking responsibility for their own risk management issues. These principles and cultures cannot be imposed.

12.7 Regardless of where the program is implemented, the following need to be present for any positive changes to be made:

- A long-term commitment from those involved;
- A very structured approach for ongoing support (in this case, from the divisions);
- Cohesive and stable workforce;
- The program needs to be implemented incrementally and adequately; and
- It needs to be self-sustaining.

12.8 Currently, some divisions comprise many overseas-trained practitioners who are on limited visas, making them unsuitable for adopting the program, as it requires a considerable degree of stability to sustain progress. Priority for implementing the program needs to be given to practices that have the stability to simply take the resources and implement them.

12.9 Costs to the division in Victoria have to date been in the vicinity of $150,000 (comprising salaries, IT, education forums, focus groups etc). Other resources have been subsidised or absorbed by MDAV.

12.10 Many of these costs are simply the costs of developing the systems- other divisions looking to implement the program would simply need to pay for practice support and staff training.

Participant Feedback

12.11 All participants who attended the roundtable were issued a feedback form, outlining key areas of interest for the Committee and inviting comments from the participant and their agency on aspects of the CALM pilot.

12.12 These responses have been collated and are provided in summary form below.

Role in Managing Health Complaints

12.13 The role of the organisations that participated in the roundtable in managing private practice complaints ranged from legal assistance (medical insurers) to investigation and prosecution (NSW Medical Board and NSW HCCC) and general practice education, training and research (RACGP and, where appropriate, medical insurers).

Key Issues for Internal Complaints Management

12.14 The key issues identified by the respective organisations that should be taken into consideration when developing strategies to improve the internal management of complaints included:

- The need for appropriate investigation by the clinic or practice;
- Equipping practices to understand and respond appropriately to cultural issues in the workplace;

- The importance of developing and promoting skills in open disclosure;
- Expanding the capacity of practices to respond to patients/families who are angry or distressed;
- The importance of having structured processes for responding to complaints in place prior to the receipt of complaints and for staff to be aware of these processes;
- Encouraging practices to learn/improve from all forms of patient feedback- including complaints;
- Developing the skills of non-medical practice staff;
- Encouraging timely and appropriate responses to complaints;
- The importance of keeping complainants informed about the progress of the complaint;
- Combating a culture of defensive reactions to complaints receipt;
- Ensuring that information from complaints is recorded and subsequently informs decisions/reviews of performance quality and program planning;
- Ensuring that practitioners are aware of when there is a need to request external advice and assistance;
- Ensuring access to complaints by external complaints bodies, where appropriate.

12.15 Additionally, overall aims of managing risk and reducing time spent by the practitioner in conflict/litigation by promoting the more effective handling of complaints early on were identified as imperative.

12.16 Complaints should not impact on future treatment of the patient. Resolution should aim to restore trust and mend the therapeutic relationship, however if this has broken down a transfer to another doctor should be arranged to enable continuity of care.[64]

12.17 The general consensus from participants was that a program like that introduced by the CALM pilot in Victoria would address many of the issues identified above.

Response to the CALM Pilot

12.18 Overall, responses to the CALM project were positive.

12.19 Some concerns were raised about the promotion of a complaints process that remains entirely within the practice involved.

12.20 It was argued that the absence of external scrutiny might potentially result in some complaints being overlooked when they should in fact be investigated.

12.21 Moreover, it was considered important for medical insurers to be involved in the early stages of a complaint, so that a response to the complaint can be considered and strategies for resolution developed.

12.22 Nevertheless, participants were supportive of the development of a central database and complaints coding system for recording and monitoring complaint trends.

[64] Response from United Medical Protection (UMP)

12.23 Respondents also appreciated the fact that the pilot allows those involved in the complaint (both consumer and practitioner) to retain significant control over the complaints process.

12.24 The comment was made that the Pilot provides an excellent opportunity for General Practices to link in with other members of the community involved in alternative dispute resolution processes.

Support for the Trial of Similar Project in NSW

12.25 All participants offered support for a trial of a similar project in NSW, and tentatively offered the involvement of their organisation provided certain conditions were first met.

12.26 In summary these conditions centred on:

- Commitment from at least one NSW Division to oversee the project;
- Collaboration between a number of key organisations to assist with the implementation and evaluation;
- Some assistance from the Victorian Divisions involved in the pilot to plan the way forward;
- The availability of project funding; and
- Commitment and ownership is present at practice-level.

12.27 Provided these conditions are met and approval is given from required management, potential roles for the organisations in a trial could include:

- NSW HCCC: The Commission could potentially adopt an advisory role and provide assistance with the evaluation of the project;
- RACGP: The College could potentially take responsibility for the development of a consistent training package for GPs and practice staff, and for monitoring the impact of the program on practices. RACGP could also ensure that risks to GPs are identified and addressed, and could assist with the evaluation of the pilot;
- NSW Health: NSW Health could potentially take an advisory role to ensure consistency of approach between General Practice and the public health system.
- Medical insurers: Medical insurers could potentially assist in promoting the systems and processes to its members and supporting education initiatives developed by the RACGP. They may also have a role in the delivery of some training to members and practice staff.

Chapter Thirteen - Future Directions

13.1 The majority of Australian health care complaints Commissions, including the NSW Health Care Complaints Commission, have a policy of referring non-serious complaints back to the original health service for early complaints resolution before they will investigate the complaint. Consequently, the responsibility for resolution of low-level complaints is largely placed back with the provider.

13.2 Clearly, then, it is in the interests of health complaints bodies to ensure that health providers are well equipped to resolve their own complaints locally.

13.3 Evidence received to the Committee inquiry suggests that there is both a practitioner and consumer component to effective complaints resolution. Consequently, the Committee strongly believes that a multifaceted approach to internal complaints management is needed that focuses on both equipping health service providers and assisting health consumers.

13.4 The Committee would therefore like to see a comprehensive approach to improved low-level resolution of complaints adopted that incorporates:

- Improved access to the Complaints Resolution Service for both providers and consumers;
- Improved access to conciliation (through the Health Conciliation Registry) and mediation services;
- NSW involvement in a comprehensive complaints management Pilot;
- Improved training in complaints management for practitioners and their staff; and
- The introduction of measures to regularly monitor patient satisfaction.

Access to the Complaints Resolution Service

13.5 Under the previous Patient Support Service the Committee felt strongly that it was inappropriate for Patient Support Officers to be acting as advocates for patients when they were employees of the Commission (which should function as an independent and impartial complaints mechanism).

13.6 Consequently, the Committee agrees with the amendment to the role of the Patient Support Office which enables the new Complaints Resolution Service to act as a neutral and independent voice to assist with the resolution of low-level complaints.

13.7 Nevertheless, it is the Committee's view that the classification of a concern raised with a CRO as a formal complaint and the resulting obligation to process it through the formal complaints procedures has been an unintended consequence of incorporating the CRS into the *Health Care Complaints Act 1993*.

13.8 Given that the Complaints Resolution Service was set up to *"assist in the timely, efficient and effective resolution of health complaints"* and to *"assist consumers and health providers to understand approaches to local resolution of health concerns"*,[65] the Committee believes that the CRS should be available to both consumers and practitioners in a manner reflective of these aims.

[65] Annual Report of the NSW Health Care Complaints Commission (2004/2005)

13.9 The requirement for a complaint to be made in writing prior to assistance being provided by a Complaints Resolution Officer undermines the very purpose for which the service was established.

13.10 Consequently, the Committee recommends that low-level concerns be permitted to be reported directly to the Complaints Resolution Service, as was the case under the prior Patient Support Service. The Committee believes the Complaints Resolution Service should retain its role as an impartial service.

RECOMMENDATION 1: That the *Health Care Complaints Act 1993* be amended to exempt low-level concerns raised with the Complaints Resolution Service from the requirement to be made in writing and progressed through formal assessment at the Health Care Complaints Commission

RECOMMENDATION 2: That the Complaints Resolution Service retain its role as an impartial complaints resolution mechanism

13.11 Given developments in other jurisdictions, particularly New Zealand and the United Kingdom, the Committee believes that the need for a consumer advocacy service, independent of the services provided by the Health Care Complaints Commission be explored in NSW.

RECOMMENDATION 3: That the need for an independent health complaints advocacy service in New South Wales be explored

Access to Conciliation and Mediation Services

13.12 Mediation and conciliation provide practitioners and consumers with an independent but formal process for exploring a complaint and deciding on a mutually agreeable outcome. The presence of an independent third party also addresses the issue of perceived and/or actual power imbalances that may affect the internal management of consumer complaints in the health setting.

13.13 In general, private health service providers do not have streamlined access to these services. All requests for conciliation through the Health Conciliation Registry currently need to come in the form of a written consumer complaint. Independent mediation services also need to be investigated and arranged by the provider on a case-by-case basis.

13.14 The Committee believes that the Health Conciliation Registry is an extremely important and currently under-utilised tool for assisting in the resolution of complaints not requiring formal investigation by the Commission.

13.15 The Committee has, on a number of occasions, recommended direct access to the Registry for health service providers. The Committee reiterates its support for independent access in this Report.

13.16 Given the considerable reduction in the number of conciliations being undertaken by the Health Conciliation Registry (as a result of the implementation of a more thorough assessment process), the Committee believes that resource constraints should not be an issue for the Registry should this recommendation be implemented.

RECOMMENDATION 4: That the *Health Care Complaints Act 1993* be amended to provide direct access to the Health Conciliation Registry for both public and private health care facilities, to assist in the resolution of low-level complaints.

13.17 The Commission currently maintains an up-to-date register of qualified mediators that are accessed by the Health Conciliation Registry. These mediators are from a variety of professional backgrounds, are all tertiary qualified and have extensive experience in the area.[66]

13.18 The Committee is supportive of this list being made available to private health facilities as an alternative option to accessing the Health Conciliation Registry.

13.19 All costs of accessing a mediator directly would be borne by the practice, however direct access will give practitioners greater flexibility in the selection of an appropriate mediator, and may be a more attractive option for practitioners who are concerned that a low-level complaint resolved through the Registry may attract unnecessary external scrutiny.

RECOMMENDATION 5: That the Health Care Complaints Commission make its list of qualified mediators available to health registration boards, Divisions of General Practice, professional associations and indemnity funds, to enable practitioners direct access to appropriately qualified and experienced mediators

Conflict and Litigation Management (CALM) Pilot

13.20 The Conflict and Litigation Management (CALM) pilot being conducted in Victoria provides practitioners and their staff with a comprehensive approach to complaints management and resolution. Combining practitioner and staff training, comprehensive data recording, monitoring and reporting and access to independent mediation, the main issues impacting on the effective management of consumer complaints appear be addressed through the program.

13.21 As discussed in Chapter Twelve, in-principle support for the program has been offered by several organisations involved in private practice complaints management in NSW.

13.22 Without a formal evaluation of the project, which has yet to be completed, no conclusions can be made about the effectiveness of the measures in reducing the number of consumer complaints/claims or in improving the responsiveness of General Practices when addressing patient concerns. Nevertheless, the Committee believes that the processes and strategies employed by the project are worth exploring in NSW.

13.23 Giving consideration to the qualities of a practice likely to assist in the success of the pilot (identified in Chapter Twelve), the Committee recommends that discussions be held between NSW Divisions of General Practice, the Central Highlands Division of General Practice, the Medical Defense Associations of Victoria and NSW, United Medical Protection and the Royal Australian College of General Practitioners to determine the feasibility of two or three NSW Divisions participating in the Trial.

RECOMMENDATION 6: That NSW Divisions of General Practice liaise with the Central Highlands Division of General Practice (Victoria), the Medical Defense Associations of NSW and Victoria, United Medical Protection and the Royal Australian College of General Practice, to explore the feasibility of two or three NSW Divisions of General Practice participating in the Victorian Conflict and Litigation Management (CALM) trial

[66] Briefing to the Committee by Kieran Pehm, Health Care Complaints Commissioner, November 2006

13.24 When the Committee met with the developers of the project in June 2006, the transferability of the systems and processes to health service providers outside General Practices was discussed.

13.25 The Committee was informed that much of the methodology could be easily transferred to other health settings with minimal modifications.

13.26 Pending the outcome of the CALM pilot evaluation, the Committee recommends that the transferability of components of the CALM project to other health service providers be explored.

RECOMMENDATION 7: That, pending the outcome of the Conflict and Litigation Management (CALM) pilot evaluation, the transferability of components of the project to other health service providers be explored

13.27 The CALM project recognises the important role played by frontline staff in the complaints handling process.

13.28 In light of statistics showing that approximately 50% of all consumer complaints will be made to a frontline staff member,[67] the Committee also believes that training for frontline staff is a critical component of the effective management of patient complaints.

13.29 Currently, the Royal Australian College of General Practice provides training in complaints management to medical receptionists undertaking the medical reception correspondence course provided through the College. The course provides receptionists with an understanding of the basis for many low-level client complaints and offers practical examples of appropriate responses to some of the most common types of minor patient complaints, including appointment availability, telephone access, waiting times etc.

13.30 With outcomes from the CALM trial not yet available, the Committee believes that training such as that provided through the RACGP would assist non-medical staff of private health facilities to respond appropriately to patient complaints.

13.31 Consequently, the Committee recommends that the RACGP consider making the complaints handling component of the medical reception correspondence course available to all frontline staff of private health facilities.

RECOMMENDATION 8: That the Royal Australian College of General Practice consider making the complaints handling component of the medical reception correspondence course available to all frontline staff of private health facilities

Practitioner Education

13.32 Given the current trend towards encouraging patients to handle non-serious complaints with their health care providers the Committee are of the view that it is imperative for each health care practitioner to possess the skills to enable them to effectively respond to complaints from patients.

13.33 The integration of subjects on communication, ethics and legal issues into the course content of qualifying degrees for registered health professions in New South Wales is encouraging. However, communication skills are especially relevant to both the

[67] Goodman, J. (1999). *Basic facts on customer complaint behaviour and the impact of service on the bottom line*. Competitive Advantage, June, 1-5.

prevention of complaints arising and to providing assistance if complaints do arise. Explicitly covering the fundamental elements of complaints handling would complement and complete the existing training and would prepare future health care practitioners for practice in the community.

13.34 The bodies that accredit educational providers have role to play in highlighting the importance of complaint handling subjects and could ensure consistency across providers by requiring coverage of complaints handling topics for accreditation purposes.

13.35 The continuing professional education arrangements of the various health care professions are markedly different. Some practitioners are not required to undertake continuing professional education and others can fulfil their requirement through a wide variety of means having options for practising health professions who want to pursue topics related to complaint handling will facilitate important skill development and enable practitioners to marry clinical experience with skills in complaint handling.

RECOMMENDATION 9: That accreditation bodies of providers of education in the health care field incorporate coverage of complaints handling topics in their mandatory criteria for educational bodies

RECOMMENDATION 10: That providers of education incorporate coverage of complaints handling topics in the courses offered in the health care field

RECOMMENDATION 11: That providers of continuing professional education incorporate coverage of complaints handling topics in the courses offered to health professionals

13.36 It is significant to the Committee that there are international moves towards requiring doctors to assess patient satisfaction. The confidence of other jurisdictions is joined by research which suggests that the assessment of patient satisfaction has an important role to play in quality improvement, in improving health outcomes and in enhancing the relationship between patients and health care practitioners.

13.37 Three means of assessing patient satisfaction are of particular interest to the Committee. They include:

1. Periodic assessment of patient satisfaction;
2. Consumer representation on consultative bodies;
3. Analysis of complaints data.

13.38 The on-going nature of many of the relationships between health care providers and their patients warrants the health care provider demonstrating an interest in the assessment of the patient's level of satisfaction with the service being provided.

13.39 It is possible that, in the absence of measures of patient satisfaction, decisions to seek alternative health care providers are made unnecessarily. These complaints could potentially have been satisfactorily resolved at an earlier date had the organisation been given the opportunity to make reforms required to improve the experience that the patient had with the health care service.

RECOMMENDATION 12: That private healthcare practices implement a system to assess patient satisfaction in order to facilitate future quality improvement

RECOMMENDATION 13: That accreditation bodies of health care professionals establish a mandatory requirement for health care practitioners to assess patient satisfaction

Appendix One- List of Submissions

1	Ms Anna Simon	
2	Ms Alison Kennedy	
3	Mrs Patricia Wheeldon	
4	Ms Francis Hand	
5	Ms Tora Blackman	Safe Water Action Network
6	Mr Kieran Pehm	NSW Health Care Complaints Commission
7	Confidential	
8	Mr Michael Jaques	NSW Dental Technicians Registration Board
9	Mr Henri Virtanen	
10	Mr Boris and Ms Erika Lovriha	
11	Ms Sue Hardman	NSW Physiotherapists Registration Board
12	Mr Andrew Dix	NSW Medical Board
13	Ms Diane Flecknoe-Brown	
14	Confidential	
15	Ms Christine McGillion	Chiropractors Association of Australia (NSW)
16	Mr Peter Rodgers	

Appendix Two- Minutes of Proceedings

Minutes of Proceedings No. 16
Thursday 24 March 2005
Room 1108, Parliament House

Members Present
Mr Jeff Hunter MP, the Hon. David Clarke, MLC, Mr Allan Shearan MP, Mr Russell Turner MP, Ms Tanya Gadiel MP.

In attendance
Ms Cheryl Samuels (Senior Committee Officer), Ms Samantha Ngui (Committee Officer), Ms Glendora Magno (Assistant Committee Officer)

Apologies
The Hon. Christine Robertson, MLC, Ms Catherine Watson (Committee Manager)

The Chairman opened the meeting at 10.35 am.

Consideration of Draft Terms of Reference for Inquiry into Complaint Handling and Consumer Satisfaction relating to practitioners and clinics in private practice

The Committee was presented with, and discussed, the terms of reference of the inquiry. **Resolved** on the motion of Mr Shearan, seconded by Mr Clarke, that the Committee accept the terms of reference of the inquiry, as follows;

The Committee is to inquire into and report on the following:

- the adequacy of existing models and methods of resolving health complaints in private practices and clinics other than those required to be formally investigated by the Health Care Complaints Commission under Section 23 of the *Health Care Complaints Act 1993*;

- alternative models and methods of resolving health complaints in private practices and clinics other than those required to be formally investigated by the Health Care Complaints Commission under Section 23 of the *Health Care Complaints Act 1993;*

- model and methods of resolving health complaints in private practices and clinics in comparative jurisdictions;

- any other related matters.

Resolved, on the motion of Ms Gadiel, seconded by Mr Clarke, that the Committee place an advertisement in the local newspapers calling for submissions.

There being no other business the meeting was closed at 10.50am

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Minutes of Proceedings No. 18
Thursday 5 May 2005

Health Care Complaints Committee

10am, Room 1254, Parliament House

1. Members Present
Mr Jeff Hunter MP, Mr Allan Shearan MP, Mr Russell Turner MP, and the Hon. Dr Peter Wong MLC.

2. Apologies
Ms Tanya Gadiel MP, the Hon Christine Robertson MLC.

3. In attendance
Ms Catherine Watson (Committee Manager)
Ms Samantha Ngui (Committee Officer)

4. Summary of Submissions Received for the Inquiry into the Adequacy of Internal Complaints Handling Systems and other Methods to Measure Consumer Satisfaction in Relation to Practices and Clinics Outside the Hospital System
The Committee are advised that a total of eight submissions had been received and that further submissions were expected by the 13 May 2005.

5. Other Business
There being no other business the meeting was closed at 10.30am.

Minutes of Proceedings No. 28
Thursday 17 November 2005
10:30am, Room 1254, Parliament House

1. Members Present
Mr Jeff Hunter MP (Chair), The Hon. David Clarke MLC, The Hon. Christine Robertson MLC, Mr Russell Turner MP, The Hon. Dr Peter Wong MLC

2. In Attendance
Ms Catherine Watson (Committee Manager),
Ms Samantha Ngui (Sr Committee Officer),
Ms Belinda Groves (Committee Officer)
Ms Jill Moir (Registrar, Health Conciliation Registry)
Ms Alex Shehadie (Health Care Complaints Commission)

3. Apologies
Ms Tanya Gadiel MP, Mr Allan Shearan MP

4. Inquiry into Internal Complaint Handling in Private Practice
- **Briefing from Jill Moir (Registrar, Health Conciliation Registry, former Patient Support Officer)**

Members received a briefing from Ms Jill Moir (acting Registrar, Health Conciliation Registry, former Patient Support Officer) on the role, functions and processes of both the Complaints Resolution Office (formally the Patient Support Office) and the Health Conciliation Registry.

5. Next steps- Discussion of potential witnesses and further options
Discussion of next steps and consideration of potential witnesses was deferred until the next meeting of the Committee in two weeks time.

7. General Business
There being no further business the meeting was closed at 11:55am.

Minutes of Proceedings No. 29
Wednesday 30 November 2005
10:15am, Room 1108, Parliament House

1. Members Present
Mr Jeff Hunter MP (Chair), The Hon. David Clarke MLC, The Hon. Christine Robertson MLC, Mr Allan Shearan MP, Mr Russell Turner MP, The Hon. Dr Peter Wong MLC.

2. In Attendance
Ms Catherine Watson (Committee Manager),
Ms Samantha Ngui (Sr Committee Officer),
Ms Belinda Groves (Committee Officer)
Mr Ian Watts (National Manager, Royal Australian College of General Practitioners)

3. Apologies
Ms Tanya Gadiel MP

4. Inquiry into Internal Complaint Handling Systems
- **Briefing from Mr Ian Watts (National Manager, Royal Australian College of General Practitioners)**

Members received a briefing from Mr Ian Watts (National Manager, Royal Australian College of General Practitioners) on the Standards of the RACGP as they relate to complaints handling in private practice, as well as training options and other related matters.

5. Next steps- Discussion of Potential Witnesses and Further Options
Members agreed that a representative from the NSW Medical Board will be invited to provide the Committee with a briefing early next year.

Members also agreed to further investigate changes in the use of the Complaint Resolution Officers over the past 12 months.

There being no further business, the meeting was closed at 11:25am.

Minutes of Proceedings No. 30
Monday 12 December 2005
11:00am, Room 1254, Parliament House

1. Members Present

Mr Jeff Hunter MP (Chair), The Hon. David Clarke MLC, The Hon. Christine Robertson MLC, Mr Allan Shearan MP, The Hon. Dr Peter Wong MLC, Ms Tania Gadiel MP

2. In Attendance
Ms Catherine Watson (Committee Manager),
Ms Samantha Ngui (Sr Committee Officer),
Ms Belinda Groves (Committee Officer)

3. Apologies
Mr Russell Turner MP

4. Inquiry into Internal Complaint Handling Systems

- Briefing from Mr Bob Holt (Operations Manager, Independent Complaints Advocacy Service, United Kingdom)

Committee members received a briefing from Mr Bob Holt on the operations of the ICAS service in the United Kingdom, including its relationship with the National Health Service and an overview of common complaints received.

There being no further business, the meeting was closed at 12:15pm.

Minutes of Proceedings No. 31
Thursday 2 March 2006
10:00am, Room 1254, Parliament House

1. Members Present
Mr Jeff Hunter MP (Chair), The Hon. Christine Robertson MLC, Mr Allan Shearan MP, Mr Russell Turner MP

2. In Attendance
Ms Catherine Watson (Committee Manager),
Ms Samantha Ngui (Sr Committee Officer),
Ms Belinda Groves (Committee Officer)
Ms Christine McGillion (President, NSW Chiropractors Association)

3. Apologies
The Hon. David Clarke MLC, The Hon. Dr Peter Wong MLC, Ms Tanya Gadiel MP

4. Inquiry into Internal Complaint Handling Systems

- **Briefing from Ms Christine McGillion, NSW Chiropractors Association**

Members received a briefing from Ms Christine McGillion, President (NSW Chiropractors Association), on the process for referral of complaints from the Association to the Chiropractors Registration Board and the Health Care Complaints Commission.

There being no further business, the meeting was closed at 11:15am.

Roundtable Event: Conflict and Litigation Management (CALM) project
11:30am, Thursday 28 September 2006
Room 814/815 Parliament House

Present
Mr Jeff Hunter MP, Chair
Ms Catherine Watson, Committee Manager
Ms Samantha Ngui, Senior Committee Officer
Ms Belinda Groves, Committee Officer

Presenters
Ms Lynda Vamvoukis, CEO – Central Highlands Division of General Practice
Dr Chris Atkins, Director and Chair (CALM Project Working Group) – Central Highlands Division of General Practice
Dr Mark Valena, CEO – Medical Defense Association (Victoria)
Ms Therese Carroll, Clinical Risk Manager – Medical Defense Association (Victoria)
Dr Richard Clark, Clinical Epidemiologist

Participants
Dr Rod McMahon, Board Member, NSW Medical Board
Mr Anthony Johnson, Legal Director, NSW Medical Board
Mr Kieran Pehm, Commissioner, Health Care Complaints Commission
Mr Michael Smith, NSW Health
Mr Graham Catt, State Manager, Royal Australian College of General Practitioners (NSW Branch)
Ms Helen Turnbull, Legal officer, United Medical Protection
Ms Elizabeth Van-Ekert, United Medical Protection
Ms Deborah Jackson, Claims Manager, Medical Defense Association (NSW Branch)

Developers of the CALM project in Victoria gave a presentation on the development, implementation and preliminary evaluation of the pilot. Participants were then engaged in a discussion about the potential transferability of components of the project to NSW General Practices.

The event concluded at 1:50pm.

Minutes of Proceedings No. 38
Tuesday 21 November 2006
5:00pm, Room 1108, Parliament House

1. Members Present
Mr Jeff Hunter MP (Chair), Mr Allan Shearan MP, Mr Russell Turner MP and
The Hon. Dr Peter Wong MLC

2. In Attendance
Ms Catherine Watson (Committee Manager),
Ms Samantha Ngui (Senior Committee Officer),
Ms Belinda Groves (Committee Officer)

3. Apologies
The Hon. David Clarke MLC, Ms Tanya Gadiel MP and The Hon. Christine Robertson MLC

4. Inquiry into Internal Complaint Handling in Private Health Practices

- Briefing from Mr Kieran Pehm, Commissioner, NSW Health Care Complaints Commission

Commissioner Kieran Pehm provided the Committee with information on the role of Commission in assisting private health facilities to manage their low-level complaints internally.

Mr Pehm commended the work being done through the CALM pilot in Victoria, and thanked the Committee for organising and hosting the Roundtable discussion with the developers of the project in September 2006. He offered the support of the Commission in extending the trial to NSW Divisions.

Mr Pehm also briefed the Committee on the outcomes of the Complaints Handling Conference recently held in Melbourne.

There being no further business, the meeting was closed at 6:10pm.

Minutes of Proceedings No. 39
Wednesday 22 November 2006
10:00am, Room 1153, Parliament House

1. Members Present
Mr Jeff Hunter MP (Chair), The Hon. Christine Robertson MLC, Mr Allan Shearan MP, Mr Russell Turner MP and The Hon. Dr Peter Wong MLC

2. In Attendance
Ms Catherine Watson (Committee Manager),
Ms Samantha Ngui (Senior Committee Officer),
Ms Belinda Groves (Committee Officer)
3. Apologies
The Hon. David Clarke MLC and Ms Tanya Gadiel MP

4. Inquiry into Internal Complaint Handling in Private Health Practices

- Consideration of Draft report

On the motion of The Hon. Dr Peter Wong, seconded by Mr Russell Turner, that the words *"professional associations and indemnity funds"* be inserted after *"health registration boards and Divisions of General Practice"* in Recommendation Five.

On the motion of The Hon. Christine Robertson, seconded by Mr Allan Shearan, that Recommendation Six of the Report be amended to read:

That NSW Divisions of General Practice liaise with the Central Highlands Division of General Practice (Victoria), the Medical Defense Associations of NSW and Victoria, United Medical Protection and the Royal Australian College of General Practitioners, to explore the feasibility of two or three NSW Divisions of General Practice participating in the Victorian Conflict and Litigation Management (CALM) trial

Resolved on the motion of The Hon. Christine Robertson, seconded by Mr Russell Turner:

That the amended draft report: "Inquiry into Internal Complaint Handling in Private Health Practices' be accepted as a report of the Committee on the Health Care Complaints Commission, and that it be signed by the Chairman and presented to the House.

On the motion of Mr Russell Turner MP, seconded by The Hon. Dr Peter Wong:

That the Chairman and Committee Manager be permitted to correct any stylistic, typographical and grammatical errors in the report.

Passed unanimously.

There being no further business, the meeting was closed at 10:30am.

Appendix Three- Summary of Complaints Handling Components of Major Qualifying Courses

Name of Educational Institute	Degree	Related Subjects	Description
Charles Sturt University	B Health Science (Nutrition and Dietetics)	NUT403 PROFESSIONAL ISSUES IN NUTRITION AND DIETETICS	This subject examines a range of topics relevant to the role of the dietitian a s a manager of resources and personnel, including strategic planning, marketing, health care teams, case mix, information technology, service evaluation, quality and safety issues, report, proposal and submission writing, finances, setting up private practice, advocacy. The subject provides an understanding of the context of dietetic services with the wider health service organisational structure
University of Wollongong	B Nutrition and Dietetics	Introduction to employment and management relations Communication in health care practice	This subject introduces students to key management theories and concepts including organisational culture, social responsibility, ethics, managing groups, motivating employees, planning, managing human resources and employee relations, strategic management, decision-making, managing operations, leadership and management control systems. The subject is designed to provide an opportunity for students to acquire understanding through a series of lectures supported by student participation in simulation activities. The subject is presented from the point of view of managers, but students will learn how the different interests between organisational stakeholders affect various management processes. The subject will introduce students to the theory and practice of communication in the professional work environment, emphasising successful communication in a range of contexts. These include client counselling, small group education, community consultation, participation in meetings, working with the media and conflict resolution. In order to promote teamwork and group skills, the subject is taught on a small group basis, and the student should prepare for each activity. In order to promote an understanding of how people learn in small groups, students are asked to keep a reflective journal and to critique the process at the completion of the subject.
Charles Sturt University	B Health Science (Speech Pathology)	HLT101 FOUNDATION SKILLS FOR ALLIED HEALTH PROFESSIONALS	In this subject students will learn foundation skills required for practice as a health professional. An understanding of their profession and its role within the multidisciplinary team will be enhanced as students develop early professional skills. Client issues in relation to culture, society, and the Australian health care system will be explored. In addition, students will acquire skills in the use of library and IT resources
University of Sydney	B Applied Science (Speech Pathology)	CSCD1025 - Professional Development I	This unit of study introduces students to the learning orientation, communication skills, and basic processes necessary for the course and work in professional settings. It provides structured observations of professional activities. Students begin accumulating and documenting professional development experiences through involvement in relevant professional, community, or clinical services. For speech pathology students these experiences are required to be documented for their portfolio submitted in the fourth year of their course.

			Each student must show evidence of completion of an accredited First Aid Course (CPR) to be eligible to receive a Pass in this unit of study.
Charles Sturt University	B Health Science (Podiatry)	HLT101 FOUNDATION SKILLS FOR ALLIED HEALTH PROFESSIONALS POD401 PROFESSIONAL ISSUES IN PODIATRY	In this subject students will learn foundation skills required for practice as a health professional. An understanding of their profession and its role within the multidisciplinary team will be enhanced as students develop early professional skills. Client issues in relation to culture, society, and the Australian health care system will be explored. In addition, students will acquire skills in the use of library and IT resources This subject covers current issues of relevance to the podiatry profession and its future development including health law and professional ethics, the role of the professional body, employment trends, practice in regional and rural areas, health of indigenous Australians, competency development of entry level podiatrists, evidence based practice, and the role of new information technology in podiatry
Charles Sturt University	B Health Science (Occupational Therapy)	HLT101 FOUNDATION SKILLS FOR ALLIED HEALTH PROFESSIONALS OTY414 MANAGEMENT ISSUES IN PRACTICE	In this subject students will learn foundation skills required for practice as a health professional. An understanding of their profession and its role within the multidisciplinary team will be enhanced as students develop early professional skills. Client issues in relation to culture, society, and the Australian health care system will be explored. In addition, students will acquire skills in the use of library and IT resources Private, public and community sectors are studied in this subject and relevant management issues examined. This includes management of resources - human and financial, quality of services, standards of practice, competencies, leadership and professional development. Career planning is introduced, including job seeking, lifelong learning and personal development strategies
University of Sydney	B Applied Science (Occupational Therapy)	OCCP1091 - Components of Occ Performance IA	This unit of study introduces students to the principles of intrapersonal and interpersonal components of occupational performance focusing on social interaction and helping skills which underpin person to person occupational therapy assessment and intervention in all areas of practice. Students will explore different theories of communication and counselling as applied in occupational therapy settings.
Charles Sturt University	B Physiotherapy	HLT101 FOUNDATION SKILLS FOR ALLIED HEALTH PROFESSIONALS PHS322 PROFESSIONAL	In this subject students will learn foundation skills required for practice as a health professional. An understanding of their profession and its role within the multidisciplinary team will be enhanced as students develop early professional skills. Client issues in relation to culture, society, and the Australian health care system will be explored. In addition, students will acquire skills in the use of library and IT resources This subject covers current issues of relevance to the physiotherapy profession and its future development including health law and professional ethics, the role of the professional body (APA), employment trends, physiotherapy practice in regional and rural areas and the Asia-

		ISSUES IN PHYSIOTHERAPY	Pacific region, competency development of entry level physiotherapists, evidence based practice, the role of new information technology in physiotherapy practice and issues in health service management and health care delivery such as case mix , managed patient care , acute care follow-up services and community health centres
University of Sydney	B Applied Science (Physiotherapy)	PHTY2046 - Professional Practice	This unit introduces the students to broad and specific issues and practices in health care delivery affecting physiotherapists. This includes the roles and responsibilities of physiotherapists and other health professionals in the context of the changing health care environment. Students will explore the Australian Physiotherapy Association Professional Code of Conduct and learn to apply this code in ethical and clinical decision-making. The importance of communication and respect for cultural differences in professional conduct will be addressed. Communication will include interviewing and the principles and process of professional documentation. The responsibility associated with being a member of a regulated profession, regulation of physiotherapy practice by the Physiotherapists Registration Act of NSW 2001 and by other health acts and the meaning of professional misconduct and other associated behaviours are explored in both lecture and tutorial format. Students will examine the impact of legislation and health policy on service delivery within health care in Australia and the distribution of funding for preventative, palliative and curative care. In addition, students will be assigned to clinical units in the metropolitan region and will undertake structured learning tasks which apply principles taught in this unit of study. Students will complete a workbook of their experiences which will form part of the assessment of the mentored clinical placement.
Charles Sturt University	B Psychology	PSY420 ETHICS AND CURRENT ISSUES IN PSYCHOLOGY	This subject gives students an in-depth understanding of the key ethical and professional responsibilities and intellectual debates central to being a psychologist today. Its aim is to promote critical thinking and reflexiveness in both its academic and practical dimensions. The subject examines the ethical context of psychological work by examining current laws, codes and standards pertaining to professional conduct. It also examines current theoretical and methodological debates which challenge the history and philosophy of the discipline
Southern Cross University	B Psychology	BHS11004 - Contemporary Issues in Psychology	Extends the students' understanding of the relationship between psychological theory and practice through a combination of invited professional speaker, site visits and collaborative hypertext development. Students will gain further understanding of ethical principles involved in research practice through structured participation in research being conducted within the School of Psychology.
		BHS40007-8 - Ethics and Professional Issues	Acquaints students with ethical issues involved in the practice of psychology in research and professional contexts. Material covered includes ethics of research and practice, professional issues (Registration Board, APS, etc) and legal matters. Involves an examination of confidentiality, the nature of the relationship with clients, and suicide.

University of Sydney	B Psychology	PSYC3019 - Communication and Counselling	Communication: This part of the unit is concerned with understanding how interpersonal communication occurs in a face to face context. The emphasis will be on the structure of language and non-language components that compose the message and the extent to which that message is correctly decoded. Counselling: This part of the unit of study aims to provide an introduction to counselling psychology, to critically examine the theoretical foundations of counselling processes and to consider relevant empirical research.
University of New South Wales	B Psychology	Introduction to Psychological Applications - PSYC1021	The approach of psychology to issues arising in the management of human affairs and to the remediation of human problems. Topics include psychology as a scientific discipline, an overview of areas such as clinical psychology, neuropsychology and developmental disabilities in which psychological knowledge is applied to help individuals to change or to function optimally, and specific areas of public concern where psychology has a major contribution to make such as education, selection, training in industry, traffic and aircraft safety, and the law. The practical component focuses on the professional and social responsibilities of psychologists.
University of Sydney	B Dentistry	Foundations of total patient care Professional and Personal Development	The necessary communication and reasoning skills for effective dental diagnosis as well as the clinical understanding and technical skills to manage the care of the patient with common and important dental conditions. The necessary personal and professional skills for effective and rewarding practice, including ethical behaviours, productive teamwork, evidence-based decision-making, self-evaluation and life-long learning
University of New South Wales	Bachelor of Medicine/Bachelor of Surgery	Foundations - MFAC1501	The overall aim of the Foundations course is to introduce students to the independent and collaborative learning approach that characterises the new Medicine program. Foundations is an integrated eight-week experience for new students, which requires them to work independently and in teams to explore their understanding of the fundamentals of cell biology, the structure of the human body, and a range of professional issues pertinent to medical practice. It consists of two separate but interlinked health scenarios, the first on immunisation for medical students, and the second on stomach pain. The teaching and learning methods are designed to incorporate issues such as information management, and written and oral communication. The Foundations course also provides an orientation for new students into the academic support and mentoring programs. Assessment will be by evidence of satisfactory participation in each of the various activities undertaken. The two courses, Society and Health 1 & 2 are complementary vertically integrated

		Society & Health 1 - MFAC1502 Society and Health 2 - MFAC1506 Society and Health 3 - MFAC2501 Health	components in phase 1 of the Medicine program. The following description refers to the areas of study students will encounter upon completion of both courses. Depending upon the year of enrolment, the exact content allocated to either component will vary. Objectives: - To gain an understanding of the inter-relationships between the health of individuals or populations and the environment in which they live. The major themes include the societal determinants of health, the diversity of society focusing both on culture and genetics, systems that provide health care and the relationship between health and human rights. These themes will be studied taking global, community and individual perspectives on health. Infectious diseases will be used as an example of how the environment influences the health of individuals and populations. Areas to be explored will include relevant aspects of genetics, microbiology, cell biology, immunology and inflammation. In one year there will also be a focus on the haematopoietic and lymphoid tissues, as well as skin and structural elements of human tissues, while in the alternate year the focus will be on the respiratory system. Each course will consider the health status of populations, as well as aspects of normal human behaviour. A series of learning activities focusing on communication skills and clinical communication operates throughout phase 1 of the Medicine program. It involves learning within clinical environments and will be integrated with content topics specific to individual courses. Assessment will involve performance in two projects/assignments and an end of course written examination. Objectives: - By using authentic clinical and practical experiences in the community as the basis for learning, students will build upon their understanding (developed in phase 1) of the relationship between the health of an individual or population and the social and physical environment. In addition, students will develop understandings of the population health aspects of relevant illnesses and the role of other health professionals and community based services in prevention of illness and addressing the social and environmental determinants of health. Students will also extend their capabilities in communication with, and assessment of, individual patients and population groups with specific health issues. A case-based teaching methodology is employed to link acquisition of clinical and public health capabilities with the learning of mechanisms and principles underlying health and illness. Approximately 60% of available time will be spent in community based clinical environments associated with the Faculty of Medicine, in which students will encounter patients or health issues relevant to the domain themes. Typical environments and/or experiences will include sexual health and infectious disease services, services for particular population groups such as indigenous people, refugees, homeless people, community specialist services such as drug and alcohol, diabetes infectious disease, respiratory, or public health services that focus on health care based in the community and preventative approaches. Clinical experiences will be augmented by a range of tutorials, laboratory classes, and face-to-face and/or electronic resources covering aspects of public health, community medicine, pathology, infectious disease and

		Maintenance 3 - MFAC2503	pharmacology. Assessment will include submission of a project report, demonstrating integration/ correlation of prior and current learning with linkage to basic biomedical sciences; medical imaging and diagnostic tests; social and behavioural determinants of health, ethics; or population health issues. In addition, the student's performance during the module will be graded as satisfactory/unsatisfactory based on attendance, participation and review of cases and problems managed. Objectives: - By using authentic clinical or practical experiences as the basis for learning, students will build upon their understanding (developed in phase 1) of the internal and external mechanisms that maintain health or lead to disease. In addition, students will develop understandings of the clinical aspects of relevant illnesses, whilst extending their capabilities in communication with, and physical examination of, patients with specified health issues. A case-based teaching methodology is employed to link acquisition of clinical capabilities with the learning of mechanisms and principles underlying health and illness. Approximately 60% of available time will be spent in clinical environments associated with the Faculty of Medicine, in which students will encounter patients or health issues relevant to the domain themes. These will typically include acute disturbances of health leading to hospitalisation including critically ill patients and conditions requiring surgical treatment, patients with acute and chronic conditions cared for in ambulatory settings, as well as learning in some community-based practices. Clinical experiences will be augmented by a range of tutorials, laboratory classes, and face-to-face and/or electronic resources. Assessment will include submission of a project/assignment report, demonstrating integration/ correlation of prior and current learning with linkage to basic biomedical sciences; medical imaging and diagnostic tests; ethics; or population health issues. In addition, the student's clinical performance during the module will be graded as satisfactory/unsatisfactory.
The University of Newcastle	Bachelor of Medicine	MEDI1011Introduction to Professional Practice	Develops the essential clinical skills and knowledge that are required for a student to begin medical practice including occupational health and safety, infection control, and interviewing skills.
University of New South Wales	B Optometry/B Science	Optometry 3A - OPTM3111 Professional Optometry 4B - OPTM4270	To produce a student with a professional attitude and good communication skills who can integrate scientific and clinical aspects of optometry. To advance student knowledge and stimulate interest in dispensing, contact lenses and binocular vision. To make Optometry students aware of the purposes and consequences of their education; to develop an awareness of professional and ethical action in optometric practice; to ensure that students are aware of their social responsibilities as optometrists.
University of	B Applied Science	400732.1 -	Communication is integral to professional relationships. In this unit students develop skills in

Western Sydney	(Naturopathic Studies)	Communication in Health	both written and verbal communication in preparation for work within the health professions. Students will develop self-awareness of their professional, interpersonal and communication skills, enhancing their ability to develop appropriate professional relationships with clients and colleagues.
University of Technology Sydney	B Health Science in Traditional Chinese Medicine	92167 Foundations of Helping and Caring	Part 1: Interpersonal and Counselling Skills. Part 2: Psychosocial Foundations of Health, Illness and Disability. This subject facilitates the development of essential interpersonal and helping skills required for the practice of TCM. The subject introduces students to approaches to understanding people and models of health and health care from the Western perspectives. Particular focus is given to the psychosocial factors that contribute to and maintain illness and disability and to therapeutic approaches and strategies to restore and facilitate wellbeing and coping. The meeting places between Western and Eastern philosophies, understandings, practices and influences are explored.
		99655 Professional Issues in Traditional Chinese Medicine	This subject acquaints the student with the current requirements of private TCM practice. Workshops are provided in current research, business, legal and professional issues. The subject also encourages students to broaden their understanding of issues and techniques related to practice, to individually pursue areas of personal interest and research, and to see themselves as part of the wider health care community.
University of Western Sydney	B Applied Science (Traditional Chinese Medicine	400732.1 - Communication in Health	Communication is integral to professional relationships. In this unit students develop skills in both written and verbal communication in preparation for work within the health professions. Students will develop self-awareness of their professional, interpersonal and communication skills, enhancing their ability to develop appropriate professional relationships with clients and colleagues
		400249.1 - Ethical and Legal Issues in Health Care	This unit enables students to explore and develop an understanding of the ethical and legal issues important within contemporary health care. Through the use of case studies students will analyse profound ethical and legal challenges facing current health care that are equally important to health professionals, consumers and society generally. Additionally, students studying to work within health care, including as complementary health practitioners will develop a comprehensive understanding of the requirements for ensuring that their practice conforms to legal doctrines and ethical standards.
University of Western Sydney	B Applied Science (Naturopathic Studies)	400732.1 - Communication in Health	Communication is integral to professional relationships. In this unit students develop skills in both written and verbal communication in preparation for work within the health professions. Students will develop self-awareness of their professional, interpersonal and communication skills, enhancing their ability to develop appropriate professional relationships with clients and colleagues.