Our ref: AF1109
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Mr Mel Keenan
Committee Manager
Committee on the Health Care Complaints Commission
Parliament of New South Wales
Macquarie Street
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Dear Mr Keenan

Inquiry into the operation of the *Health Care Complaints Act 1993*

Thank you for your letter of 17 March 2010, requesting the Commission's responses to various questions by the Committee arising from the above inquiry.

Enclosed is a document setting out each of the Committee's questions, together with the Commission's responses to the questions.

I trust that this information is of assistance to the Committee.

Yours sincerely

Kieran Pehm
Commissioner

PARLIAMENTARY COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

INQUIRY INTO THE OPERATION OF THE *HEALTH CARE COMPLAINTS ACT 1993*

RESPONSE TO THE COMMITTEE'S FURTHER QUESTIONS

TO THE HEALTH CARE COMPLAINTS COMMISSION

In the Commission's response to the Committee Discussion Paper, you pointed out a number of misconceptions about the operation of the NSW health care complaints system held by, for example, Area Health Services. Were you were aware of the extent of these misunderstandings, and how do you consider they should be addressed?

This question appears to arise from the Commission's response to Issue 27 in the Discussion Paper, where the Commission observed: *"Area Health Services have the misconception – despite the Commission's continual advice to the contrary – that they can refer difficult matters to the Commission for 'independent review'"*. As the Commission explained in its response, the scheme under the *Health Care Complaints Act* is that the Commission's powers to consider concerns about the adequacy of health services can only be exercised on receipt of a complaint – in the absence of a complaint, the Commission has no power to conduct an "independent review" of a matter referred by an Area Health Service.

In order to respond to the misconception – which, it should be said, was more pronounced in one particular Area Health Service – the Commission contacted the complaint-handling staff of the Area Health Services to clarify the situation. These discussions appear to have largely eliminated the problem – in recent times, the Commission has not been receiving any "non-complaint referrals" from the Area Health Services. Where referrals are made, the Area Health Services understand that the Commission will contact the relevant patient and family who will become the complainant.

With reference to the Committee's principles of a health care complaints system in the 21st century, set out at page 2 of the Discussion Paper – to what extent do you consider that the current system in NSW achieves these goals?

To respond to this question, the Commission has set out the relevant principles articulated by the Committee, together with the Commission's observations in relation to each.

- *<u>Accountability</u> – decision-making authorities must be accountable to the NSW community in carrying out their statutory functions.*

An important aspect of accountability is explaining the Commission's role to the general community and relevant stakeholders. The Commission provides a considerable range of information on its role and functions through the Commission's website, community outreach activities, and annual reports. In handling individual complaints, the Commission explains to

the complainant and the health service provider(s) involved how the complaint is being handled and the reasons for the Commission's decisions.

The Commission is accountable for its overall performance to both the Minister for Health and the Parliamentary Committee on the Health Care Complaints Commission. To this end, the Commission provides quarterly reports to the Minister and the Committee on its recent complaint-handling work as measured against key performance indicators.

The accountability of the tribunals that hear and determine the Commission's disciplinary proceedings against individual practitioners is reflected in the requirement that the proceedings are open to the public, and that the reasons for tribunal decisions are made public. More recently, Medical Professional Standards Committees (PSCs) have also been required to conduct their proceedings in public and to make their decisions publicly available.

- *Transparency – decision-making processes should be open, clear and understandable for both the consumers and the professions.*

As discussed above, the Commission provides detailed information on its complaint-handling processes to both the consumers of health services and the health organisations and practitioners providing those services. The Commission has put considerable effort into ensuring that this information is clear and understandable. In addition, detailed reasons are provided to explain the Commission's decisions.

- *Fairness – decision-making authorities should maintain an acceptable balance between protecting the rights and interests of patients and those of practitioners.*

The Commission is required to be independent in dealing with complaints, and is well attuned to the challenge of striking an appropriate balance between the rights and interests of patients and those of the health practitioners who have provided the services and treatment in question.

The *Health Care Complaints Act* affords procedural fairness to health service providers the subject of complaint at crucial stages of the complaint-handling process, allowing them to respond to the complaint and to any proposed adverse comment or action by the Commission. The Commission is very careful to comply with the requirements of procedural fairness.

Where a complainant is dissatisfied with the Commission's decision on their complaint, they have a statutory right to a review of the Commission's decision. The Commission's reviews are conducted thoroughly, and detailed reasons for the review outcome are provided to the complainant.

- *Effectiveness – the regulatory system should be effective in protecting the public from harm and supporting and fostering equity of access and the provision of high quality care.*

The protection of the public from harm is achieved through:

- the Commission's recommendations to hospitals and other health facilities for systems improvement

- the prosecution of disciplinary proceedings against registered practitioners before the relevant health professional tribunal or professional standards committee

- the making of prohibition orders and public statements in circumstances where unregistered health practitioners have breached the Code of Conduct for Unregistered Health Practitioners and pose a risk to public health or safety.

Fostering equity of access and the provision of high quality health care is achieved through the Commission's resolution processes – for example, the Commission can often assist the patient and the health service/practitioner the subject of complaint to overcome previous difficulties in relation to communication and/or the provision of care and treatment.

- *Efficiency – the resources expended and the administrative burden imposed by the regulatory system must be justified in terms of the benefits to the New South Wales community.*

The statutory regime under the *Health Care Complaints Act* for the handling of complaints about health services – together with the management of the Commission's operations within that regime – is efficient, in the sense that appropriate resources are allocated to the handling of individual complaints. Serious matters are dealt with the resource-intensive processes of investigation and, where appropriate, the prosecution of disciplinary proceedings against individual practitioners. Less serious matters can be dealt with more appropriately through the Commission's assisted resolution and conciliation processes.

- *Flexibility – the regulatory system should be well equipped to respond to emerging challenges in a timely manner, as the health care system evolves and the roles and functions of health professionals change.*

Notable examples of the flexibility of the system to deal with emerging challenges include:

- The Commission has improved consultation processes with the Area Health Services and the Department of Health to ensure that the Commission's recommendations to public health organisations for system improvements are as practical as possible.

- The Commission has increasingly developed its liaison with relevant stakeholders. For example, the Commission's Consumer Consultative Committee has provided the opportunity for the Commission to develop very good relationships with a range of organisations representing health consumers. The Commission has also developed its relationship with the Clinical Excellence Commission, and provides its investigation reports and recommendations to the CEC to assist the CEC in its work on improving the safety and quality of health care.

- A Code of Conduct was introduced for unregistered health practitioners, and the Commission was given the power to make prohibition orders and to issue public

statements and warnings in relation to practitioners who have breached the Code of Conduct.

- There were significant amendments to the *Medical Practice Act* in response to some of the issues highlighted by the case of Dr Graeme Reeves:

    - The processes and decisions of Medical PSCs are now better informed, through the inclusion of a presiding legal member on any PSC.

    - PSC proceedings have been made open to the public

    - The reasons for PSC decisions are available to relevant stakeholders and the general public.

The Commission's comments above under "Efficiency" are also relevant here. Complaints are continually assessed by the Commission under section 20A of the Act to ensure the appropriate allocation of resources to individual complaints.

Are there any other comments that you would like to make with respect to the Inquiry's Terms of Reference? Is there anything the Commission would like to suggest which would assist the Committee in the exercise of its oversight role?

The Commission is happy to rely on the detailed information and various suggestions for legislative reform contained in the Commission's original submission, in its further detailed submission responding to the Committee's Discussion Paper, and in this response to the Committee's questions.

<u>Questions taken on notice</u>

In the course of the hearing, you indicated that the HCCC had given consideration to mandatory notification to, and investigation by, the HCCC of serious incidents, such as the unexpected death of a patient, without the need for a complaint. Can you advise the Committee why it was you have not pursued the issue of mandatory notification?
[Context: page 34 of hearing transcript]

The question of whether the Commission should be notified of and required to investigate "SAC 1 matters" – that is, serious incidents which must be made the subject of a root cause analysis (RCA) – was the subject of informal discussions within the Commission some time ago. The Commission did not formally pursue the issue or seek the mandatory notification of SAC 1 incidents to the Commission. There were a number of reasons for this.

First, under the *Health Care Complaints Act*, the Commission's role has always been one of dealing with complaints about health service providers. This means, of course, that the Commission's role has not extended to the review of issues concerning the adequacy or quality of health services that are not the subject of a complaint. The Commission must

necessarily be conscious of the proper scope and limits of its statutory role – particularly given that Mr Bret Walker SC was critical of the former management of the Commission for not adequately appreciating the scope and limits of the Commission's statutory charter and how the Commission's complaint-handling functions should be exercised.

The Commission also took into account that there are a number of other processes in place to examine serious adverse incidents. Under NSW Health policy, these incidents must be the subject of an RCA. The RCA team investigates the incident with a view to identifying any systemic problems that contributed to the incident and, if appropriate, making recommendations intended to overcome or minimise such problems in the future. Where the RCA team identifies an issue of possible misconduct by an individual practitioner, it must refer the issue to the Chief Executive of the Area Health Service for attention. The RCA team may also refer issues of poor performance by individual practitioners to the Chief Executive. It is the duty of the Chief Executive to notify these issues to the Commission and/or the relevant registration board – thus generating a complaint or concern about the practitioner that must be considered and addressed. In addition, the Clinical Excellence Commission reviews the work of RCA teams and their recommendations for systems improvement.

There was little evidence that the existing processes to examine SAC 1 incidents were seriously inadequate, or that significant issues of public health and safety were "falling through the cracks". In those circumstances, the Commission did not consider it necessary to recommend the mandatory notification of SAC 1 incidents to the Commission.

That said – and now that the Commission has had occasion to further consider the issues involved in light of the Committee's question – the Commission has no difficulty with all SAC 1 matters being notified to the Commission by the Area Health Services. Rather than being required to investigate every matter, however, the Commission should be able to conduct an assessment, in order to decide whether the particular matter warrants investigation by the Commission. The reasons for this are as follows:

- Existing processes to examine the incident may have already satisfactorily addressed the matter – the RCA team may have made appropriate recommendations for systems improvements.

- The patient and/or the patient's family may be satisfied with the explanation of the incident provided through the "open disclosure" process, and with the outcome of the RCA process.

- There may be no issues of possible misconduct by individual practitioners that would require investigation by the Commission under one or more of the criteria set out in section 23 of the *Health Care Complaints Act*.

- A requirement for further investigation of the incident by the Commission would involve an unnecessary and inappropriate duplication of effort, with no useful outcome at the end of the investigation, and create unnecessary stress for health service providers.