RESPONSES FROM THE COMMISSIONER

OF THE HEALTH CARE COMPLAINTS COMMISSION

TO THE COMMITTEE'S QUESTIONS ON NOTICE

OVERVIEW

1. The Annual Report notes that one of the Commission's objectives is to "work with stakeholders to improve the safety and quality of health care services" [p 81]. How has the Commission furthered this objective, and what stakeholder input is sought in respect of the Commission's operations?

The Commission has worked with various stakeholders, and sought their input to improve the safety and quality of health care in the following ways:

<u>Recommendations by the Commission</u>
Many of the Commission's investigations into health organisations result in provisional and/or final recommendations designed to improve the safety and quality of health care.

Importantly, the Commission provides its draft reports containing its provisional recommendations to the relevant health organisation(s) and the Department of Health, in order to seek their comments before the finalisation of the Commission's report. Sometimes the health organisation will advise that they have accepted the Commission's provisional recommendations and immediately implement them. In other cases, the health organisation and Department of Health provide comments that assist in ensuring that the Commission's final recommendations are appropriate and practical.

Sometimes the Commission will suggest to the Department of Health that recommendations arising from the investigation of a particular health organisation should be implemented more broadly, across an Area Health Service or State-wide.

The Commission monitors the implementation of its final recommendations by obtaining reports from health organisations and the Department of Health about implementation. During 2006-07, the Commission built on its work with the Department of Health in this respect by introducing quarterly meetings with the Department's Quality and Safety Branch and Corporate Governance and Risk Management Branch, to discuss the implementation of the Commission's recommendations.

In addition, the Commissioner and the Director-General meet every three months to discuss significant issues – again, this includes discussion of the implementation of the Commission's recommendations, as well as other matters concerning or affecting the safety and quality of health services.

In relation to the actual extent of the implementation of the Commission's recommendations, 59 complaints have resulted in 137 recommendations being made to health organisations since 1 July 2005. Of the 59 recommendations made in 2005-06, 80% have now been fully or partially implemented. In addition, 28% of the 78 recommendations made in 2006-07 have already been implemented.

Area Health Services

In 2006, the Commission organised meetings with the senior management of each of the eight Area Health Services and of Justice Health. The purpose of these meetings was to improve the Commission's relationships with these services. At each meeting, the Commissioner and the Commission's Director of Assessment and Resolution discussed the recent changes to the Commission's structure and operations with the Service's Chief Executive Officer and Director of Clinical Governance. Arrangements were also made for future regular meetings between representatives of the Commission and the Area Health Services.

These regular meetings began in 2007. The Commission's Director of Assessment and Resolution and other relevant staff meet with the Service's Director of Clinical Governance and complaint management staff to discuss not only the handling of particular complaints, but also recent complaint trends and issues involving the Service.

Registration boards

The Commission is required by the Health Care Complaints Act to consult with the relevant registration board with respect to the assessment and investigation of complaints about registered health practitioners. These consultations ensure that the Commission has the benefit of advice from registration boards to assist it in determining the appropriate course of action to be taken on complaints about individual practitioners – particularly those raising concerns about the safety and/or quality of the health care provided by the practitioner.

In addition, the Commission has a monthly meeting with each registration board to discuss more general issues, including those affecting the safety and quality of health care.

Community Consultative Committee

The Commission has a Community Consultative Committee, whose membership consists of representatives of the following organisations:

- *Council on the Ageing*
- *People with Disabilities NSW Inc*
- *Association for the Welfare of Child Health*
- *New South Wales Council of Social Services (NCOSS)*
- *People Living with AIDS*
- *Mental Health Co-ordinating Council*

- *Carers NSW*
- *Rural and Remote Health Consumers of Australia*
- *NSW Council for Intellectual Disability*
- *Combined Pensioners and Superannuants Association*
- *A culturally and linguistically diverse (CALD) community representative.*

The Committee represents the interests of the health consumers, and provides a forum in which the Commission can seek and obtain advice and feedback about various issues from a consumer perspective, including matters concerning the safety and quality of health care. The Commission meets with the Committee every four months.

2. The Commission's 2006-2009 Strategic Plan notes that the Commission needs to re-establish the public's expectation of it as a credible and trusted investigator of health care complaints [p 2]. What measurable success has the Commission had in achieving this?

At the outset, the Commission would observe that measuring the public's trust in the Commission as a credible body to investigate complaints about health care is inherently a difficult task.

Nevertheless, it can be said that trust in the Commission is – or should be – enhanced by the Commission being seen as a body which is:

- *timely and effective in its work*
- *affords fairness to both complainants and health service providers in its complaint-handling processes*
- *provides clear and persuasive reasons for its decisions.*

Accordingly, the Commission would point to the following matters as indicative of the Commission's success in re-establishing itself as a credible complaint-handling agency.

<u>Better quality advice from the Commission's Inquiry Service</u>
The Commission's Inquiry Service in its current form has operated since April 2006. The Inquiry Service is staffed by Resolution Officers – more senior staff than in the past, and therefore more skilled and experienced in dealing with inquiries from members of the public.

Advice offered by the Inquiry Service is often focussed on assisting callers to resolve their concerns directly with health service providers – and providing advice about practical strategies on how to do so.

It appears that the improvement in the quality of the advice given to callers by the Inquiry Service has contributed to the Commission receiving fewer written

complaints in 2006-07 – thus allowing the Commission to deal with the written complaints that it does receive more quickly and effectively.

Where a person does wish to make a formal written complaint to the Commission, a Resolution Officer will, where appropriate, assist the person in the preparation of the complaint.

Improved handling of workload
In 2006-07, the Commission received 2722 written complaints, and finalised the assessment of 2710 complaints in the same period – thus keeping pace with its complaint workload.

Better quality assessments
In 2006-07, the Commission's redesign of its assessment process was fully implemented. The process now involves more extensive inquiries into complaints to assist in the making of properly informed assessment decisions.

Significantly, the assessment process now involves obtaining a response to the complaint by the relevant health provider(s) – thus ensuring that health practitioners and organisations see that they are being treated fairly by the Commission in its assessment processes.

The Commission's internal medical and nursing advisors have been transferred into the assessment area, reflecting the important role that these experts play in the assessment of complaints about allegedly poor medical care and treatment.

It should be emphasised that the Commission's more thorough assessment process also contributes to ensuring that only the most serious matters are referred for investigation – thus allowing the Commission's Investigation Division to use its resources more effectively, and conduct investigations in a more timely manner.

Improved timeframes for the assessment of complaints
Complainants and health providers should be able to expect that the Commission will assess complaints in a timely fashion.

In 2006-07, the Commission assessed 83.7% of complaints within the statutory timeframe of 60 days. Furthermore, on average, the Commission completed its assessment of complaints within 39 days – 22 days less than in 2005-06.

Increased resolution and conciliation of complaints
In 2006-07, the Commission assessed more complaints as being suitable for assisted resolution by the Commission's Resolution Service or conciliation by the Health Conciliation Registry.

Both areas have increased their resolution rates:

- *In 2006-07, of the 476 complaints finalised by the Resolution Service, 340 (71.4%) were fully or partially resolved.*

- *In the same period, of the 139 complaints where the parties consented to participate in conciliation, 109 (78.4%) resulted in an agreement at or before the conciliation meeting.*

Significantly, there has been positive feedback by parties involved in the Commission's resolution and conciliation processes.

In 2006-7, the Commission sought feedback from complainants and health service providers with whom there had been significant contact during the assisted resolution process through a satisfaction survey. For the 259 surveys sent to complainants, there were 122 responses (a 43% response rate); for the 209 surveys sent to health service providers, there were 112 responses (a 55% response rate).

Key results of the satisfaction survey were as follows:

- *78% thought that the Resolution Officer understood their concerns.*
- *71% found the Resolution officer helpful in generating resolution options*
- *69% considered that the involvement of the Resolution Officer in the resolution process was helpful*
- *78% thought that the Resolution Officer was fair.*

Evaluations of the conciliation process have included comments such as the following:

- *From a complainant – "The conciliator showed great insight into the underlying issues [and] drew these out so that full resolution was achieved".*
- *From a representative of a metropolitan health care facility – "The process was straightforward and fair and transparent, and the conciliation was conducted professionally with a good outcome for all the parties".*

<u>Improved timeframes for the resolution of complaints</u>
In 2006-07, 16.2% of cases referred after assessment for assisted resolution were completed within a month, and 61.6% within three months.

<u>Improved timeframes for the investigation of complaints</u>
The average time taken to complete an investigation fell from 352 days in 2005-06, to 318 days in 2006-07. Nearly 70% of investigations were completed within 12 months.

<u>Better quality recommendations to health organisations</u>
There has been an increase in the number of recommendations by the Commission to health organisations to improve systems. (The extent of the Commission's recommendations to health organisations, and the rate of implementation, have already been detailed in the Commission's answer to Question 1 above.)

Better explained reasons for assessment and investigation outcomes
In 2006-7, staff in the Assessment and Resolution Division received training in "plain English", leading to improvements in the quality of the explanations given to complainants and health providers about the Commission's reasons for its assessment decisions. The staff of the Investigation Division will undertake similar training in 2007-08.

Rate of review requests
Complainants have a statutory right to a review by the Commission of the assessment decision in relation to a complaint about a health practitioner and/or or health organisation. Furthermore, where a complaint has been investigated by the Commission, the complainant is has a statutory right of review of the outcome in relation to an individual health practitioner.

In 2006-07, the Commission received 284 requests for a review of the initial assessment – that is, for only 10% of its initial assessment decisions – and 18 requests for a review of the outcome of an investigation into a health practitioner.

3. **In evidence to the Committee in March 2006, you noted that there was not a "strong culture of supervision" nor "proper management practice" in the Commission [*Report on the 2004/05 Annual Report of the HCCC*, p 23]. What measures have been put in place to improve management culture and practice? How is the impact of these measures monitored and evaluated?**

   The measures that the Commission has adopted to improve management and supervision are:

   - *the development of a Strategic Plan, Corporate Plan, and Divisional Plans*
   - *the introduction of team structures, led by team managers who manage and supervise the work of these teams*
   - *the establishment of a case management system, supported by Casemate*
   - *the creation of the Investigations Review Group, which tracks the progress of significant investigations and investigations that have taken longer than 12 months*
   - *the implementation of a performance management system.*

   The monitoring and evaluation of the impact of these measures is reflected in the information and statistics set out in the Commission's answer to Question 2 above.

4. **How would you describe the state of the Commission's working relationships with other health-related bodies, such as the NSW Clinical**

Excellence Committee, and the various Registration Boards [2005-06 *Corporate Plan*, p 13]? Did any significant issues arise in respect of the Commission's relationships with these bodies during the 2005-06 reporting period?

The Commission believes that its relationships with other health-related bodies are good.

The Commission's answer to Question 1 has canvassed in detail the nature and extent of the Commission's regular consultations and meetings with:

- *the Director General of the Department of Health*
- *the Department's Quality and Safety Branch and Corporate Governance and Risk Management Branch;*
- *the senior management and complaint-handling staff of the Area Health Services; and*
- *the various health professional registration boards.*

The Commission also meets with the Clinical Excellence Commission when necessary.

There have been no significant issues or difficulties in the Commission's relationships with any these agencies and bodies.

PERFORMANCE REPORT FOR 2005–06

5. At what stage of preparation is the Commission's new Investigations Manual [p 9]?

The majority of the Investigation Division procedures manual has been drafted, and the manual should be finalised in December 2007. The departure of the former Director of Investigations in January 2007, and the consequent process of recruiting a new Director, caused some delay in the preparation of manual.

6. Could you please explain how the Commission's peer review process operates [p 9]?

Legislative provisions
It may be useful to begin with an outline of the provisions of the Health Care Complaints Act governing the Commission's use of experts.

Section 30(1) of the Act provides that the Commission, when investigating a complaint, may obtain a report from a person – including a practitioner registered under a health registration Act – who, in the opinion of the Commission, is

sufficiently qualified or experienced to give expert advice on the matter the subject of complaint.

The Commission is prohibited from seeking an expert report from a person who has a financial connection with the health practitioner about whom the complaint has been made (section 30(2)).

Furthermore, an expert must include with their report to the Commission a signed statement about whether or not they have a personal, financial or professional connection with the health provider about whom the complaint has been made – and, if so, particulars of that connection (section 30(3)).

Where the Commission decides to obtain expert advice for an investigation, the Commission is obliged to provide the expert with "all relevant information" concerning the complaint that is in the possession of the Commission (section 30(2A)).

Expert reports obtained in the course of the Commission's investigations may be used in disciplinary or related proceedings under health registration legislation (section 30(4)). However, they may not be admitted or used in any other proceedings except with the consent of the expert, the complainant, and the health provider about whom the complaint has been made (section 30(4)), and neither the expert not the Commission can be compelled to produce the report, or give evidence in relation to the report or its contents, in such other proceedings (section 30(5)).

<u>Nomination of experts</u>
The Commission obtains nominations for potential expert reviewers in a number of ways:

- *The Commission asks professional bodies, such as the Royal College of Physicians, to nominate eminent practitioners whom they consider have the confidence of the profession. The criteria for nomination include specialist expertise, and expertise in areas where the Commission's existing expert register is lacking.*

- *The Commission also asks its employed internal medical advisers and its existing experts for nominations.*

- *The various health registration boards also suggest potential experts from time to time.*

<u>Applications for expert status</u>
Any practitioner nominated must submit a written request to become an expert reviewer. The request must include a curriculum vitae containing details of the practitioner's qualifications and professional experience.

<u>Appointment of experts</u>
The Commissioners appoint practitioners as experts based on a consideration of the practitioner's application and a check of their complaint history (if any).

The Commission's register of experts
The Commission keeps a register of experts which details their names, qualifications, experience, and area(s) of expertise.

Selection of experts for investigations
Where the Commission requires an expert opinion for the purposes of an investigation, the relevant investigation officer selects an expert from the Commission's register based upon the nature of the issues raised by the complaint and the expertise of the practitioners included on the Commission's register.

Use of experts for assessments
The Commission's internal medical advisers may contact an appropriate expert, to assist them in providing advice on the issues raised by a particular complaint for assessment purposes. In this respect, the Commission is ultimately required to assess whether there is a sufficient basis for the complaint to be referred for investigation by the Investigation Division, and, if not, whether the complaint should be referred to the Commission's Resolution Service for assisted resolution or to the Health Conciliation Registry for conciliation.

New guidelines
The Commission has revised the guidelines document that it provides to its expert reviewers to assist them in preparing their reports. A copy of that document is attached for the information of the Committee.

7. The Annual Report notes that the Commission established a Senior Management Group [p 12]. How has this Group operated to promote leadership throughout the Commission, and what input has it sought from staff of the Commission? Has the Group identified goals in order to measure the effectiveness of its activities and initiatives?

The Senior Management Group consists of the managers within the Commission's various Divisions. The intended purpose of the group was to develop the leadership of these managers in relation to the staff that they are responsible for supervising.

Appointments to all senior positions have now been made. All of these managers have received training in performance management, and as part of the implementation of Commission's performance management system in 2006-07, have conducted reviews of the staff that they supervise.

COMPLAINT NUMBERS, TRENDS AND ISSUES

8. The Annual Report notes the difficulty with straightforward conclusions from complaint statistics due to "the problem that there is no effective measurement of the extent of awareness of health consumers about how to

make a complaint" [p 20]. How would the Commission promote public awareness of the avenues of complaint?

The Commission has developed a variety of ways to promote public awareness of avenues of complaint.

The Commission's website
The Commission's website contains extensive material about the role of the Commission and its processes.

Registration board websites
The Commission has asked the various registration boards to include information about the Commission on their websites and a link to the Commission's website.

Promotion Officer
The position of the Commissioner's Executive Assistant has recently been upgraded, so that the position includes responsibility for the development and implementation of a promotion strategy for the Commission over the next 12 months.

Resolution officers at Area Health Services
The Commission has Resolution Officers located at each of the Area Health Services. These officers are responsible for networking with health service providers and delivering public presentations to community groups.

Members of Parliament
The Commission's Director of Assessment and Resolution has been regularly liaising with the executive staff assisting Members of Parliament, to inform them of, or reinforce with them, the Commission's role and functions. This should assist in ensuring that members of the public who approach their local Member of Parliament with concerns or complaints about health providers are given appropriate advice about the role of the Commission.

9. **The Annual Report notes that there are "subjective elements to the Commission's recording of the issues raised in complaints" [p 20]. Do you consider that this has distorted outcomes? What steps has the Commission taken to address this issue in order to ensure objectivity and consistency?**

To overcome this problem, has the Commission made reference to the complaint classification of similar bodies, such as the Ombudsman?

Recording of issues
It is difficult to judge the extent to which any "subjective" recording by Commission staff of the issue(s) raised by complaints has distorted the statistical information gathered by the Commission.

In relation to the steps that the Commission has taken to ensure objectivity and consistency in the recording of issues – the recording of issues, formerly done by individual assessment officers, is now undertaken at the outset by the Manager of Assessments in conjunction with the Director of the Assessment and Resolution Division. In addition, at the completion of the assessment process, the Manager of Assessments checks the file and the Casemate system to ensure that all relevant issues have been identified and correctly recorded.

<u>Classification of issues</u>
In addition, the Commission has recently undertaken a comprehensive internal review of its issues list to redefine and/or clarify those issues and/or their categorisation. This should assist in minimising any mistakes or confusion in defining the issue(s) raised by particular complaints.

The Commission is also consulting about its revised issues list with its counterparts in other Australian jurisdictions, with a view to as much consistency as possible in the identification and recording of the issues raised in complaints about health service providers. Following this consultation, the Commission will finalise the issues list, with a view to the use of this issues list by Commission staff as from the beginning of the 2007-08 reporting period.

10. To what factor/s does the Commission attribute the continued rise in complaints made against public hospitals, and against pharmacies [p 24]?

It is not clear what factors have given rise to the increase in complaints about public hospitals and pharmacies.

11. The Annual Report notes that in relation to complaints about certificates or reports by medical practitioners in legal proceedings, the Commission takes the view that unless the complaint is serious, the issues are "best left to be determined through the relevant legal process for which the report or certificate was completed" [p 29]. Does the Commission have a process of monitoring the outcomes of such complaints?

The Commission does not have a process for monitoring the outcome of legal proceedings where the quality of a medical report is in issue.

However, where the legal proceedings proceed to determination by a court or tribunal, and the court or tribunal comments adversely on the conduct of the medical practitioner and/or the quality of the medical report in question, it is open to the complainant to lodge a further complaint with the Commission – and, in doing so, to bring to the adverse comments of the court or tribunal to the attention of the Commission. In addition, it is open to the court or tribunal itself to refer their concerns in such a matter to the Commission or the relevant registration board.

Furthermore, authorities involved in the conduct of relevant legal proceedings (for example, WorkCover in workers compensation proceedings) which have

serious concerns about the quality of a medical report prepared for the purpose of the proceedings are entitled to make a complaint to the Commission or registration board about their concerns.

12. What has been the impact upon the Commission of the commencement of the *Health Legislation Amendment (Unregistered Practitioners) Act 2006*?

There has been minimal impact on the work of the Commission with the commencement of the Health Registration (Unregistered Practitioners) Act 2006. This is because the application of the amended legislation largely depends upon the introduction of a code of conduct for unregistered practitioners under the Public Health Act. There has been some consultation between the Department of Health and the Commission and other stakeholders on a draft code of conduct. However, before the code of conduct can be finalised, the Minister for Health must publicise the draft code and consider submissions from the public on that draft. The Commission understands from the Department of Health that the Department is still planning this public consultation process.

ASSESSMENTS AND RESOLUTION DIVISION

13. What structure does the Commission have in place for consultation with specialists in the assessment of complaints [p 32]? How does the Commission access expert advice?

The answer to this question has been provided above, in the context of the Commission's answer to Question 6 about the peer review system, as follows:

The Commission's internal medical advisers may contact an appropriate expert, to assist them in providing advice on the issues raised by a particular complaint for assessment purposes. In this respect, the Commission is ultimately required to assess whether there is a sufficient basis for the complaint to be referred for investigation by the Investigation Division, and, if not, whether the complaint should be referred to the Commission's Resolution Service for assisted resolution or to the Health Conciliation Registry for conciliation.

14. The Annual Report notes that internal problems within the Assessment Branch adversely affected the Commission's capabilities in 2005-06 [see p 33]. How have these problems been resolved?

As noted in the 2005-6 Annual Report, the issues in question had been substantially addressed by the end of 2005-06. That report noted:

There has been substantial turnover of the staff in the [Assessment] area and more focussed training has been provided to existing and new staff. The re-engineering and improvement of case management systems has provided for improved tracking of the progress of cases. The removal of the Inquiry Service

from the Assessment Branch has allowed staff to concentrate on their core function of assessing complaints. From 1 April 2006, the Assessment Branch has been achieving a rate of 80% of assessment being finalised within 60 days.

In 2006-07, the Commission assessed 83.7% of complaints within the statutory timeframe of 60 days. Furthermore, on average, the Commission completed its assessment of complaints within 39 days – 22 days less than in 2005-06.

15. During 2005-06, there was a considerable increase in the number of complaints which were resolved during the assessment process, i.e. 150 as opposed to 45 in the previous reporting period [p 33]. Has the Commission identified any factors to which this increase can be attributed?

The change to the Commission's assessment process, whereby health service providers were invited to respond to the complaint as part of the assessment process, has meant that individual health practitioners and/or health organisations will sometimes offer explanations, apologies and other opportunities for redress in relation to the issues raised by the complaint. In some cases, these possibilities for resolution of the complaint are accepted by the complainant in the course of the assessment process.

Furthermore, the Commission has directed and trained its assessment staff to attempt to resolve complaints during the assessment process where that is possible and appropriate.

16. The Annual Report notes that there will always be complex cases where a complaint assessment will take time "even allowing for good case management and the receipt of relevant material within reasonable timeframes" [p 33]. How does the Commission make an estimate of the length of time for resolution of complaints at the outset of the complaint process?

The Commission does not make an estimate of the potential time for assessment processes. The time taken will depend on the complexity of the complaint; obtaining further information from the complainant; the number of health service providers involved; and the need to obtain all relevant evidence. Where clinical issues are raised, the Commission may also need to seek expert medical advice. In the most complex matters, this cannot reasonably be done within 60 days.

Where a complaint is assessed for resolution options, the time taken will depend on the complexity of the matter and the positions of the parties.

As noted above, in 2006-07, the Commission assessed 83.7% of complaints within 60 days. Furthermore, on average, the Commission completed its assessment of complaints within 39 days – 22 days less than in 2005-06.

In 2006-07, 16.2% of cases were resolved within a month, 61.8% within three months, and 98.7% within a year.

17. Could you please explain what constitutes a "partial resolution" of a complaint [p 36]?

A complainant may raise a number of distinct issues. For the Resolution Service, whether these particular issues are regarded as "resolved" or "unresolved" is assessed from the perspective of the complainant. Accordingly, if all of the issues raised by the complaint are resolved to the complainant's satisfaction, the complaint is recorded as "fully resolved". On the other hand, if none of the issues is resolved to the complainant's satisfaction, the complaint is recorded as "not resolved". Where some issues are resolved to the complainant's satisfaction, but others are not, the complaint is appropriately recorded as "partially resolved".

Under section 52 of the Health Care Complaints Act, conciliators must record whether or not there has been "agreement". There therefore appears to be no scope for "partial" agreement in the conciliation process.

18. Less than half the complainants – and approximately a third of the health providers – responded to the Resolution Service satisfaction surveys [p 37]. Has the Commission devised a strategy to encourage more participation in this process or an alternative means of obtaining client feedback?

In 2006-07, an audit conducted by external consultants identified deficiencies in the Commission's survey process, and recommended that that the Commission "consider sending surveys in conjunction with closure letters to remove subjectivity in selection of survey participants and streamline the process". The Commission has adopted this recommendation, and will be implementing it in the near future.

INVESTIGATION DIVISION

19. How frequently did the Commission use its coercive powers during 2005-06? What type of powers were used, and in what type of investigations?

The Commission does not electronically record each occasion on which its coercive powers have been used.

It should be noted that the coercive powers available to the Commission under section 34A of the Health Care Complaints Act to require the production of information and/or documents, and to give evidence, can only be applied to a

complainant, the person(s) against whom the complaint has been made, and health service providers.

Although the Commission operates on the general basis of requesting co-operation, it has frequently had resort to using its coercive powers to obtain documents and require statements of information.

In 2005-06, the Commission did not require any complainant or health service provider to give evidence before the Commission, or exercise its powers of entry, search and seizure.

20. The Annual Report notes that less than half of the Commission's recommendations were implemented [p 45]. Which recommendations were not taken up, and by which bodies/agencies? Has the Commission devised any strategies to assist in an increased uptake of its recommendations?

By way of update on the rate of implementation on the Commission's recommendations, 59 complaints have resulted in 137 recommendations being made to health organisations since 1 July 2005.

- *Of the 59 recommendations made in 2005-06, 80% have now been fully or partially implemented.*

- *Off the 78 recommendations made in 2006-07, 28% have already been implemented.*

In relation to the issue of strategies adopted by the Commission to increase the uptake of its recommendations, the Commission would refer the Committee to its answer to question 1, concerning the Commission's meetings with the Department of Health and the Commissioner's meetings with the Director General.

21. At what stage is the development and implementation of the Commission's investigations training program [p 45-6; 2005-06 *Corporate Plan*, p 9]?

A training program has been developed by the Director of Investigation, incorporating a number of subjects from courses run by the Sydney Institute. Completion of the program would result in the granting of a Certificate IV in Government (Investigation), which is nationally accredited.

The investigation staff will undertake the training in November and December 2007.

LEGAL DIVISION AND THE DIRECTOR OF PROCEEDINGS

22. Could you please advise of the status of the change in the structure of the Legal Division, and the review of the Prosecutions Manual [p 48]? How have the Commission's operations improved as a result of these changes?

The restructure of the Legal Division

The Legal Division is managed by the Director of Proceedings. Ms Karen Mobbs was appointed to this position in 2005 following the amendments to the Health Care Complaints Act which created the position.

In 2006, two Senior Legal Officer positions were created and appointments made to those positions. Each Senior Legal Officer is responsible for supervising a team comprising several Legal Officers, a Hearing Officer, and an administrative support officer. (By way of clarification, Legal Officers and Senior Legal Officers are responsible for the conduct of proceedings against registered health practitioners before disciplinary tribunals, while Hearing Officers are responsible for the conduct of such proceedings before professional standards committees established by the relevant registration board.)

Under the management of the Director of Proceedings, the Legal Division has introduced a variety of new processes and procedures. For the purposes of the Commission's updating of Casemate, its computerised case management system, the Legal Division "mapped" its processes. These have been introduced into the Casemate system.

The Legal Division Manual

There is an existing prosecutions manual, which needs to be updated to formally reflect the changes to the structure, processes and procedures of the Legal Division.

A new section on "Costs" has been written and added to the manual. Some work has also been done on a proposed new section of the manual dealing with the briefing of Counsel, including a list of suitable Counsel to represent the Commission in disciplinary proceedings.

The Legal Division has already developed templates for relevant documents such as prosecution reports, formal complaints against health practitioners, summonses to witnesses to give evidence, summonses for the production of documents, and standard letters. These will be included in the manual.

Impact on the operation of the Legal Division

These improvements will result in more timely, thorough and effective prosecutions.

MANAGEMENT AND STRUCTURE

23. With respect to the attrition of staff [p 58], what is the difference between staff resigning from the Commission and staff "transferring to another

public sector agency" for the reporting period? Has the Commission's retention rate of staff improved?

Transfers and resignations

The term "transfer to another public sector agency" is used to describe the situation where an officer of the Commission leaves their employment with the Commission to take up employment with another New South Wales public sector agency. In this case, the person ceases to be an employee of the Commission; however, their leave, superannuation and other relevant entitlements are transferred with them to the other public sector agency.

The term "resignation" is used to describe the situation where an officer of the Commission resigns from employment with the Commission to take up employment not within the New South Wales public sector. In this case, the person's leave and other entitlements are paid out.

Retention of staff

The Commission's rate of staff retention has improved. Total staff attrition for 2006-07 was 14, compared to 21 for 2005-06.

The details of staff attrition for 2006-07 are as follows:

- *Executive – one permanent staff member transferred to another public sector agency.*
- *Assessment and Resolution Division – four permanent staff resigned, one permanent staff member took a voluntary redundancy, and the secondments of two temporary staff came to an end.*
- *Investigation Division – three permanent staff transferred to another public sector agency, and two resigned.*
- *Legal Division – no staff attrition.*
- *Corporate Services – one permanent staff member resigned.*

24. Although the Annual Report states that the attrition of Commission staff in 2005-06 was "mainly attributed to the release of a number of temporary staff engaged in 2004–05 to undertake the Macarthur Investigation and clear the backlog of outstanding investigation cases", fifteen of the twenty-one staff who left the Commission during 2005-06 had been permanent staff members [p 58]. What effect has this loss of staff had on the effective operation of the Commission?

There was an attrition of 15.1 staff from 2004-05 to 2005-06. These were primarily the temporary staff engaged to undertake the Macarthur investigation

and clear the backlog of investigations. There was also an attrition of permanent staff in 2005-6.

As to the impact of the loss of the permanent staff on the effective operation of the Commission, the overall impact has been positive. The recruitment of a substantial number of new staff has brought "fresh blood" to the Commission, with a range of skills and experience well suited to the Commission's focus on the careful assessment, effective resolution and thorough investigation of complaints about health service providers.

25. How has the Commission's extension of its staff performance management system proceeded [p 63; see also 2005-06 *Corporate Plan*, p 13]?

As noted in the 2005-06 Annual Report, the Commission developed a performance management system that requires staff to prepare annual performance agreements that link individual performance targets to the Commission's objectives. Each performance agreement ties the responsibilities of the position to the key result areas of the relevant Division's business plan, thus ensuring appropriate levels of accountability for the delivery of the Commission's corporate objectives.

The staff performance management system was implemented across the Commission during 2006-07. It should be noted that 86% of all staff were rated fully competent or better in their performance reviews.