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

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

Response:

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

The Commission's objects

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

(1) The primary object of this Act is to establish the Health Care Complaints Commission as an independent body for the purposes of:

(a) receiving and assessing complaints … relating to health services and health service providers in New South Wales, and

(b) investigating and assessing whether any such complaint is serious and if so, whether it should be prosecuted, and

(c) prosecuting serious complaints, and

(d) resolving or overseeing the resolution of complaints.

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

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

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

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

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

Criteria for the investigation of complaints

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

> *The Commission must investigate a complaint:*
>
> *(a) if … the appropriate registration authority is of the opinion that the complaint should be investigated, or*
>
> *(b) if, following assessment of the complaint, it appears to the Commission that the complaint:*
>
> *(i) raises a significant issue of public health, or*
>
> *(ii) raises a significant question as to the appropriate care or treatment of a client by a health service provider, or*
>
> *(iii) if substantiated, would provide ground for disciplinary action against a health practitioner, or*
>
> *(iv) if substantiated, would involve gross negligence on the part of a health practitioner, or*

(v) if substantiated, would result in the health practitioner being found guilty of an offence under Division 3 of Part 2A of the Public Health Act 1991.[1]

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

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

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

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

De-registered practitioners

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

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

Persons subject to a prohibition order

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

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

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

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

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

Response:

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

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

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

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

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

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

- *having a financial interest in a health organisation or in the provision of health services, or having friends or relatives with such interests*
- *having or developing personal associations with a complainant or a health practitioner involved in a complaint to the Commission, that goes beyond the level of a professional work relationship*
- *accepting outside employment that may, or may appear to, compromise the integrity of the officer or the Commission*
- *participation in political matters that may relate to the affairs of the Commission.*

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

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

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

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

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

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

Response:

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

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

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

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

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

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

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

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

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

   Are officers rotated throughout the Commission?

Response:

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

- Assessment Officers – who are responsible for the handling of the assessment of individual complaints

- Resolution Officers – who are responsible for the assisted resolution of complaints where the Commission has, following assessment, determined that the complaint

does not warrant investigation, and that assisted resolution is the appropriate option for the handling of the complaint.

Resolution officers are also responsible for:

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

Assessment Officers

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

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

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

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

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

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

Resolution Officers

The caseload for Resolution Officers is as follows:

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

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

- A “resolution management plan” is developed. On this basis, various key steps for the resolution process, and timelines for completion of those steps, are created in Casemate.
- Casemate generates reports about the timelines involved in the handling of particular files, and in relation to overdue tasks.
- The Manager of the Resolution Service conducts supervision sessions every six weeks to review of the handling of all files being dealt with by the Resolution Officers. This session focuses on whether the resolution management plan has been followed; whether there has been compliance with the timelines for the completion of the tasks required; and the quality of the officer’s work. As part of the supervision session, the Manager also checks the accuracy and quality of five randomly audited inquiry calls recorded in Casemate.

- Following completion of the assisted resolution process (whether or not there has been a successful resolution of the matter), the Manager of the Resolution Service conducts a final audit of the file to ensure that all relevant data entry has been completed; that all relevant tasks have been completed; and that the outcome of the resolution process has been confirmed in writing to the parties to the complaint.

Rotation of officers

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

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

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

Response:

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

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

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

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

- Timeliness of the resolution process

  (Please note that the performance of the Resolution Service against this key performance indicator for 2006-07 is set out at page 41 of the annual report.)

- Percentage of Resolution Service clients satisfied with service

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

Response:

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

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

Response:

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

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

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

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

Response:

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

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

In November 2000, a previous Committee on the Health Care Complaints Commission prepared a report entitled "Report on mandatory reporting of medical negligence". The Committee noted by way of background to its report that section 80(1)(j) of the *Health Care Complaints Act* required the Commission to "investigate the frequency, type and nature of allegations made in legal proceedings of malpractice by health care providers", but that the Commission was unable to

perform this function because there were no legal obligations on individuals and organisations which held the relevant information to report it to the Commission (see page 10 of the Committee's report).

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