Executive Summary

1. Do you have any comment to make about the types of complaints referred to the Commission by Commissioner Garling, and the time taken to resolve those matters?

The Garling Inquiry into Acute Care in Public Hospitals referred 200 complaints to the Commission.

Types of complaints

The Commission identified 401 issues raised by these 200 complaints. The majority of issues related to:

- treatment – 53% of all issues
- communication and consent – 25% of all issues.

These percentages may be compared with the corresponding percentages of issues raised by all complaints received by the Commission in 2008-09:

- treatment – 40% of all issues
- communication and consent – 23% of all issues.

It should also be noted that issues relating to professional conduct represented only 0.02% of the issues raised by the complaints referred to the Commission by the Garling Inquiry. By way of contrast, of all the complaints received by the Commission in 2008-09, 10% raised issues of professional conduct

The above analysis reflects that the focus of the Garling Inquiry was on issues surrounding the provision of health services by public hospitals, and that the concerns expressed to the Garling Inquiry by members of the public generally concerned the quality of patient care and treatment by public hospitals and their staff, rather than issues of serious misconduct by individual health practitioners.

Timeframes

The Commission assessed 81.5% of the 200 complaints referred by the Garling Inquiry within the 60-day statutory time frame. By way of comparison, for all complaints received by the Commission in 2008-09, 88.9% were assessed within 60 days.

As noted in the annual report, of the complaints referred by the Garling Inquiry:

- 16 (8%) were resolved during the assessment process
- 72 (36%) were discontinued – that is, no further action was taken following assessment
- 13 (6.5%) were referred to the relevant registration board
- 69 (34.5%) were referred for assisted resolution
- 17 (8.5%) were referred for conciliation
- Eight (4%) were formally investigated.

Of the complaints referred for resolution processes, the average time taken to finalise the matters referred for assisted resolution was 144.6 days, compared to 84 days for the average resolution process in 2008-09. The average time taken to finalise the matters referred for conciliation was 171 days, compared to 160 days for other matters referred for conciliation in 2008-09. The average duration of the eight Commission investigations arising from the Garling Inquiry was 324 days, as compared to the general average investigation period of 274 days in 2008-09.

The longer time taken to handle complaints referred by the Garling Inquiry was due to a number of factors that prolonged the Commission's usual complaint-handling processes:

- All of the "complaints" referred to the Commission by the Garling Inquiry were in the form of transcripts of oral evidence given by witnesses to the Inquiry. It was not always clear from the transcript whether the person giving the evidence specifically wished to make a formal complaint about the public hospital(s) the subject of their evidence. In order to clarify this, the Commission needed to contact the witness. Where it emerged that a witness did wish to pursue the matter as a formal complaint, the Commission sent them a copy of the transcript of their evidence and asked them to sign the transcript and return it to the Commission. The Commission also invited them to provide any further relevant information and/or copy documents in support of the complaint.

- In some cases, the witness's evidence concerned the care and treatment of another person, such as a family member. In these cases, the Commission needed to contact the patient where possible to ascertain whether they wished to complain, and to clarify any concerns on their part.

- In some cases where evidence was given "in private"", the Garling Inquiry imposed a suppression order on publication of the transcript. The Commission therefore needed to seek and obtain a variation of the suppression order by Commissioner Garling, in order to be able to provide the transcript to the relevant health service provider(s) as a complaint that required a response in order to assist the Commission's assessment of the matter.

- Where the Commission had previously dealt with a complaint by a person who had, more recently, given evidence to the Garling Inquiry, the Commission had to obtain and examine the material on the existing complaint file, in order to determine whether relevant evidence had already been obtained.

2. Where cases cannot be assessed within the statutory 60 days, due to their complexity or the need to seek further particulars, what procedures does the Commission employ to keep the parties informed about progress?

Every complainant is advised of the name of the assessment officer handling their complaint and of the direct telephone number of that officer. Where there is a delay in the assessment process, the assessment officer is expected to advise the complainant of the delay, the reasons for the delay, and the anticipated time for completion of the assessment process.

Legislative changes

3. The Committee notes that the amendments of the Health Legislation Amendment Act 2009 came into force on 13 May 2009.

What, in practice, has been the impact of the amendments on the Commission's day-to-day work, particularly in relation to the provision of documents or evidence? Have they expedited the time taken to conduct investigations?

The legislative amendments have increased the capacity of the Investigations Division to obtain evidence from relevant witnesses, and this has expedited the Commission's investigations. However, because the Commission measures the timeliness of investigations generally, it is not possible to quantify the extent to which the exercise of the Commission's powers to require evidence from witnesses has contributed to the generally improving investigation timeframes.

The increase in the evidence available to the Commission has also assisted in the comprehensiveness and quality of the briefs referred by the Investigations Division to the Director of Proceedings to consider the prosecution of disciplinary proceedings against registered health practitioners.

4. The Annual Report (page 11) notes that: 'The amendments regarding legal representation are expected to commence in early 2010 following the development of practice notes guiding the procedures before Professional Committees'.

How frequently – if at all – do you anticipate having to rely on the assistance of legal counsel, and will this impact on the budget of the Legal Division?

The matters listed before Medical Board Professional Standards Committees from January 2010 to date are matters where the Commission's formal complaint had been referred to the PSC before the amendments about legal representation took effect. For this reason, it was thought that legal representation for the Commission and the respondent medical practitioner would not be possible. However, the Medical Board has advised that, if either or both of the parties wishes to be legally represented at a PSC hearing, the request for legal representation is likely to be granted.

There are 12 matters which fall within this category:

- Of the three matters that have already been heard, applications for legal representation were made in two. The Commission was legally represented in one matter, and a Commission hearing officer appeared in the other.

- Of the remaining nine matters, applications for legal representation were made in five. It is possible that applications for legal representation will be made in the remaining four matters.

Currently, it is intended that the Commission will brief counsel to appear in three matters, while a Commission hearing officer will appear in two matters and a Commission legal officer will appear in the remaining matter.

The use of legal representation by the Commission is higher than anticipated, as it appears that respondent practitioners are more frequently applying to be legally represented.

To date, there have been no PSC matters listed which fall entirely within the scheme established by the amendments. It is anticipated that, once the amendments take full effect, the majority of respondents in Medical PSCs will be legally represented.

In relation to the impact of the amendments regarding legal representation on the budget of the Legal Division – the Commission anticipates that the use of counsel will lead to increased legal costs being incurred by the Legal Division. The Commission will only brief "junior" counsel (that is, not Queens Counsel or Senior Counsel) in PSC matters, because such matters are generally of short duration and require much less preparation than Tribunal matters, and in order to keep costs to a reasonable level. The amount of costs paid to counsel will be kept under review by the Director of Proceedings and the Commissioner.

Currently, the Commission is required to employ both legal officers – who are legally qualified – and hearing officers – who are not legally qualified – because the relevant legislation does not permit legal representation before a Nursing and Midwives Board PSC. It is anticipated that, following the introduction of the national health registration scheme in July 2010, legal representation will be permitted in all PSCs.

5. The Annual Report (page 11) notes that: 'Amendments to the Medical Practice Act, designed to make hearings of Professional Standards Committees more transparent, came into operation in October 2008'.

Have the more transparent processes impacted upon your co-regulatory relationship with the Medical Board, and with regulatory authorities for the other professional groups? How would you evaluate overall the Commission's relationship with the professional standards committees over the past year?

The Commission has very sound working relationships with the Medical Board and the other health professional regulatory authorities. The increased transparency of Medical Board PSCs has not had any adverse impact on the Commission's relationship with the Medical Board.

6. What do you consider to be the likely effect of the amendments on the operations of the Commission's Legal Division?

The main impact of the amendments on the Commission's Legal Division has been in relation to the possibility of legal representation before Medical PSCs – see the Commission's detailed response to Question 4 above.

The Commission's hearings before Medical PSCs are now open to the public, which means that complainants, family members and other interested people can attend the hearing and see and hear the relevant witnesses – including the respondent practitioner – give their evidence.

The public reporting of decisions by Medical PSCs also means that interested parties can consider the evidence provided to the PSC, as well as the reasons for the PSC's decision. This allows officers of the Commission's Legal Division to provide much more information about the PSC proceedings and the PSC's decision to the complainant and other interested parties.

Outreach

7. The Annual Report notes a number of mechanisms for dealing with complainants who may have language difficulties.

Does the Commission actively recruit staff with multiple language qualifications? What measures are in place to ensure that those requiring assistance to make a complaint are satisfied with the service which they are offered?

The Commission has reviewed its recruitment processes to ensure that all position descriptions and job advertisements are written in plain English, and has removed any job requirements which might discourage people with language difficulties.

The Commission employs staff from a variety of backgrounds, and a number of Commission staff are able to speak in a language other than English – specifically, Italian, German, Spanish, Croatian, Macedonian, Serbian, Hindi, Punjabi, and Tagalog (Filipino). These staff have been identified and, where appropriate, are paid under the Community Language Allowance Scheme. These staff are available to assist complainants.

The Commission has a "translation kit" on its intranet which contains a list of all Commission staff who can speak a language other than English, as well as information about the interpreter and translation services available to the Commission.

The Commission assesses complainant satisfaction with its services by requesting complainants to complete and return a client satisfaction survey form at the completion of the Commission's handling of the matter. No special systems are in place to measure the satisfaction of complainants with language difficulties.

8. In addition to the outreach publications and activities referred to on page 13 of the Annual Report, does the Commission undertake any advertising of its services in the press or on air? Does the Commission conduct any advertising in local foreign language newspapers?

The Commission does not undertake any advertising of its services in the media. The primary reason for this is the high cost of such advertising. There is also the concern expressed by respondent practitioners that the Commission would be inappropriately "soliciting" complaints about health service providers.

The Commission has not advertised its services in local foreign language newspapers. However, in 2009-10, the Commission took the following steps to inform CALD communities of the Commission's role and functions:

- In January 2010, the Commission arranged for its brochure *"Concerned about your health care"* to be distributed, through the Community Relations Commission's email link, to community groups representing the ten most common language groups in NSW. The email also informed the community groups that the Commission could arrange presentations for them about the Commission's role.

- The Commission's Communications Officer has liaised with the NSW Migrant Settlement Programme run by the Department of Immigration and Citizenship. As a result, information about how people can make a complaint to the Commission has been included in the 2010 edition of the Department's booklet *"Beginning a life in Australia"*, which is translated into 37 languages and will be available on the

Department's website. In addition, the Commission has been invited to make a presentation about its services to providers of migrant settlement services at their next meeting in April 2010.

9. The Annual Report (page 13) notes that the Commission refers to the availability of the Code of Conduct for Unregistered Health Practitioners on its website and in printed form. Is there scope for further public education about the Code? If so, is there a specific strategy to undertake this?

The Commission continues to respond to inquiries, and to make presentations to the peak bodies representing the various unregistered health professions, about the Code of Conduct and the powers of the Commission to deal with inappropriate or improper conduct on the part of unregistered health service providers.

The Commission has also provided articles about these matters to the community organisations represented on the Commission's Consumer Consultative Committee, for inclusion in their communications to their members and clients.

The Commission's public statements and warnings about unregistered health service practitioners – including details of any prohibition order made by the Commission – are published on the Commission's website, and are promptly notified to relevant media outlets.

Finally, the Commission has recently been liaising with the *"Korean Times"* to include information for the Korean community on the Code of Conduct, and the Commission's role in dealing with patient complaints about unregistered health service providers.

10. The Annual Report (page 14) notes that 'The Commissioner started to write a regular column in "Australian Doctor", the leading publication for Australian general practitioners'. What feedback, if any, have you had from writing the column? What types of topics do you cover, and how do you select them?

The Commission has selected topics for its column in *"Australian Doctor"* on the basis of commonly occurring complaints. In 2009, the Commission provided columns covering the following topics:

- *Prescribing drugs of addiction, and how to deal with patients displaying drug seeking behaviour*
- *Boundary issues*
- *When young people can give their own consent to medical treatment*
- *Alternative health treatments and the obligations of GPs*
- *Can apologies prevent complaints?*
- *How the Commission uses experts to determine appropriate clinical standards*
- *The risk of missed diagnosis when treating long-term patients*
- *Mandatory reporting requirements*

While the Commission has not received any direct feedback in response to the columns, the Commission has been asked to continue providing columns on current topics in 2010. Planned topics for the column in 2010 include:

- *Follow-up of test results – whose responsibility is it?*
- *Delegating clinical tasks to nurses*
- *Explaining fees and costs to patients*
- *The Medicare dental scheme – when and who to refer*
- *Being sensitive when obtaining patient histories in relation to mental health, weight, and smoking history*
- *Different standards in rural settings?*
- *The difference between civil and disciplinary action against GPs*

11. The Annual Report (page 14) notes that 'The Commission has also engaged in closer consultation with the Clinical Excellence Commission by providing copies of investigation reports making recommendations for systemic changes'.

Can you give an example of the nature of the recommendations the Commission has made on systemic issues? Does the Commission have procedures to systematically record and communicate strategic issues to the CEC, and are they also communicated to other parties?

Since July 2009, the Commission has made a number of recommendations arising from the investigation of 21 health organisations. Examples of recommendations on systemic issues include recommendations relating to:

- clinical education for hospital staff in the regular recording and monitoring of vital signs
- audits of records of vital observations for quality and compliance
- revised referral protocols for access to acute pain services
- improved processes for the notification of critical results to clinicians
- improved processes for on-line access to laboratory results
- improved processes for ensuring that the consultant responsible for the co-ordination of psychiatric care is consistently involved in clinical decision-making.
- the recording of key decisions regarding psychiatric care in patient notes.

The CEC has advised that the Commission that it appreciates receiving copies of the Commission's reports, and that the recommendations relate to issues being addressed by the CEC.

The Commission records its recommendations so that they can be accessed to determine the recurrence of similar issues.

The Commission advises the parties to individual complaints – that is, the complainant and the health organisation the subject of investigation – of the Commission's recommendations. The Commission also notifies the Director-General of the Department of Health of all of the Commission's recommendations. The Director-General co-ordinates the Department's strategic response to the recommendations.

12. The Committee notes that, in January 2010, the Commission posted a series of eight short audio-visual presentations on its website. What feedback, if any, has the Commission received regarding these videos?

The Commission has received positive feedback about the video from the members of its Consumer Consultative Committee. The Commission has also used the video in its training sessions for expert advisers, and has received very positive feedback from the medical and nursing practitioners who attended the sessions.

In addition, the Commissioner of the Queensland Health Quality and Complaints Commission wrote to the Commission to say that the video *"is an excellent initiative, and I have forwarded it to the Chief Executive Officer to share with the HQCC staff"*. The Chairman of the Medical Oncology Group of Australia has also advised the Commission that he had found the video *"very informative and interesting"*.

Inquiry Service

13. The Committee is pleased to note the Ombudsman's positive finding in relation to the Mystery Shopper audit – in particular (page 24), that staff were "consistently professional and treated matters of sensitivity well and in a sympathetic manner. Furthermore, their responses to the letters and emails were 'of a very high standard, providing detailed and relevant information'".

What training is provided to Resolution Officers? How often is it provided?

Is training tailored to the needs of each division, and is it contained within the separate divisions or is it across the organisation?

Training for Resolution Officers

The Commission's Inquiry Service is staffed by the Commission's Resolution Officers. These are senior officers (grade 7/8) who have had many years of experience in dispute resolution. The Resolution Service team has been very stable, and there are many officers in the team with extensive corporate knowledge who have received training in resolution processes over the years.

The Resolution Officers meet at the Commission on a monthly basis, and their training is ongoing. At each meeting, two resolution cases are presented, and then reviewed by the whole group. This allows for the sharing of information and resolution strategies, and the improvement of skills by reflecting on "what worked and what didn't" and identifying how service could be improved in the future.

Another standing agenda item is a review of the challenges encountered by the Inquiry Service over the previous month. This ensures the constant review of performance, and suggestions for improvement.

Resolution Officers also have specific training days on a quarterly basis. Resolution Officers who have particular expertise often provide training to their colleagues. Topics discussed range from new internal policies and procedures, to presentations by organisations such as the Office of Fair Trading that are relevant to the work of the Resolution Officers. The most recent training day in February 2010 concentrated on improving services to the inmates of corrective services. Staff from Justice Health and the Corrective Services Unit of the Ombudsman's office gave presentations and discussed relevant issues. This has improved

the understanding of what these organisations do, clarified appropriate referral strategies, and prompted suggestions on how to improve the Commission's services.

Resolution Officers have also been provided with external training opportunities. For example, in the past year, two officers completed their accreditation as mediators with the Australian Commercial Disputes Centre.

Training generally

The Commission provides training and development activities to maintain and increase the capabilities, knowledge and experience of its staff. The Commission ensures that staff are professionally and technically proficient to meet their position's operational accountabilities and the Commission's corporate and strategic plans and objectives.

The training delivered to support theses objectives covers the following:

Divisional training

Training is tailored to meet the overall requirements of each Division by focussing on the skills needed by positions within the Division, based on functional and operational requirements.

The nature of the training for Resolution Officers has been outlined above. Investigation Officers receive specialist training, including external investigation skills training delivered by the NSW Police Force.

Commission-wide mandatory training

Other important forms of training include training sessions that fall into the Commission-wide mandatory training category – the Commission requires all staff to undertake the training. This includes training sessions on:

- the Code of Conduct
- occupational health and safety (OH&S)
- equal employment opportunities and diversity (EEO).

Commission-wide non-mandatory training

Other forms of Commission-wide training include:

- Casemate training
- IT training
- plain English writing skills
- merit selection
- the senior managers leadership program.

Individual competency training and development

The Commission supports staff attending training sessions to develop their individual capabilities, as identified by the staff member and agreed to by their manager in individual learning and development plans.

Development activities provided by the Commission include:

- job relevant training
- refresher courses
- new skills training

- participation in corporate activities
- opportunities to do work at a similar or higher grade within the Commission, or on secondment to other agencies
- training where performance has been identified as inadequate
- other career development opportunities relevant to the work of the Commission.

14. Given that during 2008-09 there were 11.8% more inquiries than 2007-08 and 24.5% more than 2006-07, to what does the Commission attribute this increase? What measures has the Commission taken to handle this increasing volume of inquiries?

The Commission is unable to clearly identify the reasons for the increased volume of inquiries. The increase may be due to a number of factors, including media publicity about the health system, and greater awareness of the Commission's role and the rights of health consumers to complain about health service provision.

The Commission's Inquiry Service has handled the increase within their existing resources.

Assessing complaints

15. How do you communicate the outcome of reviews to complainants?

The outcomes of reviews are communicated in detailed letters to complainants that explain the review process, the consideration given to the available evidence, and the reasons for the determination reached after review.

16. Has the Client Satisfaction Survey provided the Commission with any indication about clients' satisfaction with the review process?

The Commission does not send client satisfaction surveys to complainants who request reviews. The request for review indicates dissatisfaction on the part of the complainant with the original assessment decision – as 96% of the reviews in 2008-09 confirmed the original assessment decision, the majority of those requesting review are likely to remain dissatisfied.

Having considered the Commission's question, the Commission will consider introducing client satisfaction surveys for the review process which may help in ascertaining whether the review process and the reasons for review decisions are adequately explained.

17. How does the Commission explain the relatively low overall level of satisfaction with the complaint assessment process among complainants? What measures are being taken by the Commission to raise complainants' overall satisfaction levels in this regard?

The largest single category of assessment decisions (38.5% in 2008-09) involved "discontinuing" the matter – that is, taking no further action on the complaint. In these circumstances, the 61.3% of those responding to the client satisfaction survey saying that they were generally satisfied with the Commission's handling of their complaint is not a bad result.

The higher levels of complainant satisfaction with the resolution, conciliation and investigation processes reflect the higher level of resources committed by the Commission to the handling of these processes.

The Commission has put considerable effort into training its Assessment Officers to fully explain to complainants the assessment process, and the reasons for the assessment decision on their complaint.

18. The Annual Report notes that the survey response rates were as follows:

- ***Page 29: 'The response rate was 16.5% for complainants and 12.2% for providers who were sent a survey' (survey sent with assessment decision letters)***

- ***Page 33: 'The response rate was 29.3% for complainants and 27.7% for providers who were sent a survey' (Resolution Service)***

- ***Page 45: 'The response rate was 17.6% for complainants and 4.3% for providers who were sent a survey' (Investigations Division)***

Has the Commission explored avenues to attain a higher response rate to its surveys in order to attain more useful data to improve its services?

Response rates to surveys are high in conciliation, because the people attending the conciliation meeting are provided with the survey directly after the meeting. This approach is not possible with other processes, such as assessment, assisted resolution, and investigation.

The Commission's Communications Officer reviews the comments made by health service consumers and providers in their survey responses, and follows the comments up with the relevant case officers. If there appear to be grounds for systemic improvement, these are discussed with the relevant managers and directors; where appropriate, improvements to practice and procedure and/or or training have been initiated.

The Commission is considering offering electronic email surveys to parties to complaints in future, subject to the technical upgrade of its internet page.

Resolving complaints

19. The Annual Report (page 31) notes that 'The Resolution Service deals with complaints that have been assessed as being suitable for assisted resolution … Of the nine Resolution Officers, five are located in the Sydney metropolitan area, while the other four are in regional areas, based in Newcastle, Dubbo, Lismore and, since August 2008, in Queanbeyan. There is now a Resolution Officer located in each of the Area Health Services across the State'.

Do you consider more could be done to broker complaints at the local level? Are the Resolution Officers sufficiently accessible, and how do you publicise their availability?

The Resolution Officers are accessible to the public through the Commission's Inquiry Service, and do much to broker the resolution of complaints at the local level. In 2008-09, Resolution Officers:

- referred over 800 callers to other bodies that could assist them to resolve their concerns
- discussed strategies for the local resolution of health concerns with 1,800 callers
- assisted over 1,000 callers by phoning health services to pass on the caller's concerns, and to facilitate/encourage direct contact between the caller and the service.

Two of the Resolution Officers are in offices at Mt Druitt and Liverpool, and another four positions are in regional locations – Newcastle, Lismore, Dubbo, and Queanbeyan (currently the Queanbeyan position is not filled because a recent recruitment process did not attract a suitable candidate; the position will be advertised again in the near future). People can visit Resolution Officers at these sites; this is particularly helpful where a complaint has been referred to the Resolution Officer for assisted resolution, and it is beneficial to have a face-to-face meeting with the complainant to discuss their complaint.

The Commission publicises the Inquiry Service – and, in particular, how Resolution Officers can assist with resolving complaints – through its website and publications, as well as through the Commission's presentations to community groups.

20. To what would you attribute the fact that the Resolution Service completed only 63.6% of resolution plans within the target time of 21 days? What measures are being taken to improve performance in this regard?

The Resolution Officers develop a resolution management plan where the parties to the complaint have consented to the resolution process.

The main reason for not completing the resolution plan within the 21-day target timeframe is delay in obtaining consent from the parties. Consent can be delayed for the following reasons that are beyond the control of the Resolution Service:

- The Resolution Officer has to write to people who do not have a telephone or who have not provided their telephone number to the Commission – this is the case with almost all referrals of complaints from corrective service inmates and is often the case for people who prefer to communicate in writing because of their illness.

- Where the complainant is dissatisfied with the Commission's decision to refer their complaint for assisted resolution. Following the Commission's initial discussions with the complainant about possible outcomes of the resolution process and encouragement to engage in the process, complainants often requests time to consider whether they will request a review of the assessment decision rather than engage in the resolution process.

- Where the complainant wishes to consult with other family members or their legal adviser before consenting to assisted resolution

- Some of the complaints referred for assisted resolution concern events that have resulted in the death of a family member. The complainants are often immersed in grief and need time to understand why the Commission is not investigating their complaint before they are prepared to consent to engage in assisted resolution.

- In some cases, the Commission has not received a response from the health service provider before the assessment process is concluded. Some complainants wish to await receipt of the health service provider's response before considering their options and consenting to assisted resolution.

- Complainants and practitioners may be on leave when the complaint is referred to the Resolution Service, so it is not possible to contact them within the 21-day timeframe.

The Commission has emphasised to its Resolution Officers the need for timely contact with the parties and appropriate follow-up – these being matters within the control of the Resolution Officer. More recently, emphasis has also been given to the need for Resolution Officers to obtain a reasonably prompt decision by the parties on whether they are prepared to engage in the assisted resolution process. This has led to a higher number of complainants and providers not consenting to resolution than was previously the case; however, if the complainant seeks a review of the Commission's assessment decision and the original decision is confirmed, most complainants are again offered the opportunity to engage in a resolution process.

Investigating complaints

21. The Committee is pleased to note the improvement in the timely completion of complaint investigations. What is the Commission doing to ensure it continues to increase its efficiency in this regard?

To increase the efficiency and timeliness of its investigations, the Commission has adopted measures such as:

- ongoing training for investigation officers in good investigative practices
- the streamlining of its evidence-gathering processes
- the development of a report-writing framework.

Greater emphasis has been placed on weekly manager/staff investigation reviews and stringent monthly reporting processes. These have been linked to performance plans for investigators and managers alike, to ensure compliance with the Investigation Division's Business Plan.

In addition, workshops have been conducted to review all of the Investigation Division's processes, in order to identify areas of improvement and to promote staff engagement in a quality improvement culture.

Appendices

22. The Annual Report (page 86) notes that 'All staff have completed performance agreements that are reviewed annually. More than 92.6% of Commission staff were rated as competent or better'.

In what ways did those Commission staff not rated as competent or better fail to meet performance criteria? What has the Commission done to improve the performance of these employees?

The Commission has a Commission-wide performance management system (PMS) which requires each staff member to have in place a performance agreement and a learning and development plan. The PMS requires, as a minimum, then annual assessment of a staff member's performance against the identified measures and targets, the position's accountabilities and Commission-wide competencies, as outlined in the performance agreement.

There may be a number of reasons why a staff member fails to meet the performance requirements associated with their position as outlined in their performance agreement, such as:

- lacking particular knowledge or skills in an area where further training is required to get them "up to speed"
- an inability to perform some inherent aspect of their job, such as those relating to prioritisation, organisation and/or output
- producing poor quality work.

Poor performance can also stem from short-term personal issues or illness, or poor job fit.

The Commission makes every effort to determine the true causes of poor performance, so that these matters may be addressed and unsatisfactory performance not repeated, or performance factors outside the control of the staff member such as illness are acknowledged.

When performance is not to the level expected, it is Commission practice, as soon as the issue is identified, for the relevant manager to inform the employee that they are not meeting expectations. Often a combination of measures is used to assist the employee to increase their performance to a competent level. These measures may include:

- scheduling more regular feedback sessions with their manager
- closer supervision
- mentoring and coaching from other staff members
- if necessary, the development of a performance improvement plan, which could contain a combination of the above measures, as agreed to by the manager and the employee.

23. What have been the main challenges with privacy management for the Commission? How do you train staff in managing privacy issues?

The Commission receives a great deal of confidential private health information in the performance of its functions. In the course of its handling of complaints, the Commission is required to disclose private health information – for example, when obtaining expert opinions and gathering further evidence.

The statutory framework appears to provide an appropriate balance between legitimate privacy considerations and the effective performance of the Commission's functions.

The Commission has effective information security, both in handling hard copy information and through the protection of its information technology systems. Staff are well aware of the sensitivity of the information held by the Commission, and are continually reminded of it. Induction procedures also cover these issues.

Having regard to the volume of information dealt with by the Commission, it should also be noted that, in 2008-09, the Commission received only two complaints alleging a breach of privacy by the Commission (reported at page 87 of the Annual Report).

24. According to Table 17.2 (page 90), titled 'Staff numbers by employment category 2005-06 to 2008-09', the Commission was operating in 2008-09 with fewer staff than in the 2007-08 year.

Do you consider that the Commission's current staffing is adequate to pursue the outreach aspects of your activities, in addition to your complaint-handling functions?

What were the reasons for six resignations in the previous year?

Currently, the majority of the Commission's outreach presentations are undertaken by the Resolution Officers. As well as conducting outreach activities across NSW, Resolution Officers are responsible for responding to inquiries, dealing with complaints referred for assisted resolution, and reviewing assessment decisions.

The increase in the number of inquiries received, and the higher number of complaints being referred for assisted resolution, have limited the resources that can be directed to outreach activities.

The six staff who resigned from the Commission in 2008-09 did so for the following reasons:

- retirement
- moved from Sydney to rural NSW
- moved to the United States of America
- obtained a position at another agency
- obtained a position in the private sector
- took up university studies.

25. The Annual Report notes at Table 17.4 (page 91) that the Commission has achieved all targets for employment of people with a disability.

Specifically, how has the Commission achieved its targets for the employment of people with a disability? What measures does the Commission intend to take in the future through the Disability Action Plan to ensure that it continues to achieve these targets?

The Commission has ensured that it has in place measures to collect, store and accurately report on employee data relating to disability and the other EEO bench mark groups. 100% of Commission staff are included in the data gathering and reporting. To ensure that the Commission is accurately and contemporarily reporting disability data (the only benchmark group likely to change following an employee's initial data collection), the Commission annually requests staff to review their data in this area. To assist with this review, the Commission provides employees with a reminder about what is meant and covered by the definition of "disability". Consequently, data on disability is updated annually before being reported in the Commission's annual report.

The Commission promotes flexible working arrangements as part of the recruitment information contained on its website. Commission staff who convene recruitment panels are trained in merit selection techniques – this training provides a comprehensive knowledge of selection techniques in relation to EEO groups.

In the past, the Commission has also participated in affirmative action programs for the employment of staff with a disability, and has permanently employed staff as a result of this program.

The various measures in the Commission's Disability Action Plan that will be used to assist the Commission to continue to support the achievement of the target include:

- reviewing the Commission's policy on "Employment of People with Disabilities"
- reviewing the Commission's recruitment policies and procedures, and the job applicant information packages, to ensure that they are free from discrimination and address the needs of people with a disability
- reviewing current recruitment processes (for example, the wording of advertisements) to attract applications from people with a disability
- exploring options for advertising suitable job vacancies through Disability Networks
- the inclusion of TTY facilities in job vacancies
- merit selection training/refresher training to be undertaken by identified staff
- merit selection training to be undertaken by all new managers.
- the inclusion of disability awareness as a subject in external merit selection training
- ensuring that the principles of reasonable adjustment are addressed for people with a disability during the job interview process and related appointment stages.

To assist with the Commission's retention of staff with a disability, the following measures have been identified in the Disability Action Plan and will be applied:

- monitoring the Commission's Exit Questionnaire, and addressing the reasons for staff with a disability leaving the Commission.
- ensuring that all facilities leased or managed by the Commission continue to comply with the Building Code of Australia and Australian Standards for access and mobility
- ensuring that any reviews of the design of the Commission's website and intranet address the issue of people with a disability, and are in line with NSW Government Website Style Documents, to ensuring access capability
- monitoring EEO data collected from new staff to ensure disability issues and/or work-related adjustments that are identified are addressed and actioned.

26. How, specifically, is the Commission's Aboriginal Service Plan aiming to address Aboriginal issues in the key areas of service planning and delivery and staffing requirements?

The Aboriginal Service Plan commits the Commission to participation in the "Good Service Mob", a collaboration of Indigenous and non-Indigenous staff from nine complaint-handling agencies in NSW. As noted in the annual report, the Commission participated in seven "Good Service" forums in 2008-09. These forums were specifically aimed at providing support to members of Indigenous communities in accessing complaint services, including those of the Commission.

In addition, one of the members of the Commission's Consumer Consultative Committee is a representative of the Aboriginal Medical Health and Research Council.

The Commission will continue to hold and fill an identified Aboriginal and Torres Strait Islander Complaints Resolution Officer position.

Other

27. The Committee notes that the NSW Ombudsman maintains that a key focus of that body's work is 'to build a culture where complaints are seen as a positive and critical component of service improvement' (NSW Ombudsman Annual Report 2008-2009, page 61).

What strategies, if any, are now in place to help build a culture within the healthcare professions where complaints are seen as a positive and critical component of service improvement?

The Commission offers a variety of information for health providers on its website – including tips on how to respond appropriately to patient complaints. The Commission also makes regular presentations to health professionals in which it highlights complaint prevention and resolution strategies to encourage them to resolve patient complaints themselves where possible.

The Commission visits the Area Health Services and meets with their complaint-handling staff to discuss their practices in responding to complaints and their interaction with the Commission.

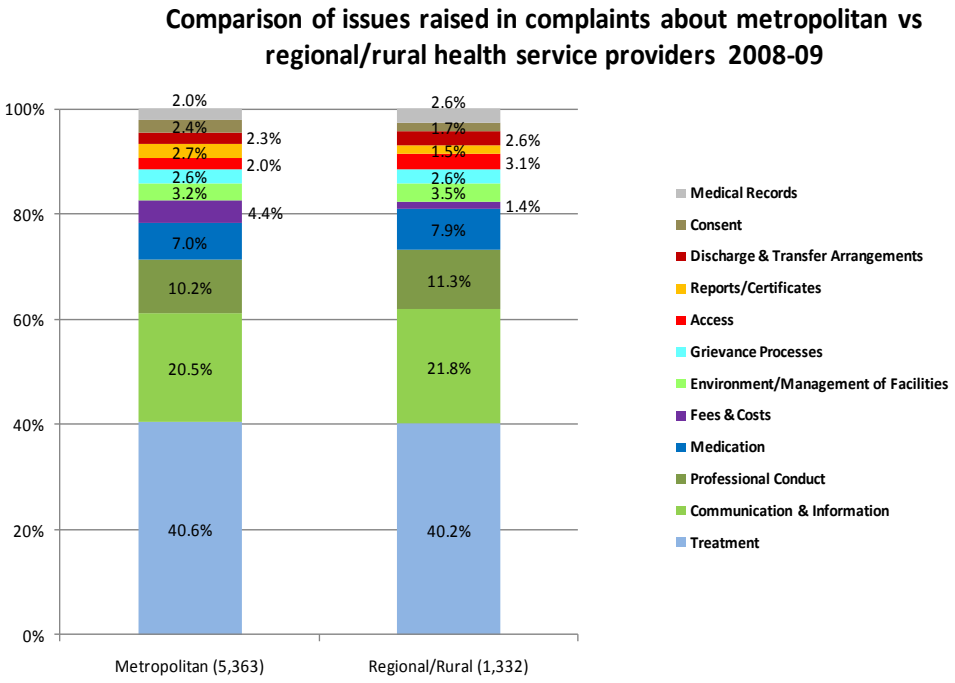
The Commission supports the "open disclosure" principle. The Commission's submission to the review by the Health Department of the privilege conferred on information obtained through root cause analysis (RCA) urged greater transparency with patients and their families in relation to incidents the subject of RCAs.

Through the Commission's website information and brochures for health consumers, *"'Concerned about your health care?"* and *"'Resolve concerns about your health care"*, the Commission encourages patients to try to resolve their concerns directly with their health service provider. The Commission's Inquiry Service also advises people on how to raise their concerns directly with their health service provider, with a view to a resolution of these concerns without the need to lodge a formal complaint.

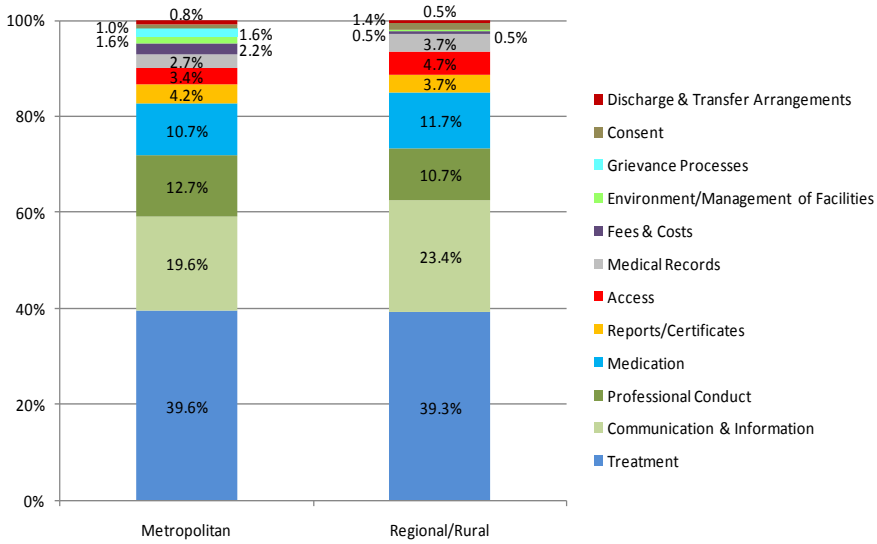
28. Last year, the Committee raised the issue of complaints about the difficulty of accessing GPs in rural areas. It was suggested that a breakdown of complaints by postcode might be useful.

Have you been able to look further into this? Are many complaints received about accessing GPs in rural areas?

The Commission has conducted an analysis of the complaints that it received in 2008-09 to identify whether there were any significant differences between complaints about metropolitan health service providers and those about rural and regional health service providers. As illustrated in the charts below, there appear to be no major differences in the type of issues raised in the complaints. This initial analysis appeared to show no statistically significant pattern, and there would have been considerable resources involved in the Commission conducting a further breakdown of the data by reference to metropolitan/rural postcodes.



Issues raised in complaints about General Practitioners by region 2008-09



AREA HEALTH SERVICE MAPPING

Northern Sydney AHS	Northern Sydney/Central Coast AHS	Metropolitan
Central Coast AHS	Northern Sydney/Central Coast AHS	Metropolitan
Western Sydney AHS	Sydney West AHS	Metropolitan
Wentworth AHS	Sydney West AHS	Metropolitan
Central Sydney AHS	South Western Sydney AHS	Metropolitan
Sydney South West AHS	South Western Sydney AHS	Metropolitan
Illawarra AHS	South Eastern Sydney/Illawarra AHS	Metropolitan
South Eastern Sydney AHS	South Eastern Sydney/Illawarra AHS	Metropolitan
Northern Rivers HS	North Coast AHS	Regional/Rural
Mid North Coast AHS	North Coast AHS	Regional/Rural
Macquarie AHS	Greater Western AHS	Regional/Rural
Far West AHS	Greater Western AHS	Regional/Rural
Mid Western HS	Greater Western AHS	Regional/Rural
Southern AHS	Greater Southern AHS	Regional/Rural
Greater Murray AHS	Greater Southern AHS	Regional/Rural
New England AHS	Hunter/New England AHS	Regional/Rural
Justice Health Service	Justice Health Service	Other
Interstate	Interstate	Other
Unknown/Other	Unknown/Other	Other