HEALTH CARE COMPLAINTS COMMISSION

Our ref: AF1347
Your ref: LAC11/320

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Committee on the Health Care Complaints Commission
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Dear Mrs Williams

Inquiry into Health Care Complaints Commission's Annual Reports 2009–10 and 2010–11

Thank you for your letter of 31 January 2012 enclosing questions on notice for the Committee's forthcoming hearing on Monday 20 February 2012.

The Commission's response to the questions on notice is attached.

Yours sincerely

Kieran Pehm
Commissioner

10 FEB 2012

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Health Care Complaints Commission response to Questions on Notice in relation to the inquiry into the Health Care Complaints Commission's 2009–10 and 2010–11 Annual Reports

Changes to assessment process

1. *In regard to the new process of assessing more complaints only on the basis of information provided in the complaint, on page 24 of the 2010/11 Annual Report it states that '[W]here it is clear that the complaint is likely to be discontinued, the Commission does not seek a response from health service providers, or call complainants to explain and discuss the decision.' What is the process for making this decision and who makes the final decision?*

Response:

The recommendation to discontinue a complaint without seeking a response from a health service provider is made by the Manager, Assessments when each complaint is received, reviewed and issues identified. The complaint is then assessed by the Commission's Assessment Committee, which includes the Commissioner and the Director, Assessments and Resolution. At the assessment meeting the Commissioner signs off on the Commission's decision to discontinue the complaint without seeking a response.

If the complaint is about a registered health practitioner, the Commission consults with the relevant registration council, as required under the *Health Care Complaints Act 1993*. The council also confirms the decision to discontinue the complaint without seeking a response.

Financial Performance

2. *What funding and resources does the Commission require to meet the current challenges and ensure it maintains adequate staffing levels to maintain a high level of quality service into the future? Should the Commission's request for capital funding to replace the Commission's information and communications technology during 2012/13 be unsuccessful, what potential impact would this have on the work of the Commission?*

Response:

Following the rearrangement of government departments and statutory bodies into clusters in April 2011, the Commission is now included in the health cluster and is negotiating with the Ministry of Health in relation to its ongoing funding. The Commission is confident it will receive adequate resources to perform its role and maintain its current service levels.

The Commission also expects that its bid for additional capital funding to replace its information and communications technology during 2012–13 will be successful. If it is not, the Commission will need to find to the additional funding out of allocated resources.

National Registration Scheme

3. *The new registration scheme started on 1 July 2010 and has now been in operation for around 18 months. Are there any issues you would like to raise in light of the Commission's experience to date with complaints handling within the new scheme? What feedback has the Commission received from the Australian Health Practitioner*

Regulation Agency, the NSW professional councils, about the Commission and complaints handling processes generally?

Response:

There are no major issues the Commission believes need raising in relation to its working relationship with the Australian Health Practitioner Regulation Agency (AHPRA) or the Health Professional Councils Authority (HPCA) since the introduction of the national registration scheme for health professionals. While there were some early teething problems with the scheme, for example the referral of 'notifications' from AHPRA to the Commission, this is no longer an ongoing issue.

The transition to a national registration scheme had no discernable impact on the Commission's complaint handling work, which is governed by the *Health Care Complaints Act*. The co–regulatory relationships between the Commission and the health registration authorities were maintained, however the old NSW boards were terminated and the NSW councils established in their place. The Commission's requirements to notify and consult with the health registration authorities on complaints did not change.

The Commission has productive relationships with AHPRA and HPCA. The Commission, HPCA and AHPRA meet regularly and raise issues as they arise and work together to deal with these constructively. In addition, the Commission and the NSW councils meet to consult on complaints. Any business issues are discussed at these consultation meetings.

4. *Given the establishment of professional councils in NSW as part of the Commission's co–regulatory relationship with the health professional boards, can you advise the Committee how this structure impacts on the work of the Commission and how it compares to other jurisdictions that do not have a separate complaints investigative agency like the HCCC? Does it lead to double handling and duplication which may in turn affect the reporting of the number of complaints received?*

Response:

As noted above, the establishment of the professional councils in NSW did not impact on the Commission's complaint–handling functions, as the new professional councils merely replaced the existing NSW registration boards. Other jurisdictions also have complaints handling entities, which are defined in the *Health Practitioner Regulation National Law* as follows:

> ***health complaints entity*** means an entity—
>
> (a) that is established by or under an Act of a participating jurisdiction; and
> (b) whose functions include conciliating, investigating and resolving complaints made against health service providers and investigating failures in the health system.

In their handling of complaints, these health complaints entities consult with national registration boards, similar to the NSW system where the Commission consults with the NSW professional councils. In other jurisdictions, where a complaint raises issues of professional conduct, health or performance, the complaint is referred to the board for investigation. In NSW, it would be investigated by the Commission.

The Commission has an obligation under section 95(1)a of the *Health Care Complaints Act* to report annually on 'the number and type of complaints made to it during the year' and 'the number and type of complaints assessed by the Commission during the year'.

All notifications and complaints received by each NSW councils are notified to, and consulted

on with the Commission. If the Commission and council determine that a notification raises issues of health or performance and is not a complaint, the Commission treats it as a notification only. No further action is taken by the Commission and it is not included in the Commission's count of complaints received. The matter is then handled by the council under section 145B(1) of the *Health Practitioner Regulation National Law (NSW).* Action taken by the council may include: referring the practitioner for a health assessment; referring the matter to an Impaired Registrants Panel; or referring the practitioner concerned for a performance assessment. A council may subsequently make a complaint to the Commission regarding a notification.

Only complaints are included in the Commission's count of complaints received. When a complaint is assessed by the Commission and Council as suitable for referral to the council, the Commission reports this as an outcome of the assessment of complaints in its Annual Report. There is no double counting by the Commission.

Under section 41H(1) of the *Health Practitioner Regulation National Law (NSW),* the NSW professional councils have an obligation to report a number of particulars in relation to complaints about registered health practitioners, including:

- complaints received by the Council during the year
- the results of any action taken during the year in relation to complaints received
- matters referred to a Performance Review Panel for performance review
- the results of all performance reviews conducted and finalised by Performance Review Panels.

In addition, the Commission is contributing to a three–year research project currently being conducted through the University of Sydney, which compares the handling of complaints against medical practitioners, nurses and midwifes, dental practitioners, psychologists and pharmacists under the National Law in NSW to the handling of such complastins in other jurisdictions. This research will specifically look at the difference in complaints management due to the unique co–regulatory structure in NSW.

Establishment of new Local Health Districts and Speciality Networks

5. *With the reorganisation of Area Health Services into 17 Local Health Districts and Speciality Networks – page 4 of the 2009/10 Annual Report and pages 5 and 28 of the 2010/11 report – the report comments that the HCCC would be working to strengthen relationships and educate them about the Commission's role and functions. How is the Commission doing this; what has been achieved to date and what plans for the future; what challenges has the Commission had to overcome? With the establishment of the Sydney Children's Hospital Network, is the Commission undertaking any specific activities with these hospitals, and with parents and young people to make them aware of the Commission's role and responsibilities?*

Response:

The Commission has established working relationships with complaint–handling staff in each of the Local Health Districts through dealing with complaints about public health organisations. On Monday 5 March 2012, the Commission is holding a full–day training to all complaint–handling staff from the Local Health Districts, excluding the Ambulance Service and Justice Health due to the specific nature of complaint–handling within these organisations. To date, over 200 participants have registered, and nine remote sites will be linked into the training day via video conference.

The event is intended to familiarise relevant District staff with the Commission's complaint handling process and the co–regulatory arrangements with the NSW Professional Councils. It will also provide the opportunity to share best practice across the Districts. The HPCA will also present at, and contribute to, the training day.

The Commission will tailor its future outreach activities to the specific needs of the Local Health Districts, which will be identified in the feedback from participants on this day.

The Sydney Children's Hospital Network has confirmed its attendance at the information day.

Complaints against health practitioners

6. *Both the 2009/10 and 2010/11 annual reports, and earlier reports, show that as a proportion of complaints against all health practitioners, complaints about medical practitioners have decreased over the past five years, and complaints about psychologists decreased by 14.4 per cent in 2010/11. Can the Commission provide any insight to account for the decrease – are medical practitioners getting the message from the Commission and other agencies such as the Clinical Excellence Commission?*

Response:

The reasons behind the decrease in the proportion of complaints against medical practitioners (and psychologists) are variable and a number of factors could be relevant. The Commission is not able to determine the specific reasons for these decreases.

Notifiable conduct

7. *Have you seen any increase in the number of health practitioners notifying the Commission or the appropriate council about health practitioners they believe to be engaging in 'notifiable conduct'? Do you believe health practitioners are now more informed about complaint handling procedures and willing to report inappropriate behaviour and practices?*

Response:

Under section 140 of the *Health Practitioner Regulation National Law (NSW)* registered health practitioners are required to notify AHPRA of 'notifiable conduct'. There is no requirement for mandatory notifications to be made to the Commission or to a NSW council. In practice, AHPRA refers all notifications regarding registered health practitioners whose principal place of practice is in NSW to the relevant council and to the Commission for consideration. The Commission then consults with the council to determine whether the council wants to make a complaint regarding the conduct the subject of the mandatory notification.

The Commission has separately identified these mandatory notifications in its complaint database since 1 July 2011. Given that the data has only been recorded for seven months, the Commission is not able to comment on any increase or decrease in mandatory notifications.

AHPRA has included some information on the number of mandatory notifications received in its annual report, however these figures are only for one year, so cannot be used to determine any increase or decrease.

Other types of notifications are received by the Commission that do not meet the criteria for mandatory notification under section 140 of the *Health Practitioner Regulation National Law (NSW).* These include:

- Self notifications where a practitioner advises the Commission of a recent diagnosis, such as a psychotic episode
- Notifications from public health employers advising that they have been made aware of possible conduct or impairment issues, however these require more information before a formal complaint is made
- Advice from police regarding criminal conduct, where the Commission is requested to not act on the advice as it may compromise the Police investigation
- Notifications from the Commonwealth Government advising of an investigation into a nursing home, where there is no evidence of inappropriate conduct by individual health practitioners

Table 7.1 shows the increase in these types of notifications is since 2007–08.

Table 7.1 – Notifications received 2007–08 to 2010–11

2007–08	2008–09	2009–10	2010–11
			9
			10
			4
1	5		
242	263	265	349
243	**268**	**265**	**372**

It should also be noted that mandatory notifications are required by employers and education providers – it is difficult to assess the extent of registered health practitioners' willingness to report.

Treatment related issues

8. *In the 2010/11 report, Chart 6.1 on page 11 indicates that treatment related issues raised in all complaints to the Commission has almost doubled from 2,504 in 2009/10 to 4,048 in 2010/11. How does the Commission account for this increase?*

Response:

In 2010–11, the Commission received 4,104 complaints raising 8,288 issues – an average of 2.0 issues per complaint. This should be compared to the figures for 2009–10 where 3,515 complaints raised 5,841 issues, an average of 1.7 issues per complaint.

While the increase in number of complaints raising treatment related issues from 2,504 in 2009–10 to 4,048 in 2010–11 was significant (61.1%), the increase in the proportion of complaints raising treatment issues was only 13.8% – from 42.9% of all issues raised in complaints in 2009–10 to 48.8% in 2010–11.

Complaints about public hospitals

9. *How do you account for the 24.3% increase in complaints about public hospitals – noting that as a proportion of all complaints received, complaints about public*

hospitals has 'remained relatively constant over the past five years, at just under 50%.' Is this a sign of an increased awareness in the community about the role and function of the Commission or a sign of deterioration in the provision of health services by the public hospital system?

Response:

Again, it is difficult for the Commission to speculate on the reasons behind the increase in complaints about public hospitals.

One factor that may account for an increase is the greater employment by public health organisations of Root Cause Analysis (RCA) and open disclosure to patients in relation to adverse events. These processes often raise further questions that patients and their families want answered.

There does appear to be greater awareness of the Commission, perhaps due to increased media coverage of adverse events, the increased reporting of Commission prosecutions and the 2008 Special Commission of Inquiry into Acute Care (the 'Garling Commission').

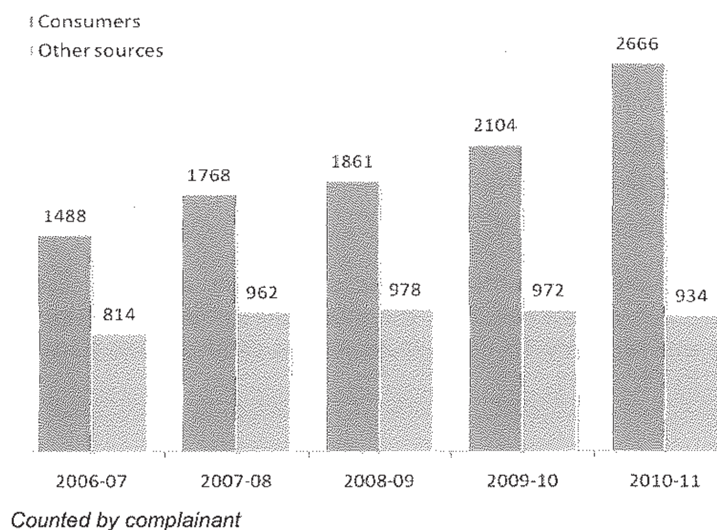
The Commission is not able to confirm if the increase in complaints about public hospitals is due to an increase in consumer awareness or a sign of deterioration. However, a number of indicators do show that there has been an increase in consumer awareness of the Commission. These were addressed in the Commission's recent submission into the Committee's inquiry into health care complaints and complaints handling in NSW. The following is an extract from this response.

Increase in the proportion of complaints received by consumers

Complaints to the Commission have increased significantly over the past five years. One measure of whether consumer awareness of the Commission has improved is shown by the increasing number and proportion of complaints received by consumers compared to other sources, such as professional councils, other health professionals and government departments.

Chart 6 shows the increase in the number of complaints received by consumers from 2006–07 to 2010–11. The proportion of complaints received by consumers increased from 64.6 % of all complaint in 2006–07 to 74.1% in 2010–11.

Chart 6 – Complaints received by consumers (2006–07 to 2010–11)



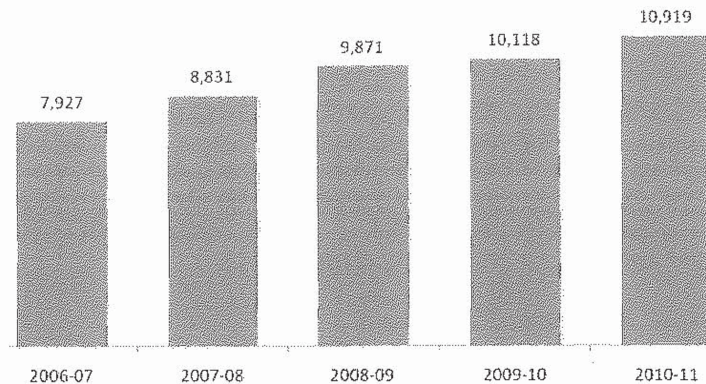
Counted by complainant

Increase in the number of inquiries to the Commission

The Commission has an inquiry line, which is usually the first point of contact for people who are concerned about the health care provided to them or a family member. Overwhelmingly inquiries to the Commission are made by consumers, rather than health professionals.

The significant increase in inquiries to the Commission is another measure of whether consumer awareness of the Commission has increased. Since 2006–07 inquires to the Commission have increased 37.7%, as shown in Chart 7.

Chart 7 – Inquiries received (2006–07 to 2010–11)



Counted by inquiry

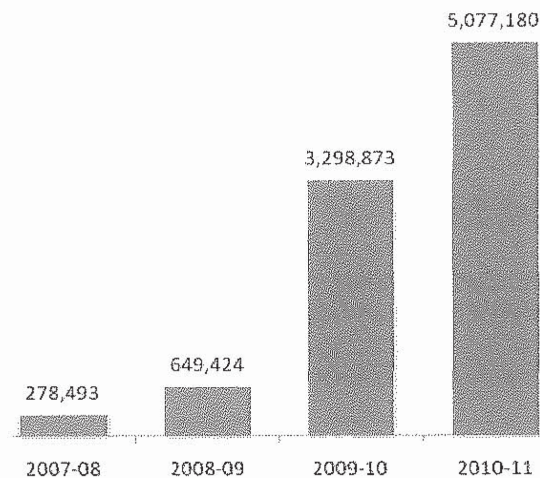
Increased traffic on the Commission's website

A major outreach activity for the Commission in 2009–10 was the launching of a new website with the ability to lodge complaints online. Inquiries to the Commission can also be made via the website.

Chart 8 shows the significant increase in hits to the the Commission's website from 2007–08 to 2010–11.

Chart 8 – Hits on the Commission's website (2007–08 to 2010–11)

In addition the number of unique visitors to the Commission's website increased from 40,440 in 2009–10 to 186,796 in 2010–11.



Counted by website hit

Complaints – metropolitan versus regional/rural

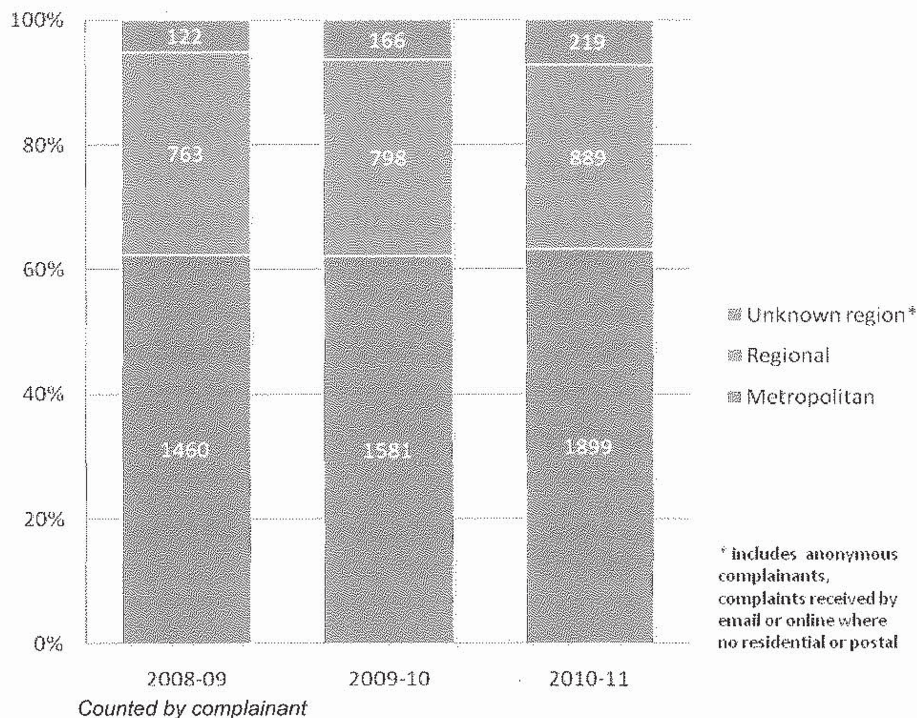
10. *Is there any information available as to the number of complaints the Commission receives from metropolitan areas versus regional and rural areas?*

Response:

The Commission recently provided the Committee with its submission into the Committee's inquiry into health care complaints and complaints handling in NSW. This included an analysis of complaints lodged with the Health Care Complaints Commission by regional and metropolitan consumers including the quantity and nature of complaints. The following is an extract from this response.

> Over the three years 2008–09 to 2010–11, 62.6% of complaints were received from metropolitan consumers, and 31.0% from regional consumers. In an average of 6.4% of complaints over the three years the regional area of the complainant was unknown. This is mainly due to complaints being received online or via email with no postal address provided by the complainant. It also includes anonymous complaints. These complainants have been excluded from the remaining analysis into the nature of complaints.

Chart 2 – Consumer complaints received by region



Counted by complainant

Complaints regarding correctional facilities and medical centres

11. *Noting that 8.9 per cent of complaints are received about correction and detention facilities – Table 16.6, page 108 of the 2010/11 Annual Report – are these facilities over–represented in the number of complaints handled by the Commission? Likewise, does the Commission have any concerns with the number of complaints regarding medical centres?*

A. Correctional facilities

In 2005–06 the Commission reported a significant increase in the number of complaints

received about correctional facilities. That year, 131 such complaints were received, which was a 156.9% increase on the 51 complaints received the previous year. At the same time, the Department of Corrections included the Commission in the list of agencies to which inmates are allowed to make free calls. This capacity to make free calls may account for the increase in complaints from inmates.

The number of complaints about correctional facilities appears to have stabilised over the past 5 years.

Table 11.1 – complaints received about correctional /detention facilities

	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11
Complaints received	31	29	51	131	93	106	138	127	136
Proportion of all complaints about health organisations	3.5%	3.1%	5.3%	10.6%	8.7%	7.8%	10.9%	10.0%	8.9%

B. Medical centres

The Commission is not concerned about the number of complaints received specifically about medical centres. Complaints are generally made against a health practitioner, mainly medical practitioners, rather than the medical centre where they might work.

2010–11 saw a decrease in complaints against medical centres as a proportion of all complaints made to the Commission about health organisations from 5.5% in 2009–10, to 4.5%, The table below sets out the types of issues raised in complaints about medical centres in 2009–10 and 2010–11. The proportion of issues relating to access to medical services, the environment and management of the facility, medical records, fees and costs is higher than in complaints about medical practitioners. The proportion of complaints relating to the professional conduct of medical centre staff is much lower than professional conduct issues raised in complaints about medical practitioners (reference: page 22 of the 2009–10 report; page 14 of the 2010–11 report).

Table 11.2: Types of issues raised in complaints about medical centres in 2009–10 and 2010–11

	2009–10	2010–11
Treatment	31.5%	24.5%
Communication and information	22.6%	13.8%
Access	12.1%	11.7%
Grievance processes	7.3%	5.3%
Environment/management of facilities	6.5%	8.5%
Medical records	6.5%	14.9%
Fees/costs	5.6%	10.6%
Professional conduct	2.4%	7.4%
Medication	2.4%	2.1%
Discharge/transfer arrangements	1.6%	–
Reports/certificates	1.6%	1.1%
Total	100.0%	100.0%

Complaints – Medicare Dental Scheme

12. *In both the 2009/10 and 2010/11 reports the Medicare Dental Scheme is mentioned as being responsible for a large number of the complaints against dental practitioners. What type of complaints is the Commission receiving regarding this scheme?*

Response:

The Commission records the types of issues raised in complaints about health practitioner groups, including dental practitioners. Due to the change in registration status with the introduction of the National Registration Scheme in July 2010, a direct comparison between 2009–10 and 2010–11 cannot be made, as in 2009–10 only complaints about dentists were recorded in this category, while in 2010–11 dental practitioners also included dental prosthetists and hygienists.

Looking at 2010–11, almost half (48.3%) of all complaints about dental practitioners related to the provision of services under the Medicare Dental Scheme.

As shown in the table below, the most common concerns raised in these complaints related to inadequate treatment (26.7%: –4.5% compared to all dental practitioner complaints), inadequate prosthetic equipment (21.1%; +8.7% compared to all dental practitioner complaints), billing practices (13.3%; +4.5% compared to all dental practitioner complaints) and inadequate or no response to a complaint (11.6%; +3.4% compared to all dental practitioner complaints).

Complaints about fees and costs accounted for 15.1% of all complaints relating to services provided under the Medicare Dental Scheme. For medical practitioners these types of complaints accounted for only 2.8% of all complaints received. Similarly, complaints about grievance processes accounted for 11.6% of the Medicare Dental Scheme related complaints, but only 2.0% of complaints about medical practitioners.

Table 12.1: Most common issues raised in complaints about dental practitioners in 2010–11

Issue Name	All Dental Practitioners	Dental Practitioners under the Medicare Scheme
Inadequate treatment	31.2%	26.7%
Inadequate prosthetic equipment	12.4%	21.1%
Billing practices	8.8%	13.3%
Inadequate/no response to complaint	8.2%	11.6%

Complaints from clients from multicultural and non–English speaking backgrounds

13. *Could you provide information as to the number of complaints received from clients from a multicultural and non–English speaking background?*

Response:

The Commission records demographic information about people who lodge a complaint on a voluntary basis. Within the two years 2009–10 and 2010–11, only 14.5% of complainants volunteered their language background to the Commission. Of those, 77.0% preferred to communicate with the Commission in English, 23.0% in another language, most commonly Arabic.

It should be noted that the data is unreliable in reflecting how many complaints are from

people with a CALD background, as some may prefer someone else to lodge the complaint on their behalf in English.

Another indication of the number of complaints from clients from CALD backgrounds is the number of hits on the Commission's website to the resources that are available in 20 community languages. As a proportion of all hits to the website, hits to translated resources have increased from 0.58% in 2009–10 to 1.03% in 2011–12. In 2010–11, there were 54,929 hits to translated resources recorded on the Commission's website and for 2011–12, there are 56,130 predicted.

Outreach activities

14. *What sort of feedback has the Commission received from its Consumer Consultative Committee as part of the Commission's work to improve services to clients from multicultural backgrounds?*

Response:

The Commission has constructive working relationships with the members of its Consumer Consultative Committee. At every meeting, the Commission's outreach activities are part of the agenda and Committee members make suggestions as to the implementation or specific issues they would like the Commission to consider. The Commission has valued this feedback mechanism and has been very responsive to suggestions from members in the past.

In 2011, the Director of Assessments and Resolutions presented to the full Council of Federation of Ethnic Communities about the role of the Commission and the strategies it uses to ensure that communities with English as a second language are able to access the Commission's services. At this meeting, members discussed current obstacles that people face when attempting to access health services in NSW and the Commission's service. The community leaders were invited to contact the Commission to arrange for presentations or further information about the Commission's services to be provided to the various communities represented. The Federation's representative on the Consumer Consultative Committee advised that the Federation members had received the presentation positively.

15. *As reported on page 57 of the 2010/11 Annual Report, the Commission is listed as a key agency for multicultural planning by the Community Relations Commission. The Annual Report notes that a progress report on performance was due in November 2011. Has the Commission now received this progress report from the Community Relations Commission? Please comment on future plans with the Commission.*

Response:

The Commission regularly reports on the results of its Multicultural Policies and Service Program to the Community Relations Commission. As set out in the Annual Report 2010–11, the last progress report to the Community Relations Commission was submitted in November 2011.

The Commission's current Multicultural Plan 2009–2012, which expires in June 2012, contains a number of initiatives and strategies that have been designed to increase the profile and understanding of CALD issues with our staff, and clients, and in building positive relations with CALD communities. Some of these strategies include:

- Information on Commission services and how to use these services is translated

and distributed to health care providers

- The Commission uses the services of accredited interpreters onsite or by telephone as appropriate
- Translated written and audio visual materials are available in priority community languages
- The Commission's Consumer Consultative Committee (CCC) has a member with experience in culturally diverse matters
- The staffing of the Commission reflects the multicultural business needs of the Commission
- The Commission identifies the linguistic and intercultural work skills needed of staff in client contact positions, to ensure that business requirements are serviced by appropriate human resourcing
- The Commission utilises the Community Language Allowance Scheme (CLAS)
- Staff in public contact positions within the Commission receive training and support relating to working in a culturally diverse environment

Trends in complaints

16. *The 2010/11 Annual Report on page 14 observes that communication issues are commonly raised in complaints across all professions, but appear to be more common in complaints against medical practitioners, and nurses and midwives, compared to dental practitioners. What are the specific communications issues for doctors and nurses/midwives and suggest how the Commission might be able to help deliver better training on communication issues?*

Response:

Table 16.1 provides a breakdown of the communication issues for medical practitioners, dental practitioners, and nurse / midwives. Overwhelmingly, the most common communication issue raised in complaints to the Commission is the attitude/manner of the practitioner.

Table 16.1 – Communication issues raised in complaints against medical practitioners, dental practitioners, and nurse / midwives.

Issue Name	Medical practitioner		Dental practitioner		Nurse/Midwife	
Attitude/manner	294	77.37%	67	88.16%	45	95.74%
Inadequate information provided	60	15.79%	5	6.58%	2	4.26%
Incorrect/misleading information provided	19	5.00%	3	3.95%		
Special needs not accommodated	7	1.84%	1	1.32%		
	380	100.00%	76	100.00%	47	100.00%

The Commission provides information regarding the types of issues raised in complaints to professional councils and associations. In addition, this type of information, as well as how to prevent complaints about communication issues, are part of the Commission's presentations to clinicians and health professions.

The Commission is also part of the Health Literacy network – a collaboration to improve health literacy – together with the Clinical Excellence Commission, the Australian Commission on Quality and Safety in Health Care, and the School of Public Health of the University of Sydney.

Assessment process

17. *The report mentions on page 24 that 'the Commission's assessment process has also become more rigorous and thorough resulting in fewer complaints being referred for investigation.' What are the details of this new assessment process and how if differs from the previous process?*

Response:

In 2004–05, following changes to the *Health Care Complaints Act 1993*, the Commission overhauled its assessment process and introduced a process that was more rigorous and thorough which obtained enough information to make an informed assessment decision. This process is still in place; however over time it has been refined. This includes targeting the Commission's effort to cope with the increasing number of complaints and only gathering information that will assist in making an assessment decision.

Requests for review

18. *In regard to the number of requests for review received during 2010/11, page 27 of the report states that 'improved letters to the parties that explain the reason for the Commission's decision may have reduced the rate of requests for review.' In what way have the letters been improved?*

Response:

The Commission has provided training to all assessment staff via a two day 'Plain English Writing' workshop conducted by the Plain English Foundation. This training is ongoing and all new assessment staff attend the workshop soon after commencing work at the Commission.

In addition, during 2010–11 the Commission provided training to managers through the 'Editing for Managers Workshop', also conducted by the Plain English Foundation.

Other improvements are that letters:

- are clear, concise, and explain the reasons for the decision
- better explain the Commission's complaint management process, including explaining the action taken by the Commission, such as requesting a response and/or records, seeking IMA and INA, consultation with the Council
- address all the issues raised in the complaint
- employ a more conciliatory tone
- manage complainant expectations while acknowledging that they may/will be disappointed with the decision
- advise that the complaint did not reach the benchmark for investigation
- indicate that peers were not critical of the treatment or the conduct
- show empathy, even though no further action can be taken.

Client survey

19. *On page 28 of the 2010/11 report, the survey responses from health providers and complainants regarding their experience/satisfaction with the assessment of a complaint indicates that health providers are more satisfied – 79.5 per cent – with their interaction with the Commission in comparison to complainants at 49.8 per cent. Why*

is there such a wide difference between the two, given the response rate from both parties were very similar? The figures from the 2009/10 report were a 72.2 per cent satisfaction rate for providers and 65.6 per cent for complainants.

(i) *Page 40 of the report states that the Commission has decided to discontinue the surveys for both providers and complainants at the conclusion of an investigation. What evaluation measures will take the place of the distribution of survey forms at the conclusion of an investigation?*

(ii) *Has the Commission ever considered hiring an independent consultant to undertake a more formal and in–depth client satisfaction survey?*

Response:

The declining satisfaction rate of complainants with the Commission's assessment process may be related to the Commission's practice of assessing more complaints solely based on the information provided in the written complaint. As there is no personal telephone contact with the complainant, and often these complaints are discontinued, understandably, complainants feel dissatisfied and express this through the customer surveys. On the other side, providers appear to be more satisfied with the Commission's assessment process, as they are now asked less often to provide a detailed response to complaints, where it is clear from the outset that the complaint does not raise significant issues of public health and safety that would warrant disciplinary action against the practitioner.

(i) If a complainant is dissatisfied they have the right to request a review of the Commission's investigation decision, except in cases where the complaint was referred to the Director of Proceedings to consider prosecution before a Tribunal or Professional Standards Committee. There were two requests for a review of an investigation decision received in 2009–10, and three in 2010–11.

The main reason behind the decision to discontinue surveys at the end of investigations was the extremely low response rate. In 2010–11 60.9% of complaints were referred to the Director of Proceedings to consider prosecution before a disciplinary body. In these complaints the investigation is not the final process, with potential prosecution still to occur.

The inherent nature of the Commission's investigations into health practitioners means that any form of evaluation by a respondent is likely to be overwhelmingly negative, given the likelihood of a negative outcome at the end of an investigation.

(ii) At the end of 2009, the Commission sought proposals from external researchers to conduct an independent, in–depth qualitative client satisfaction research study to identify satisfaction with the Commission's services, as well as barriers to accessing the services. However, the project was not approved due to budget restrictions.

<u>Resolving complaints</u>

20. *Chapter 10 of the 2010/11 report – page 31 – dealing with the resolution of complaints lists that the Commission has met its target in a number of areas, including 85.6 per cent of resolution and conciliation clients being satisfied with the Commission, exceeding the 80 per cent target. However, some targets were not met, with '69.9% of resolution matters that proceeded had a resolution plan submitted with 28 days of being referred (target 90%).' Also, '30.3% of conciliation meetings were scheduled within three months after the complaint was referred for resolution', failing to meet the target of 65 per cent. Why were these particular targets not met?*

Response:

One of the factors that led to a number of targets not being met in the Resolution Service is the increase in the workload for Resolution Officers. This has included an increase in inquiries to the Commission (2009–10: 10,118 and 2010–11: 10,919) and an increase in number of reviews (2009–10: 267 and 2010–11: 300). The Resolution Service has not had any increase in staff numbers.

The restructuring of the resolution processes resulted in an added step for complaints that are ultimately handled by a formal conciliation process. After a complaint is assessed as suitable for resolution through the Commission, the complaint is referred to the Resolution Service without trying to determine at the outset whether formal conciliation or resolution with the assistance of one of the Commission's Resolution Officers is more appropriate. The main reason for combining the two processes was to attempt to increase the consent rate for conciliation.

The targets for the 2010–11 performance measures for the Resolution Service were set at the Commission's Executive Planning Day in March 2010, before the start of the reporting year and prior to the restructure of the processes. At this meeting the Commission's Executive agreed to maintain the targets from previous years.

The 2011–12 performance measures have been amended for the corporate goal of 'efficient and timely processing, assessment and resolution of complaints and review process'.

21. *The Committee notes that the restructured resolution process, which commenced on 1 July 2010, has had beneficial outcomes. The 2010/11 Annual Report – page 31– states that 66.1 per cent of resolution and conciliation processes were finalised within four months of referral (target 70 per cent).*
    - *(i) Can the Commission further refine the processes to enable it to meet the target fully?*
    - *(ii) What criteria are used to determine whether a resolution/conciliation process is finalised?*
    - *(iii) The Commission has Resolution Officers in the three regional areas of Newcastle, Dubbo and Lismore 2010/11 Annual Report – page 32. Why were those particular areas chosen? Are there other regional areas you would like to reach? If so, which ones?*
    - *(iv) The 2010/11 Annual Report – page 34 – states that over the last two years, 222 changes to health service practice (94.5 per cent) have been implemented and eight (3.4 per cent) are still to be implemented. Does the Commission monitor the agreements after they are in place to ensure all of the agreed changes are implemented?*

Response:

(i) The complaints that are referred to resolution are more complex than in the past. As mentioned in the response to Question 20, the workload of the staff of the Resolution Service has increased, with increased numbers of inquiries and reviews. The restructured resolution process is a new process and the Commission will continue to evaluate it and improve its efficiency. 2010–11 was the first year that the timeliness of the resolution and conciliation processes were counted in this way.

As mentioned in the response to Question 20, the conciliation process is a more attenuated process, with a resolution process occurring in the first instance. The performance targets and estimates were set the previous year, without full

knowledge of how the processes would operate and perform.

(ii) Resolution processes are closed when:
– the provider does not agree to be involved in the process
– the complainant does not agree to be involved in the process
– the complainant advises that the complaint is resolved
– there are no further strategies that can be pursued to resolve the complaint.

Conciliation processes are closed either after a conciliation meeting has been held, or where one of the parties withdraws their consent to participate in the conciliation process.

(iii) In the past, the Commission had one Resolution Officer in each of the eight Area Health Services who dealt with the staff in each of the Areas. As resources were redeployed throughout the Commission, the metropolitan Resolution Officers were relocated into the Commission's Sydney office. Due to the resignation of the Wollongong Resolution Officer and advice from the then South Eastern Sydney and Illawarra AHS that accommodation for the position would no longer be available, it was decided to relocate this position to head office and service the Wollongong area remotely. Likewise with the Queanbeyan position. Recruitment for the position in Queanbeyan was also problematic. With the introduction of the LHDs (17) it is not possible for the Commission to have a Resolution Office for each District.

Dubbo, Lismore and Newcastle are large population centres with many of the district resources located there. These centre provide easy access to the surrounding areas. LHDs in these districts have agreed to cover the cost of the office space for the Commission's Resolution Officers. In Wollongong and Queanbeyan, the LHDs have advised that they have no accommodation available at this time to accommodate a Resolution Officer and the cost of establishing an independent office would be prohibitive given the Commission's current level of funding.

(iv) Yes. As reported in the Commission's 2010–11 Annual Report, since 2009–10, a total of 235 individual improvements in 93 complaints have been identified. As at 30 June 2011, 222 changes to health service practice (94.5%) have been implemented, and eight (3.4%) are still to be implemented.

22. *In 2009/10 there were 12 complaints that took more than 12 months to complete the resolution process. In 2010/11 the number increased to 23 complaints. Can you provide advice to explain the increase?*

Response:

It should be noted that the number and proportion of resolution processes that took more than 12 months to finalise is small in the context of all resolutions finalised during the two reporting periods (2009–10: 1.7% and 2010–11: 3.3%).

The Commission reviewed the relevant cases and there are complex factors relating to each individual case that resulted in a longer resolution process. These include cases where:

- The patient was an infant who had died and the mother who had lodged the complaint was too distressed to participate in a resolution process for a period of time.
- There were seven health service providers involved in the treatment and care that was the subject of the complaint, who had to be coordinated during the process.

- There was a separate Coroner's investigation and the Resolution Officer waited until the report was released to clarify any questions and issues the complainant might have had arising from the Coroner's report as part of the resolution process.
- There was partial resolution achieved during the process, but the Resolution Officer aimed to resolve the outstanding issues, in some cases unsuccessfully.

Investigating complaints

23. *Where the Commission has investigated complaints about health organisations and made recommendations it has, since 2005, made 455 recommendations from 181 investigations and 91.9 per cent have been implemented and 7.3 per cent (33) are still to be implemented. Can you provide details of the recommendations that are still outstanding?*

Response:

Of the 33 recommendations that were still to be implemented as at 30 June 2011, 14 have now been implemented.

11 are yet to be implemented. These were all made to public hospitals and include recommendations that the facility:

- Implement their Disability Action Plan 2008–11, which states that they will 'review and/or develop admission, assessment, discharge and case coordination policies, protocols and procedures for people with disabilities'.
- Implement all the recommendations as made in the Root Cause Analysis final report.
- Revise its policy and procedures re: the administration of intravenous contrast media for radiography, so that staff are required to explicitly confirm or deny renal impairment (and/or any other condition that may contraindicate the use of contrast media in a particular patient), and to report this information to the radiologist, before contrast can be administered.
- Complete a revision of the inter–hospital patient transfer and retrieval protocol, as per RCA Recommendation 5, and provide the Commission with a copy of the revised protocol and implementation timeframes.
- Conduct and provide the Commission with the results of an audit of antenatal progress notes to show compliance with policy directives.
- Implement changes to the manner in which progress notes are recorded on a patient's clinical records so that the records comply with policy directives.
- Provide the Commission with a copy of an updated procedure and results of an audit of all referrals of patients for pregnancy morphology ultrasound to show compliance with this procedure.
- Implement a procedure requiring all practitioners who refer a woman who is receiving shared antenatal care for a pregnancy morphology ultrasound, to request that the radiology clinic:
  a. Forward a copy of the report to the hospital's Pregnancy Care Clinic
  b. Notify the hospital's Pregnancy Care Clinic immediately and verbally of any abnormal pregnancy morphology ultrasound reports that require urgent or immediate follow–up.

As foreshadowed eight recommendations were not implemented. These recommendations were made to a privately run drug and alcohol treatment facility. This facility is no longer licensed so the recommendations are not capable of being implemented.

24. *The number of complaints where no further action is taken against a health practitioner continued to decline in 2010/11 – Chart 11.1 on page 37 of the 2010/11 Annual Report. What accounts for this decline? Is it due to unfounded complaints, lack of sufficient evidence to proceed further or a sign the Commission requires further resources or investigative powers?*

Response:

The main factor behind the decrease in the number of investigations into health practitioners where no further action is taken is that the assessment process is more thorough and only complaints where serious issues are raised are referred for investigation.

The decrease is not due to the lack of investigative power or need for more resources. In the past, the Commission did not have the power to compel evidence or information during the assessment of a complaint. The only way to obtain that information was if the complaint was under investigation. Since 2009, the Commission has had power under section 21A of the *Health Care Complaints Act* to obtain information during the assessment of a complaint.

25. *How does the Commission account for the decrease in the number of complaints – 184 in 2010/11 compared to 223 in 2009/10 – referred to the Investigations Division while 'the proportion of investigations that are finalised by making recommendations to health organisations or, in the case of individual health practitioners, referred for prosecution **[or]** to the professional councils has increased substantially.'*

Response:

Again the main factor behind the decrease in the number of complaints referred for investigation is a more thorough assessment process, ensuring that investigation is reserved for serious matters.

Because more of the less serious matters are adequately dealt with in assessments and not sent for investigation, the proportion of complaints where, following investigation, a health practitioner is referred to the Director of Proceedings or to the professional council has continued to rise, as shown in table 25.1. In addition, the number of matters prosecuted has continued to rise over the five years 2006–07 to 2010–11, as shown in table 25.2.

Chart 25.1 – Investigations into health practitioners that were referred to the Director of Proceedings or to the professional council 2006–07 to 2010–11

	2006–07		2007–08		2008–09		2009–10		2010–11	
Referred to Director of Proceedings	112	38.8%	129	50.8%	100	50.0%	141	59.5%	109	60.9%
Referred to professional council	36	12.5%	35	13.8%	36	18.0%	44	18.6%	37	20.7%
Total	148	51.3%	164	64.6%	136	68.0%	185	78.1%	146	81.6%

Counted by provider

Chart 25.2 – Prosecutions before disciplinary bodies 2006–07 to 2010–11

	2006–07	2007–08	2008–09	2009–10	2010–11
Tribunal	39	37	38	53	57
Professional Standards Committee	21	25	28	30	27
Board of Inquiry	1	1			
Total	61	63	66	83	84

Counted by matter

As shown in table 25.3, the proportion of investigations finalised into health organisations where recommendations and/or comments are made has also continued to rise over the five years 2006–07 to 2010–11.

Chart 25.2 – Outcomes of investigations into health organisations 2006–07 to 2010–11

	2006–07		2007–08		2008–09		2009–10		2010–11	
Comments or recommendations	50	54.3%	55	65.5%	39	63.9%	33	94.3%	22	91.7%
No further action	42	45.7%	29	34.5%	22	36.1%	2	5.7%	2	8.3%
Total	92	100.0%	84	100.0%	61	100.0%	35	100.0%	24	100.0%

Counted by provider

In complaints received relating to serious incidents involving public health organisations, the Commission will often obtain a copy of an RCA during the assessment of the complaint. If the Commission believes that the RCA has appropriately addressed the systemic issues – being the issues that the Commission would be likely to make recommendations on – the complaint is referred for resolution to assist the complainant is resolving any further concerns. In the past, these types of complaints have been referred for investigation.

The following extract from the Commission's 2010–11 Annual Report explains the decrease in the number of complaints about public health organisations referred for investigation:

> The decrease in investigations into health organisations is due to a number of factors. Serious incidents in public health organisations are usually investigated through a Root Cause Analysis conducted by the health service. Over the last few years, where a Root Cause Analysis has recommended systemic improvements that appropriately address relevant issues of public health and safety, and there are no issues of individual misconduct, the Commission has referred such complaints for resolution.[1]

<u>Unregistered health practitioners</u>

26. *Page 38 of the 2010/11 Annual Report notes that the Commission anticipates 'the number of investigations into unregistered health practitioners will continue to increase in the coming years', and on page 58 of the report you mention that consultation has occurred in regard to changing regulations in the Health Care Complaints Act for unregistered health practitioners. Can you provide further information on the proposed changes and how they will impact the work of the Commission in terms of dealing with complaints against unregistered health practitioners?*

Response:

The Code of Conduct for unregistered health practitioners is currently included as a schedule to the Public Health (General) Regulations 2002. In November 2010, the NSW Parliament passed the *Public Health Act 2010*. This act updates and revises the existing *Public Health Act 1991* and is expected to commence in early 2012 following the making of new regulations under the Act, including the code of conduct.

The Ministry of Health held a public consultation on the draft regulation, which closed on 9 September 2011. The Ministry has consulted the Commission on a minor potential change to the code, with which the Commission is in agreement. This would include the words 'possess and' in Clause 3(2)a to read:

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[1] HCCC Annual Report, pp 38

3 (2) Without limiting subclause (1), health practitioners must comply with the following principles:

(a) a health practitioner **must possess** and maintain the necessary competence in his or her field of practice,

The updated regulation will have no discernable impact on the work of the Commission, apart from amending documents to provide the appropriate reference to the new regulation. A new poster for display by health practitioners may also need to be produced.

Legal representation – Professional Standards Committee hearings

27. *On page 44 of the 2010/11 Annual Report you mention that the Commission can now be represented by qualified legal practitioners at most of the Professional Standards Committee hearings, reducing the need to engage external solicitors and barristers. What sort of savings will be made as a result of this new arrangement? The Committee notes that on page 78 of the report an amount of $960,000 is entered under 'Legal fees and adverse costs'. What are the Commission's current legal costs i.e. barrister's fees etc., and how much do these costs vary? Will the Commission's two Legal Officers require additional training before taking on their new duties?*

Response:

The amount of $960,000 recorded under line item 'Legal fees and adverse costs' is the Commission's total external legal costs. A significant proportion of this amount, however, is recovered when the Commission has been successful in prosecuting a practitioner and they are ordered to pay the costs of the Commission. During the financial year 2010–11, the Commission recovered $589,000 in legal costs.

The fees the Commission pays to external counsel have not been increased in five years. These fees are currently being reviewed and may increase during the 2011–12 financial year.

The use of two of the Commission's Legal Officers in Professional Standards Committee (PSC) hearings is not expected to significantly reduce the Commission's external legal costs. Due to an increase in the workload of Legal Officers – being an increase in number of prosecutions; longer hearings with more sitting days; hearings becoming more adversarial; and a number of hearings now being held in two stages – the Commission still expects that it will need to brief external counsel extensively, particularly in matters heard before a tribunal.

In relation to training for the two new legal officers, both officers have started their new duties and have been involved in appearing in hearings before PSCs. Prior to this they had received training from their supervisors and had also worked with counsel on a number of matters. They will continue to receive training, both internal and external, as the need is identified.

Root Cause Analysis

28. *The 2009/10 Annual mentions changes to the root cause analysis process, which the then Department of Health was to have in place by 'late 2010'. Can you advise if the changes are now in place and what impact have they had on the work of the Commission?*

The Commission sought advice from the Ministry of Health and the Clinical Excellence Commission (CEC) regarding the changes to the Root Cause Analysis process. The following advice was received from the CEC:

> The Quality and Safety functions that formerly resided within the CSQGB (including policy review) transferred to the Clinical Excellence Commission in December 2011. The CEC are aware that the existing Incident Management Policy Directive, PD 2007_061 requires review and can advise that work is progressing in response to the changes made to the *Health Legislation Amendment Act 2010*, and the RCA provisions of the *Health Administration Act* and the *Private Health Facilities Act*.
>
> The recommendations regarding the development of a plain English guide for patients and their families to explain what the RCA process can and cannot achieve have been forwarded to the Director of Patient Based Care for consideration.

Work with the Clinical Excellence Commission

29. *Can you provide the Committee with more specific details and examples of the Commission's work with the Clinical Excellence Commission to improve the health services?*

Response:

The Commission regularly provides its investigation reports into health organisations where formal recommendations have been made to the relevant health organisation and to the Clinical Excellence Commission for their consideration for ongoing projects run by the Clinical Excellence Commission.

In addition, both Commissions, together with the Australian Commission on Safety and Quality in Health Care and the School of Public Health, The University of Sydney, are cooperating on a long–term project that aims to increase health literacy in NSW. As part of this project, the Commission regularly liaises with the other partner organisations, obtains feedback and input from its Consumer Consultative Committee Members, and will be part of the upcoming seminar *Breaking Down the Barriers – Health Literacy, Communication and Health Services* featuring Dr Rima Rudd, Health Literacy Expert, Harvard School of Public Health, Boston.

Research projects

30. *In both the 2009/10 and the 2010/11 reports you mentioned that the Commission was involved in a number of research projects. Are you able to provide an update on the current status of these projects and their potential to improve the public health system?*

Response:

In relation to the research projects reported in 2009–10 and 2010–11, the Commission can provide the following information:

- Doctoral project at Griffin University: An interim report summarising the results of the interviews that were conducted with participants was provided by the researcher. The Commission is not aware that the final results have been published. The aim of the study was to better understand the nature of complaints about counselling and psychotherapy.
- The study on trust after medical incidents: The Commission assisted in the

recruitment of subjects for this study in two phases, falling into 2009–10 and 2010–11. The interviews with complainants and practitioners have been finalised and are currently being analysed as part of a doctoral project. The publication of the results is expected in 2013. The aim of this study is to identify factors that foster or hinder resolution of conflicts and complaints after medical incidents.

- The research project on the implementation of the Commission's recommendations to public health facilities: The University of Sydney lead researchers obtained ethics approval from most sites in 2011. The surveys were distributed to most of the public health facilities in December 2011. The aim of the study is to evaluate how recommendations for quality and safety improvements are being implemented long–term by the relevant health facilities, and where there have been barriers to the implementation. The results will assist the Commission in identifying areas for improvement when making and monitoring recommendations in the future.
- Chinese Hospital Association: This project has been finalised and an update on the overall exchange programme was provided by the Burnet Institute, the Australian coordination body, at the end of 2011. The Commission has not been advised of specific outcomes that resulted from the advice it provided to the Chinese Hospital Association.
- Health literacy project: This project is ongoing and has resulted in the creation of the Health Literacy Network, consisting of the Australian Commission on Safety and Quality in Health Care, the School of Public Health at the University of Sydney, the Clinical Excellence Commission and the Health Care Complaints Commission. As part of the network's activities, a free seminar has been planned for 2 April 2012. The seminar will focus on assisting health services to assess and remove health literacy barriers, and supporting health care professionals to improve communication with Aboriginal, CALD and low socioeconomic background patients. The network members meet regularly to coordinate and cooperate on a range of health literacy initiatives.

File audit

31. *The 2010/11 Annual Report – page 24 – mentions that the Commission put in place 'a system where an audit of an assessment file is conducted 28 days after a complaint is received to ensure the file has been set up correctly and that the complaint has been actioned.' On page 32 of the 2009/10 Annual Report it is mentioned that it was planned to conduct these file audits within 21 days. Can you advise why the time frame for the audits was extended from the 21 day period originally proposed to 28 days? Who undertakes these audits?*

Response:

In 2009–10 and in an attempt to better manage performance in the Assessment Branch, the Commission introduced an audit of assessment files on day 21. This was trialled for most of that year. The results showed that a single audit on day 21 did not ensure effective management of the file, in that acknowledgement letters to complainants were to be sent within 7 days and notification letters to providers were to be sent out within 14 days. A review of this model showed that the audit did not adequately ensure that the file was set up in a timely manner or that the complainant had received the acknowledgement letter. To address these issues, the model was changed to a two audit process – one on day 7 to check the file had been set up in a timely manner and that the acknowledgement letter to the complainant had been sent, with a second audit conducted on day 28 to ensure that the provider had been notified and all relevant lines of inquiry had been commenced.

Following a recent audit of the assessment process by the Commission's internal auditors, a number of recommendations were made regarding the audit process. These included automation of the day 7 audit, and moving the day 28 day audit back to day 21. Recommendations were also made regarding the development of the assessment plan. This plan is now developed by the Manager, Assessments and reviewed by a team leader prior to allocation to one of their team members to implement the plan.

The model in place now for assessment audit is as follow:–

- Automated audit at day 7 which checks the timeliness of the complaint being read, the timeliness of the file being made up and that the acknowledgement letter has been sent to the complainant.
- Day 21 audit conducted by the Team Leader, to check that notification letters to the provider have been sent and acknowledged, lines of inquiry have commenced and that the assessment plan is being auctioned.
- Team Leaders are able to add extra audit dates to check the progress of the file at their discretion after the completion of the day 21 audit.
- Audits are undertaken by the Team Leader or in their absence the Manager, Assessments or Director, Assessments and Resolution.
- Performance in relation to audits has been included in staff performance agreements and is monitored as a performance indicator.

Staffing (for the period 1 July 2011 to 30 September 2011)

32. *The Committee notes the Commission's quarterly performance report for the period 1 July 2011 to 30 September 2011 which states that the 'Commission received 1062 written complaints and assessed 856 complaints during the reporting period. The Commission will increase human resources of the Assessments Branch and address management issues in the area to deal with the shortfall between complaints received and complaints assessed.' Would you like to provide further comment on this issue and its impact on the work of the Commission?*

Response:

In its quarterly performance report for the period 1 July 2011 to 31 December 2011 the Commission commented that it has 'increased resources in the Assessment Branch. This has successfully addressed the shortfall that had occurred in the first quarter in complaints assessed compared to complaints received.'[2]

[2] Health Care Complatins Commission, Quarterly performance report for the period 1 July 2011 to 31 December 2011, pp 4