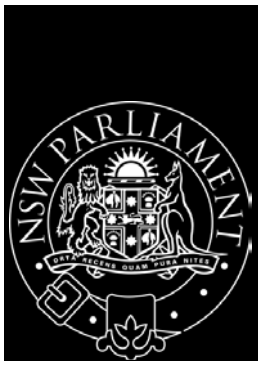

PARLIAMENT OF NEW SOUTH WALES

Committee on the Health Care Complaints Commission

9TH MEETING ON THE ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

Report No.3. May 2004

New South Wales Parliamentary Library cataloguing-in-publication data:

New South Wales. Parliament. Legislative Assembly. [Committee on the Health Care Complaints Commission]

Report of the 9TH Meeting on the Annual Report of the Health Care Complaints Commission, Committee on the Health Care Complaints Commission, Parliament NSW Legislative Assembly. [Sydney, NSW]: The Committee on the Health Care Complaints Commission ; no 3/53, May 2004, pagesp. ; 30cm

Chair: Jeff Hunter MP
"May 2004"
Running title: Report on the 9th Meeting on the Annual Report of the Health Care Complaints Commission.
Chair: Jeff Hunter.

ISBN 0734768052

1. Medical care.
I. Title.
II. Hunter, Jeff.
III. Title: Report on the 9th Meeting on the Annual Report of the Health Care Complaints Commission.
IV. Series: New South Wales. Parliament. Committee on the Health Care Complaints Commission. Report ; no. 53/?

DDC 362.1

TABLE OF CONTENTS

MEMBERSHIP & STAFF

Chairman	Jeff Hunter MP, Member for Lake Macquarie
Members	Allan Shearan MP, Member for Londonderry
	Tanya Gadiel MP, Member for Parramatta
	Russell W Turner MP, Member for Orange
	Hon Christine Robertson, MLC (Deputy Chair)
	Hon Dr Peter Wong, MLC
	Hon David Clarke, MLC
Staff	Catherine Watson, Committee Manager
	Jackie Ohlin, Project Officer
	Keith Ferguson, Committee Officer
	Glendora Magno, Assistant Committee Officer
Contact Details	Committee on the Health Care Complaints Commission Legislative Assembly Parliament House Macquarie Street Sydney NSW 2000
Telephone	02 9230 –3011
Facsimile	02 9230 –3309
E-mail	awatson@parliament.nsw.gov.au
URL	www.parliament.nsw.gov.au

FUNCTIONS OF THE COMMITTEE

The Joint Committee on the Health Care Complaints Commission was appointed in 1994. Its functions under Section 65 of the *Health Care Complaints Act 1993* are:

a. to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act;

b. to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed;

c. to examine each annual and other report made by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report;

d. to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Commission;

e. to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

The Joint Committee is not authorised:

a. to re-investigate a particular complaint; or

b. to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or

c. to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

CHAIRMAN'S FOREWORD

I present this report of the 9th Meeting on the Annual Report of the Health Care Complaints Commission as required by Section 65(1)(c) of the *Health Care Complaints* Act 1993.

In the period since the last Annual Report there have been significant changes at the Commission. Following the handing down of the Macarthur Report we have seen the dismissal of the former Commissioner, Amanda Adrian, the appointment of an Acting Commissioner, Mr Bill Grant, from 10 December 2003 to 22 March 2004 who has now been succeeded by Judge Kenneth Taylor as Acting Commissioner. Further, the two Assistant Commissioner positions have been replaced by a single Deputy Commissioner, Mr Keiran Pehm.

Subsequent to the Macarthur report the Government established a Special Commission of Inquiry into Campbelltown and Camden Hospitals headed by Mr Brett Walker SC. An interim report of the Special Commission was brought down 31 March 2004. The NSW Cabinet Office is also currently reviewing the *Health Care Complaints Act* 1993.

In December 2003, the Committee presented its *Report of the Inquiry into Procedures Followed During Investigations and Prosecutions Undertaken by the Health Care Complaints Commission*. That Report highlighted the Committee's ongoing concerns about unacceptable delays in investigations conducted by the Commission, lack of clinical expertise, lack of active investigations and lack of robust legal practices. The Report identified a number of recommendations for reform, some of which require legislative change. I acknowledged at the time that a review of the prevailing legislation was long overdue.

But the Committee also noted that important recommendations, particularly about reducing delays, increasing clinical expertise and instituting better policies and training for peer reviewers and investigators did not require legislative change but rather the will of the Commission to implement them. Previous Committee Reviews of the Commission's Annual Reports had raised such issues, particularly regarding the extent of delays in investigations and processes to redress these delays. In my Foreword to the 8th Meeting on the Annual Report I outlined the Committee's frustration at the apparent inability of the Commission to adequately report on its internal operations.

In my Foreword to the Investigations and Prosecutions Report I indicated the need for even closer scrutiny of the internal workings of the Commission and that the Committee had written to the Minister for Health, Hon Morris Iemma on 5 December 2003 requesting that he fund an independent external review of the Commission's systems for conducting investigations and prosecutions. This request, in part, led to the Walker Inquiry and its review of the regulatory and administrative arrangements of the Commission.

The Committee has provided information gathered during our previous inquiries to both the Walker Inquiry and the Cabinet Office Review.

The Walker Inquiry's interim report has set out in detail the Commission's failure to comply with legislative requirements, substantiating the Committee's original concerns. The Committee awaits with interest the Inquiry's final report and its recommendations in relation to the Commission.

Despite the problems raised by Committee with regard to the Commission's 2002-2003 Annual Report there were improvements, with a number of the Committee's previous recommendations being adopted. The improvements included: the inclusion of a performance summary at the start of the Report; more detailed explanatory comment on reported statistical data; enhanced financial and budget information; and fewer details and enhanced presentation of the case studies.

At the 8th Meeting on the Annual Report, the Committee had also indicated the need for the Commission's attention to the following matters in relation to the preparation of future annual reports. These include: adopting a more comprehensive performance reporting framework; linking the reporting of performance results to the goals of the Commission; the inclusion of performance targets; the expansion of the scope of stakeholder feedback surveys to cover all major activities of the Commission; and the benchmarking of comparative performance with results achieved by similar agencies in other Australian jurisdictions..

In its analysis of the Commission's 2002- 2003 Annual Report, the Committee was disappointed that, apart from the reporting or performance results against goals in the 'Performance Summary' section, and brief references to surveys of the Patient Support Service and investigation process, there was little further progress in relation to the above-identified issues.

The Committees review of the Annual Report was assisted by Mr Bill Grant former Acting Commissioner and Ms Susan Donnelly the then Assistant Commissioner. I acknowledge that although the period of the report does not cover the time that Mr Grant was Acting Commissioner, his review of operations at the Commission has confirmed issues of concern raised by the Committee in previous reports.

The Committee notes the significant changes instituted at the Commission by Mr Grant, which he outlined in a briefing to the Committee on 18 March 2004 and further discussed at a public hearing on 1 April 2004.

These issues include:

- a strategy for addressing ongoing investigations relating to individual matters arising from the Campbelltown and Camden reports and investigations;
- a strategy for addressing the backlog of incomplete investigations;
- organisational structure issues (including policy, administrative and procedural matters).

I am also pleased to note Mr Grant's comment that the work of the Committee, particularly its report into investigations and prosecutions, had influenced these remedial actions and his input to the legislative review being conducted by the Cabinet Office.

On 6 May 2004 the Committee also met with Acting Commissioner Judge Kenneth Taylor and the new Deputy Commissioner Keiran Pehm to discuss future directions and planned reforms at the Health Care Complaints Commission. At this meeting Judge Taylor acknowledged that previous criticisms made by the Committee of the Commission's procedures and operations were valid and that he agreed with the majority of findings and recommendations the Committee had made.

Judge Taylor recognised the Committees important work of reviewing the operations of the Commission and outlined actions being undertaken at the Commission that accord with many of the Committees previous recommendations.

At this point it is important to note that the Committees powers to review the Commission's operations are limited under the current legislation. The Committee has had to rely on information gained by written submissions, oral evidence by witnesses and importantly the willingness of the Commission to provide detailed and comprehensive responses to questioning. Unfortunately in the past the extent of the Committees powers of inquiry have been challenged by the Commission.

The Commission's previous lack of response to the Committee's recommendations has been frustrating to all Committee Members, a point recognised by Judge Taylor at the meeting. Judge Taylor indicated to members that under his leadership the Commission would be open and frank in it dealings with the Committee and this was clearly evident in our first meeting with him.

As part of this annual review the Committee again engaged expert consultant to the Public Bodies Review Committee, Mr John Chan Sew, to analyse the Annual Report in terms of performance reporting and compliance with statutory requirements of the *Annual Reports (Statutory Bodies) Act* and Regulations. His report and recommendations have been forwarded to the Commission and are attached to this Report.

The Committee expects that in the new environment of the Health Care Complaints Commission it will see in the coming twelve months a substantial lift in the Commission's performance. Notwithstanding the significant challenges the Commission will face, the Committee anticipates a clear and accountable reporting of that performance.

In conclusion, I would like to thank the former Acting Commissioner Mr Bill Grant, the former Assistant Commissioner Ms Susan Donnelly, the current Acting Commissioner Judge Taylor, the newly appointed Deputy Commissioner Mr Keiran Pehm and Mr John Chan Sew for assisting the Committee with the review. I also thank my fellow Committee Members and the Committee Secretariat for the help in the preparation of this report.

Mr Jeff Hunter MP
Chairman

SUMMARY OF KEY ISSUES

It should be noted that this year's review of the 2002-2003 Annual Report was assisted by Mr Bill Grant, the then Acting Commissioner. Mr Grant was not Acting Commissioner during the period of that report.

Number of Open Investigations

Over the last 4 reporting years, the Committee has raised concerns with the Commission about the high number of open investigations. In 1999/2000 there were over 500 cases outstanding. The Commissioner advised that it had *a major strategy in place to reduce the number of investigations that had been on going for some time. There has been significant realigning and investing of resources in the investigation area to reduce the number of investigations*. In that year, the Commission received a record number of complaints – nearly 2500 complaints were received, an increase of 18% on the previous year.

In 2000/2001, the Committee again expressed concern that a total of 863 investigations matters remained open. While the Commissioner indicated that a more active approach to investigations was current, the Committee was frustrated in its attempts to determine the number of field-based investigations undertaken. The Committee noted that the Commission had received additional resources to address caseloads, which were, according to the Commissioner *high and paralysing* for many staff. The Committee also noted the Commissioner's intent to take the emphasis off investigations as the key resolution mechanism, stating *investigation is not necessarily the resolution mechanism of choice.* In response, the Committee indicated its concern at the high number of investigation matters which had been open for more than eighteen months. The Committee indicated that lifting performance in the area of investigations was of paramount importance, irrespective of other Commission activities, and noted its anticipation of an improvement in this performance in the next reporting period.

At this time, the Committee noted that the Commission had developed draft Investigation Timeframes, with a proposed standard of an average of twelve months per investigation.

In 2001/2002, the Committee again had concerns about the great backlog of investigations, in spite of a reduction in the number of complaints assessed for investigation (down from 335 in 2000/2001 to 212 in 2001/2002). The Committee expressed the opinion that, *contrary to the Commissioner's view, the targeting of investigations does need to be regarded as the primary task of the Commission*. At the annual meeting with the Commissioner, she indicated that the number of practitioners and services under investigation had fallen to 347, however the Committee was unable to ascertain the date at which this figure was representative. Further, no figure was available for the number of investigations remaining open after eighteen months. The

Committee noted that it wished to review this figure as a comparative indicator of performance and wrote to the Commissioner seeking more information.

The Committee's report on the annual meeting notes it was *similarly concerned that the Commissioner could provide no figure for the number of field-based investigations undertaken by the Commission during the year. The Commission had been previously criticised by the Committee for largely undertaking desk-based inquiries, leading to delays and avoidable errors in the investigation process.*

The Committee noted that in 2002/2003, the Commission reported that the number of open cases from 1999 and 2000 had more than halved. At 30 June 2003, the number of investigations open for more than eighteen months was 254. By the time of this year's meeting with the former Acting Commissioner, Mr Grant, the number of investigations open for more than eighteen months had risen to 279. However, Mr Grant indicated that some two weeks previously this figure had actually been much higher, some 320. Therefore, the backlog reduction strategy he had put in place was clearly beginning to make early inroads into old matters. The longest period for an open investigation is currently 68 months.

Types of Complaints

The Annual Report summarised into categories (pages 25, 26) the types of matters complained about. Communication, or lack of it, remains the most complained about matter, with a total of 303 complaints. There was a steady rise noted in complaints about fees over the past three years, from 69 to 84 to 115 in 2002/2003. Complaints about hospital admissions on mental health grounds remained steady at 30. It was noted that complaints about refusal to hand over medical records increased from 4 to 16, although the Commission believed this change to be so numerically small as to not indicate any change in practice.

Complaints about public hospitals decreased by 62 (14%), continuing a trend begun in 2000/2001. There was a small numerical increase (by 13) of complaints about psychiatric hospitals.

The Committee enquired whether the increase in the number of complaints (51, or 5.7% on the previous year) about 'quality of care' represented an emerging trend. In response, Mr Grant indicated that the quality of care category has a number of subsets, and that the category of institution or hospital practice appears to account for most of the change in figures. While the Commission can find no apparent reason for the increase, the matters referred to include things like cleanliness, provision of meals, state of equipment and other institutional practices not elsewhere categorised.

Case Management

The Committee sought further information about the development and implementation of a case management information system referred to in the Performance Report for 2002/2003 (page 13 of the Annual Report). Ms Donnelly indicated that the proposed partnerships with Tasmania and the Australian Capital Territory in this regard had fallen through. However, an *off-the-shelf* product is currently being purchased by the Commission which is predicted to make a big difference to the management of investigation caseloads and reporting requirements.

Ms Donnelly and Mr Grant commented that as the purchase for the new system has only just gone to tender it is unlikely that implementation will be effected before December of this year. Development of planning timeframes will follow and this data will be used to inform not the forthcoming annual report but the one after it.

The Committee is disappointed with the long delay in implementing an improved case management system which has been promised by the Commission over a number of years. The fact that this long awaited system was never introduced is indicative of the failure of the previous senior management of the Commission to effectively address delays despite their repeated assurances to the contrary.

Reporting of Performance

In the review of the Commission's 2002-2003 Annual Report conducted for the Committee by consultant Mr John Chan Sew, he commented on areas of improvement in reporting. The changes are as follows:

- inclusion of a performance summary at the beginning of the Report under each of the four corporate goals
- more detailed explanatory comments on reported statistical data as prescribed under the *Health Care Complaints Act* 1993
- improved information on financial and budget results
- a significant reduction in the amount of details relating to case studies.

However, the review also concluded that a number of matters which the former Commissioner had undertaken to address in this Annual Report had been overlooked. These included:

- adoption of a more comprehensive performance reporting framework extending beyond the limited performance indicators specified in the Act

- linking performance results to the individual goals of the Commission
- inclusion of performance targets in the Annual Report
- expanding the scope of stakeholder feedback surveys to cover all major activities of the Commission
- reporting on results of all feedback surveys
- changing the design of surveys to increase response rates and to encourage the making of suggestions for service improvement
- conducting an independent review of survey methodologies and reported results on a periodic basis
- benchmarking the Commission's performance with results achieved by similar agencies in other Australian jurisdictions
- providing a breakdown on the budget allocation between key functions (particularly the investigation of complaints) as an indication of the prioritisation of activities
- providing a more comprehensive Executive Summary with the key elements previously recommended by the Committee.

The Committee was disappointed to note that these matters had not been addressed in the Commission's 2002/2003 Annual Report, and that there is still no record in the Commission's Annual Report of unmet performance.

The Committee has previously expressed a view that the former senior management at the Commission seemed preoccupied with consulting health complaints commissions in the other states who are mainly conciliation rather than investigatory and prosecutory bodies. The Committee feels that it would be valuable to consult with the interstate health professional registration boards which perform these disciplinary functions. The Committee hopes the new Commission management will make greater efforts to liaise with these boards in the future.

Former Acting Commissioner, Mr Grant commented that while he would anticipate the inclusion of considerable performance data relating to the backlog reduction strategy in the next annual report, the inward focus of the Commission adopted by the new Acting Commissioner over the next twelve months would probably be the principal way for the Commission to restore the confidence of the community in its operational activities.

During his appearance before the Committee Judge Taylor said that he felt the Commission probably required 25 extra temporary staff to address the backlog. The Commission had previously dedicated four officers to it. Funds have been provided to recruit investigators and to date 15 have commenced work at the Commission. It is predicted that the backlog should be cleared within the next 12 months.

The Committee commended the consultant's review of the Commission's Annual Report, including a proposed performance reporting framework, to the new Acting Commissioner.

Staff Training

The Committee noted that the Annual Report provided information (at page 77) about training in resolution and safety improvement. Yet the Committee was aware of deficiencies in staff training, particularly for Investigation and Resolution Officers.

Former Acting Commissioner, Mr Grant indicated that basic and advanced investigation training for all investigators and new investigators being recruited as part of the backlog reduction strategy is about to get under way. This training will be conducted through registered training authorities. The Commission has been having discussions with training authorities which conducted investigation training for the Independent Commission Against Corruption. It is proposed that trainees will receive credits toward a formal qualification. Details of staff training will be provided in the next Annual Report.

The Deputy Commissioner indicated during his appearance before the Committee that the Commission is currently investigating suitable training packages for investigators. However, the skills gaps in each individual officer depending upon their previous background and experience will need to be assessed to target training most effectively.

Complaint Resolution

Former Acting Commissioner Mr Grant said that one of the things the Commission, the Government and the community needs to do is to examine the breadth of responses that can be made in relation to a complaint. He indicated that this was a failing of the original legislation.

Among the challenges ahead which he has identified for the Commission is that of better communicating and talking with complainants about the options for addressing their complaint and how the complaint might be resolved. Mr Grant indicated that generic skills such as negotiation skills, analytical skills, written and oral communication skills are required for this task. Communicating with complainants about how complaints might be resolved is likely to receive a greater focus than any *particular doctrine of consultative resolution*, he noted.

The Committee noted the improvements adopted by the Health Conciliation Registry, reflected in the rate of agreements reached, 80.3 per cent. This was

tempered, however, with frustration at the poor rate of referral of complaints assessed by the Commission as suitable for conciliation.

In relation to conciliation of complaints, Mr Grant similarly indicated the need for better communication with people regarding the reasons their complaint is not going to be investigated and why conciliation might be the appropriate form of resolution for a particular complaint.

Mr Grant acknowledged the Committee's desire to see the rate of obtaining consents to be raised, and supported the view that, in addition to the better communications from the Commission to complainants about conciliation as described above, the Health Conciliation Registry should be the body charged with obtaining consents. This will require a legislative amendment.

Patient Support Service

The Committee commented favourably upon the Patient Support Service as a valuable component of timely local complaint resolution. It was concerned, however, that the Commission had not reported adequately on performance criteria for Patient Support Officers, including movement toward the benchmarking of achievements against objectives.

While there is a generalised description of performance monitoring processes, the only quantifiable results provided in the Annual Report (page 61) are client satisfaction surveys, which the Committee has criticised elsewhere for falling short in terms of any independent review.

The Committee had indicated to the Commissioner at the Annual Meeting in 2002 that more detailed information on the performance assessment of PSOs, preferably against benchmarked objectives was required because *in truth, the PSOs may perform admirably, but the very 'flexibility' of the model under which they operate can obscure transparency.*

Former Acting Commissioner, Mr Grant indicated that assessment procedures generally within the Commission are under review.

Judge Taylor acknowledged to the Committee that the Patient Support Officers have tended to evolve into patient advocates rather than mere support people.

The officers' roles have now been realigned as supporters rather than advocates of patients.

The Commission is currently conducting training to reinforce to the Officers the exact parameters of their position.

The Committee discussed the role of the Patient Support Officers and the relationship with the Health Conciliation Registry with Judge Taylor.

This is one of the issues that the Committee is currently considering as part of its inquiry into alternative dispute resolution.

Other Issues

The annual meeting also examined a range of 'other issues'. These are discussed below.

1. Preliminary and active Investigations

Mr Grant indicated that the Commission is moving to conduct preliminary investigations, and is pulling together a multi-disciplinary team for this purpose. It is anticipated that preliminary investigations will enable *up-front* clarification of issues, including whether a matter should be investigated, and once this is decided, a more active investigation process should follow, including field trips, interviewing people, and so on. It is also anticipated that this process will lead to a more timely investigation of matters.

Judge Taylor spoke to the Committee about the need to speed up preliminary assessments and investigations. He felt that clearly more medical input is required at all points in the process to achieve this. The Commission is currently undertaking a recruitment drive for in-house doctors in accord with a previous recommendation of the Committee. Discussions are also taking place with the Medical Board regarding the possibility of doctors who provide opinions to the Commission earning medical education credits.

2. Standards of evidence for prosecution of cases

The Committee had previously expressed concern (including in its recent Inquiry) with the merits of cases proceeding to prosecution, following investigation and recommended that cases should be independently tested. This would seek to ensure that such cases had the necessary weight of evidence, but would also help to address the costs of prosecution, both in financial and human terms.

Mr Grant indicated to the Committee his belief that the new Acting Commissioner would be paying a great deal of attention to having the required evidence to prosecute matters.

Judge Taylor was similarly of the view that more robust internal processes such as asking for external counsel opinion on the weight of evidence at various points in the investigation as well as at its conclusion should address previous problems.

3. Independent review of client satisfaction surveys

The Committee noted that the Acting Commissioner has temporarily suspended client satisfaction surveys in relation to investigations. Client surveys relating to Patient Support Officers are ongoing. However, the

Committee noted its repeated request for the Commission to arrange either for the independent conduct of those surveys or for periodic independent reviews. This is essential for public confidence in an independent and transparent assessment of performance.

Judge Taylor agreed that such outside scrutiny would be valuable.

4. "Turning Wrongs into Rights"

The Committee noted the reporting by the Commission on the project *Turning Wrongs into Rights*. The project is being conducted by the Commission on behalf of the Council for Safety and Quality in Health Care. Among the Council's recommendations are calls for a national data set for health care complaints and for agreed competencies for complaint handling staff.

Mr Grant commented that the project has developed better practice guidelines on complaints management for health care services which have received widespread stakeholder support. These are expected to receive the endorsement of the Australian Health Ministers Conference in July 2004.

The Committee welcomed these initiatives.

Additional Information

The technical review of the Annual Report undertaken by Mr John Chan Sew is attached at Appendix 1.

The HCCC Backlog Reduction Strategy is attached in Appendix 2.

TRANSCRIPT OF PROCEEDINGS

COMMITTEE ON THE
HEALTH CARE COMPLAINTS COMMISSION

At Sydney on Thursday, 1 April 2004

The Committee met at 10 a.m.

PRESENT

Mr J. Hunter (Chair)

Legislative Assembly	Legislative Council
Ms T. R. Gadiel	The Hon. Christine Robertson
Mr A. F. Shearan	
Mr R. W. Turner	

Transcript provided by CAT Reporting Services Pty Limited

WILLIAM GRANT, Chief Executive Officer, Legal Aid Commission of New South Wales, 323 Castlereagh Street, Sydney, and

SUSAN DONNELLY, Assistant Commissioner, Health Care Complaints Commission, 323 Castlereagh Street, Sydney, sworn and examined:

Mr GRANT: I appear before this Committee as former Acting Commissioner of the Health Care Complaints Commission from 10 December 2003 to 22 March 2004.

CHAIR: The Committee notes the significant changes instituted at the Health Care Complaints Commission by the then Acting Commissioner, Mr Grant, who is with us today, which he outlined in a briefing to the Committee on 18 March 2004. These include a strategy for addressing ongoing investigations relating to individual matters arising from the Camden-Campbelltown reports and investigations; a strategy for addressing the backlog of incomplete investigations; organisational structure issues including policy, administrative and procedural issues. The Committee is pleased to note that many of the recommendations it made in its report on inquiry into procedures followed during investigations and prosecutions undertaken by the Health Care Complaints Commission have been incorporated in these changes or in changes recommended to the Government. Notwithstanding these reforms, the Committee today will be seeking clarification on some issues arising from the previous annual report.

I will point out to Committee members that, while Mr Grant was acting as commissioner, I approached him and asked him whether he would appear before the Committee to help us in reviewing the annual report. Of course, it is an annual report that ran from 1 July 2002 to 30 June 2003 and tabled in Parliament at the end of December 2003, so the period of the report does not cover the time that Mr Grant was Acting Commissioner; however he agreed to appear before the Committee to give us assistance where possible and I appreciate that, and I also welcome the Assistant Commissioner, Susan Donnelly. Even though many of the issues do not relate to the period when you were in charge, you may be able to shed some light on those issues for us.

Yesterday I had the pleasure of meeting the current Acting Commissioner, Judge Taylor. He indicated his willingness to meet with the Committee in the near future. He said he has his sleeves rolled up and his head down at the Commission implementing many of the recommendations that Mr Grant put forward and he looks forward to meeting with the Committee at a later date. I did not invite the current Acting Commissioner to appear before the Committee today as he has only been in that role for a little over two weeks and I thought that that was not fair to him; it was best to speak to Mr Grant who was in the position following Amanda Adrian having left the position in December.

On the annual report, is there an opening statement you would like to make, Mr Grant?

Mr GRANT: Not an opening statement as such, but what I would like to do is provide for the information of the Committee documents which I referred to at our informal meeting a couple of weeks ago, that is a copy of the backlog reduction strategy and a copy of the action plan through until the end of June 2004.

CHAIR: May we take those as being tabled and forming part of our report?

Mr GRANT: Yes, indeed.

CHAIR: We might move on to questions: In the area of open investigations, the performance report for 2002-2003 reports that the number of open cases from 1999 and 2000 more than halved, and that is on page 13 of the report. As a matter of benchmarking, as at 30 June 2003, how many investigations were open which had been open for more than 18 months?

Mr GRANT: At that date, Chairman, the figure is 254.

CHAIR: What is the number of investigations currently open which have been open for more than 18 months?

Mr GRANT: As at 29 March, that figure was 279. I might add that, as at 15 March, that figure was 320, so it was pleasing to see that they were actually starting to make some inroads into some of those older matters fairly early. My interpretation of that reduction of about 40 would be that there were a number of matters that were pretty close to finalisation and the backlog reduction strategy was to target those matters first and to try to move through them, so it seems that they are already starting the reduction drive.

CHAIR: What is the longest period currently for an open investigation?

Mr GRANT: The oldest matter at the moment is 62 months.

CHAIR: What is the statistical purpose/significance of table 38 on page 52? It indicates the year of receipt, but is this indicative of the date when cases were referred for investigation?

Mr GRANT: Yes, it is. It indicates the number of complaints referred in the years listed for investigation. These referrals came from both the assessment process and also as a result of area health service investigations and the investigations were still open as at 30 June 2003.

The Hon. CHRISTINE ROBERTSON: So the performance report on page 13 indicates the case management system was revised and investigations over 18 months' old were reviewed. Did the revision review offer insight to the action plan and, if so, can you outline what that was?

Mr GRANT: I have to say that it did not really. The action plan was really the result of my observations of the way the commission performed its work, the officer that was assisting me with that, Anita Anderson, and also consultation with many

senior staff of the commission who were very happy to come forward with ideas for change, so really it was not informed by that earlier strategy or document of review, it was more as a result of appraising the situation and forming views as to what should happen.

Mr SHEARAN: There is still no record in the annual report, and I am referring to pages 12 and 13, of unmet performance of the HCCC and strategies to address these. Can the Committee be given an undertaking that this important annual reporting criteria will be addressed in the next annual report of the commission?

Mr GRANT: I would have to sort of be equivocal and say yes and no. I have no doubt that some of those matters will be addressed but the concern that I would express perhaps on behalf of the new Acting Commissioner is that he will be focussed very much on two things, and that would be the backlog reduction drive and I would expect there would be considerable performance data in relation to that which will be produced in the next annual report, although of course they will only be three months into that drive before the end of that reporting period, and also the Macarthur investigation.

If I can use the words that the Acting Commissioner has used to me, the commission will be very much inward focussed over the next 12 or 15 months to move those backlog strategies and Macarthur strategies forward and that is probably the principal way in which the commission can restore the confidence of the community in its operational activities.

How much it gets down to being able to completely address all of those performance targets that have been identified in the work of this Committee, I cannot give any absolute undertaking in relation to that.

I have no doubt that some of the performance matters mentioned will find their way into the annual report but probably a little too early for this one to be able to do that, but for the next one, which closes in three months time.

Mr TURNER: Mr Grant, regarding staff training, in the section of the report referring to staff education and development on page 77, information is provided about training and resolution and safety improvement. In spite of this reference, the Committee is aware of the deficiencies evident in IRO training. Could the forthcoming annual report provide some details of staff training, providing an example of dates, components, the number of staff completing modules, et cetera?

Mr GRANT: Yes, I would certainly expect that would happen in the next report. There are actually discussions at the moment in relation to training of investigation officers, or IROs, with registered training authorities and that is in the action plan which I handed up. We are actually looking at providing basic and advanced investigation training for all investigators, and all new investigators who are being recruited as part of the backlog reduction strategy. We will actually give some sort of formal qualifications to these officers as a result of this external training.

Mr TURNER: Is that training principally internal, or do you have some of the training with outside private consultants?

Mr GRANT: At this stage we are looking at private.

Ms DONNELLY: We have had discussions with the group which was running investigation training for ICAC, a registered training authority, and the training that the investigation officers would do would be to credit them with points towards a formal qualification. I cannot remember the name of it, I am sorry, but there are a number of modules this organisation offers and we can select some.

It is probably worth mentioning that there had been plans for some other training previously, but because of the Macarthur investigation and the various media interests in it last year, it was continually postponed. There had been scheduled training which never eventuated.

Ms GADIEL: Mr Grant, in relation to the investigations, on page 46 of the report it notes that the commission is moving away from paper based investigations. Investigations are becoming more active, which involves tailoring the approach taken with the nature of the complaint and parties involved. The Committee has previously expressed concern at the lack of field based investigations and notes the Acting Commissioner's proposal to increase active investigations according to an investigation plan.

In the forthcoming annual report could there be an indication provided of how the movement away from paper based investigations is occurring?

Mr GRANT: The short answer to that is yes I think they can. The HCCC is moving to conduct preliminary investigations and that is pulling together a multi-disciplinary team of investigators, lawyers, medical advisers et cetera, to more accurately work out whether a matter should be investigated and what the issues are, and that will help people clarify right up front what the investigator needs to be focussed on and on that will include field trips, interviewing people, et cetera. It will be a more active investigation.

Perhaps I can give one illustration of that. There was a very unfortunate case reported on in the media in the last few weeks and it was the lady who died as a result of childbirth, and she had a number of unfortunate incidents that happened in her after care treatment.

We had three investigators up in the Dubbo region when the coroner was conducting a hearing in that case and he handed down his decision, and they were investigating the matter actively in that period of time in conjunction with what was happening in the coronial inquiry. That is an indication of where the Commission is going with its investigations in relation to active field work.

The Hon. CHRISTINE ROBERTSON: In the last round of hearings in relation to the annual reporting of the HCCC there were a lot of issues outlined regarding the information systems and the IT. It sounded a lot like the HCCC was tangled up in a

very old problem that happened in the health sector where someone decided on this wonderful program which was not much chop. What are the chances of rectification of that for the reporting this time?

Ms DONNELLY: With the IT we have gone to tender to purchase, or have developed a new case management system. It has been in the offing for a couple of years now. Part of that was to do with the fact that the Government was interested in us having partnerships.

We explored in the first instance a partnership with Tasmania which fell through, and we explored a partnership with the ACT Health, which has recently fallen through. However, we are going alone now, having gone through the processes required by the Government. I imagine it will probably take six months.

The program is one that can be bought off the shelf and then it is modified according to our requirements. We have investigated it. There are some other departments which have also used the same system. It seems as though this will be very satisfactory and will make a big difference in terms of the managers being able to manage investigation case loads and also reporting requirements and things like that.

At the moment we are working to a system which is probably about 15 years old. It is quite inadequate. I can remember 13 years ago doing a master's thesis on the complaints unit at the time and having to use that system. It is very debilitating.

The Hon. CHRISTINE ROBERTSON: For the annual report process we will have some indication of time lines for resolution?

Ms DONNELLY: The new system will not be up and running for when the next annual report is produced. It will probably be the one after. It is a matter then of using the existing system and trying to plan ahead and getting up the timeframes that you are asking about.

Mr GRANT: Implementation of the system is probably not likely before about December of this year. It will take that long to modify the package for HCCC use.

CHAIR: In the area of prosecution of cases, in terms of tribunal and board outcomes, the Committee notes that a quarter of cases heard and determined were found to be not proven or were dismissed. That is on page 55 of the report. Of the 11 cases appealed to a higher court or jurisdiction four cases, or 36 per cent, were upheld. This is a similar figure for the outcome of appeal cases in 2001-2002, where four of 10 cases completed were appealed and upheld.

The Committee has previously expressed concern and most recently in our report of the inquiry into procedures following investigations and prosecutions undertaken by the commission, that cases proceeding to prosecution should have the necessary weight of evidence behind them.

Indeed, it has been recommended that the merits of cases be independently tested following investigation. The cost of prosecuting cases on shaky evidence in financial as well as human terms is unwarranted, the Committee believes. What were the respective costs to the commission of the cases upheld in the Court of Appeal?

Mr GRANT: Just a couple of comments if I can, chairman, in relation to that. The cost was $19,092. The commission has not as yet paid any adverse costs that were awarded against the commission.

In relation to the quarter of matters that did not result in some sort of auditing, I do not know what a good or a bad figure might be. If I can go back into my own field for a minute, my understanding is that the DPP's success rate in criminal trials is somewhere around 50 per cent, and that is pretty true across the whole country as I understand it. If there is a 75 per cent success rate in disciplinary matters that may not, of itself, be a bad figure.

The job of the commission, of course, is to present those cases and it is up to the Medical Tribunal or whatever tribunal it is to determine whether or not the standard of proof has been met this these particular cases. I cannot honestly say a 75 per cent success rate is a bad figure. It may or may not be. This was the first year we have reported on that so it would be interesting in years to come to see what the trend actually shows, whether that figure goes up or down.

The next thing I would say is that I would expect that with the new Acting Commissioner on board the Commission would be paying a great deal of attention to having the required evidence to prosecute matters over the next 15 months or so and whether that results in a change in that trend or not will be interesting to note.

Mr SHEARAN: Is there any way of getting some comparisons with other jurisdictions on their process?

Mr GRANT: That might be able to be achieved, yes, we can take that on notice and have a look at that. We can have a look at their reports.

CHAIR: I will point out for the record that when we talk about other jurisdictions we are not necessarily talking about conciliation commissions or ombudsman's offices in other States.

Mr GRANT: It would be the registration authority.

CHAIR: The Health Services Commissioner of Victoria appeared before an Upper House committee on Monday and I think she might have said that it was apples and oranges, or someone did.

The Hon. CHRISTINE ROBERTSON: We definitely are the only State to have the separated off health care complaints system in relation to investigation and referral for possible prosecution. All of the rest combine their conciliation processes and a lot of quality stuff into their health care complaints and have much less of the

HCCC role, so they are very difficult to compare. We are the only State to have this process.

Ms DONNELLY: In fact New Zealand is the other model that also prosecutes, but in the other States the prosecutions are managed by the registration board, which was the thing that was addressed in the Chelmsford Royal Commission and why the Health Care Complaints Commission in fact does have prosecutorial functions because it was seen that it was too much in-house.

Mr GRANT: I think it was Merilyn Walton who actually made the apples and oranges comment.

The Hon. CHRISTINE ROBERTSON: And the woman from Victoria.

CHAIR: The lady from Victoria pointed out that they were different. We have pointed this out before and I would hope - and I am sure he will because I raised this with him yesterday - the new Acting Commissioner, Judge Taylor, endeavours to meet with registration boards in other States which are doing a similar thing to the Commission. I have no objection to our commissioner meeting on a six-monthly basis with other commissioners, but he is meeting with conciliation commissioners and they are not doing the same job as he, except of course the people from New Zealand.

Mr TURNER: Regarding your comments, Mr Grant, the number of cases appealed and upheld may very well be within the guidelines - you do not know and I certainly do not know - but we are talking about professionals' lives and professions at stake and I would understand that some of these cases would have been open for investigation for about 18 months or more; they get a finding against them and they then appeal, and I do not know how long that takes, but in some cases I would imagine that that doctor's future is in the balance for up to three years. Whilst it might be within the guidelines, and we only talk about four cases, every one of those cases that we could eliminate far more quickly and let that doctor get on with his life if he is ultimately found to be not guilty, so to speak, regardless of the cost - you said $19,000, which in the overall scheme is not very much money - but we are talking about professionals' lives and their future and any reduction that we can achieve through a better system would be highly desirable.

Mr GRANT: With respect, Chairman, I would agree with all of those comments. It is necessary in the interests of all the parties, be it the hospital concerned, if it is concerned, the practitioner, the complainants, that these matters be resolved in a much more expeditious way.

CHAIR: Does the 75 percent success rate that you mentioned include all adverse outcomes for the practitioner or exactly the sanction that the Commission had asked for, i.e. in many cases they asked for a doctor to be struck off, but that is not the outcome. There might be an adverse decision, but it is not what the commission was actually requesting.

Mr GRANT: 25 percent of cases were dismissed or not proven, so it is 75 percent that has some outcome. There was one particular case where there was an

appeal by the practitioner against the medical tribunal decision imposing a condition on registration that for 12 months the practitioner not practise medicine as a private practitioner. There was no appeal against the finding of professional misconduct or the reprimand and the finding and reprimand were confirmed on appeal. The appeals cover a multitude of different circumstances, about whether the order should have been imposed, whether the order was unjust, whether the conditions that were attached were too onerous, et cetera.

CHAIR: Table 7 on page 34 indicates complaints referred to another body. Of these, 453 or an increase of 7.4 percent were referred to registration boards. Is this a trend and is there any explanation for it?

Mr GRANT: As far as we can see, it is not a trend. Cases are assessed in conjunction with the relevant registration boards. In previous years more cases have been referred to registration boards and to date 302 cases have been referred this financial year, so it seems to be fairly usual, if I can put it that way, that those sorts of figures come out, but there does not seem to be a particular increase or decrease in those figures.

CHAIR: I think there was some concern that that was one way that the Commission had been able to reduce its number of cases by referring them off to boards?

Mr GRANT: Can I say, without necessarily confirming or denying that statement because I have not the knowledge to do that, one would expect that any preliminary investigation model may end up changing these figures quite dramatically. It is difficult to know, but I would expect that those figures could well change.

Mr SHEARAN: In relation to the types of complaints, table 6 on page 25 categorises the types of complaints received by the Commission. In most cases this is similar to other years. Where there are emerging trends, these are commented upon in the text of the report. Is there any comment on the increase in the number of complaints about quality of care? You will notice that there has been an increase of 51 or 5.7 percent on the previous year.

Mr GRANT: In 2002-2003 the number of complaints under quality of care was 498 or 18.3 percent compared to 337 or 12.6 percent in the previous year, which was a rise of 161 or 5.7 percent. The quality of care category has many subsets. One of these is institution/hospital practice, which rose from 57 complaints in 2001-2002 to 158 in 2002-2003, a rise of 101 over that 12 month period. That seems to account for most of the change in the figures and we cannot quite find a reason why that figure rose in that particular period of time. Those matters refer to things like admission processes, cleanliness, provision of meals, state of equipment and other institutional practices that do not fall under any other category, so it is hard to know why we had that increase of about 100 matters under that particular heading.

Mr TURNER: I was talking to you earlier about the level of quality of care complaints. On the information I was given yesterday, there is a lot lower level from rural areas and we were talking about whether people are less likely to complain coming from a rural area or they get better satisfaction within the medical system in rural areas. Yesterday a lady, whose mother received less than adequate attention at a hospital - and I forget which hospital - commented to me that she was not going to bother about it and, with the publicity that this has received in the press in the last couple of days and with the assurance that I was on this Committee, that we were meeting this morning and that we were seriously looking at these complaints, she said, well, I will put in a submission because I now believe that something might be done, so maybe the publicity that it is getting is making people more aware and they are making a complaint as a result of that publicity. I do not know, it is an unknown, but maybe that is a factor.

Mr GRANT: I would think that could well be. Publicity seems to generate those sorts of things, and maybe you are a better judge than we are of who walks through your door and what they are actually asking you to do, but I would agree: I would expect this publicity to result in more complaints. I do not know that we can say at the moment that there is any trend in that. I think perhaps by the end of this financial year some trend might be evident.

The Hon. CHRISTINE ROBERTSON: A bit like the study ICAC has sent us in relation to, over the years, the levels of complaints and satisfaction and when the police investigation was going on, the incidence of ICAC issues and resolution and how the public felt about it. It was right up here and now it has settled down it has gone back to normal.

Ms DONNELLY: I think there is no doubt that media attention spurs people on to make more complaints. They respond to whatever is in the media.

Mr GRANT: One of the things we have to do, and the Government has to do, and the community has to do, is look at the breadth of responses that can be made to a complaint. I think that was a failure of the original legislation. I am aware that this Committee has another inquiry in mind to look again at alternative dispute resolution, if I can use that term, in the health complaints system and I think that is well worth doing.

It is necessary to give people an option of where to slot their complaint. Part of the difficulty with the HCCC has been that we have not communicated well with complainants and we are reviewing that. You will notice on the action plan a fair bit of work is going to go into how we tell people the results of their complaint to us.

We actually explain to them. We do not just say that we are not going to investigate it we say, for example, we think it appropriate for conciliation for these reasons, and we actually spell out those so they can try to understand why we did not think it serious enough to investigate and why we think that is the appropriate response. All of those matters have to be looked at.

Mr TURNER: Quite often with proper consultation they are happy with the outcome.

Mr GRANT: If it is explained to them.

Mr TURNER: The report refers on page 39 to consultative resolution. The Committee has some concern about how consultative resolution is defined in the literature and put into practice. How is the performance of staff assessed in the application of consultative resolution?

Ms GRANT: I think the short answer to that is that as far as I am aware it is not. Specific performance assessment criteria for staff involved with consultative resolution have not been developed. Staff are expected to have generic skills such as negotiation skills, analytical skills, written and oral communication skills, et cetera, but there is a paper that was produced in relation to consultative resolution which I am happy to make available.

I actually would not say that the Commission is going to be relying upon those sorts of processes, apart from in a general sense, in the coming period of time. I think consultative resolution to me frequently means actually communicating and talking to people about how their complaint might be resolved and there will be a lot of focus on that. I do not know that it will be relying on any particular doctrine of consultative resolution or anything of that nature. I am happy to make that document available.

CHAIR: Are you happy to table that for us?

Mr GRANT: Yes.

Mr TURNER: What is the partnership and quality improvement framework that is referred to on page 41?

Mr GRANT: It is that consultative resolution document that I have just made available.

Mr TURNER: You have answered the next one, where is this framework documented, you have tabled that. How are the outcomes of the learning approach indicated on page 40 documented and agreed by the parties?

Mr GRANT: Again it is in that document.

Ms GADIEL: The Committee is concerned that yet again the recommended independent conduct or review of investigation satisfaction surveys did not occur, pages 60 and 61 of the report. In line with previous recommendations made by this Committee will there be an undertaking to implement either independent conduct or independent review of investigation satisfaction returns?

Mr GRANT: Again, I would think that is a matter for the Acting Commissioner or beyond the Acting Commissioner's time. I think that is a substantive issue which

needs to be addressed. I suspect he might be focussed on other matters in the immediate future.

I have to say that I took a decision in January this year to stop sending out surveys. The reason I did that was because we had an awful lot of things to change in the organisation, in relation to how we communicated with people, how we did our job, how we got the material to people in response to their complaints, and I thought surveys in that particular climate was inappropriate. Those surveys will of course be reinstituted at an appropriate time.

The patient support officer surveys are still being done but not those in relation to investigations. I thought that those investigations should have been handled better and in a more timely way and a better communication process attached. I did not think the surveys would actually give a better result than we had actually formed ourselves about what needed to change.

CHAIR: Mr Grant, you did say that the patient support surveys are continuing. What we are seeking is whether there will be either an independent conduct of those, or independent review of the patient support surveys, rather than an in-house review.

Mr GRANT: Again, moving to some more independent analysis on the survey results is something that will be on the drawing board. I cannot commit on behalf of the Acting Commissioner when that will be done in the current climate, and what he is focussing on in the next 12 or 15 months.

There was some work done in relation to key performance criteria. They are in the report. I will not go through those. Obviously the Committee has the view that more needs to be done, particularly in the appraisal of the work of the patient support service. I cannot give an undertaking on behalf of the new Acting Commissioner as to how he will treat that in the priorities of what he has to do to move the commission forward.

CHAIR: I think it is important for this Committee to get on the record our feeling on certain issues so that the new Acting Commissioner, when our report is tabled in Parliament, can take advantage of reading through the report and see some areas with which the Committee is concerned.

The Committee has been criticised previously, wrongly I believe, and if you go through our annual reviews of the commission we have made many strong recommendations and many of those have been ignored by the commission in the past.

Ms GADIEL: The Committee recognises the patient support service, pages 19 to 24, as a valuable component of timely local complaint resolution. Of all the information presented in the report about PSS, the Committee is concerned that yet again there is no reporting of performance criteria or patient support officers, no moves identified towards benchmarking of activities, no discussion of assessment

processes, although each of these has been previously identified by our Committee as vital for the objective assessment of the public support service.

Will there be an undertaking to introduce these performance elements for patient support officers in the next and subsequent annual reports?

Mr GRANT: As I indicated, there are some performance criteria currently there but obviously from the Committee's point of view they are considered to be inadequate. The results of client satisfaction surveys are commented upon as well as providing feedback in a description of performance monitoring measures, page 61 of the report.

Assessment processes generally within the Commission are being reviewed and could be included in the next annual report, subject to the provisos that I provided before about what the Acting Commissioner sees as the priorities for the commission over a short period of time. I suppose I have to say possibly. I cannot commit on his behalf to actually doing that in the next annual report. Considering that the next annual report period expires in three months time, it would be difficult to provide more meaningful data because it has not been completed in the first nine months of this year.

The Hon. CHRISTINE ROBERTSON: My issue is in relation to conciliation. The report indicates on page 34 that 436 complaints were assessed for conciliation, 14 percent more than in the previous year, yet the commission was unable to obtain consents for 234 complaints, that is 53.6 percent of the complaints assessed for conciliation, and for a further 43 complaints only partial consent was received, so only 159 complaints were ultimately referred for conciliation. The Committee is very pleased with the improvements adopted by the Health Conciliation Registry and this is reflected in the results achieved by the registry, which had 169 conciliations completed and 80 percent of these resulted in agreement. The Committee would like to see the rate of obtaining consents lift dramatically. Is it possible to clarify the figures given for agreements reached and partly reached through conciliation? The figure of 80 percent provided in the last paragraph on page 35 does not accord with the figures provided in table 20 on page 36.

Mr GRANT: Yes, there is a mistake in the text. The table is the correct information. In 2001-2002, 80.3 percent had agreement or partial agreement reached and, in 2002-2003, 78.7 percent had agreement or partial agreement reached.

The Hon. CHRISTINE ROBERTSON: What other actions might be taken to achieve an improvement in the rate of obtaining consents?

Mr GRANT: I think, firstly, again there needs to be better communication with people as to why it is not going to be investigated and why conciliation might be the appropriate form of resolution for that particular complaint. I think that should go a long way towards lifting that. I think this Committee has in the past indicated that it thought the conciliation registry itself should be seeking those consents. The advice which I have is that there is a restriction in the current legislation which does

not allow that, but I would agree. I would think that the registry itself should seek those consents after the commission has appropriately communicated why it considers an investigation is inappropriate and some other resolution mechanism should be suggested, so I think removing the seeking of consent from the commission, which has just told people "No, we do not think it is serious enough to investigate" might actually get people thinking a little more clearly about whether that is a better option for resolving the complaint or not. The last thing is I think the legislation should be amended to allow that to happen.

CHAIR: In the area of consultation, the Committee has for a long time been concerned to ensure that practitioners are also consulted along with other groups as stakeholders of the commission. The Committee is pleased to note that practitioners have been included in this category in the "Turning Wrongs Into Rights" project which the commission is conducting on behalf of the Council for Safety and Quality in Health Care. The recommendation of that group on page 64 for a national data set for health care complaints and agreed competencies for complaint handling staff and associated training is long overdue. The Committee welcomes these initiatives. What further proposals to improve health care complaints handling have emerged as a result of this project?

Mr GRANT: The project has developed better practice guidelines on complaints management for health care services. The guidelines have received widespread stakeholder support and an accompanying handbook has also been developed. The Australian Council for Safety and Quality in Health Care gave support for the guidelines in March 2004 and will submit them to the Australian Health Ministers Conference for endorsement in July 2004. It will then be up to individual jurisdictions to implement them. The council is also considering other recommendations which were included in the summary report, such as the national reporting of complaints data. The Australasian Council of Health Care Complaints Commissions remains committed to the national reporting of complaints data and the maintenance of a national health complaints data set. However, resolution of the matter is dependent upon the availability of funding and requires the cooperation of a range of organisations, including the New South Wales Department of Health, that currently collect complaints data in the health care sector. The Commission, like all other health complaints commissions, is committed to promoting the guidelines and handbook to health care services by publication on its website, through speaking at conferences, running workshops, et cetera. In addition the Commission is using the research in principles of better complaints practice as part of a special project to review its own policies and procedures during 2004, so in effect the Commission will be looking at those best practice guidelines to see how it can actually alter its own procedures to comply with those.

CHAIR: Once again, the Committee has employed the services of a consultant, Mr John Chan-Sew, to review the 2002-2003 annual report. A copy of that will be attached to or incorporated in our report to Parliament. There is a number of issues raised there which hopefully the new acting commissioner will be able to address in the next annual report, certainly around the non-compliance with annual reporting requirements as set out in Treasury guidelines.

Mr Grant, yesterday the interim report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals was handed down by Mr Walker and I would like to point out for the record that in the Committee's report tabled in December, just after your appointment as Acting Commissioner, in the inquiry into procedures followed during investigations and prosecutions undertaken by the commission, the Committee pointed out that on 5 December 2003 - and this is in the Chairman's foreword - the Committee wrote to the Minister for Health, the Honourable Morris Iemma MP and requested that he consider funding an independent external review of the commission's systems for conducting investigations and prosecutions. The Committee believed that this type of detailed review was clearly outside the Committee's resources; however, the Committee felt that it was imperative that such a detailed review was undertaken as soon as possible. Throughout the inquiry the Committee has received more than enough information to raise concerns about how cases are being managed at the Commission to warrant such external scrutiny and I think the Minister has acted on our request and certainly the interim report handed down yesterday by Mr Walker covers many of the areas of concern that the Committee had. I understand that the information you have tabled with us today on reorganisation and refocus of the Commission's activities also addresses a number of those issues. Is there any other closing comment that you would like to make to the Committee?

Mr GRANT: Apart from the backlog reduction strategy which I tabled and the list of activities to be undertaken between now and the end of the year, which will of course now be reviewed and implemented as appropriate by the new Acting Commissioner, there were a couple of other matters which I did address during my time as Acting Commissioner. One of those was a legislative review, and that is being conducted by the Cabinet Office. My views have been fed in on that and, if I may say, my views were certainly influenced by the work that this Committee had done, including the work in their report which you mentioned in your introduction.

Another matter, of course, was the ongoing response to the Macarthur investigation and what I might call the Macarthur strategy has been implemented as well and is now in place and was commented upon by Mr Walker in his report yesterday. That involves bringing in outside legal expertise with senior counsel and junior counsel through the Crown Solicitor's Office, linking it up with investigators from the commission who had no prior involvement in the Macarthur investigation and combining that as well with increased medical expertise so that ongoing investigation work can be conducted as expeditiously as possible in the interests of all the parties who have been involved in this exercise.

CHAIR: I appreciate you appearing before the Committee today and certainly for the changes implemented at the Commission in the short period that you were there and I hope the Committee can continue to call upon your assistance in the future.

Mr GRANT: Thank you.

(The witnesses withdrew)
(The Committee adjourned at 11.00 a.m.)

APPENDICES

Appendix 1 –Review of the 2002-2003 Annual Report of the Health Care Complaints Commission by consultant to the Committee, Mr John Chan Sew

Appendix 2 – Health Care Complaints Commission - Backlog Reduction Strategy

APPENDIX 1

Review of the 2002-03 Annual Report of the Health Care Complaints Commission

Introduction

The main purpose of the review of the 2002-03 Annual Report of the Health Care Complaints Commission was to:

- assess the adequacy of the Commission's current approach to performance reporting;
- examine the extent of compliance with the statutory requirements as set out in the Annual Reports (Statutory Bodies) Act and Regulations; and
- identify any major deficiencies in reporting and to put forward recommendations for future improvement.

The 2002-03 Report has shown improvements in certain areas as a result of the adoption of a number of recommendations previously made by the Committee on the Health Care Complaints Commission. In particular, the following changes have been noted:

- inclusion of a performance summary at the beginning of the Report setting out, under each of the four corporate goals, the 'Aims for 2002-03', 'Performance Results for 2002-03' and 'Aims for 2003-04';
- more detailed explanatory comments on the reported statistical data as prescribed in the Health Care Complaints Commission Act;
- improved information on the financial and budget results; and
- a significant reduction in the amount of details relating to the case studies.

At the 8th Meeting on the Annual Report of the Health Care Complaints Commission held in September 2003, the then Commissioner undertook to give consideration to a number of matters in relation to the preparation of future reports including:

- adoption of a more comprehensive performance reporting framework that extends beyond the limited performance indicators that are currently specified in the Act;
- linking the reporting of performance results to the individual goals of the Commission;
- inclusion of performance targets in the Annual Report;

- expanding the scope of the stakeholder feedback surveys to cover all of the major activities of the Commission;

- reporting on the results of all feedback surveys and, in particular, the satisfaction surveys for the patient support service and the investigation process;

- changes to the design of the surveys to increase the response rates and also to encourage the making of suggestions for service improvement;

- conduct of an independent review of the survey methodologies and the reported results on a periodic basis;

- a benchmarking comparison of the Commission's performance with the results achieved by similar agencies in the other Australian jurisdictions;

- provision of a breakdown of the budget allocation between the various key functions (particularly the investigation of complaints) as an indication of prioritisation of activities; and

- a more comprehensive Executive Summary incorporating the key elements as previously recommended by the Committee.

Apart from the reporting of performance results against the individual corporate goals in the 'Performance Summary' Section and the brief references to the surveys of the patient support service and the investigation process, no or little further progress has been made in the 2002-03 Report in relation to the other eight matters outlined above.

Evaluation of Current Performance Reporting Approach

The review of the 2002-03 Report has identified a number of matters that would require attention by the Commission if the current approach to performance reporting is to be further improved.

The 'Vision Statement' and the corporate goals of the Commission both emphasise the twin roles of resolving and investigating complaints as well as maintaining and improving health standards and the quality of health care services in New South Wales. The charter of the Commission, as stipulated under the Health Care Complaints Commission Act, on the other hand, is only focussed on the primary responsibility of resolving and investigating complaints and advising the Minister and others on trends in complaints. The identification of systemic problems and the making of recommendations for improvement is not the key focus of the Commission according to the legislation. The current inconsistency between the vision and goals of the Commission and its statutory charter needs to be resolved in the review of the legislation which is currently underway.

Most of the performance indicators presented in the 2002-03 Report are related to the quantities and timeliness of the outputs and there is only limited coverage on the outcomes achieved and the effectiveness and efficiency aspects of performance. For example, no performance measures and targets have been referred to at all in the reporting of the performance results against Goals C and D on pages 17 and 18. According to the Report, additional work has recently been done in developing more meaningful indicators of performance for future reporting.

The kinds of additional performance indicators that could be incorporated in future reports include:

- average times taken to finalise the different categories of complaints and investigations;

- levels of satisfaction with the services provided by the Commission (based on surveys of stakeholders);

- average costs for the different categories of complaint handling and investigations; and

- the extent of the adoption of the Commission's recommendations by the relevant bodies.

Some of the 'Aims for 2002-03', as stated in the 'Performance Summary' Section (pages 12-18), are expressed in a non-specific way e.g. increase use of active investigations and increase use of tailored resolution strategies. Although the term 'aims' is used, they are in fact intended to identify specific actions planned for the 2002-03 year. Therefore, the 'aims' need to be specified in terms of planned initiatives and projects otherwise it would be difficult to hold the Commission accountable for the results achieved.

Where quantitative performance results are referred to in the Report, the related targets and comparatives for the current year have only been provided in some cases. Generally, the explanations given for under and over performance are not adequate. In addition, more information could have been provided on lessons learned and specific actions taken to address under performance.

The Report has not included any comments on the shared responsibilities for cross-entity performance issues and also on the Commission's contribution to the joint outcomes. The Commission has close working relationships with a number of other entities including Department of Health, Area Health Services and health professional organisations.

Further, an attempt has not been made in the Report to benchmark the Commission's performance against the results achieved by similar agencies in the other Australian jurisdictions.

'The Way Forward'

To ensure that a robust and comprehensive approach is adopted by the Commission in reporting on its performance in the future, a number of steps need to be taken.

At present, the Health Care Complaints Commission Act specifies the reporting of particular statistics about the activities of the Commission but most of them are not indicators of performance. In the 2002-03 Report, the Commission has foreshadowed the conduct of a comprehensive review of the Act during the next reporting year. The new Act should incorporate provisions giving legislative support to an appropriate performance reporting framework. The Commission will need to allocate further resources to the development of this framework as a matter of priority.

The 'Performance Summary' Section of the 2002-03 Annual Report indicates on page 17 that additional performance indicators have been identified for the key processes and that those indicators have been incorporated in the Corporate Plan. It is important for the new indicators to fully capture the efficiency and effectiveness of the key processes as well as the outcomes achieved. This will necessitate, among other things, a review of the existing charter, goals and vision of the organisation as part of the re-examination of the current legislation.

The adoption of a statutory framework for performance reporting has the benefit of ensuring that a comprehensive and consistent approach is followed from year to year. This will allow the tracking and evaluation of performance over time.

Proposed Performance Reporting Framework

To be an effective instrument of accountability, the Annual Report must contain a strong outcomes focus with clear linkages to the objectives, strategies and outputs of the organisation. In reading the Report, the stakeholders should be able to assess the extent to which the Commission has succeeded in achieving its objectives and desired outcomes.

The 'Review of Operations' Section needs to provide a balanced discussion and analysis of the performance results achieved during the year. This Section should cover not only the 'good news' but also setbacks and problems. Emphasis should be given to the reporting of performance outcomes and effectiveness (rather than the types and volumes of activities) e.g. stakeholder feedback, results of conciliations, investigations and prosecutions and time intervals involved in the complaints and investigation processes. To assist the stakeholders in properly assessing the performance of the Commission, the following information must be provided:

- a comprehensive set of key performance indicators covering all major aspects of the operations together with a commentary on the meaning and background contexts of the indicators;

- performance targets for the current year as stated in the Strategic and Corporate Plans;

- a comparison of the actual performance achieved during the year with the targets set;

- adequate explanations for instances of major under and over performance and, in the case of under performance, details of lessons learned and actions taken to improve services;

- trend data (preferably over a five year period) accompanied by a detailed commentary on the changes over time. (The aim is to give a "continuing story" on the performance of the organisation and also to enable the tracking of performance between years);

- a benchmarking comparison with the performance results achieved by similar agencies in the other Australian jurisdictions;

- an outline of the major initiatives and projects planned for the current year and details of the results achieved (together with an explanation for any delay and the revised target date for completion); and

- a commentary on the shared responsibilities for cross-entity performance issues and on the Commission's contribution to the joint outcomes achieved with other relevant bodies e.g. Area Health Services and health professional organisations.

The conduct of stakeholder surveys is an area that will require further attention. Changes that are considered necessary include:

- better designs for the survey methods (e.g. questionnaires) to enable the obtaining of more meaningful responses to issues that are related to the different aspects of the Commission's performance (including suggestions for service improvement);

- increasing the response rates to survey requests to enable more valid conclusions to be drawn from the results; and

- subjecting the survey processes to periodic independent reviews.

The feedback surveys should cover the stakeholders as identified on page 2 of the Report. The Report has noted on page 60 that the response rate to the satisfaction survey of the investigation process was poor (less than 10%) and therefore no valid conclusions can be drawn from the results. For more transparency, it would be helpful to also publish the results of all internal reviews of the Commission's operations in the Report together with details of remedial actions taken.

To adequately account for the financial performance of the Commission, the Report needs to include a separate 'Financial Management' Section providing a clear link between the financial statements and the 'Review of Operations' Section of the Report. The 'Financial Management' Section should present Statements of Financial Position, Statements of Financial Performance and Statements of Cash Flows (in

summarised forms) over a five year period together with a detailed commentary on all major variances from last year and from budgets as well as on significant changes over time. The discussion and analysis should also cover all major financial management and accounting issues faced by the Commission during the year.

In examining the Report, the readers should be able to obtain an indication of the likely performance of the Commission in the future (particularly the next financial year). This can be achieved by including a separate Section on 'Future Directions and Developments' providing forward-looking information and comments such as:

- a discussion of the future outlook for the Commission including issues and events that are likely to have a significant impact on the following year's performance;

- details of expected future changes and trends within the Commission's operating environment; and

- an outline of what the Commission aims to achieve in future years (particularly the next twelve months) e.g. planned key projects and initiatives and quantitative measures of performance.

Other Reporting Issues

There are a number of other disclosure issues identified by the review of the 2002-03 Report. These issues should also be addressed in the restructure of the form and content of the Commission's future reports.

The Executive Summary is a useful feature of the 2002-03 Report except that a number of important key performance indicators, initiatives and developments have been omitted from the Summary and instead covered in the Commissioner's Report (which is four pages long). In future, the Commissioner's Report can be reduced to only a short 'Foreword" but with the coverage of the Executive Summary being expanded to include:

- significant issues and developments which had an impact on the performance during the year and future directions and outlook for the following year (including both positive and negative factors);

- key performance targets and results achieved (including explanations for any major variances);

- trend data on performance for the key result areas;

- significant projects and initiatives completed against plans as well as key projects and initiatives identified for the following year; and

- financial results and position for the current year as compared to budgets and past trends.

There is quite a significant gap between the contents of the Executive Summary in the 2002-03 Report and the requirements as indicated above. It would also be helpful to the readers to provide appropriate cross references to different parts of the main body of the Report for more detailed information.

In the 'Review of Operations' Section of the Report, the presentation of the key performance indicators is intermingled with a large number of tables disclosing other non performance-based statistical data. The readers' comprehension of the key performance indicators can be further enhanced by presenting them together at the beginning of the review of each of the key result areas.

The Section on 'About Us' has identified the vision, charter, organisational model and stakeholders of the Commission but the four goals of the organisation have not been referred to.

The 'Five Year at a Glance' Section comprises a series of bar charts mainly on the volumes of different activities over the last five years. The charts, however, are not accompanied by any discussion and analysis of the trend data thus limiting the usefulness of the information.

Non-Compliance with Annual Reporting Requirements

Apart from the deficiencies identified in the Commission's performance reporting, there are two other instances of non-compliance with the annual reporting requirements noted by the review.

The Commission has not included a 'Statement on the performance of each executive officer of or above Level 5 holding office at the end of the reporting year.' The Commissioner's position is at Level 5 of the Senior Executive Service. According to Clause 11 of the Annual Reports (Statutory Bodies) Regulations, this Statement is required to be made by a person responsible by law for reviewing the Commissioner's performance and is to indicate the Commissioner's performance having regard to the agreed performance criteria.

The table showing the different categories of employees and their numbers on page 72 of the Report does not fully meet the requirements of the Regulations in that it has provided comparative figures only for the previous two years. Schedule 1 of the Regulations requires the disclosure of comparative figures for at least the previous three years.

Tabled 1/04/04

HEALTH CARE COMPLAINTS COMMISSION

Backlog Reduction Strategy

1. Purpose of this Strategy

To finalise all investigations commenced more than 6 months ago and current as at 1 February 2004 by 1 March 2005.

2. Scope of this Strategy

This strategy applies to all open investigations commenced after 1 August 2003.

3. Actions

Audit of Investigations

3.1 The Investigation and Resolution Officer (IRO) is to review all open investigations and is to provide the relevant Team Leader with a report advising the likely outcome of the investigation based on the information gathered, the status of the investigation and the steps required to finalise the investigation.

3.2 An Investigation Review Team comprising the Team Leader, a Legal Officer and a Medical Officer is to consider the review current investigation files and is to make recommendations to the Deputy Commissioner on the most effective and efficient means to finalise each investigation. The Review Team is to commence this process by firstly examining files that are over 3 years old together with those where the officer has indicated the investigation outcome as termination.

3.3 The Review Team is to consider all open investigations to determine if the information gathered indicates:

a. The existence of a significant issue of public health and safety;
b. The existence of a significant question of appropriate care or treatment;
c. Grounds for a successful prosecution of a health practitioner for misconduct or unsatisfactory conduct;
d. Grounds to ask a registration authority to discipline a health practitioner;

3.4 In reviewing investigations, consideration must be given to the time that has elapsed since the event and whether there have been any further complaints against the practitioner/service provider since the complaint was lodged when determining if an investigation will result in a successful prosecution or disciplinary action.

3.5 This audit is to be completed by Friday 14 February 2004.

Finalisation of Current Investigations

3.6 All investigations assessed by the audit to be in the following stages of investigation are to be completed by the IRO within 28 days of the date of audit, but no later than 12 March 2004:

i. All investigations at draft report writing stage;
ii. All investigations at section 40/43 review stage;
iii. All investigations at report review and finalisation stage; and
iv. All investigations at prosecute, review and complaint settlement stage

3.7 IROs are to take all actions necessary to ensure that investigations are completed within that time frame.

3.8 Consultation with the relevant registration authorities on the finalisation of identified investigations is to be completed by 5 March 2004.

3.9 IROs are also to concurrently take all actions necessary to progress Priority 1 Investigations to conclusion as quickly as possible while attending to these files.

Allocation of Remaining Investigations – New Team Structures

3.10 From 15 March 2004, the remaining investigations are to be re-allocated to the following new teams:

Team 1 - All matters involving pharmaceutical issues, drug dispensing, etc to the Pharmacy and Prescribing Complaints Team
Team 2 - All other matters to the General Team
Team 3 - All investigations less than 6 months old and incoming investigations

3.11 Allocated files are to be finalised in the following priority:

1. Investigations over 3 years old and Priority 1 investigations;
2. Investigations over 2 years old and Priority 1 investigations;
3. Investigations over 18 months old;
4. Investigations over 12 months old.

3.12 Files that are not suitable for re-allocation will remain with the existing IRO. Files considered not suitable for re-allocation include those where the complexity of the investigation would result in a loss of productivity or expertise in that matter if the file were to be re-allocated and Priority 1 investigations.

Investigation Planning and Monitoring

3.13 Investigation plans are to be developed for all continuing investigations within 7 days of the investigation file being allocated to an IRO.

Investigations plans are to be in the new format approved by the Deputy Commissioner.

3.14 As part of that investigation plan, all files are to be reviewed to ensure that statutory requirements have been followed to date, i.e. statutory declaration received, parties advised of assessment outcome, registration authority advised.

3.15 All investigation plans are to be developed in consultation with a medical advisor and legal advisor and must identify the medical and legal issues that the information gathered in the investigation must address.

3.16 Investigation plans are to be approved by the relevant team leader, and where the Team Leader considers it necessary, by the Deputy Commissioner within 14 days of receipt of the file by the IRO.

3.17 IROs and Team Leaders are to meet on a monthly basis to review the progress of all open investigations. If the investigation is a Priority 1 investigation or complex in nature, weekly meetings are to be held.

3.18 IROs are to seek the advice of the medical advisor and legal advisor at the following all stages of the investigation:

i. Identification of issues to be examined;
ii. Identification of evidence to be collected and the means of collection;
iii. Identification of questions to be asked of persons to be interviewed;
iv. Identification of questions to be asked of respondents;
v. Analysis of evidence collected;
vi. Formatting of questions to be asked of peer reviewers;

3.19 Investigations are to be conducted in accordance with the investigation plans and timeframes set down for each step in the plan. If an investigation falls behind the set timeframes, the IRO must provide the Team Leader and the Assistant Commissioner with written reasons for that failure together with advice on what action the IRO is taking to bring the investigation back into its time frame.

Peer Review Reports

3.20 Requests for Peer Reviews and the questions contained in letters to peer reviewers are to be approved by the relevant Team Leader.

3.21 Questions for Peer Reviewers are to be formed in consultation with a Medical and Legal Advisor and must address the specific issues raised from the information gathered.

3.22 Peer Reviewers are to be asked to provide their response within 14 days.

Investigation Reports

3.23 Investigations reports are to be prepared according to the template document approved by the Assistant Commissioner.