PARLIAMENT OF NEW SOUTH WALES

Committee on the Health Care Complaints Commission

Review of the 2005-2006 Annual Report of the Health Care Complaints Commission

Transcript of Proceedings, Written Responses to Questions and Minutes

Report No. 1/54 – February 2008

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

New South Wales. Parliament. Joint Committee on the Health Care Complaints Commission.

Review of the 2005-2006 Annual Report of the Health Care Complaints Commission / Parliament of New South Wales, Committee on the Health Care Complaints Commission. [Sydney, N.S.W.] : the Committee, 2007. –67p.; 30 cm. (Report; no. 1/54)

Chair: Hon. Helen Westwood AM, MLC.
"February 2008".
ISBN 9781921012617

1. New South Wales. Health Care Complaints Commission. Annual Report.
2. Health facilities—Complaints against—New South Wales.
I. Title.
II. Westwood, Helen.
III. Series: New South Wales. Parliament. Joint Committee on the Health Care Complaints Commission. Report ; no. 54/1

DDC 362.1

Table of Contents

Membership & Staff

Chair	The Hon Helen Westwood AM MLC
Deputy Chair	Dr Andrew McDonald MP, Member for Macquarie Fields
Members	The Hon David Clarke MLC
	The Hon Kerry Hickey MP, Member for Cessnock
	Mrs Judy Hopwood MP, Member for Hornsby
	Mr Matthew Morris MP, Member for Charlestown
	Rev the Hon (Fred) Frederick John Nile MLC
Staff	Mr Mel Keenan, Committee Manager
	Ms Jo Alley, Senior Committee Officer
	Ms Kylie Rudd, Research Officer
	Ms Jacqueline Isles, Committee Officer
	Mrs Vanessa Pop, Assistant Committee Officer
Contact Details	Committee on the Health Care Complaints Commission Parliament of New South Wales Macquarie Street Sydney NSW 2000
Telephone	02 9230 3060
Facsimile	02 9230 3052
E-mail	chccc@parliament.nsw.gov.au
URL	www.parliament.nsw.gov.au

Terms of Reference

The Committee on the Health Care Complaints Commission is a current Joint Statutory Committee, established on 27 June 2007. The Committee was established under the *Health Care Complaints Act 1993*. The Committee monitors and reviews the Commission's functions, Annual Reports and other reports it makes to Parliament. The Committee is not authorised to re-investigate a particular complaint or to reconsider a decision to investigate; is not to investigate or to discontinue investigation of a particular complaint or 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.

The Terms of Reference for the Committee are set out in Part 4, sections 64 - 74 of the *Health Care Complaints Act 1993.* Section 65 of the Act sets out the following functions of the Committee:

(1) The functions of the Joint Committee are as follows:

(a) to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act,

(a1) without limiting paragraph (a), to monitor and review the exercise of functions by the Health Conciliation Registry,

(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.

(2) Nothing in this Part authorises the Joint Committee:

(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.

(3) The functions of the Joint Committee may be exercised in respect of matters occurring before or after the commencement of this section.

Chair's Foreword

It is with pleasure that I present the Committee's review of the Health Care Complaints Commission Annual Report 2005-2006, the first report of the Committee as established by the 54th Parliament. This review is produced by the Committee in furtherance of its oversight responsibilities under s 65 of the *Health Care Complaints Act 1993* [the Act].

Overview

Following on from the investigations into Camden and Campbelltown Hospitals, the year 2004-05 had been a period of major change throughout the Commission, with all aspects of the Commission's work affected to some degree. The year 2005-06 saw a continuation of this organisational reform, including matters such as:

- staffing of the Telephone Inquiry Service by Resolution Officers;
- completion of the restructure of the Assessments Branch;
- refinements made to the new electronic case management system; and
- introduction of a performance management system.

At the outset, I would like to acknowledge the positive changes made by the Commission in response to recommendations made by the Committee in reviewing the Commission's 2004-2005 Annual Report. In particular, the inclusion of data about the outcomes of the Commission's recommendations to health service providers is appreciated. It is heartening to see that of the 59 recommendations made to health organisations in 2005-06, 80 per cent have been partially or fully implemented.

In response to the Committee's recommendations, the Commission has implemented a number of other changes, such as the establishment of an Internal Audit Committee, and creation of links from the Commission's website to allow relevant tribunal and court decisions to be easily accessed. Performance indicators contained in the Corporate Plan are now reported against in the Annual Report alongside expected timeframes and information on their status. As recommended by the Committee, more detailed information was included in the 2005-2006 Annual Report about staff turnover compared to 2004-2005.

While recognising these positive changes, the Committee considers that there are a number of areas in which the Commission has real need for performance improvement, both in terms of change and in the pace of that change. At a general level, there is a tendency to refer back to what the Commissioner has described as the 'Campbelltown/Macarthur trauma', to account for any current shortcomings of the Commission. Whilst the Committee acknowledges the institutional impact upon the Commission of the various inquiries, that time is now past, and the Committee looks forward to fully playing its role in assisting the Commission to move forward.

Moreover, whilst the Committee appreciated the Commissioner's candour in his evidence at the public hearing in relation to matters such as the limited success of the Senior Management Group, the Committee is keen to see a sense of urgency in accelerating the current pace of change. As the Commissioner has been in a senior leadership role with the Commission since April 2004, the Committee feels that he is in the best position to be the spearhead of continuous, positive organisational change.

I would now like to examine in some detail some of the most important matters which the Committee considered arose from its examination of the Commission's 2005-2006 Annual Report.

The Commission in the NSW Health Care System

Section 3A of the Act outlines the role of the Commission in relation to government agencies with functions in connection with the NSW Health Care System. These agencies are the Director General of the Department of Health, public health organisations conducting health services, and the various NSW registration authorities. Whilst that section specifies that it is explanatory only, it is implicit that the Commission has one of many complementary roles to play in the protection of the health and safety of the public of New South Wales.

I am pleased, therefore, to note that the Commission appears to have strengthened its relationships with a number of key professional associations, and that the Commissioner will be meeting with the Clinical Excellence Committee and the Department of Health's Quality and Safety Branch. The Clinical Excellence Commission undertakes systems-level data analysis, whilst the Commission's focus is the individual patient complaint and the resultant clinical incident, processes which are combined in one body in some other Australian jurisdictions. While the Committee is not recommending such an amalgamation of roles, it would be unfortunate for the NSW Health Care System as a whole if any important exchange of relevant data between these bodies did not take place, and the Committee is keen to see the potential synergies between these parties explored and maximised in the future.

Access to the Commission

In its review of the Commission's 2004-2005 report, the Committee expressed disquiet at the decrease in the number of people accessing the Commission's Complaints Resolution Service [CRS] - a reduction which may have resulted from amendments to the Act which permit the CRS to deal only with written complaints which have been formally assessed and referred to it by the Commission. Previously, the CRS was able to accept complaints directly from the public or from health services, as well as from the Commission. The Committee was concerned that complaints that may previously have been resolved immediately may now take weeks, or even longer, to resolve, if indeed they are ever actually received by the Commission.

In addition to the changes made to the processing of complaints, the Committee is concerned that health care consumers may not be bringing complaints to the Commission simply through a lack of awareness of the Commission's role, or indeed, its very existence. Accordingly, the Committee welcomes the Commissioner's commitment to focus increasingly on the promotion of public awareness of the services of the Commission in the coming year. Also, the Committee considers that the Commission may wish to investigate the capacity of Area Health Service complaints officers to deal with less serious complaints, and to ascertain whether the Commission should be taking a greater role in this area.

Assessment Timeframes

In recent years the Commission has focused on reducing the timeframes for processing complaints. In 2005-06, 55.6 per cent of assessments were completed within the statutory 60-day timeframe, compared to 87.7 per cent the previous year, and higher figures earlier. According to the Annual Report, the additional time taken is in part a reflection of the much more extensive assessment process, combined with various other factors, such as the

inexperience of staff in undertaking the more extensive assessments. The Committee notes that obtaining information from respondents as part of the assessment process should contribute to more informed decision-making. However, it looks forward to an improvement in assessment time frames in 2006-07 to more fully comply with the Commission's statutory obligations.

I am pleased to note that the large backlog of complaints under investigation has now been cleared. Although the Committee remains concerned that the time taken to complete investigations is excessive, it notes that it has nonetheless improved - 61.6 per cent of investigations were completed within twelve months in 2005-06, compared to only 38.5 per cent in 2004-05. The Commissioner has expressed his concern about these delays, and advised that he expects improvement in this area. The Committee will revisit this issue in the review of the Commission's next Annual Report.

Quality of Assessments

While the timeliness of the Commission's investigations processes is improving, it is also vital to ensure that the quality of the complaints handling process is maintained. The Committee has had access to few independent measures of the quality of the Commission's processes, with the exception of the results of the annual satisfaction survey conducted by the CRS.

The Committee has repeatedly raised the importance of assessing stakeholder satisfaction more broadly.[1] In his evidence on the 2004-2005 Annual Report, the Commissioner suggested that the Commission needed to improve its own performance and procedures before surveys of stakeholders could be undertaken. In his public examination on 21 November 2007, the Commissioner pointed out that it may be confusing for complainants to try to obtain feedback about levels of satisfaction while complaint handling processes are still continuing. Nonetheless, the Committee considers that this possible barrier may be overcome by using an appropriate methodology.

The Committee is of the view that a comprehensive assessment of user satisfaction across the breadth of the Commission's services ought to be a high priority, given that the Commission has had ample time to introduce and entrench organisational reforms, and to improve its own performance. The Committee is keen to see such surveys conducted and reported on in detail in the Annual Report each year, starting immediately.

The Committee is also of the view that a one-off key stakeholder satisfaction assessment ought to be undertaken, preferably by an external consultant. This assessment should be conducted as soon as practicable and reported on in detail in the Commission's next Annual Report. The Committee recommends that the Commission seek advice from external consultants as to an appropriate methodology, as it has already done in improving the methodology used in assessing user satisfaction of the Resolution Service.

If the consultants consider that a satisfaction survey cannot be extended to some or all of the Commission's services, the Committee proposes that the Commission develop other measures which would allow for independent assessment of the quality of the Commission's processes and services. This should be reported on in detail in subsequent Annual Reports. The Committee notes that the Commission has taken some preliminary steps in this

[1] See, e.g., *Report on 8th Meeting on the Annual Report of the Health Care Complaints Commission*, November 2003, p 6.

direction, in contracting Deloittes to conduct internal audits of the assessment process, and considers that this should be expanded to an audit of the investigations process.

Staffing Issues

In his evidence on the 2005-2006 Annual Report, the Commissioner noted that the Committee had experienced substantial staff attrition. At that time, the Commissioner suggested that this had not necessarily been a bad thing for the general productivity and the quality of the Commission's work.

While the Commissioner has noted in his recent evidence to the Committee that staff are continually consulted by way of team meetings, Director's divisional meetings and staff meetings, the Committee is of the view that other more formal processes to assess staff satisfaction should be an integral part of workplace practice. The Committee welcomes the Commissioner's undertaking to introduce staff exit interviews, if they are not already being conducted. The processes developed should be in line with public sector exit interview processes, and provide the opportunity for staff to choose to have an exit interview with a Manager other than their immediate Manager, or with the Human Relations Manager.

As there has been a large amount of organisational change and substantial staff turnover over the last three to four years, the Committee is of the view that the Commission should introduce annual staff climate surveys, to be compared with public sector benchmarks and reported on in the Annual Report. I note that the NSW Ombudsman's Office undertook such a survey in 2006-07, and reported its performance in its Annual Report,[2] and that this is not uncommon practice in a range of government and non-government organisations. This is particularly important not only for the welfare of the staff, but also because staff dissatisfaction and turnover is likely to have a negative impact on service provision.

Conclusion

The Health Care System in New South Wales has undoubtedly been very much in the public eye throughout 2007. The key role of the Commission in that system was underlined by the fact that the Joint Select Committee on Royal North Shore Hospital had as one of its Terms of Reference that any individual patient complaints identified in the course of the inquiry be referred to the Commission by those individuals. This reliance on the effective operation of the Commission in turn highlights the Committee's important oversight role.

I would like to thank both the Commissioner and the Director of Investigations for appearing before the Committee, and I look forward to seeing the work of the Commission continue to improve, with the assistance of the Committee exercising its statutory oversight role.

The Hon Helen Westwood AM MLC
Chair

[2] NSW Ombudsman, *Annual Report 2006–07*, p 34.

Chapter One - Questions on Notice

HEALTH CARE COMPLAINTS COMMISSION ANNUAL REPORT 2005-2006

OVERVIEW

Question 1

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

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

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

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

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

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

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

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

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

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

Registration Boards
The Commission is required by the *Health Care Complaints Act 1993* to consult with the relevant registration board with respect to the assessment and investigation of complaints about registered health practitioners. These consultations ensure that the Commission has the benefit of advice from registration boards to assist it in determining the appropriate course of action to be taken on complaints about individual practitioners – particularly those raising concerns about the safety and/or quality of the health care provided by the practitioner.

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

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

Council on the Ageing
People with Disabilities NSW Inc
Association for the Welfare of Child Health
New South Wales Council of Social Services (NCOSS)
People Living with AIDS
Mental Health Co-ordinating Council
Carers NSW
Rural and Remote Health Consumers of Australia
NSW Council for Intellectual Disability
Combined Pensioners and Superannuants Association
A culturally and linguistically diverse (CALD) community representative.

The Committee represents the interests of the health consumers, and provides a forum in which the Commission can seek and obtain advice and feedback about various issues from

a consumer perspective, including matters concerning the safety and quality of health care. The Commission meets with the Committee every four months.

Question 2

The Commission's 2006-09 Strategic Plan notes that the Commission needs to re-establish the public's expectation of it as a credible and trusted investigator of health care complaints. What measurable success has the Commission had in achieving this?

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

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

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

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

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

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

It appears that the improvement in the quality of the advice given to callers by the Inquiry Service has contributed to the Commission receiving fewer written complaints in 2006-07 – thus allowing the Commission to deal with the written complaints that it does receive more quickly and effectively.

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

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

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

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

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

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

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

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

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

Both areas have increased their resolution rates:

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

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

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

In 2006-07, the Commission sought feedback from complainants and health service providers with whom there had been significant contact during the assisted resolution process through a satisfaction survey. For the 259 surveys sent to complainants, there were 122 responses (a 43 per cent response rate); for the 209 surveys sent to health service providers, there were 112 responses (a 55 per cent response rate).

Key results of the satisfaction survey were as follows:

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

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

From a complainant – 'The conciliator showed great insight into the underlying issues [and] drew these out so that full resolution was achieved'.

From a representative of a metropolitan health care facility – 'The process was straightforward and fair and transparent, and the conciliation was conducted professionally with a good outcome for all the parties'.

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

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

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

Better explained reasons for assessment and investigation outcomes
In 2006-07, staff in the Assessment and Resolution Division received training in 'plain English', leading to improvements in the quality of the explanations given to complainants and health providers about the Commission's reasons for its assessment decisions. The staff of the Investigation Division will undertake similar training in 2007-08.

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

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

Question 3

In evidence to the Committee in March 2006, you noted that there was not a 'strong culture of supervision' nor 'proper management practice' in the Commission. What measures have been put in place to improve management culture and practice? How is the impact of these measures monitored and evaluated?

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

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

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

Question 4

How would you describe the state of the Commission's working relationships with other health-related bodies, such as the NSW Clinical Excellence Committee, and the various Registration Boards? Did any significant issues arise in respect of the Commission's relationships with these bodies during the 2005-06 reporting period?

RESPONSE:

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

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

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

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

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

PERFORMANCE REPORT FOR 2005–06

Question 5

At what stage of preparation is the Commission's new Investigations Manual?

RESPONSE:

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

Question 6

Could you please explain how the Commission's peer review process operates?

RESPONSE:

Legislative provisions

It may be useful to begin with an outline of the provisions of the *Health Care Complaints Act 1993* governing the Commission's use of experts.

Section 30(1) of the Act provides that the Commission, when investigating a complaint, may obtain a report from a person – including a practitioner registered under a health registration Act – who, in the opinion of the Commission, is sufficiently qualified or experienced to give expert advice on the matter which is the subject of the complaint.

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

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

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

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

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

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

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

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

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

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

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

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

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

New guidelines
The Commission has revised the guidelines document that it provides to its expert reviewers to assist them in preparing their reports. A copy of that document is attached for the information of the Committee (See Appendix 2 of this Report).

Question 7

The Annual Report notes that the Commission established a Senior Management Group. How has this Group operated to promote leadership throughout the Commission, and what input has it sought from staff of the Commission? Has the

Group identified goals in order to measure the effectiveness of its activities and initiatives?

RESPONSE:

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

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

COMPLAINT NUMBERS, TRENDS AND ISSUES

Question 8

The Annual Report notes the difficulty with straightforward conclusions from complaint statistics due to 'the problem that there is no effective measurement of the extent of awareness of health consumers about how to make a complaint'. How would the Commission promote public awareness of the avenues of complaint?

RESPONSE:

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

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

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

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

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

Members of Parliament
The Commission's Director of Assessment and Resolution has been regularly liaising with the executive staff assisting Members of Parliament, to inform them of, or reinforce with them, the Commission's role and functions. This should assist in ensuring that members of

the public who approach their local Member of Parliament with concerns or complaints about health providers are given appropriate advice about the role of the Commission.

Question 9

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

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

RESPONSE:

Recording of issues

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

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

Classification of issues

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

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

Question 10

To what factor/s does the Commission attribute the continued rise in complaints made against public hospitals, and against pharmacies?

RESPONSE:

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

Question 11

The Annual Report notes that in relation to complaints about certificates or reports by medical practitioners in legal proceedings, the Commission takes the view that

unless the complaint is serious, the issues are 'best left to be determined through the relevant legal process for which the report or certificate was completed'. Does the Commission have a process of monitoring the outcomes of such complaints?

RESPONSE:

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

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

Furthermore, authorities involved in the conduct of relevant legal proceedings (for example, WorkCover in workers compensation proceedings) which have serious concerns about the quality of a medical report prepared for the purpose of the proceedings are entitled to make a complaint to the Commission or registration board about their concerns.

Question 12

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

RESPONSE:

There has been minimal impact on the work of the Commission with the commencement of the *Health Registration (Unregistered Practitioners) Act 2006*. This is because the application of the amended legislation largely depends upon the introduction of a Code of Conduct for unregistered practitioners under the *Public Health Act 1991*. There has been some consultation between the Department of Health and the Commission and other stakeholders on a draft Code of Conduct. However, before the Code of Conduct can be finalised, the Minister for Health must publicise the draft code and consider submissions from the public on that draft. The Commission understands from the Department of Health that the Department is still planning this public consultation process.

ASSESSMENTS AND RESOLUTION DIVISION

Question 13

What structure does the Commission have in place for consultation with specialists in the assessment of complaints? How does the Commission access expert advice?

RESPONSE:

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

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

Question 14

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

RESPONSE:

As noted in the 2005-2006 Annual Report, the issues in question had been substantially addressed by the end of 2005-06. That report noted:

There has been substantial turnover of the staff in the [Assessment] area and more focussed training has been provided to existing and new staff. The re-engineering and improvement of case management systems has provided for improved tracking of the progress of cases. The removal of the Inquiry Service from the Assessment Branch has allowed staff to concentrate on their core function of assessing complaints. From 1 April 2006, the Assessment Branch has been achieving a rate of 80 per cent of assessment being finalised within 60 days.

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

Question 15

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

RESPONSE:

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

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

Question 16

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

RESPONSE:

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

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

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

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

Question 17

Could you please explain what constitutes a 'partial resolution' of a complaint?

RESPONSE:

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

Under section 52 of the *Health Care Complaints Act 1993*, conciliators must record whether or not there has been 'agreement'. There therefore appears to be no scope for 'partial' agreement in the conciliation process.

Question 18

Less than half the complainants – and approximately a third of the health providers – responded to the Resolution Service satisfaction surveys. Has the Commission

devised a strategy to encourage more participation in this process or an alternative means of obtaining client feedback?

RESPONSE:

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

INVESTIGATION DIVISION

Question 19

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

RESPONSE:

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

It should be noted that the coercive powers available to the Commission under section 34A of the *Health Care Complaints Act 1993*, to require the production of information and/or documents, and to give evidence, can only be applied to a complainant, the person(s) against whom the complaint has been made, and health service providers.

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

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

Question 20

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

RESPONSE:

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

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

- Of the 78 recommendations made in 2006-07, 28 per cent have already been implemented.

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

Question 21

At what stage is the development and implementation of the Commission's investigations training program in the 2005-06 Corporate Plan?

RESPONSE:

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

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

LEGAL DIVISION AND THE DIRECTOR OF PROCEEDINGS

Question 22

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

RESPONSE:

The Restructure of the Legal Division

The Legal Division is managed by the Director of Proceedings. Ms Karen Mobbs was appointed to this position in 2005 following the amendments to the *Health Care Complaints Act 1993*, which created the position.

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

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

The Legal Division Manual

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

A new section on 'Costs' has been written and added to the manual. Some work has also been done on a proposed new section of the manual dealing with the briefing of Counsel, including a list of suitable Counsel to represent the Commission in disciplinary proceedings. The Legal Division has already developed templates for relevant documents such as prosecution reports, formal complaints against health practitioners, summonses to witnesses to give evidence, summonses for the production of documents, and standard letters. These will be included in the manual.

Impact on the Operation of the Legal Division
These improvements will result in more timely, thorough and effective prosecutions.

MANAGEMENT AND STRUCTURE

Question 23

With respect to the attrition of staff, what is the difference between staff resigning from the Commission and staff 'transferring to another public sector agency' for the reporting period? Has the Commission's retention rate of staff improved?

RESPONSE:

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

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

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

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

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

Question 24

Although the Annual Report states that the attrition of Commission staff in 2005-06 was 'mainly attributed to the release of a number of temporary staff engaged in 2004–05 to undertake the Macarthur Investigation and clear the backlog of outstanding investigation cases', 15 of the 21 staff who left the Commission during 2005-06 had been permanent staff members. What effect has this loss of staff had on the effective operation of the Commission?

RESPONSE:

There was an attrition of 15.1 staff from 2004-05 to 2005-06. These were primarily the temporary staff engaged to undertake the Macarthur investigation and clear the backlog of investigations. There was also an attrition of permanent staff in 2005-06.

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

Question 25

How has the Commission's extension of its staff performance management system proceeded [2005-06 Corporate Plan]?

RESPONSE:

As noted in the 2005-2006 Annual Report, the Commission developed a performance management system that requires staff to prepare annual performance agreements that link individual performance targets to the Commission's objectives. Each performance agreement ties the responsibilities of the position to the key result areas of the relevant Division's business plan, thus ensuring appropriate levels of accountability for the delivery of the Commission's corporate objectives.

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

Chapter Two - Transcript of Proceedings

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE 2005-2006 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

———

At Sydney on 21 November 2007

———

The Committee met at 2.00 p.m.

———

PRESENT

The Hon. Helen Westwood (Chair)

Legislative Council	**Legislative Assembly**
The Hon. D. J. Clarke	Mr K. A. Hickey
Reverend the Hon. F. J. Nile	Ms J. Hopwood
	Mr A. D. McDonald
	Mr M. A. Morris

CHAIR: I declare the public hearing open. It is a function of the Parliamentary Joint Committee on the Health Care Complaints Commission to examine each Annual Report of the Commission and report to Parliament upon it, in accordance with section 65 (1) (c) of the Health Care Complaints Act 1993. The Committee welcomes the Commissioner and senior officers of the Health Care Complaints Commission to the table for the purpose of giving evidence on matters relating to the 2005-2006 Annual Report of the Health Care Complaints Commission. I thank you for your appearance today.

KIERAN PEHM, Commissioner, Health Care Complaints Commission, Level 13, 323 Castlereagh Street, Sydney and

BRET COMAN, Director, Investigations, Level 13, 323 Castlereagh Street, Sydney, sworn and examined:

CHAIR: In what capacity do you appear before the committee?

Mr PEHM: I am appearing as the Commissioner.

CHAIR: I am advised that you have been issued with a copy of the committee's terms of reference and also a copy of Legislative Assembly Standing Orders 332, 333 and 334 that relate to the examination of witnesses. Is that correct?

Mr PEHM: That is right.

Mr COMAN: Yes.

CHAIR: The committee has received a detailed submission from the Health Care Complaints Commission in response to a number of questions on notice relating to the 2005-2006 Annual Report. Commissioner, do you wish this submission to form part of your evidence today and to remain public?

Mr PEHM: Yes, thank you.

CHAIR: I direct that those materials be attached to the evidence of the witness to form part of the evidence. Do committee members concur with authorising the publication of the submission?

Reverend the Hon. FRED NILE: Yes, moved.

CHAIR: Commissioner, do you want to make an opening statement before the commencement of questions?

Mr PEHM: No, I do not have an opening statement. I am quite happy to rely on the report and the submission and answer any questions.

CHAIR: The committee has received your answers to its questions on notice. Would you elaborate on the operation and aims of the Commission's senior management group, which relates to question 7?

Mr PEHM: Yes, the senior management group was an attempt by us to develop the next level down of management in the Commission. After the Campbelltown/Macarthur trauma, I suppose, for the Commission all of the senior officers were replaced. We had Judge Taylor as Commissioner for a year and I took over after that. I was Deputy Commissioner during that time. We found, I think, very poor management systems, very poor controls, a lack of supervision of staff and a lack of case management. I think it is fair to say staff were pretty much left to themselves to handle the individual files as best they could and there was not a lot of support by management.

We have put in a whole lot of extensive systems through the Commission to address those issues but I think part of the reform of the Commission is to develop the capacity of the senior management group, which are essentially the team leaders. We have restructured all parts of the Commission now to really divide the staff into teams of about three to five, each with a team leader and they have been promoted to grade 9/10 level. I think it is probably fair to say that some of them have found it difficult making the transition to a culture of supervision and performance management from what was a fairly laissez faire sort of approach by management.

The idea with the senior officers group was to give them projects to work on on their own without direction from the executive management and hopefully they would display initiative, work co-operatively and start to, I suppose, develop characteristics of leadership for the Commission, and hopefully the next iteration of the Commission, the executive level would come from those officers. It has not worked as well as I had hoped it would, and it is probably fair to say we have not given it as much support and attention as it probably needed in hindsight. We are going to put a lot more work into that area of the Commission, specifically around issues of performance management with staff. The one thing I think our team leaders have found difficult is—confronting is not really the right word—dealing with issues of performance with staff members. These are people with whom they have been colleagues for a long time and they have not had the role of a Manager, which is to set clear expectations and see that staff live up to them. So the initial focus will be around managing that performance management interaction with staff.

Another project we will be giving them—and this was Bret Coman's suggestion—is to work on a service level agreement between our investigation staff and our legal staff. The problem there essentially is investigators will investigate a matter and gather evidence in various ways. It will then be transferred to the legal division, potentially for a prosecution. Evidence has to be in legally admissible form. Lawyers might pick up things that we missed in the investigation. It is also fair to say in the past those two divisions have not worked in a very co-operative way. To encourage that co-operation, rather than just leave the file with legal, and expect the lawyers to gather all the extra evidence and get it in admissible form, we have started to send it back to investigations for them to fill out the investigation brief. It is an education for the investigators where their work might need some improvement. So the senior officers group, which will be the Senior Managers of investigations and legal, will now co-operate on developing a service level agreement which will, I suppose, articulate the terms on which material will be forwarded back and forth and the way the communication will work.

CHAIR: In your answer to question 10, you state that it is not clear what has caused the increase in complaints against public hospitals and pharmacies. Does the Commission intend to make any investigation into these upward trends?

Mr PEHM: I had not intended to. I think we need a trend to develop for a bit longer than perhaps one year. It may be a spike. It may be unusual. There may be activity out there that we are not aware of, such as the Pharmacy Guild may have issued information about us. There is a real difficulty with the whole trends analysis. We have put a lot of work into this because it is one of our functions, I think under section 80, to advise government, the profession and other interested parties about trends in complaint handling. It is a laudable aim and it is a logical consequence of a function of a complaints body.

The difficulty is that our complaint numbers are extremely small in relation to patient-health service provider interactions. It is hard to lay my hands on the figures but we might get complaints against medical practitioners of about 1,200 or so. There are 28,000 registered medical practitioners in all sorts of areas. When you start to look at the number of patient interactions, like the number of admissions to emergency departments in the large central Sydney teaching hospitals there are 60,000 to 70,000 a year. We may get two or three complaints out of the emergency department of that hospital. So it is very difficult to draw conclusions, I think, from such small numbers of complaints when compared with the volume of health service provision.

I think another thing we need to do, and we will be doing this more, is to make those comparisons. Rather than just saying there were 20 complaints one year and it has gone up to 30, we will look at it in the broader context of what were the patient health service provider interactions, and is that a statistically significant increase? We can say that is a 50 per cent increase, is that important, if patient provider interactions have gone up a significant amount.

Other factors also play into it, like the level of awareness of complaints processes. One thing we will be doing this year is putting a lot more effort into education and promotion. We have started doing that already. The likelihood is we will get more complaints as a result of that. It does not mean that medical or health service provision is getting worse necessarily; it may just be that people are more aware of the avenues of complaint. We could inquire into it but my feeling is that the inquiry would end up with a whole lot of factors and a whole lot of reasons and explanations as to why conclusions could not really be drawn on increases like that.

Dr ANDREW McDONALD: I will keep you on the topic of trends. Does the Commission report complaint trends in relation to individual hospitals?

Mr PEHM: It never has, and it has not done that in its Annual Report. It has the capacity to do that. We have improved our data capture significantly now so it is not difficult to retrieve the information. We are much more careful, I think, than we have been in the past about correctly recording data, so we capture it fairly well.

The Hon. DAVID CLARKE: Do you think it would be a good idea to keep statistics on individual hospitals so that they can be compared to see whether something is out of kilter?

Mr PEHM: They are kept. They are not reported. It is a question of how much data do you report. If you go down to every hospital in New South Wales, you will be publishing pages and pages of information with zero return or one return when you are looking at small community or rural hospitals and that sort of thing.

The Hon. DAVID CLARKE: But it does show that there is a particular problem in one hospital as opposed to other hospitals—

Mr PEHM: Yes.

The Hon. DAVID CLARKE: —where processes and procedures need to be looked at. Would that not be something of importance to the Commission?

Mr PEHM: Yes, it is of importance to the Commission, certainly. We are doing that more and more. We are also working with the Department to gather that contextual information I was talking about—what does the number of complaints mean in relation to the number of presentations and so on. We do need to do more on that. There is a lot of data that is now capable of capture and capable of production. Precisely what we report on regularly is another question. There are often issues of particular moment for the reason that people are interested in very specific information. But to publish all of that data every year, you would be looking at a lot of paper, and not necessarily productive paper.

Mr COMAN: Could I just add something? We are just making our early steps into data analysis with our recommendations. We have met with our information technology [IT] people. We are looking at categorising recommendations and then keyword searches, et cetera, so that we can then start to analyse trends and the recommendations that we have made, avoid duplication in recommendations, and look at accessing coronial and other data as well—that sort of thing. That is the first step into the analysis of data and we hope that we can step into further areas as well.

Mr KERRY HICKEY: Commissioner, question 10: You say that that is just a spike in regard to complaints made about pharmacy and public hospitals?

Mr PEHM: It may be.

Mr KERRY HICKEY: Does the Commission look at this data very closely? When you are seeing 5.1 per cent compared to 4.5 per cent increase in pharmacy and the increase in public hospitals, do you not analyse that when that data comes in?

Mr PEHM: When it comes in, you enter it into the database and then it is capable of reproduction, and you interrogate the database.

Mr KERRY HICKEY: So you are saying that you have enough staff to analyse the data closely?

Mr PEHM: No. The principal time at which we analyse data is the Annual Report. That is where we interrogate the database over what has happened over the year and the trends. We have provided more information in this Annual Report. You will see there is more again in the one for the current year than the Commission has ever done before. I suppose the issue is: What does it mean? What conclusions can be drawn from this? What I am saying is that I am quite happy to provide data. What conclusions can be drawn from it I think is really problematic, given the small numbers of complaints we get in relation to the numbers of patient-health service provider contacts.

Dr ANDREW McDONALD: That brings me to the next question. You talk about individual hospitals and how you can aggregate within an Area Health Service. What about various areas of practice such as emergency or obstetrics or anaesthetics? Do you keep that sort of data as well?

Mr PEHM: Yes, we do. There is some reporting in there on that I think. We have given you the 10 most common areas on page 30 of the Annual Report, and on page 29 there is a bar chart there with the number of complaints assessed in relation to the issue of complaints, whether it is inadequate diagnosis or medication incidents and so on. Again, I guess, what does that tell us? There are obvious things like the justice health area. There are a lot of complaints about access to services because they are prisoners and their access is restricted to certain times, and that is the obvious one. We tend to try to resolve a lot of complaints in the mental health areas. There is a higher proportion there than in other areas necessarily because it is obviously better to put those people back in touch or try to resolve fractures that might have occurred in the relationship between service provider and patient.

Dr ANDREW McDONALD: My next question is about that. What would you do if you did notice, say, in a hospital or an area a significantly higher than average level of complaints?

Mr PEHM: The Director General is notified of all complaints, the Director General of the Department of Health, under section 17 of the Act, and the identity of the complaint and the nature of the complaint as soon as practicable. We have an electronic information system there so all that information is available to Health. The further question is: What happens when we notice a spike? We have, or I have, three monthly meetings with the Director General of the Department and something like that I would bring to her attention.

Dr ANDREW McDONALD: About the monthly meetings of each of the registration boards, which boards do you meet with?

Mr PEHM: There are 13 boards. The monthly meetings are to assess new complaints. Under the legislation we are obliged to consult with each of the registration boards where the complaint is against a registered practitioner. On what should be the procedure for dealing with the complaint, it depends pretty much on volume. With the Medical Board we meet weekly to do the assessments. With the nurses we meet fortnightly, once at a monthly meeting and once by teleconference, and all the others, because of the numbers of complaints being low, we meet monthly.

Dr ANDREW McDONALD: When you meet with, say, the Medical Board, you do that on a case-by-case or doctor-by-doctor basis?

Mr PEHM: Yes. Every complaint is the subject of an assessment brief. What happens when we get a complaint is we generally send it to the respondent unless it involves some question of intimidation or harassment of the complainant, and we would not do so in that case. We would ask the practitioner for a response. We may seek medical records where it is a complex clinical issue. We have internal medical advisers who will give us advice on whether the conduct in question is a significant departure. All of that material is digested into a brief and that becomes the basis of the consultation between us and the boards.

Dr ANDREW McDONALD: That brings me on to another question relating to respondent contact. You have talked about how things have changed. In previous years the respondent would only hear of a complaint when there was a fair level of substantiation. Now they hear about many more of these—that is my understanding. In the old days there was a verification process before it went to the respondent and now I think your report stated there are many more and that part of the assessment process is contact with the respondent to get the other side of the story.

Mr PEHM: Generally we will always provide the respondent with the complaint and ask for a response. There are some cases where you will not, where it is clearly vexatious or there is some mental health issue, and on the face of it you would not trouble the respondent with it. But even for the less serious complaints, we think it is important for the respondents to, one, be aware of them, and, two, just take it as feedback about their practice, if there are communication issues and those sorts of things, and just to hear their side before we make an assessment decision. In the past the Commission used to assess the complaints without the benefit of the provider's response.

Dr ANDREW McDONALD: So the respondents are getting more contact with the Health Care Complaints Commission [HCCC] than before, which is a good thing, but what effect are you aware of that it has on the respondent—the fact that they have more contact than they used to?

Mr PEHM: It varies. Some people are very happy to get the chance to respond and put their side of the story. There is some feedback we have had, both from individual respondents and also from conferences and so on that I have been to. Health service providers can be very offended by complaints. I think it has to do with their feeling that they are really just helping people and doing their best. The upshot of that has been through a misunderstanding or, for whatever the reason, the complainant has complained about the conduct.

I went to one conference in Melbourne where a psychiatrist down there had described it as similar to the stages of death. The first reaction was anger, denial, then hopefully acceptance, but his experience was that most practitioners never got past the anger and denial in Victoria. You probably could speak better than I could about how practitioners respond. Despite that culture, I suppose, I still think it is important for them to be dealt with and for practitioners, even though they may have an instantaneous reaction, just to recognise that they are providing a service and there is a system of regulation around how that service is provided, and for them to be able to put their case. I think as long as we are fair about the way we assess them and make decisions, it is beneficial for them, even though they may not like getting them initially.

Dr ANDREW McDONALD: Do you explain to them that things have changed in the last, say, 10 years?

Mr PEHM: I still think we have got a broader job to do there. I think the Commission has been concentrating very much on its internal processes. As I have set out in the Annual Report, there has been a lot of work to do to ensure that we do have fair processes and timely processes. My position has been it is a mistake to go out promoting yourself until you have your own house in order and you actually deliver a service that promises what you are delivering. I briefly alluded in an earlier question to this year going out and promoting the

Commission much more because I think we are now in reasonable shape to handle any increase in complaints, if that is the result.

Mrs JUDY HOPWOOD: Just in relation to staff and time taken to assess complaints, it seems that there has been a significant rise in the average days to assess complaints in 2005-06, yet you have two fewer staff listed in your staff allocation. I am wondering if you would like to comment on whether there is any correlation between fewer staff and increasing assessment dates?

Mr PEHM: The previous Commission's method of assessment was simply to read the complaint and make a decision as to whether it should be discontinued, conciliated, or investigated. The result of that quite low threshold at the front gate, if you like, was a certain reluctance to discontinue things, so a lot of complaints had made it over that barrier. A lot of complaints went into investigation, probably more in the past than do now.

We have changed the assessment process to really provide a more thorough analysis of the complaint and the reasons for it, and what the likely outcomes might be before we make the assessment decision. So, previously when you just had a complaint, it came in the door, you read it and made a decision, your time frame is going to be short. We now go to the respondents. We ask them for their response. There can be difficulties in older and more complex cases where you have multiple providers. Often in hospital settings there is a visiting medical officer or consultant, there are registrars and resident medical officers, and there are nurses. So, to get all of that information in can take some time. It also happens that you might get an initial response from the hospital and that will raise an issue around the conduct of an individual practitioner. So then you have to get that information in. That has been the principal reason for the extension of time in the assessment process.

The other contributing factor I think is that this was a really significant change for staff in the Commission. Previously, assessment staff got the complaint in, made up a file, submitted it to the assessment panel and wrote the letter saying, ‘This is the outcome.’ Now they are interacting a lot more both with the complainants and the health service providers. They get the responses in, then they analyse them and put together a brief with recommendations about what should be done. There were significant, I suppose, cultural issues around that change in their role. Certainly a lot of them did not respond well to it. They did not see it as their job and what they had always been doing. We had the union in about that. While all those things are going on and while you are managing those changed processes, they are all distracting you from the actual file work.

We think that it is all over now and that is all bedded down. It is in fact much more rewarding for the assessment officers in that they are actually thinking and analysing material and they are interacting with people in a way they never did before. One of the real problems in the old Commission was that it kept people at arm's length and did not inform them about what it was doing. So, we put a lot of work into staff interacting with complainants particularly, and also providers, making that adjustment for staff and also in our management systems. We had to redesign the computer systems to implement that process and provide procedures manuals and train staff. All of that contributed to the extended assessment times. The upside I think is that the assessment process is much more robust now and much fairer to all parties involved.

Mrs JUDY HOPWOOD: Could I just ask one question in relation to a concurrent coronial inquiry and a Health Care Complaints Commission inquiry? In relation to a serious

complaint, how does the HCCC inquiry work in concert with the coronial inquiry? How much information can be shared, if you like? Could you just explain how that happens where some coronial inquiries may take years to resolve and your ongoing inquiry is there as well?

Mr PEHM: Initially my position was that if there were going to be an inquest, I would leave it to the coronial inquest in the interest of not duplicating investigative effort and expending public funds in that way. I suppose it is fair to say there were, and have been—and I am not sure of the situation now, I think it has improved—significant delays in the conduct of inquests. There were a couple of matters that I thought were unreasonably delayed waiting for coronial outcomes, which took much longer than I thought they would. Now we generally proceed independently of the coroner. If a complaint is made to us and it raises significant issues, we will go through our process and we will investigate it. There is interaction in that the coroner often refers complaints to us that arise at the closure, at the outcome of inquest. They will also refer people to us in that early stage where they are in the counselling process with a complainant and they may not yet have decided about an inquest. So, we will take those and treat them as complaints.

The question about the interaction when both of us are investigating serious matters can be complex and it will depend on the nature of the complaint. There is good liaison generally. We will exchange statements with them. They will provide us with material that they may have found to be relevant to any investigation of ours. There are occasions where, for their own reasons—they might be questions of law and privilege or the interests that other parties have put to the coroner at the inquest—where they will not share information with us, immediately at least. In situations like that we will wait until the coronial procedure is concluded.

Mrs JUDY HOPWOOD: I know I have asked this question before, but I wonder how independent is 'independent' in relation to the HCCC regarding system failure? I know that you have explained that if it is a practitioner, it goes off to the relevant board, but if it is a system failure you investigate it and it goes to the Director General, who then makes recommendations on what you have provided. Could you explain that again?

Mr PEHM: Yes. If it is a systems failure, essentially, we have the power to make comments and recommendations. The comments might be, 'The system failed in that the scans were not delivered to the surgical team so that they were not aware of this complication with a patient.' We might make recommendations to address that and we would look at the systems in the hospital and look at how the scans are transferred and make some recommendations for improvement. We follow up the implementation of recommendations with the Director General. We are required to do that by the Act. That is the main topic of the three monthly meeting I have with the Director General, and there is lots of contact at the officer level about following up the implementation of those recommendations.

Mrs JUDY HOPWOOD: Is that before those recommendations are made public?

Mr PEHM: We will provide the complainant with a copy of the investigation report, which will include the comments and recommendations, set out all the reasons for it, at the conclusion of the investigation.

Mrs JUDY HOPWOOD: Before it goes to the Director General?

Mr PEHM: At the same time; at the final report. If we are not satisfied that the Director General has taken sufficient action to implement the recommendations, we can report that to the Minister. If we are not satisfied with the Minister, well, that no sufficient action has been taken within a reasonable time of reporting it to the Minister, then the Commission can ultimately report to Parliament. It has never done that, as far as I am aware, in the past on a complaint issue. We have been making a serious effort to systematise our making of recommendations, we capture the information now so we are in a good position to follow up. You will see in the next Annual Report that 80 per cent of the recommendations we made in this financial year have been implemented. Often they take time as well, depending on the complexity, but we do have a fairly robust system now for following up the implementation.

Mrs JUDY HOPWOOD: Why has the past Annual Report not been published? Why is it taking this long?

Mr PEHM: Our report is made to the Minister. We are required to do that by 31 October under the Annual Reports Act. It is then a matter for the Minister as to when it is tabled in Parliament. We may be a contributing factor there in that the first print run was very sloppy and we had to go back. We are expecting the final print run at the end of this week. I do not know, we just kept the Minister informed about that.

Reverend the Hon. FRED NILE: Following on your remarks a moment ago, you said that 80 per cent of your recommendations are implemented?

Mr PEHM: Yes, 80 per cent of recommendations we made in the 2005-06 year were implemented.

Reverend the Hon. FRED NILE: It is a question I suppose as to whether the 20 per cent had major matters that were not implemented or would you regard those as minor issues? In other words, the important issues were responded to by the Department?

Mr PEHM: We have not been concerned with a failure to implement anything. It may be that you might make five recommendations and the implementation of three might obviate the fourth, or they might come up with a different way of implementing a recommendation. There have been a few matters that have taken some time to resolve because of concerns, I suppose, at the clinical level. It is very important that the clinicians that are delivering the service have an input as to how they change practice. But there has been no case where I have been dissatisfied with the implementation of recommendations such as to prompt that statutory process of taking it further to the Minister and then up to Parliament.

Reverend the Hon. FRED NILE: So there is no case of you taking a recommendation to the Minister?

Mr PEHM: No. There is no case where we have had to report to the Minister that we are dissatisfied with the action taken by the Department—so far.

Reverend the Hon. FRED NILE: You mentioned earlier—I may have it wrong—that there were 60,000 to 70,000 admissions in emergency departments?

Mr PEHM: I think attendances at emergency departments.

Reverend the Hon. FRED NILE: And only three complaints did you say?

Mr PEHM: We just did some work arising out of the work you are currently involved in. Obviously, it is of great interest to anyone in the area. I think back to some earlier questions, I was interested to see whether complaint numbers indicated a cause for concern, perhaps a cause that something might have been picked up before the public disclosure of all these events. We went back and looked at our complaint numbers for the three big teaching hospitals—Royal Prince Alfred, Prince of Wales and Royal North Shore. I can give the Committee exact figures later, but I think we are looking at about 20 to 30 complaints a year, roughly. When you stack that up against the number of emergency department attendances and also the number of in-patient separations—they call people discharged as in-patients—it was not something that would give you cause for concern, just those numbers.

Reverend the Hon. FRED NILE: That is partly what I am getting at, whether you are only getting the tip of the iceberg with complaints?

Mr PEHM: That may be. It is very difficult to know what you are getting or to measure what the hidden element might be.

Reverend the Hon. FRED NILE: Unless some patients do not realise that something that has happened to them is a complaint-value item? They may feel, well, it is a public hospital, this has happened to me, I just have to accept it. Do they realise?

Mr PEHM: It may be that there is a tolerance level there. My feeling is, and it is nothing more, the question is the impact on the complainant. If they have suffered an adverse incident that has left them with a disability or mortality of a family member, those are the really difficult things for people to come to terms with, and they form the core subjects of the serious complaints. People will complain about less serious things, but I think a lot of patients, probably if they have no lasting adverse ill effects—I do not know, I am speculating at the moment—will think, 'Oh well, it was not a pleasant experience and I might not have liked the treatment' but they get on with their lives, I guess.

Reverend the Hon. FRED NILE: If there are some major complaints published in the media or a problem is reported in the media, it is not a complaint to you as far as you know, would you check to see whether perhaps there has been a complaint to you?

Mr PEHM: Yes.

Reverend the Hon. FRED NILE: Would you be surprised if it had not come through to you as a complaint, if it is a major item?

Mr PEHM: Surprised, not necessarily. As I was saying earlier, I think the Commission has a job to do to promote the awareness of the Commission and people's rights to complain. That is something we are looking at doing in quite a concerted way now.

Reverend the Hon. FRED NILE: You could contact those people? Are there any powers you have to say, 'We have become aware of a situation?'

Mr PEHM: We do not have an own-motion power to investigate things of our own volition. We have contacted people.

Reverend the Hon. FRED NILE: I mean to encourage a person to make a complaint to you?

Mr PEHM: Yes, we have contacted people in those situations where we think there is an issue that really needs looking at or that they should be aware of our services. We certainly have done that.

The Hon. DAVID CLARKE: Did you say there were 20 to 30 complaints per year from the four hospitals you mentioned?

Mr PEHM: Roughly in that band against each of the hospitals.

The Hon. DAVID CLARKE: That is 20 to 30 a year?

Mr PEHM: Yes.

The Hon. DAVID CLARKE: Of those 20 to 30, that is between 80 and 100 complaints a year from those four hospitals? Do I understand you correctly?

Mr PEHM: With the three hospitals you would be looking at 60 to 90.

The Hon. DAVID CLARKE: Sorry, the three hospitals. What percentage of those would you regard as serious or substantial complaints?

Mr PEHM: Well, I have not gone into the disposition of those complaints and how they have been dealt with. We publish broader information on the number of complaints against public hospitals generally. But I just cannot answer that at the moment.

The Hon. DAVID CLARKE: Do you get matters referred to you to investigate by the Minister?

Mr PEHM: We have had. It is not common. We also have matters referred to us for investigation by the heads of Area Health Services—that is not uncommon.

The Hon. DAVID CLARKE: When you say it is not common, on an average how many complaints of matters have you had referred to you by the Minister, according to your records?

Mr PEHM: Well, I think there is a bit of a difficulty there because, as I was explaining, we do not have an own motion power. If a matter is referred to us the Minister becomes the complainant.

The Hon. DAVID CLARKE: But can't there be matters where complaints have been made to the Minister and then the Minister refers them to the Commission for investigation? I am talking about those matters.

Mr PEHM: There are a lot of complaints to the Minister about incidents that happen in hospitals. Some we may already have as complaints and some we may not. If the Minister writes to us about those we will generally get in touch with the patient or the family member and seek them out as the complainant.

The Hon. DAVID CLARKE: Yes, but what I am getting at is how many referrals come through from the Minister on an average per year?

Mr PEHM: I am not sure what you mean by 'referrals'. I can give you the number of Ministerial complaints where we are asked to either explain what we have done—if you are talking about referrals by the Minister for us to investigate complaints—

The Hon. DAVID CLARKE: Yes, that is what I am talking about.

Mr PEHM: Look I cannot give you the figure off hand. It would be very rare. Actually we do have—well, it is a double category on page 118 of our Annual Report where there is a table at 14.2 and 'Parliament/Minister' is recorded as the source of complaint in the 2005-06 as 39 complaints, the year before it was 44, the year before that it was 49, and 41 in the year before that.

Reverend the Hon. FRED NILE: That was the Minister referring and members of Parliament?

Mr PEHM: Yes and I cannot give you a breakdown between the two.

Mr KERRY HICKEY: The Minister referring backbenchers' correspondence on to the Health Care Complaints Commission?

Mr PEHM: It can come that way.

Mr KERRY HICKEY: That is where it would be coming from. You would actually contact the complainant, not the Minister or the backbencher? You would go straight to the constituent?

Mr PEHM: Yes. That is right.

Mr KERRY HICKEY: So it would not be recorded in there totally?

Mr PEHM: We prefer to have the patient as the complainant because under the Act that is who we provide the report to and as it is really their grievance they should know the outcome. If the Minister becomes the complainant then the patient is not the complainant. I can give you the number of Ministerials and so on.

The Hon. DAVID CLARKE: Yes, could you do that?

CHAIR: You can take that on notice if you like.

Mr PEHM: I will certainly check whether it can be done or take it on notice. I am sure it will not be a problem.

CHAIR: If I could just take up on the Reverend the Hon. Fred Nile's earlier question about the number of complaints we see reported in the media and whether or not you have received complaints from those individuals. I did understand your answer but I am wondering do you think it would be of any use to the Commission to make contact with those people to find why it is they chose to go through the media rather than through the Commission? Were they aware of the Commission's services or was it just given the nature of the complaint in those circumstances?

Mr PEHM: It might be useful. We have had a number of complaints arising out the recent publicity and we have spoken to—we have very experienced people on our inquiry service and we have had a number of complaints arising out of miscarriages specifically.

The Hon. DAVID CLARKE: How many complaints in that category have come to you—

Mr PEHM: In the last three months or so?

The Hon. DAVID CLARKE: Yes.

Mr PEHM: I am thinking, five, six, eight or so.

The Hon. DAVID CLARKE: That is an increase of over, say, a similar period last year or two years ago? Would that be the average?

Mr PEHM: I have not gone back to do the comparison but I mean if there is an increase it is likely down to the publicity. There is one complaint I am thinking of in particular. These are very emotional and grievous experiences for the women and they cope with them in a lot of different ways. Making a complaint may not necessarily be what is uppermost in their mind at the time it happens. The one I am thinking of is about two to three years old and reading the publicity brought it back.

The Hon. DAVID CLARKE: Did it bring back just bad experiences or did it bring back mistreatment?

Mr PEHM: It brought back the bad experiences and the complaint is about mistreatment. It brought back the whole bad experiences but miscarriages—I mean I have talked to women who it happened to 10 years ago and they still have not really resolved it.

The Hon. DAVID CLARKE: It can be bad experiences but no mistreatment. I am trying to distinguish between the two.

Mr PEHM: It can be. We deal with complaints about the poor delivery of health services and that is why they would come to us, if they felt they were mistreated. We are not a counselling service. People have not rung up just to speak generally. They have come to us because they have a complaint and we have taken those complaints throughout normal processes and we are dealing with them.

Reverend the Hon. FRED NILE: Chair, the Inquiry that I am chairing has made a decision not to investigate individual complaints. We are telling those people to contact you.

Mr PEHM: Yes, and I have had some contact with the secretary of your Committee. There have been no problems there as far as I understand.

CHAIR: Are you preparing for a possible increase in workload of the Commission following this recent publicity?

Mr PEHM: There has not been a significant workload increase. There have been a number of complaints but you will see from our next Annual Report that the number of written complaints we have received in the last financial year has gone down from the year before. Again it is this point about how accurate it is as a measure of health service delivery. One of the main reasons I think it has gone down is because we have put a lot more effort into our inquiry service—we have more senior people on the phones now and they can speak more practically about what is the best option for the complainant. In the past we might have got things about Medicare or outside jurisdictions and because our inquiry service was perhaps not as sophisticated as it is now, I think we are much better at directing people who ring up who might be interested in making a complaint as to the best place to go to deal with their grievances. So consequently we get a fall in written complaints. Now I do not think you would draw from that that the health system is better because written complaints have gone down: telephone enquiries have gone up. There are so many factors that you cannot measure that impact on those figures that it is very dangerous I think and difficult to draw conclusions.

Mrs JUDY HOPWOOD: Can I ask whether or not when somebody makes a telephone inquiry whether you ask them to write down their inquiry and send it in formally?

Mr PEHM: The Act says that complaints must be in writing. We also have a duty under the Act to assist complainants to put their complaints into writing. So the inquiry service will generally talk about the grievance and get them to explain for the purpose of assessing whether it is something we should be dealing with or whether it should go better elsewhere. It depends on the urgency. We have had cases where a complainant might be concerned—there is a fairly significant problem with the discharge of elderly people into nursing homes out of accommodation, a lot of pressure on hospitals to do that. We might have, and this is a real-life example, a call where a son has rung up very distressed, 'My mother is going to be discharged today' and I think it is permissible by the Act that in a case like that the inquiry officer will take the written complaint over the phone, we will assess it as a written complaint - that is, the inquiry officer's reduction to writing - and refer that to the Resolution Service if we can get on to it on the same day. It all depends on the nature of the complaint.

Mr COMAN: Could I also add to that? Say, for example, we get a complaint of alleged sexual assault. We may take that over the phone and we will send an investigator out to get a statement straight away.

Mrs JUDY HOPWOOD: Does the investigation of a complaint and further processing of the complaint ever relate to resources available, human or financial?

Mr PEHM: That is a really interesting area. There is a section in our Act, which unfortunately I did not bring with me, that says—I wish I had brought it with me because the wording is quite interesting—it says the Commission must have regard to the resources available when making recommendations. Again I will have to get the section, but I think it is

something to the effect that we shall not make recommendations that are inconsistent with the Minister and the Department's allocation of resources. So I think it is a very difficult area.

Mrs JUDY HOPWOOD: Would you ever not take on investigating a complaint relating to human or financial resources?

Mr PEHM: No. I mean our complaints will relate to the provision of a health service. Now as we investigate it may be that the lack of resources might be a contributing factor—

Mrs JUDY HOPWOOD: I am talking about the actual Health Care Complaints Commission resources?

Mr PEHM: No. We need—for a complaint against a health organisation, and this is leaving individual practitioners aside, we need an individual incident of patient care. We cannot investigate the health service at large.

Mrs JUDY HOPWOOD: No, I am actually talking about your resources not any one else's? Your resources being able to implement an investigation, not necessarily about lack of—

Mr PEHM: No, it has not been a problem. After the Campbelltown-Macarthur—I still have not found quite the correct word to refer to that—

Mrs JUDY HOPWOOD: Inquiry.

Mr PEHM: —implosion I was going to say as far as the Commission was concerned, the Commission's budget was fairly substantially increased in broad terms from about $7.2 million to $10 million. Along with all the restructuring and the redesign of processes we have done, resources have not been a problem; certainly it has not impacted on the quality of the Commission's complaint handling service.

The Hon. DAVID CLARKE: Getting back to what you understood was the intention of Mrs Hopwood's question where you thought the resources—she was talking about not your resources but the resources of the institution.

Mr PEHM: The Department say or a hospital, yes.

The Hon. DAVID CLARKE: Are you suggesting that there could be a different standard applying into whether there has been a breach or negligence depending on the resources that have been allocated to that medical institution?

Mr PEHM: No, I think what I was saying is the Commission does not investigate general complaints of, ‘This hospital does not have enough resources.’ That is what I was saying. The Commission investigates complaints of individual patient care. Now during the investigation of that it may be that a practitioner will raise, ‘I did not have a consultant available’ or ‘I did not have this support’ or ‘There were only three registrars on and I do not feel that was adequate. That is why I was under pressure and that is why.’ That may be a contributing factor.

The Hon. DAVID CLARKE: Say you get somebody coming to you complaining of negligence, as an example, and you investigate and you feel it was a question of resources. Would that be something that you would comment upon or bring to the attention of the Minister?

Mr PEHM: Yes. We have made recommendations concerning staffing levels in particular facilities but our recommendations are based on our investigation of the patient incident.

The Hon. DAVID CLARKE: I understand. How many of those would you get? How many would be in that category?

Mr PEHM: They do not come in, in that way. That is a factor that might emerge during investigation. As I say, it may be raised by an individual practitioner in their defence.

The Hon. DAVID CLARKE: But you will come to a decision on whether it was a valid defence of that practitioner?

Mr PEHM: We will generally seek expert advice.

The Hon. DAVID CLARKE: And how many cases do you come across on average per year that involve a situation where you believe that lack of resources is a contributing factor to the unsatisfactory outcome to the patient?

Mr PEHM: It is very rare that it is raised explicitly.

The Hon. DAVID CLARKE: No, but when you investigate yourself. The patient may not raise it—

Mr PEHM: I mean raised in any way by the investigation, by the individual clinicians. It is not a defence clinicians tend to rely on. So it is raised very rarely in any way.

The Hon. DAVID CLARKE: Even if it is not raised, you are saying even by your investigators, if they became aware that that was the problem, for instance, lack of staffing, would not that the something that would figure in your outcomes?

Mr PEHM: Yes, it does.

The Hon. DAVID CLARKE: How many of those cases would there be?

Mr PEHM: I cannot give you an exact number but they would very rare and they would be the subject of recommendations we would make to the Director-General and to the facility.

Dr ANDREW McDONALD: If somebody rings the Health Care Complaints Commission with a complaint about a specific hospital and they have not been through the complaints mechanism of that hospital and they are recommended by the Health Care Complaints Commission to go to that hospital and the complaint is resolved, how is that data captured by the Health Care Complaints Commission? What is it counted as? They have done no investigation—

Mr PEHM: We were just count that as an enquiry and the outcome would be—I think we set out the outcomes of our enquiries somewhere in here. I will find it. Inquiry Service. No, actually we have not; it would probably be after this Annual Report. We have a number of different outcomes for enquiries and it might be written complaint received, complaint form material sent to the complainant, or if anything about making a complaint might be referred to another agency, that would be counted as an enquiry that was referred for self-action by the complainant.

Dr ANDREW McDONALD: And you would not investigate that?

Mr PEHM: No. I think generally the approach is to take the lowest point of resolution or, not the lowest, the most appropriate. Obviously if a complainant can resolve it directly with the health service provider, that is the best thing because they are in the local area, they may have to see them again, they may have to use that facility again, so wherever that is an option, that is the way we would like to see it done.

Dr ANDREW McDONALD: Are there area health staff employed as patient representatives in most hospitals now?

Mr PEHM: There are. I think this is another area that the Commission has to look at and in the last Annual Report you will see we have met with the heads of all the Area Health Services. We are looking at improving the liaison between them and us, and certainly all the Area Health Services have complaint handling staff—patient representatives, I think they are called.

Dr ANDREW McDONALD: How do their staff relate to the Commission's 11 resolution officers who are located in metropolitan Sydney?

Mr PEHM: We do not think there are problems there. It varies. On the whole it is pretty cooperative. With difficult complainants, or difficult complaints, it can often be useful for a patient representative to get an outside or a more independent person in to help with the process. They all work fairly well together.

Reverend the Hon. FRED NILE: Are they under the Investigation Director or do they operate separately?

Mr PEHM: No, we have a division called Assessments and Resolution, so assessments handle that initial process of assessing the complaint and the Director of that area is also responsible for the Resolution Service. There is a Manager of the Resolution Service. There is also a Conciliation Registry.

Dr ANDREW McDONALD: Moving on to the complaints process, what does the Commission have in place to help patients with mental illnesses or intellectual disabilities when they are making a complaint?

Mr PEHM: The Inquiry Service again not only handles telephone calls but handles people who walk in off the street. They are the Resolution Officers. They are very experienced in dealing with people and they are very sensitive to those issues, and one of them I know sits on the Mental Health Tribunal and so on, so we have staff who are quite

attuned to those sorts of issues. Certainly, if people walk in, they will be interviewed and a written complaint taken. We also go out and visit people. If they phone and we cannot really get a sensible complaint over the phone or they are not comfortable talking about it we will send people out to interview them in their home and assist them to make a written complaint.

Dr ANDREW McDONALD: What about those with language difficulties, with English as their second language?

Mr PEHM: We have been using translation services for a long time. We use the Telephone Interpreter Service regularly. We are getting our front-page letterhead to have printing on the back in the most common community languages—I think 13 or so—saying to ring the Telephone Inquiry Service numbers and they can hook them up with telephone interpreters. We also use the Translation Service for written material and we can get people to come in as interpreters in our interview rooms.

Mrs JUDY HOPWOOD: How many resolved complaint cases are reopened and how many of these would have initially been deemed not to be serious; and for what reason and with what result thus far, if there have been any resolved that have been reinvestigated?

Mr PEHM: A more serious matter has then had to go to investigation? There would be very few.

Mrs JUDY HOPWOOD: But has it ever happened that the Health Care Complaints Commission has deemed something not to be serious and with further persuasion from whatever pressure it has had to look at that complaint?

Mr PEHM: Yes, that has happened. The complainant has a statutory right to request a review of the assessment decision and if the assessment decision is to refer it for resolution they may come back and say, 'That is not appropriate, I don't like that and I want the matter investigated.' They will often do that. There is a review process conducted by officers—at least the investigatory work—and they are independent of the assessment process. Those are the Resolution Officers. It is rare. The review process, page 128 of the Annual Report: 89.8 per cent of the original assessment decisions were upheld and 10 per cent were changed.

Mrs JUDY HOPWOOD: Do you have any examples—not specifics, but where they started to be resolved, were considered a minor issue, and were really very serious?

Mr PEHM: Nothing springs to mind in that vein. It may be that during the review process more information becomes available; the complainant is able to produce more information, scans or relevant medical evidence, that changes the view of our expert adviser who would have given the original view. It is quite rare. A significant number of that 10 per cent would be variations probably from discontinued towards resolution options. It would be rare that a decision to discontinue or to send a matter to a resolution option would be reassessed for investigation, but not impossible. It happens.

(Short adjournment)

CHAIR: Does the Commission undertake a survey of satisfaction of stakeholders, such as the registration boards?

Mr PEHM: No, not a survey. We have very direct contact with the registration boards on a pretty consistent basis and the feedback from all of those has been positive about the way the Commission is now working. Also I have met once a year at the combined meeting of the registration boards and uniformly they seem pretty happy with the way we are operating.

CHAIR: So you think that is enough in terms of measuring their satisfaction with the Commission?

Mr PEHM: I have a very close relationship with all of them. I do not know that I need to send them a survey. We exchange views and we are both fairly frank with each other. They make recommendations about how they think we should do things and we take those on board. They are good relationships. They are robust at times. We might disagree about particular complaints, but generally I think the relationships are strong and positive.

Dr ANDREW McDONALD: You talked about stakeholders such as registration boards. What about your relationship with professional bodies such as the AMA, which I put on the record I am not a member?

Mr PEHM: I have met with the AMA a few times. I have also met with the insurers. Avant is the new principal one we deal with. There is also the medical defence associations. I had a joint meeting with the AMA and the insurers—it is probably going back nine months ago now. Again, the feedback is very positive. It is partly because such a low bar was set by the previous Commission. It is fair to say that professional groups were concerned about perceptions of bias in the way the Commission operated. I think we are demonstrating, in the way we are handling complaints now, to all those health service provider representative groups that we are fair and straightforward. Uniformly, the feedback has been very good.

CHAIR: The Complaints Resolution Service undertook a satisfaction survey of the services during 2005-06. Does the Commission intend to undertake a similar survey in relation to its assessment and investigation processes?

Mr PEHM: We have had a close look at the Resolution Service's patient satisfaction survey as part of an internal audit. One of the other things the Commission has done is we have contracted Deloittes to conduct internal audits and they have done the assessment process and it got four out of five. They have done the Resolution Service as well. One thing they picked up about the Resolution Service satisfaction surveys is that they are selective, which is not the way you do surveys, and not for bad reasons either. In some cases the Resolution Service did not want to stir up grief. A significant proportion of the resolution matters involve families and people who have lost loved ones and who are in deep grieving situations. In cases like that the Resolution Officer might make the assessment, 'I don't want to send them a survey form to say 'are you satisfied with the service' because I know it will bring it all up again.' They have probably had quite a few meetings with them.

The problem is that we are selective so we cannot say it is a random survey. I guess there is always the suspicion that it is selective in the sense that it puts the Commission in the best light. We are starting soon—and again I do not have the date at my fingertips—we will be sending every complainant a brief satisfaction survey. We have had to draft it and

have a look at it for all the processes—for the assessment, the discontinues, the resolution and the conciliation processes. There is no reason why we would not do it for investigations. It is just that the number that go to investigations are far smaller and the context generally much more intense with the complainants. But certainly for those high-volume processes we plan to do a more randomised complaint satisfaction survey.

CHAIR: Is Deloitte suggesting you do something such as with your final correspondence with complainants you send out a survey at that time?

Mr PEHM: That is right. I do not think they made any suggestions about what we should do but I think we have discussed that with them and that is what we will be doing. Every complainant now will get a survey. We will see what the response rate is. We will put in a self-addressed stamped envelope.

CHAIR: When are you planning to start that?

Mr PEHM: It is in process. I have not seen the drafts of the surveys yet. We are still doing the survey form. I cannot tell you exactly when we will start but we do intend to do it and it will happen.

CHAIR: Perhaps you can take that on notice. It will be good to know when that is going to start.

Reverend the Hon. FRED NILE: Obviously the investigation processes need to be improved. Can you outline some of those improvements that you have made as Director?

Mr COMAN: Part of that is professional development. The other part is improving our systems and processes such as developing an Investigations Manual. Just on the investigators course, we have tailored a Certificate 4 in Government Investigations for the Health Care Complaints Commission. It pretty well follows a full investigation process from the beginning to the end. It is broken up into a number of modules—at the beginning the evidence gathering or collection module and then we have our investigators interviewing. We need to develop our skills in statement taking and interviewing people. Then we have our investigation reporting, writing up our final reports, developing briefs of evidence. We identified brief preparation as an area that needs to be improved on and we are doing that. The final one is just intelligence applications, data analysis, those sorts of things as well. Then we have a couple of mandatory subjects that are dealt with in distance education, working in the public sector and compliance.

We commenced that in November and we have one more workshop to go which will be held in the first week of December. Then there is some distance work and then, providing they pass, they will gain that Certificate 4 in Government Investigation. With the Procedures Manual, we have drafted it. We just need now to finalise it. We are looking at, for some of the important things, next week introducing policy directives. A lot of that is to do with receipt and allocation of investigations; that we get the Managers involved a lot more in the initial stages. They were not getting involved until the back end of the investigation so we are getting them involved in the early stages. I get the file, I read it, I form views as to general direction, then we give it to the Investigation Manager who will prepare a file note which will identify the general direction, lines of inquiry, fast-tracked actions and also what the

challenges are. Perhaps we need to keep the complainant apprised every couple of weeks, those sorts of things.

There are also common elements, keeping the complainant apprised at least once a month—those types of things. Actively tracking that investigation and taking any corrective action that needs to be. They then meet with the investigator and develop an investigation plan. I was concerned with the initial investigation plans that we had. They looked like a table and they just sort of followed the statutory steps. Now we are adding a lot more meat, where we are looking at the evidence gathering phase of the investigation plan. We have some generic lines of inquiry that we would do and then we would put tasks underneath that. So we have a framework for the general investigation plans—general direction or terms of reference, lines of enquiry, and then identify tasks following that. Then the Manager sets the time frames with the investigator, not the investigator. It is not 12 months. We are looking at reporting periods or triggers, say, three months—they should have completed the evidence gathering phase by three months and then we are reporting by exception and we will keep following that process and if we need to we can get involved and take corrective action.

Reverend the Hon. FRED NILE: I know in your answers to questions that the average time taken for an investigation fell from 352 days in 2005-06 to 318 days in 2006-07 and that 70 per cent of the investigations were completed within 12 months. Do you still feel that this a long period for investigations and the impact that is having on the complainant?

Mr COMAN: We do.

Mr PEHM: We do. We have been very concerned about the delays. Obviously there has been a problem with the Commission for a long, long time. I guess the level we are at now—we set that 12-month benchmark in light of files that had been open for five, four and three years—we thought that was a realistic goal to set to give people something to aim towards. I think probably now they have gotten comfortable with the 12-month time frame. With the sorts of experience, skills and reform that Bret brings to the position now we think they can be done substantially quicker than that.

Reverend the Hon. FRED NILE: If there are investigations in three months, as you said a moment ago, perhaps you can complete them in six months rather than 12 months.

Mr PEHM: We do them as quickly as possible. There are some inherent procedural delays. There are sometimes problems obtaining expert evidence simply because of the commitments of your experts in other areas—they are all busy clinicians. And there are other consultation processes that we have to go through with the boards, which generally meet once a month. So there are inherent procedural delays. But we certainly think they can become a lot quicker, and they will be in future.

Reverend the Hon. FRED NILE: Can you make a decision without the board meeting? Can you make it by some other means, such as teleconferencing or emailing? Does it have to be a formal board meeting?

Mr PEHM: That is the way it is done. We introduced a teleconference with the nurses board to get them done fortnightly. It is another situation where we think we still have work we can do internally before we start telling boards that we want them to do things differently. We want to get our part of the process absolutely up to speed. Then I think we will be in a

position to ask the boards to reconfigure the way they work slightly, if it will make a difference.

Mr MATTHEW MORRIS: Before we move on to a different line of questioning, in terms of investigations—given that they still potentially take around 12 months—what mechanisms do you have in place to feed back to the original complainants about the investigation? How often do you talk to them over the 12 months to keep them at least generally informed of how you are progressing?

Mr COMAN: Ideally they should be informed at least every two weeks or once a month. I encourage investigators to contact the complainant and to work it out. Some do not want to be informed every two weeks but generally once a month or something like that—whatever they are happy with. Sometimes they might initiate regular email contact and that sort of thing. We find, too, that if we initiate contact and keep them apprised—even if we do not have a great deal of progress to report because, for example, we are waiting on the expert or for certain records—we find that they are a lot happier with that. That is built into our procedures manual: the Manager has to ensure that they have regular contact.

Dr ANDREW McDONALD: I have two quick questions for Mr Coman. What qualifications do the investigators have?

Mr COMAN: They are mixed. We have a mixture of police, who are designated or former designated detectives. We have former lawyers and we also have people with clinical or nursing backgrounds—that type of thing. So it is a good mix and we have a pretty good skills base for sharing that. We have got some very, very talented young people with dual degrees, people who had their own law practice and that sort of thing. We have got very talented people. We advertised about four months ago and we had 70 applicants. We were able to pick the best applicants from those people as well.

Dr ANDREW McDONALD: Do you read all briefs for investigation?

Mr COMAN: Yes. In fact, I read every investigation that comes through—every investigation file—and I add a file note. I get a general view of what needs to be done. I will flag the more important ones and will be kept apprised and add it on the internal reporting group, which meets once a fortnight. Then I read the briefs of evidence. The briefs of evidence may need a little bit more work, and we have got the senior officers group working with the Managers from legal to develop some processes about that as well.

CHAIR: Turning to staffing issues, the Annual Report notes that the Commission employs no Aboriginal and Torres Strait Islander staff and only half the proposed target for staff with a disability. What strategies does the Commission have in place to remedy this situation?

Mr PEHM: We now have an Aboriginal-designated position in the Resolution Service that is filled and operating. We have a Disability Action Plan, which we are required to have by government legislation. Part of that is workplace inspections and accommodation for people. We have done that in a significant number of cases—for example, we have special Dragon Speak tools to make it easier for people to use computer equipment, and we make accommodation in the form of office furniture and that sort of thing. A number of other strategies are set out in the plan.

CHAIR: I have another question about staffing. Earlier we talked about staff turnover and I think you suggested that you are more satisfied with the rate of staff turnover that the Commission is currently experiencing.

Mr PEHM: I do not think we have talked about it. You asked a question about the rate of attrition reported in this report. There has been substantial staff attrition from the Commission. I do not think that has been a bad thing for the general productivity and quality of the Commission's work. I talked about the assessment process and the change in the nature of the role. Some people are uncomfortable with that and were much happier working in the way the old Commission worked—which was minimal contact with people on both sides. We have made it very clear what we expect the Commission should do, and I think we have improved the performance of the Commission significantly. A number of people have not seen their future with the Commission. A proportion of them have just gone on to other jobs—they were there for a certain time, it was time for them to change and they have been promoted elsewhere. But there is an element who made the decision to leave because they did not like the direction in which the Commission was heading.

CHAIR: Is the current staff turnover as high as it previously was?

Mr PEHM: Next year's Annual Report has exactly the same information—the current one that is about to be tabled. It is not a concern for me. We answered this question on page 21 of our written response. The staff attrition for 2006-07 was 14 compared with 21 for the year before. So it is significantly less.

CHAIR: Are you consulting current staff about the issue of staff satisfaction?

Mr PEHM: We are consulting staff continuously through team meeting processes, through Directors divisional meetings and through staff meetings, which happen monthly and that I address.

CHAIR: Do you conduct exit surveys or exit interviews with staff who leave?

Mr PEHM: I am not sure about that. I think it is something we should do if we are not. I have certainly talked to many of the staff who have gone. But I am not sure whether we have that formal exit survey process in place.

CHAIR: But it is something you would be willing to consider.

Mr PEHM: Absolutely. I think it is a good thing to have. I think the more feedback we get the better. I will check that and if we do not, we should—and we will.

Reverend the Hon. FRED NILE: In one of your answers you said that the Commission does not have a process for monitoring the outcome of legal proceedings where the quality of a medical report is at issue. Is there any reason why you do not monitor the outcome? Would that not be important if you are initiating investigations? It is under item 11.

Mr PEHM: I see—I was thinking of our own legal processes where we prosecute practitioners. A lot of people complain to us about the outcome of workers compensation

proceedings and other disability benefits. We get a lot of misdirected complaints against the Commonwealth about entitlements to disability services. Part of all of those processes involves medicolegal reports. In a significant number of those cases people are more dissatisfied with the outcome of their compensation claim but will attack the veracity and accuracy of the medico-legal report. There are very comprehensive processes in place to deal with those, such as the Workers Compensation Commission and the motor vehicle negligence processes. We generally take the view that unless there is something significant or glaringly obvious in the medico-legal report we will get a response from the practitioner and they will give us a completely different version of events about the conduct of the consultation. We let those matters be dealt with by the legal forum to which they are related. We do occasionally get references back from those Commissions. I think the Workers Compensation Commission recently referred back its concerns about a medical practitioner's report to it. But we rely on that process. If that tribunal or that forum has a concern about the quality of evidence given they will refer it back to us. We do not go out of our way to monitor the success or otherwise of those proceedings.

Dr ANDREW McDONALD: Is there any overlap between your work and that of the Clinical Excellence Commission?

Mr PEHM: Not at this stage. We have met with the Clinical Excellence Commission a few times—and I am having another meeting with them in early December. They are generally looking at very high-level data analysis. The Department of Health has in place an Incident Management System and clinicians report adverse events and near misses through that system. All of that information is collated and analysed by the Clinical Excellence Commission and out of that information they will look at areas where they think improvements—such as handover and communication, falls and obstetrics or whatever they might be—can be made. We come from quality improvement—completely the opposite end. Our focus is the individual patient complaint and the clinical incident that arises. Where there may be some potential for overlap would be through the recommendations we make for systems improvements. They are all reported to the Director General, and we meet three monthly with the Director General about the implementation of those. The Department's Quality and Safety branch also deals regularly with the Clinical Excellence Commission. In fact, the meeting I am having with the Commission will include the quality and safety branch. That is the area where there would be an intersection. But there has not been a lot of direct interaction because we are coming at the same issue from very different angles.

Dr ANDREW McDONALD: Do they make referrals to you on the basis of an incident reported or a cause analysis?

Mr PEHM: No. They have made a couple of referrals where there have been high-profile publicity matters—not as complainants but so we are aware of the incident. But it is very rare.

Dr ANDREW McDONALD: So you usually go through the health services. Do the health services refer people?

Mr PEHM: The health services refer individual matters to us, yes.

Dr ANDREW McDONALD: Is that common?

Mr PEHM: It is not very common, no. It happens. It is another one of those areas where there is probably a lot of hidden data that we do not know. We do not know how many complaints are being made and how many clinicians are reporting or not reporting. There is also a culture in health to deal with things in an informal way, such as chats between clinicians. I do not know; it is awkward to speculate and I am not sure anything practical comes of it. For that reason I cannot comment on whether the number of matters they refer to us is high or low or what conclusion you could draw from that.

CHAIR: The Annual Report notes that a training needs analysis was completed in 2005-06 and that a facilitator would be sourced to provide the required training. What were the results of this analysis and what priority needs were identified?

Mr PEHM: The training needs analysis identified the need for telephone communication skills in the assessments area, for written communication skills—and both of those have been delivered—and for resolution management in the assessments area. Part of the new assessments process is for us to attempt to try to resolve complaints before we have to assess them. If we can work out something between the practitioner and the complainant, that is terrific, so we are trying to skill up the assessment staff to do that. Investigations have had an extensive needs analysis done. I think Bret has already talked about the outcomes of that and what we are putting in place there.

Legal tends to be pretty much self-regulating on the training front. There is mandatory continuing legal education—they go to presentations and issues of particular interest them. And the Resolution Service is an area where we think there is a need for more formal resolution management and that has not been into place, but that is under consideration now. A lot of it is involving staff input and consultation and I am currently consulting with the Resolution Service about the sort of training that it would find useful.

CHAIR: At what stage of preparation is the Commission's records management policy?

Mr PEHM: I would probably have to take that on notice. We may have a policy in place now but it is a very extensive process. The records management in the Commission was very poor. Files would be lost routinely, so there is an enormous job. The whole records management system is really about a 2½ to 3 year project. As I say, I will provide you with a more detailed answer in writing. We do have a policy in place but the policy will need to be continually revised because the systems are being improved. We have let tenders for a document management system. I think we have selected the tenderer for that but there is a three to six-month process for them to assess needs and build the system and so on.

We are talking to the State Records Office regularly about its requirements. I will correct this in writing if I am wrong but I think it was very happy with the progress we had made from where we were starting as well, and we might be reporting that in the Annual Report that is about to come out. It is a very big job in the Commission, not just a question of issuing a policy but a real change in systems, again, in culture and practise and all of those things are being done concurrently. In fact, we have created a specialist position, a 9/10 position, to manage the whole introduction of a proper records management system. That is how much work is needed.

Reverend the Hon. FRED NILE: Item 19 relates to the investigation division and says that the Commission has frequently had to resort to using its coercive powers to obtain documents and require statements of information. What are those coercive powers?

Mr PEHM: Principally the power to require documents.

Reverend the Hon. FRED NILE: Is it a summons?

Mr PEHM: It is a notice that the Act empowers us to issue. It is not a summons as such but the effect is the same and there are penalties for non-compliance with the production notice. Statements of information—less often. A statement of information we give a person when we require information in writing, and we will set out the information we are after. There is a lot of concern with health service providers about confidentiality, justifiably so because they have all that private health information. In many cases it is a concern that is not one that is based on the actual law in that they could give us the information without the requirement of notices, but often to protect themselves they will ask us for a notice before they will respond.

Reverend the Hon. FRED NILE: Is that signed by you?

Mr PEHM: Yes, they are all signed by me. We can also require a person to attend before the Commission to give oral evidence, and we have done that to facilitate an interview between investigation officers and a witness who was fearful of repercussions and would rather have had the compulsion exercised than simply to give the evidence voluntarily, so we have done it in that sort of situation. We generally try to work in a co-operative way, and our initial approach is to simply ask the respondent or the health service provider for a response. We would only think about exercising the powers where there is reluctance to give a voluntary response for the reasons I mentioned or where the delay is really getting excessive and we are not getting the information we need in a reasonably timely way.

Dr ANDREW McDONALD: Appendix B of the Annual Report shows a small number of complaints made to the Commission about medical records. Did they relate to privacy issues or to the availability of records to successive health care providers?

Mr PEHM: Generally it is the availability of records. It is where patients have gone off to a new practitioner and they have asked for either copies of the records or transferred records, and the former practitioner has not shown much alacrity in getting that done. We generally get those resolved through resolution. It just takes that little bit of extra pressure from our office for the provider to provide the records to the new provider.

Dr ANDREW McDONALD: In relation to the availability of medical records in complaints against practitioners is it a frequent issue when a practitioner says the records are unavailable and there has been a finding against them?

Mr PEHM: One practitioner complaining about another practitioner?

Dr ANDREW McDONALD: Or in an adverse event, the practitioner saying 'the old records were not made available to me, that is one of the reasons there was an adverse event.'

Mr PEHM: It is pretty uncommon. I am struggling to think of a case where that has been an issue where one practitioner has raised the lack of records. In the hospital setting the availability of records can be problematic because of the number of attending practitioners and the high volume. Communication through medical records is always difficult and they are rarely as full as we would like them to be as investigators of these incidents, to say the least.

Dr ANDREW McDONALD: Is legibility still an issue?

Mr PEHM: Yes, the handwriting of doctors is legendary. I would not have anything to add to the general myth on that one.

CHAIR: I thank you and your senior staff, for attending this afternoon. I have no doubt that members may have further questions and we will forward them to you and expect some timely answers.

Mr PEHM: We will do our best to get them to you.

(The witnesses withdrew)

The Committee adjourned at 3.53 p.m.

Chapter Three - Answers to Questions Taken on Notice

The Commission responded to several questions taken on notice during the public hearing held on Wednesday 21 November 2007.

QUESTION 1
Hon David Clarke MLC asked how many complaints did the Commission receive in which the Minister for Health was the complainant [Transcript p 31]?

RESPONSE:
In 2005-06, the Commission received 11 complaints where the Minister for Health was the complainant. During the same period, the Commission received 21 complaints that were referred by the Area Health Services.

In addition, in 2005-06, the Commission provided 31 responses to requests for information from the Minister for Health related to complaints dealt with by the Commission.

QUESTION 2
The Chair, Hon Helen Westwood AM MLC, asked when did the Commission intend to commence satisfaction surveys in relation to its assessment and investigation services [Transcript p 38]?

RESPONSE:
The Commission has always collected clients' feedback regarding the Assisted Resolution process. The survey process used was reviewed by internal audit during 2006-07 and changes to the survey process were recommended. On 1 July 2007, the Commission also began to collect feedback from clients of conciliation meetings. The Commission is currently reviewing the feedback surveys for both the Assisted Resolution and Conciliation processes, and is planning to implement an updated version on 1 January 2008.

The Commission has yet to determine whether it will extend the client feedback survey mechanism with respect to the assessment and investigation processes. Over 60 per cent of complaints are assessed for further action under the legislation, and it may be confusing for complainants to try to obtain feedback when the complaint handling processes are still continuing. Both the assessment and investigation processes also have statutory rights to a review by the complainant of the outcome.

QUESTION 3
The Chair, Hon Helen Westwood AM MLC, asked at what stage was the development of the Commission's Records Management Policy [Transcript p 44]?

RESPONSE:
The Commission's Records Management Policy was developed and approved in 2005-06 as one of the first deliverables of the Records Management Program required under section 12(2) of the *State Records Act 1998.*

In 2006-07, the Commission continued to improve its record keeping activities by implementing policies and procedures in accordance with the Commission's Records Management Program 2006-08.

To ensure the program met user requirements and incorporated the business needs for all Commission processes, a records management working group was established to allow divisional representatives to work closely with the Records Manager. Deliverables included implementation of:

- records management policy
- records management security guidelines
- management of sensitive information policy
- records management induction module
- style manual
- acronyms and abbreviations list

The Commission issued a request for quotation for an Electronic Document and Records Management System (EDRMS) in the last quarter of the 2006-07 final year following a review of the Commission's records management requirements. The TRIM Context EDRMS was selected from the available options. It is envisaged that the new system will be implemented by the beginning of the fourth quarter of the 2007-08 financial year.

Work continuing into the next year includes:

- TRIM Context implementation and integration with the Commission's case management system, Casemate;
- development and implementation of a Business Classification Scheme for records;
- review and updating of the functional retention and disposal authority for records;
- appraisal and sentencing of records and appropriate retention/disposal activities.

Ongoing training in good record keeping practices and change management programs will be provided to all staff to maximise the benefits of the new records system and the management of electronic records.

QUESTIONS NOT ASKED DUE TO TIME CONSTRAINTS

Performance Report for 2005-06

QUESTION 4

Could you please explain the rationale behind the choice of the following performance measures:

- **improved community and public sector information reporting of case performance and information measured by the percentage of Health Conciliation Registry matters where agreement/partial agreement is reached and**
- **the development of procedures/protocol for the handover of cases to the Legal Division for prosecution measured by the number of referrals for consideration of disciplinary action.**

RESPONSE:

The measure 1.3.3 on page 8 of the Annual Report relates to the strategy above the one against which it was reported. There is no measure for the strategy of better reporting case performance and information. The Commission relies generally on its improved Annual Reports and their publication.

The measure reported at 2.1.7 is incomplete. It was intended to refer to the percentage of cases referred back from Legal to Investigations for further inquiries. The strategy and measure is more properly set out in the Commission's 2006-2007 Annual Report at page 120.

QUESTION 5

How does the Commission undertake its offsite investigation risk assessments?

RESPONSE:

There are several strategies that the Commission employs to reduce risks associated with inquiries conducted in the field. First, the Commission considers the background of the person/s that the Commission is meeting. This assessment is based on material gathered during the assessment and investigation phases. The Commission also considers warnings and previous histories with the Commission, the person's medical/psychological condition, and criminal history (if contained in the information provided by the NSW Police Force). If the Commission has concerns, arrangements are made to meet in a public place with two investigators, rather than one. Managers are informed as to where the meeting will take place and when the investigators are expected back. Finally, a Commission mobile phone is available to take to meetings.

QUESTION 6

How has the Commission progressed its compliance with ISO 27001 *Standards for Information Security*?

RESPONSE:

The Commission is undertaking an independent audit by SAI Global for the purposes of achieving certification to the Standard in mid-December 2007. Further activities may be required to fully comply by March 2008. To date the Commission has finalised a 'gap analysis' audit and a 'pre-certification' audit.

QUESTION 7

The Commission has established an ICT Strategic Plan, running from 2005-08. Have any particular needs or resource implications been identified, and have any initiatives been implemented as a result of the Plan?

RESPONSE:

The ICT Strategic Plan 2005-08 identifies a range of ICT projects, and their resourcing needs, that will assist the Commission in improving the efficiency and effectiveness of its operations and activities. The implementation of projects identified in the Plan is monitored by the Commission's ICT Steering Committee.

A copy of the ICT Project Plan (status 25 September 2007), and the report to the September 2007 ICT Committee meeting on the 'Progress of Projects from the ICT Strategic Plan 2005-08' is attached for the information of the Committee (See Appendix 3 of this Report).

Complaint Numbers, Trends and Issues

QUESTION 8

Complaints about all types of health organisations increased in 2005-06, but the most dramatic increase was in respect of those made against Justice Health, which more than doubled. Is the Commission aware of any cause/s for this, and does it intend to investigate the increase?

RESPONSE:

The Commission appears to be developing a higher profile with complainants from prisons because of its responsiveness to complaints from this area. The Commission has met on a number of occasions with Justice Health Chief Executives to discuss relevant issues and is satisfied that Justice Health has in place robust complaint handling mechanisms and is responsive to complainants.

Legal Division

QUESTION 9

What, if any, do you consider has been the impact upon the Commission's investigative functions of the introduction of two new Senior Legal Officer positions?

RESPONSE:

The new Senior Legal Officer positions have had little impact on investigations. The positions are designed to increase the supervision and case management of prosecutions before disciplinary bodies. It is believed that they have had a significant impact in improving the processing of prosecutions.

Management and Structure

QUESTION 10

How often does the Commission's Internal Audit Committee meet, and does it have any external representation? Have any of its recommendations been implemented?

RESPONSE:

Ms Anne Lear, Risk Management Consultant, Suncorp, (formerly with NSW Fire Brigades) is the only external representative. There have only been three meetings. The Committee meets quarterly, subject to sufficient agenda business for the consideration of the Committee. Internal audit reports on Commission activities include management responses to audit recommendations and a timetable on the implementation of agreed actions. The Audit Committee reviews implementation of agreed actions.

QUESTION 11

How has the Commission utilised the advice and feedback from the Consumer Consultative Committee?

RESPONSE:

The Commission has utilised the feedback provided by its Consumer Consultative Committee to improve its publications that inform the public about the complaints process and how to make a complaint; to inform the Commission about appropriate venues for the Commission's program of public education; and by taking the Committee's advice on issues of concern to health service consumers, and being aware of these when assessing and otherwise managing complaints.

The Committee has also provided valuable input that will inform the Commission's response to the forthcoming review of the Root Cause Analysis (RCA) process where adverse incidents occur in the public health system, in relation to the detrimental impact that the privilege attaching to the RCA process has on the open disclosure of adverse events to patients and families that have been adversely affected.

Statistics

QUESTION 12

Table 14.2 of the Annual Report lists 3,392 complaints received in 2005-06 broken down according to category, eg, access or communication. However, Table 14.14 lists 3,884 complaints assessed with a breakdown by issues identified. Could you please explain the difference in these figures?

RESPONSE:

Table 14.2 reports issues raised by complaints received during the year, while Table 14.14 reports issues raised by complaints assessed during the year. The Commission received 3023 complaints during the year and assessed 3392 complaints during the same period. The higher number of complaints assessed than received explains the difference in the totals between the two tables.

Appendix 1 – Committee Minutes

MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (NO. 2)

10 am Friday 28 September 2007, Room 1043, Parliament House

Members Present
Hon Helen Westwood AM MLC (Chair); Dr A McDonald MP (Deputy Chair); Hon David Clarke MLC; Mr M Morris MP; Hon K Hickey MP; Hon (Fred) Frederick Nile MLC.

In Attendance
Mr Mel Keenan (Committee Manager); Ms Kylie Rudd (Research Officer); Ms Jacqui Isles (Committee Officer); Ms Lluwannee George (Assistant Committee Officer)

Apology
An apology was received from Mrs J Hopwood MP.
The Chair opened the meeting at 10.05 am.

1. Confirmation of Minutes
Resolved, on the motion of the Hon K Hickey MP:
'That the Minutes of the meeting held on 7 August 2007 be adopted'.

2. Matters Arising from the Minutes
There were no matters arising.

3. Draft Questions on Notice for Mr Kieran Pehm, Commissioner of the Health Care Complaints Commission
It was noted and agreed that Dr Andrew McDonald MP had pointed out that the word 'contribute' in question 10 be changed to 'attribute'.

Resolved on the motion of the Hon David Clarke MLC:
'That Questions on Notice for the Annual Report for 2005-06 be sent to the Chair of the HCCC, seeking his response by Friday, 26 October 2007'.

The meeting adjourned at 10.15 am.

4. Time and Date for Next Meeting
2.00 pm on Thursday 1 November 2007.

MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (NO. 3)

2.00 pm Wednesday 1 November 2007, Waratah Room, Parliament House

Members Present
Hon Helen Westwood AM MLC (Chair); Dr A McDonald MP (Deputy Chair); Hon David Clarke MLC; Mr M Morris MP; Hon K Hickey MP; Hon (Fred) Frederick Nile MLC.

In Attendance
Mr Mel Keenan (Committee Manager); Ms Jo Alley (Senior Committee Officer); Ms Lluwannee George (Assistant Committee Officer)

Apology
An apology was received from Mrs J Hopwood MP.

The Chair opened the meeting at 2.05 pm

5. Confirmation of Minutes
Resolved, on the motion of the Hon K Hickey MP:
'That the Minutes of the meeting held on 28 September 2007 be adopted'.

6. Matters Arising from the Minutes
There were no matters arising.

7. Time and Date for Next Meetings
The Committee agreed to meet:

i. at 2.00 pm on Wednesday 21 November 2007 for the examination of the Commissioner of the Health Care Complaints Commission; and
ii. at a lunchtime meeting to be held in the week beginning 3 December 2007, to be arranged.

The meeting adjourned at 3.40 pm.

Appendix 2 – Expert Guidelines of the Health Care Complaints Commission

Commission Investigations

1. The Commission's function is to investigate serious complaints that raise a significant issue of public health or safety, a significant question about the appropriate care or treatment of a patient or, if substantiated would provide grounds for disciplinary action against a health practitioner.

2. During an investigation expert advice is often sought from a sufficiently qualified or experienced practitioner. The Commission's processes for complaint handling are set out in more detail on the Commission's website *www.hccc.nsw.gov.au*.

3. The paramount principle which governs health regulation is the public interest, which includes protection of the public. Disciplinary action is not taken by the Commission with a view to punishing the practitioner but to protect patients from health practitioners who act unethically, improperly and/or significantly below the expected standard. The aim of disciplinary action is to 'maintain proper ethical and professional standards, primarily for the protection of the public, but also for the protection of the profession'.[3]

4. For unregistered practitioners, professional associations have a role in ensuring their members meet expected standards. An outcome of an investigation concerning an unregistered practitioner may include a recommendation that the professional association initiate disciplinary action or other appropriate action depending on its articles of association, by-laws or other instruments.

5. The public expects a safe service from health professionals whether they are subject to statutory regulation or self-regulation. The Commission takes action when there is sufficient evidence that practitioners are impaired, lack competence, act unethically or improperly, or practice significantly below the expected standard in terms of their skill, judgment, knowledge or care. The Commission, professional advisers and reviewers play a critical role in supporting health system safety.

6. Below are some questions and answers that may assist you in providing your report to the Commission.

What is expected of me as a reviewer?

7. As an expert reviewer you will generally be asked to comment on the health care provided by a practitioner or practitioners to a particular patient or patients. You are not asked to comment on whether you believe that there is sufficient evidence to prove a complaint.

8. You will be given certain facts which we ask that you assume to be correct for the purposes of preparing your report.

[3] *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630 at 637

9. You will be asked to describe the standard you would reasonably expect of a practitioner with equivalent training or experience to that of the practitioner the subject of the complaint. The standard should be that which applied at the time of the events the subject of the complaint. You will then be asked whether the conduct of the practitioner is below that standard, and if it is, whether it is significantly below it or otherwise and to provide reasons for your opinion.

10. You are being asked to provide an opinion which you believe reflects the opinions of your peers of good standing. If you are aware of a respectable, yet minority body of opinion which differs from yours, you should indicate that in your report.

11. You are asked to provide a balanced, objective and considered opinion and the language you use should reflect this.

What standard should I use?

12. The standard is what is reasonably expected of a practitioner with the same training or experience as the practitioner complained about at the time of the events the subject of complaint.

13. If you are of the opinion that the practitioner's conduct was below what was reasonably expected at the time of the events complained about, you should state whether it was significantly below that standard or otherwise.

14. If the complaint proceeds to a disciplinary hearing, the Professional Standards Committee or the Tribunal will ultimately decide whether the practitioner is guilty of unsatisfactory professional conduct or professional misconduct.

15. The Medical Practice Act 1992 describes 'unsatisfactory professional conduct' as
'Any conduct that demonstrates that the knowledge, skill or judgement possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.'

16. 'Professional misconduct' is defined as 'unsatisfactory professional conduct of a sufficiently serious nature to justify suspension of the practitioner from practising medicine or the removal of the practitioner's name from the Register.'

17. This definition is the same for all registered health practitioners in NSW (except pharmacists). If you are providing an opinion about the conduct of a practitioner who is not a medical practitioner, you will be provided with the relevant provisions of the legislation.

What type of disciplinary action might occur?

18. The Commission can take disciplinary action at the end of an investigation if there is sufficient evidence to prove that the conduct of a particular health practitioner may amount to unsatisfactory professional conduct or professional misconduct. This type of conduct is defined in the various registration Acts. For example, the *Medical Practice*

Act 1992 states that, among other matters, the following can amount to unsatisfactory professional conduct:

- Conduct which demonstrates that the skill, knowledge or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience;
- Contravention of the *Medical Practice Act 1992* or regulations;
- Contravention of any conditions to which the practitioner's registration is subject;
- Specified criminal convictions and criminal findings;
- Accepting or offering benefits for referrals or recommendations;
- Over-servicing;
- Assisting unregistered practitioners;
- Failing to render urgent attention;
- Failing to give information, produce documents or give evidence to the Commission when requested to do so by notice in writing, without reasonable excuse;
- Other improper or unethical conduct relating to the practice or purported practice of medicine.

19. If a Professional Standards Committee or Tribunal finds the complaint proved, it may reprimand or caution the practitioner, order that the practitioner undergo counselling or medical or psychiatric treatment, complete educational courses or report on or take advice in relation to their medical practice, or impose conditions relating to the practice of medicine. The practitioner may also be suspended from practice or their name removed from the register of practitioners. Some practitioners may also be fined in certain circumstances.

If I am critical, how do I describe my criticism?

20. If you are of the opinion that the practitioner's conduct was significantly below what is reasonably expected, you will also be asked whether that departure invites your strong criticism of the conduct of the practitioner. You may provide an opinion of what you would have done in the circumstances but your report should focus on your opinion as to the reasonable standard and whether the conduct falls significantly below it, if at all. You must give reasons for your opinions.

21. You are expected to give your opinion about matters within your area of professional knowledge and expertise. You are not expected to comment on matters or on the conduct of health professionals outside your expertise. You may raise with the

investigation officer any concerns about aspects of the complaint outside your expertise that you believe should be considered.

22. If any of the facts you have been asked to assume are inconsistent with your knowledge and experience, you should make reference to this in your report. However, in doing so you should not comment on the credibility of the complainant or any other person.

23. It is also important to note that whether there is any adverse outcome for the patient is not relevant in disciplinary cases. The Commission's role is to investigate the appropriateness of care given, not whether that care had an adverse outcome. Unlike medical negligence cases, disciplinary action can be taken without any harm having been suffered by the patient.

24. If you feel unable to give a full opinion at the time of the request because of the lack of some important information you should contact the investigation officer who will be able to either obtain the information or explain its absence.

What should my report contain?

25. The following will assist you in compiling your report:

- Accurately list all the documents and records that you reviewed in preparing your report. This list should specifically identify each document such as hospital/medical records, x-rays, transcripts, statements and interviews. If you have an email address the investigation officer will email the list of documents provided by the Commission to allow you to more easily transfer the information;

- Record the facts which you have been asked to assume;

- Describe the standard reasonably expected and give reasons for your opinion;

- Describe whether the conduct complained of falls below that standard and give reasons for your opinion by reference to the facts and other matters within your knowledge and expertise;

- Describe the extent to which the conduct fell below that standard, (if at all) that is significantly or otherwise, and give reasons for your opinion by reference to the facts and other matters within your knowledge and expertise;

- If you are of the opinion that the conduct is significantly below that standard, state whether your criticism of the conduct is strong or otherwise;

- Describe the basis on which you believe that your peers of good standing would hold the same view as you, e.g. published articles, codes of practice, guidelines etc;

- The report should be based on facts rather than assumptions. If you have found it necessary to make assumptions in order to properly comment on a matter, make this clear in your report.

How should I structure my report?

26. You should check that:

    - You have listed all the documents you have reviewed;
    - You have addressed each of the matters referred to above;
    - You have responded to any specific questions posed in the Commission's letter of request for a report.

27. Although you are asked to respond to specific questions posed by the Commission you are able to comment on other aspects of the care given, within your area of expertise.

28. Always attach to your report a copy of your curriculum vitae, including academic qualifications, membership of professional associations, experience, and publications (if not recently previously or recently provided to the Commission).

What will happen to my report?

29. On completion of the investigation, the Commission has five options available:

    1. Refer the complaint to the Director of Proceedings, whose role is to determine whether the complaint should be prosecuted before a disciplinary body (Professional Standards Committee or Tribunal).
    2. Refer the complaint to the appropriate registration authority (if any) for consideration of the taking of action under the relevant health registration Act, such as the referral of the health practitioner for performance assessment, counselling or impairment assessment.
    3. Make comments to the health practitioner on the matter the subject of the complaint.
    4. Terminate the matter.
    5. Refer the matter the subject of the complaint to the Director of Public Prosecutions.

30. Your opinion will be important in determining the outcome of the investigation. If you do not believe that the practitioner's conduct fell significantly below the expected standard, consideration will be given by the Commission to terminating the matter, making comments to the practitioner or counselling. If you do believe that it fell significantly below the expected standard and expressed strong criticism, the

Commission may prosecute a complaint before a Professional Standards Committee or a Tribunal.

31. If, at the completion of the investigation, the Commission proposes to do anything other than terminate the investigation, it must first give the practitioner an opportunity to make submissions. The Commission will usually provide the practitioner with a copy of your report but any identification of you will be deleted. You may be asked to provide additional information in response to any submissions or further information obtained by the investigation officer.

32. At the end of an investigation, the investigation officer will write to advise you of the outcome. If disciplinary action is proposed, you may be called to give evidence before the relevant disciplinary body. If this is the case, you will be contacted at a later time by the Commission's legal advisers to discuss your role as a witness and the anticipated date of the hearing.

What if I have a conflict of interest?

33. If you are providing a written report, the *Health Care Complaints Act 1993* requires you to complete a statement concerning your personal, financial or professional connection with the health practitioner under investigation. The Commission cannot obtain a report from a person with a financial connection with the practitioner. The Commission will assess other connections and will discuss any concerns with you.

Will I be identified as a reviewer?

34. The Commission's policy is not to disclose the identity of an expert to the practitioner against whom the complaint is made during the investigation process. Your identity will be disclosed if disciplinary action is taken and you are required to give evidence in those proceedings. When copies of any reports are provided to health practitioners during the investigation stage any reference to your name and contact details will be removed.

35. The Commission will disclose the identity of the reviewer to a registration authority, and often provide a copy of the report to it, during consultation about the most appropriate action to take at the end of an investigation.

How will my report be used?

36. Expert reports may be used in disciplinary or related proceedings under a health registration Act but can only be used in other legal proceedings (such as civil claims) with the consent of the expert, the complainant and the health practitioner whose conduct is the subject of the report. The expert, the Commission and the Commissioner cannot be compelled to produce the report or give evidence in relation to it in any proceedings other than disciplinary hearings.

37. The Commission is exempt from providing information in response to applications under the *Freedom of Information Act 1989* in relation to its complaints handling, investigative, complaints resolution and reporting functions.

38. The Commission is subject to the jurisdiction of the NSW Ombudsman and the Independent Commission Against Corruption and may be required to provide information, including copies of expert reports, to those bodies.

What confidentiality issues should I be aware of?

39. As a health provider, you will already be aware of the need to keep information about particular patient care confidential. In addition to your professional obligations, there are confidentiality restrictions imposed by the *Health Care Complaints Act 1993.*

40. As a reviewer you are expected to safeguard the confidentiality of complainants, patients and the practitioners involved. The material you are given must not be divulged to any other person, nor can you discuss the complaint with any of the parties involved.

41. On completion of the review, the Commission's investigation officer will ask you to return the information provided to you or to keep it safe until the investigation is concluded.

How much will I be paid?

42. The Commission has a set rate of fees for experts and peer reviewers. There is a set fee for straightforward cases and one for more complex cases where there are multiple complaints. The investigator will discuss with you the applicable fee.

43. Payment can only be made on a tax invoice quoting your Australian Business Number (ABN). The tax invoice must be addressed to the Office of the Health Care Complaints Commission, abbreviations are not acceptable. The investigator will provide you with a tax invoice form.

44. Goods and Services Tax (GST) can only be paid if you are registered for GST with the ATO (please note that having an ABN does not automatically register you to charge GST). If you do not have an ABN you must include a statement that acknowledges that you understand that the Commission will apply Withholding Tax of 48.5 per cent to your payment.

45. The Commission will pay reasonable witness fees and expenses set by the appropriate court scale for experts and peer reviewers who have to attend a disciplinary hearing and give evidence. The fee set by the Commission may not reflect the work that you put into it. The Commission knows that many of our reviewers spend a significant period of time researching and writing a report. The fees paid by the Commission are all-inclusive, and there will not normally be payment for subsequent reports that are requested due to the receipt of new information.

46. If there is doubt about the rate to be paid, you should contact the investigator prior to accepting the matter for review. All claims for payment should be made in writing stipulating the file number and the names of the identified practitioner or health service and the complainant and the date on which the report was forwarded to the Commission.

Appendix 3 – Information Communications & Technology Progress on Projects from the ICT Strategic Plan 2005-08 as at 25 September 2007

Further to question 7 of Answers to Questions Taken on Notice

Pr	*Project Title*	Costs			*Priority*	*2005-06*				*2006-07*				*2007-08*			
		ISR	*Extern*	*Capital*		*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*
1	CASEMATE Enhancement	$150 K	$120K	$0	High												
	PHASE I: COMPLETED *All outstanding Casemate issues with Eclipse have been dealt with. Legal 'Quick Fix' has been implemented. All reports including Annual Reports have been modified, verified, documented and uploaded on to the Intranet. To improve Casemate performance a new dual processor server has been purchased and installed with SQL2005 Server and latest version of Pivotal. This has significantly improved the system performance which now running very well. CPG has been regularly meeting and issues discussed and priority set for implementation. Requirements for new updated processes for Assessments have been complied and system has been modified to incorporate these. After extensive testing and user training, the enhanced system was put into production along with the new server. The updated system is running very well. Currently there are no outstanding issues with Casemate. Minor enhancement will be carried out on an ongoing basis and released into production once every three months.* *PHASE II: IN-PROGRESS* *Assessments processes have been completed. Legal processes are currently being implemented. HCR process templates and Survey forms have been competed. Annual Report automation is in-progress and Investigation processes will then follow.*																
2	**Infrastructure Upgrade**	$0	$0	$118k	High												
	COMPLETED *Server and network upgrade has been completed. New servers, firewalls have been commissioned. Outdated Novell file system has been replaced with Windows Filebase and all files migrated to the new platform. The new architecture is more secure and reliable with multiple firewalls and redundant communication lines.*																
3	**Computer Room Upgrade**	$0	$0	$100k	High												
	COMPLETED *Work included removal of the partition, construction of raised flooring, installation of fire suppression system, secondary air-conditioning unit and racks for servers and cabling work. All these works have now been completed. Staff training of the fire suppression system has also been completed.*																

Appendix 3 – Information Communications & Technology Progress on Projects from the ICT Strategic Plan 2005-08 as at 25 September 2007

Pr	*Project Title*	Costs			*Priority*	*2005-06*				*2006-07*				*2007-08*			
4	**Document Scanning**	$20k	$0	$20k	High												
	A scanner has been purchased for Assessment as an interim solution. Rest of the document scanning will be included in the stage 2 of the Electronic Document and Records management system project.																
5	**Records Management System**	$50k	$10k	$150k	High												
	IN-PROGRESS *Following a 'Request for Quotation (RFQ)', Tower Software has been selected to supply and implement Trim Context 6.2 Electronic Document and Records management System (EDRMS). Ezy-File trading as Infologic would undertake the integration to Casemate work. A Scoping study was undertaken to fully describe the project activities and project plan. The project is due to commence on 2nd October 2007 and expected to be completed by end of April 2008. (Project Plan attached)*																
		ISR	*Extern*	*Capital*		*05-06 Q1*	*Q2*	*Q3*	*Q4*	*06-07 Q1*	*Q2*	*Q3*	*Q4*	*07-08 Q1*	*Q2*	*Q3*	*Q4*
6	**Remote Access**	$0	$0	$35k	High												
	COMPLETED *New Citrix Server with RSA secured has been implemented. All CROs in the field have reasonably fast access including Newcastle where an ADSL connection for broadband has been installed and the access is now satisfactory.*																
7	**Accreditation to ISO27001 Standards for Information Security**	$40k	$40k	$0	High												

Pr	*Project Title*	Costs			*Priority*	*2005-06*	*2006-07*	*2007-08*
	IN PROGRESS • An Information Security Management System (ISMS) has been developed and approved • Various policies and procedures have been developed have been approved by the Commissioner. • ICT Disaster Recovery Plan and Business Continuity Plans have been developed, approved and tested. IT • Operations Manuals and User manuals have been developed. • Risk Assessment has been completed and a Threat & Risk Register along with the controls to mitigate identified risks have been prepared • Statement of Applicability of various controls as required in the Standards have been completed • Internal gap analysis has been completed and work is being undertaken to meet the non-complying controls. • An Information Security Coordination Group (ISCG) has been formed as required under the Standards to provide a Commission-wide consultative platform. • The first gap audit by the certifying authority SAI Global was conducted in last week of April. • Pre-certification audit is scheduled for 8th-9th October. • It is expected that the final audit would be conducted by end of December.							
8	Intranet Website Development	$20k	$10k	$50k	Medium			
	Phase I: COMPLETED *In this initial stage Intranet has been redesigned and contents regrouped to provide a new look and feel and better navigation.* ***Stage II: In-Progress*** *This will involve a complete new design and development with database driven contents management. .* *After reviewing various contents management system (CMS) available in the market, Manager Application Systems prepared a prototype using Microsoft Share-point platform. This prototype was initially demonstrated to Senior Managers and then to the Executives. The feedback has been positive. A proposal will need to be submitted to the Treasury for approval. (A project brief attached).*							
9	**Internet Website Development**	$20k	$10k	$20k	Medium			
	A staging Internet website had been created and contents have been uploaded. All future uploads will be tested on this staging site and approved by stakeholders prior to live uploads on the Internet website. *A new website is being developed for the ICAC. It is recommended that subject to licensing availability, same or similar website should be implemented for the HCCC.*							

Appendix 3 – Information Communications & Technology Progress on Projects from the ICT Strategic Plan 2005-08 as at 25 September 2007

Pr	*Project Title*	Costs			*Priority*	*2005-06*				*2006-07*				*2007-08*			
10	**Internet Access**	$4K	$0	$0	Low												
	COMPLETED *The Internet access which was previously provided through the DoH was extremely slow. Only Executives had a faster Internet access through Optus with a separate 128KB line. Internet access has now been replaced with a 2MB direct link with Optus. This has provided with a fast link to all Commission staff and is also little bit cheaper then the service via DoH. The 128KB link has been retained as a backup line with an automatic fiber-logic change over switch installed.*																
		ISR	*Extern*	*Capital*		*05-06 Q1*	*Q2*	*Q3*	*Q4*	*06-07 Q1*	*Q2*	*Q3*	*Q4*	*07-08 Q1*	*Q2*	*Q3*	*Q4*
11	**Web-site Hosting**	$10	$10	$30K	Low												
	Work on this will commence soon. Internal hosting website would greatly improve the administration and control of the website. (Project brief attached)																
12	**External Interfaces via the Net**	$4K	$0	$0	Low												
	Work on this will be undertaken in the 2007-08 financial year.																
13	**Integrated Network Faxing**	$10K	$50	$20	Low												
	Work on this will be undertaken in the 2007-08 financial year.																
	Total Costs	$328 k	$305k	$563k													

Notes: ISR – Internal staff resources, Extern. – External costs recurrent

	Original schedule in the ICT Strategic Plan
	Work already completed or in progress

Other Miscellaneous Projects not included in the ICT Strategic Plan

Implementation of a Helpdesk and Asset Management System This system will enable users to lodge helpdesk and Casemate related requests online. This will also allow IT to prioritise, allocate and more efficiently manage helpdesk requests, manage assets, licenses and contracts and produce reports.	June 06	*After reviewing a few off-the-shelf systems, 'Manage Engine Service Desk Plus' Helpdesk and Asset Management system has been purchased and installed.* *After completing a pilot testing on a small number of desktops, the Software has been installed on all desktops across the Commission.* *Staff training has been provided on how to use the Helpdesk system.* *As planned, the new Helpdesk System went into production in first week of July.*	*COMPLETED*
Enhancement of Mail Registration System	May 06	*Specification work has been completed. Changes to both the Mail Registration and Casemate have been made. The updated system has been tested and staff training completed. The system was put into production on 27th November as planned.*	*COMPLETED*