PARLIAMENT OF NEW SOUTH WALES

Committee on the Health Care Complaints Commission

11TH MEETING ON THE ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

June 2006

New South Wales Parliamentary Library cataloguing-in-publication data: New South Wales Parliament. Joint Committee on the Health Care Complaints Commission. Meeting on the Annual Report of the Health Care Complaints Commission (11th: 2006)
11th Meeting on the Annual Report of the Health Care Complaints Commission/ Parliament of New South Wales, Committee on the Health Care Complaints Commission. [Sydney, N.S.W.] : NSW Parliament, 2006. – 74p; 30 cm. (Report; no. 12/53, 2006)

Chair: Jeff Hunter.
"2006".

ISBN 1 92101229 3

1. New South Wales. Health Care Complaints Commission. Annual report.
2. Health facilities—Complaints against—New South Wales.
I. Title.
II. Hunter, Jeff.
III. Series: New South Wales. Parliament. Joint Committee on the Health Care Complaints Commission. Report; no. 53/12

DDC 362.1

Table of Contents

Membership & Staff

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

Functions of the Committee

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

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

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

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

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

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

The Joint Committee is not authorised:

a. to re-investigate a particular complaint; or

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

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

Functions of the Health Care Complaints Commission

The Health Care Complaints Commission has been established under the *Health Care Complaints Act 1993* (the Act) for the purposes of:

a. receiving and assessing complaints under this Act relating to health services and health service providers in New South Wales, and

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

c. prosecuting serious complaints, and

d. resolving or overseeing the resolution of complaints.

The *Act* states that in exercising its functions under the *Act*, the Commission is to have as its primary object the protection of the health and safety of the public.

Terms of Reference

Terms of Reference for the review of the Health Care Complaints Commission's Annual Report include:

a) whether the Report reflects a true and accurate record of the Health Care Complaints Commissions performance over the 2004-2005 financial year;

b) whether the mechanisms used by the HCCC in the report adequately and appropriately measure the key responsibilities and objectives of the Health Care Complaints Commission as prescribed by the *Health Care Complaints Act 1993* and in the Health Care Complaints Commissions Corporate and Business Plans;

c) the extent to which the Health Care Complaints Commission has explained results in the report;

d) the extent of user-friendly accessibility of the report, in terms of content matter and distribution mechanisms;

e) other relevant matters.

Chairman's Foreword

It is with pleasure that I present the Committee's eighth review of the Health Care Complaints Commission's Annual Report while I have been Chairman.

The period covered by the Commission's 2004/2005 Annual Report saw the appointment of Mr Kieran Pehm as the NSW Health Care Complaints Commissioner. It also saw the introduction of the *Health Legislation Amendment (Complaints) Bill,* which made some significant changes to the Commission's governing legislation, the *Health Care Complaints Act 1993.*

I would like to begin by congratulating the Commission on some significant improvements which have been accomplished during the 2004-2005 financial year and then move onto some areas which are still of concern to the Committee.

Firstly, I would like to acknowledge the changes made by the Commission in response to recommendations made by the Committee last year. In particular, the inclusion of comparative performance data over the last five consecutive years is appreciated. However, the Committee considers that greater focus could still be given to providing written analysis of the trends over time as well as the factors affecting those changes.

The addition of new staff to the Investigations Division assisted the Commission to finalise 315 outstanding investigations between June 2004 and April 2005. This was a pleasing result given the concern that the Committee has expressed for some time about the large backlog in investigations.

However, due to the introduction of a more thorough assessment process, the Commission was only able to complete 51 per cent of new investigations within the 12-month timeframe. A target of 80 per cent had originally been set. However, the Commissioner told the Committee that he believed that 80 per cent was still a reasonable goal to pursue. The Committee agrees that 80 per cent is still reasonable and supports the continued pursuit of this standard.

The Committee is concerned about the new legislative restrictions placed upon the Complaint Resolution Service, which was previously known as the Patient Support Office. As the Complaints Resolution Service (CRS) has now been brought under the framework of the *Health Care Complaints Act 1993,* a complaint dealt with by the Service must now meet the complaint criteria contained in the Act. It must also be submitted in writing to the Commission. Previously Patient Support Officers received and resolved complaints directly from the public and area health services as well as from the Commission. The Complaint Resolution Service can now only deal with written complaints that have been formally assessed by the Commission.

I believe that the formality of this process will deter many complainants and practitioners from using the CRS to accelerate the resolution of low-level complaints. This appears to be backed up by the fact that there has been a significant drop in usage of the Complaints Resolution Service during 2004/2005 in comparison to the previous year.

Complaints that may previously have been easily and quickly resolved at the local level may now take much longer. It would be a useful exercise for the HCCC to assess what the response has been at the local level to the changes in the system, and the Committee intends to pursue this over the coming months.

One of the key functions of the Commission, as outlined in the *Heath Care Complaints Act 1993*, is to improve the health care system through recommendations from investigations. However, Commissioner Pehm reported that, until recently, the Commission did not have a procedure in place to monitor the implementation of the recommendations.

The Committee believes that the outcomes of the Commission's recommendations to health service providers are a key indicator of the performance of the Commission's functions under the *Act* and, as such, should be monitored and reported each year in the Commission's Annual report. This is in line with the procedures of the Police Integrity Commission, the NSW Ombudsman and the Independent Commission Against Corruption.

The Commission does not currently have an internal audit committee. This is not in line with best practice within the NSW public sector. The Committee, therefore, is of the view that one should be established as soon as practical.

The Committee still strongly believes that Medical Tribunal decisions should be either published on the Commission's website or that a link direct the reader to them.

Until recently the Committee was unaware that health professional associations for registered practitioners were receiving and dealing with complaints as well as those for unregistered practitioners. It is therefore of concern that no formal processes are in place for the exchange of information between the Commission and professional associations.

The Committee would like to see the Commission strengthen its relationships with key professional associations in order to facilitate referrals and improve the efficiency of the entire complaints handling process for consumers.

The Commission is to be congratulated on the finalisation of Casemate, their new case management system which has been in operation since March 2005.

The Committee, with input from financial consultant John Chan Sew, has several additional comments to make about the structure and content of the Annual Report.

The use of case studies throughout the report has also been more appropriately employed this year. The Committee remains of the opinion that some further reductions in the quantity of case studies may make the document more streamlined. Case studies could potentially be placed in the Appendix or on the Commission's website.

Several other factors have been identified by the Committee as important for inclusion in future Annual Reports. These include:

- More detailed information on staff turnover (attrition) rates
- Benchmarking of performance against like organisations in other jurisdictions and against national standards (where these exist)

The consistency of quantitative performance reporting against Key Performance Indicators is also in need of improvement. For the purposes of transparency and accountability, it is the responsibility of the Commission to ensure that all performance indicators contained in the Corporate Plan are reported against in the Annual Report alongside expected timeframes and information on their status.

Whilst the 2004/05 Annual Report made significant improvements in this area compared to the previous year, several indicators reported against in the Annual Report were not included in the 2004-05 Corporate Plan, and target dates or timelines for implementation were absent for many planned initiatives.

As part of the review of the 2005/2006 Annual Report of the Health Care Complaints Commission, the Committee intends to arrange an independent audit of the Commission to assess compliance with legislative requirements for the handling of complaints,

Finally, given that the Health Conciliation Registry has been incorporated by legislation under the Commission, the Committee met separately with the Registrar of the Health Conciliation Registry for the first time as part of the Committee's review of the Health Care Complaints Commission's 2004/05 Annual Report. Given the importance of the Registry, it is the intention of the Committee to continue to do this in future years.

The Committee was pleased to hear that the newly appointed Registrar, Ms Julia Lines, planned to keep the services of the Registry flexible and accessible and importantly, clearly separated from the processes of the Commission.

The Committee is of the view that the Health Conciliation Registry could have an important role to play in early complaints resolution, and suggests consideration be given to expanding the current role of the Registry to tap into this potential.

The Committee strongly suggests that the Registrar establish ties with similar bodies in other Australian jurisdictions. Likewise, the Commission itself should be liaising regularly with investigations bodies in other Australian states and territories, particularly medical boards and nurses' registration boards.

I congratulate Commissioner Pehm on the improvements the Commission has made during 2004/2005 and thank both the Commissioner and the Registrar for appearing before the Committee. My thanks go to my fellow Committee members for their ongoing interest and commitment to the deliberations of the Committee. I also acknowledge the work of the Committee secretariat in the preparation of the Report.

Jeff Hunter MP
Chairman

Chapter One - Background and Overview

1.1 The year 2004/05 saw the Health Care Complaints Commission focus on restructuring and consolidation after the Camden and Macarthur inquiries and on completing the enormous task of carrying out all investigations generated as a result.

1.2 Additional temporary staff were recruited for the task, and 100% of the investigations backlog was completed. These additional staff contracts have since ceased.

1.3 The Commission underwent structural and legislative change, resulting in greater emphasis being placed on the thorough assessment of more serious complaints.

1.4 Given this, the Commissions target of completing 80% of all new investigations within 12 months proved unachievable. The Commission completed 51% of all new investigations within the proposed timeframe. Nevertheless, the Committee supports the intention of the Commissioner to continue to strive for the original target of 80% in the next financial year.

1.5 The Committee is pleased to see the progress made by the Commission on a number of key areas, including the development and implementation of the new case management system Casemate and the reformation of the Consumer Consultative Committee.

1.6 However, concerns have been raised by the Committee about several other aspects of the Commission's operation, including: the deficiency of reported data on the implementation of recommendations made by the Commission; the absence of an internal audit committee; and the failure of the Commission to develop significant guidelines including an Ethnic Affairs Priority Statement and the long-awaited five-year strategy.

1.7 Additionally, the impact of legislative changes on the accessibility of the Complaints Resolution Service (formally the Patient Support Service) for low-level complaints is of concern to the Committee.

1.8 Finally, the Committee is eager to see an expansion of the Commission's assessment of stakeholder satisfaction with a view to making continued improvements to the relationship between the Commission and it's various stakeholder bodies.

1.9 The Committee acknowledges that the Commission has taken positive steps towards more efficiently fulfilling its functions under the *Health Care Complaints Act 1993*, and anticipates continued improvements in the following year.

Chapter Two - Key Issues

2.1 A number of major changes took place within the Commission during the year 2004/2005. These changes affected the structure of the Commission, as well as its functions and priorities.

2.2 Overall, changes were made to the Commissions processes with the aim of ensuring that the assessment of complaints is conducted more thoroughly than was done in the past:

> *'The main change is that we are now doing much more careful assessments of complaints than the Commission did in the past. Previously the practice was simply to make an assessment decision based on the complaint. We now generally get responses from the respondent. In clinical issues we will obtain medical records and may get expert advice at that stage. The object is to make a more informed and better assessment decision so that the complaint can be dealt with in the best way'.*[1]

2.3 The Commission has refocused its efforts on investigating more serious complaints handling.

2.4 Whilst some of the changes brought welcome improvements to the operation of the Commission, the Committee is concerned that others may have established further obstacles to consumers wishing to access independent complaints services.

Legislative Change

2.5 On 1 March 2005, amendments to the *Health Care Complaints Act 1993* (NSW) took effect.

2.6 The Commission reports that the aim of the amendments are to refocus the Commission on its principle objectives, being to investigate, resolve and prosecute complaints about health care providers.

2.7 Major changes to the *Act* include the following:

- When assessing and investigating a complaint, the Commission is now authorised to require the production of hospital/medical records and information about a professional's practice, as well as documents and additional evidence.
- Where the subject of a complaint is believed to breach either the *Public Health Act 1991* (NSW) or the *Health Services Act 1997* (NSW), the Commission is now able to refer the matter directly to the Director-General of Health.

[1] Transcript, Public Hearing, 8 March 2006

- Where a complaint is referred to a registration board, the Commission must discontinue dealing with it. Prior to the amendments to legislation the Commission usually also referred those complaints to a Patient Support Officer.
- The Commission is no longer permitted to refer a complaint to an Area Health Service for their investigation and report back to the Commission. It may, however, continue to refer to a public health organisation (such as Area Health Services) for resolution of non-serious complaints.
- The Complaints Resolution Service (formally the Patient Support Service) was given legislative recognition for the first time under the *Act*.
- The position of Director of Proceedings was established, and given the authority to make decisions independently of the Commissioner on whether or not to take disciplinary proceedings against a practitioner.
- Inclusion of the Health Conciliation Registry as part of the Health Care Complaints Commission.

Complaints Resolution Service

2.8 Changes to the *Act* as it relates to the Patient Support Service (now the Complaints Resolution Service) are significant. It is this aspect of the legislative changes that are of concern to the Committee.

2.9 Acknowledgment of the Complaints Resolution Service under the *Act* has resulted in a reported "scoping in" of its functions.

2.10 By including the Complaints Resolution Service under the Act, a complaint to the service must now meet criteria contained in the Act in order to be recognised by the Commission as a complaint. Namely, it must be submitted in writing and include particulars of the allegations on which it is founded (Section 9). This is reflected on p.25 of the Annual Report:

> *'Previously the Service received complaints directly from the public or from health services as well as from the Commission. The CRS now deals with only written complaints that have been formally assessed and referred by the Commission'*.

2.11 The Committee is of the view that this new requirement will create a barrier to complainants wishing to access timely low-level complaints resolution services.

2.12 The Committee also believes that the same requirement will serve as a deterrent to practitioners in private practice who would ordinarily consider referring a low-level complaint to a Patient Support Officer, but who would now hesitate to do so if the referral is guaranteed to result in a formal complaint.

2.13 Statistics on the number of Complaints Resolution Service clients in the period 2004/2005 reflect the Committees concerns. The Commission's Annual Report show a significant drop in access of CRS services in 2004/2005 compared to the previous year (see Figure 3).[2]

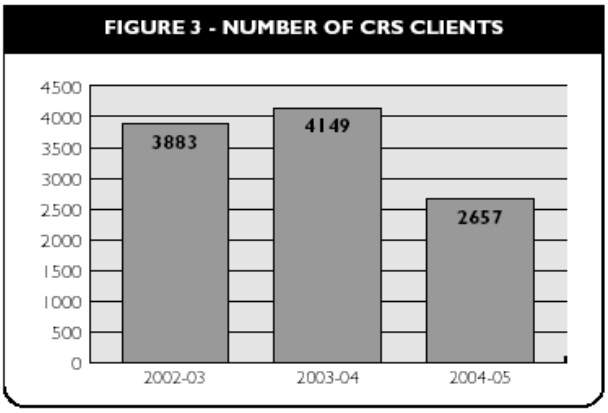

Figure 3: Number of Complaints Resolution Clients between 2002-2005

2.14 Figure 3 shows the number of Complaints Resolution Service clients falling from 4149 in 2003/04 to 2657 in 2004/2005, a difference of 1492 clients.

2.15 In response to this concern, Commissioner Kieran Pehm explained to the Committee at the Public Hearing of 8 March 2006 that the reported 2004/05 figure was for the period June 04-March 05 (nine months in total), and as such is significantly smaller than it would have been if the full 12 months had been reported.

> *'That decrease of 1,492 is page 25 of the annual report, the figure there for 2004-05 which is 2,657 is only a figure for the nine months of the year because come 1 March 2005, the last quarter of the year, we did not count the old complaint resolution service clients separately. They were just treated as complainants and matters referred to the complaint resolution service, so if you add a quarter on to that 2,675 number it is not the significant level of increase that it seems'.*

2.16 Nevertheless, even taking into account the correction to the figures, a decrease in access by 607 clients is observed.

2.17 Given the redirection of the Commission's resources away from involvement in low-level complaints handling, the Committee is concerned that complaints that may previously have been resolved immediately may now take weeks or even longer, if they are received by the Commission at all.

[2] Health Care Complaints Commission (2005), *Annual Report of the Health Care Complaints Commission 2004-2005*.

2.18 The Annual Report shows that complaints to the Complaints Resolution Service in the category of 'Corporate Service' has dropped from 26 complaints in 2003/04 to 11 complaints in 2004/05 (Table 9).

TABLE 9 - CATEGORY OF COMPLAINTS ASSESSED FOR INVESTIGATION 2002-03 TO 2004-05

Category	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Professional Conduct	92	39.7%	119	26.2%	232	44.3%
Treatment	85	36.6%	264	58.0%	196	37.5%
Miscellaneous	5	2.2%	5	1.1%	62	11.9%
Access	12	5.2%	18	4.0%	14	2.7%
Corporate Services	22	9.5%	26	5.7%	11	2.1%
Communication	7	3.0%	9	2.0%	6	1.1%
Privacy/Discrimination	2	0.9%	4	0.9%	2	0.4%
Consent	6	2.6%	6	1.3%	0	0.0%
Cost	1	0.4%	3	0.7%	0	0.0%
Grievances	0	0.0%	1	0.2%	0	0.0%
Total	**232**	**100.0%**	**455**	**100.0%**	**523**	**100.0%**

Miscellaneous: Re-registration 52; Convictions 4.

Table 9: Category of Complaints Assessed for Investigation between 2002-2005

2.19 Commissioner Pehm clarified the types of complaints coded as 'Corporate Service' as including complaints to do with car parking, cleaning, catering, grounds, laundry, maintenance, security, hygiene, environmental standards and administrative services like clerical process and admissions.[3]

2.20 It appears to the Committee that such issues would most easily benefit from immediate access to resolution, without the requirement of submitting a written complaint for assessment by the Commission.

2.21 Overall, changes to the role of the Complaints Resolution officers may have inadvertently created a gap in service for those complainants requiring prompt responses to immediate concerns. This gap would be felt the greatest in private practice, where no alternative means to resolution (such as the Patient Representative in Area Health Services) exists.

2.22 Commissioner Pehm followed up on this concern by providing the Committee with information on the number of complaints received by the Complaints Resolution Service that were referred by professionals in private practice.

2.23 These figures show that 0.5%, 1.5% and 2.6% of CRS cases for the years 2002-03, 2003-04 and 2004-05 respectively were referred by practitioners in private practice.

2.24 The Committee acknowledges that this proportion is relatively small.

[3] Transcript of Public Hearing, 8 March 2006.

2.25 Nevertheless, the Committee is also of the view that the Complaints Resolution Service could potentially play an important role in assisting private practitioners with little access to other complaints support mechanisms to more efficiently handle low level complaints within their practice.

2.26 At present, clinics and practices that are privately run do not have access to mechanisms for low-level resolution that are more widely available in public health systems.

2.27 In practices that are particularly large or especially busy, lower level complaints can get lost, overlooked or poorly resolved. Smaller practices may not have the resources to manage complaints effectively.

2.28 In either case, consumer complaints may linger longer than is necessary, increasing the opportunity for greater consumer dissatisfaction.

2.29 Although the number of referrals to the CRS from private practice is, at present, minimal, the Committee is of the view that with greater promotion and consideration of the needs of private practitioners, the CRS has a valuable role to play in the resolution of complaints made against private health practitioners and that it should remain a viable option in the dispute resolution processes available to this group of practitioners.

Structural Change

2.30 The Health Care Complaints Commission has been divided into three major divisions:

- Assessments and Resolution
- Investigations
- Proceedings

2.31 The Assessments and Resolution Division was established, assuming administrative responsibility for the Health Conciliation Registry and full responsibility for the Complaints Assessment Team and the former Patient Support Service (now the Complaints Resolution Service).

2.32 The start of the 2004-2005 financial year saw the Investigations division divided into six teams, each comprising a team leader and 4-5 investigators. Come June 2005, these were reduced to three teams, after substantial progress was made on processing the backlog of investigations.

2.33 Although 2004/2005 saw new legislative empowerments to the Director of Proceedings and a substantial increase in the number of matters referred for prosecution by the Legal Division, no significant structural changes were made to the Legal Proceedings Division.

2.34 A new Senior Executive team was also established in 2004/2005, with Kieran Pehm appointed as Commissioner in June 2005, Christopher Hanlon as Director of Assessments and Resolution in February 2005 and Karen Mobbs as Director of Proceedings in March 2005.

2.35 The addition of staff to the Investigations division assisted the Commission to finalise 315 backlog investigations between June 2004 and April 2005. The Commission is to be commended on its elimination of the investigations backlog.

Finalised Investigations

2.36 During the reporting period (2004/05), 15.7% of all complaints received by the Commission were assessed as suitable for investigation. 53.8% of these complaint investigations were terminated by the Commission, while 17.2% resulted in the prosecution of the practitioner before a disciplinary body. Only one matter (0.1%) was referred to the Director of Public Prosecutions. [4]

2.37 The Commission set a corporate goal of completing 80% of all new investigations within 12 months. However, as stated in the Annual Report, *"this proved too ambitious for current capacity"*.[5]

2.38 Due to the more thorough assessment process introduced and a refocus on the investigation of predominantly more serious complaints, the Commission was only able to complete 51% of new investigations within the 12-month timeframe set.

2.39 However, Commissioner Pehm reiterated at the recent Public Hearing that the Health Care Complaints Commission was committed to achieving the higher target of 80% in the coming financial year.

> *'I still think 80 per cent within 12 months is a reasonable goal to pursue and I think that we have been providing the Chair with quarterly reports more recently and I think we have got over that 50 per cent, closer to the 80 per cent'.*[6]

2.40 The Committee believes that a target rate of 80% is still appropriate, and supports the continued pursuit of this standard.

[4] Health Care Complaints Commission, 2005, *Annual Report of the Health Care Complaints Commission 2004-2005*, p. 37
[5] Health Care Complaints Commission, 2005, *Annual Report of the Health Care Complaints Commission 2004-2005*, p. 6
[6] Transcript, Public Hearing, 8 March 2006

Recommendations of the Commission

2.41 One of the key functions of the Commission, as outlined in the *Heath Care Complaints Act 1993*, is to improve the health care system through recommendations from investigations.

2.42 The Committee requested information from the Commission at the recent public hearing about the number of recommendations that resulted from investigations and the implementation of these recommendations.

2.43 Commissioner Pehm reported that, until recently, the Commission did not have a procedure in place to monitor the implementation of the recommendations, as this was largely the responsibility of the Director-General of the Department of Health:

> *'There were 26 investigations that resulted in the Commission making comments or recommendations to the health service provider during 2004-05. We have only recently set up the process for monitoring those beyond the individual health service provider and that is the meeting I was referring to with the Director- General of Health every three months, so prior to that time there was no monitoring of the implementation of the recommendations, and that is something we will be reporting on in our next Annual Report. There is a bit of an issue in the Act with the provision of that information. The way the Act reads at the moment it is solely the responsibility of the Director-General to publish that sort of information and the Act provides that the Commission shall not publish it. I now think it is very important that it should be published and I will be talking to the Director-General about publishing that in our Annual Report. I am sure she will have no problems with that.'*

2.44 The Committee believes that that the outcomes of the Commission's recommendations to health service providers are a key indicator of the performance of the Commission's functions under the *Act*.

2.45 Moreover, the Police Integrity Commission, NSW Ombudsman and the Independent Commission Against Corruption (who are also required under their respective Acts to make recommendations as a result of investigations), all request that affected agencies provide information on the implementation of recommendations for inclusion in their respective Annual Reports.

2.46 Consequently, the Committee agrees with the Commissioner that reporting of related figures in the Commission's Annual Report would be beneficial.

2.47 The Committee recommends that the Commissioner discuss this possibility with the Director-General of the NSW Department of Health, and include data on the number and implementation of the Commission's recommendations in future Annual Reports.

Internal Committees

2.48 When the Committee met with the Commission at the public hearing of March 2005, the Committee raised the concern that the Commission provided no information on the role and makeup of internal committees in its Annual Report.

2.49 At the recommendation of the Committee, the Commission agreed to provide this information in future Annual Reports.

2.50 In following up this recommendation in 2004/05, the Committee observed that some detail was provided about a number of internal committees of the Commission in the current Annual Report, including information on the Consumer Consultative Committee and the Workplace Consultative Committee.

2.51 However, during the course of the hearing, it was learned that the Commission does not currently have an internal audit committee.

2.52 The NSW Treasury '*Statement of Best Practice: Internal Control and Internal Audit'* (1995) explains that:

> *"To achieve effective Internal Control, best practice requires a robust Internal Audit function complementary with other tools such as fraud controls, safety audit and program evaluation. Thus one of the principal functions of Internal Audit is the examination of Internal Control systems. Internal Audit provides the Board/CEO, together with senior management, with a valuable resource to evaluate Internal Control systems, and to provide assurance concerning the effectiveness of control systems".*[7]

2.53 Effectively, an internal audit committee plays a major role in the performance monitoring process.[8]

2.54 Consequently, whilst not required by Treasury Guidelines or mandated under the *Annual Reports (Statutory Bodies)* or *Public Finance and Audit* Acts, it is considered best practice for New South Wales government agencies to have internal audit committees.

2.55 The Committee, therefore, is of the view that the establishment of internal audit committee (preferably with external representation) would be an important step.

[7] NSW Treasury, *Statement of Best Practice: Internal Control and Internal Audit*, June 1995.
[8] NSW Treasury, *Statement of Best Practice: Internal Control and Internal Audit*, June 1995.

Stakeholder Consultation

2.56 The 2004/05 Annual Report provides information on the Commission's assessment of stakeholder satisfaction through the Complaints Resolution Service Satisfaction Survey.

2.57 The Committee enquired as to the Commission's intention to expand this assessment to encompass the satisfaction of other major stakeholders in relation to additional operations of the Commission.

2.58 In response, Commissioner Pehm explained that much feedback is already received about areas of improvement for the Commission through the normal complaints handling process. Key areas already identified by this means are investigation delays and response rates. Consequently, Commissioner Pehm concluded that the Commission has *'a lot more work to do internally in improving our own performance and procedures*' before surveys of stakeholders are undertaken.

2.59 However, Commissioner Pehm agreed that surveying key stakeholders (such as health professional registration boards) would be a highly beneficial measure of the value of the service provided by the Commission:

> *'It is very difficult to measure the quality. One measure might be the success, or the proportionate success, of prosecutions in tribunals and lack of any adverse comments from tribunals about the quality of prosecutions and in the past there has been some adverse comment. That might be one measure. I suppose stakeholder satisfaction, opinions of the registration boards we work with, we might look at surveying some of those further down the track'.*

2.60 Appreciating the factors affecting the Commission's ability to undertake such an extensive activity at this point in time, the Committee remains of the view that the exercise of assessing stakeholder satisfaction would establish a foundation upon which improvements can be made to the relationship between the Commission and its various stakeholders.

2.61 Additionally, the activity would make an important contribution to both accountability and performance measurement for the Health Care Complaints Commission.

2.62 During the course of the Public Hearing, the Committee also enquired as to the status of the relationship between the Commission and health professional associations. The Committee was informed that no formal processes are in place for the exchange of information between the Commission and professional associations.

2.63 At present, professional associations are performing the role of a complaints handling body especially when the practitioner involved is not a member of a registered profession. As a consequence, associations are often well-placed to refer complainants to the Commission in the event that a serious breach has occurred.

2.64 Given this, the Committee believes that strengthened relationships between the Committee and key professional associations would enhance referrals and, consequently, improve the efficiency of the complaints handling process for consumers.

Casemate

2.65 At the recent Public Hearing, the Committee was informed that the development stage of the Commission's new case management system Casemate has been completed, and that the system has been in operation since March 2005.

2.66 Commissioner Pehm explained that the tool is to be continually updated to reflect new procedure changes within the Commission.

2.67 The Commission is to be congratulated on the finalisation of this tool, which is expected to enhance the consistency of data reporting and provide greater accountability mechanisms for the performance of the investigation teams.

Content of the Annual Report

2.68 The Committee, with input from consultant John Chan Sew, has several additional comments to make about the structure and content of the Annual Report.

2.69 Firstly, the Committee acknowledges changes made by the Commission in response to recommendations made by the Committee in the previous year. In particular, the inclusion of performance data for five consecutive years is to be applauded. Greater focus could still be given to providing written analysis of the trends over time, and the factors affecting the changes.

2.70 The use of case studies throughout the report has also been more appropriately employed this year. The Committee remains of the opinion that some further reductions in the quantity of case studies may make the document more streamlined. Case studies could potentially be placed in the Appendix or on the Commission's website.

2.71 Several other factors have been identified by the Committee as important for inclusion in future Annual Reports. These include:

- More detailed information on staff turnover (attrition) rates
- Benchmarking of performance against like organisations in other jurisdictions and against national standards (where these exist)

2.72 The consistency of quantitative performance-reporting against Key Performance Indicators is also in need of improvement. For the purposes of transparency and accountability, it is the responsibility of the Commission to ensure that all performance indicators contained in the Corporate Plan are reported against in the Annual Report alongside expected timeframes and information on their status.

2.73 Whilst the 2004/05 Annual Report made significant improvements in this area compared to the previous year, several indicators reported against in the Annual Report were not included in the 2004-05 Corporate Plan, and target dates or timelines for implementation were absent for many planned initiatives.

Chapter Three - Health Conciliation Registry

3.1 The Committee met separately with the Registrar, Health Conciliation Registry, on Thursday 4th May 2006. Briefing notes from this meeting are at Appendix Three.

3.2 Given the recent appointment of a new Registrar, Ms Julia Lines, the Committee was interested in finding out about the direction that the Registrar intended to take on a number of key aspects of the Registry's administration.

3.3 Specifically, the Committee was interested in the Registrar's intentions regarding the structure of conciliation, access to services in regional and rural areas and access to supports for parties involved in the conciliation process.

3.4 The Committee supports the provision of flexible conciliation services as a means of promoting greater access to conciliation and, as a consequence, increased resolution of lower-level complaints.

3.5 Consequently, the Committee was pleased to learn that conciliation services will continue to be made available in regional and rural areas through the contracting of conciliators in various locations across the state.

3.6 Moreover, Ms Lines confirmed that conciliators are able to meet with both complainants and providers outside of standard business hours. This, in the Committee's opinion, is imperative to promoting greater participation by providers in the conciliation process.

3.7 The Committee also heard that Ms Lines was amenable to the use of support services by both parties to conciliation, and to the availability of both separate and joint meetings for provider and complainant. The Committee supports this approach.

3.8 Several issues of concern relating to the role and use of the Health Conciliation Registry were raised with the Registrar during this meeting.

3.9 These included current referral patterns, absence of liaison with similar services in other Australian jurisdictions, possible public perception that the Registry is not entirely independent of the Commission and the relationship between the Registry and health professional associations.

Referral Patterns

3.10 Firstly, the Committee expressed concerns about the decrease in referrals to the Registry over the last three reporting years.

3.11 In response to this, Ms Lines referred the Committee to data on the number of complaints originally assessed by the Commission for suitability for conciliation. These figures showed a decrease at the point of assessment from 372 in 2003-2004 to 164 in 2004-2005.

3.12 Ms Lines informed the Committee that the decrease in referrals is likely to directly stem from the fact that all complaints are now assessed prior to referral, and must be deemed likely to be resolved by conciliation in order for a referral to be made.

3.13 Ms Lines also pointed out that the rate of successful conciliation (those where agreement was either reached or partially reached) rose from approximately 31% to approximately 50% in the same time period (when looking at successful resolution as a proportion of complaints originally assessed for conciliation).

3.14 As such the argument was made that a decrease in the number of referrals to the Registry may in fact result in only those complaints likely to be resolved by conciliation being referred, thus increasing the likelihood of successful resolution.

3.15 Appreciating that there is significant logic behind this argument, the Committee is of the view that the increase in successful resolution is not proportionate to the reduction in complaints being referred.

3.16 Moreover, the Committee is concerned about the outcomes for the approximately 300 consumers whose complaints would normally have been referred to conciliation but are now deemed unsuitable.

3.17 The Committee recognises that this issue is one that needs to be addressed by the Health Care Complaints Commission as it has responsibility for the assessment process, and commits to following this up with the Commissioner.

Contact with Other Australian Jurisdictions

3.18 Previously, the Committee has expressed a desire for the Commissioner (Health Care Complaints Commission) and the Registrar (Health Conciliation Registry) to meet regularly with representatives of similar complaints bodies in other Australian jurisdictions.

3.19 Ms Lines confirmed that this was not currently happening with regards to the NSW Health Conciliation Registry.

3.20 The Committee is of the view that such contact would be extremely valuable not only to promoting good relations between jurisdictions, but also in assisting NSW to keep abreast of the developments, trends and strategies employed by similar complaints bodies.

3.21 Ms Lines agreed that there would be some mutual benefit to having such contact with similar organisations.

3.22 Consequently, the Committee recommends that some contact be made by the Registrar with such organisations in the following year.

3.23 The Committee's preference is that this contact is made in person, however telephone contact may also be beneficial in the early stages of establishing this relationship.

Public Perception of the Relationship Between the Health Conciliation Registry and the Health Care Complaints Commission

3.24 The Committee raised with Ms Lines the possibility of the physical locality of the Registry (being situated in the same building as the Commission) posing a barrier to consumers and providers accessing conciliation services.

3.25 The Committee was concerned that this, combined with the inclusion of the Registry under the Commission as a result of legislative changes in March 2005, may lead to consumer uncertainty as to the independence of the Registry's services from those of the Commission.

3.26 The Committee enquired as to whether Ms Lines had encountered comments to this effect from consumers or providers accessing the Registry.

3.27 Ms Lines reported that no such concerns had been raised, and that many strategies had been put in place to assure those accessing the Registry that the process of conciliation was indeed separate to the investigative processes of the Commission.

3.28 Ms Lines explained that the independence of the Registry is emphasised in the initial letter received by both parties, clarifying that any information provided to the Registry is treated as confidential.

3.29 Additionally, only the Registrar is permitted to access the files of the Registry, which are stored separately to the Commission's files.

3.30 Ms Lines agreed to provide the Committee with a copy of the initial letter sent to providers and consumers who are considering participating in conciliation.

Relationship with Professional Associations

3.31 For some time the Committee has been interested in identifying alternative mechanisms of complaints resolution for practitioners in private practice.

3.32 As part of this the Committee has considered the potential role of the Registry in assisting private practitioners in handling less serious complaints more efficiently.

3.33 With this in mind, the Committee questioned Ms Lines about the relationship that currently existed between the Health Conciliation Registry and health professional associations.

3.34 Ms Lines informed the Committee that no links between the Registry and health professional associations have been established.

3.35 It was Ms Lines' view that, as all complaints are currently subject to the Commission's assessment process, it would be inappropriate to establish a separate link to the Registry for professionals in private practice.

3.36 Acknowledging the legislative restrictions affecting access to the Registry at this time, it is the view of the Committee that timely access to conciliation could play an important role in facilitating more efficient low-level complaints resolution in private practices.

3.37 The Committee commits to exploring this issue as part of it's current inquiry into the *'Adequacy of Internal Complaint Handling Systems and Other Methods to Measure Consumer Satisfaction in Relation to Practices and Clinics Outside the Hospital System'*.

Conclusion

3.38 The Committee recognises that Ms Lines is relatively new to the position of Registrar, and that many of the issues raised with her in the meeting of 4 May 2006 concerned trends and practices that existed before her time.

3.39 In all, the Committee was encouraged by the approach Ms Lines intends to take with the Registry, and looks forward to observing the progress made by the Registry over the next twelve months.

APPENDIX ONE- TRANSCRIPT OF PROCEEDINGS

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

Review of the 2004-05 Annual Report of the Health Care Complaints Commission

---

At Sydney on Wednesday, 8 March 2006

The Committee met at 10 a.m.

PRESENT

Mr J. Hunter (Chair)

Legislative Council	**Legislative Assembly**
The Hon. D. Clarke	Ms T. R. Gadiel
The Hon. Christine Robertson	Mr A. F. Shearan
The Hon. Dr P. Wong	Mr R. W. Turner

Transcript provided by CAT Reporting Services Pty Limited

KIERAN PEHM, Commissioner, Health Care Complaints Commission, Level 12, 323 Castlereagh Street, Sydney, sworn, and affirmed:

KAREN MOBBS, Director of Proceedings, Health Care Complaints Commission, Level 12, 323 Castlereagh Street, Sydney, affirmed:

CHAIR: Commissioner, before we get into asking you some questions, is there an opening statement you would like to make to the Committee?

Mr PEHM: Yes, I have a brief opening statement, Mr Chair, which I will table onto the record for Hansard's purposes, but I will run through it in a brief paraphrased way. The year 2004-05 has been one of continuing reform and consolidation of the Health Care Complaints Commission. Essentially the commission has been divided into three divisions. The first division is the assessment and resolutions area and, in effect, it is the front end to the commission. We have beefed up the staffing and the management and supervision in the assessments area. The main change is that we are now doing much more careful assessments of complaints than the commission did in the past. Previously the practice was simply to make an assessment decision based on the complaint. We now generally get responses from the respondent. In clinical issues we will obtain medical records and may get expert advice at that stage. The object is to make a more informed and better assessment decision so that the complaint can be dealt with in the best way.

The number of complaints received by the commission rose by 15 per cent during the year. Partly that increase may be due to a change in the Act which came into force from 1 March 2005, which formalised the operation of the former patient support service. We are now calling it the complaint resolution service. It does not begin to deal with complaints until they are made in writing to the commission. Formerly the patient support service was receiving referrals, verbal and telephone, from anywhere and most particularly from hospitals and they dealt with those in an independent way that was not very, I suppose, accountable to the commission. We think that the rise in complaint numbers is probably due in large part to the requirement that those complaints previously informally dealt with are now formally dealt with.

The complaint resolution service is continuing largely in the same manner that it has been, other than being brought into the Act now under Division 9. The Health Conciliation Registry completes that assessment and resolutions area. That has been brought into the commission from 1 March 2005. The investigations division probably was the area that got the most attention during this particular year. We were dealing with a very large backlog of complaints, the flow through from the Macarthur and the Walker Special Commission of Inquiry and the vast bulk of the subject went into the investigations division. The commission completed 870 investigations during the year compared with an average of about 339 for the previous four years. Delays in finalising investigations have always been a feature of the commission as far as I can work out, going back many, many years. We had complaints as old as five years old when I started. We set a goal in our corporate plan to try to complete 80 per cent of all new investigations within 12 months and that proved to be a bit too ambitious and I can go into the reasons for that a little bit later. We in fact completed 51 per cent of new investigations within 12 months.

The legal area is the third division and there has been some considerable change there. The Act has appointed now a Director of Proceedings and Karen Mobbs is appearing before you today. She was appointed Director of Proceedings in March 2005. The director's role is to make decisions on whether or not complaints should be prosecuted before disciplinary bodies, independently of the Commissioner. As a result of the finalisation of the 870 investigations, a significant proportion of those investigations, about 200 during the year, were referred through to the legal area. We have taken on extra temporary staff to deal with that flow through. I understand the tribunals and professional standards committees have made arrangements to appoint extra hearing officers to get that work moving.

In conclusion I would just say that although a great deal has been done at the commission there is still a great deal more to do. While we have got the broad structure in place there is a significant program of cultural change that needs to take place at the commission and we are implementing that in various ways, from more efficient strategic and corporate planning, we have to have a performance management system implemented by the end of this year, and through a structure that promotes much tighter supervision of staff than was the case in the past and imposes more direction on the way matters are handled.

I would like to publicly thank Judge Kenneth Taylor, who was the Commissioner for the bulk of this reporting year and he, I think, finished in May 2005. The judge laid the foundations of the reforms that we are seeing in place now and his contribution in terms of legal expertise was invaluable during that process and I am confident that in the next year we will see a continuation of the reform and further improvements in the commission's performance.

CHAIR: We have a number of questions which you have touched on but we will proceed with those anyway. The number of telephone inquiries decreased by 316 during the course of this reporting year. Is this the result of less promotional activities being undertaken?

Mr PEHM: I do not know how much you can read into one figure. Although telephone inquiries decreased, written complaints increased by 15 per cent. It is true to say that during the year there was not a very concerted or well organised program of promotional activities. We have updated our complaints guides, our brochures and pamphlets. We have redesigned our web site. We have presented papers at seminars and conferences and towards the end of the year we have involved the complaint resolutions officers and this is at the suggestion of our Consumer Consultative Committee in much more, I suppose, systematic and concerted promotional activities and that will involve addressing groups with interests in this area such as Council for Intellectual Disabilities and Physically Disabled People, Council for the Aged and the Combined Pensioners Association. Our Consumer Consultative Committee has suggested this program. We consult with them on the groups that we need to talk to. That is under way and we have done a great deal of work in that area during this current year.

It is always difficult to say what influences complaint numbers. Often it is publicity in more general terms. The Macarthur business obviously generated a lot of publicity and awareness about the commission. That is publicity you cannot self-generate no matter how much promotional work you do. The way complaints are running this year we are looking at a very substantial increase and I am not really sure what all the factors involved in that are.

CHAIR: You mentioned earlier in your opening statement about the decrease in the number of patient support service clients. That has decreased by 1,492 over the reporting period. Can you please explain the factors affecting this number?

Mr PEHM: That decrease of 1,492 is page 25 of the annual report, the figure there for 2004-05 which is 2,657 is only a figure for the nine months of the year because come 1 March 2005, the last quarter of the year, we did not count the old complaint resolution service clients separately. They were just treated as complainants and matters referred to the complaint resolution service, so if you add a quarter on to that 2,675 number it is not the significant level of increase that it seems. We have had a process of going through all of the clients of the complaint resolution service and we closed about 700 files there, mainly for reasons that they were basically inactive files where not a lot had happened for a long time and administrative action was needed to close them off.

One of the problems with the old patient support service was, I think, the lack of accountability to the commission in its daily file handling and we had a very troubling case, which I think might have been the year before this reporting year, but the then Leader of the Opposition held a press conference with a complainant who said that she had taken her matter to the Health Care Complaints Commission two and a half years ago and they had done nothing. We had no record of it. She was someone who was referred to a patient support service officer through a hospital. We went back through the patient support officer's papers and it seems that there was confusion about who would do what. They had a meeting and the client expected the patient support officer to draft a complaint for her. The patient support officer thought that the client would go away and do her own drafting. Publicly that comes out, and I can understand why the complainant saw it that way, I have been to the Health Care Complaints Commission and they have done nothing with it for two years. That was a problem with the complaints resolution service and in closing off those 700 files we found a lot of files that were inactive or there was nothing practical further to be done.

CHAIR: The number of complaints finalised rose to 3,035. Is that proportionate to the budget enhancement received?

Mr PEHM: It is an increase from 2,777. Whether it is proportionate or not, I think it is not necessarily helpful to take one figure and say that shows you only closed 10 or 20 per cent more but you got a 30 per cent budget increase. If we focus on investigations, they go from 321 to 870. That is a 270 or 300 per cent increase. Do we say you got a 40 per cent budget increase and you increased your investigation output by 300 per cent? It depends on where you are putting your resources and in this particular year because of the concerns about Macarthur and the backlog, the resources were put very strongly into investigations.

The Hon. CHRISTINE ROBERTSON: I would like to extend that last question. Do you have other indicators that would measure the value of that increase in budget other than the number of complaints finalised?

Mr PEHM: The number of complaints, the timing of complaints I think would be an important indicator. Quality of complaint answering is a very difficult thing to measure. We do have a set of performance indicators in our strategic and corporate plan which we will report on next year. A significant amount of the budget has gone into, I suppose, creating a structure of senior management and upgrading the skills of the commission's middle managers. Those sorts of things we envisage will improve the quality and timing of complaints handling but they will take some time to filter through.

The Hon. CHRISTINE ROBERTSON: So that is the outcome of your planning process? The quality is the outcome of your changes in planning process?

Mr PEHM: The quality will improve. It is very difficult to measure the quality. One measure might be the success, or the proportionate success, of prosecutions in tribunals and lack of any adverse comments from tribunals about the quality of prosecutions and in the past there has been some adverse comment. That might be one measure. I suppose stakeholder satisfaction, opinions of the registration boards we work with, we might look at surveying some of those further down the track.

The Hon. CHRISTINE ROBERTSON: I was looking at other indicators of value rather than numbers. While the commission's corporate goal was to complete 80 per cent of all new investigations within 12 months, the result proved too ambitious for current capacity. Only 51 per cent were closed within 12 months. Please elaborate.

Mr PEHM: It seemed like a good idea at the time. It seemed like a reasonable goal to set when we set that goal. I suppose the investigation capacity and skills of the commission are not strong, the commission's investigations officers, and they do need a lot of development. It is very much a paper based investigation process and it is very much a one step at a time process. The practice has been to send the complaint to the respondent. Hopefully we will get a response. If they do not respond for a month, two months, three months we tend to sit back and not do very much rather than go out and gather supporting, interview witnesses, support the complainant, get an expert opinion. There were big delays through, I suppose - these are the sorts of things we hope to remedy through the tighter supervision and more experienced investigators in senior supervisory positions.

There are some delays that are inherent in the processing. We are obliged to consult with registration boards. I am not critical of this at all. It is part of process, but you can pretty much lock in two or three months on top of what a normal investigation would be for the preparation of consultation papers with boards. They generally meet once a month so if you get in on the staff one month you add a month to it. There are procedural fairness requirements, which again are obvious and it goes without saying that they are a good thing and have to be there, to give the respondents the chance to respond at the end of an investigation, even though you might have a substantive response from them before that.

Getting medical and clinical records there are often delays with, particularly in very complex matters where we have to gather records from a number of different hospitals and area health service providers and also getting our own expert opinions. We get some reasonably significant delay there because our experts are very highly qualified professionals who are busy and, I think, do this as a sort of public spirited public service sort of issue and I think at times the provision of their expert opinion can slow it, so there are some external factors that are, to an extent, out of control. There is a lot more we can do to improve our own investigation process and improve that time. I still think 80 per cent within 12 months is a reasonable goal to pursue and I think that we have been providing the Chair with quarterly reports more recently and I think we have got over that 50 per cent, closer to the 80 per cent.

The Hon. DAVID CLARKE: Given the concerns raised in the last hearing about the effectiveness of the Consumer Consultative Committee, has the committee membership, structure or purpose changed to enable it to be effective and to justify its reconvening?

Mr PEHM: I am not sure that there were concerns about the committee so much as Judge Taylor gave evidence, I think, to the effect that he did not see the committee as having very constructive input during that very difficult reform process that we had within the commission where we had an enormous backlog and we had all of that external pressure from the Macarthur matters. I do not know if it was a criticism or question of a fault with the committee and its structure and processes so much, it was just that at that time, given the priorities of the commission, we were not sure that it could contribute a lot.

We have reconvened the committee now and it has been meeting throughout this reporting year and is continuing to meet. It has provided some very valuable input, particularly in relation to the reach of the complaint resolution service to which I alluded earlier. We had one member of the committee who I think was an aged persons representative who actually worked in one of the hospitals where one of our CROs worked and she was not aware of the service, had never heard of it. Other groups there - I think the representative of the Council of Intellectual Disabilities - requested a CRO to come out and address the counsellor informally about the processes, and we have had similar requests, in particular the migrant resource centres, and there is a list of those that I will publish in next year's annual report. They have been very valuable in that process.

The committee is made up of a fairly broad representative group of consumer interests in the health area. We have rural representatives, people with physical and intellectual disabilities, aged persons, as I say, and migrant or culturally and linguistically diverse representatives as well. We meet three-monthly now and we find the meetings quite constructive and their input quite valuable.

The Hon. DAVID CLARKE: How close is the five-year strategic plan to completion, given the expected completion date of the end of 2005, which was offered at the last meeting?

Mr PEHM: We have completed the plan. We had a meeting planning day in February, I think on 21 February, where we modified some small things, but it is substantially complete now and it will be finalised shortly.

The Hon. Dr PETER WONG: Can I return to an earlier question about the goal of 80 percent of investigations? Of all the factors that you have mentioned so far, what is the most important factor in delay?

Mr PEHM: Well, the most important factor within our control is our own investigative capacity and the way in which investigations are conducted.

The Hon. Dr PETER WONG: Is it case by case? I mean do you manage every case? If there is undue delay, would there be a red flag to indicate: This case has been delayed, so we have to speed it up?

Mr PEHM: Yes. We have now an investigations review group that I chair that meets fortnightly and every case that is more than 12 months old is on that agenda and a report is prepared for those cases and we go through them. Also on that agenda is every case where a registration board has either suspended or imposed conditions on a practitioner. They are seen to be more urgent because obviously the practitioner's capacity to practise is inhibited and we do not want that extending for years. Within the investigations area you have to have a number of strata of supervision and it may be that we now need to tighten up that 12-month delay, whether it is something like six to nine months.

On top of that, the investigation area is divided into three teams of about four to five investigators with a team leader. They conduct monthly file reviews. There is not a strong culture of supervision and, I suppose, proper management practice in the commission, so the team leaders are perhaps not as rigorous as they could be with, putting it simply, making demands and giving directions. It is not a culture of the commission. They have a very collegiate sort of "suggest you do this" and "perhaps you might try that", more like colleagues working together rather than team leaders giving direction. That is quite a difficult change in culture and it will take some time. We are hoping the introduction of a performance management system will provide the formal framework for that sort of feedback to take place between management and a staff member.

The Hon. Dr PETER WONG: If the goal is 80 percent in 12 months, surely there will be a red flag once six months expire and the case is going nowhere?

Mr PEHM: Yes. It was really a question of capacity and how long you wanted these meetings running. When we started there were so many older than 12 months that, to make it any shorter, there would have been hundreds of cases. It is now down to a much more manageable level, so we can look at tightening that now.

The Hon. Dr PETER WONG: One of the past complaints was that doctors were not cooperating with the commission. Is that still the case?

Mr PEHM: I think that is rare. We are finding that during the assessment process the staff or the professional appreciates getting the chance to respond to a complaint before a decision is made to investigate it or not, and generally the responses are very timely and very constructive. In the investigations area the proportion of doctors who delay in responding would be very small, and it is probably in cases where there are significant issues like impairment or there are very significant matters, but generally they are insured and their insurers respond for them and they are reasonably timely.

The Hon. Dr PETER WONG: I notice that the commission did not prepare an ethnic affairs priority statement. I really want to know, as someone who was Ethnic Affairs Commissioner previously under a different Government, it was necessary - in fact compulsory - for the government sector to prepare a policy report. Is that still the case, that every department must prepare a report?

Mr PEHM: It is an oversight that it was not prepared and I am embarrassed that it wasn't and it should be. I am not sure of the precise status of it and what the nature of the compulsion is, but I take it as something that we must do and we should do and we are doing one for this year. We had difficulties in that area. Our director of corporate services left the commission in the course of preparing this annual report and it was her responsibility to prepare the ethnic affairs priority statement, which was not done, and in effect by the time we came to preparing the report we did not have one done. We could have, I suppose, tried to knock one up and say we had it done, but I thought it more open and better to sit down with the community relations commissioner and actually prepare a proper constructive one. They were certainly very concerned about the failure to prepare this one and wrote to us and I have been in touch with them and we are working together now.

The Hon. Dr PETER WONG: It was not meant to be a criticism, I just had the perception - maybe I am wrong - that it was not regarded as important.

Mr PEHM: It was not a conscious decision to not do it because we did not think it is important; it was really a question of other priorities and administrative oversight that by the end of the year it had not been done. It is very important for us and I think there are questions later, and in view of the Committee's report on traditional Chinese medicine as well, if that does become law, then obviously with the clients we will be dealing with there will be a lot of issues around communication and cultural difficulties about complaining that we have to come to grips with, so it is only going to become more important for us.

The Hon. Dr PETER WONG: In addition, there have been complaints recently in Queensland and in New South Wales about overseas doctors' performance and ability to communicate with patients. Do you see that as an important aspect of the commission's policy?

Mr PEHM: It is a problem that appears in some of our complaints, but it is difficult to say how widespread it is. I am not sure our plan would go to addressing that particular issue. Our plan would be about how we can best provide our services to culturally and linguistically diverse people and be sensitive to the cultural barriers they face in making complaints, but that is a problem that arises.

CHAIR: A question we were going to ask you related to the TCM inquiry and the fact that you did not have the ethnic affairs priority statement. Did that relate to an inability at that time to identify the cultural and linguistic background of complainants at the TCM public hearing?

Mr PEHM: We sent out a survey to complainants that asked them questions about those issues - Aboriginality, cultural background, whether they needed interpreters, preferred language - and there were responses to that, but that is a general survey, we do not collate those particular complaints. The only way we have of identifying the cultural background of someone is individually from the nature of the complaint. Obviously if it is in Mandarin or Chinese you would need to have it translated, that is fairly clear. It becomes less clear when you are dealing with English speakers who are from a different cultural background. It is not as easy to deal with them. We plan to address that partly through

this program about complaints resolution officers going to migrant resource centres and addressing those particular ethnic groups and advising them about the practices of the commission.

The Hon. CHRISTINE ROBERTSON: The change in referrals to the CRS was made for what purpose; what has been the response, and is it appropriate in terms of encouraging easy access and early intervention, plus the method used to monitor the number of complaints made, is any comparison of data pre- and post-March comparable, given the alteration in the recording methods outlined in data given to the Committee recently?

Mr PEHM: The purpose behind the change I am not really sure. I think the draftsman was asked to include the complaints resolution service as a division of the commission and as a source of referral for complaints.

CHAIR: So once in the legislation it came under your general policy?

Mr PEHM: All complaints must be in writing, it is said at the start of the Act, so consequently all complaints being reduced to writing before they can go to the complaints resolution service has become the law. As I said earlier, I think there are certain accountability benefits to that. Problems that arose where people could just go and chat and nothing was ever reduced to writing - we became aware of those through a number of sources, not the least being embarrassing media reports. It is always a difficult balance, to balance the recording and accountability of a process with the capacity to act quickly and respond. We do not think the requirement to put matters in writing is going to be too onerous. The commission has an obligation to assist complainants to make written complaints. We are currently looking now at the complaints resolution service taking over the telephone inquiry service of the commission and we want to put some protocols in place about that. The sort of complaint where, if they can hook someone up with the right area of the health service, or they can make a quick call and fix something, we are quite happy for them to do that but we do not want that stretching out into a long involvement that does require documentation. If it does reach that point, what we are planning to do is that the complaints resolution officer can simply send an e-mail to the assessment committee which meets Monday, Wednesday and Friday and reduce it to writing. There will be no need for the complainant to actually make a written complaint and sign it, as long as the complaints resolution officer emails the gist of the complaint and suggests, if it is a referral back to the complaints resolution officer as an official complaint, we will take that email as a complaint and send it off to them to handle. Although at first blush it might seem like a bit of a barrier we think that there are ways to resolve that, both in keeping the letter of the law and allow for fairly quick responses.

CHAIR: I know you highlighted earlier an instance where someone has said they had made a complaint through the patient support office or the complaint resolution service on the ground with an area health service and two years had gone on and the commission had done nothing about it and that was because the commission head office had not been notified. I understand that and that may be one good reason why the change in legislation could be beneficial, but we currently have an inquiry looking into how complaints that are made in private clinics can be dealt with prior to them proceeding on to a full blown complaint of the commission and hence save the commission a lot of work. Hopefully it will nip the complaint in the bud at an early stage.

It is quite clear to us that this unintended consequence of the legislation change means that a doctor, dentist in private practice, once knowing that they refer a complainant to the complaint resolution officer at a local level to assist in resolving a complaint, that that is going to generate a written complaint and an official complaint to the Health Care Complaints Commission. I do not see a GP in private practice referring them over to your service. That meant that it is going to cut out, and I think that is evident from the figures, it is going to cut out many hundreds of people who would have had low level complaint resolution done by your former patient support officers and now your complaint resolution officers.

That leaves out a great void out there of people who are dealing with that in a private setting, and that is private practitioners who are not going to refer them to the complaint resolution service because it will generate an official complaint against them with the Health Care Complaints Commission, so I think that there will be a reluctance. How do we go about instigating a service that is able to resolve complaints at that lower level before it becomes an official complaint to the commission? Do we need a separate advocacy service? There are some in some other jurisdictions, such as New Zealand. There was talk about introducing an advocacy service in Queensland. That was one of the recommendations coming out of a major inquiry in Queensland into the problems they had up there.

Mr PEHM: I can understand why you have that impression although I am not - I do not think we know. I really do not think we know that there is this vast proportion of people who are going to go on and not be dealt with.

CHAIR: But your figures show that there has been a dramatic drop since the legislation came into force and the number of people using that service.

Mr PEHM: Those figures were for nine months. If you extrapolate them for a year it is roughly equivalent with the previous.

CHAIR: I think if you deal with them on a month by month basis for the months after the legislation came into force there was a major drop in the number of complaints going through that service.

Mr PEHM: We have closed a lot of the complaints that the complaints resolution service was dealing with because nothing was happening, in effect.

CHAIR: It is something I would like you to have a look at further and give us some suggestions for our other inquiry.

Mr PEHM: Perhaps we can investigate the nature of the matters that the complaints resolution service were dealing with. I am not sure that private practice referred a lot of matters to the patient support service directly anyway. I think most of their work came from the public system and from public hospitals, because that is where they are located. The public systems are aware of them, but we can look further at the proportions.

The Hon. CHRISTINE ROBERTSON: Would you have a perception that possibly private practice perceived these people to be connected with the health system in some way, the public health system, the department and the hospitals?

Mr PEHM: They may. I do not think externally private practice distinguishes between our patient support officers and the hospital patient support service. The hospital had patient representatives.

CHAIR: We had your Health Conciliation Registrar, acting conciliation registrar, appear before the Committee for an informal briefing and she had been a patient support officer in an area health service and she did say that she did deal with private practice.

Mr PEHM: They do, but I am not sure what proportion of those come through as complaints to the commission that were referred to, matters that are referred to direct.

CHAIR: I do not have that information in front of me.

Mr PEHM: I can look into it and try to give you some data anyway.

Mr SHEARAN: Mr Commissioner, what stage is the implementation of casemate at?

Mr PEHM: Casemate went live on 7 March 2005.

The Hon. CHRISTINE ROBERTSON: Did you have a party?

Mr PEHM: We did have a little celebration.

The Hon. CHRISTINE ROBERTSON: It was a long time.

Mr PEHM: It was a long time in production, about four or five years.

CHAIR: It might have spanned two commissioners.

Mr PEHM: It is very much a work in progress, casemate. Its original design reflects a lot of the old practices of the commission because it was designed by a committee, by staff input and participation and I think it has been overengineered in lots of ways in that they are trying to get it to do every little thing in a complaint. We are going through a process of business reengineering, they call it now, where we will be simplifying the stages. That will allow us to get these exception reports out. At the moment there is so much in it that to find out when something has not been done is quite difficult.

The Hon. CHRISTINE ROBERTSON: It will be a quality tool.

Mr PEHM: It is much simpler. If you have three or four major steps then you can say tell me the ones that were not done by a certain date so there will be an ongoing process of reengineering. It will never be finished. It is one of those things where you are always improving your procedures and you are always modifying casemate to keep up with it.

CHAIR: I am not sure what happened. There was collaboration with other commissions in other states and this was going to be a joint project, but I recall that that cooperation fell over.

Mr PEHM: It did.

CHAIR: What is the latest with that?

Mr PEHM: I think the ACT and Tasmania were in on the project for a while, but it never happened and, in effect, with Macarthur and the Walker inquiry, the Government decided to fund the commission to a much greater extent than it had in the past. We could not tie up those. They are very small, those commissions as well and they did not have the capacity really to commit to it or commit any funds to it. We have had the ACT up to look at it since and South Australia as well is interested in taking it on and I think there is some interest from Western Australia, but that is not health related. Essentially we went ahead on our own and implemented it.

Mr SHEARAN: Several key performance goals from 2004-2005 corporate plan that were not achieved in that time period were not given revised dates for completion. Are you able to provide some indication of the timelines for review of prosecution guidelines?

Mr PEHM: Yes. The former head of the legal division left during this reporting period. The legal process has changed now with the appointment of a Director of Proceedings. The registration acts have all changed with the definition of unsatisfactory professional conduct, so that all has to be written in as well. We are hoping - and this is really largely Karen's responsibility - that we will complete a new prosecutions manual within the next 12 months. We have been working some way along and in fact we have reviewed the guidelines for peers, which is expert opinion, which is a very important part of prosecution process and we have got legal advice and revised our peer guidelines to take into account the new registration act definitions and we have sent those out to peers, so that is the state of play with the prosecution guidelines.

CHAIR: Can I ask whether Ms Mobbs would like to make any additional comment? We have not asked you anything directly yet but this relates to your area.

Ms MOBBS: The only thing that I could add is with the changes to the act there was an introduction of criteria in relation to the decision making process. Section 90C of the Health Care Complaints Act actually sets out criteria which were not previously there. To some extent that is generally part of the prosecution's policy, which takes some of the need to have a policy reflecting what those criteria are, which means that there is much more of a refocus on a prosecutions manual rather than guidelines for the decision making process. To a large extent, because of the amendments to the act, the devolution of the decision in relation to making determinations to prosecute to the legal section, the drafting of complaints, has meant a huge change to those procedures which are really only fairly recently starting to fall into place, so it is probably now a good time to rework the prosecutions manual to reflect those current policies and what is actually occurring.

Mr SHEARAN: Secondly, the development of the code of practice.

Mr PEHM: The code of practice was again one of those things which I thought when I started should not be too difficult. Unfortunately it is quite complex mainly because the commission does not have well devolved internal procedures at the moment. There have been changes as to the assessment procedures. We need to develop and finalise our own internal procedures before we go externally. We have, in the assessments area, written assessment guidelines which we circulate to all the registration boards for comment and we have had comments back by the end of January so they can be finalised shortly. We need to finalise our investigation processes as well as to whether they are changing, and they need to be bedded down. It is not until we get that done that we can go into the development of a code of practice, so I find it very difficult to put a timeline on that.

Mr SHEARAN: Are there plans to formalise in any way the liaison with the Clinical Excellence Commission, that is, establish a protocol for information sharing or a memorandum of understanding?

Mr PEHM: We met with the chairman and the chief executive officer of the Clinical Excellence Commission some time back. The roles of the Clinical Excellence Commission and our commission are very different. We come from the individual complaint point of view and they come from a broad systemic area. The point of intersection is, in effect, the Department of Health. Part of the patient safety improvement program, in addition to the Clinical Excellence Commission, is that each of the area health services now has clinical governance, each with directors. Our point of intersection with both the commission and the directors of clinical governance is through the Department of Health through the director general. Starting in November 2005 we set up three-monthly meetings with the directors. Under the Act we send them all of our finalised investigations where we make recommendations for systemic improvement and the directors send it to the Director General. The individual director of clinical governance in the area health system will notify us whether they are intending to implement the recommendations and the director general will consider whether they have any capacity to be implemented more widely across the system. We have an informal arrangement with the Clinical Excellence Commission where there is an individual case that has significant implications to look at immediately, but our regular liaison and intersection with the Clinical Excellence Commission is through the director general of health.

The Hon. Dr PETER WONG: I wish to ask you about an article published on 23 February in the Sydney Morning Herald regarding an obstetrician. I mention it because Professor Bruce Barraclough had briefed the Committee and mentioned a systemic problem at Camden and Campbelltown, implying that at least in some instances it may not be the doctor's or nurse's fault. I think it is an example of a systemic error and in the tribunal Judge Reg Blanch said, "In my view there is no substance at all to these complaints and they should be dismissed". If the commission contacted Professor Bruce Barraclough early on, would it not know then that, as the judge said and also from information I obtained, there really was either no case or a very doubtful case, and why would the commission persist with cases like that?

Mr PEHM: The decision in that case was made before the director of proceedings came into being by Judge Taylor. Part of the investigation process is for the commission to obtain its own expert opinion and in that case we had the opinion of an expert gynaecologist from Adelaide. A big problem with a lot of these Macarthur matters revolves around this debate of systemic responsibility versus individual responsibility and there was a very widespread view amongst the profession that the problems at Campbelltown were largely systemic in nature. It is not the commission's role to investigate systemic issues as such. In fact that was a course that the former commissioner, Amanda Adrian, embarked on with her report into Macarthur. The idea was that we would not attribute individual blame, we would write a report examining the systemic issues. Now it is a matter of law, and the Parliament's intention, that the role of the commission is to investigate individual complaints. The extent to which an individual is responsible is often an inherently difficult question. One of the reasons we went to Adelaide was - and this happened in a lot of the Macarthur matters, we had to get peers interstate - because a lot of the experts we contacted in New South Wales essentially said they felt very awkward about giving any opinion on Macarthur matters because of the publicity and because of this whole debate about systemic issues. You cannot always predict the outcome of a prosecution at the beginning. That matter was prosecuted on counsel's advice and on the advice of an expert who we believed to be a very eminent expert. I think one of the turning points in the case was that he was from a tertiary hospital whereas the hospital at the time was not as well equipped as a tertiary hospital, so the clinical decisions made were different.

The Hon. Dr PETER WONG: I am trying to highlight the point that sometimes it is hard differentiate between individual cases and systemic matters and therefore the commission ought to have a closer relationship with the centre of excellence.

Mr PEHM: If we take a matter to a disciplinary body we have to have our own expert. I don't know how the Clinical Excellence Commission would feel. I do not think they would be prepared to provide expert evidence as a witness because that expert is then cross-examined.

The Hon. Dr PETER WONG: I am not saying that, I am referring to consultation. As soon as Professor Bruce Barraclough briefed this Committee I became aware that systemic error could be the case. I had a similar idea to the commission, but once it was mentioned to me that perhaps there was systemic error the alarm bells rang in my head: Maybe I was wrong. I thought it highlighted the need for a better relationship.

Mr PEHM: I take the point.

The Hon. CHRISTINE ROBERTSON: Do you know what the terms of reference and the outcomes expected from the two organisations are? I know you know what yours are, but do you know what theirs is?

Mr PEHM: Theirs is a very broad remit. It is to identify system-wide issues and to set up committees to look at how they might address those issues across the system. They have things like a working group on falls, which is a big issue and contributes to a lot of time. They also have a role to audit what we call root cause analyses. In the health system, whenever there is a serious patient incident of a particular level of seriousness, the hospital must do a root cause analysis, which is going back over what happened and learning what you can from it and making recommendations to improve it in the future. The Clinical Excellence Commission trains people conducting that analysis and has a role to go around and audit that process.

The Hon. CHRISTINE ROBERTSON: So do you perceive the two functions are complimentary?

Mr PEHM: Yes.

The Hon. CHRISTINE ROBERTSON: Are you comfortable with the level of communication that you have at the moment as far as your two separate functions are concerned?

Mr PEHM: Yes, there is no difficulty at all. They are open to any input from us and vice versa. The practical pathway through the director general of health is working well.

CHAIR: Is there any time during the course of the year that you would have either formal or informal meetings with the Clinical Excellence Commission? You have regular six-monthly meetings with other commissioners in other States and in New Zealand. I presume you have regular meetings with the Department of Health. I am just wondering if there is any connection at all with the Clinical Excellence Commission?

Mr PEHM: No, not at the moment. We have three-monthly meetings with the director general of health. Bruce Barraclough certainly left it open to look at regular liaison and at that stage they had not appointed their executive staff.

The Hon. Dr PETER WONG: I suppose the Chairman would be thinking of having liaison with them on a regular basis.

Mr PEHM: I am certainly open to that and we will follow that up.

CHAIR: I have said to previous commissioners - and I think I have mentioned to yourself - that it is important that you liaise with medical boards, in particular in other States, which have the same function as the commission. We might move on.

Mr TURNER: Could you describe the adequacy of administrative and other supports to the Health Conciliation Registry?

Mr PEHM: The registry is adequately supported. At the moment it consists of a registrar and a clerical support officer. There have been no difficulties from the registrar or any complaints or any requests for further resources. It has been managing itself quite well.

Mr TURNER: There was a noticeable jump in the number of referrals to registration boards. Can you explain why?

Mr PEHM: No, I think there might be a bit of a misunderstanding there. On page 22, table 8 of the annual report shows 483 referrals in 2003-04 and in 2004-05 there were 482 referrals, so it is actually a drop of one. I think what

has happened is the percentage number of referrals has gone up and that is due to far fewer complaints being referred to area health services, so the actual number sent to registration boards is consistent.

Mr TURNER: There was a pronounced decline in the number of referrals to AHS. Why was this the case?

Mr PEHM: Well, in the past the commission had a practice of referring quite difficult and serious complaints to area health services to directly investigate themselves and to either send a report back to the commission and advise or to deal directly with the complainant. There is a threshold. Section 23 of our Act says that the commission must investigate serious complaints. We have been very careful and that is why we have a more extensive assessment process now to ensure that we fulfil the obligation to investigate serious complaints ourselves. The other problem with those referred to the area health services is that we have had a lot of requests for review from the complainants and from patients who were not happy with the outcome of the area health service investigation and they were entitled to have a review of the decision to refer it out there in the first place.

Mr TURNER: Could that be the result of some people perhaps thinking that the area health service was investigating itself?

Mr PEHM: I think that perception is always going to be there regardless of the quality of the investigation. People will always feel: Well, how impartial can it be? They are investigating themselves. We have also reviewed a number of cases that we had to take on for investigation because the health service investigation had not answered the questions and serious issues remained, so we are referring far fewer matters out to area health services now for that reason. I think it was part of that education and development process that the commission had. It had a sort of partnership unit and the idea I think, which is not a bad idea in principle, is that you refer the matters back to the area health service and they deal with them and we just have a bit of a monitoring role or something. I think it was also partly in response to the big backlog of complaints and the commission had so many itself that it had to deal with.

The Hon. CHRISTINE ROBERTSON: Can you give some examples of the types of concerns raised by CRS clients that are classified as corporate services?

Mr PEHM: Yes. These are national categories and we have changed the categories that the commission used to have. Corporate services include things like hotel services, car parking, cleaning, catering, grounds, laundry, maintenance, security, hygiene, environmental standards and administrative services like clerical process, admissions and those sorts of things, so bits and pieces like that.

The Hon. CHRISTINE ROBERTSON: Do you know any of the details?

Mr PEHM: I have not gone through individual complaints, but it is that sort of thing, car parking, lack of security--

The Hon. CHRISTINE ROBERTSON: Housekeeping?

Mr PEHM: Yes.

The Hon. CHRISTINE ROBERTSON: Does 59.5 percent of outcomes at total or partial resolution seem appropriate to you?

Mr PEHM: I am not sure what you mean by "appropriate". It is a pretty good outcome, we think. 59 percent of the total complaints are resolved either totally or partially. Of the complainants that do not simply say, "I don't want to participate in the process" or "I'll go off and do my own thing and take legal action", 87 percent of matters where complainants actually participate in the process are resolved, and we think that is quite a high rate of resolution.

The Hon. CHRISTINE ROBERTSON: On page 30 you provide statistics on consumer satisfaction from the CRS Satisfaction Survey 2004-05. Was there any notable change in consumer satisfaction following the amendments to legislation and the subsequent change to the role of the CRS? Have you had any indicators that it has made a difference?

Mr PEHM: No, there has been no change really.

Mr TURNER: The response rate to the CRS satisfaction survey 2004-2005 was reported as 27 per cent. Does the commission has have any plans or strategies to increase this rate?

Mr PEHM: Those surveys are sent out to every complainant that participates in a complaint resolution process. The return is voluntary. It is up to them whether or not they return it. I am not sure how 27 per cent compares with other surveys. I do not know whether it is a good or bad number. The only thing I can think of to increase that is to actually have people go out and door knock.

The Hon. CHRISTINE ROBERTSON: That is very expensive.

Mr PEHM: It seems like not a very wise investment of resources.

Mr TURNER: As a politician I often put surveys out and we think we are doing well if we get 10 per cent so 27 per cent is probably not bad. Does the commission have any plans to expand its assessment of stakeholder satisfaction levels to encompass any of the following in the immediate future: One, the complaints assessment, investigation, legal and prosecution processes?

Mr PEHM: I think I have answered this broadly in the answer to previous questions and that is that I still think that we have a significant amount of work to do internally. We know what our problems are. We get plenty of feedback from complainants and respondents through the normal complaint handling process. It is very clear that our problems are delays and response rates, timeliness. I think we have a lot more work to do internally in improving our own performance and procedures before we go out surveying people. You are getting into refinements at that stage where you are looking at how you can fine tune and tweak things when you are looking at stakeholder satisfaction, so no immediate plans.

Mr TURNER: You have probably partly answered this one as well, the internal governance and management arrangements, such as the effectiveness of the case management and records management systems.

Mr PEHM: Again we have a lot of problems there. The case management systems will improve now with casemate. There is still a gap with general commission records. We have had a consultant in to look at our records systems, or lack thereof, and there is an enormous amount of work to do there. There is no effective electronic records system. We have been talking to State records about that and how to improve it, but that is going to be quite a big project. That is something we will have to go to Treasury for, for funding for a system to do that.

Case management records are much better but the difficulty we have is that when matters come in the door and before they get registered in the case management system there is a gap there that we need to address. Again that is an area where we know what needs to be done. We have had consultants look at our systems and, rather than survey stakeholders, we have a fair idea of what we need to do.

Mr TURNER: The public education strategies for raising awareness of the resolution of complaints about health care.

Mr PEHM: I have covered this, I think, in terms of the complaint resolution service and have had consultations with the Consumer Consultative Committee. They are good forum for assessing consumer stakeholder needs, and they did identify that need for the complaint resolution service to be out there addressing peak groups and bodies, and we are implementing that.

Mr TURNER: The liaison role with the Clinical Excellence Commission and the Department of Health regarding contribution to improved quality assurance systems.

Mr PEHM: We have a very good relationship with the Department of Health and with the area health services, through the Director-General. I think our direct liaison role with the Clinical Excellence Commission, I will take that up.

Mr SHEARAN: What alternatives, if any, exist for consumers given the refocussing of the work of the Complaints Resolution Service?

Mr PEHM: This relates back to the issue that the Chair was raising earlier, that he feels there is a big gap in the service. I am not sure that that is the case and I do not have any data to necessarily support that. Within the public hospital system a lot of hospitals have patient representatives, patient support.

The Hon. CHRISTINE ROBERTSON: Patient representatives usually, are they not?

Mr PEHM: They are Department of Health employees attached to hospitals and people can go to them and they can be liaison points to deal with problems people are having with hospitals. In the private sector I do not think that there is very much to assist complainants, apart from the commission, so I do not think there are many alternatives.

Mr SHEARAN: I must admit that I had a constituent came in who felt that the hospital service was not the best and she complained to the commission and felt frustrated in how the procedure went through, and I must admit that to some extent I agree with the Chair that the CRS process might be in need of a further look, just for that extra facility. The requirements seem to prevent that flow of work.

Mr PEHM: Your constituent is frustrated with the bureaucracy, or the process?

Mr SHEARAN: Overall, and I have made a formal complaint on her behalf, which no doubt will be sent through to you. I think that is the issue about the alternatives anyway. Is cultural competency training included in the training plan for 2005-2006?

Mr PEHM: It has not been. Our training programs have been focussing on very basic skills like communication, analytical skills, investigation, statement taking, interviewing techniques, those sorts of things, so it is certainly something we need to address and we will be looking at in the next financial year.

Mr SHEARAN: Can you comment on the handling of complaints when the practitioner is not registered with the registration authority?

Mr PEHM: A lot of health practitioners are not registered, naturopaths, homeopaths, psychotherapists and so on. They are still health service providers under our act. People can complain about them. We can investigate those complaints. The difference is in the outcomes. Those registered practitioners can go before disciplinary tribunals, be suspended, or have conditions imposed. The most we can do with non-registered practitioners is make comments to them at the end of an investigation to the effect that their practice was substandard, or dangerous, depending on the nature of the case. We can also refer matters to the Director of Public Prosecutions if we feel there is evidence of criminal breaches.

The Hon. CHRISTINE ROBERTSON: Is this question about people who do have a registration process or do not register when they have got one?

CHAIR: Unregistered practitioners.

The Hon. CHRISTINE ROBERTSON: Practitioners who cannot register.

Mr SHEARAN: Has the commission considered listing the names of deregistered practitioners on its web site?

Mr PEHM: We have considered it and what we would like to do is not just publish names, but do it in a broader context where we publish a decision of the tribunal, but it is quite a big IT project, I understand, because it goes back many years and we are probably the only agency that has a complete collection. The boards might for their own practitioners or they would, I think. The project is to get the IT capacity to do it. All those documents have to be scanned in, in reference to names, and I have talked to our IT section about that and they tell me it is quite big and it will take some time. We will have to look at funding to do it as well.

CHAIR: Could you not start to implement it from 1 July for future cases and the past cases could be something that could be done over time.

The Hon. CHRISTINE ROBERTSON: Excuse me please, the health department actually has a system for listing doctors, because they send it out to the public health practitioners regularly, so maybe the question could be about whether or not it is worth finding out what systems are in place to notify people of deregistered people, how can it be complemented?

Mr PEHM: I was aware not aware that Department of Health had something.

The Hon. CHRISTINE ROBERTSON: They send out a full list of the new deregistrations and the ones that have gone back.

CHAIR: Maybe you could follow up on that and we will be talking to you during our other inquiry which is on those unregistered health practitioners. Dr Wong just came back into the room because he had to go to the Upper House. Could you repeat what you were saying about the cultural competency training? I think he has some more questions on that.

The Hon. Dr PETER WONG: Is the cultural competency training included in the training plan of 2005-2006? Have you been asked that?

Mr PEHM: I am happy to answer it. It has not been. We have been concentrating on basic investigation skills like statement taking and interviewing techniques and written communication but it is something we will look at for the next year.

CHAIR: Thank you. Dr Wong has a particular interest in that area. In general, you would be aware of the particular case that we sent to you last year where a constituent of a Member of Parliament raised a complaint with the Committee. We forwarded that to you. That was concerning delays in the processing of the complaint and the lack of communication about the progress of the complaint on the part of the commission. In general terms, without referring to the particular complainant or the case, is that case representative?

Mr PEHM: I do acknowledge that we have had difficulties in our assessment process. I was explaining that we are now engaging in a much more careful analysis of complaints and getting responses and so on. We have expanded the area of the commission that is dealing with that. It is not something that the officers in that section are used to doing. Their previous job was simply to make up the file with the complaint and that was really the end of the job. We are now asking them to do a lot more, to analyse the complaint, to get responses and to read it. There have been difficulties there. We are addressing those through training and through changing procedures and in particular when the new act came in on 1 March and for probably six months after that we had a lot of problems in that area. Those things are improving now and I do not think this case would be representative of the way we handle things now.

CHAIR: In the gallery today we have Christine McGillion from the New South Wales Chiropractors Association and Ms McGillion appeared before the Committee last week and we had an informal briefing on the chiropractic association and what they do with handling complaints about their members, and that was part of our inquiry into unregistered health practitioners. We advised Ms McGillion that you would be appearing before us today and that she may like to come along and hear what the commission is doing as it is a public hearing and I will take the opportunity to introduce you to her at the conclusion of the hearing. What is your understanding of the role of professional associations in the complaints handling process?

Mr PEHM: There is no formal role in a complaints handling process. A professional association can make a complaint, and that does happen, in which case they are they complainant and they are treated as the complainant and are advised and consulted with on the way through. I suppose it is a question of numbers. Most complaints are against doctors so we have had meetings with the College of Surgeons and the College of Physicians and so on in relation to recruiting peers and experts, but there is no formal role for professional associations in complaint handling.

CHAIR: Are you aware that from the information we have gathered that a number of associations do perform the role of assisting in resolving complaints at a lower level? They may not find their way to the commission.

Mr PEHM: I am aware that some do. We have had some limited contact with professional associations where they have been dealing with complaints, but their member has thrown up the shutters and briefed barristers and they have come to us and say what do we do with it now. In effect there is nothing much they can do because they do not have the power to deal with it without the consent of the person. Limited contact like that, but no regular liaison. There is not a loss of crossover in our experience.

CHAIR: From the information we received from our briefing last week, we think that there are opportunities that could be explored if we could set up a mechanism of a regular exchange of information between the associations, that is why there has been a line of questioning. We will follow it up with you after the public hearing today.

One of the functions of the commission in 2004-05 was to improve the health care system through recommendations from investigations. What recommendations were made in 2004-05, how many of the recommendations were accepted and what improvements have been proposed as a result?

Mr PEHM: There were 26 investigations that resulted in the commission making comments or recommendations to the health service provider during 2004-05. We have only recently set up the process for monitoring those beyond the individual health service provider and that is the meeting I was referring to with the director general of health every three months, so prior to that time there was no monitoring of the implementation of the recommendations, and that is something we will be reporting on in our next annual report. There is a bit of an issue in the Act with the provision of that information. The way the Act reads at the moment it is solely the responsibility of the director general to publish that sort of information and the Act provides that the commission shall not publish it. I now think it is very important that it should be published and I will be talking to the director general about publishing that in our annual report. I am sure she will have no problems with that.

CHAIR: Going back to the article that Dr Wong referred to in the Sydney Morning Herald on 23 February, the article mentioned two doctors. There was a second case that you had taken to the tribunal and the tribunal cleared both doctors. I was just wondering if you could give us the reasons why the second case was also taken to the tribunal if there was not sufficient evidence to win the case?

Mr PEHM: The second case concerned an allegation made by a nurse that a doctor did not conduct an examination and later falsified medical records to the effect that he did. The nurse was interviewed by counsel before the decision to proceed with the prosecution was made. I am not across all the details of the supporting evidence - Karen might want to add to this later - but I think that essentially it turned on credibility under cross-examination: One witness was believed and one wasn't. You always make assessments of credibility on the way through, during the investigation, but it is not really until the final court or tribunal hearing that it comes to the crunch. We do not prosecute frivolous complaints where witnesses are obviously not credible. We rely on counsel for an assessment of the credibility of a witness, but Karen might be more familiar with that.

Ms MOBBS: I think that is essentially correct, that it really did come down to an issue of credit. The decision to prosecute any matter is really a balancing exercise and that is reflected in the criteria, but what you are looking at is how serious is the offence and the conduct and the consequences on the public safety. You look also at the strength of the evidence and the likelihood of proving the offence, so you do have to look at those issues. Obviously if this matter was established it is a very serious matter and one that the public would want to see tested. We had counsel in the preliminary stages conference the witnesses, provide advice as to the likelihood of the matter proceeding; we had separate experienced counsel running the hearing, interviewing witnesses and again making an assessment that there were reasonable prospects. Matters happen, different issues arise, and I think that is just part and parcel of the prosecution process and the adversarial system.

CHAIR: Would you be able to tell the Committee what percentage of the cases that went before the tribunal were successful? The other question I was going to ask that you might be able to answer also is that in your report is there listed the amount of money that was expended in 2004-05 on taking cases to the tribunal?

Mr PEHM: There is a line item "Legal fees and other adverse costs" on page 78 in expenses. There is some peculiar item there. I think it is running at around $600,000.

CHAIR: $699,000, closer to $700,000. What are adverse costs?

Mr PEHM: Adverse costs are costs orders against the commission. In the medical tribunal, for some reason - I don't know why it is different from the others - costs usually follow the event. If we win the case, the doctor pays our costs, and vice versa. In the other tribunals that is not the case.

Ms MOBBS: In the various tribunals - the nurses tribunal, for example - there is no cost.

Mr PEHM: All of these registration acts were written at different times and for whatever reasons at the time they are all different. It needs really to be a project of regularising them all because it complicates our processes as well, but adverse costs are where we lose the case and costs are awarded against us.

Ms MOBBS: I think the question was in relation to the number of successful prosecutions. Just referring to page 47 of the report, in this reporting year the commission finalised 85 cases, 73 disciplinary matters. Of those, seven were withdrawn for various reasons, namely that the complainant may have been dead, the practitioner had withdrawn themselves from the register; two were dismissed on the basis that the complaint had not been proved, so I am not sure what percentage that is, but of those 73 disciplinary matters that were heard, two were actually heard and found not to be proved, so a very small number.

CHAIR: At the hearing held in 2005 on the previous year's annual report the commission agreed to make a number of inclusions in future annual reports. Are you able to comment on the absence of two of these inclusions in the 2004-05 annual report? One is the detailed information on any internal committees of the commission and the second is cross-referencing of statistical information in the appendices with the main body of the report.

Mr PEHM: The internal committees of the commission - on page 63 we refer to the Consumer Consultative Commission and list the members of that committee. On page 64 we talk about our Workplace Consultative Committee under commission representatives and Public Service Association representatives. We are a very small commission and other than general management mechanisms, which I don't know whether they are committees, we have management meetings involving directors of the commission every fortnight. We have an Investigations Review Group, to which I referred earlier, that monitors progress of investigations. I do not know whether they are the committees the report on our annual report was referring to. It would not be normal to publish details of the membership of those normally in an annual report.

CHAIR: Does the commission have an internal audit committee?

Mr PEHM: No, that is done as part of our management committee. You need a committee when you have a big organisation where you have a lot of different departments, you have representatives from different departments to put forward a program and audit it over a period of time. That is quite manageable with our management committee.

CHAIR: But the total budget for the year in question was $10.41 million.

Mr PEHM: Yes.

CHAIR: The Committee provided you with a review of the annual report prepared by our consultant, John San-Sew. Are there any comments you want to make about that review, because we will be including that in our report that goes to the Parliament?

Mr PEHM: There are lots of things that I do not necessarily agree with in it. I think the review last year complained that the report before this one had a commissioner's foreword rather than an executive summary. So this year we have an executive summary and it says we should have a commissioner's foreword as well as an executive summary. There is a complaint about including case studies in the body of the report. For some reason he seems to think that they should be put in an appendix. We have had very good feedback on the case studies and the Consumer Consultative Committee and other people think it is a good idea to have real life cases rather than just numbers in the body of the annual report, so I would not be proposing to put those in an index.

The second part of your last question is something that that review raises, which talks about cross-referencing tables in the appendices. The way the report is written is that data that relates to the performance of the commission in terms of complaints process and turnover and timeliness and all of those sorts of factors are dealt with in the body of the report. The information in the back in the appendices is more general information about the categories of complaints, where complaints are made, the types of practitioner they are made against, whether it is public, private, nursing home, those sorts of issues. That data is probably more of interest to academics or people who are interested in the provision of health services generally. The report suggests that we should cross-reference that data with text in the annual report. I am just not sure what "text" is necessarily referring to. Those are the things that occurred to me just off the top of my head when I read it. There are obviously some good things in there and criticisms that we will take on board and look at next time.

CHAIR: You are aware of the problems that occurred in Queensland and there was initially a Bundaberg Hospital Commission of Inquiry and a Queensland Public Hospitals Commission of Inquiry report, which was released in November 2005. There were also separate reviews into the Queensland health system and a final report released. I was just wondering whether you have had an opportunity to look at those reports or whether, in your liaison with the Queensland Health Rights Commission, anything came out of those reports that would help us in the way we handle health care complaints in New south Wales?

Mr PEHM: I have spoken to the Queensland Commissioner about them and he has advised me of some of the consultations that are currently taking place into what a new system might be. I must say I have not read the report and I am not sure of the extent of his consultations during the reform process and the confidentiality of those. They, like the rest of the Australian states, have a system where the medical board is the principal governor, if you like. The Health Rights Commission there is more in a conciliation and resolution mode. As you know, we have an investigation prosecution role as well as a resolution one. At first blush, from my discussions with him, I am not sure there is a lot coming out of that inquiry that would go to recommending changes in our system.

CHAIR: We will be looking at those reports carefully to see if there is anything to be learned. That brings me back to my earlier comment and something I have raised with previous commissioners and that is that I really believe that it is important that the Health Care Complaints Commission start up a dialogue with medical boards in other states who are charged with this investigation process that your commission here in New South Wales is also. Most of the other commissions, as we know, are into conciliation and not necessarily the investigation and prosecution of cases before tribunals.

Mr PEHM: They are all very distinctive. As I was saying, in New South Wales different registration acts came into power at different times. In the interstate ones there are all sorts of procedures that do not exist in ours. In Queensland, for example, they have the power to get a practitioner to give them unbinding undertakings, so rather than prosecute someone they can stop short of prosecution and say if you undertake to do this course or not to do this procedure we will leave it at that and rely on your undertaking. There are lots of differences that are not necessarily transferable. There are lots of problems in enforcing those conditions. Where I do come into contact is where practitioners move interstate and conditions that are in place in one state might not be enforceable in another because of mutual recognition problems in that the mechanism existing in one state does not exist in the other.

CHAIR: That was one of the recommendations out of one of the inquiries.

Mr PEHM: I think the Productivity Commission has recommended a national registration board.

The Hon. Dr PETER WONG: I briefly mentioned about overseas doctors and as the Chairman indicated part of the finding in Queensland related to overseas qualified doctors. As we in the country need more overseas doctors and nurses I think an accusation either true or otherwise will be constantly in the mainstream. Will the commission brief the Committee or monitor the situation and give us advice on what the problems are, how we can solve the problems, or prevent such an issue becoming a hot topic?

Mr PEHM: It is more within the responsibility of the New South Wales Medical Board. They accredit overseas trained doctors and there are specific categories of doctors, area of need doctors, where their practice is limited to perhaps the rural area and in a particular discipline, but I can certainly talk to them about it and let you know.

The Hon. Dr PETER WONG: As a complaint comes up maybe you are familiar with the investigation and assessment and you can maybe highlight some problems.

Mr PEHM: I will see what we can find.

The Hon. Dr PETER WONG: Something that we should be aware of.

Mr PEHM: I am happy to look at that.

CHAIR: Commissioner, or Ms Mobbs, are there any closing comments you would like to make?

Mr PEHM: I do not think so. We have been fairly thorough we have covered a lot of ground.

CHAIR: We look forward to seeing you again and speaking to you in relation to our other two inquiries that we have under way.

(The witnesses withdrew)

(The Committee adjourned at 11.50 a.m.)

APPENDIX TWO- TECHNICAL REVIEW BY JOHN CHAN SEW

Introduction

A detailed review was conducted of the Annual Report and the related Corporate Plan of the Health Care Complaints Commission (HCCC) for the 2004-05 year. The key focus of the review was on:

- the form and content of the Commission's planning document;
- the reporting of performance results and outcomes achieved during the year; and
- compliance with the statutory disclosure requirements as specified in the Annual Reports (Statutory Bodies) Act 1984 and Regulations and the Health Care Complaints Act 1993.

This report is intended to assist the Joint Committee on the HCCC in its conduct of an examination of the 2004-05 Annual Report of the Commission in accordance with section 65 (i)(c) of the Health Care Complaints Act 1993.

Both the Strategic and the Annual Corporate Plans are a critical part of the overall framework for accountability in that the key initiatives and the performance measures and targets specified in the plans are expected to be used by the Commission to account, by means of the Annual Report, for the performance results and outcomes achieved.

Performance reporting has been an issue of strong interest to the Joint Committee in recent years as it allows a wide range of stakeholders to assess the Commission's achievements and value for money. In reading the Annual Report, the stakeholders should be able to gain an insight into how well the resources are managed and whether the functions and activities performed are in line with the intended outcomes of the Commission and community expectations.

It has also been generally acknowledged that good performance reporting can assist in embedding a culture and a systematic process of continuous improvement in resource management as well as providing an incentive for agencies to actively manage for the results that they have set out to achieve.

Set out below in this report are:

- the key findings and recommendations arising from the review of the Annual Report and the related Corporate Plan; and
- the detailed results of the examination of the two individual documents.

Key Findings and Recommendations

The coverage of the 2004-05 Corporate Plan is reasonably adequate although there are some issues with the key performance indicators and the planned initiatives presented in the document. In particular, it has been found that:

- a large number of the key performance indicators disclosed in the Annual Report do not actually appear in the Plan; and

- the target dates or timelines have not been shown for all planned initiatives and projects.

Apart from the above, a number of other recommendations have been made to further improve the quality of the planning document by incorporating, for example, a commentary on the financial outlook and brief details relating to resource requirements and allocations.

Overall, the Annual Report has shown some improvement in the area of performance reporting although a gap still exists between the current approach and the best practice position.

A key area for future focus is the expansion of the existing suite of key performance indicators to measure the efficiency and effectiveness of all major aspects of the Commission's operations. The indicators adopted must be accompanied by targets for performance tracking. It is not the case in most instances under the existing reporting regime.

The assessment of the satisfaction levels of the wide range of stakeholders as indicated on page 3 of the Report is another related issue that requires further work if the performance reporting approach of the Commission is to be further enhanced.

There are other recommendations made with regard to the inclusion of additional performance information in the Report dealing with issues such as trend analysis, benchmarking comparisons, financial review and commentary and environmental scan.

The review for compliance with the other statutory disclosure provisions has identified a few instances where the requirements of the annual reporting legislation have not been fully met.

Review of Corporate Plan

The Corporate Plan contains a number of the usual elements such as the vision, values and corporate goals of the Commission as well as a brief outline of the challenges and priorities for 2004-05 together with some information on the business risks and stakeholder expectations. In addition, the document has also presented a series of strategies under each of the corporate goals and also details of the measures to be used to assess performance.

There are two concerns with the performance measures as disclosed in the Plan and they are detailed below:

- it has been found that quite a number of the key performance indicators presented in the Annual Report do not actually appear in the Plan. Examples of those indicators are:

  - % of complaints assessed within 60 days (page 20);

  - average number of days to finalise non-investigative complaints (page 20);

  - % of complaints referred to Complaints Resolution Service, Health Conciliation Registry and Investigation Division (page 18);

  - number of requests for review of assessment decisions (page 23);

  - % of matters resolved or partially resolved by Complaints Resolution Officers (page 28);

  - timeliness of the Complaints Resolution Service (page 29);

  - client satisfaction levels for the Complaints Resolution Service (page 30); and

  - % of Health Conciliation Registry matters where whole agreement/partial agreement reached (page 36).

  It is vital for the whole accountability and reporting process that all the key performance indicators against which the Commission is to be held accountable be clearly set out, on an ex-ante basis, in the planning documents. Firstly, it ensures consistency in the ex-post reporting of performance and secondly it overcomes any possible criticism of selective disclosure.

- some of the performance measures shown in the plan are, in fact, in the form of planned initiatives but target dates or timeliness have not been given in all cases. The following are examples of initiatives where target dates could have been provided:

  - review of prosecution guidelines;

  - development of a Code of Practice under section 80 of the Health Care Complaints Act; and

  - implementation of the Ethnic Affairs Priority Statement and Disability Action Plan.

The coverage of the 2004-05 Corporate Plan is reasonably adequate subject to the resolution of the two issues identified above. However, it is believed that the document can be further improved by the inclusion of:

- a 'Commissioner's Foreword' conveying a series of personal messages about the key priorities and focus for the planning period, the critical success factors and also commitment to performance targets;

- additional information on resource requirements (including human, information technology and capital resources) as well as staffing allocations to the different functional areas to give an indication of the prioritisation of activities; and

- a commentary on the financial outlook together with a set of projected financial and budget statements (prepared in a summarised form).

Review of Annual Report

Performance Reporting

The focus of the Commission during the 2004-05 year was on reducing the backlog of complaints and investigations, the restructuring of the organisation and its internal business processes as well as implementing a wide range of changes to the policies, procedures and systems.

Overall, the Annual Report has shown some improvement as compared to the previous year in terms of the reporting on key performance indicators and major initiatives. Further, there are less descriptive details on projects and activities and the Report has also benefited from the inclusion of an Executive Summary. However, a gap still exists between the current approach and the best practice position.

A positive feature of the Report is the systematic comparison between those initiatives and projects as disclosed in the Corporate Plan and the actual results achieved. Where a particular initiative was not able to be delivered because of, for example, other competing priorities, some explanations have been given. It is recommended that in future, wherever possible, a target date or timelines be provided for each planned initiative or project to allow an assessment of the Commission's success in meeting its commitments. This has not been done in the 2004-05 Corporate Plan.

In relation to the reported key performance indicators, there are a number of major issues that will have to be addressed in future reports. The existing suite of key performance indicators needs to be further expanded to measure both the efficiency and effectiveness of all major areas of operations. The indicators adopted must be accompanied by targets which are to be reported against in the Annual Report. Any performance shortfall should be explained together with details of remedial actions. It has been found that most of the indicators in the Report are not accompanied by any targets. For the more significant indicators, trend data together with a commentary and analysis must also be provided.

More work still needs to be done in assessing stakeholders' satisfaction with the different aspects of the Commission's operations (apart from complaints resolution) such as:

- the complaints assessment, investigation, legal and prosecution processes;

- the internal governance and management arrangements (e.g. the effectiveness of the case management and the records management systems);

- the public education strategies for raising awareness of the resolution of complaints about health care; and

- the liaison role with the new Clinical Excellence Commission and the Department of Health regarding contribution to improved quality assurance systems.

It has been noted that the response rate for the Complaints Resolution Service Survey conducted during 2004-05 was only 27%. This is not considered sufficient to provide the necessary degree of reliability. Therefore, it is recommended that the methodology for the surveys be modified with a view to increasing the response rates and also encouraging the making of suggestions for performance improvement. To ensure public confidence in the integrity of the approach, the surveys should also be subjected to periodic independent reviews. As part of the accountability process, the Report must also give an outline of the issues and trends identified in the surveys as well as any remedial actions taken by the Commission.

Although one of the functions of the Commission during the year was to achieve improvement to the health care system through recommendations from investigations, there is no information at all in the Report on the number of recommendations made, the % of recommendations accepted as well as details of the system improvements proposed and adopted.

The following are other issues in relation to performance reporting that have been noted:

- the Report does not contain a 'Review by the Chief Executive Officer' conveying a series of key personal messages on such matters as highlights for the year and commitment to performance targets; acknowledgement of successes and failures, key performance results in comparison with targets and benchmarks; and future plans and challenges;

- the 'Five Year at a Glance' Section (page 4) comprises a series of bar charts showing the volumes of different activities over the last 5 years. The charts, however, are not accompanied by a discussion and analysis of the trend data thus limiting the usefulness of the information. There is a similar concern with the multi-year data shown in a large number of the tables. Although it is one of the functions of the Commission to advise the Minister and others on trends in complaints, there is very limited trend analysis given throughout the Report;

- there is an absence of a commentary on the shared responsibilities for cross-agency performance issues and on the Commission's contributions to the joint outcomes achieved with other relevant bodies e.g. Department of Health, Area Health Services and health professional organisations;

- at present, the Report does not provide a benchmarking comparison with the performance results achieved by similar agencies in other Australian jurisdictions;

- a 'Financial Commentary and Analysis' Section should be included to provide a clear link between the financial statements and the 'Review of Operations' Section of the Report. The Section needs to present a table showing the major categories of assets, liabilities, revenues and expenses and also the operating results over a 5 year period together with a commentary on the past trends as well as on the financial management and activities of the Commission;

- The inclusion of a 'Future Directions' Section is another positive aspect of the Report. However, the coverage of the Section needs to be expanded to incorporate not only planned initiatives (as is presently the case) but also:

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

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

- all of the case studies should be transferred to the Appendices Section with only the major issues relating to the studies being discussed in the main body of the Report. This is to avoid an unnecessary distraction from the performance focus of the Report; and

- at the Hearing held in May 2005 on the 2003-04 Annual Report of the Commission, a number of reporting issues were raised but, in reviewing the latest Report, it has been found that no further progress have been made with certain issues including:

  - providing details on the internal committees of the Commission (e.g. terms of reference and membership composition); and

  - cross-referencing the statistical information in the appendices to the main body of the Report.

Other Statutory Disclosures

It has been found that there are a few instances where the requirements in the annual reporting legislation have not been fully met. In particular, the disclosures relating to the implementation of the E.E.O. Principles and the Ethnic Affairs Priorities Statement have not incorporated an outline of the proposed strategies for next year. Also, in the case of E.E.O., the Report has not given any details on the planned outcomes for next year nor the distribution indices for the different target groups (apart from women).

The Report has complied with all of the statutory disclosure requirements as specified in the Health Care Complaints Commission Act.

APPENDIX THREE- MEETING WITH HEALTH CONCILIATION REGISTRY (BRIEFING NOTES)

Review of the 2004-2005 Annual Report of the Health Care Complaints Commission

Briefing- Ms Julia Lines, Registrar, Health Conciliation Registry
Mr Ian Thurgood, Director, Assessments and Resolution
10:00am Thursday 4 May 2006, Room 1108 Parliament House

Could you provide the Committee with an overview of the role of the Health Conciliation Registry, including the types of complaints usually received and the usual responses and processes for handling these complaints?

- The role of Registrar, Health Conciliation Registry, is to manage and administer complaints that have been referred by the Commission for conciliation.
- The Registrar meets regularly (currently Monday, Wednesday and Friday) at assessment meetings with the Commission and also informally reviews files to determine whether referral for conciliation is appropriate.
- Previously, there was a clerical assistant attached to the Registrar's position. Clerical assistance is currently provided by the Commission when required.
- A decision is made at the assessment stage that conciliation is appropriate. This is based on an assessment that that there is insufficient evidence to support the investigation of a provider and that the complaint is likely to be resolved by conciliation.
- The HCR must obtain consent from both parties to participate in conciliation.
- In the last 6 months, the rate of non-consent to conciliation by complainants has exceeded that of practitioners by almost 3 to 1.
- Pursuant to s53, a report on the outcome of conciliation is provided to the Registry by the conciliator.
- Sometimes, providing a copy of the provider's response to the complainant can itself resolve a complaint.
- The involvement of the HCR ranges from minimal intervention (e.g. an initial phone call) to conciliation that requires one or more subsequent conciliation meetings.
- The Registry maintains records of the number of complaints referred by the Commission, whether or not consent is given and the outcome of conciliation (including whether agreement was reached and whether the complaint was resolved).
- The question was raised as to what happens if, in the process of conciliation, staff become of the opinion that the complaint did, indeed, warrant investigation.

- Ms Lines explained that if new information is brought forward and is of such concern, the conciliator would determine whether conciliation could continue in relation to the other existing issues. If the conciliator was of the view that continuing the conciliation would be inappropriate, then the conciliation meeting would be terminated and the Registry would refer the complaint back to the Commission for reassessment.

- The Conciliation Process is confidential. The Act provides that things said or documents created for or during the conciliation process are not admissible in a court or tribunal. The only exception to this is if all of the parties who attended the conciliation or who were named during the conciliation consent to their use in a court or tribunal. If a new serious issue of public health or safety arises, or a new provider is identified during the course of conciliation, then the conciliation maybe terminated. The conciliator would then note in his/her s53 report a recommendation that the Commission investigate the complaint.

- The Registrar records the reasons why a complainant does not consent to conciliation. Sometimes, reluctance to meet on the part of one party may relate to their perception about what conciliation entails or the way the other party is likely to respond. In these cases, the Registry endeavours to dispel any misconceptions and to explore with the parties the advantages offered by participation in conciliation. The HCR accommodates the specific needs of both parties.
- The Registry manages a large panel of professional conciliators from a range of different backgrounds, including lawyers and nurses. They are engaged on a contract basis to deal with individual complaints, some of whom are based in regional New South Wales.
- The Commission deals with the administrative aspects of recruitment of conciliators and puts forward recommendations for appointment of conciliators by the Government. These appointments are for a three year term and are due to expire during August and December 2006.

Can you address your intentions for the Registry in terms of:

a. The use of support people by persons accessing the Registry?

b. Availability of the service after hours and in rural areas?

c. *Structure of conciliation services (for example, will conciliation consist of one-off sessions or longer-term communications, bringing parties to a complaint together or meeting with them separately)?*

- Either party may bring support people to conciliation. Both the Registry and the conciliator explain confidentiality to the parties and how it relates to support people.
- Conciliations are held in a location that is convenient to the parties. A significant number of conciliations occur in metropolitan and regional areas in a location that is neutral.

- The Registrar is responsible for notifying the parties of the referral to the Registry, that the process is voluntary and that their consent is required. An explanation is also provided about the conduct of conciliations, the potential outcomes and the reasons why conciliation is considered to be appropriate. The Registrar is responsible for the allocation of the complaint to a conciliator and for organising the necessities of the conciliation process.
- Although the Act focuses on a conciliation conference, within that model the conciliation process is flexible. A single meeting may be appropriate to resolve a complaint. In other cases the Registry may arrange a pre-conciliation meeting with the parties (either separately or together) so that the issues for discussion can be narrowed and particularised.
- There have been discussions concerning whether the Commission should move the Complaints Resolution Service to the HCR. Ms Lines identified one of the disadvantages of this, being that the CRS does not offer the confidentiality provided by the conciliation process and this may hinder the more immediate response that characterises the CRS.
- It may be useful to consider providing the Registry with additional general ADR powers as the work of the Registry is currently legislatively geared towards holding a conciliation conference. Since the Act was drafted, there has been significant research into ADR and there are now various mainstream ADR approaches that can be effectively utilised by the Registry to assist the parties to resolve the complaint.

Can you explain the drop in referrals to the Registry between 2002/03 and 2004/05 (from 239 referrals to 90 referrals respectively)?

- The current Annual Report of the HCCC sets out the range of complaint issues dealt with by the Registry. Ms Lines confirmed that this is an accurate representation of the types of complaints that continue to be referred for conciliation. The majority of complaints managed by the Registry deal with treatment issues involving poor and/or unexpected outcomes, inadequate explanations relating to treatment as well as provider communication and attitude.
- In regards to the reduction in referrals, the relevant number is the number of complaints that are being assessed for conciliation, which was 436 in 03/04 compared to 164 in 04/05.
- Despite the reduction in complaints referred for conciliation, the success rate of conciliation increased substantially from 31% to 52% (agreement reached/partially reached as a proportion of those assessed for conciliation). Of those referred to conciliation, the increase in agreement reached/partially reached was 0.5% (83.7% in 2003/04 to 84.2% in 2004/05).
- As previously noted, the Registrar now meets with the Commission's assessment committee three times a week.

- In order to be referred to conciliation, the complaint needs to be assessed as likely to be resolved by conciliation. Although fewer complaints may be referred for conciliation, the rate of resolution should continue to increase given the introduction of a more robust assessment process. Furthermore, it is apparent that some complaints that may have been referred to the Registry in the past are now being referred for local resolution.
- Many complainants state that that their concerns haven't been addressed or that adequate explanations have not been provided. Sometimes a person may not understand an explanation when they are feeling acute stress and this issue can also be addressed as part of the conciliation process.
- The Registry works with parties prior to the meeting to assist them with preparation including identifying outcomes they are seeking. Outcomes can include explanations, apologies, refunds, compensation and changes in policy and procedure. The formality of the process and without prejudice protection can encourage providers to participate if they are otherwise reluctant and to also be more open about acknowledging failures in the provision of their health service.
- Complainants also benefit from having an independent person manage the process who will also address any perceived power imbalance.

What measures are being taken to assure consumers accessing the Registry that information they provide in the process of conciliation can not be accessed by staff at the Commission?

- The initial letter to both parties addresses the issue of the HCR's independence from the Commission. The letter is on the Registry's letterhead and refers to the separate roles of the Commission and the Registry.
- The initial letter explains the reasons for the Commission's decision to refer the complaint for conciliation, provides an explanation of the process and emphasises and explains the confidentiality aspect of conciliation.
- Only the Registrar is permitted to access the files of the HCR.
- The files are stored separately from the Commission.
- There are security measures in place that make it extremely difficult for anyone in the Commission to obtain access to the HCR information.
- The Registrar has not received any complaints about the HCR being located in the same building as the Commission.
- The HCR consists of a conference room, two separate smaller rooms and a reception area[*]
- The location of the Registry is in the initial letter to the complainant and provider.
- Ms Lines agreed to provide the Committee with a copy of the letter.

[*] Information provided by Ms Lines to the Committee following the briefing explained that the sign at the entrance to the HCR (directly outside the lift) reads 'Health Conciliation Registry' beneath the HCCC logo.

What contact, if any, does the Registry have with similar conciliation agencies in other jurisdictions?

- With the exception of the ACT, an equivalent of the HCR does not exist in any other Australian jurisdiction.
- However underpinning the Registry's conciliation role is its work to maintain and build upon the quality and diversity of its conciliation practice according to benchmarks reported by other complaint handling agencies that have a conciliation function.
- Although the Registry does not have formal contact with similar agencies, the NADRAC definition of 'statutory conciliation' adopted by many conciliation agencies provides an appropriate broad description of the conciliation work by the Registry and the conciliators as they both have an active role to assist parties to resolve the complaint on terms that accord with the requirements of the Act.
- There would be some mutual benefit to having formal contact with agencies having a statutory conciliation function both at the local or national level. This could be facilitated by attendance at annual conferences such as the National Mediators Conference or those organised by the NSW based LEADR (association of dispute resolvers).

Are there currently any provisions within the Registry to enable referrals between the Registry and professional associations? If not, do you feel that there would be merit in establishing these links, given that professional associations are currently handling complaints against member health practitioners?

- Ms Lines believes that the particular role of the Registry provided for in the legislation precludes referrals as described. Although the existing legislation does not permit professional associations to refer complaints directly to the Registry, the Boards often write to the HCCC requesting conciliation when they have reached the end of an investigation. As it is the Commission's role to assess complaints, currently requests by a particular Board or professional organization for referral to conciliation have to be formally assessed prior to referral to the Registry.
- The Registrar is beginning to visit the health practitioner registration boards to build on existing relationships established through the Registry's provision of 6 monthly reports to the professional registration bodies pursuant to s55.

APPENDIX FOUR- EXAMPLE LETTER (INVITATION TO PARTICIPATE IN CONCILIATION)

Example- Complainant letter

Our ref:

Dear *[complainant name]*

Your complaint regarding *[name of provider]*

I am writing to you about your complaint to the Health Care Complaints Commission (the Commission) regarding

The Commission has considered the information you provided in your complaint, as well as information provided by provider in response to your complaint. (The Commission has also sought advice about the matter from one of the Commission's Internal Medical Advisors, who has reviewed your letter and the medical records, as well the responses provided by provider) After consideration of all of this information, the Commission has decided that the most appropriate means of resolution is by referring the matter for conciliation by the Health Conciliation Registry. The reasons for this decision are:

1) The complaint does not disclose evidence that would be likely to support disciplinary proceedings against a health practitioner;
2) This means that the Commission has decided not to investigate the complaint.

However, your complaint indicates that you have outstanding concerns and questions about provider that may benefit from discussion. Conciliation will provide you with the opportunity to discuss the matter directly with provider/representative/s of provider, with the assistance of a professional conciliator, with a view to resolving the matter.

Conciliation is voluntary and all parties must consent to conciliation before it can proceed. Conciliation provides an opportunity for the parties to discuss the complaint and agree on ways in which it might be resolved. The conciliation is led by a conciliator who is independent of the Commission and the parties. The conciliator assists the parties to reach a resolution and does not have any power to make decisions about how a complaint should be resolved. The conciliator's role is to help the parties clarify the issues of concern, talk with each other about them and identify ways the concerns can be resolved.

Complaints can be resolved in many different ways, and almost any form of resolution is possible as long as the parties agree to it. The ways in which complaints can be resolved include providing better information about what happened and why, health service providers making changes to their policies and procedures or making an apology for poor or inappropriate treatment, or refunding costs and other expenses.

The conciliation process is confidential. The Health Care Complaints Act 1993 provides that things said or documents created for or during the conciliation process are not admissible in a court or tribunal. The only exception to this is if all of the parties who attended the conciliation or who were named during the conciliation consent to their use in court or in a tribunal. This provides an opportunity for the parties to discuss the matters of concern without fearing that what they say will be used against them.

If the parties reach an agreement in conciliation, this will be put in writing and signed. Agreements are made in "good faith" for the parties to follow through and are not enforceable by the Registry or the Commission. If a resolution involves a financial element, the Registry recommends that parties formalise this on the basis of a Deed of Release rather than the less formal conciliation agreement. If a Deed of Release is required, then the parties will be given an opportunity to request the conciliation proceedings be adjourned for a few weeks in order to obtain legal advice.

I have enclosed a consent form for your consideration. You will see that the consent form contains additional information about conciliation and there is a section for you to complete and send back to the Registry in the reply paid envelope. If you prefer, you may telephone the Registry on (02) 9219 7474 (direct line) or 1800 043 159 (local call cost) and let me know whether you wish to proceed with conciliation. If you do so, I can advise you about what to expect and offer to help you to prepare for the meeting. The Registry will also schedule a date, time and venue for the conciliation that suits the parties.

Where the parties are located in the Greater Sydney area conciliations are usually held at the Health Conciliation Registry, level 12, 323 Castlereagh Street, Sydney (close to Central Station). Where the parties are located in rural or remote areas the Registry will make every effort to arrange the conciliation in the local area. Both parties need to agree to this. In a very few cases, a telephone conference may be an option.

If you or provider do not consent to conciliation, the conciliation cannot proceed. You are entitled to seek a review of the Commission's decision if you are not satisfied with the Commission's assessment decision. To have the Commission's decision reviewed please make a request in writing direct to the Commission within 28 days of the date of this letter.

If you require any additional information or would like to discuss your complaint with me, please call (02) 9219 7474.

Yours sincerely

Julia Lines

Registrar
Health Conciliation Registry

CONSENT FORM

Consent

I, *[name of complainant]* consent to conciliation of complaint number *[insert complaint number]* against provider *[provider name]*

Signed: _____

Name: _____

Date: _____

_ _

No Consent

I, *[name of complainant]* do not consent to conciliation of complaint number *[insert complaint number]* against provider *[provider name]*

Signed: _____

Name: _____

Date: _____

Please return this form within 21 days to:

The Registrar
Health Conciliation Registry
LMB 18 Strawberry Hills NSW 2012

or telephone 9219 7474 to let the Registry know your decision.

Example- Provider letter

Dear *[provider name]*

[Insert complaint from complainant]

I am writing to you about the above complaint and to your letter to the Commission in response of date. The Commission has considered the information complainant provided in his/her complaint, as well as information you provided in response to the complaint. The Commission has also sought advice about the matter from one of the Commission's Internal Medical Advisors, who has reviewed the information on the file, including complainant's medical records. After consideration of all of this information, the Commission has decided that the most appropriate means of resolution is referral of the matter for conciliation by the Health Conciliation Registry. The reasons for this decision are:

1) The complaint does not disclose evidence that would be likely to support disciplinary proceedings against a health practitioner;
2) This means that the Commission has decided not to investigate the complaint.

[Complainant's name] complaint indicates that he/she has outstanding concerns and questions about his/her experience, which may benefit from discussion. Conciliation will provide the parties with the opportunity to discuss the matter directly, with the assistance of a professional conciliator, with a view to resolving the matter.

Conciliation provides an opportunity for the parties to discuss the complaint and agree on ways to resolve the concerns. The conciliation is led by a conciliator who is independent of the Commission and the parties. The conciliator's role is to help the parties clarify the issues of concern, talk with each other and identify ways the concerns can be resolved.

Conciliation is voluntary and all parties must consent to conciliation before it can proceed. The conciliator assists the parties to reach a resolution and does not have any power to make decisions about how a complaint should be resolved.

For many complainants, conciliation may be the first opportunity they have had to speak directly to the people who were involved in their care or the care for the person on whose behalf they have complained. Conciliation provides an environment where a provider can talk with a complainant in a controlled and impartial setting about the experiences that have distressed or concerned them, and try to provide the information and explanations that may assist them to better understand their experiences. Even if a complainant has spoken with a provider previously and their concerns have not been resolved, the presence of an impartial conciliator can assist the parties to communicate more clearly with each other about their concerns and the resolution they are seeking.

Resolution of a complaint can involve many things, and almost anything is possible as long as the parties agree. Apart from practical solutions, complainants generally express that they want to have their feelings and their concerns acknowledged and understood.

The practical ways in which most complaints are resolved include things such as a provider giving better information about a situation, changes in policy, apologies, or refunds of expenses. If a complainant feels that they have incurred expenses as a result of the treatment they received, or they want to make some other claim for financial compensation, the Registry will generally notify the provider of this prior to the conciliation.

This will enable the provider to obtain advice from their insurer about whether they should enter into any discussions about refunds or other compensation. Although parties at

conciliation cannot be legally represented in conciliation, they are able to consult with their insurers or employers via telephone during breaks from the conciliation with a view to trying to resolve a matter.

The conciliation process is confidential. The Health Care Complaints Act 1993 provides that things said or documents created for or during the conciliation process are not admissible in a court or tribunal. The only exception to this is if all of the parties who attended the conciliation or who were named during the conciliation consent to their use in court or in a tribunal. This provides an opportunity for the parties to discuss the matters of concern without fearing that what they say will be used against them. Many providers find that conciliation provides them with the most secure opportunity to openly explain to complainants about the treatment provided and their views about whether that treatment fell below an acceptable standard. It also provides a forum where discussions can occur about financial remedies without these discussions being used subsequently as admissions of liability.

If the parties reach an agreement in conciliation, this will be put in writing and signed. Agreements are made in "good faith" for the parties to follow through and are not enforceable by the Registry or the Commission. If a resolution involves a financial element, the Registry recommends that parties formalise this on the basis of a Deed of Release rather than the less formal conciliation agreement. If a Deed of Release is required, then the parties will be given an opportunity to request the conciliation proceedings be adjourned for a few weeks in order to obtain legal advice.

I have enclosed a consent form for your consideration. You will see that the consent form contains additional information about conciliation and there is a section for you to complete and send back to the Registry. If you prefer, you may telephone the Registry on (02) 9219 7474 and let me know whether you want to proceed with conciliation. If you do wish to go ahead, the Registry can advise you about what to expect and offer to help you to prepare for the meeting. The Registry will also schedule a date, time and venue for the conciliation that suits the parties.

Where the parties are located in the Greater Sydney area conciliations are usually held at the Health Conciliation Registry, level 12, 323 Castlereagh Street, Sydney (close to Central Station). Where the parties are located in rural or remote areas the Registry will make every effort to arrange the conciliation in the local area. Both parties need to agree to this. In a very few cases, a telephone conference may be an option.

If either you or complainant do not consent to conciliation, the conciliation of the complaint cannot proceed. If complainant is not satisfied with the Commission's assessment decision he/she can request a review of that decision.

If you require any additional information or would like to discuss the complaint with me, please call (02) 9219 7474 (direct line).

Yours sincerely

Julia Lines
Registrar
Health Conciliation Registry

CONSENT FORM

Consent

I, provider name, consent to conciliate complaint number *[insert complaint number]* by complainant *{insert complainant name]*

Signed: _____

Name: _____

Date: _____

_ _

No Consent

I, provider name, do not consent to conciliate complaint number *[insert complaint number]* by complainant *[insert complainant name]*

Signed: _____

Name: _____

Date: _____

Please return this form to:

The Registrar
Health Conciliation Registry
LMB 18 Strawberry Hills NSW 2012

or telephone 9219 7474 to let the Registry know your decision.

APPENDIX FIVE- MINUTES

Minutes of Proceedings No. 31
10:00am, Wednesday 8 March 2006
Waratah Room, Parliament House

1. Members Present
Mr Jeff Hunter MP (Chairman), The Hon David Clarke MLC, Ms Tanya Gadiel MP, The Hon Christine Robertson MLC, Mr Allan Shearan MP, Mr Russell Turner MP and The Hon Dr Peter Wong MLC

2. In Attendance
Ms Catherine Watson, Committee Manager
Ms Samantha Ngui, Senior Committee Officer
Ms Belinda Groves, Committee Officer
Mr Kieran Pehm, Commissioner, Health Care Complaints Commission
Ms Karen Mobbs, Director of Proceedings, Health Care Complaints Commission

3. Apologies
Nil.

The Chairman opened the public hearing at 10:00am

RE: REVIEW OF THE 2004/2005 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

PUBLIC HEARING
The Committee heard evidence from:

Mr Kieran Pehm, Commissioner, Health Care Complaints Commission, sworn and examined.

Ms Karen Mobbs, Director of Proceedings, Health Care Complaints Commission, affirmed and examined.

Evidence concluded, witnesses withdrew.

Hearing closed at 11:15am

Minutes of Proceedings No. 35
Wednesday 7 June 2006
10:15am, Room 1108, Parliament House

Members Present
Mr Jeff Hunter MP (Chair), Ms Tanya Gadiel MP, Mr Allan Shearan MP,
Mr Russell Turner MP, and The Hon. Dr Peter Wong MLC

In Attendance
Ms Catherine Watson (Committee Manager),
Ms Samantha Ngui (Sr Committee Officer),
Ms Belinda Groves (Committee Officer)

Apologies
The Hon David Clarke MLC and The Hon Ms Christine Robertson MLC

Report on the 2004-2005 Annual Report of the Health Care Complaints Commission

On the motion of Ms Gadiel, seconded by Mr Turner:

> That the draft report: "11th Meeting on the Annual Report of the Health Care Complaints Commission" be accepted as a report of the Committee on the Health Care Complaints Commission, and that it be signed by the Chairman and presented to the House.

Passed unanimously.

On the motion of Mr Shearan, seconded by Ms Gadiel:

> That the Chairman and Committee Manager be permitted to correct any stylistic, typographical and grammatical errors in the report.

Passed unanimously.