PARLIAMENT OF NEW SOUTH WALES

Committee on the Health Care Complaints Commission

REPORT 1/55 – MAY 2012

REVIEW OF THE 2009-2010 AND 2010-2011 ANNUAL REPORTS OF THE HEALTH CARE COMPLAINTS COMMISSION

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The motto of the coat of arms for the state of New South Wales is "Orta recens quam pura nites". It is written in Latin and means "newly risen, how brightly you shine".

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Terms of Reference

The Committee on the Health Care Complaints Commission is a current joint statutory committee, first established 13 May 1994, re-established 22 June 2011.

The Committee monitors and reviews the Commission's functions, annual reports and other reports it makes to Parliament. The Committee is not authorised to re-investigate a particular complaint; or to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

The terms of reference for the Committee are set out under section 64-74 of the *Health Care Complaints Act 1993*.

The functions of the Committee are as follows:

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

> (a) to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act,
>
> (a1) without limiting paragraph (a), to monitor and review the exercise of functions by the Health Conciliation Registry,
>
> (b) to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed,
>
> (c) to examine each annual and other report made by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report,
>
> (d) to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Commission,
>
> (e) to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

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

> (a) to re-investigate a particular complaint, or
>
> (b) to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint, or

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

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

Chair's Foreword

I am pleased to present the Committee's Review of the Health Care Complaints Commission's Annual Reports 2009 – 2010 and 2010 – 2011 pursuant to the Committee's responsibilities under section 65 of the *Heath Care Complaints Act 1993* to examine all reports of the Commission. This is the Committee's first review in the 55th Parliament, and its first since the Committee was reconstituted on 22 June 2011.

This is also the Committee's first report since the National Registration Scheme took effect. This was a major policy and legislative initiative that commenced operation on 1 July 2010 and provides for a nationwide scheme of accreditation for medical practitioners and some allied health professionals. The nationwide reform required implementation of three separate tranches of legislation and regulation, and the Committee is pleased to note the smooth rollout of the regime.

Further amendments to the *Health Care Complaints Act 1993* have also been effected to equip the Commission with additional powers for use during an investigation. These amendments were borne out of shortcomings identified by the Commission during one of its investigations. No other major reforms that relate to the operation of health care complaints have taken place in the past two years.

Aside from legislative changes, there have been some new policy developments in the health care oversight landscape. These include a reorganisation of the former Area Health Services, to the establishment of the Local Health Districts, expanding the previous eight to 15 different districts, plus two additional speciality networks.

With respect to the Commission's complaint handling function, the Committee notes the increase in workload, both in volume of complaints received as well as the types of practitioners that complaints are made against, together with a slight downward trend in staff numbers. A composite of factors may be responsible for this increase, including new policies that may bring more practitioners into the health care complaints remit, and changes in the assessment process, in particular, ways in which the Commission identify certain respondents.

Understandably, the increase in complaints corresponds with an increase in workload, and in response, the Commission has made changes to its assessment process to facilitate speedier complaint management and ensure backlogs do not develop. These changes may affect the internal complaint-handling practices of the Commission, but it is not expected that it will have any material impact on the outcomes of complaints.

With respect to community outreach, the Committee recognises the considerable efforts placed in promoting the work of the Commission and making its services more accessible to a diverse public. This includes publishing material that explains the function of the Commission, and collaborating with stakeholders to help distribute the material published. The Committee also notes the Commission's efforts in ensuring access to the Commission's services for people from a non-English speaking background.

The report reflects on the past two years of annual reports provided by the Commission, together with responses received to questions on notice and transcripts of evidence from a hearing with the Commissioner held at Parliament House on 20 February 2012.

Finally, I would like to thank the Commissioner and his staff for providing information in a timely way, my fellow Committee Members for their ongoing interest, and the Committee staff for their assistance in the preparation of this report.

Leslie Williams MP
Chair

Chapter One – Introduction

1.1 The functions of the Committee on the Health Care Complaints Commission ('the Committee') include examining each annual and other report of the Commission and reporting to both Houses of Parliament on any matter appearing in, or arising out of, such reports.

1.2 The Committee is considering the 2009-10 and 2010-11 Annual Reports together because the Committee of the 54th Parliament did not have time to consider the 2009-10 report before the expiration of the Parliament prior to the 2011 election.

1.3 As part of the review process, the Committee held a public hearing at Parliament House on 20 February 2012, with the Commissioner, Mr Kieran Pehm as well as senior members of the HCCC executive: Mr Tony Kofkin, Director of Investigations; and Ms Karen Mobbs, Director of Proceedings, attending from the Commission.

1.4 Prior to the hearing, the Committee provided the Commission with a series of questions on notice on matters arising out of the Annual Reports. The Questions on Notice and the public hearing focussed on a range of issues, including changes to the assessment process; financial performance; the national registration scheme and its impact on the work of the Commission; the establishment of new Local Health Districts to replace the previous Area Health Services, and how the Commission is collaborating with these new entities as part of the complaints handling process; and the Commission's community outreach activities and how it engages with and educates the general public about the role and function of the Commission.

1.5 During the public hearing the Commissioner also agreed to provide responses to additional questions that were taken on notice, which were subsequently provided to the Committee.

1.6 The answers to questions on notice, together with the transcript of evidence from the public hearing, are reproduced as appendices to this report.

1.7 This report is comprised of six chapters. Chapter One addresses complaints handling and changes to the assessment process; Chapter Two outlines recent legislative and policy changes; and Chapter Three outlines the Commission's corporate and community outreach services.

1.8 The final chapters append information obtained from the Commissioner and his office after questions directly put by the Committee. Chapters Four and Six respectively detail the responses to questions on notice both prior to and subsequent to the public hearing. Chapter Five is the formal transcript of proceedings from the public hearing on 20 February 2012.

Chapter Two – Complaint Handling

COMPLAINT TRENDS

2.1 The Commission is the main authority that receives complaints about both individual health practitioners and health organisations. Complaints about individual practitioners can be about both registered practitioners, such as doctors, nurses and dentists, or unregistered practitioners, such as naturopaths and massage therapists.

2.2 Complaints can often touch on any one, or many, of a broad range of issues. In assessing complaints, the Commission uses a 12 tiered classification system that categorises complaints according to the specific issues the complaint raises, including communication issues, access to treatment, fees and costs, medication, treatment and professional conduct.[1]

2.3 Both the 2009-10 and 2010-11 Annual Reports note an increase in the number of enquiries and complaints received by the Commission.

Number of enquiries and complaints received

	2009-10[2]	**2010-11**[3]
Number of enquiries received	10,118	10,919
Number of complaints received	3,515	4,104

2.4 During the past five years, the Commission has seen a 40 per cent increase in the number of enquiries and a 50 per cent increase in the number of written complaints. At the same time, this increased workload has been managed with decreased staffing levels.[4]

2.5 Complaints that relate to a practitioner's treatment of a patient constitute almost half of all complaints received.[5] This includes a practitioner's alleged wrong or inadequate diagnosis or treatment of a patient, unexpected complications and delay in treatment. This is followed by issues that relate to communication impediments between practitioner and patient, including poor attitude or manner, inadequate information being provided, or incorrect or misleading information provided.

2.6 The Committee notes the Commissioner's views in relation to the apparent lack of communication, or miscommunication, between health care professionals and patients as a reason for many complaints. As noted by the Commissioner:

[1] Health Care Complaints Commission, Annual Report 2009-10, p. 10.
[2] Ibid, p. 6.
[3] Ibid, p. 6.
[4] Ibid, p. 5.
[5] Ibid, p. 11.

> Patients often cannot find a single point of reference in the health system to explain to them what is happening. It is partly a result of the fragmentation of care and the level of specialisation now.[6]

2.7 Problems arising from a lack of communication can be compounded in situations where a patient may have a number of chronic conditions (or co morbidities) such as hypertension and diabetes, and the patient may be receiving treatment by a number of different health professionals. This could result in a lack of integrated care and communication with the patient and their family.[7]

2.8 Complaints relating to the professional conduct of the health service provider are the third most common cause of complaint, and this can potentially relate to a practitioner's impairment, competence, illegal practice or professional misconduct.[8]

2.9 The three most commonly complained about health practitioners are general practitioners, dental practitioners, and nurses or midwives. [9]

2.10 According to the 2010-11 Annual Report, there was a small increase from 2009-10 in the number of complaints received regarding medical practitioners at 1,337 in 2010-11, up from 1,263 in 2009-10. However, as a proportion of all complaints, medical practitioners have decreased over the past five years from 66.5 per cent of all complaints in 2006-07 to 52 per cent in 2010-11.[10]

2.11 There were notable increases in complaints received against both dental practitioners and pharmacists. These increases respectively reflect new Commonwealth dental health policies and changes in the way the Commission handles complaints received against pharmacists.[11]

2.12 With respect to dental practitioners, there was a 33.2 per cent increase in complaints received by the Commission when compared to complaints received in 2009-10. The Commission attributes this significant variance to the increased number of patients being treated under the Chronic Disease Dental Scheme.[12] This scheme was introduced in 2008 to treat people with chronic dental health issues.[13]

2.13 Meanwhile, there were 100 complaints received against pharmacists in 2010-11, compared to 22 the previous year. This substantial increase reflects changes in the way the Commission identifies complaints, now identifying specific pharmacists rather than just pharmacies.[14] The Commission advised that it believes this is a more effective and realistic way to assess complaints related to

[6]Transcript of Evidence, 20 February 2012, p. 6.
[7]Ibid.
[8]Health Care Complaints Commission, Annual Report 2010-11, pp. 11-12.
[9]Ibid, p. 13.
[10]Ibid.
[11]Ibid.
[12] The 'Chronic Disease Dental Scheme' is referred to as the 'Medicare Dental Scheme' throughout the Commissioner's Annual Reports and in responses to Questions on Notice.
[13]Ibid.
[14]Ibid.

the dispensing of medication as, previously, when only the pharmacy itself was identified, dispensing errors were not properly picked up when the at-fault pharmacists transferred to a different pharmacy.[15]

2.14 There was no significant increase in 2010-11 in the number of complaints against nurses and midwives, with 227 complaints compared to 221 in 2009-10.[16]

2.15 While acknowledging the increased number of complaints 2010-11, it should also be noted that the number of complaints and enquiries received by the Commission remains relatively small in comparison to the almost two million attendances at public hospital emergency departments and more than 35 million recorded attendances with general practitioners.[17]

2.16 The Committee also notes that there has been an increase in the number of complaints regarding mental health, particularly in regard to treatment issues. In 2009-10 there were 115 complaints regarding treatment out of a total of 363 mental health related complaints,[18] and in 2010-11 there were 203 treatment complaints out of a total of 450 complaints.[19]

2.17 As noted by the Commissioner:

> Mental Health is an area that stands out when you read all the complaints. They are the most heart-rending complaints because the consequences can be terrible.[20]

2.18 Further, rural and regional mental health patients often experience particular disadvantage due to distance and a lack of locally available mental health resources. Assessments in regional and rural areas are often provided via a tele-consult as these areas lack on-site psychiatrists or specialist mental health nurses.[21]

CHANGES TO ASSESSMENT PROCESSES

2.19 In the 2010-11 Annual Report, the Committee noted that the Commission has had to change its practices in assessing complaints as a result of the increased number of complaints and the increased pressure on its resources. As such, the Commission now assesses more complaints based solely on the information provided in the complaint, and no longer contacts the complainant to discuss the issues raised.[22] In addition, the Commission does not seek a response from the health care provider in circumstances where it appears that the complaint is likely to be discontinued, nor does it call complainants to discuss and explain the outcome, opting instead for written advice only.[23]

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[15] Transcript of Evidence, 20 February 2012, p. 11.
[16] Ibid.
[17] Ibid, p. 10.
[18] Health Care Complaints Commission, Annual Report 2009-10, p. 25.
[19] Health Care Complaints Commission, Annual Report 2010-11, p. 17.
[20] Transcript of Evidence, op. cit., p. 23.
[21] Ibid.
[22] Health Care Complaints Commission, Annual Report 2010-11, p. 24.
[23] Ibid, pp. 4 and 24.

2.20 The Committee notes the Commission's advice that each 'complaint is still read and considered and judged on its merits'.[24] The Commission advises that this process is limited to the complaints that relate to fees, waiting times and practitioner attitude unrelated to clinical outcomes, and is not a process employed universally. Generally, with these less serious complaints, the Commission would not normally be required to take action. In this respect, the Commission assured the Committee that it is not overlooking issues of public safety or compromising effective oversight of health practitioner practices.[25] Despite expectations that this change would result in an increase in requests for a review of assessment decisions, this has not eventuated.

Committee Comment

2.21 The Committee notes that changes to the assessment of complaints, even those of a less serious nature, may potentially undermine the Commission's provision of a high level of customer service to complainants and the maintenance of public confidence in the work of the Commission. The Committee is currently undertaking an Inquiry into health care complaints and complaint-handling in NSW and these issues, amongst others, may be more closely addressed through this Inquiry.

2.22 The Committee notes the Commissioner's advice that:

> The Commission has been moved from the Treasury portfolio to the Health portfolio for budgetary purposes and so far the discussions are very encouraging that the Commission will receive a significant increase in budget next financial year, which I am certainly hoping will be the case.[26]

2.23 The Committee welcomes the possibility of the Commission receiving increased resources and encourages the Ministry to ensure the Commission receives additional funding as required.

2.24 The Committee supports the provision of appropriate budgetary increases and resources to ensure the Commission is sufficiently equipped in handling the increasing level of complaints it assesses and handles.

2.25 The Committee also encourages the Commission to continue its work, particularly as part of the Health Literacy Network,[27] in educating health professionals and their councils and associations about the types of issues raised by complainants, and how such issues can be addressed and prevented from arising in the first instance. [28]

[24] Transcript of Evidence, op, cit., p. 3.

[25] Ibid, pp. 2-3.

[26] Ibid, p.5.

[27] The Health Literacy Network is a long-term collaborative project with the Clinical Excellence Commission, the Australian Commission on Quality and Safety in Health Care, and the University of Sydney's School of Public Health, looking at how patients' health literacy can be improved

[28] Response to Questions on Notice before the Public Hearing, no. 16.

Chapter Three – Legislative and Policy Changes

3.1 In 2009-2010, legislation was passed to give effect to the national registration scheme, which commenced operation on 1 July 2010. The legislation that set up this framework, together with ancillary legislation that made slight but important amendments to the *Health Care Complaints Act 1993*, was the only significant legislative change in the past two years.

NATIONAL REGISTRATION SCHEME

3.2 On 1 July 2010, the *Health Practitioner Regulation National Law (NSW)* ('the National Law') came into effect. This new system is designed to create a single registration and accreditation scheme for ten health professions. Previously, health practitioners had to register in each jurisdiction in which they wished to practise. Now, these practitioners can register just once in any one jurisdiction and are recognised to practise anywhere in Australia.[29]

3.3 There are national registration boards for the ten health professions covered by the national registration scheme. The professions covered by the scheme include: medical practitioners; nurses and midwives; dentists; chiropractors; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists and psychologists. Dental technicians and optical dispensers, who were previously registered practitioners in NSW, are not part of the national registration scheme. As a result, these professions will now default to the unregistered health practitioners code of conduct, due to be operative from 1 July 2012.

3.4 The ten national boards are supported by the Australian Health Practitioner Regulation Agency ('AHPRA'). The role of this agency is to support the national boards in protecting public health and safety; managing the health registration process for health practitioners and students Australia-wide; and managing investigations into professional conduct and performance issues of registered health professionals, although this final function is not applicable in NSW.[30]

3.5 Apart from the ten identified boards, there will be four additional boards joining from 1 July 2012. They are: the Chinese Medicine Board; Medical Radiation Board; Occupational Therapy Board; and the Aboriginal and Torres Strait Islander Health Practice Board. The Committee welcomes the Commission's work with organisations such as the Australian Traditional Chinese Medicine Association to make them aware of the role of the Commission and to work with them in handling complaints.[31]

3.6 In 2009, the NSW Parliament passed the *Health Practitioner Regulation (Adoption of National Law) Act 2009* which established the principal architecture for the

[29] Health Care Complaints Commission, Annual Report 2009-10, p. 8.
[30] Ibid, p.8.
[31] Transcript of Evidence, op. cit., p. 7.

operation of this scheme. This legislation was then followed by the *Health Practitioner Regulation Amendment Act 2010* which amended a variety of health-related legislative instruments to compliment the national scheme, as well as maintaining existing complaint handling arrangements in NSW. As a result, NSW and the Commonwealth now work in tandem in a co-regulatory environment.[32]

3.7 In all jurisdictions except NSW, the relevant national health profession board is responsible for handling complaints made against practitioners in that field. In NSW, however, the Commission is responsible for complaints against all registered practitioners, regardless of specific profession.

3.8 As a result of the co-regulatory environment in NSW, councils have been established to liaise with the Commission about complaints made to a national board. These councils have replaced the former registration boards. The Commission is to be notified of those complaints made to a national board. Similarly, the Commission is required to notify the council about complaints it receives and it consults with the council about appropriate ways of handling complaints.[33]

3.9 With respect to implementation, the Commissioner advised that, apart from some 'early teething problems' involving 'notifications' from the AHPRA, there are no issues of ongoing concern.[34]

3.10 The Committee was also advised that the new registration scheme has not impacted on the Commission's workload. Through regular and constructive meetings, the Commission has established a good working relationship with AHPRA and the Health Professional Councils Authority.[35]

Committee Comment

3.11 The Committee is pleased that the transition across to the National Registration Scheme has not disrupted the operation of the Commission, or adversely affected the complaints-handling regime more generally. The Committee encourages the Commission to liaise to the Committee any systemic issues should they arise, which may warrant further parliamentary review or legislative reform.

MANDATORY REPORTING

3.12 Although health practitioners in NSW have had obligations to report certain types of notifiable conduct to the NSW Medical Board since 2008, a key feature of the national registration scheme includes an expansion of the types of conduct that are to be reported. The complete list now includes where a practitioner has:

- Practised while intoxicated by drugs or alcohol;
- Engaged in sexual misconduct;

[32] Health Care Complaints Commission, Annual Report 2009-10, p. 8.
[33] Ibid. p.8.
[34] Response to Questions on Notice before the Public Hearing, no. 3.
[35] Ibid.

- Placed the public at risk of substantial harm; or
- Placed the public at risk of harm because they have practised in a way that constitutes a deviation from accepted professional standards.[36]

3.13 Practitioners are protected from civil and criminal liability for any defamation claims arising out of reports they made about a practitioner in good faith.

3.14 Although failure to report does not constitute a criminal offence, the Commission notes that such inaction could form the basis of a complaint against a practitioner.[37] There are some exemptions from mandatory reporting, including where a practitioner knows or reasonably believes that notifiable conduct had already been reported, or in cases where a practitioner also works in another professional capacity for a health practitioner potentially subject to a complaint and it would make it untenable for that practitioner to bring notice about the conduct. [38] For example, an insurer that provides professional indemnity insurance or a legal practitioner also engaged in providing legal services to a health practitioner engaged in potentially notifiable conduct would both be exempt from bringing notice of suspect conduct.

OTHER LEGISLATIVE CHANGES

3.15 In 2009, the Commission investigated a complaint that a dental technician had been carrying out dentistry despite not being qualified or registered to do so. Throughout the course of the investigation, the Commission identified a number of shortcomings with respect to its own investigatory powers. These issues related to the Commission's limited ability to seize documents, its inability to seize drugs, and lack of power to issue an interim prohibition on an unregistered health practitioner from providing health services while an investigation was on foot. On this last issue, the Commission advised that the dental technician was still able to provide health services throughout the period of the investigation despite this posing a serious risk to public health and safety.[39]

3.16 Prompted by these concerns, the NSW Parliament passed the *Health Practitioner Regulation Amendment Act* in 2010 to rectify the identified shortcomings. These new powers enable the Commission to seize documents subject to them being returned 'as soon as practicable', seize drugs indefinitely, and issue interim prohibition orders for up to eight weeks on a health practitioner who the Commission reasonably believes to be in breach of the code of conduct for unregistered health practitioners, and where it considers the practitioner to pose a serious risk to public health and safety.[40]

Committee Comment

[36] Ibid, pp.8-9.
[37] Health Care Complaints Commission, Annual Report 2009-10, p. 9.
[38] Ibid, p.9.
[39] Health Care Complaints Commission, Annual Report 2009-10, p. 10.
[40] Ibid, p. 10

3.17 The Committee is pleased that amendments were made to the *Health Practitioner Regulation Amendment Act 2010* to give the Commissioner greater investigatory and suspension powers. The Committee welcomes advice by the Commissioner of any further legislative changes required to ensure the Commissioner has sufficient and appropriate powers.

UNREGISTERED HEALTH PRACTITIONERS

3.18 The *Public Health Act 2010* provides for regulations to be made to cover unregistered health practitioners and it is flagged that new code of conduct regulations will commence in 2012. These new regulations will give the Commission the ability to investigate unregistered health practitioners, and enable it to make appropriate orders to ensure public health and safety. The Committee notes that the Commission was part of the consultation process instigated by the Ministry of Health in preparation for the draft regulation.[41]

3.19 The Committee also notes the Commission's advice that, following the introduction of the new code of conduct, it anticipates the number of complaints regarding unregistered health practitioners to increase.[42]

ESTABLISHMENT OF NEW LOCAL HEALTH DISTRICTS

3.20 As a result of NSW Health reforms, 2011 there was a reorganisation of the eight former Area Health Services, replaced by 15 new Local Health Districts and two speciality networks.

3.21 Each Health District is responsible for improving local patient outcomes, ensuring equitable access to healthcare, oversighting health care facilities in the district, and responding to specific needs of the local community.

3.22 The Commission has sought to establish working relationships with each of the Local Health Districts, particularly with complaints handling staff.[43] Over the past few years, the Commission has referred an increased number of complaints for local resolution and the Commission is hopeful that the recent restructure will allow this trend to continue.[44]

3.23 As part of establishing a strong working relationship with each of the new Local Health Districts, the Commission organised a training day for Local Health District staff on 5 March 2012. The training not only allowed the Commission to establish a working relationship with the complaints handling staff of each Local Health District, it also provided Local Health District staff with an understanding of the Commission's complaints handling processes, regulatory requirements, and an opportunity to exchange ideas about best practice.[45]

[41] Response to Questions on Notice, op. cit., no. 26.

[42] Health Care Complaints Commission, Annual Report 2010-11, p. 38.

[43] Response to Questions on Notice, op. cit., no. 5.

[44] Transcript of Evidence, op. cit., p. 4.

[45] Response to Questions on Notice, op. cit., no. 5.

3.24 The Commissioner advised that approximately 200 staff would attend the training, and that it was the Commission's intention to have further individual meetings with each Local Health District during the year.[46]

Committee Comment

3.25 The Committee commends the Commission's work developing a cooperative relationship with the Local Health Districts and its emphasis on resolving an increased number of complaints at the local level.

3.26 The Committee encourages the Commission to continue its work to have more complaints resolved at the local level. Resolving complaints at the local level can allow for complainants to have their concerns heard in a more informal setting and have complaints resolved within a shorter timeframe.

3.27 The Committee agrees that it is important for each of the Local Health Districts to have sufficient training and resources, and have a strong Clinical Governance Unit to ensure complaints are dealt with efficiently and in a manner that focuses on providing a high level of customer service to patients and their families.[47]

[46] Transcript of Evidence, op. cit., p. 4.
[47] Ibid.

Chapter Four – Corporate and Community Services

COMMUNITY OUTREACH AND MANAGING CLIENT EXPECTATIONS

4.1 The Committee was pleased to note that the Commission continues its community outreach activities and in 2009-10 undertook two new initiatives. This includes: the publication of brochures and posters available to all public health facilities that explain how the Commission works, and the collaboration with general practitioners' groups to have printed material available in general practices.[48]

4.2 The increased number of complaints received by the Commission can, in part, be attributed to the work of the Commission in raising its profile with the general public and raising awareness of the statutory avenues available to lodge a complaint about inadequate health service.

4.3 The Committee also welcomes the Commission's ongoing community outreach activities to all sections of the community, particularly to people from culturally and linguistically diverse backgrounds. This includes the Commission's work with the Federation of Ethnic Communities Council, and also with the Commonwealth to provide recent arrivals and refugee settlement programs with advice about the Commission's services.[49]

4.4 The Committee is pleased to note that the Commission increased its outreach to Aboriginal health workers and is now a regular component of the training program at the Aboriginal College at Little Bay, Sydney.

4.5 The Committee notes that in 2010-11 there were 54,929 recorded hits to the Commission's translated resources on its website, and the Commission predicts this will increase to 56,130 in 2011-12.[50] The Committee also notes that the Commission translates its information into the 20 most prevalent community languages, based on data provided by the Australian Bureau of Statistics.[51]

4.6 On the issue of managing client expectations, it is imperative that upon contacting the Commission, complainants are fully apprised of both the complaint handling processes, and the likely outcome of their complaint. The Commission often deals with emotional complainants and an appropriate management of complainants' expectations is important to ensure that complainants are not further aggrieved by the process.

4.7 As noted by the Commission, there are instances where complainants 'often do not feel resolution is a serious enough consequence'.[52] It is important that the

[48]Ibid, pp. 6-7.
[49]Ibid, p. 10.
[50]Response to Questions on Notice, op. cit., no. 13.
[51]Transcript of Evidence, op. cit., p. 10.
[52]Ibid, p. 13.

Commission has adequate resources and time to effectively address and manage complainants' expectations and sensitivities by making complainants aware that a full investigation or prosecution is not warranted for every complaint.

4.8 The Commission also has procedures in place to enable complainants who are unsatisfied with the Commission's assessment decision or the outcome of an investigation to have the Commission review its decision. In addition, the Commission sends satisfaction surveys on a regular basis to complainants and health service providers to gauge reaction to the Commission's services and handling of matters.

4.9 The Commission is subject to the provisions of the *Privacy and Personal Information Protection Act 1998* and *Health Records and Information and Privacy Act 2002* and it manages its obligations through the Commission's Privacy Management Plan. Further to the Commission's information and data records obligations, it is subject to requirements under the *Government Information (Public Access) Act* and, for 2009-2010, its predecessor legislation, the *Freedom of Information Act 1989.* However, the Commission is exempt from application for access to documents in relation to the Commission's complaint-handling functions.

ONLINE SERVICES

4.10 The numbers of visitors to the Commission's website has increased with 186,796 visitors and a total of 5,077,180 hits recorded in 20010-11, a 53.9 per cent increase from 2009-10.[53]

4.11 The Committee notes this significant increase and encourages the Commission to continue its work in upgrading and enhancing its online resources. The Committee also notes the Commissioner's comments that the Commission 'could probably get more sophisticated with the information we put on the website in the frequently asked questions section'.[54]

ROOT CAUSE ANALYSIS

4.12 The Committee notes the commencement of the *Health Legislation Amendment Act 2010* which amended provisions of the *Health Administration Act* and the *Private Health Facilities Act* dealing with the Root Cause Analysis (RCA) process.[55] Further, the Clinical Excellence Commission (CEC) is now working on reviewing Incident Management Policy Directive, PD 2007_061 in response to these changes.[56]

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[53]Health Care Complaints Commission, Annual Report 2010-11, p. 8.

[54]Transcript of Evidence, op. cit., p. 20.

[55]Health Care Complaints Commission, Annual Report 2009-10, pp. 11-12.

[56]Response to Questions on Notice, op. cit., no. 28.

4.13 The Committee also understands that the CEC is considering the development of a plain English guide for patients and their families. The guide will detail the RCA process and explain what the process can and cannot achieve.[57]

NEW INFORMATION COMMUNICATION TECHNOLOGY

4.14 The Committee notes the Commission's intent to upgrade its information communication technology to a virtualised platform using servers, removing the need for individual personal computers. While requiring additional capital expenditure initially, a move to a virtual platform will provide longer term savings for the Commission as there will be no need to replace computer hardware as regularly.[58]

CORPORATE GOVERNANCE

4.15 The Committee notes that the Commissioner, Mr Kieran Pehm, was appointed for a second five-year term on 28 June 2010.[59]

4.16 As at 30 June 2011, the Commission employed a total of 77 staff, 66 of whom were full-time and 11 part-time. The average full time equivalent staffing for 2010-2011 was 69.3, continuing a slight downward trend from staffing levels in the preceding years.[60]

4.17 In the 2010-2011 financial year, the Commission had a total budget of $10.50 million, a decrease on the $10.70 million of 2009-2010. Of the Commission's 2010-2011 budget, some $7.55 million was spent on employee-related expenses while in the previous year, expenditure totalled $7.48 million. In total, the Commission spends about 80% of its budget on such expenses. Conditions of employment together with salaries and allowances are provided for under the *Crown Employees (Public Sector – Salaries 2007)* and staff are appointed under the *Public Sector Employment and Management Act 2002.*[61]

4.18 The Commission noted it finished the year with a surplus of $27,000, whereas in 2009-2010, the Commission finished the financial year with a deficit of $61,000.

4.19 The Committee notes that, as with other independent statutory agencies, the Commission has a raft of corporate and human resource policies and practices in place to ensure an effective and appropriately organised office. This includes: staff development training; performance management procedures; an occupational health and safety plan; an equal employment and diversity program; the existence of a workplace consultative committee; and a disability action plan.[62]

[57] Ibid.

[58] Transcript of Evidence, op. cit., p.16.

[59] Health Care Complaints Commission, Annual Report 2010-11, p. 52.

[60] Ibid, at pp. 53-54.

[61] Ibid, at p. 5.

[62] Ibid, at pp. 55- 57.

4.20 The Committee also notes grievance procedures are provided for and, following a review by an independent external consultant, recommendations were made to improve the general management of employees.[63]

Committee Comment

4.21 The Committee appreciates the significant support work that is required for running the core functions of the Commission. The Committee supports the allocation of capital funding for ICT upgrades to ensure the Commission can better meet its operational requirements.

[63] Health Care Complaints Commission, Annual Report 2009-10, p. 60.

Chapter Five – Response to Questions on Notice

CHANGES TO ASSESSMENT PROCESS

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

Response:

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

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

FINANCIAL PERFORMANCE

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

Response:

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

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

NATIONAL REGISTRATION SCHEME

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

Response:

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

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

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

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

Response:

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

health complaints entity means an entity—

(a) that is established by or under an Act of a participating jurisdiction; and

(b) whose functions include conciliating, investigating and resolving complaints made against health service providers and investigating failures in the health system.

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

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

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

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

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

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

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

ESTABLISHMENT OF NEW LOCAL HEALTH DISTRICTS AND SPECIALITY NETWORKS

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

Response:

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

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

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

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

COMPLAINTS AGAINST HEALTH PRACTITIONERS

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

Response:

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

NOTIFIABLE CONDUCT

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

Response:

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

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

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

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

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

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

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

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

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

TREATMENT RELATED ISSUES

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

Response:

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

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

COMPLAINTS ABOUT PUBLIC HOSPITALS

9 How do you account for the 24.3% increase in complaints about public hospitals – noting that as a proportion of all complaints received, complaints about public hospitals has 'remained relatively constant over the past five years, at just under 50%.' Is this a sign of an increased awareness in the community about the role and function of the Commission or a sign of deterioration in the provision of health services by the public hospital system?

Response:

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

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

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

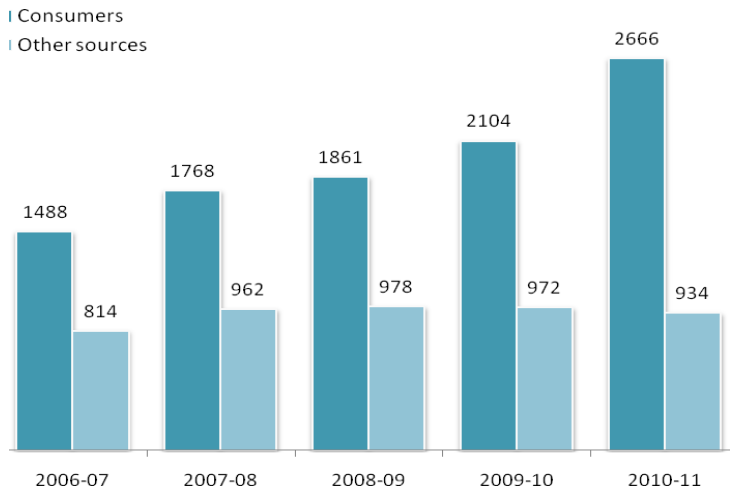
The Commission is not able to confirm if the increase in complaints about public hospitals is due to an increase in consumer awareness or a sign of deterioration. However, a number of indicators do show that there has been an increase in consumer awareness of the Commission. These were addressed in the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

Increase in the proportion of complaints received by consumers

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

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

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

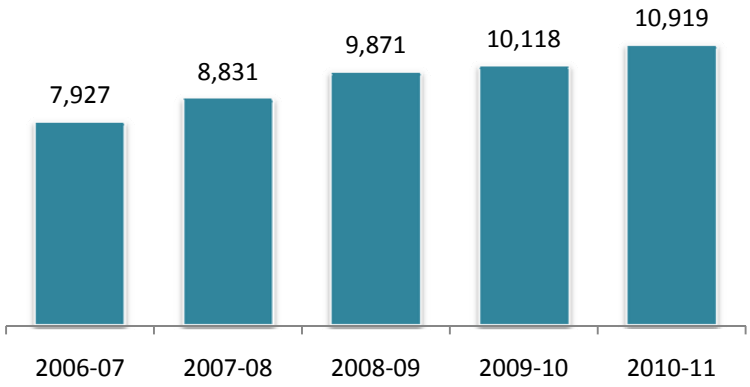


Increase in the number of inquiries to the Commission

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

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

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



Counted by inquiry

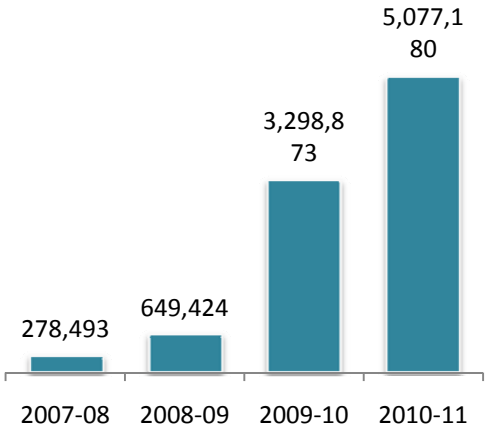
Increased traffic on the Commission's website

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

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

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

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



Counted by website hit

COMPLAINTS – METROPOLITAN VERSUS REGIONAL/RURAL

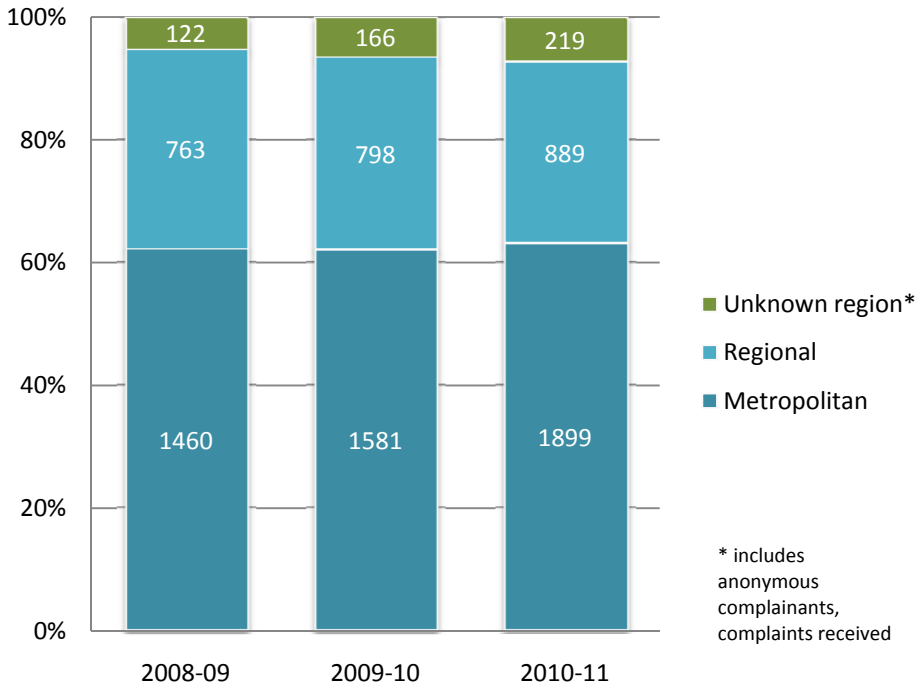
10 Is there any information available as to the number of complaints the Commission receives from metropolitan areas versus regional and rural areas?

Response:

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

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

Chart 2 – Consumer complaints received by region



Counted by complainant

COMPLAINTS REGARDING CORRECTIONAL FACILITIES AND MEDICAL CENTRES

Noting that 8.9 per cent of complaints are received about correction and detention facilities – Table 16.6, page 108 of the 2010/11 Annual Report – are these facilities over–represented in

the number of complaints handled by the Commission? Likewise, does the Commission have any concerns with the number of complaints regarding medical centres?

Response:

A. *Correctional facilities*

In 2005–06 the Commission reported a significant increase in the number of complaints received about correctional facilities. That year, 131 such complaints were received, which was a 156.9% increase on the 51 complaints received the previous year. At the same time, the Department of Corrective Services included the Commission in the list of agencies to which inmates are allowed to make free calls. This capacity to make free calls may account for the increase in complaints from inmates.

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

Table 11.1 – complaints received about correctional /detention facilities

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

B. *Medical centres*

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

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

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

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

COMPLAINTS – MEDICARE DENTAL SCHEME

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

Response:

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

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

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

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

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

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

COMPLAINTS FROM CLIENTS FROM MULTICULTURAL AND NON–ENGLISH SPEAKING BACKGROUNDS

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

Response:

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

It should be noted that the data is unreliable in reflecting how many complaints are from people with a CALD background, as some may prefer someone else to lodge the complaint on their behalf in English.

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

OUTREACH ACTIVITIES

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

Response:

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

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

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

Response:

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

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

Information on Commission services and how to use these services is translated and distributed to health care providers

The Commission uses the services of accredited interpreters onsite or by telephone as appropriate

Translated written and audio visual materials are available in priority community languages

The Commission's Consumer Consultative Committee (CCC) has a member with experience in culturally diverse matters

The staffing of the Commission reflects the multicultural business needs of the Commission

The Commission identifies the linguistic and intercultural work skills needed of staff in client contact positions, to ensure that business requirements are serviced by appropriate human resourcing

The Commission utilises the Community Language Allowance Scheme (CLAS)

Staff in public contact positions within the Commission receive training and support relating to working in a culturally diverse environment

TRENDS IN COMPLAINTS

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

Response:

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

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

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

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

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

ASSESSMENT PROCESS

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

Response:

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

REQUESTS FOR REVIEW

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

Response:

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

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

Other improvements are that letters:

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

CLIENT SURVEY

18 On page 28 of the 2010/11 report, the survey responses from health providers and complainants regarding their experience/satisfaction with the assessment of a complaint indicates that health providers are more satisfied – 79.5 per cent – with their interaction with the Commission in comparison to complainants at 49.8 per cent. Why is there such a wide difference between the two, given the response rate from both parties were very similar? The figures from the 2009/10 report were a 72.2 per cent satisfaction rate for providers and 65.6 per cent for complainants.

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

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

Response:

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

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

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

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

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

RESOLVING COMPLAINTS

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

Response:

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

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

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

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

20 The Committee notes that the restructured resolution process, which commenced on 1 July 2010, has had beneficial outcomes. The 2010/11 Annual Report – page 31– states that 66.1 per cent of resolution and conciliation processes were finalised within four months of referral (target 70 per cent).

i. Can the Commission further refine the processes to enable it to meet the target fully?

ii. What criteria are used to determine whether a resolution/conciliation process is finalised?

iii. The Commission has Resolution Officers in the three regional areas of Newcastle, Dubbo and Lismore 2010/11 Annual Report – page 32. Why were those particular areas chosen? Are there other regional areas you would like to reach? If so, which ones?

iv. The 2010/11 Annual Report – page 34 – states that over the last two years, 222 changes to health service practice (94.5 per cent) have been implemented and eight (3.4 per cent) are still to be implemented. Does the Commission monitor the agreements after they are in place to ensure all of the agreed changes are implemented?

Response:

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

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

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

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

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

Dubbo, Lismore and Newcastle are large population centres with many of the district resources located there. These centre provide easy access to the surrounding areas. LHDs in these districts have agreed to cover the cost of the office space for the Commission's Resolution Officers. In

Wollongong and Queanbeyan, the LHDs have advised that they have no accommodation available at this time to accommodate a Resolution Officer and the cost of establishing an independent office would be prohibitive given the Commission's current level of funding.

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

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

Response:

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

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

- The patient was an infant who had died and the mother who had lodged the complaint was too distressed to participate in a resolution process for a period of time.
- There were seven health service providers involved in the treatment and care that was the subject of the complaint, who had to be coordinated during the process.
- There was a separate Coroner's investigation and the Resolution Officer waited until the report was released to clarify any questions and issues the complainant might have had arising from the Coroner's report as part of the resolution process.
- There was partial resolution achieved during the process, but the Resolution Officer aimed to resolve the outstanding issues, in some cases unsuccessfully.

INVESTIGATING COMPLAINTS

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

Response:

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

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

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

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

23 The number of complaints where no further action is taken against a health practitioner continued to decline in 2010/11 – Chart 11.1 on page 37 of the 2010/11 Annual Report. What accounts for this decline? Is it due to unfounded complaints, lack of sufficient

evidence to proceed further or a sign the Commission requires further resources or investigative powers?

Response:

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

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

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

Response:

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

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

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

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

Counted by provider

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

	2006–07	2007–08	2008–09	2009–10	2010–11
Tribunal	39	37	38	53	57

Professional Standards Committee	21	25	28	30	27
Board of Inquiry	1	1			
Total	61	63	66	83	84

Counted by matter

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

Chart 25.3 – Outcomes of investigations into health organisations 2006–07 to 2010–11

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

Counted by provider

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

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

> The decrease in investigations into health organisations is due to a number of factors. Serious incidents in public health organisations are usually investigated through a Root Cause Analysis conducted by the health service. Over the last few years, where a Root Cause Analysis has recommended systemic improvements that appropriately address relevant issues of public health and safety, and there are no issues of individual misconduct, the Commission has referred such complaints for resolution.[64]

[64] HCCC Annual Report, pp 38

UNREGISTERED HEALTH PRACTITIONERS

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

Response:

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

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

> 3 (2) Without limiting subclause (1), health practitioners must comply with the following principles:
>
> a health practitioner **must possess** and maintain the necessary competence in his or her field of practice,

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

LEGAL REPRESENTATION – PROFESSIONAL STANDARDS COMMITTEE HEARINGS

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

Response:

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

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

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

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

ROOT CAUSE ANALYSIS

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

Response

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

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

WORK WITH THE CLINICAL EXCELLENCE COMMISSION

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

Response:

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

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

RESEARCH PROJECTS

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

Response:

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

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

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

- The research project on the implementation of the Commission's recommendations to public health facilities: The University of Sydney lead researchers obtained ethics approval from most sites in 2011. The surveys were distributed to most of the public health facilities in December 2011. The aim of the study is to evaluate how recommendations for quality and safety improvements are being implemented long–term by the relevant health facilities, and where there have been barriers to the implementation. The results will assist the Commission in identifying areas for improvement when making and monitoring recommendations in the future.

- Chinese Hospital Association: This project has been finalised and an update on the overall exchange programme was provided by the Burnet Institute, the Australian coordination body, at the end of 2011. The Commission has not been advised of specific outcomes that resulted from the advice it provided to the Chinese Hospital Association.

- Health literacy project: This project is ongoing and has resulted in the creation of the Health Literacy Network, consisting of the Australian

Commission on Safety and Quality in Health Care, the School of Public Health at the University of Sydney, the Clinical Excellence Commission and the Health Care Complaints Commission. As part of the network's activities, a free seminar has been planned for 2 April 2012. The seminar will focus on assisting health services to assess and remove health literacy barriers, and supporting health care professionals to improve communication with Aboriginal, CALD and low socioeconomic background patients. The network members meet regularly to coordinate and cooperate on a range of health literacy initiatives.

FILE AUDIT

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

Response:

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

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

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

- Automated audit at day 7 which checks the timeliness of the complaint being read, the timeliness of the file being made up and that the acknowledgement letter has been sent to the complainant.

- Day 21 audit conducted by the Team Leader, to check that notification letters to the provider have been sent and acknowledged, lines of inquiry have commenced and that the assessment plan is being auctioned.

- Team Leaders are able to add extra audit dates to check the progress of the file at their discretion after the completion of the day 21 audit.
- Audits are undertaken by the Team Leader or in their absence the Manager, Assessments or Director, Assessments and Resolution.
- Performance in relation to audits has been included in staff performance agreements and is monitored as a performance indicator.

STAFFING (FOR THE PERIOD 1 JULY 2011 TO 30 SEPTEMBER 2011)

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

Response:

In its quarterly performance report for the period 1 July 2011 to 31 December 2011 the Commission commented that it has 'increased resources in the Assessment Branch. This has successfully addressed the shortfall that had occurred in the first quarter in complaints assessed compared to complaints received.'[65]

[65] Health Care Complaints Commission, Quarterly Performance Report for the period 1 July 2011 to 31 December 2011, p 4

Chapter Six – Transcript of Proceedings

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE 2009-2010 AND 2010-2011 ANNUAL REPORTS OF THE HEALTH CARE COMPLAINTS COMMISSION

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At Sydney on Monday 20 February 2012

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The Committee met at 2.15 p.m.

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PRESENT

Mrs L. G. Williams (Chair)

Legislative Council	**Legislative Assembly**
The Hon. P. Green	Mr R. J. Park
	Mr A. R. Rohan
	Mrs R. E. M. Sage

CHAIR: In accordance with section 65 (1) (c) of the Health Care Complaints Act it is the function of the Parliamentary Joint Committee on the Health Care Complaints Commission to examine each annual report of the commission and to report on it, and any matters arising out of it, to the Parliament. The Committee welcomes the Commissioner and his staff here today for the purpose of giving evidence on matters relating to both the 2009-10 annual report and the 2010-11 annual report of the Health Care Complaints Commission. Due to the expiry of the previous Parliament prior to the 2011 election this is the first opportunity the Committee has had to review the commission's previous two annual reports.

KIERAN TIBOR PEHM, Commissioner, Health Care Complaints Commission, and

TONY ALAN KOFKIN, Director of Investigations, Health Care Complaints Commission, sworn and examined:

KAREN BERNADETTE MOBBS, Director of Proceedings, Health Care Complaints Commission, affirmed and examined:

CHAIR: Commissioner, I am advised that you have been issued with the Committee's terms of reference and Legislative Assembly Standing Orders Nos 291, 292 and 293, which relate to the examination of witnesses. Is that correct?

Mr PEHM: That is correct.

CHAIR: The Committee has received written responses from the commission in response to some questions that it put on notice. Are you satisfied that those responses form part of your formal evidence today?

Mr PEHM: Yes, I am happy for them to form part of the evidence.

CHAIR: Would you like to make a brief opening statement before we commence questions?

Mr PEHM: No, thank you. I am happy to proceed to answer questions.

CHAIR: The New South Wales public health system is the largest public health system in Australia, providing a range of complex medical services and a high level of care to the people of New South Wales. From your perspective as the Commissioner of the Health Care Complaints Commission how satisfied is the commission with the overall level of service and care provided?

Mr PEHM: That is a very big question. It is very difficult from the very narrow perspective the commission has, and its viewpoint on the public health system, to give a really well-informed answer. The Committee will understand that our commission sees the worst of things that happen in the public health system. We see complaints about the most awful disasters and tragedies. I cannot say that I am in a position to give an opinion on the overall functioning of the health system. I will say though—and this may assist the Committee—that since I have been commissioner, for about six years now, there has been a very determined and well resourced effort within Health to address adverse events that occur within the public health system. There are policies and requirements for clinicians to report mishaps and adverse events and for investigations to be done into those to improve the way systems

operate. I can say that the public health system is much more responsive to adverse events now than it was when I commenced as commissioner.

CHAIR: In terms of the assessment process, given the increase in the number of complaints over the past year and the commission's decision not to undertake further inquiries when complaints are received and relying more on the initial information that has been provided, are you concerned that long term this decision could have a negative impact on the work and reputation of the commission?

Mr PEHM: I think that certainly is a concern. Let me say first that I do not think the commission is missing any risks to public health or safety or that it is discontinuing complaints that should be investigated. However, from a customer service point of view, the commission is not able to devote the same level of resources to the assessment of complaints that it has in the past. The commission's previous practise was, on receipt of the letter of complaint, to ring the complainant, discuss it with them, make sure that the commission had actually got the point of the complaint. We would generally seek a response from the health service provider and use that to inform our assessment decision. In advising the complainant of the reasons, in cases where we decided to take no further action, again the assessment officer would engage in a discussion with the complainant to try to explain to them the reasons.

We felt this was useful in addressing the sometimes very high or the high expectations and sometimes unreasonable expectations of complainants and make them more or perhaps better equipped in their future dealings with the health system. Unfortunately due to the increase in the number of complaints and the lack of a commensurate increase in resources, we have had to adopt a practise of making an assessment where it is fairly clear that the complaint is not going to require any action from us and there are no public health and safety issues. There are no questions of conduct by any individual practitioners that would amount to disciplinary proceedings. In matters like that now we simply make that assessment on the complaint and write to the complainant.

We have put a lot of work into addressing the nature of the letters we send to them. We are trying to make those clearer and provide better reasons and explanations. But I just do not think it is as successful in terms of customer satisfaction or client satisfaction to get a letter dismissing your complaint as it is to have someone talk to you, give them the feeling that their complaint has been understood and their concerns have been properly considered. I think it is much more effective doing that in person than by writing. So it is a rather long-winded way of saying I think there is a potential of damage to the commission's standing with complainants if we have to continue to do that.

Mr ANDREW ROHAN: The 2010-11 annual report states that the commission no longer seeks a response from the provider, on page 4. Does the commission ensure that the provider is aware that a complaint has been made to the commission and that the provider has an opportunity to discuss the matter further if necessary where it is clear that the complaints will not continue? What steps have been taken to ensure that these changes do not adversely affect access by disadvantaged groups to the complaints handling process, given that the commission no longer clarifies issues and only gives notice of the outcome in writing?

Mr PEHM: I think there is the potential for greater disadvantage to disadvantaged groups, people with limited English skills, people who are perhaps not as literate and not as well able to frame and formulate their complaints than others. I think the commission still

does exercise discretion in the way it deals with complaints, so where we perceive a difficulty or a failure or an inadequacy in expressions and we think the complaint is not clear because of some element of disadvantage in the complainant, in those cases we do take extra steps to clarify the complaint and make sure we have got it clear. When I talk about the new practice, it is not a blanket policy. Every complaint is still read and considered and judged on its merits. The majority of complaints we deal with are fairly clear in their written form so an informed decision is able to be made. Where there is doubt and the issue raised seems to be a significant one we will make further inquiries. I cannot say that we can produce any data on that because it is a matter of discretion on each individual complaint. Does that answer the question?

Mr ANDREW ROHAN: Yes.

CHAIR: What would happen if someone that you telephoned—you have received their written complaint, you telephone them but there was obviously some barriers there for you to understand whether you are clear in your mind about what their complaint is about? What options does that person then have or what options do you have?

Mr PEHM: In terms of language barriers, all of our complaint information is published on our website in 20 community languages. We have the use of a telephone interpreter service so that we can have a discussion through an interpreter on the telephone. Finally, complainants can always come in and an interpreter be arranged for a meeting with them.

Mrs ROZA SAGE: Were other options considered by the commission before the decision was made not to undertake additional inquiries when a complaint is received?

Mr PEHM: I think we were in a position where that seemed like the only viable option to allow us to continue to deal with complaints that raise significant issues. Certainly it was the subject of a lot of discussion and meeting within the office and various types of strategies were considered. That seemed to be the only one that would allow us a sufficient saving in human resource time in dealing with complaints and allow those human resources to be invested, if you like, in matters more likely to be protective of public health and safety. It is a bit hard going back and thinking what the other options were because that seemed to be the most viable and productive one. But certainly it was the subject of a lot of discussion in the commission.

Mr RYAN PARK: You would be aware that there has been a move to increase the number of local health districts from the previous eight area health services. Do you expect to see an increasing number of complaints referred to those new local health districts for resolution at that local level, given that the structure has changed?

Mr PEHM: I certainly hope that we will be able to do that and we have been referring an increasing number of complaints for local resolution over the past few years. We are holding a training day with local health district staff on 5 March and we have about 200 staff coming to that. That will help us to build the bridges and establish human relationships with people. I think there is more scope for local health districts to pick up complaints and handle them at the local level. The general rule with complaint handling is the more local the better. That is the agency that they have to deal with. That is the hospital they will have to turn up to. So it is best that it is resolved there and it is certainly our intention to have as many matters resolved there as possible. As I said, we are doing training that will probably be followed up by

more individual meetings with local health districts over the coming year. So the answer is yes, we will refer as many complaints as possible back for local resolution and I hope that that number increases over time.

Mr RYAN PARK: Are they resourced to do that? I agree with the premise that it is handled better locally; I certainly support that. When I have gone through the annual reports and the performance reports I have seen that the numbers are fairly significant at a regional level and I am wondering whether there is the same support and expertise in those local health districts.

Mr PEHM: I am still wondering about that myself. When there were eight area health services each area health service had a clinical governance unit and over the past five years or so they became, on the whole, quite professional in dealing with complaints. With the devolution into 17 local health districts the staff of those eight units have been devolved into areas and I am not familiar enough with the amount of resources in each local area or the level of expertise at this stage to have a confident view one way or the other about their capacity to handle complaints.

The Hon. PAUL GREEN: I am concerned about the resources at a local level. I note that some of the submissions suggested that dealing with local issues would probably help reduce the workload for the commission and probably more appropriately given the fact that some of those issues may not need attention at another level. It is good that they are probably going to be handed back. My concern is resources, as is Mr Park's, seeing the numbers that are coming through the Health Care Complaints Commission. They are becoming exponential especially with the web site and I have some suggestions for later on in the inquiry. Are you at all concerned that in handing back to local districts they will not have the resources to cope? Can you comment on how we could address that matter given your experience in resourcing and resolution of such issues?

Mr PEHM: I probably have to rely on my last answer. I do not know enough about the level of resourcing or the levels of competence to be either confident or concerned as to whether or not they can handle matters. We have a variety of approaches with the lower level complaints. One is local resolution. There are times when complainants feel they have exhausted their options with the local health district. In cases like that we can allocate one of our resolution officers to act as an honest broker between them and try to repair the relationship. I cannot say at this stage I have a strong enough or comprehensive enough understanding of the level of resources and competence to venture a firm opinion.

The Hon. PAUL GREEN: You mentioned education. I see in one of the submissions that one of the concerns is that the health care professionals are probably not educated in the processes that are part of the Health Care Complaints Commission's approach. It might be a good idea to educate health care professionals about the processes and why they exist. You said you would possibly resource them with an officer but table 14.3 on page 54 of the 2010-11 annual report shows the full-time equivalent staffing levels from 2007-08 to 2010-11 and indicates a decline in staff numbers. How do you account for the decline and what plans does the commission have to increase staff numbers to ensure it has sufficient staff, never mind the ability to send people out to help?

Mr PEHM: The 2010-11 annual report sets out what in my view is becoming critical for the commission in that while the actual dollar amount of budget was remaining consistent the

real buying power of that budget meant fewer and fewer staff because of wage rises and productivity savings. As that annual report shows, the number of staff the commission could afford with its budget was continually decreasing while complaints were going up. There are two developments in that area since that annual report. One is that complaints this year seem to have levelled out at about the same level that they were at the end of 2010-11. The other thing I can report is that the commission has had some very positive and encouraging discussions. The commission has been moved from the Treasury portfolio to the Health portfolio for budgetary purposes and so far the discussions are very encouraging that the commission will receive a significant increase in budget next financial year, which I am certainly hoping will be the case.

The Hon. PAUL GREEN: Are you confident you will be able to deal with that decline in staff numbers through budgetary processes?

Mr PEHM: At this stage yes, I am confident, but I guess nothing is final until the money is in the budget.

CHAIR: I want to read you something Minister Jillian Skinner said at a board of chairs. She said she wants to see a health system where patient care is seamless and integrated, where the patient is respected, listened to and informed and is the focal point of the integrated service, which involves all elements of health care in a way which is both seamlessly easy and effective. What role do you see yourself playing in providing feedback to the department and then obviously to the Minister about how we measure whether we are delivering a seamless and integrated system on patient care?

Mr PEHM: Again, that is a very good question and a very complex one with many facets to it. One of the very significant features of our complaints illustrates exactly the point of poor communication. Patients often cannot find a single point of reference in the health system to explain to them what is happening. It is partly a result of the fragmentation of care and the level of specialisation now. Patients going into hospital with a chronic condition will be seen by any number of specialties. Even a simple broken leg might be thought to be an orthopaedic problem but if the person has a chronic illness like diabetes or high blood pressure there might be haematologists and surgeons and various other people involved. The hospitals are staffed by registrars and resident medical officers. The consultant in charge is often a visiting medical officer who will do their rounds at 6 o'clock in the evening maybe and if the patient's family is there or the patient is lucky enough to catch them they might get a good explanation. Often more junior staff do not feel they are in a position to provide as full an explanation as people want. The problem is very complex. Of course, what the Minister is talking about is what we all want and what we would want for ourselves and our loved ones in care.

When the commission investigates complaints it makes recommendations on these issues and we provide those to the Clinical Excellence Commission. The idea is that the Clinical Excellence Commission is constantly working to improve systems and communication. They put a lot of work into handover of patients. Another communication problem is when the new shift coming on is not properly or adequately communicated with by the old shift. Gaps can occur in care. There obviously is no simple solution to this. There is no one answer and no one measurement so that we could say things are improving. It is probably a measurement across a whole range of indicators and gauging patient satisfaction. You do that generally through

surveys and you can do it through customer satisfaction on exit. All of those sorts of measurements could feed into it but obviously there is no simple solution.

Mr ANDREW ROHAN: I refer to outreach activities. Page 13 of the 2009-10 annual report states that there was a significant increase in the distribution of brochures and other information material—198,163 items compared with only 19,073 in 2008-09 and 20,320 in 2010-11 according to page 8 of that year's report. Who does the commission target and how does it evaluate use by stakeholders? Does the commission have a formal process for recording feedback on the effectiveness of this material to allow for improvement in future brochures for the education of providers to assist them in responding appropriately to a complaint? Do you follow up in any way to check that it is useful to them and to invite suggestions on presentation and content?

Mr PEHM: The first question asked whether we seek feedback on the quality of our publications.

Mr ANDREW ROHAN: Yes.

Mr PEHM: Not in a formal sense. We have a community consultative committee, which has community representatives, and we get a lot of feedback from professionals by doing presentations. We do presentations for colleges and other groups of professionals. Those publications explain how we work. We put a lot of work and thought into the material that goes into those publications and they are reviewed regularly. In 2009-10 we did two things that we had not done before. First, we actively went to all public health facilities and asked them to put up the posters and to make the brochures available. That is ongoing. Secondly, we became involved in a project with the general practitioners' practice group to get all our material into GP practices as well. That would account for the large number that went out that year.

There is no formal feedback system to evaluate precisely how effective that material is in communicating to the target groups, apart from our general feedback from consumer consultative committees and professional groups. The Consumer Consultative Committee informs new target areas. We have just done one on mental health services as a result of its advice on an identified need. Rather than a specific program of formal feedback and evaluation, we are engaged in dialogue with the groups that we need to talk to on an ongoing basis. The second question was about the effectiveness of our guides about how to respond to complaints. Again, there is no formal process by which we ask for evaluation of the effectiveness of those guides. We look at the nature of their responses and see whether they are addressing the sorts of issues we think they need to and whether they are keeping the more emotive sides of complaints out of the process. Of course, we also have the client survey information that we send out to the parties on the conclusion of complaints. They are the feedback mechanisms.

Mr ANDREW ROHAN: The committee is pleased to note that outreach to Aboriginal health workers is now a regular component of the training program at the Aboriginal Health College. Does the commission undertake or is it planning to undertake similar outreach to training programs for other groups of health workers?

Mr PEHM: We have fairly well established training opportunities with the established health professionals. Aboriginal health workers have been around for a long time, but it is

proposed under the national registration law they will become registered professionals from July 2012. That is why we have reached out to them to get their input and to try as much as we can to explain how we work. Traditional Chinese medicine practitioners will also be registered to practice from July 2012. We will be making similar efforts with the new council that has been set up to co-regulate with us on complaints in that area. The two others are occupational therapists and radiation therapists. They are the areas we will be targeting in the coming year.

Mrs ROZA SAGE: Has the commission evaluated its own participation in the Good Service Forum? I refer to page 15 of 2009-10 annual report and page 9 of the 2010-11 annual report. Is the purpose only to provide information about the commission or is it also to receive information or feedback? Has the commission considered specific initiatives in collaboration with the forum, for example, engaging in focus groups to discuss a range of complaints or complaint-handling issues that member groups might have in common?

Mr PEHM: The Good Service Forum is primarily a platform for government agencies to provide information about how they operate and how they work. It consults community groups about where it should go and the best places to get in touch with the areas it wants to contact. There is no evaluation about its effectiveness. We have representatives from the target groups on our Consumer Consultative Committee. The forum is about getting in touch with remote rural areas, particularly Aboriginal clients. There is no formal feedback or evaluation of the success of that process. The view is taken that it is a good thing in itself to be out there and to be available.

Mr RYAN PARK: Some of the submissions, and in particular the submission from the Nurses' Association, raise concerns about the commission's process of engaging legal counsel and question whether it would be better for the commission to employ a full-time hearing officer to undertake the advocacy role at professional standards hearings to avoid having senior counsel up against a nurse who may want to represent herself or himself. Has the commission considered establishing a full-time position rather than engaging legal counsel?

Mr PEHM: We have not one but two. Ms Mobbs is the director of proceedings and handles all the legal areas.

Ms MOBBS: The annual report makes some reference to that being an idea that we are proposing to implement this financial year.

Mr RYAN PARK: It does.

Ms MOBBS: We have proceeded with that. Prior to the national law taking effect in July 2010, we were not able to use legal representatives in the professional standards committees. Post July 2010, in any prosecution under the national law we have been able to use solicitors, but we have also had some matters that were commenced under the previous legislation where we could not. We retained a non-legally-qualified hearing officer until late last year. Due to family circumstances that person resigned and we were able to look at replacing employing a legally-qualified officer. We also looked at the other hearing officer position which was currently vacant and decided to trial two solicitors in that role basically acting as advocates. Obviously it is a difficult area and it is not one that you can bring in people straight away who are going to know the jurisdiction: it is very specialised. What we have done with those two officers, one is from quite a strong advocacy background with experience in legal aid and the other has a more general background. They have been involved initially

running matters with junior barristers. I cannot think of a situation when we would have briefed a senior counsel in a PSC although respondents may do.

We have used fairly junior counsel just because of our own staffing numbers. We had a huge number of matters to be prosecuted over the past year or two, not sufficient lawyers within the commission to be able to run all of those, and just with changes of staff and hearing officers we did use external counsel. With the appointment of the two new legal officers they have used counsel initially to help get them used to the jurisdiction, and over time we are taking away those counsel, all those barristers, and having the officers run their own hearings. Both of our hearing officers have run hearings of their own and will continue to do more and more, especially in the nurses jurisdiction. So we agree with the association: we certainly do not want it to be a jurisdiction with barristers. We do not want it become overly legalistic.

The Hon. PAUL GREEN: You said that respondents tend to get a Queens Counsel, is that because the Nurses Union backs them. Obviously quite a lot of the people who end up in this area are of low income and do not have the capacity to fund it at that level.

Ms MOBBS: I hope I did not mislead you in any way. I was probably referring more to the medical PSCs. I think there are a lot more insurers that have that capacity to fund that. It would be unusual in the nurses PSC although occasionally you do get privately funded nurses who may have some family and will put their own resources into having someone but generally they would not be Senior Counsel.

The Hon. PAUL GREEN: The submission from the nurses states: Why should a nurse have to explain a shortcoming in the system to a complaining patient or family member. I note on page 38 you state:

> The commission anticipates the number of investigations into unregistered health practitioners will continue to increase in the coming years.

Will you provide a snapshot of the unregistered health practitioners? Why are they unregistered? Do you perceive that with the new retraining to get re-entry of nurses these numbers may increase? You talk about unregistered health practitioners increasing as time goes on. Why is that so?

Mr PEHM: There might be some confusion in terminology there. "Unregistered practitioners" means all of those practitioners who are not capable of registration, that is, not nurses, doctors. We are not talking about nurses who can be registered but do not get registered.

The Hon. PAUL GREEN: I only picked nurses but will you provide an understanding of who you are referring to?

Mr PEHM: We are talking about traditional Chinese medicine although they will be registered from July, acupuncturists, hypnotherapists and psychotherapists. There are a lot of grey areas when you get into things like counselling, life coaches and things like that. We have not had any test cases like that.

The Hon. PAUL GREEN: It is not people whose registration has elapsed?

Mr PEHM: No, not anyone that is capable of being registered. If a nurse goes out and does health servicing and is not registered, that is an offence that can be prosecuted in the Local Court. The unregistered practitioners do not like the term either. No-one else has devised a good way to describe them. We are describing all of those health service providers—herbalists, naturopaths, iridology, all those sorts of alternate type therapists, if you like. Why it is becoming more common, I suppose, is that there is now an avenue for complaint. I think the word is just getting around that you can complain, and we are starting to publish the results of investigations on our website. We have gone into education campaigns with all of the peak bodies for those groups, like there is the Australian Traditional Chinese Medicine Association and there is a Psychotherapy Association so we got in touch with them. Some of them had complaint handling processes as well so we liaise with them about what we do and they have been referring complaints to us as well. For that reason I think the number will grow.

CHAIR: I refer to the 2009-10 and 2010-11 reports. Earlier we talked about feedback and commissioner you made mention of the client satisfaction survey. The response rate in both years was only about 4.7 per cent. In the report for last year you said that the survey would be discontinued. What is the alternative? Do people not respond because of the way it is set out? Why is the response rate so low?

Mr PEHM: The response rate to the assessment process and the resolution areas is about 20 per cent which is reasonable. The 4 per cent is just on the investigation process. I really think it is the nature of the process. We are now, in effect, referring 65 per cent of practitioners to Karen to consider prosecution. It is a bit like surveying people, who the police charged with crimes, about whether they are happy with the service. It has gone beyond a client service when you get into investigations because the outcomes are prosecution of a practitioner so it is very unlikely they will respond at all, and, if they do, it is not going to be "You are going to prosecute me so I think the process was right". They are in a defensive mode. I am not sure why complainants do not respond so much. I think by that time it has become a very involved thing. They will also be involved in future prosecutions as well so, in a way, the matter is not over for them either; it will continue on. The low response rate was one reason but really it is more the nature of the process and whether it is appropriate to be asking for consumer satisfaction with something like that.

Mr ANDREW ROHAN: The 2010-11 annual report of the Community Relations Commission on page 28 discussed four divisional advisory council meetings in 10 regions of New South Wales. It lists approximately eight government agencies which have addressed those meetings to raise community awareness and discuss issues of concern in relation to a spectrum of government services. The Committee notes that the commission was not among the participating government agencies. My question is: Is making closer contact with multicultural community organisations through the Community Relations Commission network something the commission might consider?

Mr PEHM: Yes. We have a representative from the Federation of Ethnic Communities Council on our Consumer Consultative Committee. We have been out to address members of that federation and that was well received. We make presentations to local migrant resource centres as well. We have linked in with the Commonwealth's information that is provided to recent arrivals and refugee settlement programs about our services. But certainly if there are more avenues to explore we are happy to do that, and we do. We have used the Community link email service but we can certainly look at what else we can do.

Mr RYAN PARK: One of the submissions talked about perhaps increasing the number of languages, the material and brochures that you provide, particularly in the area of Sydney with a high multicultural mix. Has the commission given thought about trying to translate some of its materials into some of those CALD community languages in order to target them in a more effective manner?

Mr PEHM: We have. We went into a consultation process with the Community Relations Commission that did the translations of our website material and we were advised that there are 20 community languages that account for something like 95 per cent of community languages. We have translated our material into all of those languages. It was based on Australian Bureau of Statistics data about the prevalence of the spoken languages. Those 20 were by far the majority of languages out there. We can check to see if there has been a shift there because it has been about four years since we have done that.

Mrs ROZA SAGE: In regard to timeliness of assessing complaints, in 2010-11 I think 84.6 per cent of complaints were assessed within the 60 days, which was an improvement from the previous year where the figure was only 82.3 per cent. What action is the commission taking to ensure that there is a continued improvement in the timeliness of assessing complaints, so that it meets its 100 per cent target within the 60 days? The Committee notes that from the most recent performance report covering the first two quarters of the current financial year, that during this period 86.3 per cent of assessments were finalized within the statutory 60 day period and that on average new complaints were assessed within 42 days during the reporting period, which is a slight decrease in average days on the previous years.

Mr PEHM: Complaints for 2009-10 and 2010-11 have dropped slightly from previous years. There is a number of things to say about this. Firstly, the 100 per cent is not an achievable target. We put 100 per cent in out of deference to the statutory timeframe. I think the previous committee looked at this whole issue and agreed that 100 per cent is not always achievable and made a recommendation—which I am not sure you took up—that the commission could go beyond that 60 days in suitable cases where the reasons justified it, in order to make a proper assessment. The alternative is, you get to the end of the 60 days, you do not have enough information and you make a flawed decision which is in no-one's interests. So the small drop in the percentage determined within 60 days over the last two years you could attribute to the increasing complaint numbers. The thing we have done to address that is to have a more efficient assessment process in that we do not seek responses in as many cases now as we did before, so that is why we are able to maintain the above 80 per cent. Whenever a case runs beyond the 60-day timeline, the officers have to put a case to me as to whether it should be extended and they have to set out what has been done, that we have requested responses and the reason why the respondent is in a difficult position. Through January and February the health system often finds it difficult to gather material and get responses in during the Christmas holiday season when a lot of clinicians are on holidays. We have quite a rigorous internal process for making sure that it is a legitimate request for an extension of time and not just that no-one has done anything on the file. That is how we have managed that.

Mr RYAN PARK: In terms of pharmacists and the complaints raised about them, there has been a significant increase, based on reporting in 2010-11 as a result of the commission's change from a category around pharmacies to individual pharmacists. Do you think that this new method of identifying individual pharmacists is going to raise concerns? Is there anything that should be addressed in relation to that, or do you think that this is going to be an area

that you are going to have to monitor more carefully? How do you see that process and what do you see its impact on the commission being?

Mr PEHM: We think it is a more effective and realistic way to assess those complaints. They would previously be dealt with by reference to the principal pharmacist at a pharmacy. Every pharmacy must have a registered pharmacist but they also employ pharmacists as well. The tradition was that the principal registered pharmacist would answer for all complaints. That meant that you never picked up dispensing errors or whatever errors the employed pharmacist was making, when pharmacists transferred to different pharmacies. This system will be more effective. the only downside being that it results in more complaints to assess although it is not a significant number. The Pharmacy Council is diligent in policing pharmacists and it takes up a lot of the work. Its officers go out and inspect pharmacies and the Pharmacy Council is vigorous on that score, so it should not result in too much extra work for the commission.

The Hon. PAUL GREEN: In regard to the timeliness of investigations, the performance report refers to the impact that the finalisation of 35 investigations into two practitioners—following their criminal convictions and sentencing—has had on the time taken by the commission to complete investigations. Are you able to provide the Committee with any details regarding these complaints and what part, if any, does the commission play in such instances where there are police investigations and criminal proceedings involved?

Mr PEHM: I do not think I can provide you with the names of the practitioners and so on but I can give you a general description in both coronial and criminal investigations. A typical example in a criminal matter might be that a medical practitioner has sexually assaulted a patient or patients. We would generally take a back seat to that because the police will be investigating. They will do their usual criminal investigation—statements of witnesses, briefs of evidence— and will go to the Director of Public Prosecutions who will then look at prosecution. And the course of those criminal proceedings can take 18 months to two years—it depends on the case, how complex it is and how many more people come forward.

In Coronial matters there is a Coronial Investigation Unit and the Coroner may or may not decide to have an inquest. We tend to cooperate a bit more closely with the Coroner because there is often not the prospect of criminal charges at the end because the Coroner looks at the cause of death. In some cases we have taken statements and given our material to the Coroner and the Coroner has used that to decide whether or not to have an inquest. In terms of the timeliness of the investigation, it means for us that in the case of criminal charges, we wait to see whether the respondent practitioner is convicted of the criminal offence. Naturally, the verdict and the sentencing remarks and all of that material is relevant to any potential prosecution.

If the practitioner is acquitted of that criminal offence, then we have to look at whether there are disciplinary issues that might remain. Even though a practitioner has been acquitted, there is a different standard of proof as to whether he or she is suitable to be a practitioner. If there is a conviction, then the sentencing remarks and the term of the sentence goes to the Director of Proceedings to put before a tribunal in order to then make the formal decision as to deregistration—whether to deregister and if so, for how long. Our timeliness is heavily impacted by criminal proceedings and coronial matters. Tony is our Director of Investigations so I will see if he has anything to add to that.

Mr KOFKIN: It is not always a default position for the commission that we will pause our investigation if there is a police inquiry or even at times a coronial inquiry. We will make sure that we obtain and gather as much material evidence as we can. But we can get to a point where we have information and we will get internal expert reviews to see whether or not there are any new respondents who need to be added or any new allegations. Then we work closely with the police and we come to a point where we decide to pause the investigation but we make sure that, whilst the material is fresh in people's minds, we do everything we can to gather that information, because the matter could be paused for a number of years and we do not want to go back three years later to get witness statements. So, it is not always a default position where we pause investigations but in the majority of cases we do. We have some matters coming up soon for coronial hearings. We have actually already concluded our investigation and made recommendations. As the commissioner said, we pass all of that material on to the Coroner so he can have a look at it and possibly decide whether or not to call in our investigator as a witness during the coronial inquest.

The Hon. PAUL GREEN: Given that the case would be pretty important, at what point do you inform the clients or colleagues that some person has been put into question in terms of their practice?

Mr KOFKIN: I am sorry I did not quite hear the last bit of your question.

The Hon. PAUL GREEN: At what time do you inform clients or colleagues of the particular person who is under investigation? Do you inform them that someone is under investigation if it is quite serious? If the process of timeliness of an investigation is quite long what does the Health Care Complaints Commission do in terms of where they put a line in the sand and say they either need to carry the investigation or let go of it?

Mr KOFKIN: In terms of whom we inform? Did you say clients?

The Hon. PAUL GREEN: It is just that one of the submissions makes the comment that the point at which the Health Care Complaints Commission informs people can be detrimental to the healthcare professional.

Mr KOFKIN: Certainly if there is a police investigation then what will happen is that the police will inform either the council or the commission, they would consult on that and then obviously the practitioner would be aware. Under the legislation we can actually inform the current employer of the practitioner. It is also within the Act as well that depending on what the circumstances are, and whether or not they would be prejudicial to the individual or to the investigation, we can as well inform their new employer. Sometimes by the time these investigations get to us they are fairly historic, so in terms of whom their employer was at the time of the allegation and then who it is afterwards may change. We have discretion in relation to making that call basically. In terms of investigations we have to look at all the circumstances and see whether or not it is proportionate and justified in the circumstances to actually make that call and then we discuss it with the commissioner in relation to what course of action we take.

The Hon. PAUL GREEN: I am asking in regards to the style of the investigation.

Mr PEHM: There are a lot of competing interests there. I mean the practitioner under investigation believes no-one should be informed because they have not been convicted of

anything and it will damage their reputation. Their employer thinks they should be informed so they can mitigate any risk in the way they practice. Patients may well think they should be informed because someone is out there with serious charges against them. There are various mechanisms. The council has the power to hold an immediate hearing and either place conditions or suspend the practitioner, and that can happen depending on the nature of what is against them. Police in a criminal case will generally inform—if it has happened in the public health system they will have to investigate the circumstance, so the employer would be aware through that. We have a duty to inform the employer at the time the conduct occurred of an investigation. The public would not be informed unless, I suppose, there are charges in public court or the registration council holds a hearing and decides to impose conditions or suspend the practitioner.

The Hon. PAUL GREEN: Thanks for that. It might be pretty simple to you guys but it is good for me to know the process.

Mr PEHM: It is not; it is complicated. There is nothing simple in this business.

CHAIR: I take you to page 32 of the 2010-11 annual report where it talks about the outcomes of resolutions. It says that in 2010-11 the commission's resolution officers finalised 649 complaints but 24 per cent of those did not proceed and that was often due to the fact that the complainant was unhappy about the commission's decision to refer to the resolution service. Why would people be unhappy with that direction to the resolution service?

Mr PEHM: Because a lot of people when they complain to us want their matter investigated and they want practitioners deregistered. They have often reached a stage in dealing either with the practitioner themselves, with the public hospital or with the respondent that they feel frustrated; they do not feel things have been explained to them enough. In the case of the loss of someone near and dear, a loved one, there can be a lot of anger associated with that and they want, naturally enough I suppose, full investigation and people prosecuted. They want to see some serious consequence. They often do not feel resolution is a serious enough consequence. That would be the principle thing.

CHAIR: You are saying in most of those cases it would probably be complaints against nursing or nurses or medical staff in an acute setting generally?

Mr PEHM: It is hard to say. Probably mostly against medical practitioners because it tends to be that the more serious consequences flow from decisions of medical practitioners than nurses. It is often not necessarily the seriousness of the complaint objectively speaking but how serious the complainant feels it to be. A good example of that might be a medico-legal case where it is a workers compensation matter. They get a professional report from an orthopaedic surgeon that does not think they have the degree of incapacity that they think and it is going to affect their entitlements. That is the sort of thing people fight very hard. For us that is not a serious matter. That can be worked out before the compensation court, the practitioner can be examined, other medical experts can be got, and the compensation court can reach its position. But the degree of anger a complainant might bring to that, having found the practitioner rude and insulting during the consultation process and then getting an unfavourable report that is the sort of thing they can protest fairly very vehemently.

The Hon. PAUL GREEN: Do you get a lot of commercial vexatious complaints—for example, where someone puts someone else in to nobble their opportunity in health?

Mr PEHM: It is fairly rare. We sometimes get complaints about industrial-type issues about management within hospitals, say there is bullying or that sort of thing, or the disciplinary action taken against a practitioner has been unfair and they want to complain against the hospital. We sometimes get complaints about private practitioners taking the patients when they leave the practice so there is a commercial element to it. Our mandate is public health and safety so unless there are patient care issues and there is an issue about the danger to the safety of people we do not become involved in those commercial or sort of industrial-type disputes.

Mr ANDREW ROHAN: Page 80 of the 2009-10 annual report includes a chart comparing the issues raised in complaints in other jurisdictions. Under the new national registration arrangements what capacity does the commission have to provide a similar analysis in a chart of complaints and issues compared against those received in other jurisdictions?

Mr PEHM: That proved very difficult and you will see it is not in our 2010-11 annual report. When we compiled that chart in 2008 or 2009—

Mr ANDREW ROHAN: No, 2009-10.

Mr PEHM: Sorry, 2009-10 that was the year leading up to national registration we went to all of the State bodies and asked them for their complaint data. There are slight differences in the way they categorise issues to the way we do and we thought we had accounted for those differences and made accommodations where we could and that this was a reasonable sort of representation. There were some concerns from the interstate bodies about doing that again this year because they did not feel that it accurately represented their complaint data. So we decided the 2010-11 year it was not really feasible to do that. With the Australian Health Practitioner Regulation Agency [AHPRA] and the national registration system it should theoretically be much simpler in future. Although they have only had one year up and the annual report for 2010-11 does not have a lot of complaint data in it; it is focussing mainly on registration rather than the complaint-handling side of things. In future years I expect that will broaden out and there should be much more capacity for making comparisons.

Mrs ROZA SAGE: In terms of investigating complaints, there was an increase in seven days in the average time taken to complete an investigation from 278 days in 2009-10 to 285 days in 2010-11. Is this statistically significant, a natural variation or a reflection on the fact that, as you said, you have less resources?

Mr PEHM: It is not a big variation although it does imply that things have not improved significantly between 2008-09 and 2009-10 and then on to 2010-11. We have had to reduce the resources in investigations in order to cope with the increasing rate loading assessments. So over time the resources in investigations have been depleted and those resources put into assessments. That may well have an impact. We still think that is too long and that time frame can be improved. But perhaps the director of investigations, current since about April this year, can add something to that.

Mr KOFKIN: I do not think it is hugely significant. The numbers in terms of the way we report on our performance do not always give a good account in terms of the complexity of the investigations as well. Some of our investigations are relatively straightforward. For

example, they can be a breach of practice conditions, which are very simple; admission has already been made and they can be turned around fairly quickly. Other investigations, as I am sure you are aware, are incredibly complex. They involve a large number of providers—nurses, doctors—sometimes a number of patients, and sometimes more than one facility as well. So when we are measuring in terms of the length of investigations, we are measuring all the investigations. It does not always take into account the actual complexity.

A year is too long in terms of an investigation. It is not due to capability of staff; it is sometimes in terms of capacity and in terms of workload and prioritising as well. For example, some of our investigations, if it is a prescribing matter and there is a doctor it could be 100 patients, which are very complex investigations. Attention to detail is absolutely vital because unless we get the schedule correct when we are presenting our evidence it means that by the time it gets down to legal they are using those schedules to draft their complaints. I think seven days as a whole is not a huge discrepancy but we need to, in relation to customer satisfaction, in relation to complainants and respondents, reduce that year but that is in relation to capacity rather than capability.

Mrs ROZA SAGE: At what stage do you send an investigation to the relevant professional councils?

Mr KOFKIN: When we are closing the investigation. So that would be, in terms of our time frames, first of all the investigation will go through the assessment stage and be allocated to the investigation division. We have 14 days to compile an investigation plan where we scope the investigation, identify the key lines of inquiry. We always keep the review of the investigation ongoing as well under our Act so as new information comes in we can broaden the complaint and we can add new allegations and new respondents.

Mr PEHM: We have to consult with the council if we are adding to the complaint or adding new respondents. At that stage we have to consult before we do that.

Mr KOFKIN: Then by the time we have received all the information we go to experts. We would task the appropriate expert. We would draft the expert request with certain questions and provide the expert with all the material. Once that report comes back from the expert that is when we get to what is called the section 40 stage, where we write to the provider and give them the substance of the grounds of what outcome we propose. We only have to do that if our outcome is going to be referral to the director of proceedings or we make comments of referral to the relevant council. If we are terminating the complaint we do not need to do that. It is at that point that once we have had the response from the provider after 28 days we then go to the council and we consult in relation to what our proposed recommendation is. So it is very close basically to the end of the investigation, and once that investigation is closed, once the decision is made in consultation with the council, the investigation is then closed and then it opens up a new process where we compile a brief of evidence. We take all the relevant material from the investigation and pull it into a brief of evidence and then we pass that to the director of proceedings for determination.

Mr RYAN PARK: You talked a little earlier and you talk about in your report, or some of your responses in relation to the report, that you are looking for additional capital funding for improvement to the ICT capital. You seem to be reasonably confident that you will get that. Have you talked to the Minister about that?

Mr PEHM: That was part of our general—to the Minister's staff. I have not spoken directly to the Minister about it. I had a meeting with her staff about a week or so ago. There are two parts. The big one is recurrent funding—an increase in our budget for ongoing staffing costs—and the second is the capital expenditure. The capital is really the IT system. It is four years old and we would like to replace it and go to a more modern platform. I am very confident about the recurrent funding, which is the major part of it. We might be looking at extending our IT system for another year and going back about that later but it is still open to discussion.

Mr RYAN PARK: What benefits will the new ICT system bring in terms of the way in which you carry out your business?

Mr PEHM: It will not make material changes to the way we carry out the business. Our current IT system is in a continuous improvement cycle so when our case management system needs upgrading we have an in-house IT person who manages it and can do that. What it will do is make it cheaper in the long run although more expensive up front. That is probably the way most IT is going into a virtualised platform. Rather than having an individual PC on every desk, you will simply have a screen and keyboard and all the computer functions will be done on servers. So the capital replacement cost in future is less because you do not have to replace every PC every four years. But the actual software, which is the way we run a case management system, should not change at all; it is more the hardware of the IT that we are looking to replace.

The Hon. PAUL GREEN: Who is responsible for setting the commission's performance targets or key performance indicators and how often are they reviewed or adjusted?

Mr PEHM: The commission sets them annually and we are meeting again in March to set them for the upcoming financial year. They are part of my performance agreement with the Minister so that is signed off with the Minister and discussions are held about those KPIs as well. Yes, that is the answer.

The Hon. PAUL GREEN: Do you foresee any issues that may negatively impact the commission's ability to meet its targets and potentially improve its performance against the 2010-11 results?

Mr PEHM: I have answered questions earlier on budget. Without an increase I think there will be an impact but, as I say, I am confident about getting that increase. So I am hoping that we will be able to improve on 2010-11.

CHAIR: In the 2009-10 annual report on page 49 you talk about the investigations division and you were going to develop models for particular types of investigations such as investigations dealing with the competency of a particular health service provider. Can you give us some further information regarding that project about developing a model and what the benefits may have been of these new investigative models?

Mr PEHM: Prescribing is a particularly difficult one, and I might hand over to Mr Kofkin to answer that. Prescribing matters are essentially medical practitioners overprescribing to parties and their patients. As Mr Kofkin said, there might be 100 patients involved. When you prosecute a matter like that it is a bit like a complex fraud prosecution. In effect you have to prove every prescription so there is a process of matching up the medical records with the

pharmacy prescriptions and material from the Pharmaceutical Benefits Scheme, Medicare payments and a lot of sources of information. All of that has to be put together before you can get it prosecuted or get an idea of what happened.

Performance cases can also be very complex. In the nursing area, for instance, we get complaints where a hospital will have performance concerns about a nurse. The nurse may have undergone two or three supervised performance assessments with a clinical nurse consultant, which may be adverse. The nurse may contest that and say either the consultant got it wrong or the nurse may take it down to the level of each patient: "I am alleged to have not made a record on that patient" or "I am alleged not to have done observations on these patients. I contest that." Then you have to get the medical record and say there are no observations. The nurse may say, "Well, I didn't make that observation because I was called by someone else to do something." Then you have to check that. In terms of the time taken for investigation they can be very complex. Having said how complex they are I will hand over to our Director of Investigations to tell you how he is addressing those sorts of problems.

Mr KOFKIN: In relation to the prescribing matters, the commission employs a number of pharmacy students and medical students who assist us in creating the schedules. As the Commissioner said, when we are looking at prescribing matters we are looking at several sources of data. We are looking at the medical records and at Medicare data and dispensing records and then we put them in certain schedules. That drives our investigation into what types of drugs have been prescribed, what types of authorities they required, and whether or not they were a Schedule 8 or a Schedule 4D drug. Normally they are predominantly those types of drugs. Historically they are incredibly time consuming. Those are the types of investigations, when you are looking at previous performance, that take over a year and sometimes considerably over a year. That means it pushes out quite considerably the figures for the average length of each investigation as a whole.

With the advent of our pharmacy students and medical students we train them and task them in relation to going through those records and compiling those schedules. They work closely with us so it is a real team-based approach in relation to prescribing matters. They are difficult investigations not only for us but also once they get down to the legal division. That is working really well; the unfortunate thing is our pharmacy students are very clever and very talented and they go and get great jobs, so we have to recruit over and over again. We have lost some really skilled pharmacy students recently who may one day become experts for us as their careers develop. We have recently recruited some medical students. It is very much a team-based approach for those really complex weighty investigations. That is how our division has developed over the last 18 months.

Mr ANDREW ROHAN: Commissioner, my next question is a simple one and I know probably half the answer but I will ask it. The commission's director of investigations resigned from the commission in 2011 and a temporary appointment was made to the position until the end of 2011. Has a permanent replacement now been appointed to the position?

Mr PEHM: He is pretty good. He can answer for himself.

Mr KOFKIN: Yes he has and he is enjoying it very much, thank you.

Mr ANDREW ROHAN: That is why I said I know half the answer.

Mrs ROZA SAGE: On the issue of staffing, are there any particular concerns or issues the commission experiences when undertaking recruitment? I note that in the 2009-10 annual report there is mention that the commission closed the resolution services at the Queanbeyan office because it failed to fill a vacant position despite two attempts at recruitment.

Mr PEHM: We do not have a great deal of difficulty recruiting in the Sydney office. The story with the resolution office is a little complex in the historical sense in that we had more outsourced some time ago than we do now. We had some in metropolitan areas like Liverpool, I think, and Royal North Shore Hospital. That was really because the area health service was based there and they would have helped with resolution matters. With the restructuring to 17 we cannot possibly have one because we do not have 17 resolution officers. We did want to keep the southern area open. We have an officer in Dubbo who services the whole south-west area. We had two rounds of recruitment in Queanbeyan for a resolution officer and there was just no success and we decided we would make do with what we had. We do not generally have difficulty recruiting officers but perhaps it was the location of the Queanbeyan position—I am not sure what the reasons are—but there were very few applicants and no suitable applicants.

Mr RYAN PARK: In your groupings of regional metropolitan areas you broke out Newcastle and Wollongong and put them into the metropolitan grouping. What was the reason for that?

Mr PEHM: Is that the submission to your complaint handling inquiry where we gave you all the data on the division between rural and regional?

Mr RYAN PARK: It is the way in which you break it out in local government areas. You broke it out again when it came to regional and metropolitan areas.

Mr PEHM: We can take that on notice. The officer who did that is not here today; she is on leave for another week or two. There is an appendix to that submission. I think we used Australian Bureau of Statistics statistical geography standard. I am not sure what is in general use.

Mr RYAN PARK: You did and my understanding from the report is that the commission then created a metropolitan area grouping that included greater Sydney, the city of Newcastle and Wollongong. I am interested in the reasons for moving Newcastle and Wollongong into the metropolitan group when in the regional grouping there are local government areas such as Kiama and Shellharbour, which are literally next door.

Mr PEHM: I do not know the answer to that but we can find out and let you know.

The Hon. PAUL GREEN: The Ombudsman's report indicates that 12 complaints regarding the commission were assessed by his office with five complaints undergoing preliminary or informal investigation. It is appendix G on page 148 of the report. Can you provide the Committee with the details of the complaints handled by the Ombudsman?

Mr PEHM: Not off the top of my head but we can do that. Whether we have the details from the Ombudsman—often with annual reports we just call them up and get the raw numbers. We might know if we have files that the Ombudsman sent us so we might be able to tell you which ones they have done preliminary inquiries on but perhaps not the ones they

have done no inquiries on. We will take that on notice and come back to you and give you an idea.

The Hon. PAUL GREEN: I am interested in a snapshot of what the issues may have been.

CHAIR: You highlighted some of the issues with recruitment. I note that you made some attempts to recruit more Aboriginal staff but that has not happened. Do you know why that has been a problem? Does the commission have any plans relating to how you might encourage Aboriginal staff to the commission?

Mr PEHM: We have one Aboriginal identified officer in Dubbo. We make extra efforts, and we did so in trying to recruit an Aboriginal person to the Queanbeyan position. We advertised in the Aboriginal publication and got in touch with the local Aboriginal organisations but we were not successful.

CHAIR: You spoke about some Aboriginal law graduates. Did you have any success with getting them to complete some of their legal training at the commission?

Mr PEHM: Yes. We have not done that yet. That is an idea to try to increase recruitment in the legal pool. But we have not made those approaches yet.

Mr ANDREW ROHAN: I refer to page 59 of the 2010-11 annual report, which states that the commission will work to identify files that are no longer required to fulfil its legal and business requirements and to dispose of them under new sentencing and disposal guidelines, once they are approved. Have those guidelines be been approved and what is the commission's long-term plan to ensure the protection of files?

Mr PEHM: The guidelines have not been drawn up or approved yet. The commission's sentencing guidelines date from its establishment in 1993. They are very rigorous and onerous, and we are required to keep files for 99 years in many cases. The process is that we draw up new sentencing guidelines and we talk to the State Records Authority about approving them. Once they are approved, we can dispose of files in accordance with the new guidelines. Our current file storage requirements cost about $25,000 or $30,000 a year. Given that those guidelines have not been reviewed since the 1990s, this process is long overdue. There may be a saving in terms of the amount of paper we are required to store. There is also the capacity with electronic techniques to scan material and to store it much more cheaply. It is a big project. The new records officer has been in place for nine months to a year and much of her work has involved tidying up and getting a grip on the extent of the holdings in preparation for drawing up the guidelines.

Mrs ROZA SAGE: It is noted in both the 2009-10 annual report at page 13 and in the 2010-11 annual report at page 8 that the commission provided quarterly reports on its complaints handling performance for the Minister and the parliamentary Committee and that there were no requests for further information. Is quarterly reporting useful to the commission or is it a waste of time? Do you have any comments or suggestions about establishing more regular dialogue with the Committee about quarterly reports?

Mr PEHM: It is not a significant drain on our resources. We constantly maintain performance data and we undertake reviews all the time. I introduced the quarterly reports

because I thought it would be useful for the Committee. The question is whether the Committee finds them useful. If it does not want them, we do not need to provide them. On the broader question, I am happy to explore more frequent or different kinds of communication with the Committee.

Mr RYAN PARK: Does the Minister discuss these reports with you?

Mr PEHM: The Minister's staff have. There was a discussion about performance indicators with the Minister in my annual performance review.

Mr RYAN PARK: I refer to the hits on the commission's website. It has certainly been a success.

Mr PEHM: They have gone through the roof.

Mr RYAN PARK: The number has increased by an astronomical amount. I wish our vote in the last election had done that. There have been more than five million hits—and I understand that they are hits and not necessarily inquiries. Has that increased the commission's workload or has channelling people through that portal decreased it because they can get information more readily? It is interesting because these things are designed reduce workload. I accept that and I am a big fan, but at times they have the opposite effect. Having been on the bureaucratic side, I am interested to know whether it has been beneficial and has streamlined the work or whether it has had the opposite impact.

Mr PEHM: We do not really know how many people have visited the site and gone away happy because they got an answer. The number of complaints has increased, but it is hard to know whether more information generates more complaints or satisfies more people. Often when you open up processes that people are not aware of they generate more complaints. We could probably get more sophisticated with the information we put on the website in the frequently asked questions section.

We cannot do much about fees; the private professions can charge what they like in excess of the scheduled Medicare fee. Fees sometimes come as a shock to people. For example, general practitioners might refer patients for pathology services and they will assume it is covered by Medicare. Some general practitioners are very good and inform their patients about the extra charges and some pathology services are covered and some are not. We can put frequently asked questions on our website dealing with that. I am sure it will not stop people ringing up or writing. The website also allows people to lodge online complaints. Again, it is anecdotal and many people jump on the site and start banging away. It is very easy to lodge a complaint. Opening up the website opens up the organisation to more complaints as well as to answering questions. It is hard to gauge which is which.

The Hon. PAUL GREEN: Is the commission expecting to develop an app for Iphones and Ipads or Androids given community mobility?

Mr PEHM: Katja Beitat, our communications officer, has done an excellent job upgrading the website and improving our interaction. It has not occurred to me, but I am sure it has to her.

The Hon. PAUL GREEN: It is part of the education process and accessibility is everything. I think Australia has more Iphones and Androids than anywhere else in the world.

Mr PEHM: The odd thing is that when people search "health complaints" the Health Care Complaints Commission comes up second on the Google list. We occasionally get complaints from Georgia and California. The online complaint box pops up and away they go.

The Hon. PAUL GREEN: The Ombudsman's 2010-11 annual report refers to public interest disclosures and the establishment of a public interest disclosures steering committee following recent amendments to the Public Interest Disclosures Act 1994. This committee is responsible for providing advice to the Premier on the operation of that Act and recommending necessary reforms. The report advises that following a recommendation from the Independent Commission Against Corruption to the steering committee, the committee will, among other issues, consider including the Health Care Complaints Commission as an investigating authority. Can you comment on that?

Mr PEHM: No, I cannot. We had some communication with the Ombudsman a few months ago about preparing ourselves to handle the new public interest disclosures legislation. I am not aware of moves to make us an investigating authority or what that means in terms of the Public Interest Disclosure Act. The Health Records and Privacy Information Act provides that we are exempt, we are also exempt from defamation under the Defamation Act, so it may be an extension of that. I cannot give an update.

CHAIR: I refer to the performance report for 1 July to 31 December 2011. Page 4 of that report contains a table dealing with the outcome of assessments of complaints. It includes the total for the first two quarters of 2011-12 and an estimated total. I note that discontinued complaints are predicted to decrease by 47 per cent. Complaints referred to registration boards and councils are also predicted to decrease. However, local resolutions are predicted to increase. Can you comment on those trends and the predictions?

Mr PEHM: I do not have that quarterly report in front of me. Local resolution has certainly increased in the past year or so. We think that is a good thing. It is part of the—

CHAIR: Change in districts?

Mr PEHM: The proportion of complaints estimated to be discontinued is about 47 per cent. It was 48 per cent in 2010-11 so there is not a big change. In fact, it has dropped slightly. Local resolution has gone from 1.7, 1.2 and then 5 per cent last and we estimate 7 per cent this year. That will certainly be the focus of our training with the local health district complaints staff as well, and we intend to refer them out there if we can.

CHAIR: In terms of that training you will provide them, who comes from the local health district to the training? I assume it is compulsory for them to attend?

Mr PEHM: We just wrote to all the chief executives of the local health districts and asked them to nominate people. It is a huge attendance. There are 196 as of today. We are splitting it into two different sessions. It is mainly complaint handling staff. There are a lot of nurse unit managers. We can probably give you a list of people—directors of medical services. I think anyone who has anything to do with responding to complaints right from directors of medical services, nurse unit managers. They may not do it every day as part of their job but as

well as the actual complaint handling staff and the patient safety representatives, a lot of clinicians are coming in as well. We are doing it at five remote sites to north coast, Far West. It is an absolute extravaganza.

CHAIR: It would be useful for looking at complaints handling in regional areas if we could get a breakdown of who will be attending in the districts.

Mr PEHM: We are just finalising the agenda and the presentations today. We are getting feedback from the participants as well so maybe we can just do a report for you after it is over and include the feedback as well.

CHAIR: When does the training start?

Mr PEHM: On 5 March. That will be the platform to look at what future training we provide. We've got to get their feedback about what they think they need.

CHAIR: What sort of feedback do you seek from them? Will it be on the training day?

Mr PEHM: No, about future needs as well and future training. There are lots of way we could do it. We were talking about this this morning. We can either do one every six months for new staff that come in, and limit it to about 50 or something, or we could go out and visit the areas as well if there are special issues that are out there. But we need to see what they need first before we decide what we will do.

CHAIR: That would be of interest in terms of our next inquiry about what sort of feedback you are getting, and from that how you plan to move ahead in terms of future training.

Mr PEHM: Certainly we can give you the agendas. We are doing a manual for them as well. Some of the presentations, and after it is finished we can give you the feedback. We can put all that together for you by, say, the end of March.

Mr ANDREW ROHAN: In November 2011 this Committee was pleased to advised a briefing from your good self regarding proposed changes to the Health Care Complaints Act 1993. Will the commission provide advice concerning the current status of the proposed changes to the Act?

CHAIR: Have you had some discussions with the Minister?

Mr PEHM: I think I had some discussions with the Minister before I met you in November.

CHAIR: Since then the Committee has written to her as well about the recommendations.

Mr PEHM: The other one that I thought might be a bit controversial was the notification of RCA SAC-1 incidents to the commission. Remember I thought the clinicians might have some concerns about that and I knew that the department did. I met with some Minister's staff about a week ago on budget issues and the feedback from them was that the

Minister was quite positive about that change as well. I understood they would be talking to you so I am in no position to give you any further feedback on that.

Mrs ROZA SAGE: Given that there has been some talk about some of the computer software that some of the department's have had, have the implemented enhancements to the Casemate, the commissioner's case management system, provided the commission with increased efficiencies and led to an increased quality of reporting? What further necessary enhancements to the system are planned in 2011-12?

Mr PEHM: An electronic case management is system is an essential tool for complaints management. It lets you know when things are overdue. It can throw up anomalies and you can report on your outcomes. Our system was pretty well designed, I think, to start with but it is a continuous improvement process. There is an internal system where the directors of all the divisions are constantly getting feedback from their staff about what is right and what is wrong with it, and what does not work. They make request to IT to make enhancements, they call them, the technical jargon.

Mrs ROZA SAGE: Tweaking?

Mr PEHM: Tweaking, enhancements, depending on the complexity and cost of those, we prioritise them. We upgraded the Casemate system about a year ago now, I think in March last year from an old platform to a new one which is faster and better and provides for more complexity. Assessments have had a lot of changes to and improvements to processes made. I think investigations have got a wish list of things they want changed and improved as well, legal probably does as well.

Mrs ROZA SAGE: Has that increased the efficiency of reporting on what you do?

Mr PEHM: Yes, it acts as an aide to the case officers that are using it because they can get reports on what is overdue or what needs to be done, and or when they have to report to managers. From the management point of view it can tell us how quickly you are processing things and where there might be bottlenecks and where there are delays and so on.

Mr RYAN PARK: The regional and metropolitan complaints, and the types of breakdowns, look fairly similar in relation to what people report. From your experience and the experience of your staff, from a layman's perspective where are there some differences between complaints from the regional and rural areas and the metropolitan areas? There is talk about access but it is hard to break it down based on those charts because on the surface it has a percentage here, half a percentage there. Where do we see some differences between the types of complaints that might come from the regional areas compared with the metropolitan area?

Mr PEHM: Yes, you are right, the numbers do not tell us much. I was talking to our consumer consultative committee representative of regional and rural areas and she said that country people do not complain as much as city people so you are never going to get a proper assessment. There are inhibitions on country people complaining too because sometimes, reasonably frequently, it is a sole service provider and in a small town environment they do not want to become known as a complainer. Procedural fairness requires us to notify the practitioner of the complaint and they cannot give a decent response unless they know who it is from, that is the sole general practitioner and they have got to drive 200 miles to see

another general practitioner. So there is a reluctance to complain. We do get complaints which people withdraw on that basis or when they find out we have got to send it to the practitioner they say "No, I would rather not. I will sort it out myself." We can talk to them about how to do that. Another area with glaring needs is mental health services in rural and regional areas. It is probably not the number of complaints but their nature and where psychiatric assessments often have to be done by teleconsulting.

Mr RYAN PARK: Yes, that is what I was trying to get at, that the raw numbers seem reasonably similar but there must be some breakdown within those groupings.

Mr PEHM: It is more the anecdotal evidence and the way the individual complaints strike you as obviously hard for the people out there and hard for the clinicians as well. A person may turn up to a regional hospital at 3 a.m. on a weekend morning and the only person on duty is a nurse and often not a mental health specialist nurse. She might have a psychiatrist on call to talk to but then they have to do a teleconsult in order to decide whether the person needs detention. It is a very difficult circumstance under which to make judgments which are sensitive and difficult, even when made face to face. All those problems are exacerbated in rural areas because of the distance and the lack of resources. But Mental Health is an area that stands out when you read all the complaints. They are the most heart-rending complaints because the consequences can be terrible.

CHAIR: Do any of you have further questions relating to the annual reports? Commissioner, did you have any further comments that you wanted to add?

Mr PEHM: No, I hope I have answered everything to your satisfaction and as best I can.

CHAIR: Are you happy that if the Committee has further questions we can put them in writing and the replies will form part of this evidence?

Mr PEHM: Yes, of course.

(The witnesses withdrew)

(The Committee adjourned at 4.12 p.m.)

Chapter Seven – Responses to Questions Taken on Notice at the Public Hearing

NEWCASTLE/ WOLLONGONG REGIONAL GROUPINGS

1. *In your groupings of regional metropolitan areas you broke out Newcastle and Wollongong and put them into the metropolitan grouping. What was the reason for that – what are the reason for moving Newcastle and Wollongong into the metropolitan group when in the regional grouping there and local government areas such as Kiama and Shellharbour, which are literally next door?*

Response:

As mentioned in our response to the Committee's inquiry into health care complaints and complaints handling in NSW, the Commission faced some difficulty in accessing current information sources that would allow it to map postcode data to a Local Government Area (LGA) and then to a regional/metropolitan area grouping.

The Commission also faced difficulties in sourcing a definitive list from other government agencies of LGAs included in metropolitan and regional groupings. A number of agencies use different classifications for regional and metropolitan groupings.

The Ministry for Health classifies eight Local Health Districts (LHDs) in the metropolitan region and seven LHDs in rural and regional NSW. The metropolitan region includes the areas of Central Coast, Illawarra/Shoalhaven and Nepean/Blue Mountains.

<u>Metropolitan NSW Local Health Districts</u>

- Central Coast
- Illawarra Shoalhaven
- Nepean Blue Mountains
- Northern Sydney
- South Eastern Sydney
- South Western Sydney
- Sydney
- Western Sydney

<u>Rural & Regional NSW Local Health Districts</u>

- Far West
- Hunter New England
- Mid North Coast
- Murrumbidgee
- Northern NSW
- Southern NSW
- Western NSW

On the other hand the Office of Local Government in its classification of 'Metropolitan Councils' excludes LGAs from the Illawarra/Shoalhaven area but includes the following:

- Blue Mountains City Council
- Campbelltown City Council
- Gosford City Council
- Hawkesbury City Council
- Wollondilly Shire Council
- Wyong Shire Council

The Commission based its metropolitan area grouping on ABS statistical areas included in ABS's Australian Statistical Geography Standard (ASGS).

In order to provide the Committee with a different perspective, the Commission has re-classified the metropolitan and regional groupings and has re-analysed the data regarding complaints received from regional and metropolitan consumers in the years 2008-09 to 2010-11. The re-classification essentially separates the Sydney Metropolitan area for the rest of NSW, which is classed as regional.

New Groupings

Regional
Albury
Armidale
Bathurst
Blue Mountains
Bourke - Cobar - Coonamble
Broken Hill and Far West
Clarence Valley
Coffs Harbour
Dapto - Port Kembla
Dubbo
Gosford
Goulburn - Yass
Great Lakes
Griffith - Murrumbidgee (West)
Inverell - Tenterfield
Kempsey - Nambucca
Kiama - Shellharbour
Lachlan Valley
Lake Macquarie - East
Lake Macquarie - West
Lithgow - Mudgee
Lower Hunter
Lower Murray
Maitland
Moree - Narrabri
Newcastle
Orange
Port Macquarie
Port Stephens
Queanbeyan
Richmond Valley - Coastal
Richmond Valley - Hinterland
Shoalhaven
Snowy Mountains
South Coast
Southern Highlands
Tamworth - Gunnedah
Taree - Gloucester
Tumut - Tumbarumba
Tweed Valley
Upper Hunter
Upper Murray exc. Albury
Wagga Wagga
Wollondilly
Wollongong
Wyong

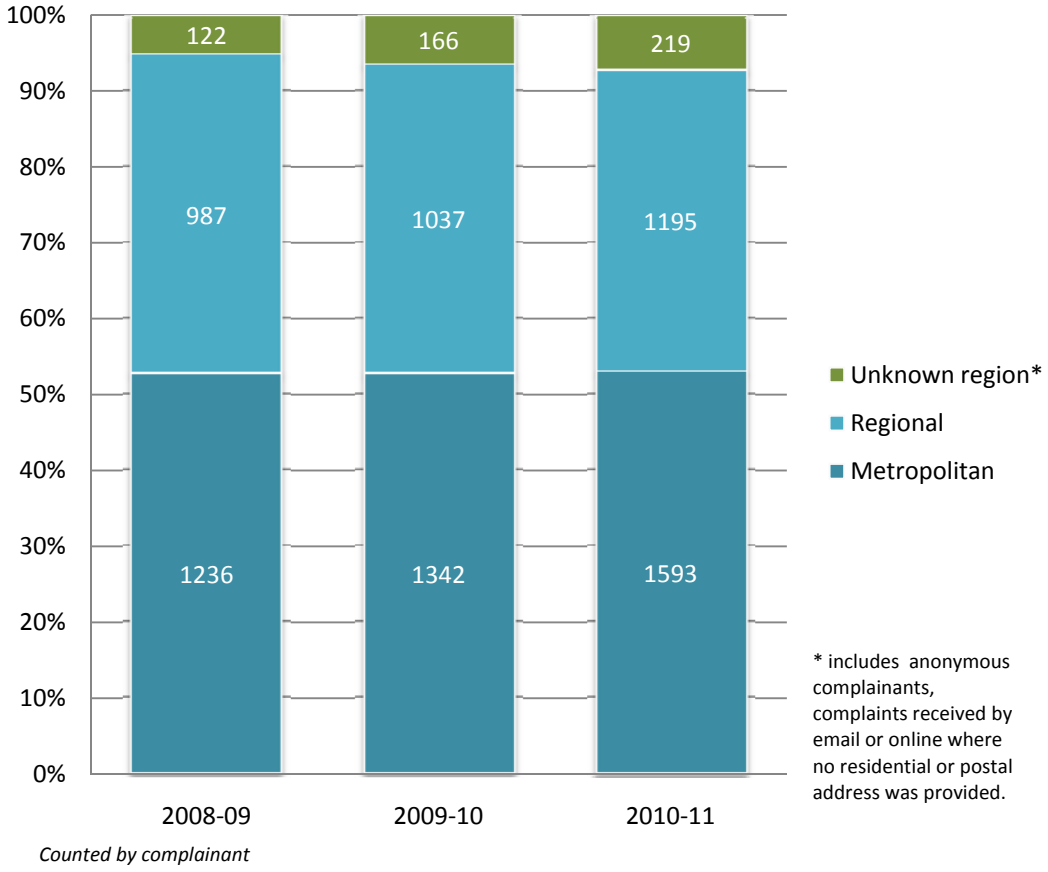
Metropolitan
Auburn
Bankstown
Baulkham Hills
Blacktown
Blacktown - North
Botany
Bringelly - Green Valley
Camden
Campbelltown (NSW)
Canada Bay
Canterbury
Carlingford
Chatswood - Lane Cove
Cronulla - Miranda - Caringbah
Dural - Wisemans Ferry
Eastern Suburbs - North
Eastern Suburbs - South
Fairfield
Hawkesbury
Hornsby
Hurstville
Kogarah - Rockdale
Ku-ring-gai
Leichhardt
Liverpool
Manly
Marrickville - Sydenham - Petersham
Merrylands - Guildford
Mount Druitt
North Sydney - Mosman
Parramatta
Pennant Hills - Epping
Penrith
Pittwater
Richmond - Windsor
Rouse Hill - McGraths Hill
Ryde - Hunters Hill
St Marys
Strathfield - Burwood - Ashfield
Sutherland - Menai - Heathcote
Sydney Inner City
Warringah

Quantity of complaints received by regional and metropolitan consumers

Given the regrouping the proportion of complaints received over the three years 2008-09 to 2010-11 from regional or metropolitan consumers have been revised and are shown in chart 1. The new proportions are:

- 52.8% of complaints were received from metropolitan consumers
- 40.8% from regional consumers
- In 6.4% of complaints the regional area of the complainant was unknown.

Chart 1 - Consumer complaints received by region grouping

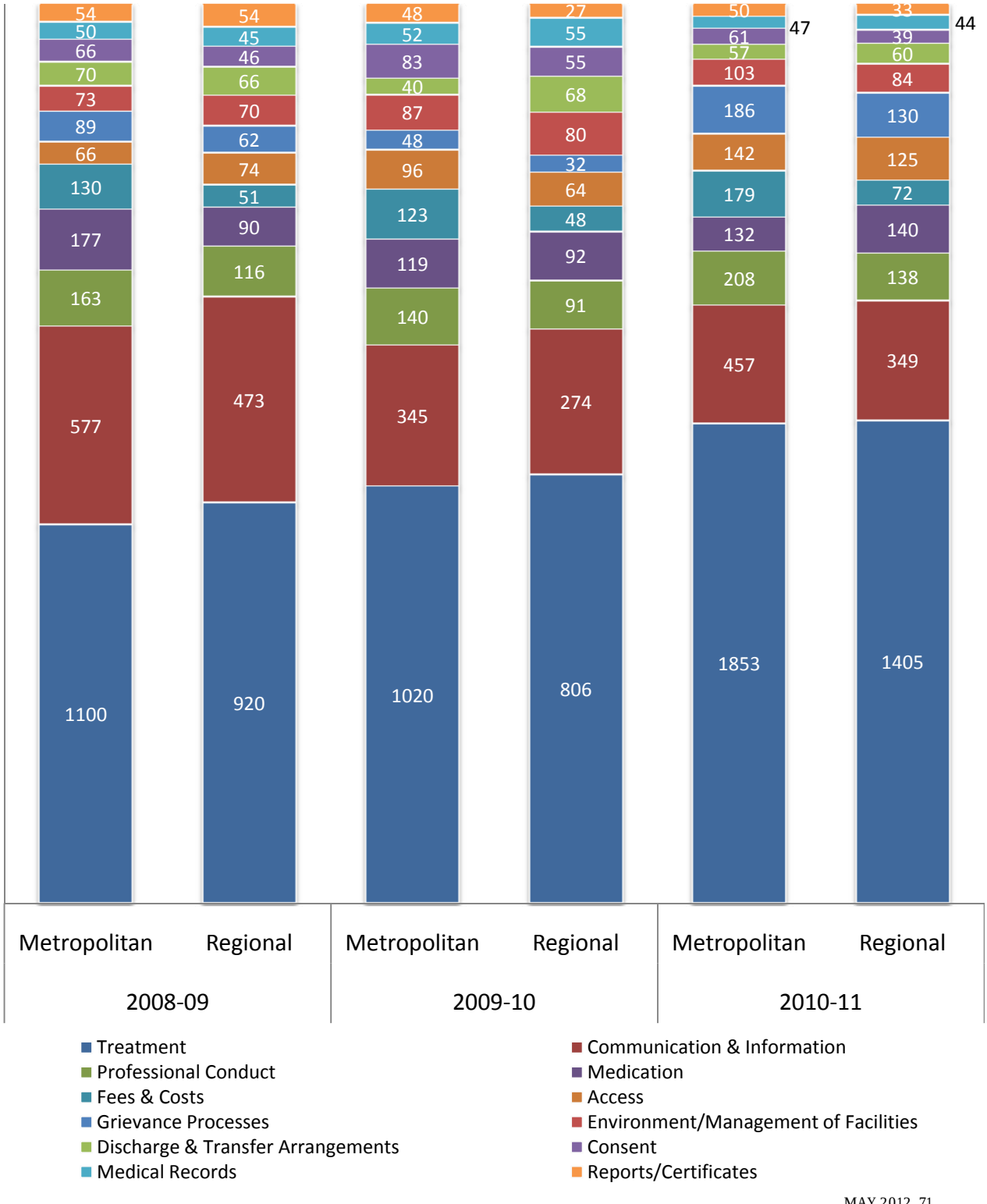


Counted by complainant

Nature of complaints received by regional and metropolitan consumers - Issues

The Commission has also re-analysed the data regarding issues raised in complaints received. Chart 2 shows the revised issues raised in complaints received from regional and metropolitan consumers over the years 2008-09 to 2010-11. Table 1 also shows the same data by proportion.

Chart 2 - Issues raised in complaints received from regional and metropolitan consumers (2008-09 to 2010-11)



Counted by complainant

Table 1 - Issues raised in complaints received from regional and metropolitan consumers (2008-09 to 2010-11)

	2008-09			2009-10			2010-11			
Issue category	Metropolitan	Regional	TOTAL	Metropolitan	Regional	TOTAL	Metropolitan	Regional	TOTAL	Grand Total
Treatment	42.1 %	44.5 %	43.1 %	46.3 %	47.6 %	46.9 %	53.3 %	53.6 %	53.5 %	48.4 %
Communication & Information	22.1 %	22.9 %	22.4 %	15.7 %	16.2 %	15.9 %	13.2 %	13.3 %	13.2 %	16.9 %
Professional Conduct	6.2%	5.6%	6.0%	6.4%	5.4%	5.9%	6.0%	5.3%	5.7%	5.8%
Medication	6.8%	4.4%	5.7%	5.4%	5.4%	5.4%	3.8%	5.3%	4.5%	5.1%
Fees & Costs	5.0%	2.5%	3.9%	5.6%	2.8%	4.4%	5.2%	2.7%	4.1%	4.1%
Access	2.5%	3.6%	3.0%	4.4%	3.8%	4.1%	4.1%	4.8%	4.4%	3.9%
Grievance Processes	3.4%	3.0%	3.2%	2.2%	1.9%	2.1%	5.4%	5.0%	5.2%	3.7%
Environment/Management of Facilities	2.8%	3.4%	3.1%	4.0%	4.7%	4.3%	3.0%	3.2%	3.1%	3.4%
Discharge & Transfer Arrangements	2.7%	3.2%	2.9%	1.8%	4.0%	2.8%	1.6%	2.3%	1.9%	2.5%
Consent	2.5%	2.2%	2.4%	3.8%	3.3%	3.5%	1.8%	1.5%	1.6%	2.4%
Medical Records	1.9%	2.2%	2.0%	2.4%	3.3%	2.7%	1.4%	1.7%	1.5%	2.0%
Reports/ Certificates	2.1%	2.6%	2.3%	2.2%	1.6%	1.9%	1.4%	1.3%	1.4%	1.8%
Grand Total	**100. 0%**	**100. 0%**	**100. 0%**	**100. 0%**	**100. 0%**	**100. 0%**	**100. 0%**	**100. 0%**	**100. 0%**	**100. 0%**

Counted by complainant

There are no distinguishable differences in the re-analysed data presented in Chart 2 and Table 1 in this document with the data presented in the Commission's response to the Committee's inquiry into health care complaints and complaints handling in NSW

COMPLAINTS TO THE OMBUDSMAN OFFICE

2. *The Ombudsman 2010/11 Annual Report - Appendix G, page 148 – indicates that 12 complaints regarding the commission were assessed by the Ombudsman's office with five complaints undergoing preliminary or informal investigation. Can you provide the*

Committee with the details of the complaints handled by the Ombudsman?

Response:

The Ombudsman's Annual Report 2010-11 reports that a total of 17 complaints were made regarding the Health Care Complaints Commission. Of these 12 were declined without any inquiries by the Ombudsman. The Ombudsman Annual Report 2010-11 states that the declined complaints included:

> Conduct outside jurisdiction, trivial, remote, insufficient interest, commercial matter, right of appeal or redress, substantive explanation or advice provided, premature — referred to agency, concurrent representation, investigation declined on resource/priority grounds.[66]

The remaining five complaints were finalised after preliminary or informal investigation. The Ombudsman reports that in three cases the complaint was finalised as 'Advice/explanation provided where no or insufficient evidence of wrong conduct'[67]. One complaint was finalised as 'Further investigation declined on grounds of resource/priority'[68]. and the remaining complaint was 'Resolved to Ombudsman's satisfaction'[69]..

No complaints made to the Ombudsman in 2010-11 regarding the Health Care Complaints Commission were formally investigated.

The Commission is not always made aware of complaints made to the Ombudsman. In order to provide a response to the Committee, the Commission contacted the NSW Ombudsman and requested details of the 17 complaints received by them during 2010-11. Table 2, as supplied by the Ombudsman, provides the details of these complaints.

Table 2 : Complaints received by the NSW Ombudsman during 2010-11 about the NSW Health Care Complaints Commission (HCCC)

	Date received	Nature of complaint	Ombudsman Outcome
1.	02/08/10	Complaint about HCCC's decision in regards to her complaint.	Declined at outset. No evidence of wrong conduct by H CCC.
2.	03/08/10	Complaint that HCCC are pursuing a vexatious complaint.	Declined at outset. Concurrent representations. Complaint still before the HCCC for review.

[66] NSW Ombudsman Annual Report 2010–11, pp 150.
[67] Ibid.
[68] Ibid.
[69] Ibid.

	Date received	Nature of complaint	Ombudsman Outcome
3.	13/08/10	Complaint about a lack of transparency in the HCCC's assessment process. Reference made to the fact that the HCCC does not prescribe to a professional standard of care and the absence of criteria against which a clinician's conduct can be measured. Complaint that advice from Internal Medical Advisors is based on opinion not fact. Complainant no longer wishes to pursue her original complaint against her physician but does want an investigation into the HCCC's assessment process.	Decline at outset. No evidence of wrong conduct. Explanation provided concerning our role. Professional opinions of IMA noted as providing assistance only in HCCC's assessment process.
4.	25/08/10	Complaint regarding the Medical Council and HCCC's handling of her matter. Query as to oversight body of Medical Council and HCCC.	Decline at outset. Explanation of our jurisdiction, referral of complainant to Medical Council's appeal process if unhappy with their decision and explanation concerning jurisdiction of H CCC, Medical Council and AHPRAS provided.
5.	01/09/10	Allegation that the HCCC assessed a submission it received that, according to the complainant's legal advisors, may not have been a "complaint" as the word is defined in the HCCC Act.	Telephone enquiries made to the HCCC to obtain a copy of the letter it sent to the complainant which provided reasons for its decision in this matter. Review of letter. No evidence of wrong conduct. Matter finalised on this basis.
6.	13/10/10	Complaint that the HCCC did not properly assess her complaint.	Declined at outset. Premature. Complainant had not first raised matter with the HCCC, giving it a chance to review its decision.
7.	06/12/10	Complaint about HCCC handling of his complaint.	Declined at outset. Premature. Complainant had not first raised matter with the HCCC, giving it a chance to review its decision. Advice given also as to our role regarding complaints about the H CCC.

	Date received	Nature of complaint	Ombudsman Outcome
8.	20/12/10	Complaint that a nurse and neighbour of the complainant improperly accessed his medical records and discussed those details with their neighbours.	Declined at outset on grounds of resources/utility. HCCC have carried out inquiry into this issue and written to the complainant re its findings. Matters raised in this complaint also canvassed in another complaint concerning Housing NSW and Police.
9.	10/01/11	Complaint about HCCC's conduct before the Medical Tribunal.	Declined at outset as subject of complaint not within our jurisdiction pursuant to Schedule 1 clause 8 of the *Ombudsman Act 1974.*
10.	28/02/11	Complaint about the HCCC's decision that the conduct he complained about in 1993 was too remote in time to investigate.	Declined at outset. No evidence of wrong conduct. Decision of HCCC permissible under its Act.
11.	08/03/11	Complaint that the HCCC did not investigate his complaint about NCIRS properly.	Declined at outset. No evidence of wrong conduct. Referral of concerns re NCIRS to Federal Department of Health and Aging.
12.	09/03/11	Complaint that the HCCC did not investigated his complaint that a phony doctor had drugged his wife and provided her with medical certificates falsely indicating that he was crazy.	Declined at outset. Complainant advised that complaints about his Doctor and wife are not within our jurisdiction as they are private individuals. Referral to HCCC re allegations of professional misconduct by his medical practitioner.
13.	14/04/11	Complaint that the HCCC did not adequately investigate his complaint.	Declined at outset. Matter is premature. Complainant referred to HCCC for review of its decision.
14.	21/04/11	Complaint about delay by HCCC in assessing her complaint.	Telephone enquiries made with HCCC disclosed reasons for the time taken by its office to review complaint. No evidence of wrong conduct. Matter finalised on this basis.
15.	20/05/11	Complaint about the HCCC's decision that there was no evidence that her doctor had injected her with poison and 'mentally abused' her.	Telephone enquiries made with both the complainant and HCCC for further information. Substantial discussions in person with the complainant. No evidence of wrong conduct. Matter declined on this basis. Review request declined as no reasons for a review provided.

	Date received	Nature of complaint	Ombudsman Outcome
16.	31/05/11	Complaint that the HCCC's investigation into her complaint that she was not given adequate pain relief after having her leg amputated was inadequate.	Complainant contacted for copies of correspondence sent to her by the HCCC. Review of submissions. No evidence of wrong conduct. Declined on this basis.
17.	01/06/11	Complaint that the HCCC ignored evidence he submitted and took six months rather than six weeks to assess his complaint.	Declined at outset. No evidence of wrong conduct by HCCC.

Appendix One – List of Witnesses

Public Hearing - 20 February 2012, Waratah Room, Parliament House

Witness	Organisation
Mr Kieran Pehm	Commissioner, Health Care Complaints Commission
Ms Karen Mobbs	Director of Proceedings, Health Care Complaints Commission
Mr Tony Kofkin	Director of Investigations, Health Care Complaints Commission

Appendix Two – Extracts from Minutes

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

10.02 a.m., Tuesday, 9 August 2011

Room 1254, Parliament House

Members Present

Ms Cusack, Mr Green, Mr Park, Mr Rohan, Mrs Sage, and Mrs Williams.

Apologies

An apology was received from Ms Westwood.

1. Confirmation of Minutes

Resolved, on the motion of Mrs Sage, seconded by Ms Cusack:

"That the Committee adopt the minutes of the meeting of 23 June 2011".

2. Briefing on Committee's Statutory Functions

The Chair referred to the briefing and invited Members to raise matters of interest. Discussion ensued. The Chair suggested that the particular matters raised could be pursued with the Commissioner during the visit of inspection on 5 September 2011.

3. ***

4. ***

5. General Business

Resolved, on the motion of Ms Cusack, seconded by Mr Park:

"That the Committee defer consideration of the 2009-2010 Annual Report of the Health Care Complaints Commission until after the 2010-2011 Annual Report has been tabled and conduct one Review of both Reports".

The Chair noted that the review would take place in the first quarter of 2012.

The Committee adjourned at 10.30 a.m. until Wednesday 14 September at 10.00 a.m.

MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (NO. 6)

10.13 a.m., Friday, 25 November 2011
Room 1153, Parliament House

Members Present

Mrs Williams, Mrs Sage, Mr Rohan, and Ms Westwood.

Apologies

Apologies were received from Ms Cusack, Mr Green and Mr Park.

Officers in Attendance: Vicki Buchbach, Kieran Lewis, Jacqueline Isles

1. Confirmation of Minutes

Resolved, on the motion of Mrs Sage, seconded Mr Rohan: That the Committee adopt the minutes of the meeting of 10 November 2011.

2. ***

3. ***

4. ***

a) ***
b) Reviews of Annual Reports

The Committee agreed to conduct a review of the 2009/10 and 2010/11 Annual Reports of the Health Care Complaints Commission on Monday 20 February at 2.00 p.m.

5. ***

The Committee adjourned at 10.42 a.m. until Monday 20 February 2012 at 2.00 p.m.

MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (NO. 7)

Monday 20 February 2012

2.10 pm, Waratah Room, Parliament House

Members Present

Mrs Williams (Chair), Mrs Sage (Deputy Chair), Ms Cusack, Mr Green, Mr Park, and Mr Rohan.

Officers in Attendance

Vicki Buchbach, Jason Arditi, Kieran Lewis and Jacqueline Isles.

1. Apologies

An apology was received from Ms Westwood.

2. Confirmation of Minutes

Resolved, on the motion of Ms Cusack, seconded by Mrs Sage: That the Minutes of the meeting of 25 November 2011 be adopted.

3. ***

4. ***

5. Review of Annual Reports

(i)Commissioner's Response to Questions on Notice

Resolved, on the motion of Ms Cusack, seconded by Mrs Sage: That the Commissioner's responses to Questions on Notice be published on the Committee's website, subject to the approval by the Commissioner.

(ii)Discussion of allocation of questions for hearing

The Chair referred Members to the questions for the public hearing in the distributed papers. Discussion ensued on the allocation and order of questions.

Ms Cusack withdrew.

6. ***

7. ***

8. Public Hearing – Review of the 2009-10 and 2010-11 Annual Reports of the Health Care Complaints Commission

At 2.30 pm the Chair declared the commencement of the hearing and the witnesses and the public were admitted.

Mr Kieran Pehm, Commissioner, Health Care Complaints Commission and Mr Tony Kofkin, Director Investigations were sworn and examined.

Ms Karen Mobbs, Director of Proceedings, was affirmed and examined.

Evidence concluded, the witnesses withdrew.

Resolved, on the motion of Mr Rohan, seconded by Mrs Sage: That the transcript of the witnesses' evidence be published on the Committee's website, after making corrections for recording inaccuracy, together with responses to questions on notice received before today, and the answers to any questions taken on notice in the course of today's hearing.

The Committee adjourned at 4.12 pm until a time and date to be determined.

MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (NO. 9)

Wednesday 9 May 2012

1:16 pm, Room 1043, Parliament House

Members Present

Mrs Williams (Chair), Mrs Sage (Deputy Chair), Ms Cusack, Mr Green, Mr Park, Mr Rohan and Ms Westwood (from 1:37 pm)

Officers in Attendance

Jason Arditi, Vicki Buchbach, Jacqueline Isles and Kieran Lewis.

1. Confirmation of Minutes

Resolved, on the motion of Mrs Sage, seconded by Mr Green: That the Minutes of the meeting held on 15 March 2012 be adopted.

2. ***

3. ***

4. Review of the 2009-2010 and 2010-2011 Annual Report of the Health Care Complaints Commission

The Chair advised that the report was being drafted by the secretariat and the Chair's draft would be ready to be considered for adoption at the next meeting.

5. ***

6. ***

7. ***

The Committee adjourned at 1:56 pm.

Minutes of Proceedings of the COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (no. 10)

Wednesday 30 May 2012
1:10 p.m., Waratah Room, Parliament House

Members Present

Mrs Williams (Chair), Mrs Sage (Deputy Chair), Mr Green, Mr Park , Mr Rohan and Ms Westwood

Officers in Attendance

Vicki Buchbach, Jason Arditi, Kieran Lewis and Jacqueline Isles

Apologies

Ms Cusack

1. Confirmation of Minutes

Resolved, on the motion of Mr Ryan, seconded by Mrs Sage: That the Minutes of the meeting held on 9 May 2012 be adopted.

At 1.15 p.m. the meeting adjourned and the following Members withdrew to attend a Division in the Chamber: Mrs Williams, Mrs Sage, Mr Park and Mr Rohan.

At 1.27 p.m. the meeting resumed.

2. Review of the 2009-2010 and 2010-2011 Annual Reports of the Health Care Complaints Commission

i. Consideration of Report:

The Committee proceeded to consider the Chair's draft Report as previously circulated.

Resolved, on the motion of Mr Rohan, seconded by Mr Park: That the draft Report be considered *in globo*

ii. Call for amendments

The Chair asked Members if they wished to make any amendments to the draft Report.

Resolved, on the motion of Mrs Sage, seconded by Mr Park: That references to the 'Medicare Dental Scheme' be replaced with a reference to the 'Chronic Disease Dental Scheme' and that this takes place wherever occurring throughout Chapters 1 - 4 of the Committee's Report. Further, that a footnote be inserted at paragraph 2.12 to note that the Commission has, in its Annual Report and in responses to Questions on Notice, referred to the 'Medicare Dental Scheme'.

iii. Publication of the Report

Resolved, on the motion of Mrs Sage, seconded by Ms Westwood:

(a) That the Report as amended be the Report of the Committee and that it be signed by the Chair and presented to the House,

and

(b) That the Chair and the Committee staff be permitted to correct stylistic, typographical and grammatical errors,

and

(c) That once tabled, the Report be placed on the Committee's website'

3. ***
4. ***
5. ***

The Committee adjourned at 1:41 p.m. until Wednesday 20 June at 9.15 a.m.