



PARLIAMENT OF NEW SOUTH WALES

# COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REPORT 3/55 – OCTOBER 2013

REVIEW OF THE 2011-2012 ANNUAL REPORT 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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# Membership

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# Terms of Reference

The Committee on the Health Care Complaints Commission is a current joint statutory committee, 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 in Part 4 of the Health Care Complaints Act 1993, sections 64-74.

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 (HCCC) Annual Report 2011-2012 pursuant to the Committee's responsibilities under section 65 of the *Health Care Complaints Act 1993* to examine all reports of the Commission. This is the Committee's second review in the 55<sup>th</sup> Parliament.

The Committee took this opportunity to examine and review the current complaint pathways available to NSW health consumers. Significant changes in recent years have meant a reorganisation of complaint avenues and processes, and the Committee considered it timely to take stock of the current health complaints architecture.

Throughout the review process, the Committee also examined the trends in complaints before the HCCC, with particular regard to the types of matters brought to the Commission, and the types of practitioners complained about. The Committee had noted that changes in complaint handling practice had previously led to a decline in satisfaction rates among complainants. This was largely due to an increase in the volume of complaints, together with decrease in staffing numbers. The Committee now notes that there have been recent budgetary increases, and that this should assist in relieving the impacts on existing resources, and in turn lead to an increase in complainant satisfaction rates.

The Committee also noted the various amendments to the *Health Care Complaints Act 1993* (the Act) that have recently occurred. The Committee took particular interest in changes to the Act that will now enable the Commissioner to investigate the delivery of health services by a health service provider directly affecting the clinical management or care of a client if the health service affects, or is likely to affect, the clinical management or care of an individual. This change was prompted by a recent Supreme Court decision unfavourable to the Commission. The Committee supports these amendments, and will be monitoring the use and effectiveness of these new powers.

The Committee also noted and supported the Commission's ongoing outreach and community liaison activities, to maximise awareness and interest of the Commission's purpose and functions. This includes online activities, personnel visits to Local Health Districts, and engagement with diverse language communities.

This report reflects on the last annual report 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 29 April 2013.

Finally, I would like to thank the Commissioner and his staff for providing information in a timely way, together with fellow Committee Members for their ongoing interest and involvement in the work of the Committee.

**Leslie Williams MP**  
Chair



# Chapter One – Introduction

## INTRODUCTION

- 1.1 Pursuant to section 65 of the *Health Care Complaints Act 1993* ('the Act'), the Joint Committee on the Health Care Complaints Commission ('the Committee') is required to examine each annual report made by the Health Care Complaints Commission ('the Commission'), and present 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.<sup>1</sup> Section 95 of the Act outlines the content the Commission must include in its annual report.<sup>2</sup>
- 1.2 The functions of 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. This review considers the 2011-2012 annual report of the Commission, and is the second review of the 55<sup>th</sup> Parliament.
- 1.3 As a part of the review process, a public hearing was held at Parliament House on 29 April 2013. Evidence was taken from three witnesses from the Commission: the Commissioner, Mr Kieran Pehm, Director of Investigations, Mr Tony Kofkin, and Director of Proceedings, Ms Karen Mobbs.
- 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 report. The Commission provided responses to the questions on notice on the 26 April 2013. 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 responses to the questions on notice, together with the transcript of evidence taken at the hearing, are reproduced as appendices to this report, and are also available on the Committee's webpage.
- 1.7 This report is comprised of seven chapters. This chapter outlines the terms of reference of the Committee and basis for the inquiry; Chapter Two discusses some of the health care complaint handling pathways in New South Wales, which the Committee considered timely to review following recent legislative changes; Chapter Three evaluates some of the trends in complaints; Chapter Four evaluates recent legislative and policy change occurrences; and Chapter Four considers corporate and community services provided by the Commission.

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<sup>1</sup> *Health Care Complaints Act 1993*, s65

<sup>2</sup> *Health Care Complaints Act 1993*, s95

## Chapter Two – Complaint Pathways

### COMPLAINT PATHWAYS

- 2.1 The Commission is the principal authority that receives complaints about both individual health practitioners and health organisations. Complaints about individual practitioners can be about both registered and unregistered practitioners.
- 2.2 In New South Wales complaints about individual practitioners or health care organisations can be lodged with one of four government authorities, depending on the nature of the complaint. The four government agencies are:
- the Australian Health Practitioner Regulation Agency (AHPRA);
  - the Health Professional Councils Authority (HPCA), or by directly dealing with any one of 13 councils with specific responsibility regulating allied health professionals, including chiropractic, dental, nursing, optometry and psychology;
  - NSW Fair Trading; and
  - the Commissioner.
- 2.3 Given recent administrative changes which may affect understanding which agency is best to deal with health care complaints, the Committee considered it timely to review some of the procedures available to health care consumers.
- 2.4 The four agencies were each formed under different Acts to serve different purposes. AHPRA was formed under the *Health Practitioners Regulation National Law Act 2009*; the New South Wales health professional councils under the *Health Practitioner Regulation (Adoption of National Law) Act 2009*, the Commission under the *Health Care Complaints Act 1993*; and NSW Fair Trading under the *Fair Trading Act 1987*.
- 2.5 The *Health Practitioner Regulation National Law* ('the National Law') came into effect in 2010. This new system is designed to create a single national registration and accreditation scheme while retaining NSW as a co-regulatory jurisdiction. In effect, this means NSW is part of the National Scheme, but manages notifications about practitioner performance and conduct differently than that of all other Australian States and Territories.<sup>3</sup> Notifications of complaints in NSW are handled by the Commission and the NSW health professional councils supported by the HPCA.<sup>4</sup>

### AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY

- 2.6 The Australian Health Practitioner Regulation Agency (AHPRA) is the national accreditation and registration body for all health care practitioners. AHPRA handles all national queries relating to registration or applications for renewal. In

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<sup>3</sup> Australian Health Practitioner Regulation Agency (AHPRA) 2011-2012 Annual Report, p10

<sup>4</sup> Australian Health Practitioner Regulation Agency 2011-2012 Annual Report, p85

addition, all issues relating to the training and accreditation of registered health practitioners are dealt with by the appropriate National Board. AHPRA assists the various National Boards.<sup>5</sup>

- 2.7 Under the National Law, all mandatory notifications must be made to AHPRA.<sup>6</sup> If the notification of a complaint relates to a practitioner in NSW, AHPRA will forward it to the Commission and the relevant NSW professional health council.<sup>7</sup> The Commission and relevant NSW health professional councils are co-regulators and each body is required to consult with the other about the assessments, investigation and prosecution of complaints in NSW.<sup>8</sup> The HPCA also works closely with the National Boards for each profession and AHPRA.
- 2.8 If the Commission or a NSW health professional council imposes conditions on the registration of a practitioner or on an endorsement of registration, the conditions will be published on the register of practitioners. The register of practitioners is maintained by AHPRA. The aim of a condition is to restrict a practitioner's practice in some way to protect the public.<sup>9</sup>

## NSW HEALTH PROFESSIONAL COUNCILS

- 2.9 The Health Professional Councils Authority (HPCA) is an administrative body of the Health Administration Corporation. The HPCA provides administrative and secretarial support to each of the 14 NSW health professional councils in their primary role of protecting the public.
- 2.10 The NSW health professional councils operate in consultation with AHPRA and the Commission on all notifications of complaint. However, the NSW councils can take carriage of notifications of complaint regarding clinical care and treatment, professional conduct or the health of a registered health practitioner.<sup>10</sup> These notifications of complaint can be lodged by patients, a parent or guardian, a relative, a friend or representative chosen by the patient, a health service provider or any other concerned person.<sup>11</sup>
- 2.11 The NSW health professional councils have the powers to impose interim orders to suspend a practitioner or impose conditions on a practitioner's registration, for the protection of the health or safety of any person or persons or in the public interest. Generally, after these interim orders are made, the NSW health professional council must then refer the matter to the Commission for investigation. The Commission does not have equivalent powers as with NSW councils to impose interim order suspensions or the imposition of conditions on a NSW health practitioner.

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<sup>5</sup> <http://www.hccc.nsw.gov.au/Information/Information-For-Health-Consumers/Referral-of-a-complaint-to-the-Director-of-Proceedings>

<sup>6</sup> <http://www.hccc.nsw.gov.au/Information/Information-for-health-providers/National-Registration-Scheme>

<sup>7</sup> <http://www.hccc.nsw.gov.au/Information/Information-for-health-providers/National-Registration-Scheme>

<sup>8</sup> <http://www.hccc.nsw.gov.au/Information/Information-For-Health-Consumers/Referral-of-a-complaint-to-the-Director-of-Proceedings>

<sup>9</sup> <http://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx>

<sup>10</sup> <http://www.hpca.nsw.gov.au/Frequently-Asked-Questions/default.aspx>

<sup>11</sup> <http://www.hpca.nsw.gov.au/Frequently-Asked-Questions/default.aspx>

## NSW HEALTH CARE COMPLAINTS COMMISSION

- 2.12 The Health Care Complaints Commission ('the Commission') is a statutory body representing the Crown. The Commission's function is to receive and assess complaints relating to health service providers in NSW, resolve or assist in the resolution of complaints, investigate serious complaints that raise questions of public health and safety, and prosecute serious complaints.<sup>12</sup>
- 2.13 The Commission falls under the responsibility of the Minister for Health. However, it has broad statutory autonomy with respect to its critical functions which include:
- the assessment and investigation of a complaint;
  - prosecution of disciplinary action against a person;
  - terms of any recommendations of the Commission; and
  - the contents of a report of the Commission including the Commission's annual report.<sup>13</sup>
- 2.14 The Commission can handle all types of health care complaints, however the Commission can refer the matter if it relates to a relevant government agency's jurisdiction.
- 2.15 Notifications of complaint regarding health associated professions which do not fall within NSW health professional councils' ambit, including dietitians, dental technicians, optical dispensers, social workers or speech pathologists who are not registered health practitioners, can be directed to the Commission. Similarly notifications of complaint regarding health services such as public and private hospitals, day surgeries and medical centres should also be directed to the Commission.

## OTHER RELEVANT BODIES

- 2.16 NSW Fair Trading administers fair trading laws, protects the rights of consumers, advises NSW businesses and traders on fair and ethical practices, and aims to achieve fairness in the marketplace.<sup>14</sup> Notifications of complaint which should be referred to NSW Fair Trading are those that relate to the fee charged by a health service provider.<sup>15</sup>
- 2.17 If an individual or organisation is dissatisfied with the way in which one of these four government agencies handles a notification of complaint, depending on what the issue is and which government agency it is regarding, concerns and feedback can be provided to the Privacy Commissioner, NSW Anti-Discrimination Board, Office of the Minister for Health or Office of the Minister for Fair Trading. Systemic issues about complaint handling practices can be brought to the Committee or the Ombudsman.

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<sup>12</sup> <http://www.hccc.nsw.gov.au/About-Us/About-the-Commission/default.aspx>

<sup>13</sup> NSW Legislation - <http://www.legislation.nsw.gov.au/maintop/view/inforce/act+105+1993+cd+0+N>

<sup>14</sup> [http://www.fairtrading.nsw.gov.au/FAQs.html#What\\_does\\_Fair\\_Trading\\_do](http://www.fairtrading.nsw.gov.au/FAQs.html#What_does_Fair_Trading_do)

<sup>15</sup> <http://www.hpca.nsw.gov.au/Frequently-Asked-Questions/default.aspx>

# Chapter Three – Complaint Trends

## COMPLAINTS TRENDS

3.1 Given the various pathways available to lodge a complaint about an individual practitioner or health care organisation in New South Wales, the Committee notes the Commission's position that:

It is important to recognise that the Commission is not the only body that deals with health care complaints. Complaints are often handled by hospital management or the Local Health Districts, without the Commission being involved. Therefore, Commission data cannot be a comprehensive indicator of the overall standard of health care delivery in NSW.<sup>16</sup>

3.2 The Committee recognises that this, together with possible reticence to lodge complaints or lack of awareness about complaint processes available, make it difficult to use the number of complaints received as an indicator of the number of actual matters existing that could be subject to a complaint. The Committee explored these issues in its recent Report on the *Inquiry into Health Care Complaints and Complaint Handling in NSW*.

3.3 Turning to the complaints handled by the Commission, the Committee is always interested in reviewing key features, including the nature of the complaint, and the category of practitioner that is subject to the complaint.

3.4 Based on its Annual Report, the Commission received 4,130, in which there were 7,253 issues raised, for an average of 1.8 issues per complaint during 2011-2012.<sup>17</sup> After many years of a steady increase in the volume of complaints received, this trend now appears to be levelling off.<sup>18</sup>

3.5 The most common issue raised by complainants concerned practitioner treatment (46.2 per cent). This is in line with previous years, in which concerns with treatment constituted nearly half of all complaints received. However, there has been a notable fall-off in complaints about treatment in actual numbers when compared with the previous year. Treatment has been defined by the Commission to include alleged wrong and inadequate diagnoses or treatment, or unexpected treatment outcomes and complications.<sup>19</sup>

3.6 Once again, communication issues were the second most common subject of a complaint (15.1 per cent).<sup>20</sup> The Commission classifies the category of communication as the provision of wrong or inadequate information, or where there are concerns about the attitude and manner of a health service provider.

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<sup>16</sup> Health Care Complaints Commission (HCCC) Annual Report 2011-2012, p11

<sup>17</sup> HCCC Annual Report 2011-2012, p11

<sup>18</sup> HCCC Annual Report, 2011-2012, p6

<sup>19</sup> HCCC Annual Report, 2011-2012, p11

<sup>20</sup> HCCC Annual Report 2011-2012, p12

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COMPLAINT TRENDS

Within each category, the attitude of the practitioner is the most complained about issue.<sup>21</sup>

- 3.7 The professional conduct of a health service provider (11 per cent) was the third most commonly complained about matter. Professional conduct is defined to include matters of a more grave nature, including lack of competence, assault, sexual misconduct, fraud, and inappropriate disclosure of information.
- 3.8 The Committee notes the Commission's extensive collection of data and analysis of statistics on complaints regarding health professionals. Based on comparable data from 2007-2008 to 2011-2012, complaints were most commonly made against medical practitioners, dental practitioners, nurses and midwives, pharmacists and psychologists.<sup>22</sup>
- 3.9 Medical practitioners remain, by far, the most commonly complained about profession.<sup>23</sup> As advised by the Commission, this simply reflects the overall numbers of interactions between the public and general practitioners. As an overall proportion of complaints received against all practitioners, general practitioner complaints have been declining somewhat in recent years. This is largely due to an increase in the number of complaints against dental practitioners, which remain the third most complained about type of practitioner. The Commissioner has previously advised that this was largely a result of the increase in dentistry services now subsidised by Medicare.<sup>24</sup>
- 3.10 Surgeons were the second most complained about type of practitioner, again in line with previous years. The Commission advises that this is largely due to the likely complexity of surgical procedures, and a higher-than-average potential for complications.<sup>25</sup>
- 3.11 When considering the issues raised by complaints about health practitioners, it is apparent that a significant majority of complaints against dental practitioners relates to treatment with a further number of complaints being about fees. Meanwhile, a large plurality of complaints against nurses and psychologists are about professional conduct. The Committee appreciates the higher propensity for complaints about dental practitioners to be about costs given the expensive nature of dental work. Similarly, the Committee recognises that the interface between nurses or psychologists and patients will likely give rise to an increased number of complaints due to communication issues.
- 3.12 The Committee also reviewed the results of statistical analysis carried out by the Commission on complaints about health organisations. Over the past five years public hospitals generated the highest number of complaints, which reflects the huge volume and nature of services public hospitals provide.<sup>26</sup> In 2011-2012

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<sup>21</sup> HCCC Annual Report 2011-2012, p13

<sup>22</sup> HCCC Annual Report 2011-2012, p14

<sup>23</sup> Response to Questions on Notice – Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, 26 April 2013, p7

<sup>24</sup> HCCC Annual Report 2011-2012, p15

<sup>25</sup> HCCC Annual Report 2011-2012, p15

<sup>26</sup> HCCC Annual Report 2011-2012, p17

public hospitals accounted for 45.9 per cent of health organisation complaints. The second and third categories which received the largest number of complaints are correction and detention facilities (11.2 per cent) and medical centres (6.4 per cent), which have both increased in 2011-2012 when compared with the previous year.<sup>27</sup>

- 3.13 Of complaints received about public hospitals, the most commonly raised concerns are in respect of emergency medicine and surgery, which together account for 44.1 per cent of all public hospital complaints. On this issue, the Commission comments:

Emergency and surgical patients are often less able to interact with their practitioners. In addition, both areas have a high potential for complications and unexpected treatment outcomes.<sup>28</sup>

- 3.14 In terms of reporting data available, the Committee also acknowledges the Commission's response to a question on notice regarding reporting outcomes that:

... the Commission can only report on outcomes of complaints that were finalised by the Commission. The Commission is usually not advised of the final outcome of complaints that were referred to a health professional Council, to a public health service for local resolution or that were referred to another body.<sup>29</sup>

## INTERNAL PROCESSES

- 3.15 The Committee notes that in 2011-2012, the Commission did not meet its key self-set performance indicators relating to the timely processing of assessments, resolution of complaints and review processes.<sup>30</sup>

- 3.16 On this point, the Committee notes the Commission's statistics on its assessment of complaints in its Annual Report 2011-2012 and that a substantial majority, or 88.1 per cent, of complaints were assessed within the 60-day statutory timeframe. This is an improvement on the 84.6 per cent recorded in the previous year. The Commission advised that where assessment was not achieved within 60 days, it was often the case that the Commission was waiting for a response.

- 3.17 Despite these achievements, only 76.1 per cent of reviews were completed within six weeks. The Commissioner advised that there were various legitimate reasons for this delay, noting:

It is sometimes a case where you have to obtain further information from the health service provider, which takes time and further information from our own expert advisors, our internal medical advisors and they sometimes have to consult specialists.

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<sup>27</sup> HCCC Annual Report 2011-2012, p103

<sup>28</sup> HCCC Annual Report 2011-2012, p15

<sup>29</sup> Response to Questions on Notice – Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, 26 April 2013, p7

<sup>30</sup> Transcript of Evidence, 29 April 2013, p11

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COMPLAINT TRENDS

Where a complainant comes back after a discontinued decision and provides a lot more information, the review will take into account that information, if necessary, and make further inquiries. That is a legitimate reason for it to take longer than six weeks.

I think we had some management issues in that area that were also contributing to them not being done in a very timely way and they have been fixed up now. I think we just had some administration problems where correspondence would come in and go on the complaint file without being registered as a review, so the review process did not kick off within a reasonable time.<sup>31</sup>

- 3.18 The Commissioner commented that the organisation was experiencing a strain on its resources and capacity due to an approximate 50 per cent increase in the volume of complaints and budget restraints in the form of productivity savings over a four to five year period.<sup>32</sup>
- 3.19 In its 2010-2011 Annual Report, the Commission reported that it had made changes to its practices in assessing complaints as a result of the increased volume of complaints and resultant pressures on staff. This caused the Commission to reduce the amount of time a staff member can individually spend on handling a complaint and liaising and communicating directly with complainants. The Commission attributes this to the drop in individual client satisfaction rates in 2011-2012.<sup>33</sup>
- 3.20 On this issue, just 47.2 per cent of individual complainants who made a complaint and responded to a client survey were satisfied with the Commission's service. This is a significant drop from 65.6 per cent two years prior. It is noted however that satisfaction rates of health service providers stayed constant at 77.6 per cent, comparable with 72.2 per cent and 79.5 per cent in the previous two years.<sup>34</sup> These matters have been probed further in the Committee's recent Report following the *Inquiry into Health Care Complaints and Complaint Handling in NSW*.
- 3.21 On the matter of the Commission's change in complaints assessment practice, the Committee commented at the time:
- 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.<sup>35</sup>
- 3.22 The Commission reassured the Committee that despite the drop-off in customer satisfaction, public health and safety was never compromised.<sup>36</sup>

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<sup>31</sup> Transcript of Evidence, 29 April 2013, p11

<sup>32</sup> Transcript of Evidence, 29 April 2013, p2

<sup>33</sup> Transcript of Evidence, 29 April 2013, p2

<sup>34</sup> HCCC Annual Report 2011-2012, p31

<sup>35</sup> Committee on the Health Care Complaints Commission, *Review of the 2009-10 and 2010-11 Annual Reports of the Health Care Complaints Commission*, Parliament of New South Wales, May 2012, p5

<sup>36</sup> Transcript of Evidence, 29 April 2013, pp2 – 3

- 3.23 Since then, the Commission advised the Committee that there has been a 9.2 per cent funding increase for 2012-2013 which has allowed the Commission to reinstate its prior level of service, interaction and communication with complainants.<sup>37</sup> As a result the Commission has hired two additional assessment officers, two resolution officers, one investigation officer and one legal officer.
- 3.24 The Committee has previously noted and supported the Commissioner's advice that:

The Commission is now adequately staffed and funded. The Commission requires this continued increased funding to maintain high levels of service and adequate client satisfaction rates from both individuals and health organisations.<sup>38</sup>

### COMMITTEE COMMENT

- 3.25 The Committee notes the increase in funding to relieve the impacts on existing resources. The Committee expects that this be reflected by an increase in the satisfaction of health care consumers who have lodged complaints with the Commission.

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<sup>37</sup> Transcript of Evidence, 29 April 2013, p2

<sup>38</sup> Committee on the Health Care Complaints Commission, *Review of the 2009-10 and 2010-11 Annual Reports of the Health Care Complaints Commission*, Parliament of New South Wales, May 2012, p7

# Chapter Four – Legislative and Policy Changes

## LEGISLATIVE CHANGES

- 4.1 The Committee recognises that legislative changes in the past 18 months extended the remit of the Commission in some respects, while key court findings have found the Commission to be acting outside of its remit in others. These changes have made an impact on the types of complaints the Commission is able to investigate. The Committee also noted some changes that came into effect after the 2011-2012 reporting period, but considered it appropriate and timely to refer to these changes in this Report.
- 4.2 Firstly, the National Registration Scheme that came into effect 1 July 2010 in the form of the *Health Practitioner Regulation National Law (NSW)*. This Scheme formed one of the most substantial reorganisations of health accreditation and oversight in recent NSW history. The Commission's Annual Report 2011-2012 figures relate to the Scheme's second year of operations.<sup>39</sup>
- 4.3 The Committee recognises that implementing these changes was no easy feat, and commends the collaboration between the Commission and NSW health professional councils supported by the HPCA to provide data on notifications to enable AHPRA to produce comparable data across all States and Territories.<sup>40</sup> The Committee further recognises and commends the Commission and the HPCA for working towards providing more extensive data to AHPRA in the future.
- 4.4 One of the major changes flowing from the *Health Practitioners Regulation National Law (NSW)* was the implementation of the code of conduct for unregulated health practitioners. The *Public Health Regulation 2012* commenced operation on 1 September 2012. This code sets minimum standards for unregistered health practitioners concerning matters that may be a risk to public health and safety. Breaches of the code can be referred to the Commission, which is empowered to make prohibition orders against the practitioner.<sup>41</sup>
- 4.5 Further, from 1 July 2012, four new categories of health professions were required to register to practice in Australia. This includes practitioners of Aboriginal and Torres Strait Islander health, traditional Chinese medicine, medical radiation, and occupational therapy.<sup>42</sup>
- 4.6 A third major change concerns the mandatory notification requirement that now applies to all registered health practitioners and their employers. Amendments to the *Health Practitioner Regulation National Law* now make it mandatory for registered health practitioners and their employers to report certain types of notifiable conduct when they have a reasonable belief that a fellow practitioner

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<sup>39</sup> AHPRA Annual Report 2011-2012, p85

<sup>40</sup> AHPRA Annual Report 2011-2012, p85

<sup>41</sup> AHPRA Annual Report 2011-2012, p56

<sup>42</sup> AHPRA Annual Report 2011-2012, p57

or employee has engaged in certain types of problematic behaviour. This includes practicing while under the influence of drugs or alcohol, engaging in sexual misconduct with a patient, placing the public at risk of substantial harm due to an impairment, or where the practitioner has engaged in a practice that constitutes a significant departure from accepted professional standards. The Committee recognises that these new requirements may lead to an increase in complaints lodged with the Commission.

- 4.7 In the Committee's *Inquiry into the Operation of the Health Care Complaints Act*, the Committee recommended that a number of amendments be made to the Act. These amendments were suggested as a way of improving the effectiveness of the Commission's complaint handling processes.
- 4.8 The current Committee met with the Commissioner in November 2011 to discuss its position with respect to the prior Committee's recommendations, together with further recommendations suggested by the Commissioner.
- 4.9 These further suggestions concerned:
- enabling the Commissioner to formally refer back complaints for investigation when further information is required;
  - providing consistency regarding penalties for non-compliance;
  - removing duplication of investigation by enabling the Commission to *not* investigate when already being investigated by another body; and
  - providing for protection from self-incrimination charges in certain evidence matters.
- 4.10 The Health Legislation Amendment Bill 2013 gave effect to some of these recommendations, along with other miscellaneous changes.

## COURT DECISIONS AND RESPONSES

- 4.11 The Committee also notes that changes to the *Health Care Complaints Act 1993* that were included in the Health Legislation Amendment Bill 2013 took effect on 14 May 2013.
- 4.12 One of the key amendments to the Act is to provide a broader scope to the Commission's jurisdiction, as the Commission no longer requires an individual client or patient to lodge a complaint before it can commence investigative action.<sup>43</sup>
- 4.13 This amendment was a direct result of a court decision in *Australian Vaccination Network Inc (AVN) v Health Care Complaints Commissioner* [2012] NSWSC 110, which the Committee has followed closely. The AVN is a vaccine-sceptic organisation that campaigns against mass immunisation and promotes online discussion about the supposed possible effects and consequences of vaccination.

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<sup>43</sup> Transcript of Evidence, 29 April 2013, p7

As a result, two complaints were made with the Commission against the AVN, in which it was alleged that the AVN was engaged in misleading and deceptive conduct about the information it provided. Given the adverse public health impacts of promoting vaccine refusal, the Commission decided to investigate the complaint.

- 4.14 Following completion of the investigation, the Commission made a recommendation that the AVN publish a disclaimer on its website. When the AVN failed to do so, the Commission issued a public health warning pursuant to section 94A of the *Health Care Complaints Act 1993* (the Act). The warning stated:

The AVN's failure to include a notice on its website of the nature recommended by the Commission may result in members of the public making improperly informed decisions about whether or not to vaccinate, and therefore poses a risk to public health safety.

- 4.15 The AVN appealed to the Supreme Court, arguing that the Commission's handling of the complaint and the making of the public warning was outside of the Commission's jurisdiction. Specifically, the AVN argued that section 7(1)(b) of the Act did not apply as the complaints made did not 'affect the clinical management or care of an individual client' as mandated by the Act. The Commission argued that even though no individual was identified in the complaint, the actions of the AVN do affect individual clients.

- 4.16 In its decision of 24 February 2012, the Supreme Court found in favour of AVN, finding that a complaint must have 'a concrete (even if) indirect effect on a particular person or persons'.<sup>44</sup>

- 4.17 The Committee met with the Commissioner in June 2012 to discuss possible amendments to the Act to ensure the Commission is afforded sufficient powers to deal with public health issues which may not necessarily affect a single, individual client, or where an individual complainant has not been identified. The Committee wrote to the Minister and endorsed the Commissioner's proposed course of recommended action.

- 4.18 On 13 March 2013, the Minister introduced legislation that, amongst other things, gave the Commissioner the power to initiate an investigation on his or her own accord without first requiring an external complainant to trigger the investigation. Although the provisions of the legislation differed somewhat from the Commissioner's original recommendations, the effect is substantially similar.

- 4.19 Specifically, the amendments give the Commission powers to investigate the delivery of health services by a health service provider directly affecting the clinical management or care of clients; the issue to be investigated may or may not be the object of a particular complaint but may arise out of a complaint or complaints.<sup>45</sup>

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<sup>44</sup> HCCC Annual Report 2011-2012, p56

<sup>45</sup> *Health Care Complaints Act 1993*, s8(2)

- 4.20 The amendments also clarified that a complaint can be made against a health service practitioner if the health service affects, *or is likely to affect*, the clinical management or care of an individual. As such, the amendment removed the direct nexus that was previously required between a complainant and a health service practitioner for a complaint to be investigated.

#### COMMITTEE COMMENT

- 4.21 The Committee will be monitoring the use and effectiveness of these new powers. The Committee strongly supports the new powers afforded to the Commission and encourages the Commission, within its remit and resource capacities, use the new powers to investigate other organisations which promote activity that could be detrimental to public health and safety.

# Chapter Five – Corporate and Community Services

## COMMUNITY OUTREACH

- 5.1 The Committee has been particularly keen to understand the Commission’s approach to promoting awareness of its activities. This was a particular focus of the Committee’s recent Report on the *Inquiry into Health Care Complaints and Complaint Handling in NSW*. Therefore the Committee welcomes the opportunity to review the Commission’s community outreach activities.
- 5.2 Activities include the Commission’s interaction and collaboration with Local Health Districts and Specialty Networks, website and technological interface advances, new publications, assistance to people with special needs and raising awareness of the role of the Commission.
- 5.3 The Committee recognises the following activities of the Commission during 2011-2012:
- 66 presentations to community and health professional groups across NSW;
  - Distribution of 61,209 brochures, posters and other informational materials to stakeholders across NSW; and
  - Over 5.6 million website hits; and
  - Issuing 68 media releases.<sup>46</sup>
- 5.4 The Committee notes the Commissioner’s visits to all Local Health Districts, Specialty Networks and St Vincent’s Health Network between May to December 2012. In addition, most districts accepted the offer of a half day workshop for complaints-handling staff.<sup>47</sup>
- 5.5 The Committee encourages and supports the series of bi-monthly webinars started by the Commission in February 2013 for health workers, including staff of the Local Health Districts. Topics include the role and functions of the Commission, the management of incidents and prevention of complaints, mandatory reporting, communication issues and boundary issues.<sup>48</sup> The Commission also sought evaluation and feedback from participants in an effort to improve their information, service and delivery.<sup>49</sup>

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<sup>46</sup> HCCC Annual Report 2011-2012, p8

<sup>47</sup> Response to Questions on Notice – Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, 26 April 2013, p2

<sup>48</sup> Response to Questions on Notice – Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, 26 April 2013, p2

<sup>49</sup> Response to Questions on Notice – Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, 26 April 2013, p3&p5

- 5.6 The Committee also supports the Director of Assessments and Resolution re-visiting the Local Health Districts and Speciality Networks in 2013-2014.<sup>50</sup>
- 5.7 The Committee welcomes the re-design of the Commission's website. The Commission has altered its website's technological architecture and in the process has improved accessibility, user-friendliness, content and provided an enhanced mobile-friendly website interface.<sup>51</sup> The Committee supports the ongoing efforts of the Commission to enhance its technological interface with the public through initiatives such as scoping and implementing the use of mobile phone applications and QR codes.
- 5.8 The Committee looks forward to the outcomes of the Commission's feasibility study of the proposed development of iPhone and/or android mobile applications, as well as the use of QR codes.<sup>52</sup>
- 5.9 The Committee recognises the Commission's engagement to assist people in the community with special needs, and that the Commission offers:
- Information in 20 community languages on its website which is also available through the website of the NSW Multicultural Health Communication Service; and
  - Services for the hearing impaired, intellectual disabled and individuals with low literacy levels.<sup>53</sup>
- 5.10 The Committee also notes the Commission's quarterly meetings with its Consumer Consultative Committee members who comprise 17 various special needs organisations. As mentioned in the public hearing, the Committee looks forward to the Commission's continued work to assist individuals with special needs, through initiatives such as the development of an additional 'simple plain English visual guide'.<sup>54</sup>

## CORPORATE GOVERNANCE

- 5.11 As at 30 June 2012, the Commission employed a total of 84 staff, up from the 77 recorded at 30 June 2011. Despite this increase, there was a decrease in the number of full time equivalent staffing from 72.8 at 30 June 2011, to 70.8 at 30 June 2012. The discrepancy is accounted by the significant increase in part time staff, up from 11 to 17. Staff are employed under the Crown Employees (Public Sector – Salaries 2007) Award, and salary increases of 2.5 per cent were provided for at both 1 July 2011 and 1 July 2012.

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<sup>50</sup> Response to Questions on Notice – Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, 26 April 2013, p2

<sup>51</sup> Response to Questions on Notice – Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, 26 April 2013, p4

<sup>52</sup> Response to Questions on Notice – Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, 26 April 2013, p5

<sup>53</sup> <sup>53</sup> HCCC Annual Report 2011-2012, p9

<sup>54</sup> Response to Questions on Notice – Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, 26 April 2013, p3

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION  
CORPORATE AND COMMUNITY SERVICES

5.12 In the 2011-2012 financial year, the Commission had a total budget of just under \$11 million, an increase from the \$10.5 million from the previous year. Despite this increase, the Commission advised that it incurred a budget deficit of \$231,000. This was due to:

... an unbudgeted depreciation expense amount of \$69,124 for recognising make good expenses at the expiry of the current office accommodation lease in addition to actuarial adjustments of \$200,000 for long service leave. Whilst liabilities are higher than assets, the Commission anticipates that for the following financial year total assets will exceed liabilities due to significant capital expenditure being incurred to upgrade its information technology and communications infrastructure.<sup>55</sup>

5.13 The Committee notes that the Commission will endeavour to return to surplus in the near future. Further, the Committee welcomes the upgrades to the Commission's IT and communications systems.

5.14 The Committee recognises the staff development training facilitated both within the Commission and through external providers, including the 12.1 hours of training per full time equivalent staff member.<sup>56</sup>

5.15 The Committee also recognises the raft of corporate and human resource policies and practices in place including: ongoing performance management procedures; a workplace consultative committee; work health and safety risk management plan; an equal employment opportunity and diversity program; and a disability action plan.

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<sup>55</sup> HCCC Annual Report 2011-2012, p56

<sup>56</sup> HCCC Annual Report 2011-2012, p55

# Chapter Six – Response to Questions on Notice

Our reference: AF 2064  
Your reference: D13/0931  
Contact person: Katja Beitat,  
Phone: [REDACTED]  
Email: [REDACTED]



Mrs Leslie Williams MP  
Chair  
Joint Parliamentary Committee on the Health Care Complaints Commission  
Parliament of NSW  
Macquarie Street  
Sydney NSW 2000

Submitted by email to: [chcc@parliament.nsw.gov.au](mailto:chcc@parliament.nsw.gov.au)

Dear Mrs Williams

**Response to questions on notice – review of the 2011-12 Annual Report of the Health Care Complaints Commission**

Thank you for your letter of 16 April 2013 enclosing questions on notice for the Committee's forthcoming hearing on Monday, 29 April 2013.

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

Yours sincerely

[REDACTED]  
Kieran Pehm  
Commissioner

26 APR 2013

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COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION  
RESPONSE TO QUESTIONS ON NOTICE

Response to questions on notice  
Review of the 2011-12 Annual Report of the Health Care Complaints Commission

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**Question 1**

1. In relation to outreach and accountability statistics:

(a) Are you aware how many enquiries and complaints were assisted during 2011-12 using internal and external telephone, oral and written interpreter services?

(b) Are you aware how many enquiries and complaints made by members of the community with a hearing impairment were assisted during 2011-12 through the TTY number or National Relay Service?

**Response**

The Commission has analysed its billing information to establish how often it has used translating and interpreting services in 2011-12.

According to the Commissions' data, there were 196 external translation and interpreting engagements in 2011-12. Of these, 168 related to inquiries to the Commission, 24 to complaints during the assessment or resolution process and five related to legal matters.

The majority of interpretations and translations were provided by TIS National (167), followed by the Community Relations Commission (23) and NSW Multicultural Health (5). In addition, there was one engagement of an interpreter during a disciplinary hearing.

The Table below lists the most common languages translated in these engagements.

Table 1: Language for translating and interpreting services 2011-12

Language translated	No. of engagements
Arabic	51
Persian	24
Mandarin	22
Croatian	13
Spanish	11
Korean	11
Vietnamese	11
Greek	10
Other languages	43
<b>Total</b>	<b>196</b>

*Counted by translation engagement*

In relation to the number of people using the Commission's TTY service or the National Relay Service, the Commission is unable to provide exact data, as such calls are not separately recorded. Anecdotally, it appears that it is a very small number of calls that are received on the TTY number. This may be a result of people using email more commonly to communicate with the Commission.

The Commission has approached the National Relay Service to obtain data about the number of services provided to clients who wish to contact the Commission. The Commission was advised that the National Relay Service cannot release that type of information due to privacy reasons.

Response to questions on notice  
Review of the 2011-12 Annual Report of the Health Care Complaints Commission

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**Question 2**

*2. On pages nine and 30 of the Annual Report, it is noted that the Commission has developed a targeted half-day training program and has started to visit individual Local Health Care Districts to meet with senior executive staff and train complaint-handling staff on responding to and resolving complaints.*

- (a) Which Local Health Districts does the Commission intend on visiting?*
- (b) In what time-frame does the Commission aim to visit these Local Health Care Districts?*
- (c) How does the Commission determine the order in which it visits the various Metropolitan and Rural and Regional NSW Local Health Care Districts?*
- (d) Are the Specialty Networks and St Vincent's Health Network included in this visits and training program?*

Response

Between May and December 2012, the Commission visited all Local Health Districts and Specialty Networks and St Vincent's Health Network. The order of the visits was determined by the availability of relevant staff, including the Chief Executive Officers and Directors of Clinical Governance. All visits included a meeting with the Senior Executive and complaints managers. In addition, most districts accepted the offer of a half day workshop for complaints-handling staff.

Following the visits, in February 2013, the Commission started a series of bi-monthly webinars for health workers, including staff of the Local Health Districts about topics including the role and function of the Commission, the management of incidents and prevention of complaints, mandatory reporting, communication issues and boundary issues.

The Director of Assessments and Resolution is planning to re-visit the Local Health Districts and Specialty Networks again during 2013-14.

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION  
RESPONSE TO QUESTIONS ON NOTICE

Response to questions on notice  
Review of the 2011-12 Annual Report of the Health Care Complaints Commission

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**Question 3**

*On page eight, it is noted that 66 presentations were given to community and health professional groups across New South Wales.*

- (a) How many presentations were made in regional areas?*
- (b) What was the target audience for presentations in regional areas?*
- (c) Has the content/method of presentation changed over recent years?*
- (d) Is feedback sought from participants about the presentation and information provided?*
- (e) Is the above information gathered by the Commission but not included in the Annual Report?*

Response

The Commission internally records its outreach activities, including the date of the presentation, the topic, presenter, audience, and usually the venue. The registry entries are used for the Commission's reporting on outreach activities in the annual report.

In 2011-12, the Commission presented at 17 regional venues, including Newcastle, Dubbo, and Singleton. Please note that Commission presentations at statewide conferences or meetings that are held in Sydney also reach regional participants. For example, the Commission presented to Legal Aid Solicitors at their annual meeting that included participants from all over the state. Similarly, the Commission's information day for staff of the Local Health Districts on 5 March 2012 was also attended by workers from all over the state.

In general, the regional audiences are the same as for metropolitan areas. They include health consumers, carers and advocates, as well as regional health workers. The regional outreach is focused on areas where the Commission has one of its Resolution Officers located. Currently, regional offices of the Commission are located in Dubbo, Lismore and Newcastle.

To increase its outreach to regional audiences, in February 2012, the Commission has started a bi-monthly webinar series both for health workers, as well as health consumers.

Commission presentations respond to the information needs of the audience. A great number of presentations are about the role and functions of the Commission and the contents are updated mirroring changes in our legislation that have impact on the way the Commission deals with complaints. Health workers are more interested in topics such as preventing complaints and information on mandatory reporting.

The Commission does not obtain formal feedback for all presentations, but has relied on feedback obtained during events that attract a larger number of participants and were organised by the Commission. For example, the Commission sought feedback for its information day for Complaint handling staff of the Local Health Districts as well as from its visits to LHDs and has used that feedback to design the webinar series that commenced in early 2013. Feedback is sought from participants to the webinars.

REVIEW OF THE 2011-12 ANNUAL REPORT  
RESPONSE TO QUESTIONS ON NOTICE

Response to questions on notice

Review of the 2011-12 Annual Report of the Health Care Complaints Commission

The Commission also seeks regular feedback from experts attending its basic and advanced training courses. The feedback has been used to internally improve the training.

Details of the actual outreach activities and related feedback have not been included in the annual report, but have been used for internal purposes.

*Table 2: Regional outreach activities 2011-12*

Date	Agency/Group Name	Local Health District	Audience	Topic
04-Aug-11	Lismore Community Health Centre		Nursing Students	HCCC and other complaint information
11-Aug-11	Lismore Community Health Centre	NNSWLHN	Nursing Students	HCCC and other complaint information
29-Sep-11	Toukley Medical Services	CCLHD	General Practitioners, Practice Nurses, various allied health staff	Health Care Complaints Commission, Managing Complaints
18-Oct-11	NSW institute of Psychiatry	WLHD	Accredited Person's Workshop	Health Care Complaints Commission - Managing Complaints
26-Oct-11	Bathurst Base Hospital	WLHD	Health Care Providers	Hospital Staff - complaints Handling
03-Nov-11	Clinical Nurse Consultants Midwifery	WLHD	Midwives	HCCC and other complaint information
08-Nov-11	Lismore Community Health Centre	NNSWLHD	Nursing Students	HCCC and other complaint information
29-Feb-12	Coffs Harbour Base Hospital	MNCLHD	Nursing Managers	Health Care Complaints Commission - Managing Complaints
15-Mar-12	Lismore Community Health Centre	NNSWLHN	Nursing Students	HCCC and other complaint information
16-Mar-12	Quota Wellington	WLHD	Community	HCCC and other complaint information
19-Mar-12	Newcastle Uni - Callaghan Campus	HNE	Nursing Students	Role of HCCC, Strategies for managing complaints
23-Mar-12	Newcastle Uni - Port Macquarie Campus	Mid North Coast	Nursing Students	Role of the Health Care Complaints Commission. Strategies for managing Complaints
27-Mar-12	Lismore Community Health Centre	NNSWLHN	Nursing Students	HCCC and other complaint information
27-Mar-12	Good Services Forum - Newcastle	HNE	Aboriginal Community Members	Role of the Commission, Procedure for making a complaint, other strategies for resolving concerns
19-Apr-12	Scleroderma Support Group	HNE	Health Consumers	HCCC and other complaint information
23-May-12	Ostomy Association	WLHD	Health Consumers	HCCC and other complaint information
30-May-12	Southern LHD	Queanbeyan	Complaint staff	Complaint-handling workshop

Counted by presentation

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION  
 RESPONSE TO QUESTIONS ON NOTICE

Response to questions on notice  
 Review of the 2011-12 Annual Report of the Health Care Complaints Commission

**Question 4**

*Chart 6.3 on page 13 indicates that in 2011-12 over 70% of complaints about communication/information related to the attitude and manner of the health practitioner. Are you able to identify which service areas these attitude/manner complaints related to? E.g. medical practitioners, nurse/midwives, pharmacists, dental practitioners etc.*

Response

The Commission provides a further breakdown of the complaints relating to attitude and manner in the following tables 3 and 4. Table 3 shows the most common service areas for complaints about attitude and manner, while table 4 shows the most common type of provider and if it is an individual their profession for complaints about attitude and manner.

*Table 3: Number of complaints raising issue of attitude/manner by service area 2011-12*

Service area	Number of complaints about attitude/manner
General medicine	219
Emergency medicine	77
Surgery	64
Dentistry	61
Mental health	39
Medico-Legal	37
Pharmacy/Pharmacology	24
Aged Care	23
Psychology	18
Psychiatry	15
Obstetrics	15
Palliative care	11
Radiology	11
Neurology	10
Non-health related	10
Other service area	136
<b>Total</b>	<b>770</b>

*Counted by provider*

REVIEW OF THE 2011-12 ANNUAL REPORT  
RESPONSE TO QUESTIONS ON NOTICE

Response to questions on notice  
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*Table 4: Number of complaints raising issue of attitude/manner health service provider type 2011-12*

Health provider type		Number of complaints about attitude/manner
Health practitioner	Medical practitioner	331
	Dental practitioner	60
	Nurse/midwife	40
	Psychologist	19
	Pharmacist	14
	Physiotherapist	4
	Counsellor/therapist	3
	Chiropractor	3
	Administration/clerical staff	3
	Optometrist	2
	Social worker	2
	Dietitian/nutritionist	1
	Audiologist	1
	Podiatrist	1
	Other/unknown health practitioner	1
	Assistant in nursing	1
	Sonographer	1
Acupuncturist	1	
Medical radiation practitioner	1	
<b>Health practitioner total</b>		<b>489</b>
Health organisation	Hospital	174
	Medical centre	24
	Correction and detention facility	16
	Community Health Service	11
	Psychiatric hospital/unit	8
	Ambulance service	7
	Pharmacy	7
	Radiology facility	7
	Aged care facility	6
	Medical practice	5
	Aboriginal health centre	4
	Dental facility	3
	Local Health District	2
	Drug and alcohol service	2
	Blood Bank	1
	Other/unknown health service	1
	Day procedure centre	1
Pathology centres/labs	1	
Alternative health centre	1	
<b>Health practitioner total</b>		<b>281</b>
<b>Grand total</b>		<b>770</b>

*Counted by provider*

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION  
 RESPONSE TO QUESTIONS ON NOTICE

Response to questions on notice  
 Review of the 2011-12 Annual Report of the Health Care Complaints Commission

**Question 5**

Similarly, of the 228 complaints received about nurses and midwives, 482 complaints about dental practitioners, 104 complaints about pharmacists and 97 complaints about psychologists in 2011-12, how many were related to attitude and manner? (Chart 6.5, page 14).

Response

Table 5 below sets out the number and proportion of complaints about selected professions that involved issues of attitude and manner in 2011-12. Please note that these complaints may have also raised other issues in addition to attitude and manner.

Table 5: Complaints about attitude/manner in complaints about medical practitioners, nurses/midwives, dental practitioners, pharmacists and psychologists 2011-12

Professions	Total number of complaints received	Number of complaints raising issues of attitude/manner	% of all in profession
Medical practitioner	1,488	331	22.2%
Dental practitioner	482	60	12.4%
Nurse/midwife	228	40	17.5%
Pharmacist	104	14	13.5%
Psychologist	97	19	19.6%
<b>Total</b>	<b>2,399</b>	<b>464</b>	<b>19.3%</b>

Counted by provider

**Question 6**

In regard to Chart 6.14 on page 22, is the Commission able to identify the outcome of complaints referred to:

- (a) the Commission's Resolution Service
- (b) professional council
- (c) local resolution
- (d) another body

What percentage of each of these categories was successfully resolved?

Response

The Commission can only report on outcomes of complaints that were finalised by the Commission. The Commission is usually not advised of the final outcome of complaints that were referred to a health professional Council, to a public health service for local resolution, or that were referred to another body.

The Commission reported the outcomes of its resolution processes - assisted resolution and conciliation - on page 115 of the annual report 2011-12 in tables 16.20 and 16.21. These tables are replicated below.

REVIEW OF THE 2011-12 ANNUAL REPORT  
RESPONSE TO QUESTIONS ON NOTICE

Response to questions on notice  
Review of the 2011-12 Annual Report of the Health Care Complaints Commission

Table 16.20 – Outcome of assisted resolutions 2007-08 to 2011-12

		2007-08		2007-08		2009-10		2010-11		2011-12	
Outcome		No.	%								
Resolution did proceed	Resolved	228	38.9%	244	39.4%	216	39.1%	262	40.4%	239	36.6%
	Partially resolved	124	21.2%	167	26.9%	119	21.5%	143	22.0%	152	23.3%
	Not resolved	81	13.8%	103	16.6%	99	17.9%	88	13.6%	54	8.3%
<b>Resolution did proceed total</b>		<b>433</b>	<b>73.9%</b>	<b>514</b>	<b>82.9%</b>	<b>434</b>	<b>78.5%</b>	<b>493</b>	<b>76.0%</b>	<b>445</b>	<b>68.1%</b>
Resolution did not proceed		153	26.1%	106	17.1%	119	21.5%	156	24.0%	209	31.9%
<b>Grand total</b>		<b>586</b>	<b>100.0%</b>	<b>620</b>	<b>100.0%</b>	<b>553</b>	<b>100.0%</b>	<b>649</b>	<b>100.0%</b>	<b>653</b>	<b>100.0%</b>

Counted by provider identified in complaint

Table 16.21 – Outcome of conciliations 2007-08 to 2011-12

		2007-08		2007-08		2009-10		2010-11		2011-12	
Outcome		No.	%	No.	%	No.	%	No.	%	No.	%
Conciliation process did proceed	Resolved	63	30.4%	43	18.9%	26	18.2%	21	47.7%	18	81.8%
	Agreement reached at conciliation meeting	17	8.2%	15	6.6%	6	4.2%	1	2.3%	-	0.0%
	Complaint resolved with the assistance of the Registry	25	12.1%	34	14.9%	20	14.0%	4	9.1%	2	9.1%
Not Resolved	Consent withdrawn	16	7.7%	10	4.4%	6	4.2%	-	0.0%	2	9.1%
	Parties did not reach agreement during conciliation meeting	10	4.8%	27	11.8%	8	5.6%	10	22.7%	-	0.0%
	The conciliation was helpful in clarifying concerns	75	36.2%	99	43.4%	77	53.8%	8	18.2%	-	0.0%
<b>Total conciliation process did proceed</b>		<b>131</b>	<b>63.3%</b>	<b>129</b>	<b>56.6%</b>	<b>66</b>	<b>46.2%</b>	<b>36</b>	<b>81.8%</b>	<b>22</b>	<b>100.0%</b>
Conciliation process did not proceed		76	36.7%	99	43.4%	77	53.8%	8	18.2%	-	0.0%
Complaint resolved prior to conciliation		1	0.5%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
<b>Total conciliation process did not proceed</b>		<b>76</b>	<b>36.7%</b>	<b>99</b>	<b>43.4%</b>	<b>77</b>	<b>53.8%</b>	<b>8</b>	<b>18.2%</b>	<b>-</b>	<b>0.0%</b>
<b>Grand total</b>		<b>207</b>	<b>100.0%</b>	<b>228</b>	<b>100.0%</b>	<b>143</b>	<b>100.0%</b>	<b>44</b>	<b>100.0%</b>	<b>22</b>	<b>100.0%</b>

Counted by provider identified in complaint

In relation to complaints finalised by the Commission's Resolution Service in 2011-12, it is reported on page 33 of the annual report the Commission that: '208 [resolution] processes (30.8%) did not proceed because one or both of the parties did not wish to participate.

Of the remaining 467 complaints, 409 (87.6%) were fully or partially resolved. This includes complaints where an agreement was reached between the parties at a formal conciliation meeting.

In 58 complaints (12.4%) of the complaints that did proceed to resolution, no agreement or resolution could be achieved.

Sometimes, complaints were not resolved because the parties disagreed on what actually occurred. In other cases, the expectations of the person who made the complaint could not be met, or the options for resolution offered by one side were not acceptable to the other.'

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION  
RESPONSE TO QUESTIONS ON NOTICE

Response to questions on notice  
Review of the 2011-12 Annual Report of the Health Care Complaints Commission

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**Question 7**

*In reference to page 28, what percentage of complaints was discontinued without making any further inquiries?*

Response

The Commission does not separately record complaints it assesses without making further inquiries. To estimate the number and proportion it has analysed how many complaints were assessed within 14 days of being received. This timeframe indicates that it is very unlikely that the Commission made further inquiries, such as seeking a response from a provider.

As reported in table 16.13 on page 108 of the annual Report, in 2011-12, the Commission discontinued dealing with 2,017 complaints after its assessment. This represents 49.2% of all complaints that were assessed in that period. Of these, 408 (20.2% of all complaints discontinued or 9.9% of all complaints assessed) were assessed by the Commission within 14 days of receipt indicating that no further inquiries were made. Reasons included that the complaint contained sufficient information to make an assessment decision, or that the complaint had been withdrawn. Please note that this number may include complaints where the Commission sought clarification from the complainant, but did not seek a formal response from the provider.

# Chapter Seven – Transcript of Proceedings

REPORT OF PROCEEDINGS BEFORE

## COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

### REVIEW OF THE 2011-2012 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

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At Sydney on Monday 29 April 2013

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The Committee met at 2.30 p.m.

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#### PRESENT

Mrs L. Williams (Chair)

**Legislative Council**  
The Hon. C. Cusack  
The Hon. P. Green

**Legislative Assembly**  
Mrs R. Sage  
Mr A. Rohan

Transcript provided by Pacific Solutions

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION  
TRANSCRIPT OF PROCEEDINGS

**CHAIR:** Thank you commissioner for attending our hearing today and for your time, and your staff as well. I will now declare the hearing open. Before the proceedings commence, may I remind everyone to switch of mobile phones as they can interfere with the Hansard recording equipment. If your phone is on silent, please switch it off completely.

In accordance with section 65(1)(c) of the Health Care Complaints Act, it is a function of the Parliamentary Joint Committee on the Health Care Complaints Commission to examine each annual report of the commission and to report on 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 the 2011-2012 annual report of the Health Care Complaints Commission.

Following on from our review of the 2009-2010 and 2010-2011 annual report, this is the second opportunity that this Committee has had to review the work of the commissioner.

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

**Mr PEHM:** Yes, thank you.

**CHAIR:** As part of the formalities it is a requirement that each witness be examined under oath or affirmation.

**KIERAN TIBOR PEHM**, Commissioner, Health Care Complaints Commission, LMB 18, Strawberry Hills NSW 2012, sworn and examined:

**TONY ALAN KOFKIN**, Director of Investigations, Health Care Complaints Commission, LMB 18, Strawberry Hills NSW 2012, sworn and examined:

**KAREN BERNADETTE MOBBS**, Director of Proceedings, Health Care Complaints Commission, LMB 18, Strawberry Hills NSW 2012, affirmed and examined:

**CHAIR:** The Committee has received written responses from the Commission in response to some questions that we did put on notice. Are you satisfied that these responses form part of the formal evidence here today?

**Mr PEHM:** Yes, I am.

**CHAIR:** We will commence. There will be other Committee members coming, one of them is just running a bit late at this stage.

On page 5 of your annual report there were some comments in the executive summary with regard to client satisfaction and in paragraph 4 you talked about the level of service had suffered, that you had received some negative feedback about the lack of communication and update of feedback forms. Would you like to expand on those comments?

**Mr PEHM:** I think last time I was here we talked about the strain that was being placed on the commission by the number of complaints and increasing volume of complaints. We had to cut back on a practice we had previously had of talking to complainants a lot more, during this year with the funding cuts. Previously the practice was to call a complainant and confirm that we understood their complaint, to see if they had anything to add and when we had made an assessment decision, to call them again and explain the decision.

Because of the pressure of work, we decided in fairly straight forward complaints that we could assess on the written material, simply to write to them. So they were not getting that personal explanation and we think that is what contributed to the adverse feedback on the customer service forms.

I am happy to report, and this will be clear in next year's annual report, that due to funding increases we have been able to reinstate much of that service and the consumer satisfaction has increased a good deal from those days.

**CHAIR:** I assume therefore there will be some that you will just respond with the written response advising that you had made an assessment and some that you would telephone. How will you differentiate between which ones, bearing in mind that you might be able to increase that service again?

**Mr PEHM:** The more complex the matter, generally it is much better if someone gets a personal explanation; if they have questions about it, if there are language difficulties, English language difficulties, it helps to talk things through rather than just get a letter. Those would be the main issues you would take into account.

There is a degree of emotional involvement too I suppose. A lot of our complainants come having suffered mishaps themselves or have relatives who have and there is often a great deal of emotional content involved. It helps them to talk things through rather than just getting a letter.

**The Hon. PAUL GREEN:** In terms of the budget cut, was there a cut in that particular section and now it has been reinstated, or is it new money and how much is it?

**Mr PEHM:** It is new money. It was not so much a budget cut as our budget remained steady and was reduced by productivity savings over probably four or five years, but the volume of work was increasing and over that time our workload went up 50 per cent.

We tried to maintain our frontline service as much as possible. Over time there was a lowered number of staff but from last July the commission got a 9.2 per cent funding increase and we understand that will continue now. So we have been able to put on two extra assessment officers, two more resolution officers and the resolution officers take the inquiries, the phone calls; one investigation officer and one legal officer.

We have got adequate staffing now and hopefully we will be able to maintain that into the future.

**The Hon. PAUL GREEN:** A couple of reports ago on the financial side you were confident with the cuts made that the commission could maintain its level of service but it seems that it did struggle.

**Mr PEHM:** I think this was the year that it hit hardest, the 2011-2012 year. I think we were managing reasonably well up until that time. I think I always made it clear we would have to cut back the level of service simply because you can only do so much with what you have. I do not think we were compromising the public health and safety aspects. I still think we were addressing the right issues but the customer service elements, which are important in this area, because people have quite high expectations and it is important for people to be resolved with the health services. If they get disillusioned, if they are suspicious or frightened of the health services and do not go, then that is potentially a very bad outcome.

**The Hon. PAUL GREEN:** As the Chair said, what is the percentage change that you have gone from verbal to non-verbal response? What is the increase there?

**Mr PEHM:** That is a bit hard to estimate. It is a matter of discretion for the assessment officers to make that call.

**The Hon. PAUL GREEN:** The initial contact is a verbal one?

**Mr PEHM:** Yes.

**The Hon. PAUL GREEN:** Then it is identified whether it will be a non-verbal response is it?

**Mr PEHM:** Well no, it may be that there is no verbal response at all. If the complaint is very straight forward and not justified, such as a typical complaint might be I went into my GPs on the off chance that I would be seen. I had been told he would see me as soon as possible. I sat there for two hours, other people were going in and then I finally got sick of it and had a fight with the receptionist. That is the sort of complaint we get. There is not much really we can do about that and there are probably unreasonable expectations in the complainant as well. That is not necessarily the sort of thing we engage in a lot of discussion and conversation about.

More complex things where there is a hospital stay, the loss of a family member for instance and we come to the decision that we do not find any clinical misconduct or there is no reason to investigate; that is a very difficult thing for people to understand because they want a very thorough look at it. We put that into a resolution to talk it through more with the service provider. That is at the other end where it would be very important to engage in conversation with them, explain to them what the resolution process is, why it is not being investigated and what they can expect from resolution process.

In between those extremes there are a myriad of different complaints. We have to trust our staff to make those calls as best as they can.

**The Hon. PAUL GREEN:** I understand that. What I am eluding to is the fact that more complaints are coming up through the non-verbal approach, maybe it should be switching back to the verbal approach.

**Mr PEHM:** We are, we are definitely doing that this year, there is an increase and it has shown in the customer surveys. We will have the correct figures in the report but I think we had something like a 20 per cent satisfaction rate here from complainants and it is now up to approximately 60 per cent. I think that is due to our staff talking to people more.

**CHAIR:** I want to focus now on outreach and accountability. What I am specifically interested in is the way that we provide information to consumers about the services that the commission has. I want to get your thoughts on how people, for example with an intellectual disability or if you are dealing with a mental health client, what steps have you taken to ensure that they understand that the service is available and what their rights are as a health consumer?

**Mr PEHM:** We have the Council for Intellectual Disability on our Consumer Consultative Committee and part of our engagement with them was to develop a very simple plain English visual guide to making a complaint and what you can expect from the commission. We have a couple of mental health consumer groups on our Consultative Committee as well and we have just last week received training from the Mental Health Co-ordinating Council. Some of their consumers with mental health issues have come in and trained all of our assessment staff and all our resolution staff, all the frontline staff, either who take calls or get written complaints, and explained the consumer experience.

We have all the usual outreaches, the website and we are hoping to do presentations to community groups, including them, at any time. We meet quarterly with our Consumer Consultative Committee and we are always happy to work with them and to generate new ways of getting the message out.

**Mr ANDREW ROHAN:** Commissioner, on the subject you just mentioned, on page 9 of the annual report, what changes are being made to the website to improve accessibility, for example, user friendliness and content on such issues?

**Mr PEHM:** It is a bit hard to explain without actually seeing what it was like before and going onto it now. The screen readers are much faster. You can access the website from mobile devices now. We have completely changed the technical architecture behind it so that things are more accessible. Not being an IT person myself, I would be at a bit of a loss to explain how all that works.

**The Hon. PAUL GREEN:** I was going to ask you if you had a QR code.

**Mr PEHM:** We may have, but I would not know. I think it is the proof in the pudding really. If you get on the website now it is a lot easier to find things and a lot quicker to find things. All the multi-cultural non-English speaking background material is there. A lot of our material has been translated so there are translations in the major community languages.

**CHAIR:** I assume as part of the customer satisfaction survey you ask questions about the accessibility and friendliness of the website.

**Mr PEHM:** No, that is really related to individual complaints. We send those surveys to everyone who makes a complaint at the end of the complaint process. It is more about their experience interacting personally with our staff and their assessment of the quality of service.

I suppose one test of useability is the number of hits on our website. It has gone up astronomically every year and I think we are up to six million or something this year. There is a feedback tool on the website as well but I am not able to give you a report on what that says at the moment.

**The Hon. PAUL GREEN:** Do you have the statistics of what the complaints are from the website? You have seen increased hits but is that equating to increased complaints, and if so, what is the percentage?

**Mr PEHM:** There probably is a relationship but we cannot correlate people who just access the website with those that do or do not make a complaint, so you cannot really say there is a relatable nexus there that you can count.

**The Hon. PAUL GREEN:** It would be helpful, would it not, because the whole idea is to try and get accessibility for people to be able to lodge a complaint if they want.

**Mr PEHM:** So we would have to survey complainants about how they heard about the commission when they came in the door.

**The Hon. PAUL GREEN:** Yes and just what information they are getting off the website.

**Mr PEHM:** We can certainly look at what is being accessed on our website.

**The Hon. PAUL GREEN:** Like a pathway?

**Mr PEHM:** Yes, how much of it is from complainants and how much is on the professional side and how many complaint forms are downloaded. Certainly they can do that straight off the website.

**The Hon. PAUL GREEN:** Because I was glad to hear that you actually mentioned that the information is mobile friendly now, which obviously is the way that technology is going. So it is great to hear that forward work happening.

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION  
TRANSCRIPT OF PROCEEDINGS

I think last time I asked if you were coming up with an iApp or an android. Do you know if that has been any further progressed?

**Mr PEHM:** We are working on it at the moment. We are just doing a feasibility study. The concept is that once you lodge your complaint you will get an acknowledgement of receipt on your mobile device and at the various stages of the complaint process, when it is assessed you will be told it has been assessed and that you will receive the written notice in 14 days. People get updates as the complaint goes on automatically. It will be linked to our complaints data base so when some stage is completed in our data base, the theory is it will automatically send a message to the mobile device.

**The Hon. PAUL GREEN:** That is where the QR code comes in. For instance, it can be on all our brochures throughout the hospitals and of course, it is like a bar code basically. Everyone just scans that and it gives them all the information. I am making sure we are putting that on our brochures.

**Mr PEHM:** Yes, that is on our radar too.

**CHAIR:** One of the things that we have been interested in when we did our site visits for our inquiry, which is ongoing, was we visited a number of local health districts. In your report you at page 9 and page 9 you talked about how you are continuing to build professional relationships with the local health districts. Could you expand on what sort of steps you are taking to achieve that?

**Mr PEHM:** That has been a really interesting project and I think it is part of the questions on notice dealt with our progressing that. Since the annual report, which was written over the past few months, I think we finished this in about February or March this year, we visited every local health district, met with the chief executives and their clinical governance staff to discuss ways in which the commission might work better with them and get feedback from them.

As well we delivered a half day workshop on complaint handling for clinicians, for frontline clinicians. That was pretty well received. We have since then met with the Health and Education Training Institute to look at how that might fit into their program, because we got very good feedback from the staff about the training that we provided.

It is conceptually really very simple. It is that thing of not taking a complaint as a slight or an attack and just stepping back for a minute and dealing with it professionally and not seeing your professional standing or reputation at risk.

A lot of nurse unit managers came along to that and we had heads of emergency departments come. Emergency departments often get the hard edge of demand and fairly insistent demand.

We will be helping HETI with its own review of complaint handling training and in the mean time we have also started doing a series of webinars with discreet topics like how to handle a complaint. They will be doing one in a couple of weeks on mandatory reporting, what your obligations are and what it means; dealing with consumers as well about how to make a complaint, what the commission does and targeting specialist consumer areas. That is where that is taking us.

**The Hon. PAUL GREEN:** How do you evaluate those programs, the webinars for instance? How will you get feedback and see whether they are being helpful or not?

**Mr PEHM:** Again, there is an online survey that the webinar participants fill out and do. That is all fairly readily to hand. I have even got it tabulated on the ones we have done so far. I think we have done about four so far.

**The Hon. CATHERINE CUSACK:** I just wanted to follow up on this point. As you know, the Committee has been trying to facilitate and hasten a solution to the problems in your Act arising from the AVN case. I wondered if the legislation that was introduced by the Minister does, in your view, solve that problem?

**Mr PEHM:** Yes, it should do.

**The Hon. CATHERINE CUSACK:** When do you anticipate that will come into effect?

**Mr PEHM:** It was introduced into the Lower House just before you last rose, so I presume it will kick on now. I am not sure exactly what the process is, but I would think within a month or so.

**The Hon. CATHERINE CUSACK:** Once it passes and gets proclaimed.

**Mr PEHM:** Gets consent.

**The Hon. CATHERINE CUSACK:** Is it your intention then to revive those issues with the AVN?

**Mr PEHM:** There are other things going on with the AVN as well. Fair Trading is taking a case in the Administrative Decisions Tribunal, you have seen that one, which would, in effect, have the same sort of effect in that there is a requirement to publish a disclaimer about the advice they provide. They have changed their website substantially.

**CHAIR:** Their name?

**Mr PEHM:** No, not their name but they have changed their website pretty substantially since we last looked at it as well.

The short answer is I am not sure at this stage, I have to see what other things have happened in relation to them where there was still an opportunity for us there, whether there was still a health and safety risk.

**The Hon. CATHERINE CUSACK:** Can I just ask you to take that on notice and let us know when you have had a chance to have a look at it?

**Mr PEHM:** Well I guess we will not know until the Act is through and we see the result of this Administrative Decisions Tribunal case as well, because that in effect will be the same outcome that we were seeking previously.

**The Hon. CATHERINE CUSACK:** Are there any other organisations that you feel could be pursued as a result of these changes to the legislation?

**Mr PEHM:** There are many organisations that provide online health advice and offer services. The LG business is a big one where a lot of claims are made about treatments and cures. They are a fairly regular source of complaint. There are a number of different types and a number of different areas. I would not want to name any ones in particular at the moment.

**The Hon. CATHERINE CUSACK:** Just in answer to my question, do you think that the changes to the legislation could be used in relation to any of those other organisations?

**Mr PEHM:** Yes, I think it gives us a lot more scope because we now will not require an individual client or patient in order to ground a complaint. We will be able to make an assessment of the

risk to public health and safety generally and whether if there was a client who followed that advice, would it be likely to affect their treatment. It is quite a broadening of the commission's jurisdiction.

**The Hon. CATHERINE CUSACK:** There has been some interesting research by Dr Chapman in relation to some claims that were made about wind farms where he argues that the false information being put out about wind farms is actually generating an illness in its own right; that it is not the wind farms that are making people ill, but it is the false information telling them about all of these illnesses that is causing anxiety, which is actually triggering health complaints.

**Mr PEHM:** I have followed that debate in the media. We have not had any complaints in that area. I am not sure where that information is coming from but I think you are right, there is anxiety about wind farms and claims are made about the health effects of them. I am not sure whether those claims are by health service providers or who they are by. I am not sure about that one.

Anyone can give health advice; that does not necessarily make them a health service provider. If a farmer or if someone feels that they have been affected and says they have read things—

**The Hon. CATHERINE CUSACK:** I think the issue with the Waubra Foundation is that there is a registered medical practitioner [REDACTED] who is telling people that you will get bone cancer; that all of these illnesses have been proven to be associated with living within a certain distance of a wind farm.

**Mr PEHM:** I was not aware of that.

**The Hon. CATHERINE CUSACK:** She is not in New South Wales but of course the information is on the website. It is avidly followed by many people in New South Wales.

**Mr PEHM:** That is another tricky jurisdictional problem if they are not in New South Wales and the web gives rise to lots of problems with contempt laws and all sorts of things. I suppose theoretically we could make a prohibition order stopping something being published in New South Wales but then how do you enforce it if it is published in Queensland on the net?

**The Hon. CATHERINE CUSACK:** There are still real problems with the legislation that need to be resolved?

**Mr PEHM:** If an organisation that is incorporated and existing in New South Wales is publishing false and misleading information; that would not be a problem. If they are not incorporated and publishing it in New South Wales, even though it is available in New South Wales, I think there is a tricky legal question there as to whether we would have power to stop that.

**The Hon. CATHERINE CUSACK:** So who would you expect to take the lead on that?

**Mr PEHM:** Well you would hope the jurisdiction where they are physically based.

**The Hon. CATHERINE CUSACK:** I am just talking in terms of protecting New South Wales' residents from all this false health information. Is that something that you do not really see as your priority as commissioner?

**Mr PEHM:** Well it is not a question of it not being a priority and if the advice was egregiously misleading we would do everything we can. I am just not sure of the commission's power to prevent someone in Queensland uploading misleading information on the web that is then accessible in New South Wales. Without some mechanism by who—I do not know who—Government or somehow filter, like the Chinese filter with massive firewalls and protection to stop information coming through, but there

is a huge technical apparatus involved in all that which I do not think exists in New South Wales. We certainly do not have it and I do not see how we could enforce it.

**The Hon. CATHERINE CUSACK:** Because it is egregiously misleading, so that is why I am obviously pursuing it. But you do not have any power basically over an organisation in a different state?

**Mr PEHM:** No. We are an organisation of the New South Wales Government.

**The Hon. CATHERINE CUSACK:** I understand the Health Care Complaints Commission in South Australia might be investigating the matter; so do you work across borders with the other commissions? Is there any co-ordination of this?

**Mr PEHM:** We meet with the commissioners reasonably regularly. The South Australian jurisdiction has just had the Code of Conduct for Unregistered Practitioners introduced quite recently and I have had a couple of calls from the South Australian commissioner discussing issues that are facing them and how we might go about investigating.

**The Hon. CATHERINE CUSACK:** Sure, but I am talking specifically in relation to false information published on the internet that is affecting all jurisdictions. Is there a co-ordinated approach or is there potential for a co-ordinated approach?

**Mr PEHM:** South Australia now has a code, we have a code; none of the other states do. If there is no jurisdiction within a particular state, Queensland for example, to take action, I cannot see how New South Wales or South Australia acting together could do anything about it.

**The Hon. CATHERINE CUSACK:** So just do not worry about? You cannot really do anything.

**Mr PEHM:** It is a worry but we have got to act within the limits of our legislation and power, and if you do not, the result is you are defeated in Court and you waste a lot of time and energy trying to do something that cannot be done.

**The Hon. CATHERINE CUSACK:** Absolutely, which is why I am asking you, is it worth doing something about it or not, or are you just saying nothing can be done?

**Mr PEHM:** Well, the Australian health ministers are currently discussing implementation of the Code of Conduct for Unregistered Practitioners. That is a process that has been going on for quite some time, about two years I think.

**The Hon. CATHERINE CUSACK:** This person is registered.

**Mr PEHM:** A registered practitioner? Well it is the first I have heard of it. I would be happy to look at it.

**The Hon. CATHERINE CUSACK:** I am just trying to understand the issues in relation to the information published on the internet. In this particular case it happens that it is a registered practitioner.

**Mr PEHM:** A registered medical practitioner in Queensland—

**The Hon. CATHERINE CUSACK:** I think in South Australia.

**Mr PEHM:** There are actions which can be taken under the national law against registered practitioner for unsatisfactory professional conduct. One of the definitions is improper or other improper

or unethical conduct, so it is a catch-all phrase if you like. In South Australia a complaint can be lodged about that practitioner, it would be the Medical Board of Australia in South Australia guise that would have the responsibility to investigate that and prosecute that practitioner and they would do that before the equivalent of our Medical Tribunal. A registered practitioner there would be of that ranking.

**The Hon. PAUL GREEN:** On page 24 it is noted that minor complaints about a public health organisation can be referred back to the organisation to try and resolve the matter locally with the person who made the complaint if the organisation agrees with this.

**Mr PEHM:** Yes.

**The Hon. PAUL GREEN:** In these cases does the commission have a feedback mechanism to ascertain if the complaints were viewed to be successfully resolved by the complainant and the health organisation?

**Mr PEHM:** No, we do not have any feedback actually. They are fairly low level complaints. They are often things about—not that hygiene is a low level problem but the facilities, parking, low level complaints against staff attitude, not very serious. We get the consent of the health service and the complainant before we send them off for local resolution. We put them together to hopefully resolve it. But we do not have any feedback.

**The Hon. PAUL GREEN:** How many complaints are we talking about on that occasion? I think it is the next couple of pages.

**Mr PEHM:** It is a small number, it is about four per cent or something that we send for local resolution; 239 in this year, it is up to 5.8 per cent.

**The Hon. PAUL GREEN:** Do you think it would be worthwhile checking up just randomly to ensure that the system is working?

**Mr PEHM:** I am sure they have records. I am sure local health districts would have records, so we could do that.

**Mr ANDREW ROHAN:** Commissioner, just going back to page 10. You mentioned that people who have lodged their complaints, you are assessing their comments regularly about their experience of the commission's services. Can you summarise the complaints made about the services delivery and can you provide an example of changes that have been made to service delivery as a result of the consumer feedback?

**Mr PEHM:** Yes. Complainants can request a right of review of the outcome of their decision, and some of them do that. If we get a feedback form that someone is unhappy with the experience, we will talk to them and see first and foremost whether they want us to review the outcome. We will talk to the staff members who handled their matter to see what their side of the interaction was and where they can learn from it. It does bring to our attention letters that are poorly drafted. There is a whole series of feedback mechanisms there and we engage closely with our staff.

One concrete thing we did do in response to the feedback was develop these fact sheets which we put out in the last year. At the end of each process, for instance if the assessment is that the complaint is going to go into resolution, we have got a double sided fact sheet explaining what the resolution is, or if it is going to be sent to a professional council. We have gone into a lot more detail about what that involves. The same thing at the end of any investigation that is being sent to the legal area for consideration of prosecution, we have now got a much more detailed explanation for the parties about what they can expect and when it is likely to happen. That came out of customer survey feedback.

**CHAIR:** At page 35 of the report you talked about the fact that you are recruiting some more resolution officers.

**Mr PEHM:** Yes.

**CHAIR:** That was specifically to increase outreach services?

**Mr PEHM:** Well, resolution officers also take the phone inquiries and walk in inquiries. Those were going up along with complaints, and that was probably the main driver. One of their functions is also to do presentations on outreach. So both, but certainly the main driver has been to cope with the phone call inquiries.

**CHAIR:** Would you look at expanding outreach services, considering that there will be an increase in your funding annually now? Would you look at increasing outreach services overall and if you could, how would you expand them?

**Mr PEHM:** We can but we are trying to be smarter about how we do it rather than do face to face presentations. We will probably keep those at about the same level. The main tool now is the webinar process, which I have done a couple of them now. They allow you to get in big groups. We had approximately 100 at the first one from all other the state participating in a live session. We are advertising those fairly widely and getting good uptake. Resolution officers will be doing some of those.

**CHAIR:** They are open to the public?

**Mr PEHM:** I think we are targeting more specific consumer groups, health professionals as well as specific consumer groups. However, they are advertised on our website so anyone can sign up for them.

We also find out topics of interest from our consumer consultative groups and there are speciality areas as we mentioned, intellectual disability, mental health; we can arrange to do a webinar presentation on that area.

**CHAIR:** If we look at the chart that is on page 20, chart 6.12. It indicates that since 2007/2008 there has been a steady increase in the percentage of complaints discontinued compared to those referred, investigated or resolved during assessment. Could you comment on that increase in the percentage being discontinued?

**Mr PEHM:** The general point is right but this relates to the different areas of practice and a proportion in each area like general medicine and dentistry. There is another table, 6.13 at the back. You are right, the percentages of complaints discontinued has gone from 41 per cent in 2009-2010 to 48 per cent in 2010-2011 to 49 per cent in the year we are talking about 2011-2012. Although I think this year we are back to about 47 per cent.

I do not know if it is a steady increase, I think it has probably reached a plateau at around 47 or 48 per cent. It was down to 47.4 per cent from 49 per cent, so it has gone down again this year. Again, I think that is partially as a result of the extra staff we have had and the resources we have had to take on.

**The Hon. PAUL GREEN:** On page 7, commissioner, one strategy employed by the commission was to assess some of the complaints without making further inquiries in order to maintain the overall timeliness of the assessment process. This increased the level of complaint assessed with the statutory 60 day period by 3.5 per cent and that is to 88.1 per cent. Is there any measureable decrease in client satisfaction that could be directly attributed to the strategy, and if so, by how much?

**Mr PEHM:** I think it was and I think that our complainant satisfaction rate in this financial year was down to 20 per cent of respondents said they were satisfied or very satisfied with the process. I think in previous years we were up around 60 per cent and this year we are back up around 60 per cent.

Sorry, I was over estimating the impact. On page 31 of the report we give detail there and say 47 per cent of people who made a complaint responded to the survey and were satisfied with their interaction with the assessment officer, but that was a drop from 65 per cent. So it was a drop of 20 per cent in the satisfaction rate from 60 per cent to 40 per cent.

**The Hon. PAUL GREEN:** You are going to pick that up this year?

**Mr PEHM:** We have already I think on our current feedback.

**CHAIR:** That is because of an increase in staff members do you think?

**Mr PEHM:** Yes, I think staff were able to take more time, discuss things more with complainants and give them more feedback.

**The Hon. PAUL GREEN:** The commission set another target, to complete 90 per cent of reviews of assessment decisions within a six week timeframe. 76.1 per cent of the assessments in 2011-2012 were reviewed within six weeks. What were the barriers which prevented the achievement of the 90 per cent target that you set?

**Mr PEHM:** There are sometimes legitimate reasons for them not being done in that time. It is sometimes a case where you have to obtain further information from the health service provider, which takes time and further information from our own expert advisors, our internal medical advisors and they sometimes have to consult specialists.

Where a complainant comes back after a discontinued decision and provides a lot more information, the review will take into account that information, if necessary, and make further inquiries. That is a legitimate reason for it to take longer than six weeks.

I think we had some management issues in that area that were also contributing to them not being done in a very timely way and they have been fixed up now. I think we just had some administration problems where correspondence would come in and go on the complaint file without being registered as a review, so the review process did not kick off within a reasonable time.

**The Hon. PAUL GREEN:** So you do not have a “stop the clock” situation happening?

**Mr PEHM:** No, we stop the clock in investigations where there are coronial and criminal proceedings on, but this is really our fault. It is all within our control. We do not stop the clock if we have made an error.

**The Hon. PAUL GREEN:** You anticipate that you will get back to the 90 per cent in the near future?

**Mr PEHM:** I think we will be closer to 90 per cent than we were this year.

**The Hon. PAUL GREEN:** When the commission has finalised an assessment all parties are informed in writing about the outcome and reasons for the decision. 86.2 per cent of the letters were sent out within 14 days. The target of the commission is to send 100 per cent of letters out within 14 days. What steps is the commission taking to improve the timeliness of letters being sent out and what are the

barriers to reaching 100 per cent?

**Mr PEHM:** I think we are about 98 per cent now. We are nearly at 100 per cent.

**The Hon. PAUL GREEN:** It says 86.2 per cent.

**Mr PEHM:** That is in the 2010-11 year. We have just sent you a quarterly report and I think we were well into the high 90s. Again, the only reason it might take longer than 14 days is if it is a very complex matter and our assessment officer has to go back and discuss it with one of our internal medical advisors to get the terminology and the language right. But really, we think 14 days should be ample time for us to get a letter out once a decision is made.

**The Hon. PAUL GREEN:** I just have a question on that. On page 28 the commission comments that it has put intense effort to improve the quality of its written communications. What changes have been made to improve written communications, can you give us some indications of what you are doing differently?

**Mr PEHM:** We have done plain English workshops with our assessment officers and advanced plain English workshops so the quality of their letters is improving I think. We have put a greater focus on the team managers in assessments to keep on people's backs to follow things up. Rather than wait for the expiry of the deadline, get onto them five days before expiry to get things done. I guess it is by tightening management control and equipping the staff with better skills to be more confident to do that job.

**CHAIR:** In addition to that, once a decision is made you are saying within 14 days; that is the aim to get a letter out. Are there times where you perhaps would contact them personally and then maybe follow up with a letter in more serious cases?

**Mr PEHM:** Yes, definitely, particularly if it is an adverse decision or a decision they are not expecting. As I said, a lot of people where there are serious cases that involve death or permanent disability of a loved one, they want an investigation and we might do a very thorough assessment and find there are no individual clinicians responsible for this or at least at the level requiring prosecution and a better approach might be to have a resolution process and bring the complainants together with the service provider to make a disclosure process.

That is the sort of decision where we would be much more successful persuading them to participate in a resolution process by talking it through with them beforehand. Again, I think we do have to allow our assessment officers some discretion there but as I said, their team leaders should be on top of those issues. They read all complaints when they come in; they know who has the difficult ones and they should be prompting their officers to talk to the complainants where it is desirable.

**Mr ANDREW ROHAN:** Commissioner on page 25 you mentioned that recommendations could be made to the health organisation where there has been poor health service delivery and systemic improvement should be made accordingly. The question is, can you summarise what recommendations have been made with regard to systemic improvements and how does the commission monitor whether its recommendations to health organisations are being implemented or not?

**Mr PEHM:** It is hard to be comprehensive because we make different recommendations depending on the nature of the case. We have just started this year and we will report on this in next year's annual report, undertaking audits of the implementation of recommendations. We have gone to the Clinical Excellence Commission and engaged their assistance in the process of undertaking the audits. We have just finished one in a local health district involving two cases we had. One was a maternity case. I think the problem was the presentation was in a regional hospital and the patient should have been

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transferred to a better equipped hospital earlier. So we made recommendations about staff training and hand over.

The other case was one of chemical restraint situation where the patient is very agitated and we did not think proper protocols had been used. So we made those recommendations and last month I had a look at the draft report of the implementation of recommendations this week. All the recommendations have been implemented and more than that, they have been subsumed into wider clinical initiatives that have been undertaken as part of the Clinical Excellence Commission in general, clinical governance.

We did have a concern; you can make recommendations and get an assurance on paper that they have been implemented but we were concerned to verify that. So we now are undertaking this audit process. We are going to do two of those this year.

The audit involves going onsite to the hospital, speaking with the senior clinical staff and the staff that have to work in practical terms in implementing the recommendation, discussing how they work and satisfying ourselves that the recommendations have been implemented.

**The Hon. PAUL GREEN:** In terms of auditing, internal auditors have also identified three major areas for improvement within the commission, one being communications with the team, two, file allocation procedures and three, accountability of management. Can you take us through how you are meeting these improvements or are you meeting these improvements?

**Mr PEHM:** Yes, I would not say they were major improvements.

**The Hon. PAUL GREEN:** They are to the consumer if their case is being delayed.

**Mr PEHM:** Well I do not think they are serious or significant issues. They usually rate their concern in terms of significant problems or things that should be fixed and the file allocation problem was one we had in assessments and I think it also contributed to the point you raised earlier about the delay in reviews being conducted.

That has all been reviewed. Whenever there is an internal audit the recommendations, management then commits to implementing them or not and explains why they are not going to implement them. We had an internal audit and review committee that meets quarterly and the commission reports the implementation of the recommendations to that committee. All the recommendations made by our internal audits have been implemented.

**The Hon. PAUL GREEN:** How independent is it? I know it is internally and of course having internal auditors always brings a bit of subjectivity with it. How is the independence handled?

**Mr PEHM:** Well it is done by Deloitte; that is their business. They tendered for it sometime ago now.

**The Hon. PAUL GREEN:** They are consultants basically?

**Mr PEHM:** Yes. Consultants come in and they do random audits of files basically. They will look at the procedures manual and say this is what you are supposed to do, pick 20 files and they will identify the files where it has not been done.

**The Hon. CATHERINE CUSACK:** Internal auditors have a reputation for being ferociously independent.

**Mr PEHM:** They are not shy about making recommendations.

**Mrs ROZA SAGE:** How often do you get internally audited?

**Mr PEHM:** Twice a year. We pick the areas. In this year we did assessments and we have a rolling program, assessments, investigations and legal are all audited once every two years. We do things like fraud and financial management reports and those sorts of things. I think this year we are doing our case mode system, the IT side of things. But twice a year we have audits.

**The Hon. CATHERINE CUSACK:** They are very thorough.

**Mr PEHM:** They are, yes.

**The Hon. PAUL GREEN:** In terms of the third point, accountability of management, how do you process that?

**Mr PEHM:** I do not remember that one.

**The Hon. PAUL GREEN:** It is holding management to accountability one would think; that is how it is written.

**Mr PEHM:** I just cannot remember the nuts and bolts of that one. Is it in the annual report?

**The Hon. PAUL GREEN:** Yes.

**Mr PEHM:** Can you give me a page reference or something?

**CHAIR:** Page 31.

**Mr PEHM:** I do not think they are talking about executive management; they are talking about the management of the assessment teams. That was what I was talking about earlier where the team leaders of the assessment teams are taking a more active approach rather than just handing on the files and saying come back to me when it is done; keeping on people, chasing things up, doing audits, getting onto files before they are due rather than waiting for them to be overdue.

**The Hon. PAUL GREEN:** Earlier trigger points?

**Mr PEHM:** Yes.

**The Hon. PAUL GREEN:** That sort of accountability?

**Mr PEHM:** That is what we are talking about there.

**Mrs ROZA SAGE:** Can I jump to something else about investigating complaints. In 2011-2012 there were six investigations into unregistered health practitioners and they were terminated with no further action being undertaken. Can you let us know why that happened or any other comments you would like to make on why there was no further action taken?

**Mr PEHM:** It was really a question of the evidence in each case and in the end we were not satisfied that there had been a breach of the Code of Conduct and a risk to public health and safety. It is difficult to be general about those, it depends on each case; the nature of the complaint and the quality of the evidence. We investigate them very thoroughly and we have hearings and witnesses in those. Sometimes you do not accept that a complaint is substantiated or can be verified to the level required where you are going to prevent someone from practising.

I could probably give you a brief summary of each complaint if that would help.

**Mrs ROZA SAGE:** It would be good if you could do that.

**Mr PEHM:** We can take that on notice.

**The Hon. CATHERINE CUSACK:** Could I direct a question to the director of proceedings in relation to determinations being made on time. It says in the annual report that you exceeded your target of 80 per cent of determinations being made on time and that is defined as being within three months. Is that correct, the matter being referred to you, as to whether to prosecute a complaint or not?

**Ms MOBBS:** That's right, a matter is being considered within that three month period.

**The Hon. CATHERINE CUSACK:** My first question is why do you set yourself an 80 per cent target of determinations on time, why not set a 100 per cent target?

**Ms MOBBS:** I think because the review of the matter involves, on occasion, many, many boxes of materials and 11 or 12 lever arch folders of material. It can involve very complex matters, not just of law but of fact. It can mean interviewing witnesses. It can mean having to get counsel involvement to review particular areas of law to interview witnesses to assess credit. I think that target was reached as a balance between getting the majority of matters through in a very quick way, but also allowing for those more complex matters to be given a little more time to allow them to be properly assessed.

The way in which they are looked at from a legal perspective can often be a little bit different from the matters that are taken into account throughout an investigation process.

**The Hon. CATHERINE CUSACK:** Three months does seem like a reasonably good period of time though to review a case. I do understand legal inquiries may need to be made, but what would you say is a maximum figure that you would find acceptable to review a matter?

**Ms MOBBS:** I think in an ideal world where staff are devoted entirely to reviewing matters, but it is a balance between matters being in tribunal, reviewing matters all at the same time. Each officer is allocated a number of matters that are in review process as well as in tribunals, as well as a number of civil matters. So everyone has a busy practice, so it is not a matter of being exclusively able to review one case.

**The Hon. CATHERINE CUSACK:** I understand but just from the point of view of this Committee though to work out how things are progressing, how would we know if things are progressing reasonably or not reasonably?

**Ms MOBBS:** I think by the timeframes that are in place in terms of the amount of time by which they are reviewed, the number that are reviewed within those timeframes, the fact that 92.7 per cent are met.

We have also introduced, which will show up in this year's annual report, a further timeframe which will indicate the amount of time before the complaint is referred to a tribunal; so again just to show further accountability in terms of that timeframe.

**The Hon. CATHERINE CUSACK:** In terms of the length of time that some of these matters can take, I understand they can take quite a long time, I did want to ask the position that can leave a health service in when they have a professional who is under investigation for a very serious allegation. Of course, they then get notified about that, so they are aware of the allegation but not able to take any

action in relation to that person due to natural justice considerations.

**Mr PEHM:** They often do take action. As employers they have got their own responsibility to manage a workplace issue and if they think there is a risk to the health and safety of the public which they have to manage, it is not uncommon for employers to take employment action, including suspending people and not letting them practice or only practicing under supervision. They need not wait for our process before they take action.

**The Hon. CATHERINE CUSACK:** If it was a really serious matter they might suspend the person on full pay. They could not do it without pay because—

**Mr PEHM:** There are industrial ramifications.

**The Hon. CATHERINE CUSACK:** Absolutely. If the Health Care Complaints Commission then takes a number of years to process a matter, the health service can be paying a very big salary to somebody who is not doing any work for very long periods of time. I do know this to be a frustration, that they really want matters to be resolved. That is why I am so interested in these timeframes and understanding why it takes so long.

**Ms MOBBS:** I think it is in everybody's interests concerned, the timeframes; at each and every stage there is an intention to move them through as swiftly as possible. What we have found though is that if the time is put in to reviewing matters in the determination phase, it saves time at the prosecution phase because if we can look at a matter at an early stage, get counsel involved where they are needed and actually determine what the issues are rather than doing a very preliminary quick view and saying, yes we will prosecute that. We will draft a complaint in this format. It then moves to a tribunal situation, we then look more deeply into documentation and realise that maybe we made some assessments that were not correct, we then spend further time, there are delays in the legal proceedings in order for us to have to further assess and further review; I think that just then leads to further delays down the track.

So the aim is to try and get it as correct as possible as early as possible and to limit those delays to only the most complex of matters and even to limit the delays to as short a period of time as possible.

**The Hon. CATHERINE CUSACK:** Do you have tracking system of all of the cases that are currently going on at the moment?

**Ms MOBBS:** Yes.

**The Hon. CATHERINE CUSACK:** You have got very specific information about when the matter is referred and the milestones that have been accomplished along that?

**Ms MOBBS:** Yes.

**The Hon. CATHERINE CUSACK:** Is there a committee that reviews that progress and decides that we have got to bump things up or this is fantastic?

**Mr PEHM:** Executive management internally reviews it. We have fortnightly management meetings. We do these quarterly reports and we are also constantly modifying the key performance indicators. As Karen said, we have just introduced another one in her area to put another milestone in post-determination as to when after consultation ends it is lodged with the disciplinary body. We can view those on screen; how they are being met.

**The Hon. CATHERINE CUSACK:** Have you looked at ideas to speed things up a bit?

**Mr PEHM:** Yes, constantly.

**The Hon. CATHERINE CUSACK:** Is it on a wish list? What would be three things that you could do to try and get this moving along more quickly?

**Mr PEHM:** I find it hard to think of us doing a lot more than we are currently doing. They are very hard fought. They are very litigious and the simple thing would be for practitioners to say okay, I admit it and take the action. It has happened once in my whole time in the commission and I nearly fell off my chair when I got that letter. They generally legal up heavily and they are fought really, really hard. Many practitioners in particular, it is their whole career and future and their earning capacity is at stake. They are insured and they engage senior counsel, Queens Counsel and they fight them very, very hard. They fight them like criminal matters and that means challenging every piece of evidence you have.

The determination is one thing, but then the actual course of the tribunal is something else. I do not know if there is an average time for that.

**Ms MOBBS:** There is not and what we are finding is that even for what we would qualify as a straight forward matter; that the timeframes are getting longer and longer before a matter has been listed for hearing. There are requests for further and better particulars, there are arguments about documents and as the commissioner has mentioned, it has become much more legal where every particular is challenged, where matters are being taken up on appeal. I suppose that determination process and preparation of the complaint document, which is really part of that, becomes quite an important part of the preparation.

**The Hon. CATHERINE CUSACK:** Can I put it to you, if someone is a medical professional and that means they are suspended on full pay, they can see that the end could be coming; then they have got a massive incentive to string this matter out as long as they can. If you can do it for a period of years on full pay, then you are actually being paid by the system to do that.

**Ms MOBBS:** I am not sure about that.

**The Hon. CATHERINE CUSACK:** There is an incentive to prolong the matter, a financial incentive.

**Mrs ROZA SAGE:** That is in the public system though; it would be different in private practice.

**The Hon. CATHERINE CUSACK:** Well, as long as people are aware of losing their licence. Is there not a third way, a no fault return whereby mistakes can be addressed without it going through a legal process? Is there another path that we could create so that the actual issues could be resolved?

**Mr PEHM:** The whole idea of open disclosure is exactly that and it has taken an enormous effort to move from where it was five years ago to where it is now. I still do not think it is as open as it could be. One thing we went into when we visited all the local health districts is the issue of where do you involve the clinician who made the error in the open disclosure process. Most of them do not because it is counter-productive, they are so involved, their reputation is at stake and it is just not in the medical culture to admit mistakes. If you admit mistakes you are admitting a fault in your competence is how it is seen and it affects your reputation, all the referrals you are going to get. The whole business works on referrals. Who is going to refer patients to you?

So the culture really militates against that and traditionally the attitude has been to deny liability and to lawyer up. It has come a long way and I think the public system has done a lot to promote open disclosure. Making work a system where an admission could be made and some reasonable penalty imposed on practice, I just find it hard to—

**The Hon. CATHERINE CUSACK:** I am actually more interested in redefining the problem than in placing a penalty.

**Mr PEHM:** But that is what it comes to.

**The Hon. CATHERINE CUSACK:** The idea is that you would reward somebody for owning up. There is no reward in the system at the moment for owning up, is there?

**Mr PEHM:** Yes, that can work and I agree with you, a practitioner should be encouraged to own up and should be rewarded for it, but the culture does not quite currently do that. The problem in a lot of those cases—and there are not many—is where you do have unsafe practitioners or dangerous practitioners and they need to be deregistered or have conditions put on their practice. Now that is a job for the legal team.

**The Hon. CATHERINE CUSACK:** That is going to court, I understand that.

**Mr PEHM:** That is all we do in legal.

**Ms MOBBS:** Those are the ones that really are prosecuted. Even the lower level matters, I suppose those ones where there is a reprimand placed on someone's practice. I do not know if they would necessarily be amenable to the reward system for owning up. It is a really critical balance of protection of the public versus openness. The matters that generally come through the prosecution stage are not there to be punished, they are there really to protect the public, whether it be by way of reprimand to change their practice in the future, but there really is serious conduct and the less serious matters would have been weeded out through perhaps conciliation or resolution along the way. That is where you are really hoping that you push them into the processes that will lead to apologies or resolution from the parties to achieve those types of outcomes.

**Mr PEHM:** There are mechanisms that support that like the Medical Council, to name one of the councils, has an impairment program and a performance program. The impairment program obviously is to help practitioners who might have mental health issues or drug addiction problems. They will be closely monitored and supported. The same thing with performance, they will be given mentors and supervisors to bring them up.

There are lots of opportunities for practitioners to develop and if they show insight and recognise that they have an issue that needs to be addressed, there are plenty of mechanisms there to encourage them to do that. The ones that end up in legal are the ones who do not show that insight and really there needs to be action taken regarding their capacity to practice.

**Ms MOBBS:** Also that the public perceive that that action is being taken rather than it being dealt with behind closed doors by the council, that there is an open process by which they can see that those conditions or that training is being imposed by maybe an independent body just to give that reassurance to the public that that discipline is being maintained; so not punitive but protection; that it is being seen to be done. I think there is huge confidence being placed in the system when those participants and maybe those affected by the complaint in the first place are able to come along to see that in play and to see the outcome.

**Mrs ROZA SAGE:** You go on to talk about assessing complaints and client satisfaction. There are quite a low number of complainants and health service providers that are actually given any sort of feedback as to the way that you operate, the commission's client satisfaction survey. Do you see any ways in which you can improve that, because often that is the way that you can improve if that feedback is given back to you?

**Mr PEHM:** Improve the quality? I think it is about 20 per cent or something at the moment.

**Mrs ROZA SAGE:** A bit lower than that according to the report.

**CHAIR:** About 11.7.

**Mr PEHM:** Yes, that is low.

**Mrs ROZA SAGE:** Why do you think that is the case?

**Mr PEHM:** I do not know; I really do not know. We do everything we can to encourage it. I think we are going to do online surveys as well to make it easier. I think we will have that in this year and that might encourage people to do it. Currently it is paper based, a self-addressed envelope and we pay for the envelope.

**Mrs ROZA SAGE:** What you are saying really is it is not as easy to give feedback just with the paper based system but once you get it onto the web it will be much easier do you think? There will be more of an uptake?

**Mr PEHM:** I think so. Well, I am hoping so. That is the whole idea, to give them a quicker, more instant way of doing things. We will see and hopefully that will increase the rates. There are lots of reasons. It would depend on the individuals involved, maybe they are sick of it; they have had enough of it at that stage. Not all complaints are really life involving things for people, they move on and they are over it.

**Mrs ROZA SAGE:** But you hope to hear all the good things that you do too.

**Mr PEHM:** We do, we get compliments too. We get lots of good feedback. We are trying to encourage as much feedback as we can and I am hoping the online survey will help with that.

**Mr ANDREW ROHAN:** Commissioner, in last year 2011-12 the commission says there were over 4,100 complaints with the outcomes summarised on page 29 of the report. Which areas would you like to see improvement in for the following year, 2012-13 compared to the last year?

**Mr PEHM:** Well I would like to see improvements in all of our key performance indicators, our timeliness. Most importantly the issue we were talking about before is the reasons given to people for decisions. I would like us to be able to communicate those effectively so people understood what our role was and what we could do.

One of the difficult things about this job is that people's expectations are really very high. It is a tribute to the health services in a way that they are so high. When they have that incident that fractures their trust, they get really angry. It is sort of an inverse relationship to have, once they put their faith in the service to start with. I think that individual communication with people to talk to them about realistic expectations and what they can expect from health services. I think we would be doing the health services a good turn as well by doing that. It would make our job easier because people would make more reasonable complaints and want more achievable outcomes. That is quite a hard thing to measure, but that is the area I think we need to improve in.

**The Hon. PAUL GREEN:** In general have the complaints in the public hospital system gone down or are they going up and what are the statistics for that?

**Mr PEHM:** I think it is a bit static actually. There is at table at the back, table 16.17 on page

103 that shows the falling of complaints against public hospitals and the numbers are all there. It is 763 in 2007-08, 620, 614, 7634 again and 698. It is hovering around that late 600 to 700 mark. Health services are increasing all the time and the volume of health services is growing, so there is not really an increase there that is significant I do not think when you look at the overall percentage increase in complaints generally.

**The Hon. PAUL GREEN:** The other thing I note as well, talking about efficiencies and the hope that you will meet the key performance indicators; that virtually some information upgrades were done with the computers. Has that all taken place and is it producing fruit as you were hoping it was going to?

**Mr PEHM:** There is a constant process. We have got a help desk system where managers will log requests for improvements and they will be more or less significant. It is really making it more useable and easier for staff to use a lot of them.

**The Hon. PAUL GREEN:** That is my question, is it making a dent in the statistics that you are providing?

**Mr PEHM:** I think our key performance indicators are getting better, so I think it is working. There is quite a well-integrated system where we have very good IT specialists at the moment and he understands the system really well; so we can do all of that in-house.

**The Hon. PAUL GREEN:** There are no major upgrades right now, you are finished that, it has been budgeted and paid for?

**Mr PEHM:** Not in terms of a capital expenditure and getting consultants in. We just do it all in-house. I think that we just completed the last one about two or three weeks ago. We had the new case mate launched. That was probably about six months work internally though. One person is doing that as well as maintaining the system and doing his other job.

**The Hon. PAUL GREEN:** Where would you expect to see the gains in such a system in terms of statistics and reporting?

**Mr PEHM:** Accuracy of reporting is a big thing. We used to have to do a labour intensive data cleansing process because with the data we would get out of the computer there would be anomalies. We would have to go back and look at the files by hand. So the information should be much more accurate. We are hoping this year we would be able to completely just rely on the computer generated data.

**CHAIR:** Can I just ask a question about the complaints received about public hospitals for example, which obviously are the majority of complaints that you get. In your opinion is one of the reasons that is so high is because people are not aware of the local complaints process at a local hospital for example? Do you find that a lot of those complaints that come to you could have potentially been resolved at a local level had the complaints process been clear to the consumer?

**Mr PEHM:** That local resolution figure is about five per cent; there are a few things we do there. Generally the inquiries section will take a call. Most people will ring and discuss it, although with online applications people are just putting in written complaints. The five per cent that we send back for local resolution, they are matters that probably could have resolved in the hospital had they gone there to start with.

**CHAIR:** Just on that five per cent that gets sent back for local resolution, do you think that they could have not come to you in the first place? I guess we were exploring this in our inquiry, is it because the consumer is not aware that there is a complaints process at the local level; they should go to the nurse

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unit manager first?

**Mr PEHM:** Quite possibly. We would not send something back for local resolution if they had already been through a local process and they were still unhappy; there would be no point. But we are not sure that they have either not been able to access it or they have had a quick look and decided we are most accessible.

**CHAIR:** I guess as a Committee, if that is an area that could be improved at a local level in terms of communicating the process, would you see that is something that potentially could be improved?

**Mr PEHM:** Yes and we are all for complaint handling at the grass roots at the lowest possible level, on every level, even the verbal complaints I think need to be dealt with more constructively than they are. The classic story we get, there is a question on our complaint form, have you gone to the local provider and it is circled yes. We say what was the outcome and they say, they gave me this form and told me to come to you. That is the sort of reaction we really want to discourage. People have got to deal with things and the more they do that, the less things will come to us, so we can concentrate on maybe the serious ones that they have not been able to resolve.

We do everything we can to push people. We are not pushing them, we take their complaints, but to encourage them to engage locally and there is a chart on page 27 with our inquiries staff. There is roughly between 15 and 20 per cent where we discuss strategies for resolution with the complainant and say well look, this is the sort of thing that you would be better off going to them and if you do, prepare yourself a list and these are the sorts of questions you should ask. We try and equip complainants to take responsibility and handle their complaints themselves.

Yes, I think it is a good area. As I said earlier about the training we have been doing, there is still a bit of fear and reluctance at the local coalface level with health service providers to directly engage with complainants. In some cases it might be easier for them to say it's not my problem, there is a complaints process there, go and use it. I am a clinician; I do not deal with that sort of thing. We want to see complaints as part of the total health service delivery and patient care; so yes, to certainly encourage it.

**CHAIR:** I might refer you back to page 24 of the annual report which stated 49.2 per cent of complaints were discontinued and obviously they can be discontinued for a number of reasons by the commission. Can you summarise what reasons would lead to a discontinuation of a complaint and is there an opportunity to analyse the reasons for discontinuation over successive years?

**Mr PEHM:** There would be many reasons. I am just thinking about the question of trying to analyse them and short of reading the discontinued letters and somehow tabulating them, I cannot see that our data base would allow that. We do not subdivide our discontinued category into different types of discontinued letters.

There are things that could be discontinued up front if you like, those very casual encounters with the health service provider where there is an unhappy experience. It is often a personality clash or an attitude thing or demands are made which a practitioner cannot satisfy and a complainant does not want anything to do with them anymore anyway. If they are in the private health sector, they do not have to go and see that doctor again or they are in an urban area, so there is plenty of choice.

We do not put a lot of time into trying to resolve complaints like that. They have had their say. It is not the sort of conduct that is going to amount to an investigation or a disciplinary outcome for the practitioner. There is no ongoing relationship.

The sorts of matters that we put into resolution are where a person either has chronic illnesses and there is a need to continually engage with the local hospital or with the practitioner or a specialist in a

particular area. They might have lost faith or have a crisis with confidence, they might not trust that health service provider at that time, but they are the cases we put into resolution to try and reconnect with the health system.

**CHAIR:** I guess we are particularly, as a Committee, interested in that aspect of it because predominantly in regional areas we are looking at that part of the issue, they do not have a choice about who the provider is.

**Mr PEHM:** Yes and we recognise that in regional areas. You do get the complaints where you might have had a falling out with this general practitioner and the nearest one is 150 miles' drive. Those are the sorts of cases we will put in the effort and try and persuade the general practitioner to take the patient back on.

It is something that I will take on notice; we can probably give you an indication of the sorts of issues that are raised in complaints that are discontinued compared to other issues. I am not sure how much it will tell you because the big issue categories are treatment and communication. Communication can range from they gave me the wrong appointment time to my father died and they just said suck it up and get over it.

I am not sure it will get down to the level of detail that will help but we can certainly try to give you something.

**CHAIR:** I guess it is all about whether or not from that we could find out ways of improving things.

**Mr PEHM:** Certainly we can take that on notice and see what we can do.

**The Hon. PAUL GREEN:** I am just wondering if it is right in terms of process, if the commission can give us an update on the investigations, where they are up to in terms of cases and are there any implications in terms of process that are slowing things down in systemic terms or is everything running as per usual and progressing?

**Mr PEHM:** Tony is new to the job, well he has been there a bit over a year now and he has introduced a fair bit of change there, so I am happy to leave it to Tony to inform you about that.

**The Hon. PAUL GREEN:** If you could tell us some of those changes, we would really appreciate that.

**Mr KOFKIN:** Certainly in terms of the number of investigations which have been allocated, I think that is fairly stable. I think if we are looking at this financial year in terms of the number of investigations which would be closed; that is fairly stable. The timeframes are fairly consistent as well. When there is a lag in the timeframe in relation to that year, invariably it is because, and I mentioned this last year in relation to very complex prescribing matters, delays with getting Medicare data which we need to be able to prove the conduct and sometimes delays with our experts who have given us their reports because it can take them sometimes three or four months to compile a report and without the report we cannot move onto the next stage. We do our best to support them and keep them on board but there are certain barriers which we cannot really overcome.

I think you may have noticed from the quarterly report is that there has been a decrease recently in terms of the amount of investigations which are referred to the director of proceedings. I personally went through every single investigation this year where the outcome has been a referral back to the council to make sure that we are being very consistent in terms of what our experts are telling us in terms of what our outcomes are.

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There has certainly been an increase in practitioners who during the investigation have retired or come off the register. So what we have done is we have gathered all our relevant information, gone to the expert and got the report. In terms of our section 40 letter, we have written to the practitioner and told them that we intend to refer them to the director of proceedings but once we get everything together and we are going to consult the council, there have been occasions where we have referred the matters back to the council because the issue is public health and safety. The person is not practising anymore. Some of them have retired; some have been fairly elderly, in their eighties as well. Sometimes you find the instigation of an investigation and that letter from the commission which actually pushes them over the edge to actually take themselves off the register and retire.

What we have done in those matters is that we have referred the matter back to the council so they can take any action that they need to take, but as well, they refer all of our information from our investigation and our expert report and any other relevant information, plus their own opinion on the practitioner's fitness to practice. They refer that to the National Board. So in the event that the individual tries to register again in the future, the National Board can take that into account. So they cannot use it as a taxi where they come off the register and try and re-apply in 18 months' time.

What we also do, when we are consulting with the councils and they write to the National Board, the National Board also has the option to actually send the complaint back to the commission and we can re-open it and actually prosecute if need be.

We are cognisant of the fact that there has been a drop and questions will be asked in relation to that. Certainly in terms of having gone through every single matter, myself and the commissioner, it is an effective use of resources because it means that we do not have to go through the brief of evidence and then we do not have to go through and make a determination because it may well be—and I cannot speak for the director of proceedings—but that needs to be taken into account in terms of threat to public health and safety, whether or not we are going to prosecute a practitioner.

Certainly I think we have just hit this temporal oddity in terms of the number of practitioners who have come to our attention who are on the cusp of retirement. There is also a number of matters where there have been investigations which have been allocated very early on in terms of conduct issues and behind those conduct issues there are health issues and impairment issues. Under the Act we have to re-assess the complaint continuously, under section 28 of our Act.

I think we are a lot more effective and efficient in terms of re-assessing the complaints and there have also been a number of practitioners where three or four months into the investigation a health assessment has been requested by the Professional Council and quite clearly this individual is impaired in terms of mental health or drug addiction. So there is an opportunity to manage that practitioner to protect the public on the health program. So therefore we can re-assess that complaint and refer that investigation back to the council.

Again, that is safeguarding the public and if they are managed on the health program and they do not comply, then the complaint comes back to us and we re-open the investigation. The proposed outcome can be a prosecution for impairment.

There has been a trend recently, I do not know why, we have not got control about who makes complaints and which ones come to us, but there has just been a trend in terms of those types of practitioners and impairment cases as well.

Sometimes as well, certainly with the real clinical matters, the real complex clinical matters, the commission has 60 days to assess a complaint. It is not feasibly possible sometimes to assess a complaint within 60 days, so therefore the decision will be made for it to go to investigation. We can have a real

thorough look at it and ask a number of experts. There are occasions—not a lot—but noticeable occasions where after investigating for three or four months and going through all the information, the conduct is not conduct which warrants disciplinary proceedings, it is conduct which can actually be managed by performance and referral back to the council with consultation in terms of managing that risk.

That is the reason why I think there has probably been a dip. I am not saying that will happen again next year. It is just each case on each individual basis really. That is the reason why, certainly the commissioner, Karen and I have been discussing this in terms of racking our brains of what are we doing any differently. I just think it is a run of practitioners who have come through.

In terms of investigation timelines, in terms of the changes within our division, we now have a legal officer who works with us full time. We had a bit of a restructure last year where we went from three managers to two managers, which gave us the funding to actually have our own legal officer who works with me and my managers and the investigators.

That certainly works really well. Again, that gives us another layer in terms of the legal perspective in terms of where possibly the investigation is going and whether or not it does meet that threshold of disciplinary action or whether or not there is an alternative pathway in relation to that.

Certainly the legal officer has been really useful in terms of the way we investigate unregistered practitioners because with our hearings now, with our legal officer and the investigation officer, our legal officer will lead and will ask all the questions to the respondent and the witnesses as well, and will draft our statements of decision. So that has worked really, really well in terms of professionalising our process even more in terms of dealing with unregistered practitioners and drafting our statements of decision.

**The Hon. PAUL GREEN:** Can you quantify the saving that that has?

**Mr KOFKIN:** I think for me, and has been explained by the commissioner and the director of proceedings, we always try and resolve our investigations or our complaints as thoroughly and quickly as possible. I think the reduction in timeframes will be proof in the pudding really in relation to that.

As well, sometimes it is difficult to actually measure that qualitative stuff. We already have really successful outcomes when our investigations go to legal and are prosecuted, but when we are talking about customer service as well, it gives us time to actually engage a lot more with complainants and with witnesses. Certainly in relation to what we do in investigations when we are talking about adverse outcomes, and sometimes if the proposed outcome is not what the complainant expected, particularly if it is death or life changing injuries, we will go out and visit the complainants and their families. We will take our investigation report and depending on the nature of the outcome, we will disclose that and give them a copy of that investigation report. We will discuss all the issues that we want with them. I guess that gives us more time in relation to doing everything with the investigation, to give more customer service and reassurance really.

So it is difficult to measure that. A lot of it really comes from phone calls or emails or even things that you hear sometimes in terms of the work that we are doing or feedback you get from the local health districts as well.

**Mr ANDREW ROHAN:** Commissioner, the annual report mentions that 440 out of the 460 recommendations arising from investigations into health organisations have been implemented. That is on page 38. Do you have any concerns about the certain recommendations identified which still have not been implemented and can you comment on the recommendations that were not implemented or which the commission will not require any further action?

**Mr PEHM:** The bulk of those were made to an organisation that does not exist anymore.

**CHAIR:** Is that the 13 that were not implemented?

**Mr PEHM:** Yes. Thirteen were not implemented, 10 of those were made to a privately owned drug and alcohol facility. The principal manager of that facility, the man that was running the whole show, he has also been prosecuted and deregistered actually. He was a psychologist; although he is appealing that decision. While we made the recommendations in relation to the organisation that he ran, subsequent to that action was taken against him as an individual and the Department of Health under the Private Health Facilities Act also took action and withdrew the licence that he had to run that facility.

In effect the recommendations that were made, they were not implemented because the thing no longer existed, but there is no danger to public health or safety in the lack of implementation. That is why no further action was taken.

The other one, we put a lot of effort in with respondents and health facilities to make sure we make reasonable recommendations that can be implemented, they are practical and they are feasible. It appears that one we made here simply was not feasible. It is a study that has to be done on a much broader scale with a lot more resources available to the facility and probably has wider input.

One thing we do is send all of our investigation reports and recommendations to the Clinical Excellence Commission which often picks up the broader systems recommendations that we make and looks at their application through the system more generally.

**Mrs ROZA SAGE:** Talking about that new legal officer position, how long has it been in place and do you think that that will make a difference to the effectiveness and the quality of the service that you have and probably the timeliness of it?

**Mr KOFKIN:** Yes, absolutely. That is one of the reasons why we wanted that really. I think there has always been a willingness from the commission to have a legal officer within the division. Number one it is about funding, and number two, it is about whether or not we could get increased funding; which we did. It was about managers in place. We just had an opportunity where a manager left on a permanent appointment and we had that opportunity. I felt that the way the division was organised was that we could run with two managers and have that legal officer.

The great thing about having a legal officer within the division is a number of things; first of all the training. With our investigation officers they have direct access to a legal officer on a daily basis. So they learn from the insights of that lawyer who has been working for the commission for the past 10 years.

What we have also done as well, we brought a number of processes forward as a result of having our legal officer, particularly in terms of expert request letters. Traditionally the manager and the investigator would draft the expert request letters and they would sign off. Now in terms of quality assurance, those expert request letters are read by myself, the legal officer, the manager and of course the investigator who drafts them. Then we sit down together, have a meeting and we make sure we have covered off on all the issues which we have identified and everything else which are questions which we maybe should be looking at asking the expert; so it is not picked up further down the line from legal.

What that means is, is that will in the long run and also in the short and medium term, reduce the amount of supplementary reports we need to get from experts.

**Mrs ROZA SAGE:** And hence the timeframes as well?

**Mr KOFKIN:** Yes, exactly and as a cost implication as well, because sometimes if we miss

something and we need to get a supplementary report, then there is a cost implication for the cost expert as well. So certainly in terms of timeframes, but it is about as well my end user is the director of proceedings and it is about actually getting things right the first time so when that investigation brief of evidence gets down to the director of proceedings, you have got your investigation report, you have all of your evidence, you have your expert reports and assisting the legal officer to actually draft the complaint and the particulars in terms of the investigation report and the expert report. So it is about just trying to make sure that we make it as thorough as we can, we get it right the first time and then we try and assist our end users in terms of legal in relation to giving them a quality brief of evidence. It is continuously trying to improve in terms of what we do.

Certainly in terms of the timeframes as well, I think our unregistered practitioners in terms of investigating them, the timeframes have been reduced. They are a priority for us. Sometimes they are very risky because there are no controls and we are very cognisant of the risk of unregistered practitioners. That has certainly helped with our timeframes in relation to the investigation of those matters and the hearings, and as well, compiling the statement of decision, which is vigorous; making sure that we actually have a really evidence-based statement of decision which will bear any scrutiny if there is any appeal.

**Mrs ROZA SAGE:** How long has the legal officer been in place?

**Mr KOFKIN:** About seven or eight months. It will be a rotation. So what we will do is we have one legal officer at the moment and then that legal officer after a year will go back down to legal and then we will have another legal officer that comes up. In that way we get that really good relationship between the investigation officers and the lawyers and then we get the advantage because all the lawyers have different skills and experiences as well, so we get that cross-fertilisation really of ideas between legal and investigation.

Certainly the feedback from the division has been excellent and it is certainly something which I see is here to stay really.

**Ms MOBBS:** Can I just add a comment from the legal perspective. I have the ability to refer matters back to the investigations division if perhaps a brief of evidence is deficient and that is one of those matters that may fall into the 20 per cent of matters that is not able to be determined within the three month timeframe, where perhaps there is an expert witness statement or material that was not followed up in the initial investigation, and to have a legal officer in the investigations division who will pick up that issue, to have that time saved both from our perspective but also the practitioner and the complainant as well, to have it all dealt with together and all of those issues sorted at the same time, is incredibly helpful, saves time and also I think improves the key performance indicators of investigations to reduce the number of matters that are being referred back. That has been very helpful.

Also I think in terms of the relationship between investigations and legal, so rather than that ping pong effect of matters being moved from one section to the other and a real us and them, having the officer there helps explain why, it is not just a requirement, someone ticking a piece of paper saying you must do this, but a real training exercise and explanation as to why it is necessary and how it helps the matter, so that next time that issue comes up, without having that legal officer there, the investigator understands the rationale of it and it just becomes part of the process. It is much better than just referring to a procedures' manual. Hopefully there is an understanding of the process which is much more useful in the longer term. It certainly leads to a much better brief of evidence and a better legal outcome as well.

**The Hon. PAUL GREEN:** In terms of your legal fees and adverse costs, I see that they are down to \$928,000 on page 74. I see that the costs recovery is about \$426,000 as opposed to last year where it was \$960,000 and the recovery costs were \$589,000. What is the breakdown of the outstanding amount in between that? Is it a loss of a case or is it just moneys to manage the case?

**Mr PEHM:** It shows we recovered \$589,000 in legal costs in 2011 and then in 2012 it was \$426,000, which is a bit less. What is the question?

**The Hon. PAUL GREEN:** I am just wondering what the breakdown is? You are dividing up this finance to outsourced legal views to what I see and then you obviously prosecute and you are able to retrieve money back as part of audit to pay.

**Mr PEHM:** Yes.

**The Hon. PAUL GREEN:** In terms of what the difference is paid, why is not the full cost recovery for instance?

**Mr PEHM:** I will defer to Karen on this one.

**Ms MOBBS:** In part whilst under the national law we are able to recover legal costs from all practitioners, prior to the introduction of the national law we were only able to recover costs from medical practitioners. In certain cases we were able to recover costs from nurses, but that was only with exceptional circumstances. So the award of costs against nurses was very rare. There were certain other cases we were able to recover costs against, but again, that was somewhat rare.

Recovery of legal costs against uninsured practitioners, especially those who have had their registration cancelled, as you can understand, is somewhat difficult. There is no insurer to assist and often their personal circumstances are very difficult. So the recovery of costs in full is very, very difficult. Sometimes we will take reduced costs and sometimes we are not able to recover any costs at all.

Under the national law costs are now available against all practitioners, but again, it is not always possible to recover costs in every jurisdiction. That is the main difference between practitioners, but certainly bills are sent out in relation to all matters.

The other issue is that we are not able to recover costs in professional standards committees, so we are still paying costs, although they have been reduced over time, we are doing a lot more of those in-house, but this particular financial year, just due to the number of matters and some changeover with staff, we were briefing counsel in a number of matters just to keep them rolling through and to keep our timeframes fairly low.

**The Hon. PAUL GREEN:** That was a detailed answer. I thought you were going to say because of compassion and mercy that the Health Care Complaints Commission has not sought all costs.

**Ms MOBBS:** We do show some compassion as well at the end of the day, but it is all a balance.

**Mr PEHM:** The commission had not chased costs for a long time. We have got quite a rigorous process now to make sure we recover whatever we can.

The other problem is the whole cost process, if the respondent contests, the amount of costs is a very complicated procedure through the Supreme Court costs assessing and often you save money by accepting an offer that is probably as good as you get rather than spend money going through the process.

**Ms MOBBS:** That is right.

**The Hon. PAUL GREEN:** At page 42 of the 2011-2012 annual report it states that 33.3 per cent of the bills of legal costs were prepared within a 90 day timeframe, with a drop of 55 per cent for the previous year. What measures have been taken to make improvements in this area and meet the target of

80 per cent?

**Ms MOBBS:** Boys are not good in doing bills, especially lawyers that do disciplinary matters. It is a key performance indicator. It forms part of all of the legal officers' performance agreements. It is monitored and forms part of the meeting between the managers and the staff. The primary aim is costs recovery but obviously it is important to ensure that that is done in a timely way and the sooner those bills can be sent out obviously it is fairer to the respondent and the higher likelihood of payment. So it really is by way of management and ensuring that those timeframes are met.

**The Hon. PAUL GREEN:** What are you going to do to increase that efficiency of that 55 per cent drop?

**Ms MOBBS:** In part I think it will be remedied because of increased budget, increased staff. The drop was primarily due to the increased workload, more work, less staff, the priority was really on making sure that the matters in the tribunals were being run. With more money, more staff there will be more time to actually allow those matters to be attended to. So really it is working on the front office matters as the priority, of getting matters run, meeting timeframes and making sure that matters are rolling through the tribunals. Those matters are being looked at and addressed at the moment.

**The Hon. PAUL GREEN:** What would be the figure that we could look forward to in your crystal ball?

**Ms MOBBS:** I have to take that on notice. I could certainly pull those figures out but I do not have them on hand.

**The Hon. PAUL GREEN:** I would be interested to see if you are making some improvement already since those statistics.

**Ms MOBBS:** My understanding is that there is an improvement, although I do not have them on hand.

**The Hon. PAUL GREEN:** Commissioner you talked about something in one of the questions about handover. I know you might have to take it on notice but do you know how many complaints were received in terms of patient confidentiality being breached by bedside handover by medical and nursing practitioners?

**Mr PEHM:** Confidentiality being breached during handover?

**The Hon. PAUL GREEN:** Yes, whether you have had complaints? Are there any complaints from patients or clients, consumers, of those handovers at bedsides? From what I understand there are two methods. Healthcare providers can hand over in an office where it is fairly confidential and you have the confidence of the other healthcare providers, whereas now there is another method that is being used by healthcare professionals, which is a bedside handover and of course, you get to broadcast your health condition to three other members in the four bedded ward for instance. Do you have any statistics of those sorts of complaints?

**Mr PEHM:** We had 81 complaints of inappropriate disclosure of information. I do all the assessments, so I see all the complaints, but I cannot recall one complaint in that particular circumstance.

**The Hon. PAUL GREEN:** Can we have a breakdown of those 81 complaints?

**Mr PEHM:** We might be able to do that.

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**The Hon. PAUL GREEN:** On notice.

**Mr PEHM:** We can try and do a key word search. Yes, we can try and give you some information but that handover issue, the complaints we get; they are more about inadequate information. So from our point of view the bedside handover is a really good tool, at least the incoming shift know exactly what has happened to the patient and the patient is there to verify it as well.

**The Hon. PAUL GREEN:** The other patients are there to verify it as well.

**CHAIR:** That is what they are moving to, more bedside handover?

**Mr PEHM:** Yes, it is very much the incoming thing.

**The Hon. PAUL GREEN:** That is why I draw it to your attention. I heard it is the incoming thing.

**Mr PEHM:** I can see how it might be concerning. I am pretty sure we have not had any complaints in the hospital context about that.

**The Hon. PAUL GREEN:** I am wondering if there is a way we can track this and evaluate it as it is going, because not everyone is going to make a complaint about their information but I am sure there would be a lot of reserved consumers that are thinking, well I cannot really tell the doctor this because it is fairly broadcast. I would be interested to know how it is going.

**Mr PEHM:** We will see what we can do.

**The Hon. PAUL GREEN:** Put it this way, would the commission maybe survey the consumers to see if there is an unsaid situation arising here?

**Mr PEHM:** We can raise it with our community consultative committee. They certainly had a big concern about the shared sex wards when that was a problem a little while ago. We can see if that is an issue with them.

We do get complaints in that vein where in a general practice the doctor will come out still discussing the patient's condition into the waiting room or the receptionist might say something. It has come up in that context but I am pretty sure not in the bedside handover, although I can see how that is related. We will see what we can find out.

**The Hon. PAUL GREEN:** The unsaid material, because obviously a lot of clients would not say something openly.

**CHAIR:** I note that there are five questions on notice from today and Jason will put them in writing to you so that you can respond to those. Commissioner, are you happy for the Committee to send you any further questions in writing?

**Mr PEHM:** Yes.

**CHAIR:** The replies, of course, will form part of your evidence.

**Mr PEHM:** That is fine.

**CHAIR:** On behalf of the Committee I would just like to thank the commissioner and the staff for appearing before the Committee for its review of the commission's 2011-2012 annual report. Before

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the part of the hearing concludes I ask members for a resolution to publish the transcript of the witness' evidence on the Committee's website after making corrections.

I now close the public hearing and declare this meeting adjourned. Thank you once again for your attendance and for the responses to questions on notice today.

**(The witnesses withdrew)**

**The Committee adjourned at 4.28 p.m.**

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



Our ref: AF1231

Mr Jason Ardit  
Inquiry Manager  
Committee on the Health Care Complaints Commission  
Parliament of NSW  
Macquarie Street  
Sydney NSW 2000

Dear Mr Ardit,

#### **Inquiry into health complaints handling in NSW - additional questions**

Thank you for your letter of 21 January 2013 requesting a response to additional questions from the Committee. The Commissions responses are set out below:

1. *Would it be possible to make changes to the database to allow for an analysis of consumer satisfaction surveys comparing responses between metropolitan and regional areas?*

As at 1 July 2012, the Commission implemented changes to its customer satisfaction surveys that allow linking the surveys to the relevant case number through the use of a bar code that can be scanned when the survey results are entered into the database. This will allow analysing responses by a range of criteria.

The Commission has analysed the responses to its client satisfaction survey that were received between 1 July to 31 December 2012 from people who lodged a complaint.

#### Results – Assessment of complaints

In total, 1,844 surveys were sent to complainants in the six-month period and 198 responses received (response rate 10.7%)

Included in the following analysis are 145 survey responses where the Commission used the post code of the postal address of the complainant and clustered them into metropolitan and non-metropolitan groups. This classification reflects the grouping used by the "Australian Bureau of Statistics - Australian Statistical Geography Standard (ASGS)".

The remaining 53 responses were not included in the analysis as they related to complainants who were living interstate, overseas or where the information was insufficient to establish their address, for example because only an email address was used.

Of the 145 included responses, 101 (69.7%) were from complainants in metropolitan areas and 44 (30.3%) from complainants from non-metropolitan areas.

71.8% of complainants from metropolitan areas were satisfied with their interaction with the Commission during the assessment of their complaint. In comparison, 69.7% of complainants from non-metropolitan areas were satisfied with their interaction with the Commission during the assessment of their complaint.

#### Results – Resolution of complaints

In the six-month period, 251 surveys were sent to complainants who were involved in a resolution or conciliation process.

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In total, the Commission received 51 responses (response rate 20.3%): 22 from complainants in metropolitan areas and 19 from complainants in non-metropolitan areas. 10 responses were excluded for the same reasons as stated above.

85.7% of complainants from metropolitan areas were satisfied with their interaction with the Commission during the resolution process.

83.1% of complainants from non-metropolitan areas were satisfied with their interaction with the Commission during the resolution or conciliation process.

2. *In addition to the website, what information does the Commission provide to other organisations which they can use to promote the Commission's work? How much work does the Commission do with other organisations to provide information on the work of the Commission?*

The Commission has two key brochures – “Concerned about your health care” and resolve concerns about your health care”. The Commission also has posters and developed a simplified fact sheet for complainants with an intellectual disability about how to make a complaint. In the 2011-12 year, the Commission distributed 61,209 posters, brochures and other information material to stakeholders across NSW, including public hospitals, community health centres, private hospitals, day surgeries and support services, such as Tresillian.

In 2011-12, in addition to 68 media releases about the decisions of disciplinary bodies following Commission prosecution, the Commission provided 21 articles and reports to health professional and health consumer bodies and media including five regular contributions to the general practice weekly magazine “Australian Doctor”.

Over the past 18 months, the Commission has been engaged in an extensive education program about the role of the Commission and how to handle complaints with relevant staff in Local Health Districts throughout NSW. In 2013, the Commission will be hosting an ongoing project of bi-monthly webinars for both complainant groups and staff in the health system.

The Commission also delivers presentations on the role of the Commission to both consumer and health provider groups and organisations. In the 2011-12 year, there were 66 such presentations including to the Little Bay College for Aboriginal Health workers; medical staff professional development programs; associations, such as the Audiological Society of NSW, the Brain Injury Association of NSW; as well as training provided to the Legal Aid Mental Health Advocacy Service.

In addition to providing information, the Commission consults with 17 consumer groups quarterly providing information about the Commission's work and initiatives and encouraging them to inform and educate their members and stakeholders.

The Commission is also part of several professional networks, including the health literacy network, the JOIN program of government agencies and has been part of the Good Service forum – a collaboration of complaint handling bodies.

The Commission is also engaged with universities and is involved in several research programs and has been invited contribute to academic publications that relate to the expertise and work of the Commission.

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3. *When the Commission investigates a matter, what information is provided to the complainant throughout the process? Are complainants updated on the status of their complaint?*

As there has been some confusion between the various parts of the Commission's complaint handling processes, the response below will cover each area of the Commission's complaint handling:

Assessments

Complainants receive an acknowledgement of receipt of their complaint within five days. If the Commission requires further information, the assessment officer will contact the complainant to discuss their complaint with them. If assessment takes longer than 60 days, the complainant is advised in writing of the delay and the reasons.

Following assessment of the complaint, complainants are advised of the assessment decision within 14 days. The decision letter, depending on the outcome of the assessment decision will enclose a fact sheet explaining the relevant decision and what further action, if any, may be expected. Copies of those fact sheets are enclosed. Complainants are also advised of their statutory right to request a review of the assessment decision.

Resolutions

If a complaint is assessed for resolution, it will be transferred to the Manager of the Resolution Service and allocated to a Resolution Officer. The Resolution Officer will contact the complainant within 14 days to discuss the options for resolution.

As resolution processes can vary depending on their complexity and the capacity of the parties to engage, there are no set timeframes that can be provided to complainants in advance. Complainants have the contact details of the officer managing their case and resolution only proceeds if the complainant agrees to participate in the resolution process. Resolution Officers keep in regular contact with the complainant throughout the process.

Timeframes from the Commission's 2011-12 annual report show that 70% of resolution cases were completed within four months and 95% within nine months.

Investigations

The complexity of investigations also varies significantly and no set timeframes will apply to all cases. Each investigation has a plan that will set indicative timeframes relevant to the individual case.

Within 14 days, complainants are advised that the Investigations Division has received their complaint and the name and contact details of the officer who is handling their matter. Investigation Officers will contact the complainants to obtain relevant evidence and are also required to keep complainants regularly updated on the progress of their complaint, at least monthly.

At the conclusion of an investigation, complainants are provided with a detailed report on the outcome of the investigation, except where the outcome is to refer the matter to the Director of Proceedings to consider prosecution of an individual health service provider, in which case, a copy of the enclosed fact sheet is included. If the investigation concludes by referring the matter to a health professional Council, they will be provided with the same fact sheet as at the end of the assessment process.

On occasions, particularly where the outcome has been death or life changing injuries, the Director of Investigations with the Investigating Officer will brief the family in person and explain the investigation process. This is also the case when the family requests such a meeting.

Complainants are also advised of their right to request a review of the outcome of the investigation.

REVIEW OF THE 2011-12 ANNUAL REPORT  
RESPONSES TO QUESTIONS TAKEN ON NOTICE AT THE PUBLIC HEARING

Prosecutions

If a complaint is referred to the Director of Proceedings at the end of an investigation, the complainant is given the name and contact details of the Director of Proceedings to make inquiries. If a determination has not been made within three months of the matter being referred, the complainant will be updated on at least a three-monthly basis.

Once a determination has been made to prosecute the matter, the Legal Officer who has been allocated the case will keep the complainant updated on the progress and complainants are invited to contact the Legal Officer at any time.

Thank you for the opportunity to respond to the Committee's further questions and please feel free to contact the Commission should anything further be required.

Yours sincerely,



Kieran Pehm  
Commissioner

30 JAN 2013

## Appendix One – List of Witnesses

Monday 29 April 2013 Jubilee Room Parliament House

<b>Witness</b>	<b>Organisation</b>
Mr Kieran Pehm	Commissioner Health Care Complaints Commission
Mr Tony Kofkin	Director of Investigations Health Care Complaints Commission
Ms Karen Mobbs	Director of Proceedings Health Care Complaints Commission

## Appendix Two – Extracts from Minutes

### MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (NO. 16)

Wednesday 27 February 2013  
1.07 p.m. Parkes Room, Parliament House

#### Members Present

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

#### Officers in Attendance

Jason Arditi, Sarah-Anne Fong and Jacqueline Isles

#### Apologies

Mr Green and Mr Rohan

#### 1. Confirmation of Minutes

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

That the Minutes of the meeting held on 19 November 2012 be adopted.

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#### 4. General Business

a) Annual Review with the Health Care Complaints Commissioner

Committee staff distributed at the meeting hard copies of the 2011-2012 Annual Report and Quarterly Performance Reports for the period 1 July 2012 – 31 December 2012. Members agreed to hold the public hearing for the Annual Review of the 2011-12 Annual Report on Monday 29 April 2013.

#### 5. Next Meeting

The Committee adjourned at 1.18 p.m. until Wednesday 13 March 2013.

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### MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (NO. 17)

Wednesday 13 March 2013  
1.04 p.m. Room 1254, Parliament House

## **Members Present**

Mrs Williams (Chair), Mrs Sage (Deputy Chair), Mr Green (from 1.15 pm), Mr Rohan and Ms Westwood

## **Officers in Attendance**

Abigail Groves, Jason Ardit, Sarah-Anne Fong and Jacqueline Isles.

## **Apologies**

Ms Cusack and Mr Park

### **1. Confirmation of Minutes**

Resolved, on the motion of Mrs Sage:

That the Minutes of the meeting held on 27 February 2013 be adopted.

### **2. Annual Review with the Health Care Complaints Commissioner**

Members deliberated and agreed that the hearing be held on 29 April 2013 at 2.30 pm in the Jubilee Room.

Resolved, on the motion of Mr Rohan:

That the Committee conduct an Inquiry into the 2011-2012 Annual Report of the Health Care Complaints Commission and that it invite the Commissioner and his delegates to a hearing to be held on 29 April 2013, and in addition that it authorise the Chair to prepare and distribute indicative questions to be sent to the Commissioner in advance of the hearing.

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### **4. Next Meeting**

At 1.29 pm the Committee adjourned until the date of the public hearing to be held on 29 April 2013 at 2.30 pm in the Jubilee Room.

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## **MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (NO. 18)**

Monday 29 April 2013

2.32 p.m. Jubilee Room, Parliament House

## **Members Present**

Mrs Williams (Chair), Ms Cusack, Mr Green (from 2.40 pm), Mr Rohan, Mrs Sage (from 3.20 pm) and Ms Westwood (until 2.40 pm)

## **Officers in Attendance**

Abigail Groves (until 2.50 pm), Jason Ardit, Sarah-Anne Fong, Jacqueline Isles, Meike Bowyer (until 2.45 pm).

### **1. Apologies**

Dr McDonald.

### **2. Confirmation of Minutes**

Resolved, on the motion of Ms Westwood:

‘That the Minutes of the meeting held on 13 March 2013 be adopted.’

### **3. Annual Review with the Health Care Complaints Commissioner: Preparatory Resolutions**

#### **a) Responses Received to Questions on Notice**

Resolved, on the motion of Mr Rohan:

‘That the Committee resolves to accept the responses to Questions on Notice that the Committee sent to the Commissioner in advance of today’s hearing’.

#### **b) Authorisation of Media into Hearing**

Resolved on the motion of Mr Green:

‘That the Committee authorise the audio-visual recording, photography, and broadcasting of the public hearing on 29 April 2013 in accordance with the guidelines for coverage of proceedings for parliamentary committees, as administered by the Legislative Assembly’.

Resolved on the motion of Ms Cusack:

‘That the resolution authorising audio-visual recording, photography and broadcasting in accordance with Legislative Assembly guidelines be adopted as a standing motion for all future meetings’.

### **4. Public Hearing -Annual Review with the Health Care Complaints Commissioner:**

At 2.35 p.m. the Chair declared the commencement of the public hearing and the witnesses and the public were admitted.

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

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

Mr Pehm agreed that his responses to questions on notice be accepted as part of his evidence. Mr Pehm also agreed to provide written responses to the remaining questions without notice

and to any additional questions Members may have after perusing the transcript of proceedings.

Evidence concluded, the witness withdrew.

Resolved on the motion of Ms Cusack:

‘That the Committee publish the transcript of the witnesses’ evidence on the Committee’s website, after making corrections for recording inaccuracy, together with the answers to any questions taken on notice in the course of today’s hearing.’

The Committee adjourned at 4.30 p.m.

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## UNCONFIRMED MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (NO. 20)

Wednesday 16 October 2013

1:01 p.m., Room 1043, Parliament House

### Members Present

Mrs Williams, Chair, Mrs Sage, Deputy Chair, Ms Cusack, Mr Green, Mr McDonald, Mr Rohan  
Ms Westwood

### Staff Present:

Jason Ardit, Sarah-Anne Fong; Abigail Groves, Jacqueline Isles.

### 1. Apologies

### 2. Confirmation of Minutes

Resolved, on the motion of Mrs Sage: That the Minutes of meeting Number 19 held on 21 August 2013 be adopted.

### 3. Review of the 2011-2012 Annual Report of the Health Care Complaints Commission

The Chair spoke to the Draft Report previously circulated. The Chair invited Members to suggest amendments to any part of the report.

Resolved, on the motion of Ms Cusack: That the Committee Comment at Paragraph 3.25 be amended by omitting the words “welcomes and supports” in the first line and inserting the word “notes”, and that the remainder of the sentence including the words “... and ensure the Commission is sufficiently equipped to handle the increasing level of complaints it assesses” be deleted.

Resolved, on the motion of Ms Westwood: That the second line of Paragraph 3.25 be amended by omitting the word “trusts” and inserting the word “expects” and by omitting in the same

sentence the words “ ...increase the satisfaction rate” and inserting “be reflected by an increase in the satisfaction of”.

Resolved, on the motion of Dr McDonald: That the first line of Paragraph 3.9 be amended by deleting the word “General” before “medical practitioners” and that a cross-reference be inserted by footnote to Table 5 on Page 34.

Resolved, on the motion of Mrs Williams, seconded by Mrs Sage: That the Committee adopt the Draft Report, as amended, to be the Report of the Committee and signed by the Chair for presentation to the House.

Resolved on the motion of Mrs Williams, seconded by Mrs Sage: That the Committee authorises the Secretariat to correct stylistic, typographical and grammatical errors as required.

Resolved, on the motion of Mrs Williams, seconded by Ms Westwood: That, once tabled, the report be posted on the Committee’s website.

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## 6. Next Meeting

The Committee adjourned at 1:45 pm sine die.

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