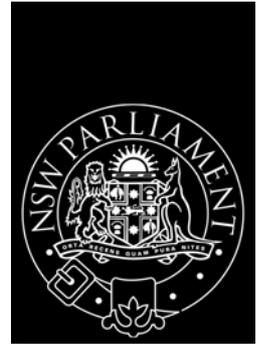


PARLIAMENT OF NEW SOUTH WALES



Committee on the Health Care Complaints Commission

Review of the 2008-09 Annual Report of the Health Care
Complaints Commission

Transcript of Proceedings, Written Responses to Questions, and
Minutes

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Terms of Reference

The Committee on the Health Care Complaints Commission is a current Joint Statutory Committee established under the *Health Care Complaints Act 1993*. The Committee was first established in June 1994 and re-established in the 54th Parliament on 7 August 2007. The Committee monitors and reviews the Commission's functions, Annual Reports and other reports it makes to Parliament. The Committee is not authorised to re-investigate a particular complaint or to reconsider a decision to investigate; is not to investigate or to discontinue investigation of a particular complaint or to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

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

- (1) The functions of the Joint Committee are as follows:
 - (a) to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act,
 - (a1) without limiting paragraph (a), to monitor and review the exercise of functions by the Health Conciliation Registry,
 - (b) to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed,
 - (c) to examine each annual and other report made by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report,
 - (d) to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Commission,
 - (e) to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.
- (2) Nothing in this Part authorises the Joint Committee:
 - (a) to re-investigate a particular complaint, or
 - (b) to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint, or
 - (c) to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

Chair's Foreword

I am pleased to present the Committee's Review of the Health Care Complaints Commission's Annual Report 2008-09, pursuant to the Committee's responsibilities under s.65 of the *Health Care Complaints Act 1993* to examine all reports of the Commission. This is the Committee's fourth such review in the 54th Parliament.

In my Foreword to the Committee's review of the 2007-08 Annual Report, I referred to the uncertainty surrounding the current role of the Commission in the wake of the proposed National Registration and Accreditation Scheme for Health Professionals. An enormous amount of work has gone into this scheme, and I am pleased to be able to note that the *Health Practitioner Regulation Act 2009* (NSW) provides for the retention of the existing co-regulatory complaints handling system in New South Wales. Consequently, legislation to consolidate the role of the Commission will be introduced into the New South Wales Parliament later this year. The progress of the national scheme is examined in Chapter One of this Report.

The year in review was marked by a number of important amendments to the *Health Care Complaints Act*. The most significant of these is a provision which allows the Commission to require any person to provide information, documents or evidence for the purpose of the assessment or investigation of a complaint. Furthermore, the Commission has been given the power to have regard to any associated complaint, and to reopen closed cases when this is considered appropriate. In addition, the Code of Conduct for unregistered health practitioners came into force on 1 August 2008, so that the Commission is now able to take appropriate action if it finds that an unregistered health practitioner has breached the Code.

The Committee believes that these broadened powers will enhance the Commission's assessment, investigation and prosecution capabilities. The Committee is currently conducting an Inquiry into the operation of the *Health Care Complaints Act*, and will report to the Parliament on its findings shortly.

The Annual Report for 2008-09 noted the continuation of a remarkable rise over the past three years in the number of complaints made which related to communication. Indeed, the Commissioner advised the Committee that communication was probably the biggest single problem in the health system; and that it was not simply communication between practitioner and patient, but that there was also a lack of communication between practitioners in regards to the ongoing care of people. Complaints about lack of informed consent were a major issue, but there was also a considerable systemic problem involving handover of information during shift changes, requiring patients to continually recount their story to different medical staff.¹

One issue raised with the Commissioner during the public hearing for the Annual Review was the high number of complaints made about treatment provided through medical centres at correctional and detention facilities. Complaints in this category involve both staff and procedures of Justice Health and the Department of Corrective Services; and the Committee notes the potential for overlap between the Commission and the Ombudsman when dealing with such complaints. The Committee examines these, and other issues raised during the Annual Review, in Chapter Three.

¹ Transcript of Evidence, 19 April 2010, pp. 13-14.

In terms of the Commission's performance, the Committee in its last Review noted that significant improvements had been made during 2007-08. Committee Members are therefore pleased that the Commission's performance has continued to improve, and that the NSW Ombudsman's 'mystery shopper audit' found that staff Commission were "consistently professional and treated matters of sensitivity well and in a sympathetic manner".²

Overall, the Committee was pleased to note a concerted effort at both improving the provision of services by the Commission and ensuring that the Commission's services are widely known and utilised. I would like to suggest that any members of the public who are interested in the work of the Commission will find from the detail contained in the evidence which the Committee has obtained in the course of its Inquiry – set out in the Transcript and in the answers to the probing questions which the Committee put to the Commissioner and other senior officers of the Commission – that this material appropriately addresses those questions.

Finally, on behalf of Committee Members, I would like to take this opportunity to thank Ms Cheryl Samuels, Research Officer to the Committee, for her work in preparing this Review of the Commission's 2008-09 Annual Report.



Hon Helen Westwood AM MLC
Chair

² Health Care Complaints Commission, *Annual Report 2008-09*, p. 24.

Chapter One - National Registration and Accreditation Scheme for the Health Professions

- 1.1 New South Wales is the only Australian jurisdiction in which the investigation and prosecution of complaints is handled by an independent body. For all other jurisdictions, complaints are handled by the relevant registration board.³
- 1.2 In its review of the NSW Health Care Complaints Commission's 2007-08 Annual Report, the Committee referred to the uncertainty surrounding the current role of the Commission under the proposed national registration of health practitioners scheme.⁴
- 1.3 On 1 July 2010, a single national registration and accreditation system for ten health professions will come into force. These are as follows:
- chiropractors,
 - dentists (including dental hygienists, dental prosthetists and dental therapists),
 - medical practitioners,
 - nurses and midwives,
 - optometrists,
 - osteopaths,
 - pharmacists,
 - physiotherapists,
 - podiatrists and
 - psychologists.
- 1.4 In addition, four partially regulated professions, Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice and occupational therapy, will be included from 1 July 2012. The scheme will be managed by the Australian Health Practitioner Regulation Agency.
- 1.5 Implementation of the scheme required the adoption of a three-part National Law [Acts A, B and C] by all states and territories. The first part, The *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* [Act A], was hosted by the Queensland Parliament and commenced in November 2008. The second part, the *Health Practitioner Regulation National Law Act* [Act B] continued the administrative arrangements established under Act A and provided for the full operation of the Scheme, including registration and accreditation arrangements, complaints, conduct, health and performance arrangements, privacy and information sharing arrangements, and transitional arrangements.⁵

³ Transcript of Evidence, 19 April 2010, p. 2.

⁴ NSW Parliament, Committee on the Health Care Complaints Commission, *Review of the 2007-2008 Annual Report of the Health Care Complaints Commission*, Report No. 4/54 – May 2009, p. viii.

⁵ Australian Health Practitioner Regulation Agency, *Legislative framework*.

- 1.6 The National Law allows a co-regulatory jurisdiction, such as New South Wales, to adopt and apply the National Law, but to use its State legislation for handling complaints about health, conduct or performance matters.⁶
- 1.7 New South Wales adopted the National Law [Act C], with the exception of Divisions 3 to 12 of Part 8 relating to health, performance and conduct, in November 2009.⁷ This permits New South Wales to retain its current health care complaints system and precludes national registration boards from dealing with complaints about matters occurring in New South Wales.⁸
- 1.8 As the Minister noted in her Agreement in Principle Speech, with respect to support for the current NSW healthcare complaints handling scheme:
- [s]takeholders in New South Wales have uniformly welcomed the commitment of the Government to retain the existing complaints system and recognise the benefits that a robust, independent and transparent system delivers to the public, health practitioners and the health system as a whole.⁹
- 1.9 Further New South Wales legislation will be required to consolidate the role of the Health Care Complaints Commission. It is anticipated that the requisite legislation will be introduced before the end of the current session.¹⁰ This Committee is also currently undertaking a review of the operation of the *Health Care Complaints Act 1993*.

⁶ A “co-regulatory jurisdiction” means a jurisdiction in which the Act applying the National Law declares that the jurisdiction is not participating in the health, performance and conduct process provided by the National Law. *Health Practitioner Regulation National Law Bill 2009*, Explanatory Notes, p. 82.

⁷ *Health Practitioner Regulation Act 2009* (NSW). The Act comes into force on 1 July 2010.

⁸ Hon Carmel Tebbutt, MP, Deputy Premier and Minister for Health, Legislative Assembly *Hansard*, *Health Practitioner Regulation Bill 2009*, Agreement in Principle speech, 28 October 2009, p. 2.

⁹ Hon Carmel Tebbutt MP, Deputy Premier and Minister for Health, Legislative Assembly *Hansard*, *Health Practitioner Regulation Bill 2009*, Agreement in Principle speech, 28 October 2009.

¹⁰ See Hon Carmel Tebbutt MP, Deputy Premier and Minister for Health, Legislative Assembly *Hansard*, 28 October 2009.

Chapter Two - Legislative Changes During 2008-09

- 2.1 A number of amendments to the *Health Care Complaints Act 1993* [the Act] came into force on 13 May 2009. According to the Commission's 2008-09 Annual Report, these amendments have improved the Commission's assessment, investigation and prosecution capabilities.¹¹ Significant changes include:
- the power of the Commission to obtain information, records and evidence [s 21A & s 34A]; and
 - the power to consider associated complaints [s 29A].
- 2.2 Amendments to the *Medical Practice Act 1992* also came into effect to improve transparency in proceedings before a Medical Professional Standards Committee [PSC] and to provide for legal representation in matters before a PSCs [s 177].
- 2.3 The Committee also notes that a Code of Conduct for unregistered health practitioners came into force on 1 August 2008.

Power of Commission to obtain information, records and evidence

- 2.4 The most significant of these amendments is the provision which allows the Commission to require any person to provide information, documents or evidence for the purpose of the assessment or investigation of a complaint under s 21A of the Act.¹² The strengthening of this power was recommended by Hon Deirdre O'Connor in her 2008 review of the *Medical Practice Act 1992* [MPA], and reiterated by the Committee in its Report on the Investigations by the Health Care Complaints Commission into the complaints made against Mr Graham Reeves.¹³
- 2.5 The Commissioner informed the Committee that he was satisfied that this was a very useful power which now allows the Commission to obtain all relevant information, as is the power to require people for interview:
- Paper can only tell you so much. It has become a quite regular practice now for our investigators to attend hospitals and to interview clinicians on site, both [to] do an inspection of the area and conduct interviews. That was a bit difficult to begin with because it is not something I think people were used to, but it seems to have bedded down fairly well...¹⁴
- 2.6 The Commissioner noted that although it was not possible to quantify the extent to which this power had improved the timeliness of investigations, the legislative amendments had undoubtedly increased the capacity of the Investigations Division to obtain evidence from relevant witnesses, and this has expedited investigations. The increase in the amount of evidence available to the Commission had also assisted in the comprehensiveness and the quality of the briefs referred by the Investigations Division to the Director of Proceedings to consider the prosecution of disciplinary proceedings against registered health practitioners.¹⁵

¹¹ Health Care Complaints Commission, *Annual Report 2008-09*, p.10.

¹² *Health Care Complaints Act 1993*, ss. 21A & 34A.

¹³ NSW Parliament, Committee on the Health Care Complaints Commission, *Report on the Investigations by the Health Care Complaints Commission into the complaints made against Mr Graham Reeves*, Report no. 3/54 – June 2008, Recommendation 3, p. 45.

¹⁴ Transcript of Evidence, 19 April 2010, p. 5.

¹⁵ *Answers to Questions on Notice before the Public Hearing*, no. 3.

Power to consider associated complaints

- 2.7 When a complaint is registered by the Commission, information about any previous complaints and cases is generated. In the case of serial complaints - particularly those involving sexual misbehaviour - the Commission was previously only able to take complaints histories into account. However, the Commission now has the power under s 29A of the Act to not only have regard to any associated complaint, but to also reopen old cases that had been closed due to insufficient evidence.¹⁶

Medical Professional Standards Committees

- 2.8 Amendments to the MPA designed to make hearings of a PSC more transparent came into operation in October 2008. These amendments now allow complainants, family members and other interested parties to attend the hearing. The public reporting of PSCs also means that interested parties are able to consider the evidence provided to the PSC, as well as the reasons for the PSC's decision. This, according to the Commissioner, allows officers of the Commission's Legal Division to provide much more information about PSC proceedings and the PSC's decision to the complainant and other interested parties.¹⁷
- 2.9 The *Health Legislation Amendment Act 2009* also included amendments to the MPA in relation to legal representation before a PSC. The Annual Report notes that previously, legal representation was not permitted for either the Commission or the practitioner and that the Commission's prosecution of complaints was conducted by "hearing officers" who were not admitted to practise as lawyers in New South Wales.¹⁸
- 2.10 When asked whether the need to rely on legal representation would impact upon the budget of the Legal Division, the Commissioner responded that the use of legal representation had been higher than anticipated, as it appeared that respondent practitioners were more frequently applying to be legally represented. It was therefore anticipated that the majority of respondents would be legally represented, which would lead to increased legal costs being incurred by the Legal Division, but that this would be kept under review.¹⁹
- 2.11 Currently the Commission is required to employ both legal officers and hearing officers, as the relevant legislation does not permit legal representation before a Nursing and Midwives PSC. It was anticipated, however, that following the introduction of the national registration scheme on 1 July 2010, legal representation would be permitted in all PSCs.²⁰

Code of Conduct for unregistered health practitioners

- 2.12 Under s 41A of the Act, the Commission is able to take action if it finds that an unregistered health practitioner has breached the Code of Conduct. The Committee noted that only 68 complaints were received in 2008-09 about unregistered health

¹⁶ Transcript of Evidence, 19 April 2010, p. 6.

¹⁷ *Answers to Questions on Notice before the Public Hearing*, no. 6.

¹⁸ Health Care Complaints Commission, *Annual Report 2008-09*, p.11.

¹⁹ *Answers to Questions on Notice before the Public Hearing*, no. 4.

²⁰ *Answers to Questions on Notice before the Public Hearing*, no. 4.

practitioners, compared to 73 in the previous year,²¹ and questioned whether this might reflect a deficiency in public awareness about the Code of Conduct for unregistered health professionals.

- 2.13 The Commissioner responded that one would have expected that, with the Code of Conduct coming into force and the Commission making public determinations, that there would be more complaints and awareness. His experience was that people are not aware of the avenues available to make complaints until something goes wrong, and he was not sure about the value of doing a widespread public education campaign about the coverage of unregistered health practitioners.²²
- 2.14 The Commission had, however, put a considerable amount of effort into promoting the Code, but had concentrated on professional groups, as this was where it was thought the Commission would get the best return.²³ Thus, the Commission had made presentations to the peak bodies representing the various unregistered health professions, and had also provided articles to the community organisations represented on the Commission's Consumer Consultative Committee, for inclusion in their communications to their members and clients. Information is also available about the Code on the Commission's website.²⁴
- 2.15 The Commissioner also noted that the Commission does not presently have the power to make interim provision orders in dealing with unregistered practitioners, but that this is anticipated to be part of the next round of legislative amendments.²⁵

Dental technicians

- 2.16 After the National Registration and Accreditation Scheme comes into force on 1 July 2010, dental technicians working in New South Wales will no longer be registered. Dental technicians would then be covered by the Code of Conduct for unregistered practitioners.
- 2.17 The Commissioner advised the Committee that the Commission had been in contact with the Dental Technicians Registration Board with a view to advising about future coverage by the Code. The Commissioner also noted that the Commission had raised the issue of educating dental technicians about the coverage of the Code with the Department of Health, but that the view of the Department appeared to be that the technicians do not deal directly with patients - they should always work to a dentist and be referred.²⁶
- 2.18 In contrast, the Committee has heard evidence from the President of the Dental Technicians Registration Board that dental technicians do in fact have some contact with patients. Accordingly, the Committee will continue to monitor whether there are any complaints made to the Commission about dental technicians.

²¹ Health Care Complaints Commission, *Annual Report 2008-09*, Table 17.9 Complaints received about registered and unregistered health practitioners 2006-07 to 2008-09, p.100.

²² Transcript of Evidence, 19 April 2010, p. 11.

²³ Transcript of Evidence, 19 April 2010, p. 11.

²⁴ *Answers to Questions on Notice before the Public Hearing*, no. 9.

²⁵ Transcript of Evidence, 19 April 2010, p. 2.

²⁶ Transcript of Evidence, 19 April 2010, p. 11.

Open disclosure and statutory privilege for Root Cause Analysis

- 2.19 When a serious adverse event happens in a public hospital, a Root Cause Analysis [RCA] is undertaken to identify systemic causes. Legal privilege attached to information obtained through the RCA means that this information currently cannot be used to explain in detail to the patient or their family the reasons for the event.
- 2.20 In June 2009, the Department of Health issued a Discussion Paper on a review of the statutory privilege conferred on RCA and quality assurance committees. The Commission argued in its submission to that review that:
- ...the privilege is fundamentally incompatible with the process of open disclosure that has been promoted by the Department of Health within the public health system.²⁷
- 2.21 The Commission suggested that the privilege should not be maintained or - if it is to be maintained - should be extended to allow the use of information gathered during the process to provide open and frank explanations to patients and their families about adverse events.²⁸
- 2.22 Under the Department's open disclosure policy, patients are given a copy of the final RCA Report. However, the Commission believes that this does not address their questions. When giving evidence to this Committee's review into the operation of the *Health Care Complaints Act*, the Commissioner noted that the Commission's position is that:
-the information gathered during a root cause analysis should be able to be used for open disclosure with the family, but that privilege should apply for use of that material in legal proceedings, to address the clinician concerns that the material can be used against them.²⁹
- 2.23 He added that the Commission had been the "lone voice" with respect to this position and that all other submissions to the Department's review were very strongly in favour of retaining the current privilege.³⁰ The Commissioner subsequently advised the Committee that, after conducting the review, the Department had come to the view that the privilege should be retained and entrenched.³¹
- 2.24 The need for open disclosure was also raised during the Committee's Inquiry into the Operation of the *Health Care Complaints Act 1993*. The RCA is designed to look at identifying and improving *systemic* problems, and is not a detailed forensic investigation. Committee Members can therefore understand the reluctance on the part of persons involved in the process to volunteer full and honest information without the ability to do so in a privileged manner. Nonetheless, the Committee believes that patients and their families should have access to as much information as possible in order to fully understand what happened during a critical event and will therefore discuss this issue further in the Committee's Report on that Inquiry.

²⁷ Health Care Complaints Commission, *Annual Report 2008-09*, p. 11.

²⁸ Health Care Complaints Commission, *Annual Report 2008-09*, p. 11.

²⁹ *Inquiry into the Operation of the Health Care Complaints Act*, Transcript of Evidence, 4 March 2010, p. 37.

³⁰ *Inquiry into the Operation of the Health Care Complaints Act*, Transcript of Evidence, 4 March 2010, p. 37.

³¹ Transcript of Evidence, 19 April 2010, p. 11.

Committee Comment

- 2.25 The Committee believes that these broadened powers, particularly those which allow the Commission to obtain information, records and evidence, and to consider associated complaints, will enhance its assessment, investigation and prosecution capabilities.
- 2.26 As noted earlier, the Committee is also currently conducting an inquiry into the operations of the Health Care Complaints Act, and will report to the Parliament on its findings shortly.

Chapter Three - The Year in Review

Trends in complaints

3.1 The 2008-09 Annual Report notes that the number of inquiries grew by 11.8 per cent and the number of complaints by 7.4 per cent on the previous year.³² When asked what measures the Commission had taken to handle this increasing volume, the Commissioner responded that whilst the Commission was unable to identify the reasons for the increased volume, the Commission's Inquiry Service had handled the increase within their existing resources.³³

Issues

3.2 On 1 July 2008, the Commission introduced an improved issues categorisation system to allow for a more detailed analysis of the complaints that it receives. Under this new system, issues can be categorised as:

- Access;
- Communication and information;
- Consent;
- Discharge and transfer;
- Environment and management of a facility;
- Fees and costs;
- Grievance processes;
- Medical records;
- Medication;
- Professional conduct;
- Reports and certificates; and
- Treatment.³⁴

3.3 With respect to the database, the Commissioner advised the Committee as follows:

The old database of the Commission only accommodated one complaint per issue. If the complaint was about poor treatment, bad communication and bad medication, you really had to pick the most important one... There has been a bit of a cultural change getting people to identify more issues. We think it is useful the more that are identified. It is certainly a topic in education forums. When I talk to a practitioner about what a complaint is about, rather than having one issue per complaint you can give them a broader idea. So we have been more diligent about identifying issues in complaints.³⁵

3.4 In terms of trends in complaints about health practitioners, the report notes that there has been a significant increase of 18 per cent on the previous year, whereas complaints about health organisations fell by 6.4 per cent.³⁶

³² Health Care Complaints Commission, *Annual Report 2008-09*, Chart 4.1, Number of inquiries received 2006-07 to 2008-09 and Chart 4.2, Number of complaints received 2006-07 to 2008-09, p. 6.

³³ *Answers to Questions on Notice before the Public Hearing*, no. 14.

³⁴ Health Care Complaints Commission, *Annual Report 2008-09*, pp. 15-16.

³⁵ Transcript of Evidence, 19 April 2010, p. 3.

³⁶ Health Care Complaints Commission, *Annual Report 2008-09*, p. 18.

Health practitioners

- 3.5 According to the 2008-09 Annual Report, the three health professions most commonly complained about were medical practitioners, dentists and nurses. When considered in relation to the number of practitioners, the number of complaints remains relatively small, but is increasing each year. Treatment, followed by communication, are the biggest issues of complaint for most practitioners, however, nurses have a higher proportion of complaints raising issues of professional conduct than other health service providers.³⁷

Health organisations

- 3.6 Most complaints about health organisations relate to public hospitals. The 2008-09 Annual Report noted that this reflects both the large number of patients dealt with by public hospitals and the more complex range of health services – associated with higher risks – provided by public hospitals.³⁸

- 3.7 Committee Members were interested in how the Commission monitored systemic issues arising from complaints about public hospitals, particularly for communicating them into the new *Caring Together Network*. In reply, the Commissioner said:

At the end of an investigation into a public hospital we can make recommendations, and the hospital must report back to us about the implementation of those recommendations. We have about a 95 per cent implementation rate for recommendations. ... the Department has also set up a governance unit to keep track of both our recommendations and coronial recommendations. Our power relates to making recommendations about a particular institution. The Department's governance unit picks up those recommendations, and where they think they might be more widely applicable they can take broader action to implement them across an area health service or statewide.³⁹

- 3.8 The Commissioner noted also that some matters “beg for state wide implementation, whereas other matters can be more particular to the level of institution”. Similarly, some issues arise in relation to tertiary hospitals, as distinct from rural hospitals. The Commission was also sending investigation reports - where these make comments and recommendations - to the Clinical Excellence Commission.⁴⁰

Medical centres at correctional and detention facilities

- 3.9 In 2008-09 the Commission received 138 complaints about correctional and detention facilities providers, raising 238 issues. An additional five complaints concerned private health service providers.⁴¹ A breakdown of the facilities involved in these complaints can be found in Chapter 6.

- 3.10 The Commissioner advised the Committee that the Commission is accessible to prisoners. There was, however, a potential for overlap between the Commission and the Ombudsman, because complaints could involve both Justice Health and Corrective Services NSW:

Prisoners will complain both about the conditions they are placed under and that medical orders are not enforced by Corrections staff. We cannot look at Corrections

³⁷ Health Care Complaints Commission, *Annual Report 2008-09*, p. 18.

³⁸ Health Care Complaints Commission, *Annual Report 2008-09*, p. 18.

³⁹ Transcript of Evidence, 19 April 2010, p. 3.

⁴⁰ Transcript of Evidence, 19 April 2010, p. 3.

⁴¹ *Answers to Questions Taken on Notice during the Public Hearing*, no. 7.

staff, although we can look at Justice Health. There have been a number of cases where we have had job meetings with Ombudsman staff, our staff, and Justice Health to really sort out who should be doing what at an early stage.⁴²

3.11 The Committee notes that 41 of the issues raised by prisoners with the Commission in 2008-09 related to a range of “medication” issues, a significant proportion of which involved the distribution of methadone and buprenorphine in jails. The Commissioner noted that:

...is a difficult matter of administration for Justice Health because there is a problem of diverting and trafficking internally and we get complaints about people that say they have been unjustly thrown off that program and the explanation from Justice Health will be that they have been suspected of diversion.⁴³

3.12 Delays in treatment were also raised in complaints from prisoners, but, as the Commissioner noted, that is not an uncommon complaint in the general community. It was exacerbated in prisons, however, because of the need to transfer prisoners from Long Bay Jail to the Prince of Wales Hospital for any serious tests. Consequently, there have been security measures that Corrective Services NSW has been required to put in place with respect to these transfers.⁴⁴

Performance 2008-09

3.13 The 2008-09 Annual Report states that the Commission’s performance during the year shows that it is capable of continuously improving and dealing with challenges, and that, despite a reduction in the number of staff, the Commission’s performance has improved on previous years in most categories.⁴⁵ Table 1 provides a summary of the Commission’s results against corporate key performance indicators for 2008-09.

3.14 In its last review, the Committee noted that the Commission had made significant improvements during 2007-08. The Committee is therefore pleased to note that the Commission’s performance has continued to improve.

3.15 In early 2009, the NSW Ombudsman conducted a “mystery shopper” audit of the Commission. The Committee was pleased to note the Ombudsman’s positive finding in relation to the audit, in particular, that staff were “consistently professional and treated matters of sensitivity well and in a sympathetic manner”. In addition, responses to letters and emails were “of a very high standard, providing detailed and relevant information”.⁴⁶

3.16 The Committee also notes that the Commission has taken steps to address suggestions made by the Ombudsman for some minor areas for improvement.⁴⁷

⁴² Transcript of Evidence, 19 April 2010, pp. 4 & 8.

⁴³ *Answers to Questions Taken on Notice during the Public Hearing*, no. 4 & Transcript of Evidence, 19 April 2010, p. 8.

⁴⁴ “There was also a problem with prisoners not being able to obtain the same medications that they had previously had access to on the outside, because either Justice Health did not think that it was necessary, or they have a substitute one that they dispense”. Mr Kieran Pehm, Commissioner, Transcript of Evidence, 19 April 2010, p. 8.

⁴⁵ Health Care Complaints Commission, *Annual Report 2008-09*, p. 5.

⁴⁶ Health Care Complaints Commission, *Annual Report 2008-09*, p. 24.

⁴⁷ Health Care Complaints Commission, *Annual Report 2008-09*, p. 24.

Table 1: Comparison of commission results against corporate key performance indicators 2008-09

Number of inquiries and complaints received

	07-08	08-09⁴⁸
Number of inquiries received	8,831	9,871
Number of complaints received	3,128	3,360 ⁴⁹

Goal: efficient and timely processing and assessment of complaints and review processes.⁵⁰

The Commission assessed 3,349 complaints during the year, keeping up with the 3,360 received in the same period. This compared to 2,889 complaints being assessed in 2007-08 when 3,128 complaints were received.

Performance indicator	Target	Result 07-08	Result 08-09
Number of complaints finalised		2,986	3,462
% of complaints assessed within 60 days	85%	88.2%	88.9%
Average time to assess complaints		39 days	42 days
% of complaint assessment decision letters finalised within 14 days	90%	91.1%	90.6%
% of complaints resolved during assessment	8%	7.1% ⁵¹	5.6%
% of complaints assessed subject to a request for review	>10%	8%	8.4%
% of reviews completed within 40 days	n/a	n/a	74.4%
% of reviews in which original decision was confirmed	n/a	89.3%	96.0%
% of complainants satisfied with their interaction with the assessment officer	n/a	n/a	61.3%
% of providers satisfied with their interaction with the assessment officer	n/a	n/a	75.6%

Goal: to promote complaint resolution services to the people of NSW: resolving complaints.⁵²

Performance indicator	Target	Result 07-08	Result 08-09
Number of presentations made to community members and health professionals	60	81	88
% of resolution processes finalised within six months	n/a	89.8%	89.4%
% of matters complaints referred to the Resolution Service had a resolution plan approved within 21 days	n/a	n/a	63.6%
% of complaints fully or partly resolved in assisted resolution	75%	81.3%	80.0%
% of complainants satisfied with service	80%	n/a	74.2%

⁴⁸ Health Care Complaints Commission, *Annual Report 2008-09*, Charts 4.1 & 4.2, p. 6.

⁴⁹ The high number of complaints finalised during the year is partly due to a high influx of complaints from the Special Commission of Inquiry into Acute Care at the end of 2007-08. Most of these complaints were finalised in early 2008-09. Health Care Complaints Commission, *Annual Report 2008-09*, p. 6.

⁵⁰ Health Care Complaints Commission, *Annual Report 2008-09*, pp. 6, 26, 28-30.

⁵¹ Target for 2007-2008 was 7.0%.

⁵² Health Care Complaints Commission, *Annual Report 2008-09*, p. 31.

% of providers satisfied with service	80%	n/a	90%
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Goal: to promote complaint resolution services to the people of NSW: conciliation.⁵³

<i>Performance indicator</i>	<i>Target</i>	<i>Result 07-08</i>	<i>Result 08-09</i>
Number of complaints referred to the Health Conciliation Registry		198	167
Number of complaints finalised by the Health Conciliation Registry		207	228
% of complaints resolved through conciliation, where both parties engaged in a voluntary consultation process	n/a	75.5%	45% ⁵⁴
% of complaints finalised by the Health Conciliation Registry within 6 months	n/a	66.2%	74.6%

Goal: to ensure a best practice approach for the conduct of all investigations.⁵⁵

In 2008-09 the Investigations Division finalised 261 investigations. There were 200 investigations into health practitioners and 61 into health organisations.

<i>Performance indicator</i>	<i>Target</i>	<i>Result 07-08</i>	<i>Result 08-09</i>
Number of investigations completed	370	338	261
Average time for an investigation		309 days	274 days
% of investigations completed within 12 months	85%	68.3%	80.8%
Requests for review of investigation decision		15	4
% of complainants satisfied with their interaction with the investigation officer	n/a	n/a	95.7%
Number of investigations referred to Director of Proceedings		129 (50.8%)	100 (50%)
% of investigations referred to the Director of Proceedings further information was requested	15%	5.4%	26% ⁵⁶

Goal: to improve health care systems through recommendations arising from investigations.⁵⁷

- During 2008-09, the Commission finalised 61 investigations about health organisations. Of these, 31 resulted in the Commission making 67 recommendations.
- Since 1 July 2005, the Commission has made 300 individual recommendations in 134 investigations. Of these recommendations 86 per cent had been implemented as of 30 June 2009 (target 80 per cent).

⁵³ Health Care Complaints Commission, Annual Report 2008-09, pp. 35-36.

⁵⁴ A further 20.9% said that the conciliation process was helpful in clarifying concerns, even though no final agreement could be reached.

⁵⁵ Health Care Complaints Commission, Annual Report 2008-09, pp. 7, 39, 44, 45.

⁵⁶ Changes to investigation procedures in January 2009 reduced the request rate in the last quarter of the year to 3.8%.

⁵⁷ Health Care Complaints Commission, Annual Report 2008-09, p. 39.

Goal: independent and timely determination to prosecute and professional and competent prosecutions of serious complaints in the public interest.⁵⁸

Performance indicator	Target	Result 07-08	Result 08-09
% of matters reviewed within 3 months of referral	80%	76%	71.9%
% compliance rate with Court and Tribunal deadlines	80%	n/a	79%
% of legal advices provided within requested timeframe	80%	89%	75%
Number of legal matters finalised	n/a	79	85
Number of prosecutions before Professional Standards Committee	n/a	26	28
Number of prosecutions before Professional Standards Committee proved/upheld	n/a	21	24

Accountability

Performance indicator	Target	Result 07-08	Result 08-09⁵⁹
% of briefs/advice to Minister completed within 14 working days from date received	90%	n/a	42%
Number of website visitors	38,000	41,505	38,987

The Organisation

Performance indicator	Target	Result 07-08	Result 08-09⁶⁰
% of staff performance rated fully competent or better	90%	94%	96.2%
Average number of training/staff development training sessions per FTE employee	>5	3	4.2

Monitoring client satisfaction

- 3.17 During the reporting period, the Commission also introduced a client satisfaction survey. The Commissioner informed the Committee that he was concerned that the response rate was fairly low - 16.5 per cent for complainants and 12.2 per cent for providers - possibly because people who had better experiences were more likely to respond than someone who was disgruntled.⁶¹
- 3.18 Nonetheless, useful feedback had been received which had assisted in improving procedures that would enable the Commission to better meet client needs in the future.
- 3.19 When asked whether the Commission had considered any other methodology for measuring client satisfaction, such as an independent audit, the Commissioner replied that other methods had been considered, but that the most effective way was probably to commission a consultancy to interview people, rather than an audit which would just check that forms had gone out and been returned, and that data was correct.

⁵⁸ Health Care Complaints Commission, Annual Report 2008-09, pp. 46, 47, 48.

⁵⁹ Health Care Complaints Commission, Annual Report 2008-09, p.12.

⁶⁰ Health Care Complaints Commission, Annual Report 2008-09, pp. 86 & 92.

⁶¹ Transcript of Evidence, 19 April 2010, p. 7; & Health Care Complaints Commission, Annual Report 2008-09, p. 29.

The only other way we thought might be effective is to have someone independent to do a consultancy, which would involve focus groups contacting individuals and getting them in for a meeting to talk about their experiences. We did not go with that last year, partly because the customer satisfaction process is not very old at this stage. And it is the expense of it as well, whether it is justified within our budget... Certainly that is something my communications officer has raised as a possibility but we were not in a position budget-wise with other priorities to do it last year or this year.⁶²

Complaints referred from Garling Inquiry

- 3.20 The Commission received 200 complaints from the Special Commission of Inquiry into Acute Care (the Garling Inquiry). Of these, 72 were discontinued, 69 were referred for assisted resolution, 17 were referred for conciliation, 16 were resolved during the assessment of the complaint, 13 were referred to the relevant Registration Board, and 8 were formally investigated. The remaining five related to ex-practitioner Graeme Reeves, and the Commission is awaiting the outcome of legal proceedings before finalising these complaints.⁶³
- 3.21 When asked by the Committee why such a high percentage of these complaints had been discontinued, the Commissioner responded that a lot of people made representations to Commissioner Garling to voice their feelings about the health system because they had had bad experiences and they wanted the commissioner to know how they felt. He added that the complaints referred to the Commission ran the whole gamut, from the very serious to the perhaps less serious, and included matters that had been dealt with before, and that this might explain the slightly higher discontinuation rate.⁶⁴
- 3.22 The Commissioner informed the Committee that, although 81.5 per cent of the complaints were assessed within the 60-day statutory time frame, the time taken to finalise matters was longer than the average time taken in 2008-09 for complaints referred direct to the Commission. This was due to a number of factors that prolonged the Commission's usual complaint-handling processes. These are outlined in the Commissioner's Answers to Questions on Notice included in this Report (see Chapter Four).

Improving the health care system

Implementation of recommendations made to health organisations

- 3.23 A major part of the Commission's work consists of addressing systemic issues by making recommendations to health organisations to improve their systems. The 2008-09 Annual Report noted that, since 1 July 2005, the Commission has made 300 recommendations in 134 investigations. Of these, 258 (86 per cent) had been implemented as at 30 June 2009.⁶⁵
- 3.24 The Committee asked the Commissioner to explain what measures were taken to ensure the timely implementation of investigation recommendations, whether they were implemented to the fullest extent, and ongoing. The Commissioner responded that this was a difficult area, to which he had been giving consideration recently:

⁶² Transcript of Evidence, 19 April 2010, p. 7.

⁶³ Health Care Complaints Commission, *Annual Report 2008-09*, p. 5.

⁶⁴ Transcript of Evidence, 19 April 2010, p. 3.

⁶⁵ Health Care Complaints Commission, *Annual Report 2008-09*, p. 43.

... at this stage we rely largely on the organisation, the health institution that we are investigating, to report back to us. That report back can include new policies, details of training and the number of staff who have gone through training... When we conclude an investigation we write to the organisation and say, "We have now made these recommendations. You have three months generally to advise us of the implementation." In some rare cases that is not long enough because they have to do a lot of consultation themselves about implementation with staff and so on, but they do report back and generally fairly fully. They also report to the Director General who can pick up those recommendations for any wider implementation.⁶⁶

3.25 He added that:

What we do not do, and what I think we have to look at although there is a resource question, is going [*sic*] back six months later and nine months later to see that things are still in place. I have already raised that with the Director General and that is not a problem from their point of view; it is really a question of designing an audit program almost that we could implement to track both the implementation and the longevity of the recommendations.⁶⁷

3.26 Committee Members consider that designing and implementing such an audit program would strengthen the implementation of the Commission's recommendations, and the Committee will continue to follow with interest the manner in which the Commission monitors implementation.

Feedback to complainants about outcomes

3.27 Under s 28 of the Act, the Commission is required to report back to complainants, and also to any other person that the Commission believes should be notified. The Commissioner advised the Committee that this occurs at the end of the investigation, when the complainant receives a copy of the investigation report; and that the complainant is also advised when the hospital advises that recommendations made by the Commission have been implemented.⁶⁸

3.28 The Annual Report noted that the Commission had implemented a module in its case management system Casemate, which allows it to capture systemic quality improvement results from the resolution of complaints as from 1 July 2009.⁶⁹

3.29 When asked whether the Commission had given any consideration as to how it might use its knowledge base for quality improvements to communicate wider outcomes of complaints, the Commissioner responded that complainants are advised of improvements as part of the resolution of their individual complaints, but that the Commission was waiting for sufficient data before publishing more widely what systemic changes arose from resolution of complaints, and how that compares with the nature of issues under investigation.⁷⁰

3.30 The Committee then questioned whether it would be useful for the Commission's brochures to show how changes can occur by talking about some that had been made as a consequence of particular cases. The Commissioner replied that he thought that it was a good idea:

⁶⁶ Transcript of Evidence, 19 April 2010, p. 5.

⁶⁷ Transcript of Evidence, 19 April 2010, pp. 4-5.

⁶⁸ Transcript of Evidence, 19 April 2010, p. 6.

⁶⁹ Health Care Complaints Commission, *Annual Report 2008-09*, p. 26.

⁷⁰ Transcript of Evidence, 19 April 2010, p. 13.

We can use it in promotions to say to people that it is worth complaining, you can change things, things could change. Hospitals can tend to be quite monolithic in lots of ways when it goes beyond the individual patient care.⁷¹

- 3.31 The Committee considers that adapting the Commission's brochures in this way would be a practical and effective way to help build public confidence in the work of the Commission, and looks forward to its implementation by the Commission.
- 3.32 The Committee noted that during the year under review, the Commission also enhanced its case management system in order to record and monitor voluntary improvement actions taken by health organisations. The Commission considers that this would eventually become a valuable resource for assessing new complaints and ensuring that outcomes from investigations and other complaint handling processes are informed by improvements made elsewhere in the health system.⁷² Committee Members look forward to reviewing the impact of this enhancement at a future date.

Outreach

- 3.33 The Annual Report notes that one of the Commission's goals is "to promote complaint resolution services to people across New South Wales", and that the Commission works towards this goal through its meetings with local and regional community and health professional groups to inform them about the Commission's services.⁷³

Audio-visual presentations

- 3.34 As foreshadowed in its 2008-09 Annual Report,⁷⁴ the Commission in January 2010 posted on its website a series of eight brief audio-visual presentations about the complaint process, aimed at both health consumers and health service providers. The Commissioner advised the Committee that positive feedback had been received about the presentations from the members of the Commission's Consumer Consultative Committee.
- 3.35 The Commission has also used the video in its training sessions for expert advisers, and had received very positive feedback from the medical and nursing practitioners who attended the session. Strong support had also been received from Universities, the Commissioner of the Queensland Health Quality and Complaints Commission, and from the Chairman of the Medical Oncology Group of Australia.⁷⁵

Undergraduate and professional development programs for health professionals

- 3.36 The Committee was particularly interested to learn whether specific complaints handling training was provided to undergraduate and professional development programs for health professionals, especially doctors, dentists and nurses. The Commissioner responded that requests were received from time to time from Universities and training institutions, and that these were met as best they could. He added that Universities had incorporated the audio-visual presentation mentioned

⁷¹ Transcript of Evidence, 19 April 2010, p. 13.

⁷² Health Care Complaints Commission, *Annual Report 2008-09*, p. 5.

⁷³ Health Care Complaints Commission, *Annual Report 2008-09*, p. 12.

⁷⁴ Health Care Complaints Commission, *Annual Report 2008-09*, p. 14.

⁷⁵ *Answers to Questions on Notice before the Public Hearing*, no. 12.

above into their training programs. Also, whereas the Commission consults with registration boards regularly, most of its professional training effort was directed at medical practitioners, through continuing education programs and conferences.⁷⁶

Mandatory reporting

3.37 As foreshadowed during the 2007-08 review hearing, staff of the Commission had given presentations to an Obstetric Malpractice Conference and also to a Medico-Legal Conference about the development of mandatory reporting requirements for medical practitioners, and had provided background briefing on mandatory reporting to health professional colleges. The Commission had also published an article in the 22 January 2010 edition of *Australian Doctor* which discussed the mandatory reporting obligations of medical practitioners.⁷⁷

Persons from culturally and linguistically diverse backgrounds [CALD]

3.38 The Committee is pleased to note that information about the Commission and its services is published in 20 community languages on the Commission's website, and that a telephone interpreter service is available. The Commissioner advised the Committee that a "translation kit" is also available on the website, which contains a list of Commission staff who are able to deal with potential complainants in a language other than English.

3.39 The Commission had also distributed its brochure *Concerned about our health care* to community groups representing the ten most common language groups in New South Wales through the Community Relations Commission, and had liaised with the NSW Migrant Settlement Programme run by the Department of Immigration and Citizenship.

3.40 However, the Commission does not have any special system in place to measure the satisfaction of complainants with language difficulties.⁷⁸

3.41 The Committee considers that it would be enhance the considerable improvements made by the Commission in respect of accessibility of its services if CALD-specific statistics were to be kept by the Commission.

Health Conciliation Registry

3.42 The Committee asked the Commissioner what were the particular challenges faced by the Conciliation Registry with regard to assessments, and why a number of cases sent for conciliation were aborted due to parties withdrawing their consent. The Commissioner responded that he had been giving a lot of thought to conciliation lately and that he did not think that the conciliation system was operating as well as it should be because people were not "warmed up" to the value of conciliation and what they could get out of it.

⁷⁶ Staff from the Commission's Investigation Division have also given presentations to the College of Nursing, and at university courses for nurses and midwives, and had provided an article to "LAMP", the magazine of the NSW Nurses Association, about how the Commission handles complaints about nurses and midwives, Transcript of Evidence, 19 April 2010, pp. 1, & 5-6 & *Answers to Questions Taken on Notice after the Public Hearing*, no. 1.

⁷⁷ *Answers to Questions Taken on Notice during the Public Hearing*, no. 3.

⁷⁸ *Answers to Questions on Notice before the Public Hearing*, nos. 7 and 8 and *Answers to Questions Taken on Notice during the Public Hearing*, no. 2.

3.43 In terms of parties withdrawing their consent, complainants sometimes believed that with the matter was not being taken seriously enough if it was referred to conciliation – in effect they wanted a form of retribution. The Commissioner added that the Commission had been considering having conciliation more as part of the assisted resolution process rather than an upfront option as a means of encouraging people to participate. The Director of Assessments and Resolution had been asked to create a proposal, and this would be considered during the next financial year.⁷⁹

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⁷⁹ Transcript of Evidence, 19 April 2010, pp. 14-15.

Chapter Four - Answers to Questions on Notice before the Public Hearing

Executive Summary

1. Do you have any comment to make about the types of complaints referred to the Commission by Commissioner Garling, and the time taken to resolve those matters?

The Garling Inquiry into Acute care in Public Hospitals referred 200 complaints to the Commission.

Types of complaints

The Commission identified 401 issues raised by these 200 complaints. The majority of issues related to:

- treatment – 53% of all issues
- communication and consent – 25% of all issues.

These percentages may be compared with the corresponding percentages of issues raised by all complaints received by the Commission in 2008-09:

- treatment – 40% of all issues
- communication and consent – 23% of all issues.

It should also be noted that issues relating to professional conduct represented only 0.02% of the issues raised by the complaints referred to the Commission by the Garling Inquiry. By way of contrast, of all the complaints received by the Commission in 2008-09, 10% raised issues of professional conduct

The above analysis reflects that the focus of the Garling Inquiry was on issues surrounding the provision of health services by public hospitals, and that the concerns expressed to the Garling Inquiry by members of the public generally concerned the quality of patient care and treatment by public hospitals and their staff, rather than issues of serious misconduct by individual health practitioners.

Timeframes

The Commission assessed 81.5% of the 200 complaints referred by the Garling Inquiry within the 60-day statutory time frame. By way of comparison, for all complaints received by the Commission in 2008-09, 88.9% were assessed within 60 days.

As noted in the annual report, of the complaints referred by the Garling Inquiry:

- 16 (8%) were resolved during the assessment process
- 72 (36%) were discontinued – that is, no further action was taken following assessment
- 13 (6.5%) were referred to the relevant registration board
- 69 (34.5%) were referred for assisted resolution
- 17 (8.5%) were referred for conciliation
- Eight (4%) were formally investigated.

Of the complaints referred for resolution processes, the average time taken to finalise the matters referred for assisted resolution was 144.6 days, compared to 84 days for the average resolution process in 2008-09. The average time taken to finalise the matters referred for conciliation was 171 days, compared to 160 days for other matters referred for conciliation in 2008-09. The average duration of the eight Commission investigations arising from the Garling Inquiry was 324 days, as compared to the general average investigation period of 274 days in 2008-09.

The longer time taken to handle complaints referred by the Garling Inquiry was due to a number of factors that prolonged the Commission's usual complaint-handling processes:

- All of the "complaints" referred to the Commission by the Garling Inquiry were in the form of transcripts of oral evidence given by witnesses to the Inquiry. It was not always clear from the transcript whether the person giving the evidence specifically wished to make a formal complaint about the public hospital(s) the subject of their evidence. In order to clarify this, the Commission needed to contact the witness. Where it emerged that a witness did wish to pursue the matter as a formal complaint, the Commission sent them a copy of the transcript of their evidence and asked them to sign the transcript and return it to the Commission. The Commission also invited them to provide any further relevant information and/or copy documents in support of the complaint.
- In some cases, the witness's evidence concerned the care and treatment of another person, such as a family member. In these cases, the Commission needed to contact the patient where possible to ascertain whether they wished to complain, and to clarify any concerns on their part.
- In some cases where evidence was given "in private", the Garling Inquiry imposed a suppression order on publication of the transcript. The Commission therefore needed to seek and obtain a variation of the suppression order by Commissioner Garling, in order to be able to provide the transcript to the relevant health service provider(s) as a complaint that required a response in order to assist the Commission's assessment of the matter.
- Where the Commission had previously dealt with a complaint by a person who had, more recently, given evidence to the Garling Inquiry, the Commission had to obtain and examine the material on the existing complaint file, in order to determine whether relevant evidence had already been obtained.

2. Where cases cannot be assessed within the statutory 60 days, due to their complexity or the need to seek further particulars, what procedures does the Commission employ to keep the parties informed about progress?

Every complainant is advised of the name of the assessment officer handling their complaint and of the direct telephone number of that officer. Where there is a delay in the assessment process, the assessment officer is expected to advise the complainant of the delay, the reasons for the delay, and the anticipated time for completion of the assessment process.

Legislative changes

3. The Committee notes that the amendments of the Health Legislation Amendment Act 2009 came into force on 13 May 2009.

What, in practice, has been the impact of the amendments on the Commission's day-to-day work, particularly in relation to the provision of documents or evidence? Have they expedited the time taken to conduct investigations?

The legislative amendments have increased the capacity of the Investigations Division to obtain evidence from relevant witnesses, and this has expedited the Commission's investigations. However, because the Commission measures the timeliness of investigations generally, it is not possible to quantify the extent to which the exercise of the Commission's powers to require evidence from witnesses has contributed to the generally improving investigation timeframes.

The increase in the evidence available to the Commission has also assisted in the comprehensiveness and quality of the briefs referred by the Investigations Division to the Director of Proceedings to consider the prosecution of disciplinary proceedings against registered health practitioners.

4. The Annual Report (page 11) notes that: 'The amendments regarding legal representation are expected to commence in early 2010 following the development of practice notes guiding the procedures before Professional Committees.'

How frequently – if at all – do you anticipate having to rely on the assistance of legal counsel, and will this impact on the budget of the Legal Division?

The matters listed before Medical Board Professional Standards Committees from January 2010 to date are matters where the Commission's formal complaint had been referred to the PSC before the amendments about legal representation took effect. For this reason, it was thought that legal representation for the Commission and the respondent medical practitioner would not be possible. However, the Medical Board has advised that, if either or both of the parties wishes to be legally represented at a PSC hearing, the request for legal representation is likely to be granted.

There are 12 matters which fall within this category:

- Of the three matters that have already been heard, applications for legal representation were made in two. The Commission was legally represented in one matter, and a Commission hearing officer appeared in the other.
- Of the remaining nine matters, applications for legal representation were made in five. It is possible that applications for legal representation will be made in the remaining four matters.

Currently, it is intended that the Commission will brief counsel to appear in three matters, while a Commission hearing officer will appear in two matters and a Commission legal officer will appear in the remaining matter.

The use of legal representation by the Commission is higher than anticipated, as it appears that respondent practitioners are more frequently applying to be legally represented.

To date, there have been no PSC matters listed which fall entirely within the scheme established by the amendments. It is anticipated that, once the amendments take full effect, the majority of respondents in Medical PSCs will be legally represented.

In relation to the impact of the amendments regarding legal representation on the budget of the Legal Division – the Commission anticipates that the use of counsel will lead to increased legal costs being incurred by the Legal Division. The Commission will only brief “junior” counsel (that is, not Queens Counsel or Senior Counsel) in PSC matters, because such matters are generally of short duration and require much less preparation than Tribunal matters, and in order to keep costs to a reasonable level. The amount of costs paid to counsel will be kept under review by the Director of Proceedings and the Commissioner.

Currently, the Commission is required to employ both legal officers – who are legally qualified – and hearing officers – who are not legally qualified – because the relevant legislation does not permit legal representation before a Nursing and Midwives Board PSC. It is anticipated that, following the introduction of the national health registration scheme in July 2010, legal representation will be permitted in all PSCs.

5. The Annual Report (page 11) notes that: ‘Amendments to the Medical Practice Act, designed to make hearings of Professional Standards Committees more transparent, came into operation in October 2008’.

Have the more transparent processes impacted upon your co-regulatory relationship with the Medical Board, and with regulatory authorities for the other professional groups? How would you evaluate overall the Commission’s relationship with the professional standards committees over the past year?

The Commission has very sound working relationships with the Medical Board and the other health professional regulatory authorities. The increased transparency of Medical Board PSCs has not had any adverse impact on the Commission’s relationship with the Medical Board.

6. What do you consider to be the likely effect of the amendments on the operations of the Commission’s Legal Division?

The main impact of the amendments on the Commission’s Legal Division has been in relation to the possibility of legal representation before Medical PSCs – see the Commission’s detailed response to Question 4 above.

The Commission’s hearings before Medical PSCs are now open to the public, which means that complainants, family members and other interested people can attend the hearing and see and hear the relevant witnesses – including the respondent practitioner – give their evidence.

The public reporting of decisions by Medical PSCs also means that interested parties can consider the evidence provided to the PSC, as well as the reasons for the PSC’s decision. This allows officers of the Commission’s Legal Division to provide much more information about the PSC proceedings and the PSC’s decision to the complainant and other interested parties.

Outreach

7. The Annual Report notes a number of mechanisms for dealing with complainants who may have language difficulties.

Does the Commission actively recruit staff with multiple language qualifications? What measures are in place to ensure that those requiring assistance to make a complaint are satisfied with the service which they are offered?

The Commission has reviewed its recruitment processes to ensure that all position descriptions and job advertisements are written in plain English, and has removed any job requirements which might discourage people with language difficulties.

The Commission employs staff from a variety of backgrounds, and a number of Commission staff are able to speak in a language other than English – specifically, Italian, German, Spanish, Croatian, Macedonian, Serbian, Hindi, Punjabi, and Tagalog (Filipino). These staff have been identified and, where appropriate, are paid under the Community Language Allowance Scheme. These staff are available to assist complainants.

The Commission has a “translation kit” on its intranet which contains a list of all Commission staff who can speak a language other than English, as well as information about the interpreter and translation services available to the Commission.

The Commission assesses complainant satisfaction with its services by requesting complainants to complete and return a client satisfaction survey form at the completion of the Commission’s handling of the matter. No special systems are in place to measure the satisfaction of complainants with language difficulties.

8. In addition to the outreach publications and activities referred to on page 13 of the Annual Report, does the Commission undertake any advertising of its services in the press or on air? Does the Commission conduct any advertising in local foreign language newspapers?

The Commission does not undertake any advertising of its services in the media. The primary reason for this is the high cost of such advertising. There is also the concern expressed by respondent practitioners that the Commission would be inappropriately “soliciting” complaints about health service providers.

The Commission has not advertised its services in local foreign language newspapers. However, in 2009-10, the Commission took the following steps to inform CALD communities of the Commission’s role and functions:

- In January 2010, the Commission arranged for its brochure “*Concerned about your health care*” to be distributed, through the Community Relations Commission’s email link, to community groups representing the ten most common language groups in NSW. The email also informed the community groups that the Commission could arrange presentations for them about the Commission’s role.
- The Commission’s Communications Officer has liaised with the NSW Migrant Settlement Programme run by the Department of Immigration and Citizenship. As a

result, information about how people can make a complaint to the Commission has been included in the 2010 edition of the Department's booklet "*Beginning a life in Australia*", which is translated into 37 languages and will be available on the Department's website. In addition, the Commission has been invited to make a presentation about its services to providers of migrant settlement services at their next meeting in April 2010.

9. The Annual Report (page 13) notes that the Commission refers to the availability of the Code of Conduct for Unregistered Health Practitioners on its website and in printed form. Is there scope for further public education about the Code? If so, is there a specific strategy to undertake this?

The Commission continues to respond to inquiries, and to make presentations to the peak bodies representing the various unregistered health professions, about the Code of Conduct and the powers of the Commission to deal with inappropriate or improper conduct on the part of unregistered health service providers.

The Commission has also provided articles about these matters to the community organisations represented on the Commission's Consumer Consultative Committee, for inclusion in their communications to their members and clients.

The Commission's public statements and warnings about unregistered health service practitioners – including details of any prohibition order made by the Commission – are published on the Commission's website, and are promptly notified to relevant media outlets.

Finally, the Commission has recently been liaising with the "*Korean Times*" to include information for the Korean community on the Code of Conduct, and the Commission's role in dealing with patient complaints about unregistered health service providers.

10. The Annual Report (page 14) notes that 'The Commissioner started to write a regular column in "Australian Doctor", the leading publication for Australian general practitioners'. What feedback, if any, have you had from writing the column? What types of topics do you cover, and how do you select them?

The Commission has selected topics for its column in "*Australian Doctor*" on the basis of commonly occurring complaints. In 2009, the Commission provided columns covering the following topics:

- *Prescribing drugs of addiction, and how to deal with patients displaying drug seeking behaviour*
- *Boundary issues*
- *When young people can give their own consent to medical treatment*
- *Alternative health treatments and the obligations of GPs*
- *Can apologies prevent complaints?*
- *How the Commission uses experts to determine appropriate clinical standards*
- *The risk of missed diagnosis when treating long-term patients*
- *Mandatory reporting requirements*

While the Commission has not received any direct feedback in response to the columns, the Commission has been asked to continue providing columns on current topics in 2010. Planned topics for the column in 2010 include:

- *Follow-up of test results – whose responsibility is it?*
- *Delegating clinical tasks to nurses*
- *Explaining fees and costs to patients*
- *The Medicare dental scheme – when and who to refer*
- *Being sensitive when obtaining patient histories in relation to mental health, weight, and smoking history*
- *Different standards in rural settings?*
- *The difference between civil and disciplinary action against GPs*

11. The Annual Report (page 14) notes that ‘The Commission has also engaged in closer consultation with the Clinical Excellence Commission by providing copies of investigation reports making recommendations for systemic changes’.

Can you give an example of the nature of the recommendations the Commission has made on systemic issues? Does the Commission have procedures to systematically record and communicate strategic issues to the CEC, and are they also communicated to other parties?

Since July 2009, the Commission has made a number of recommendations arising from the investigation of 21 health organisations. Examples of recommendations on systemic issues include recommendations relating to:

- clinical education for hospital staff in the regular recording and monitoring of vital signs
- audits of records of vital observations for quality and compliance
- revised referral protocols for access to acute pain services
- improved processes for the notification of critical results to clinicians
- improved processes for on-line access to laboratory results
- improved processes for ensuring that the consultant responsible for the co-ordination of psychiatric care is consistently involved in clinical decision-making.
- the recording of key decisions regarding psychiatric care in patient notes.

The CEC has advised that the Commission that it appreciates receiving copies of the Commission’s reports, and that the recommendations relate to issues being addressed by the CEC.

The Commission records its recommendations so that they can be accessed to determine the recurrence of similar issues.

The Commission advises the parties to individual complaints – that is, the complainant and the health organisation the subject of investigation – of the Commission’s recommendations. The Commission also notifies the Director-General of the Department of Health of all of the Commission’s recommendations. The Director-General co-ordinates the Department’s strategic response to the recommendations.

12. The Committee notes that, in January 2010, the Commission posted a series of eight short audio-visual presentations on its website. What feedback, if any, has the Commission received regarding these videos?

The Commission has received positive feedback about the video from the members of its Consumer Consultative Committee. The Commission has also used the video in its training sessions for expert advisers, and has received very positive feedback from the medical and nursing practitioners who attended the sessions.

In addition, the Commissioner of the Queensland Health Quality and Complaints Commission wrote to the Commission to say that the video *“is an excellent initiative, and I have forwarded it to the Chief Executive Officer to share with the HQCC staff”*. The Chairman of the Medical Oncology Group of Australia has also advised the Commission that he had found the video *“very informative and interesting”*.

Inquiry Service

13. The Committee is pleased to note the Ombudsman’s positive finding in relation to the Mystery Shopper audit – in particular (page 24), that staff were “consistently professional and treated matters of sensitivity well and in a sympathetic manner.” Furthermore, their responses to the letters and emails were “of a very high standard, providing detailed and relevant information”.

What training is provided to Resolution Officers? How often is it provided?

Is training tailored to the needs of each division, and is it contained within the separate divisions or is it across the organisation?

Training for Resolution Officers

The Commission’s Inquiry Service is staffed by the Commission’s Resolution Officers. These are senior officers (grade 7/8) who have had many years of experience in dispute resolution. The Resolution Service team has been very stable, and there are many officers in the team with extensive corporate knowledge who have received training in resolution processes over the years.

The Resolution Officers meet at the Commission on a monthly basis, and their training is ongoing. At each meeting, two resolution cases are presented, and then reviewed by the whole group. This allows for the sharing of information and resolution strategies, and the improvement of skills by reflecting on “what worked and what didn’t” and identifying how service could be improved in the future.

Another standing agenda item is a review of the challenges encountered by the Inquiry Service over the previous month. This ensures the constant review of performance, and suggestions for improvement.

Resolution Officers also have specific training days on a quarterly basis. Resolution Officers who have particular expertise often provide training to their colleagues. Topics discussed range from new internal policies and procedures, to presentations by organisations such as the Office of Fair Trading that are relevant to the work of the Resolution Officers. The most recent training day in February 2010 concentrated on improving services to the inmates of corrective services. Staff from Justice Health and the Corrective Services Unit of the Ombudsman’s office gave presentations and discussed relevant issues. This has improved

the understanding of what these organisations do, clarified appropriate referral strategies, and prompted suggestions on how to improve the Commission's services.

Resolution Officers have also been provided with external training opportunities. For example, in the past year, two officers completed their accreditation as mediators with the Australian Commercial Disputes Centre.

Training generally

The Commission provides training and development activities to maintain and increase the capabilities, knowledge and experience of its staff. The Commission ensures that staff are professionally and technically proficient to meet their position's operational accountabilities and the Commission's corporate and strategic plans and objectives.

The training delivered to support these objectives covers the following:

Divisional training

Training is tailored to meet the overall requirements of each Division by focussing on the skills needed by positions within the Division, based on functional and operational requirements.

The nature of the training for Resolution Officers has been outlined above. Investigation Officers receive specialist training, including external investigation skills training delivered by the NSW Police Force.

Commission-wide mandatory training

Other important forms of training include training sessions that fall into the Commission-wide mandatory training category – the Commission requires all staff to undertake the training. This includes training sessions on:

- the Code of Conduct
- occupational health and safety [OH&S]
- equal employment opportunities and diversity [EEO].

Commission-wide non-mandatory training

Other forms of Commission-wide training include:

- Casemate training
- IT training
- plain English writing skills
- merit selection
- the senior managers leadership program.

Individual competency training and development

The Commission supports staff attending training sessions to develop their individual capabilities, as identified by the staff member and agreed to by their manager in individual learning and development plans.

Development activities provided by the Commission include:

- job relevant training
- refresher courses
- new skills training
- participation in corporate activities
- opportunities to do work at a similar or higher grade within the Commission, or on secondment to other agencies
- training where performance has been identified as inadequate
- other career development opportunities relevant to the work of the Commission.

14. Given that during 2008-09 there were 11.8% more inquiries than 2007-08 and 24.5% more than 2006-07, to what does the Commission attribute this increase? What measures has the Commission taken to handle this increasing volume of inquiries?

The Commission is unable to clearly identify the reasons for the increased volume of inquiries. The increase may be due to a number of factors, including media publicity about the health system, and greater awareness of the Commission's role and the rights of health consumers to complain about health service provision.

The Commission's Inquiry Service has handled the increase within their existing resources.

Assessing complaints

15. How do you communicate the outcome of reviews to complainants?

The outcomes of reviews are communicated in detailed letters to complainants that explain the review process, the consideration given to the available evidence, and the reasons for the determination reached after review.

16. Has the Client Satisfaction Survey provided the Commission with any indication about clients' satisfaction with the review process?

The Commission does not send client satisfaction surveys to complainants who request reviews. The request for review indicates dissatisfaction on the part of the complainant with the original assessment decision – as 96% of the reviews in 2008-09 confirmed the original assessment decision, the majority of those requesting review are likely to remain dissatisfied.

Having considered the Commission's question, the Commission will consider introducing client satisfaction surveys for the review process which may help in ascertaining whether the review process and the reasons for review decisions are adequately explained.

17. How does the Commission explain the relatively low overall level of satisfaction with the complaint assessment process among complainants? What measures are being taken by the Commission to raise complainants' overall satisfaction levels in this regard?

The largest single category of assessment decisions (38.5% in 2008-09) involved "discontinuing" the matter – that is, taking no further action on the complaint. In these circumstances, the 61.3% of those responding to the client satisfaction survey saying that

they were generally satisfied with the Commission's handling of their complaint is not a bad result.

The higher levels of complainant satisfaction with the resolution, conciliation and investigation processes reflect the higher level of resources committed by the Commission to the handling of these processes.

The Commission has put considerable effort into training its Assessment Officers to fully explain to complainants the assessment process, and the reasons for the assessment decision on their complaint.

18. The Annual Report notes that the survey response rates were as follows:

- **Page 29: 'The response rate was 16.5% for complainants and 12.2% for providers who were sent a survey' (survey sent with assessment decision letters)**
- **Page 33: 'The response rate was 29.3% for complainants and 27.7% for providers who were sent a survey' (Resolution Service)**
- **Page 45: 'The response rate was 17.6% for complainants and 4.3% for providers who were sent a survey' (Investigations Division)**

Has the Commission explored avenues to attain a higher response rate to its surveys in order to attain more useful data to improve its services?

Response rates to surveys are high in conciliation, because the people attending the conciliation meeting are provided with the survey directly after the meeting. This approach is not possible with other processes, such as assessment, assisted resolution, and investigation.

The Commission's Communications Officer reviews the comments made by health service consumers and providers in their survey responses, and follows the comments up with the relevant case officers. If there appear to be grounds for systemic improvement, these are discussed with the relevant managers and directors; where appropriate, improvements to practice and procedure and/or or training have been initiated.

The Commission is considering offering electronic email surveys to parties to complaints in future, subject to the technical upgrade of its internet page.

Resolving complaints

19. The Annual Report (page 31) notes that 'The Resolution Service deals with complaints that have been assessed as being suitable for assisted resolution ... Of the nine Resolution Officers, five are located in the Sydney metropolitan area, while the other four are in regional areas, based in Newcastle, Dubbo, Lismore and, since August 2008, in Queanbeyan. There is now a Resolution Officer located in each of the Area Health Services across the State'.

Do you consider more could be done to broker complaints at the local level? Are the Resolution Officers sufficiently accessible, and how do you publicise their availability?

The Resolution Officers are accessible to the public through the Commission's Inquiry Service, and do much to broker the resolution of complaints at the local level. In 2008-09, Resolution Officers:

- referred over 800 callers to other bodies that could assist them to resolve their concerns
- discussed strategies for the local resolution of health concerns with 1,800 callers
- assisted over 1,000 callers by phoning health services to pass on the caller's concerns, and to facilitate/encourage direct contact between the caller and the service.

Two of the Resolution Officers are in offices at Mt Druitt and Liverpool, and another four positions are in regional locations – Newcastle, Lismore, Dubbo, and Queanbeyan (currently the Queanbeyan position is not filled because a recent recruitment process did not attract a suitable candidate; the position will be advertised again in the near future). People can visit Resolution Officers at these sites; this is particularly helpful where a complaint has been referred to the Resolution Officer for assisted resolution, and it is beneficial to have a face-to-face meeting with the complainant to discuss their complaint.

The Commission publicises the Inquiry Service – and, in particular, how Resolution Officers can assist with resolving complaints – through its website and publications, as well as through the Commission's presentations to community groups.

20. To what would you attribute the fact that the Resolution Service completed only 63.6% of resolution plans within the target time of 21 days? What measures are being taken to improve performance in this regard?

The Resolution Officers develop a resolution management plan where the parties to the complaint have consented to the resolution process.

The main reason for not completing the resolution plan within the 21-day target timeframe is delay in obtaining consent from the parties. Consent can be delayed for the following reasons that are beyond the control of the Resolution Service:

- The Resolution Officer has to write to people who do not have a telephone or who have not provided their telephone number to the Commission – this is the case with almost all referrals of complaints from corrective service inmates and is often the case for people who prefer to communicate in writing because of their illness.
- Where the complainant is dissatisfied with the Commission's decision to refer their complaint for assisted resolution. Following the Commission's initial discussions with the complainant about possible outcomes of the resolution process and encouragement to engage in the process, complainants often requests time to consider whether they will request a review of the assessment decision rather than engage in the resolution process.

- Where the complainant wishes to consult with other family members or their legal adviser before consenting to assisted resolution
- Some of the complaints referred for assisted resolution concern events that have resulted in the death of a family member. The complainants are often immersed in grief and need time to understand why the Commission is not investigating their complaint before they are prepared to consent to engage in assisted resolution.
- In some cases, the Commission has not received a response from the health service provider before the assessment process is concluded. Some complainants wish to await receipt of the health service provider's response before considering their options and consenting to assisted resolution.
- Complainants and practitioners may be on leave when the complaint is referred to the Resolution Service, so it is not possible to contact them within the 21-day timeframe.

The Commission has emphasised to its Resolution Officers the need for timely contact with the parties and appropriate follow-up – these being matters within the control of the Resolution Officer. More recently, emphasis has also been given to the need for Resolution Officers to obtain a reasonably prompt decision by the parties on whether they are prepared to engage in the assisted resolution process. This has led to a higher number of complainants and providers not consenting to resolution than was previously the case; however, if the complainant seeks a review of the Commission's assessment decision and the original decision is confirmed, most complainants are again offered the opportunity to engage in a resolution process.

Investigating complaints

21. The Committee is pleased to note the improvement in the timely completion of complaint investigations. What is the Commission doing to ensure it continues to increase its efficiency in this regard?

To increase the efficiency and timeliness of its investigations, the Commission has adopted measures such as:

- ongoing training for investigation officers in good investigative practices
- the streamlining of its evidence-gathering processes
- the development of a report-writing framework.

Greater emphasis has been placed on weekly manager/staff investigation reviews and stringent monthly reporting processes. These have been linked to performance plans for investigators and managers alike, to ensure compliance with the Investigation Division's Business Plan.

In addition, workshops have been conducted to review all of the Investigation Division's processes, in order to identify areas of improvement and to promote staff engagement in a quality improvement culture.

Appendices

22. The Annual Report (page 86) notes that 'All staff have completed performance agreements that are reviewed annually. More than 92.6% of Commission staff were rated as competent or better'.

In what ways did those Commission staff not rated as competent or better fail to meet performance criteria? What has the Commission done to improve the performance of these employees?

The Commission has a Commission-wide performance management system (PMS) which requires each staff member to have in place a performance agreement and a learning and development plan. The PMS requires, as a minimum, then annual assessment of a staff member's performance against the identified measures and targets, the position's accountabilities and Commission-wide competencies, as outlined in the performance agreement.

There may be a number of reasons why a staff member fails to meet the performance requirements associated with their position as outlined in their performance agreement, such as:

- lacking particular knowledge or skills in an area where further training is required to get them "up to speed"
- an inability to perform some inherent aspect of their job, such as those relating to prioritisation, organisation and/or output
- producing poor quality work.

Poor performance can also stem from short-term personal issues or illness, or poor job fit.

The Commission makes every effort to determine the true causes of poor performance, so that these matters may be addressed and unsatisfactory performance not repeated, or performance factors outside the control of the staff member such as illness are acknowledged.

When performance is not to the level expected, it is Commission practice, as soon as the issue is identified, for the relevant manager to inform the employee that they are not meeting expectations. Often a combination of measures is used to assist the employee to increase their performance to a competent level. These measures may include:

- scheduling more regular feedback sessions with their manager
- closer supervision
- mentoring and coaching from other staff members
- if necessary, the development of a performance improvement plan, which could contain a combination of the above measures, as agreed to by the manager and the employee.

23. What have been the main challenges with privacy management for the Commission? How do you train staff in managing privacy issues?

The Commission receives a great deal of confidential private health information in the performance of its functions. In the course of its handling of complaints, the Commission is

required to disclose private health information – for example, when obtaining expert opinions and gathering further evidence.

The statutory framework appears to provide an appropriate balance between legitimate privacy considerations and the effective performance of the Commission's functions.

The Commission has effective information security, both in handling hard copy information and through the protection of its information technology systems. Staff are well aware of the sensitivity of the information held by the Commission, and are continually reminded of it. Induction procedures also cover these issues.

Having regard to the volume of information dealt with by the Commission, it should also be noted that, in 2008-09, the Commission received only two complaints alleging a breach of privacy by the Commission (reported at page 87 of the Annual Report).

24. According to Table 17.2 (page 90), titled 'Staff numbers by employment category 2005-06 to 2008-09', the Commission was operating in 2008-09 with fewer staff than in the 2007-08 year.

Do you consider that the Commission's current staffing is adequate to pursue the outreach aspects of your activities, in addition to your complaint-handling functions?

What were the reasons for six resignations in the previous year?

Currently, the majority of the Commission's outreach presentations are undertaken by the Resolution Officers. As well as conducting outreach activities across NSW, Resolution Officers are responsible for responding to inquiries, dealing with complaints referred for assisted resolution, and reviewing assessment decisions.

The increase in the number of inquiries received, and the higher number of complaints being referred for assisted resolution, have limited the resources that can be directed to outreach activities.

The six staff who resigned from the Commission in 2008-09 did so for the following reasons:

- retirement
- moved from Sydney to rural NSW
- moved to the United States of America
- obtained a position at another agency
- obtained a position in the private sector
- took up university studies.

25. The Annual Report notes at Table 17.4 (page 91) that the Commission has achieved all targets for employment of people with a disability.

Specifically, how has the Commission achieved its targets for the employment of people with a disability? What measures does the Commission intend to take in the future through the Disability Action Plan to ensure that it continues to achieve these targets?

The Commission has ensured that it has in place measures to collect, store and accurately report on employee data relating to disability and the other EEO bench mark groups. 100% of Commission staff are included in the data gathering and reporting. To ensure that the Commission is accurately and contemporarily reporting disability data (the only benchmark group likely to change following an employee's initial data collection), the Commission annually requests staff to review their data in this area. To assist with this review, the Commission provides employees with a reminder about what is meant and covered by the definition of "disability". Consequently, data on disability is updated annually before being reported in the Commission's annual report.

The Commission promotes flexible working arrangements as part of the recruitment information contained on its website. Commission staff who convene recruitment panels are trained in merit selection techniques – this training provides a comprehensive knowledge of selection techniques in relation to EEO groups.

In the past, the Commission has also participated in affirmative action programs for the employment of staff with a disability, and has permanently employed staff as a result of this program.

The various measures in the Commission's Disability Action Plan that will be used to assist the Commission to continue to support the achievement of the target include:

- reviewing the Commission's policy on "Employment of People with Disabilities"
- reviewing the Commission's recruitment policies and procedures, and the job applicant information packages, to ensure that they are free from discrimination and address the needs of people with a disability
- reviewing current recruitment processes (for example, the wording of advertisements) to attract applications from people with a disability
- exploring options for advertising suitable job vacancies through Disability Networks
- the inclusion of TTY facilities in job vacancies
- merit selection training/refresher training to be undertaken by identified staff
- merit selection training to be undertaken by all new managers.
- the inclusion of disability awareness as a subject in external merit selection training
- ensuring that the principles of reasonable adjustment are addressed for people with a disability during the job interview process and related appointment stages.

To assist with the Commission's retention of staff with a disability, the following measures have been identified in the Disability Action Plan and will be applied:

- monitoring the Commission's Exit Questionnaire, and addressing the reasons for staff with a disability leaving the Commission.
- ensuring that all facilities leased or managed by the Commission continue to comply with the Building Code of Australia and Australian Standards for access and mobility
- ensuring that any reviews of the design of the Commission's website and intranet address the issue of people with a disability, and are in line with NSW Government Website Style Documents, to ensuring access capability
- monitoring EEO data collected from new staff to ensure disability issues and/or work-related adjustments that are identified are addressed and actioned.

26. How, specifically, is the Commission's Aboriginal Service Plan aiming to address Aboriginal issues in the key areas of service planning and delivery and staffing requirements?

The Aboriginal Service Plan commits the Commission to participation in the “Good Service Mob”, a collaboration of Indigenous and non-Indigenous staff from nine complaint-handling agencies in NSW. As noted in the annual report, the Commission participated in seven “Good Service” forums in 2008-09. These forums were specifically aimed at providing support to members of Indigenous communities in accessing complaint services, including those of the Commission.

In addition, one of the members of the Commission’s Consumer Consultative Committee is a representative of the Aboriginal Medical Health and Research Council.

The Commission will continue to hold and fill an identified Aboriginal and Torres Strait Islander Complaints Resolution Officer position.

Other

27. The Committee notes that the NSW Ombudsman maintains that a key focus of that body’s work is ‘to build a culture where complaints are seen as a positive and critical component of service improvement’ (NSW Ombudsman Annual Report 2008-2009, page 61).

What strategies, if any, are now in place to help build a culture within the healthcare professions where complaints are seen as a positive and critical component of service improvement?

The Commission offers a variety of information for health providers on its website – including tips on how to respond appropriately to patient complaints. The Commission also makes regular presentations to health professionals in which it highlights complaint prevention and resolution strategies to encourage them to resolve patient complaints themselves where possible.

The Commission visits the Area Health Services and meets with their complaint-handling staff to discuss their practices in responding to complaints and their interaction with the Commission.

The Commission supports the “open disclosure” principle. The Commission’s submission to the review by the Health Department of the privilege conferred on information obtained through root cause analysis (RCA) urged greater transparency with patients and their families in relation to incidents the subject of RCAs.

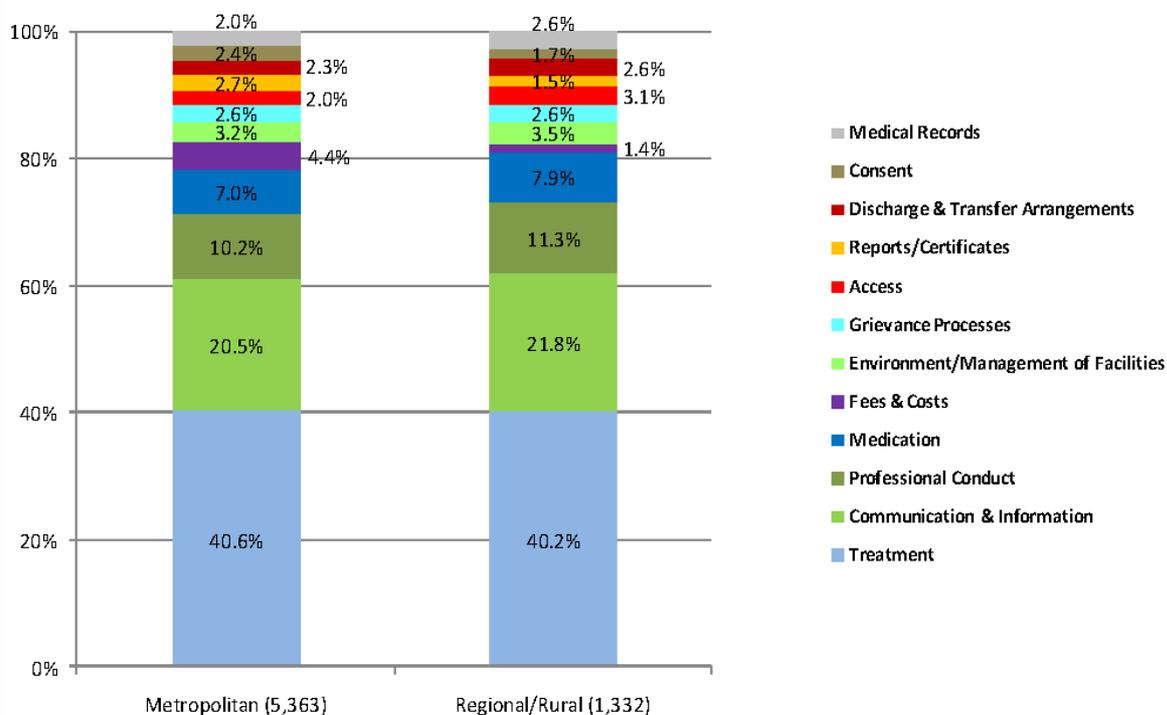
Through the Commission’s website information and brochures for health consumers, “*Concerned about your health care?*” and “*Resolve concerns about your health care*”, the Commission encourages patients to try to resolve their concerns directly with their health service provider. The Commission’s Inquiry Service also advises people on how to raise their concerns directly with their health service provider, with a view to a resolution of these concerns without the need to lodge a formal complaint.

28. Last year, the Committee raised the issue of complaints about the difficulty of accessing GPs in rural areas. It was suggested that a breakdown of complaints by postcode might be useful.

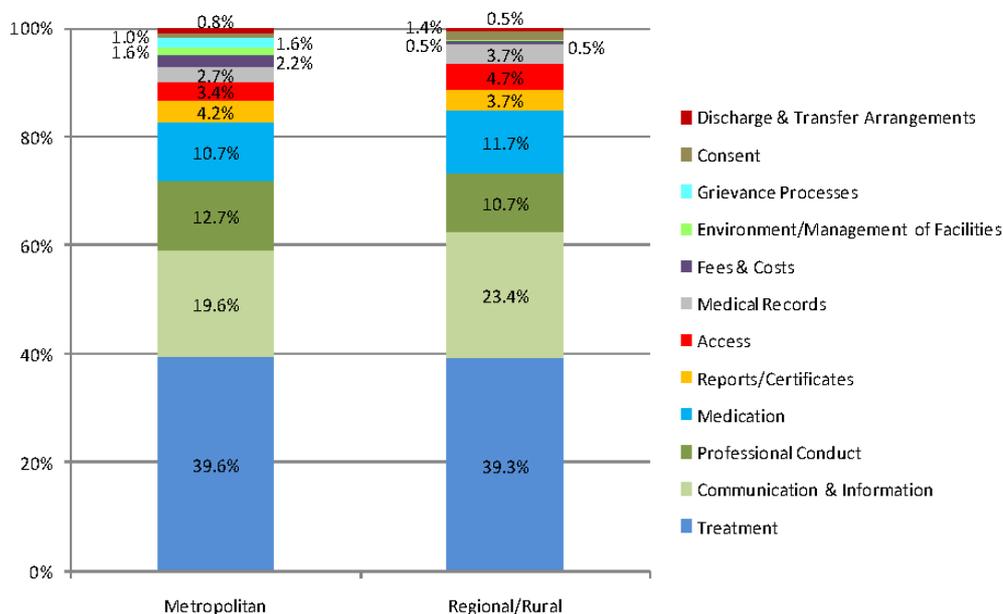
Have you been able to look further into this? Are many complaints received about accessing GPs in rural areas?

The Commission has conducted an analysis of the complaints that it received in 2008-09 to identify whether there were any significant differences between complaints about metropolitan health service providers and those about rural and regional health service providers. As illustrated in the charts below, there appear to be no major differences in the type of issues raised in the complaints. This initial analysis appeared to show no statistically significant pattern, and there would have been considerable resources involved in the Commission conducting a further breakdown of the data by reference to metropolitan/rural postcodes.

Comparison of issues raised in complaints about metropolitan vs regional/rural health service providers 2008-09



Issues raised in complaints about General Practitioners by region 2008-09



AREA HEALTH SERVICE MAPPING

Northern Sydney AHS	Northern Sydney/Central Coast AHS	Metropolitan
Central Coast AHS	Northern Sydney/Central Coast AHS	Metropolitan
Western Sydney AHS	Sydney West AHS	Metropolitan
Wentworth AHS	Sydney West AHS	Metropolitan
Central Sydney AHS	South Western Sydney AHS	Metropolitan
Sydney South West AHS	South Western Sydney AHS	Metropolitan
Illawarra AHS	South Eastern Sydney/Illawarra AHS	Metropolitan
South Eastern Sydney AHS	South Eastern Sydney/Illawarra AHS	Metropolitan
Northern Rivers HS	North Coast AHS	Regional/Rural
Mid North Coast AHS	North Coast AHS	Regional/Rural
Macquarie AHS	Greater Western AHS	Regional/Rural
Far West AHS	Greater Western AHS	Regional/Rural
Mid Western HS	Greater Western AHS	Regional/Rural
Southern AHS	Greater Southern AHS	Regional/Rural
Greater Murray AHS	Greater Southern AHS	Regional/Rural
New England AHS	Hunter/New England AHS	Regional/Rural
Justice Health Service	Justice Health Service	Other
Interstate	Interstate	Other
Unknown/Other	Unknown/Other	Other

Chapter Five - Transcript of Proceedings

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE 2008-09 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

—

At Sydney on Monday 19 April 2010

—

The Committee met at 2.00 p.m.

—

PRESENT

The Hon. H. M. Westwood (Chair)

Legislative Council

Reverend the Hon. F. J. Nile

Legislative Assembly

Mr K. A. Hickey

Ms J. Hopwood

The Hon. N. Rees

CHAIR: I declare the hearing open. It is a function of the Parliamentary Joint Committee on the Health Care Complaints Commission to examine each Annual Report of the Commission and report to the Parliament upon it in accordance with section 65 (1) (c) of the Health Care Complaints Act 1993. I would like to convey the thanks of the Committee for your appearance here today for the purpose of giving evidence on matters relating to the 2008-2009 Annual Report of the Health Care Complaints Commission. I am advised that you have been issued with a copy of the Committee's terms of reference and also a brochure entitled "Information for witnesses appearing before Parliamentary Committees", is that correct?

Mr PEHM: Yes, thank you.

CHAIR: That is more for Mr Wilson; both Ms Mobbs and Mr Pehm have had experience in the past.

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

KAREN BERNADETTE MOBBS, Director of Proceedings, Level 13, 323 Castlereagh Street, Sydney, and

ROBERT IAN WILSON, Director of Investigations, Level 13, 323 Castlereagh Street, Sydney, affirmed and examined:

CHAIR: The Committee has received a written submission from the Commission in response to some questions on notice. Do you wish that submission to form part of your evidence today?

Mr PEHM: Yes, I am happy for that, Madam Chair.

CHAIR: Before we proceed to questions, would you like to make an opening statement?

Mr PEHM: No, I do not think I need to. We will rely on the report and on the responses to questions. I am happy to take questions.

CHAIR: Why has the Commission consistently failed to meet its target in providing timely responses to the Minister's office and what is being done to rectify this situation? I am referring to one of the items in the Annual Report on page 12, if you would like to refer to that?

Mr PEHM: The year before the one we are reporting on, those responses were done by my Executive Officer personally and we decided to delegate that out to the officers who had carriage of the matters to draft the ministerials and then get them to her for checking and bring them to me. That is really the cause of the delay. The 14-day deadline perhaps was interpreted by the officers holding the file, not allowing enough time for the checking.

CHAIR: I am sorry?

Mr PEHM: I think the problem was caused because we delegated that function out to the individual case officers on the file. When I saw that figure I was not very happy with it and that has gone back to the executive officer to handle those requests personally now. I think you will see a much-improved figure for the current year.

Mrs JUDY HOPWOOD: Has the Commission considered providing any specific complaints handling related input to undergraduate training and/or professional development programs of health practitioners, especially doctors, dentists and nurses as these are the three health professions about which most complaints are received?

Mr PEHM: We do get requests from time to time from universities and training institutions and we meet those as best we can. I cannot give you the number of attendances we have done specifically for training purposes. One of the bigger initiatives in the last year was to produce the DVD explaining the role of the Commission, which the universities are very happy with and they are taking it up and lots of them are incorporating it into their training programs.

Mr NATHAN REES: This is possibly an unfair question. Are there any jurisdictions in the world that you are aware of that do this better than us and, if you are aware, what are the things that we should do to match them?

Mr PEHM: We would be the only jurisdiction, apart from New Zealand, where the investigation and prosecution of complaints is handled by an independent body from the professions—that I am aware of anyway. I think New Zealand does it well. So if there is any benchmarking, it would be New Zealand for New South Wales. For all the other jurisdictions in Australia, the complaints are handled by the registration boards. I did a bit of a comparison when we were making our submissions regarding the national registration process and it was very difficult even to get performance information from the boards throughout Australia.

The only international travel I have done has been to New Zealand and looked at their system and we modelled our Director of Proceedings position on their system to introduce some independence from the Commissioner in between the investigation and prosecution process. That came about as part of the package of reforms in 2005. We get quite a lot of interest from international delegations and I think on Thursday this week we have quite a big delegation coming back from the Chinese, who liked our system and thought they could learn from it and they are going to spend a whole day at the Commission.

Mrs JUDY HOPWOOD: Have you looked at Canada?

Mr PEHM: No, not in any detail.

Mrs JUDY HOPWOOD: Canada has done a lot of innovative work.

Mr NATHAN REES: I have a follow-up question of an entirely different dimension. On page 11 you have a table with the different components in the system, the number of complaints and so on. With regards obstetrics and midwifery, I do not understand how you have more investigations than there have been referrals to the Board?

Mr PEHM: Obstetric complaints, when they are made, generally have very serious outcomes. The consequences of mistakes or errors in that area are much more severe, generally speaking, in that you can have babies born with permanent disabilities.

Mr NATHAN REES: My question is how do you have more investigations by your people than there have been referrals to the registration boards? It seems to be atypical with all the rest of them?

Mr PEHM: The Commission investigates the most serious matters and the less serious matters where an outcome might be counselling of a practitioner or training and education, those matters are referred to the Board.

Mr NATHAN REES: I did not pick that from the flow chart; that is fine.

Mr PEHM: With obstetrics, because of the seriousness of the outcomes, there is a much higher proportion.

Reverend the Hon. FRED NILE: Mr Pehm, you have often helped with the process of your Commission by making suggestions about amendments to legislation and we have been able to succeed in getting those things carried through. Are there any other matters at this stage of your career and looking into the future where you feel some amendments would assist the Commission in its powers, et cetera, in carrying out investigations?

Mr PEHM: As you know, we have not been backward in putting things forward as they arise. I have to say that the Department has been very responsive and the Minister in taking legislative suggestions for change forward. There are another couple coming through, along with the national registration package, which involve the power to make interim provision orders in dealing with unregistered practitioners. That is a power we did not have; we could only make an order at the end of the investigation, where in urgent situations that might be difficult, and some expansion of the powers to search warrants, which I think we discussed at the last meeting, so, no.

Reverend the Hon. FRED NILE: Your wish list, as it were?

Mr PEHM: As I say, we have not been shy about putting them forward but there is nothing really pressing that comes to mind at the moment.

Mr KERRY HICKEY: In the executive summary 200 complaints were referred to by the Special Commission and 72 or 36 per cent were discontinued. That is a pretty high figure to discontinue. Is there any background to that?

Mr PEHM: A lot of people went to the Special Commission to voice their feelings about the health system. They had had bad experiences and they wanted the Commissioner to know how they felt. A significant number had already made complaints to the Commission, and we had dealt with those complaints one way or another. By law, the Special Commission had to refer to us every person that came before it. In lots of cases, we went back to the complainants and they were surprised that a complaint had been referred, because either they were happy with what we had done or they did not think any more needed to be done by us. The complaints to the Special Commission just ran the whole gamut, from the very serious to the perhaps less serious, and matters that had been dealt with before might explain the slightly higher discontinue rate.

Mr KERRY HICKEY: In 2008-09 you received 3,360 complaints, which raised 2.1 issues per complaint. In 2007-08 it was only 1.4 issues per complaint. Are we getting better at reading our complaints?

Mr PEHM: Yes. That is the short answer. The old database of the Commission only accommodated one issue per complaint. If the complaint was about poor treatment, bad communication and bad medication, you really had to pick the most important one. The new database caters for—I am not sure how many, but a large number. There has been a bit of a cultural change getting people to identify more issues. We think it is useful the more that are identified. It is certainly a topic in education forums. When I talk to a practitioner about what a complaint is about, rather than having one issue per complaint you can give them a broader idea. So we have been more diligent about identifying issues in complaints.

CHAIR: Commissioner, this is also about the trends in complaints. On page 18 of your report you talk about the increase in the complaints about public hospitals. My question relates to that. How is the Commission monitoring systemic issues arising from complaints about public hospitals, particularly for communicating them into the new Caring Together network?

Mr PEHM: At the end of an investigation into a public hospital we can make recommendations, and the hospital must report back to us about the implementation of those recommendations. We have about a 95 per cent implementation rate for recommendations. More broadly than that, because the health system is so scattered around the place and so localised, the Department has also set up a governance unit to keep track of both our recommendations and coronial recommendations. Our power relates to making recommendations about a particular institution. The Department's governance unit picks up those recommendations, and where they think they might be more widely applicable, they can take broader action to implement them across an Area Health Service or statewide.

There are some things that beg for statewide implementation. One was a radiation oncology patient who got 100 times the dose, or a much larger dose, than should have been given, so the procedures were reviewed and more double-checking of the dosage was introduced. That was picked up. Our power of investigation related to one institution. It was picked up by the Director-General and a policy directive—I am not sure of the title—was issued, so those changes were implemented statewide.

Other matters can be more particular to the level of institution, and there are different issues that arise in tertiary hospitals as distinct from rural hospitals and so on. We are also sending the investigation reports, where we make comments and recommendations, to the Clinical Excellence Commission. They tell us that the cases we have reflect the issues that they are working on. A very common one is the deteriorating patient after surgery. That is where, if something goes wrong—for example, if there is a nick or an organ is accidentally cut and sepsis sets in—it can be very difficult to pick up and the deterioration can be sporadic.

People can go along well for days and days, and then suddenly decline very quickly. The Clinical Excellence Commission's Between the Flags project is all about monitoring post-surgical periods. Of course, we do not claim credit for that, that is their project, but certainly our complaints fit into that. The Clinical Excellence Commission tells me they love

getting our reports because they are the best teaching tools: for clinicians they are real-life stories. It is the difference between having an academic structure and lots of reasons and explanations why something is good, and a story of a real person who has suffered that sort of situation. They tell me they really appreciate getting the reports.

Reverend the Hon. FRED NILE: I note that your report states that 10 complaints had been made to the New South Wales Ombudsman's Office regarding the Health Care Complaints Commission. According to your report, the complaints were examined and it was found that there was no basis behind the complaints. What sort of relationship do you have with the Ombudsman's Office? Is there some duplication? Does it assist you when the complaints go to the Ombudsman?

Mr PEHM: The Ombudsman generally defers to us on any health-related matters. If people go to them with a complaint about a health service practitioner or hospital, they will refer that to us and we will look at it. We participate with the Ombudsman in some training activities. There is a thing called the Good Service Forum, which is an outreach activity to rural and regional indigenous communities. I think what we are talking about here are complaints about the Commission, where complainants are dissatisfied with us. The Ombudsman overlooks us as an administrative agency, the same as anyone else. People can go to the Ombudsman and complain about us.

I am not sure how many of those 10 were by the one person, but I think a substantial proportion of them may well have been. The Ombudsman has not seen fit to take any complaints against us through to a formal investigation. In some cases they have made preliminary inquiries; in others they have had contact with the same person at the same time as we have as well. Of course, you would like to have no complaints against you, but I guess dealing with a range of people as we do, there will probably always be some.

Reverend the Hon. FRED NILE: Does it amount to some duplication, with the Ombudsman backtracking over what you have been investigating?

Mr PEHM: No. And we liaise fairly early on. One area where there is potential for overlap perhaps more than others is in the Prison Medical Service. Prisoners will complain both about the conditions they are placed under and that medical orders are not enforced by Corrections staff. We cannot look at Corrections staff, although we can look at Justice Health. There have been a number of cases where we have had joint meetings with Ombudsman staff, our staff, and Justice Health to really sort out who should be doing what at an early stage.

Reverend the Hon. FRED NILE: So there is a good relationship between you and the Ombudsman?

Mr PEHM: Yes, it is a very comfortable relationship—not comfortable; it is a good working relationship. They do oversight us, after all.

Mrs JUDY HOPWOOD: Who was responsible for the complaint investigation audit and what was its ambit? How did the audit assess the Commission's investigations? I refer to page 39, where an internal audit found no breaches of statutory requirements.

Mr PEHM: We have an internal audit committee with an independent chair. Under its auspices, the Commission conducts two internal audits a year. Deloitte are the commissioned auditors. I think we have just signed up with them for another three years, or perhaps five years. Audits are really to look at compliance with procedures. We have an investigations manual, and they randomly select a number of files and look at whether or not the procedures have been complied with. They also make suggestions for change. This year we have had an audit on the way we manage our expert panel.

They made quite a few recommendations, which we think are very good ideas. That involves increased training of the experts, providing more feedback to experts, which we are starting to do, and doing a quality assurance or an assessment of experts—which is a bit difficult, because they are experts in their field—and we are rating them on timeliness and whether their report addresses the criteria in the Act that it should. We find them very useful. Luckily—or more due to good work, I think—we have had no glaring problems arise from all this. They rate them on a sort of 1 to 5 scale, with three being satisfactory. We have generally come in around the three or four scale, either good or satisfactory.

Reverend the Hon. FRED NILE: What measures does the Commission take to ensure the timely implementation of investigation recommendations, that they are implemented to the fullest extent, and that implementation is ongoing—I refer to page 43 of your report?

Mr PEHM: That is a difficult area and we have been giving quite a bit of thought to that lately. I must also say that at this stage we rely largely on the organisation, the health institution that we are investigating, to report back to us. That report back can include new policies, details of training and the number of staff who have gone through training, and they will do hand washing audits or audits of clinical note taking and they report back to us with the results of those. When we conclude an investigation, we write to the organisation and say, "We have now made these recommendations. You have three months generally to advise us of the implementation." In some rare cases that is not long enough because they have to do a lot of consultation themselves about implementation with staff and so on, but they do report back and generally fairly fully. They also report to the Director-General who can pick up those recommendations for any wider implementation.

If we are satisfied with their report back, and we go back and ask questions as well, we count the recommendations as implemented. What we do not do, and what I think we have to look at, although there is a resource question, is going back six months later and nine months later to see that things are still in place. I have already raised that with the Director-General and that is not a problem from their point of view; it is really a question of designing an audit program almost that we could implement to track both the implementation and the longevity of the recommendations.

Reverend the Hon. FRED NILE: So of those 42 recommendations that were not implemented, or not by the deadline, were there any serious matters that would have concerned you that were not acted on?

Mr PEHM: No. The way the Act is structured is that if we are not satisfied with the action taken to implement the recommendations, we can report to the Minister and then to Parliament, but we have never found it necessary to do that. There are occasions where a hospital or an Area Health Service will itself have identified a problem and have started to

implement a different solution. Our recommendation might be to develop a policy about this aspect and they might say that it is part of their broader program to address wider issues and that included. But, no, it is very difficult to think of actual examples of recommendations that have not been implemented—and I cannot think of any at the moment—but we have not thought any non-implementation serious enough to take any further action.

Reverend the Hon. FRED NILE: So they would be relatively minor matters?

Mr PEHM: Yes, minor or overtaken or superseded.

CHAIR: In the part of your Annual Report dealing with legislative changes you note that the most significant amendment is the provision that allows the Commission to require any person to provide information, documents or evidence for the purpose of the assessment or investigation of a complaint. Are you satisfied that these provisions will ensure that all the necessary history will in future be placed before the Commission when cases of malpractice and/or impaired performance are being assessed and investigated?

Mr PEHM: By "history" do you mean evidence for the particular case?

CHAIR: Yes, the history of the case.

Mr PEHM: Yes, I think the powers are sufficient. There is always a question with investigations that if you do not ask you do not get, and sometimes when you ask you get just what you asked for and no more, because people do not always volunteer everything they should. So there are always judgements to be made about how fulsome you believe the responses are and whether you should require more. But certainly it is a very useful power and allows the Commission to obtain all the relevant information, and it has come in very handy. Part of the problem with the old Commission, before we had this power, was that a provider could simply not respond or refuse to respond and there was really nothing the Commission could do. We have found some quite long matters in the old files where that had happened and the thing had gone on and on. We can bring things to a conclusion much more quickly now.

The power to require people for interview is also very important. Paper can only tell you so much. It has become a quite regular practice now for our investigators to attend hospitals and to interview clinicians on site, both do an inspection of the area and conduct interviews. That was a bit difficult to begin with because it is not something I think people were used to, but it seems to have bedded down fairly well and the areas are used to it now and the Nurses' Association has come along, not always willingly, but it is working reasonably well.

Mrs JUDY HOPWOOD: To what extent, if at all, does the Commission contribute to the professional development of healthcare practitioners other than doctors? Has the Commission consulted with the other professions to identify further opportunities for contributions to their professional development programs? I relate my question to page 18 where it says, "nurses have a higher proportion of complaints raising issues such as professional conduct than other health service providers".

Mr PEHM: We consult with registration boards regularly including the Nurses Board and others, but I must say that most of the professional work we do is with medical

practitioners because it is the largest number of complaints and certainly the most serious of the complaints. I think perhaps there are more forums and venues for that to occur in the medical profession. The medical profession is very big on continuing education and there are conferences all the time where the Commission can be invited and does speak. We have covered nurses peripherally in some of those, dealing with obstetrics, dealing with midwives and obstetricians where they have had joint conferences, and our resolution officers do presentations to nursing staff in hospitals as well. We did contact The College of Nursing when we were updating our expert nursing list and they were very helpful, but I must say most of our effort goes into the medical profession.

Mrs JUDY HOPWOOD: In relation to The College of Nursing, are there any courses available that you know of—I do not know of one—where you could make a contribution regularly?

Mr PEHM: I would be happy too. That is something we can search out actually.

Mr NATHAN REES: Do you make any assessment of people who are of non-English-speaking background or who do not have appropriate literacy levels and so on as to whether they are making it into the complaints process? Am I making any sense?

Mr PEHM: Yes, but not a systematic one. We do collect demographic information but the response rate is fairly low—I think about 20 per cent or so. So we do assess that and we put a lot of effort into assisting people to make complaints. Where we perceive there are difficulties with literacy, we will allocate the letter to an Inquiry Officer or ring the person up and talk to them about it and, if necessary, help them to write something down. With people of a non-English speaking background or culturally and linguistically diverse, as they are now called, we have a number of officers within the Commission who receive the Community Language Allowance Scheme who can talk to people who come in. We use them informally. There is also the Translation Interpreting Service. I just do not have the data as to the proportion of people of that sort of background.

Mr NATHAN REES: There is an awareness of it; that is sufficient. This may be covered in the Annual Report and I missed it. In the event of a practitioner who has had serial complaints made against him and for whatever reason investigation of the complaints has been discontinued, to what extent is previous form brought to bear on decision-making as to whether to pursue a complaint?

Mr PEHM: That is a good question. It was very specifically inserted into the Act to compel us to do that. It arose out of the Graeme Reeves case, the compulsion to do that. We had previously taken into account complaints histories. When we register a complaint, a computer will generate the previous complaints and cases against him. The legislative reform also allowed us to reopen cases that had been closed. The most obvious example is sexual misbehaviour where you might have two or three older complaints where there was insufficient evidence. A third one comes in and the Act specifically now allows us to go back and reopen the old ones.

Reverend the Hon. FRED NILE: In many cases you have a successful outcome as a result of complaints. Do you give feedback to the person who made the complaint, perhaps where the complaint led to important improvements in the system?

Mr PEHM: Yes. Again, the Act requires us to report back to complainants and also to any other person we think should be notified. The complainants at the end of an investigation get a copy of the investigation report, except where we are prosecuting an individual practitioner. Then they can always attend the prosecution. We do that so as not to prejudice the proceedings. The investigation reports are fairly extensive and thorough and they will set out the complaint, the nature of the investigation, what steps were taken, what the findings were and what the recommendations were. We write to them at the end of that. We also write to them when the hospital comes back and says, "We have implemented the recommendations." We provide the complainant with a copy of the material sent to us and give them advice that we now consider the recommendations to be implemented.

Reverend the Hon. FRED NILE: They can clearly see that their complaints led to those improvements? They can see the link?

Mr PEHM: Yes.

Mrs JUDY HOPWOOD: At last year's hearing you expressed the view that it might be suitable for the Commission and the Area Health Services to have input into practitioner area education conducted by the New South Wales Medical Board and you undertook to follow this up with the Chief Executives of the Area Health Services. Has there been any progress? Referring to the transcript dated 29 April 2009, the Chair asked:

CHAIR: Are you aware of an education program that is being run amongst practitioners either within the organisations or within individual health services?

The second question from the Chair was:

CHAIR: Do you think that this is something that the Commission could have some input into or make some recommendations on either to Government or various health care providers?

You answered:

Mr PEHM: I am not sure of the details but I am reasonably sure the Medical Board has taken a role there. It is certainly—I meet fairly regularly with all the Chief Executives of the Area Health Services. But I will have a closer look at that. It might be that if the Medical Board is conducting a campaign, as I believe it is, we might have some joint input on that. That would be quite suitable.

Mr PEHM: I have to apologise because I have not followed that up in any specific terms at all. We have another round of meetings coming up with the area Chief Executives of the Area Health Services but they have concentrated on complaint and interagency liaison so we can get smooth flows of information. Again I can only apologise. It has slipped my mind. I would have read the transcript as well. It is something I will definitely take on board and get back to you on that.

Mr KERRY HICKEY: The Annual Report indicates that you continue to get feedback by sending out satisfaction survey assessments and decision letters. Have you considered any other methodology for measuring client satisfaction, as suggested last year? Would you consider arranging an audit conducted independently, at least on a trial basis?

Mr PEHM: We have considered other methods. Probably the most effective way is to commission a consultancy to interview people. An audit will just check that forms have gone out and forms have been returned and so on and check that our data is right, which I believe it is. The only other way we thought might be effective is to have someone independent to do a consultancy, which would involve focus groups, contacting individuals and getting them in for a meeting to talk about their experiences. We did not go with that last year, partly because the customer satisfaction process is not very old at this stage. And it is the expense of it as well, whether it is justified within our budget. You probably could not get away with it for much under \$30,000 or \$40,000 minimum, I would have thought. Certainly that is something my Communications Officer has raised as a possibility but we were not in a position budget-wise with other priorities to do it last year or this year.

Mr KERRY HICKEY: How long before you look at your client satisfaction outcomes, considering your system is fairly new? What would you consider fairly old?

Mr PEHM: The client satisfaction outcomes are pretty good, as they stand. What I am concerned about is the response rate. The response rate is fairly low. It is about 20 per cent. I am not sure what we can do to get that up. It may be that those people have had better experiences and are more prepared to respond rather than someone who is completely disgruntled, rips it up and throws it in the bin. I am not sure how you actually get around that. I guess the idea of commissioning a consultancy to randomly pick people and talk to them is that you would get that broader spread. That is where it may be valuable. It really came down to budget and whether it was a good expenditure for us to do that. I am still not sure it is actually.

Reverend the Hon. FRED NILE: Do you have lines of communication with the new Bureau of Health Information? Does it assist the Commission, particularly in solving systematic problems?

Mr PEHM: It is probably early days for the Bureau of Health Information. I think they are still recruiting and setting up. We have not had much to do with them directly. Most of our communication on systems issues is with the Clinical Excellence Commission. They will also have a very close working relationship with the Bureau of Health Information. We thought that was a very important issue, the availability of health information, and we made submissions to the Garling Inquiry to that effect. It is an excellent initiative. But so far, I think, their job really is to look at the massive data that is input into the system by clinicians on the ground, and that is a vastly superior number to the number of complaints. I think it is 3,000 complaints and 120,000 clinical incidents entered by staff. Their job is to try to interpret all that and feed it back to staff so they can learn from it.

Reverend the Hon. FRED NILE: There will not be any problems of overlap?

Mr PEHM: No, I do not think so. Again, we have a more particular slice of the same market. Theirs is likely to be much broader from the clinician's point of view as well. Although complaints will be entered into it as well, it will be much more clinician data.

Mr KERRY HICKEY: The Annual Report notes a considerable increase in complaints around medical centres at correctional and detention facilities. What does the Commission attribute this to? Does the Commission consider that it is an area of concern that needs to be looked at? What action, if any, is being taken to curb the increase?

Mr PEHM: From 93 in 2006-07 to 106 to 138 last year, and the proportions are up as well.

Mr KERRY HICKEY: More prisoners?

Mr PEHM: Perhaps more prisoners. We are quite accessible to prisoners. We are on thier speed dial, like the Ombudsman, us and a few others, where prisoners can call out directly. So their inquiry line comes straight to us.

Mr KERRY HICKEY: Are the complaints real or are they fictitious?

Mr PEHM: They are all real enough. There is a proportion of complaints around the methadone, buprenorphine distribution in jails, and that is a significant number. That is a difficult matter of administration for Justice Health because there is a problem of diverting and trafficking internally and we get complaints about—people say they have been unjustly thrown off that program—and the explanation from Justice Health will be that they have been suspected of diversion.

Reverend the Hon. FRED NILE: How many would there have been out of that category? That might have accounted for quite a few of them.

Mr PEHM: I would not say quite a few. You notice them when they come in but it is only anecdotal; I do not think we have separately categorised them.

Mr KERRY HICKEY: Can we have access to that information?

CHAIR: Can we have more detailed information on those?

Mr KERRY HICKEY: Can you provide us with that information later on notice?

Mr PEHM: It might be in the description on the issues with the computer search. We could get that. There is also the problem with Justice Health, and I have alluded to this before, it is not just a Health problem, it is also a Corrections one. As I say, we have met with the Ombudsman to try and sort out those overlapping jurisdictions. They are not on the very serious side of things. There are big complaints about delays—

Reverend the Hon. FRED NILE: In treatment?

Mr PEHM: Delays in treatment, yes. But that is not an uncommon complaint in the general community and it is exacerbated in prisons because generally for any serious tests they have to go to Long Bay and then be treated out of Prince of Wales Hospital for any serious cancer-related sort of conditions and tests. There are all those security problems that Corrections has to put into place with the transfers and so on. Availability of medications—people might have had a medication on the outside, that they are used to getting, that they do not get on the inside; it is either Justice Health thinks it is not a necessary one or they have a substitute one that they dispense and deal with.

I think the only Justice Health one that has been serious enough for an investigation involved the transport of a prisoner who complained that he had a heart condition and that

was not taken into account medically. We thought that was potentially a serious issue of health and safety and we did investigate that, and there were some amendments to the procedures internally as a result of that. We have also had a number of prosecutions of individual practitioners involving Justice Health.

Ms MOBBS: Two assaults, and I think another one in terms of records and not following regulations in terms of sign-off of records. So there has certainly been anecdotally an increase in the number of those types of matters coming out of Justice Health.

Mr KERRY HICKEY: The doctor assaulted the patient or the patient assaulted the doctor?

Ms MOBBS: Not within the last year's statistics.

Mr PEHM: No, it is not a doctor. I was talking about the system of Justice Health. There are also individual practitioners that we will investigate.

CHAIR: Do you have the same proportion of complaints about the system as opposed to practitioners as you would in the health system outside the justice system? It may be hard to get that figure because it is probably quite a small number.

Mr PEHM: We could try and find that out, although when we register an individual practitioner in that health system we would have to see if that linked to a Justice Health complaint or not. We can try and find that out.

CHAIR: It is about the system and the treatment within it rather than the practice of a practitioner. It may not be that easy to determine.

Reverend the Hon. FRED NILE: The doctors and nurses are employed by whom?

Mr PEHM: Justice Health, which is a department of the Department of Health rather than Corrections. They are health workers rather than prison officers.

Mr NATHAN REES: I do not think we have any private providers of medical services in the jails, do we?

Mr PEHM: I think in Junee there might be some, but I think in relation to the psychological and social work counselling type aspects. I am not absolutely sure about that.

Mr NATHAN REES: In the context of that other material it would be useful to know whether they are overrepresented or underrepresented in any complaints. It has been a concern of Justice Health for a long time that the private provision of health care is seriously questionable. I do not know whether there is a basis for that or not.

Mr PEHM: We can provide that information.

Mr NATHAN REES: If you could pretty readily extract the numbers it would be handy.

Reverend the Hon. FRED NILE: You identify where the complaints have come from, whether it is Long Bay, Junee or other prisons?

Mr PEHM: We might have to do a manual count, but there are only 138, so it would not be too difficult.

CHAIR: Junee is the only one until now.

Mr PEHM: I think Junee is the only long-term privatised one.

CHAIR: And it was until Parklea, and I think that over in Parklea it would be Justice Health. I think that was part of that contract.

Mr NATHAN REES: I am not even sure of Junee. I think they may use Justice Health. I cannot recall.

CHAIR: The RNs administer the methadone and I am not sure if they are Justice Health or not.

Mrs JUDY HOPWOOD: In relation to a response to the Registrar of the Medical Board, and it is dated 6 April, it is related to communications between the Commission and the Medical Board and it states that the Commissioner attends a monthly meeting with the members of the Board Committee and secretariat and the Board's Medical Director attends a weekly meeting with the Commissioner. I am just wondering, do you meet as often with other boards, for example, the Nurses and Midwives Boards?

Mr PEHM: No, the Medical Board is the most often because of the volume. With the nurses we have a teleconference with a subcommittee of their conduct committee. We have a monthly meeting and in between that, fortnightly, we have a teleconference to deal with new complaints. That is the most volume. I think all the others would meet monthly when the boards had their general meeting.

Reverend the Hon. FRED NILE: You might have to take this question on notice; it relates to the court's criticism. The Commission was recently subject to some serious criticism from the Court of Appeal with respect to its use of the power under section 66 of the Health Care Complaints Act to extend the suspension of medical practitioners. Do you consider that the extensions complained about are indicative of the manner in which the Commission uses section 66 and what are you doing to address the court's criticism?

Mr PEHM: I am not aware of that decision. Section 66 of the Medical Practice Act involves the suspension of medical practitioners, which is the role of the Medical Board rather than the Commission. So I am not sure whether that criticism is—

CHAIR: It was in relation to Dr Gorman's case.

Mr PEHM: The role of the Medical Board is to suspend practitioners that they believe are a danger to the health and safety of the public. We do not do that. Section 66 is their Act and their decision, but we know them as section 66 decisions.

Mr NATHAN REES: When I read that material it was not clear to me that the judge knew the demarks between the different organisations involved in this.

Mr PEHM: It is complex. I have not seen it but I would be happy to take it on notice and give you an answer as to whether it is our fault.

Reverend the Hon. FRED NILE: You could clarify that and then perhaps let the judge know.

Mr NATHAN REES: They are always so timely.

Mrs JUDY HOPWOOD: I refer to question on notice no. 9 and the code of conduct for unregistered health practitioners. Apparently the Minister is pursuing deregistration of dental technicians. If a practitioner were deregistered today for undertaking certain activities would he or she be able to practice after July, when registration is abandoned? Can you make recommendations about a profession that you believe should retain the requirement for registration? Dental technicians have raised with me at least one practitioner about whom they are seriously concerned.

Mr PEHM: We have been in touch with the Dental Technicians Registration Board with a view to advising about future coverage by the code of conduct. We have made the code available and explained how it will work. We have investigated a dental technician as well. We made a public statement on our website about a technician practising as a dentist—giving injections and so on. There would be no difficulty from our point of view investigating a dental technician who was no longer registered because he or she would be covered by the code of conduct if they breached any of those provisions. I have not thought about whether they should be registered, nor have I sought to buy into the issue. I think that the Department of Health's view is that no other State registers them.

Mrs JUDY HOPWOOD: Queensland is continuing registration.

Mr PEHM: I do not know.

CHAIR: It is the only jurisdiction that is.

Mr PEHM: We raised the issue about what we would do to educate dental technicians about the coverage of the code in our discussions with the Department. Its view seems to be that the technicians do not deal directly with patients—they should always work to a dentist and be referred. For that reason—because they do not deal directly with the public—the imperative for registration was not as great.

We get a small number of complaints about dental technicians. Those complaints are not serious; they are usually about ill-fitting dentures and refusal to remedy the situation. The only serious case involved a dental technician practising as a dentist without being registered. We investigated that case and issued prohibition orders. We also liaised with the police, and that kicked off an infection control investigation by the Area Health Service. On the broader question, I have not looked at recommending whether or not a profession should be registered.

Mrs JUDY HOPWOOD: Evidence given at our last hearing by the dental technicians' governing body indicated that they do have some contact with patients. They deal with teeth colour and other matters. It was not straightforward. However, the point of the question was whether you have an opinion about registration.

Mr PEHM: I do not.

CHAIR: Further on the question about unregistered health professionals, page 100 of the Annual Report indicates that fewer complaints were received in 2008-09 compared with the previous year. The Committee notes there were only 68 complaints for that year. Do you believe that this might reflect a deficiency in public awareness about the code of conduct for unregistered health professionals?

Mr PEHM: It might. It is hard to say what causes complaint numbers to fluctuate. It is not a great fluctuation. However, one would expect that with the code coming into force and the Commission making public determinations that there would be more complaints and awareness. We have liaised with all the professional associations, published the code of conduct and we have held evening seminars.

Health is a difficult area. My experience is that people are not aware of the avenues available to make complaints until something goes wrong. Then they will look around. I am not sure of the value of doing a widespread public education campaign about coverage of unregistered practitioners. We have had complainants directed to us by professional associations such as the therapeutic massage body. We have those channels working from the professional bodies.

It must also be said that the consequences of maltreatment by an unregistered practitioner are generally not serious. Of course, there can be extreme cases, such as the case before the coroner of a person fasting and suffering liver complications after consulting a naturopath. However, generally they have a fairly light touch and the consequences are not so significant that people are moved to make complaints. I do not know; I am speculating. We have put a lot of effort into promoting the code and education, but we have concentrated on professional groups because that is where we thought we would get the best return.

Mr NATHAN REES: The Commission has expressed a position on privilege that attaches to material unearthed in root cause analyses. Can you give the Committee an update on the consideration of those matters?

Mr PEHM: I think the Department recently conducted a review that has been published. It will provide some amendments to the Health Administration Act to tidy up the existing privilege. The Department has come to the view that the privilege should be retained and entrenched. I think we discussed with the Committee the last time we met how dearly held that is by practitioners.

Mr NATHAN REES: Is there a way around that? This is one of those situations where both ends of the argument are correct.

Mr PEHM: There does not appear to be. It depends on the greater public interest. At present the balance seems to be that the value in having practitioners come forward and declare errors for future learning is greater than the understanding of individual patients who might be affected by those errors. That is a public interest call that it is your job to make. We are impartial, but we understand the patients' perspective. We have seen some awful cases that have aggravated the patient's family's suffering. Our position is informed by all of that. I

can understand the other position and I understand how deeply entrenched is the practitioners' fear of complete open disclosure. That is a very strongly held position.

Reverend the Hon. FRED NILE: Page 20 of your report states that most complaints are about public hospitals. You explain that that is probably because of the large number of patients dealt with by public hospitals. Are there any other reasons? For example, are patients in private hospitals given information about the Commission's role? Are they encouraged to complain or discouraged?

Mr PEHM: Again, I would be speculating. I think private hospitals generally deal with less complex procedures where the chance of things going wrong is perhaps not as great as in the complex clinical presentations that public hospitals deal with. A lot of admissions to private hospitals are through private practitioners whom the patient has a relationship with, and their surgery or procedure would be done by that practitioner. As you know, in a public hospital you can turn up and be dealt with by a registrar. The public hospitals are training people all the time. We get a smattering of complaints, "I expected my private practitioner to do it" and it turns out that practitioner was just supervising a registrar in a public hospital. So that direct doctor-patient relationship that they have developed in the private sector militates against complaints as well, because they have that level of trust because if something does go wrong in the private sector, the practitioner, having seen their whole history and having dealt with them longer, is in a better position to give an explanation that they are happy with, rather than something going wrong in an operation with a junior registrar.

Certainly, public hospitals and the Department have been good, in our view, in getting information out about how to complain and they are responsive to complaints and they are not shy in sending complaints to us where they are unable to deal with them. I cannot think of where we have ever had a referral of a patient from a private hospital to us to complain about a private hospital. What the reasons for that might be I am not sure, but those would be some of the reasons why perhaps private hospitals generate less complaints than public.

Reverend the Hon. FRED NILE: You mentioned junior registrars a couple of times. Does that reflect that complaints come more from the level of action by those junior registrars or doctors in training rather than experienced, qualified doctors? Is that one of the reasons for the number of complaints?

Mr PEHM: It is a factor. In public hospitals people are being trained and to be trained they need to do procedures. I do not want to give the impression that they are less experienced or worse. What I was referring to was the patient's discomfort on learning they had been operated on by someone they consider to be junior and perhaps not as good as their private practitioner in a private hospital whom they have dealt with all along. I could not really say on the breakdown between medical practitioners whether there is more against junior, less experienced people or more experienced people. I do not know.

Reverend the Hon. FRED NILE: Some junior doctors have made complaints in the media that they have been working very long hours and this could lead to errors in dealing with patients if they are fatigued. Could that be a factor, the pressure within the public hospital system?

Mr PEHM: It could be. It is partly how they are trained too. Interns in public hospitals would go in the first year out of medical school and they work enormous hours, very long

shifts, and in some cases they sleep in the hospitals. That is traditional, that is the way it has always been done. Whether it is a good system or not—certainly from the point of view of the interns it is not. They have support, though. They have more senior registrars and career medical officers and consultants, so the system is designed to support them. I would not venture an opinion on whether junior, tired people are making more mistakes giving rise to complaints or not.

Reverend the Hon. FRED NILE: Could you look into that, whether it is a factor?

Mr PEHM: We could try. I think it would be quite difficult. It would be anecdotal, and again we could look at cases, but I do not think we record the level of training and experience so that it would be accessible across a broad range and across the whole range of data, but we will give it some thought.

Mrs JUDY HOPWOOD: I note the considerable efforts the Commission has made in making its services more accessible and specifically that you propose to work with the Council for Intellectual Disability New South Wales to develop a further fact sheet that will contain more detailed information about the Commission's role and functions. I wondered how that is progressing?

Mr PEHM: It is well underway. We are currently doing the illustrations and we will be consulting again with the Council for Intellectual Disability shortly and we hope to have it finalised by the end of June.

Mr NATHAN REES: Perhaps this is not your purview, Commissioner, but why is the training of medical practitioners such an endurance test?

Mr PEHM: I do not know. It is not my purview. It is partly traditional, cultural. It is the way they have always been trained. I think it is a problem but as for all the reasons why that cultural position has become entrenched, I am not familiar enough with it. I am not a doctor and my first contact with the health system was in this job.

Mr NATHAN REES: It goes to a much broader issue, obviously.

Mr PEHM: Yes, they are very broad issues.

CHAIR: On page 26 of the Annual Report, assessing complaints, the Commission talks about implementing a module in its case management system Casemate, which allows it to capture systemic quality improvement results from the resolution of complaints as from 1 July 2009. Has the Commission given any consideration as to how it might use its knowledge base for quality improvements to communicate to complainants wider outcomes of their complaints? That is, to show how their cases had gone to improve the system, even though it may not give them satisfaction in their particular case? We are familiar with people not being satisfied with the outcome of their case but if they had some knowledge that it led to very good outcomes for the system, that may make people more satisfied with the process.

Mr PEHM: Definitely. The reason we are trying to record it more systematically is to feed into the issue we talked about earlier about our formal power to make recommendations after investigation for systemic change. Often in resolution processes

complainants will get together with hospitals and practitioners, and the hospitals will agree that things need to be improved and they will start to put those in place. So the complainants will be advised that is part of the resolution of their individual complaints. I think we are waiting for more data to come out to publish more widely what systemic changes emerge out of resolution of complaints and see how it compares with the nature of the issues we are investigating.

CHAIR: I wonder if it would not be useful in the Commission's brochures to have information for people making complaints or just talking about some of the changes that have been made as a consequence of particular cases. I think often complainants have an expectation of an outcome that suits their specific needs. I think if they have an understanding that it is broader than that, that might be useful.

Mr PEHM: I think that is a good idea. We can use it in promotions to say to people that it is worth complaining, you can change things, things could change. Hospitals can tend to be quite monolithic in lots of ways when it goes beyond the individual patient care.

CHAIR: I think if you engage people and show it is worthwhile that the system takes note of their complaints and change can occur as a consequence of their complaint or their action.

Mr PEHM: I agree.

Mrs JUDY HOPWOOD: In reference to page 97, Appendix C, complaint statistics, in relation to communications: I note in 2006-07 there were 366; in 2007-08, 642; and in 2008-09 1,432, despite the fact that you have an elongated list of other ways or other categories. Over the page there are breakdowns. That seems to be an extraordinarily high jump. Do you have any comments to make in relation to that?

Mr PEHM: Probably the biggest single problem in the health system is communication, and the Clinical Excellence Commission will say the same thing and they are putting a lot of work into that. We touched on earlier about how we may be getting better at identifying issues, so that may account for part of the increase, but it is communication at so many levels between general practitioner and specialist. I mean, from the patient's point of view, the health system is this seamless thing where everyone should know about their condition and all the transfers of records should all be done instantly. The idea of patients having to turn up and tell the same story, even when they are in hospital, three times a day because the different doctors will come, and all that sort of stuff. In acute care in hospitals you have shifts changes and handover—and handover is a huge problem. Again the Clinical Excellence Commission is trying to address that. Just precisely what the new team coming in is told about the patient's condition during the previous shift, those are the sorts of communication issues that can impact heavily on complainants.

So it is a lot bigger than just the practitioner's communication with the patient, which in itself can be a problem. When you are sick you are vulnerable and you want to be healed and you keen to hear not what you want but what will make you think you are going to be healed, so we get complaints about lack of informed consent where people are not advised of side effects and complications of surgery, so they have a poor outcome later and say, "I was never told that was going to happen". There are those sorts of direct communication

problems but also the issue of communication between practitioners in the ongoing care of people. I have lost the original question.

Mrs JUDY HOPWOOD: I just wanted you to make a comment. I put to this Inquiry that what you have mentioned is not a late event. Being a nurse myself, these situations have occurred over a long time. I would like you to comment on whether you think the stress on the health system is contributing to that increase in communication problems? By stress, I mean reduction in staff numbers under staff establishment and when you are more likely to see the things that you are describing in terms of inter-practitioner communication with the patient?

Mr PEHM: If you are stressed and under strain, communication will suffer. It takes time to communicate properly with people and you need room to do that, so work pressures can contribute to poor communication. I am not in a position to say whether the stress is greater now and whether that is the main contributor to increased communication problems. I think the profession itself is only coming to appreciate how important communication is. Again, the Clinical Excellence Commission has done a lot of work in trying to identify that. I would not say that the sole factor is overwork and stress, although I think it is a contributing one. There are a lot of techniques you can use with patients to check that they have understood and to have them talk back their understanding of conversations you have had with them. There are tools you can use and diagrams and things that can improve communication. It is a complex issue with a lot of contributing factors and certainly stress can be a significant one.

Reverend the Hon. FRED NILE: What are the particular challenges faced by the Conciliation Registry with regard to assessments? Can you comment on the fact that a number of cases sent for conciliation are aborted because parties withdraw their consent?

Mr PEHM: Yes. I have been giving a lot of thought to conciliation lately and I do not think it is operating as well as it should be. There is a history to conciliation in that originally there was no assisted resolution in the Commission, which is a much less formal way of conciliating complaints. It is riven around with privileges that again come from the fear of practitioners that things that they say in resolving complaints are going to be used against them. It was set up as a separate unit of the Health Department and then brought back into the Commission.

I think the big problem with consent rates in conciliation is that people are not warmed up to the idea of the value of conciliation and what they can get out of it when something is sent for conciliation. Because the Registrar, like a court registrar, is more like an office, they make bookings; they get the complaint in, they book it in to an independent conciliator, arrange a meeting. In assisted resolution, the Resolution Officers can take a lot more time explaining to the complainants and finding out what they really want out of the complaint. People want different things and it is important to know what they want so as to be able to nurse them into a position where they are going to be amenable to resolution.

At the moment—and I am not sure that there is a different way to do this—at the Conciliation Registry, matters are allocated for conciliation, and the complainants will get a big long letter saying, "It has been sent for conciliation. This is the process. It is voluntary and do you consent?" With a resolution, the first thing they will get is a phone call, "Tell us more about your problem" and get them more involved. We are thinking actually—and we might do it this year—of having conciliation more as part of the assisted resolution process

rather than an upfront option so that the Resolution Officers can warm the parties up to the prospects of conciliation, then put matters in that formal conference with the independent conciliator when we have got consent, so we think we can do more to obtain consent and encourage people to participate.

Reverend the Hon. FRED NILE: Who mainly withdraws the consent? Is it the medical side rather than the patient?

Mr PEHM: No, it is mainly complainants actually.

Reverend the Hon. FRED NILE: What would be the reason for that?

Mr PEHM: They do request reviews of the assessment decision to conciliate. They believe that with the matter being referred to conciliation, it is not being taken seriously enough. Sometimes they want retribution.

Reverend the Hon. FRED NILE: They want direct action?

Mr PEHM: They want investigation and they want people—

CHAIR: —held to account?

Mr PEHM: Held to account; they want individual practitioners sometimes struck off and they will say that—"I want them deregistered and conciliation is not what I want". We have the figures in there of the proportion of complainants to respondents.

Reverend the Hon. FRED NILE: There appears to be delays, even where they do consent, in finalising conciliation cases. In 2008-09 the Registry finalised half of the complaints within three months; 74 per cent within six months and 90 per cent within 12 months?

Mr PEHM: Yes, that is getting better, believe it or not. We tend, in conciliation, to leave it to the parties. In a way that was dealing with these consent problems. If the party said, "No, I do not consent", we would give them time to think about it. Often where a clinical error occurs with someone close, a loved one or spouse, everything is very raw and tender and people sometimes just cannot deal with the prospect. There may be a complaint and they want something done but they just cannot personally face it. What we are saying to them now is, "Look, you have made your complaint. You can make your complaint again when you are ready to deal with it", rather than just leaving complaints open and waiting for people to be prepared to participate.

Reverend the Hon. FRED NILE: You cannot force conciliation?

Mr PEHM: No, it is voluntary.

Reverend the Hon. FRED NILE: That is why it can take so long?

Mr PEHM: No, and you do not want to either, to put someone in a position where it can be counterproductive. We had a recent case where it was counterproductive to the practitioners as well because when the complainant got into the conciliation, she just vented

and really gave them a piece of her mind, to use the colloquialism, and they got very affronted by that, so there was no resolution and no meeting of the minds. You do not want to put people in that situation unless you feel there is likely to be resolution.

CHAIR: Do you have a time line for those changes you have just outlined or are you further reviewing them?

Mr PEHM: Yes. I have asked my Director of Assessments and Resolution to come up with a proposal and he has discussed it within the office—this year, I would think; within the next financial year.

CHAIR: After July?

Mr PEHM: Yes.

CHAIR: Thank you for appearing before the Committee for its review of the Commission's 2008-09 Annual Report.

(Evidence continued in camera)

Chapter Six - Answers to Questions Taken on Notice during the Public Hearing

Question 1

In relation to the College of Nursing, are there any professional development courses available where the Commission makes a regular contribution?

[Transcript of evidence, page 6]

The Commission has offered and makes presentations to the College of Nursing on request. Staff from the Commission's Investigations Division gave presentations to the College of Nursing in March 2008 and November 2009.

The Commission also made ten other presentations in 2008-09 that were specifically directed to nurses and midwives – including four presentations at universities.

In addition, the Commission has provided an article to “*LAMP*” – the magazine of the NSW Nurses Association – on how the Commission handles complaints about nurses and midwives.

Question 2

Do you make any assessment of people who are of non-English-speaking background or who do not have appropriate literacy levels as to whether they are making it into the complaints process?

[Transcript of evidence, page 6]

The Commission regularly makes presentations on the Commission's role and work to health consumer groups from culturally and linguistically diverse (CALD) backgrounds.

In 2008-09, this included presentations to:

- Migrant Services Inc.
- African community leaders
- Indian-Pakistani community members
- Filipino New Settlers
- Filipino Senior Citizens Group.

The Commission arranged for its translated information resources to be included on the Multicultural Health website of the Department of Health.

The Commission also used the email link service of the Community Relations Commission to provide its translated information resources to community groups representing ten community language groups in NSW. These community groups were encouraged to contact the Commission to arrange presentations to their communities.

As a result of the Commission's liaison with the Department of Immigration and Citizenship, the Department has agreed to include information about the Commission, and the Commission's counterparts in other Australian jurisdictions, in the 2010 edition of the Department's information resource "*Beginning a life in Australia*". This resource is translated into 37 languages, and is available through the Department's website at <http://www.immi.gov.au/living-in-australia/settle-in-australia/beginning-life/booklets/english.htm>. The information about the Commission and its counterparts is currently being translated and will be available shortly.

The Commission recently made a presentation to the Refugee Settlement Service Providers Forum, which was attended by 94 service provider representatives from across NSW. The forum was hosted by the Refugee Settlement Programme of the Department of Immigration and Citizenship.

On 29 July 2009, the Commission was awarded a certificate of commendation for its publications "*Concerned about your health care?*" and "*Resolve concerns about your health care*", which are available in 20 community languages on the Commission's website. As a result, bilingual Commission staff were interviewed by SBS Radio for the Spanish and Filipino communities.

The Commission employs a number of staff who can speak in a language other than English – Italian, German, Spanish, Croatian, Macedonian, Serbian, Hindi, Punjabi, and Tagalog (Filipino) – and who are available to assist complainants speaking these languages. Where appropriately qualified, these staff are paid under the Community Language Allowance Scheme.

Question 3

At last year's hearing, you expressed the view that it might be suitable for the Commission and the Area Health Services to have input into practitioner area education conducted by the New South Wales Medical Board, and you undertook to follow this up with the chief executives of the Area Health Services. Has there been any progress?

[Transcript of evidence, pages 6-7]

The comments about possible input by the Commission into the education of medical practitioners were in the specific context of an earlier question and answer regarding the introduction of a legislative requirement for mandatory reporting by medical practitioners of other practitioners suspected of engaging in sexual abuse, drug or alcohol abuse, or conduct involving a gross departure from accepted standards – see page 18 of the transcript of evidence at the Committee's hearing on 29 April 2009.

Against that background, the Commission provides the following information:

The NSW Medical Board published guidelines for medical practitioners on the issue of mandatory reporting. These guidelines are available on the Medical Board's website.

On 25 November 2009, the Commissioner gave a presentation to an “*Obstetric Malpractice*” conference in Sydney about the development of the mandatory reporting requirements for medical practitioners.

In November 2009, the Commission also provided a background briefing on mandatory reporting to the following health professional colleges, with an offer to make presentations on the subject:

- Royal Australian College of General Practitioners
- Royal Australasian College of Surgeons
- Royal Australasian College of Physicians
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Royal Australasian College of Radiologists
- Royal Australian and New Zealand College of Psychiatrists
- Australasian College for Emergency Medicine
- Australasian College of Dermatologists.

The Commissioner’s column in the 22 January 2010 edition of “*Australian Doctor*” – the leading publication for general practitioners in Australia – discussed the mandatory reporting obligations of medical practitioners.

The Commission’s Communications Officer made a presentation on mandatory reporting to a “*Medico-Legal*” conference in Sydney on 23 March 2010.

Finally, the Commission notes that the national registered health profession boards have developed detailed guidelines on mandatory reporting that will be available to registered health practitioners through the boards’ websites.

Question 4

When answering a question relating to complaints around medical centres at correctional and detention facilities, you responded that:

There is a proportion of complaints around the methadone, buprenorphine distribution in jails, and that is a significant number. That is a difficult matter of administration for Justice Health, because there is a problem of diverting and trafficking internally, and we get complaints from people that say they have been unjustly thrown off that program, and the explanation from Justice Health will be that they have been suspected of diversion ... It might be in the description on the issues with the computer search. We could get that.

How many would there have been out of that category?

[Transcript of evidence, page 8]

In 2008-09, the Commission received 138 complaints about correctional and detention facilities, raising 238 issues. 41 of these issues (17.2%) related to “medication”. However,

this figure includes a range of medication issues that did not necessarily involve methadone or buprenorphine.

Question 5

Do you have the same proportion of complaints about the system in medical centres at correctional and detention facilities as opposed to practitioners, as you would in the health system outside the justice system?

[Transcript of evidence, page 9]

As noted above, the Commission received 138 complaints about correction and detention facilities in 2008-09. Linked to these cases were four additional complaints about health service providers outside Justice Health – one about a medical practitioner, two about public hospitals, and one about a psychiatric hospital.

Accordingly, in 2008-09, the Commission received a total of 142 complaints about correction and detention facilities and associated providers. Only five of these concerned private health service providers.

In 2008-09, the Commission received a total of 3,360 complaints. As noted above, 142 of these concerned correction and detention facilities and associated providers. Of the remaining 3,218 complaints, 1,311 concerned public health service providers, with 789 relating to public health organisations and 522 relating to individual health practitioners in the public health system.

In general, where the complaint concerns issues of a systemic nature, the Commission records the complaint as being about the relevant health organisation. Complaints containing allegations of improper or unreasonable conduct by individual practitioners are recorded as complaints about those particular practitioners.

Question 6

Are private providers of medical services in the jails over-represented or under-represented in complaints?

[Transcript of evidence, page 9]

In 2008-09, the Commission received 138 complaints about correction and detention facilities. Only five of these (3.6%) were about the Junee private correction facility.

The Commission does not have ready access to data that would allow it to relate these figures to either the general number of services delivered by private health facilities, or the proportions of prisoners held in public and private correctional facilities in NSW.

Question 7

Of the 138 complaints from persons in correctional and detention facilities, can you identify which facilities the complaints came from?

[Transcript of evidence, page 9]

The Commission has set out below an analysis of the complaints that it received in 2008-09 about correction and detention facilities, by reference to the particular facility where the health service was provided. (For 27 complaints, the location of the Justice Health facility was not specified in the Commission's recording of the complaint.)

Health service provider	
Justice Health (Matraville)	59
Justice Health (facility not specified)	27
Justice Health (Goulburn)	9
Justice Health (Silverwater)	8
Justice Health (Wellington)	6
Justice Health (Long Bay)	5
Junee Correctional Centre	5
Justice Health (Kempsey)	3
Justice Health (South Windsor)	2
Justice Health (Berrima)	1
Silverwater Correctional Centre	1
Mid North Coast Correctional Centre	1
Cessnock Correctional Centre	1
Wellington Correctional Centre	1
Emu Plains Correctional Centre	1
Justice Health (Emu Plains)	1
Frank Baxter Juvenile Justice Centre	1
NSW State Coroner's Court (Glebe)	1
Justice Health (Parramatta CC)	1
Villawood Immigration Detention Centre	1
Justice Health (Bathurst)	1
Justice Health (Grafton)	1
Goulburn Correctional Centre	1
Total	138

Question 8

With regard to Dr Gorman's appeal, the Commission was recently subject to some serious criticism from the Court of Appeal with respect to its use of the power under section 66 of the Health Care Complaints Act to extend the suspension of medical practitioners. Do you consider that the extensions complained about are indicative of the manner in which the Commission uses section 66, and what are you doing to address the Court's criticism?

[Transcript of evidence, page 10]

The Commission has now had the opportunity of considering the Court of Appeal's judgment of 3 March 2010 in the case of *Gorman v NSW Medical Board*.

The case involved an appeal by Dr Gorman against a decision by the Medical Tribunal on 2 July 2009 to confirm a decision by the NSW Medical Board to suspend Dr Gorman from practising medicine, and subsequent decisions by the Board to extend the period of suspension. The Court of Appeal dismissed the appeal.

The power to suspend a medical practitioner

At the outset, it should be emphasised that it is the Medical Board – not the Health Care Complaints Commission – that has the power to suspend a medical practitioner. Section 66 of the *Medical Practice Act* provides that the Medical Board must suspend a medical practitioner where the Board is satisfied that it is “*appropriate to do so for the protection of the health or safety of any person or persons*” or that suspension is “*otherwise in the public interest*”.

It is also the Medical Board – not the Commission – that has the power to extend the period of suspension. This power is conferred by section 67 of the *Medical Practice Act*.

Investigation by the Commission

Where the Medical Board suspends a medical practitioner, section 66B(1) of the *Medical Practice Act* requires the Board to promptly refer the matter to the Commission for investigation. (The Board's referral must be made “as soon as practicable” and, in any event, within seven days after the suspension.)

Sections 66B(2) and (3) stipulate how the Commission must deal with such a referral. Section 66B(2) provides that that the Commission must deal with the matter as a “complaint” about the practitioner. Section 66B(3) requires the Commission to investigate the complaint, and also – if the Commission “*considers it appropriate to do so*” – to refer the complaint to the Medical Tribunal or to a Professional Standards Committee “*as soon as practicable after the completion of the investigation*”.

Section 29A of the *Health Care Complaints Act* provides that the Commission's investigation of any complaint must be conducted “*as expeditiously as the proper investigation of the complaint permits*”.

The Court of Appeal's comments

The Court of Appeal questioned the time taken by the Commission between July and November 2009 to investigate the issues giving rise to Dr Gorman's suspension, and also the time taken by the Commission's Director of Proceedings to determine whether disciplinary proceedings should be instituted. The Court pointed out that Dr Gorman was suspended from practice pending the outcome of the Commission's complaint-handling processes.

Specifically, the Court of Appeal observed that it “*may be a matter of debate*” as to whether the Commission's investigation between July and November 2009 had been expeditious, and that “*prima facie*” that did not appear to have been the case. However, is important to

note that the Court also said: *"I accept and acknowledge that the Commission has not been heard on the subject"*.

The chronology of the matter

The overall chronology of the matter is as follows.

Background

29 August 2008 – A performance assessment was conducted of Dr Gorman's treatment of a number of patients.

28 October 2008 – Following its consideration of the report on the outcome of the performance assessment, the Medical Board's Performance Committee resolved that a complaint should be made to the Commission about Dr Gorman. The Performance Committee also suggested that the Board should hold an inquiry under section 66 of the *Medical Practice Act* to determine whether Dr Gorman should be suspended or conditions placed on his practice.

28 November 2008 – The Medical Board notified the Commission of the complaint about Dr Gorman, and also advised the Commission that the Board would be holding a section 66 inquiry on 4 December 2008.

2 December 2008 – The Commission assessed the complaint as being suitable for investigation, subject to consultation with the Medical Board.

5 December 2008 – The Medical Board decided to suspend Dr Gorman.

9 December 2008 - The Medical Board advised the Commission that it had suspended Dr Gorman.

11 December 2008 – The Commission consulted with the Medical Board, and decided to investigate the matter, as required by section 66B of the *Medical Practice Act*.

16 December 2008 – The Commission notified Dr Gorman of the investigation.

The Commission's investigation up to July 2009

9 January 2009 – The Medical Board provided the Commission with its written decision on the outcome of its section 66 inquiry. The Commission's Director of Investigations then arranged for the allocation of the file to an investigation officer and suggested certain lines of inquiry for the investigation.

11 January 2009 – The Commission required Dr Gorman to provide copies of relevant medical records and invited his response to the complaint.

12 January 2009 – The Commission wrote to the Medical Board to arrange for statements to be obtained from the medical practitioners who had conducted the performance assessment of Dr Gorman.

17 February 2009 – Dr Gorman advised the Commission of arrangements for accessing his medical records and provided his response to the complaint.

19 February 2009 – The Commission asked the practice manager of the clinic at which Dr Gorman had been practising to provide the medical records. The medical records were received on 2 March 2009.

3 and 9 April 2009 – The Crown Solicitor's office provided the Commission with statements by the medical practitioners who had conducted the performance assessment of Dr Gorman.

11 May 2009 – The Medical Board advised the Commission that Dr Gorman had appealed to the Medical Tribunal against his suspension by the Board, and that the hearing of the appeal was listed for eight days. The Board said that the evidence to be considered by the Tribunal and the outcome of the appeal might be relevant to the Commission's investigation.

14 May 2009 – The Commission asked the practice manager of the clinic at which Dr Gorman had been practising to provide further medical records.

25 May 2009 – The Commission asked the Medical Board to provide the medical records for the patients reviewed during a performance assessment of Dr Gorman in October 2007.

10 June 2009 – The Commission investigator attended the Medical Board, inspected 12 volumes of documents concerning Dr Gorman, and obtained copies of documents relevant to the investigation. The investigator also asked the Medical Board to supply a transcript of the Board's section 66 inquiry and of Dr Gorman's appeal against his suspension.

2 July 2009 – The Medical Tribunal decided to dismiss Dr Gorman's appeal against his suspension.

8 July 2009 – The Commission received a copy of the Medical Tribunal's decision.

The Commission's investigation from July to November 2009

16 July 2009 – The Commission sought an expert opinion on the matter.

9 September 2009 – The expert provided his opinion, which was that Dr Gorman's treatment of five patients during the performance assessment on 29 August 2008 fell "significantly below" the standard expected of a medical practitioner of an equivalent level of training and experience.

21 September 2009 – The Commission provided Dr Gorman with a copy of the expert's report, advised him that it proposed to refer the matter to the Director of Proceedings for the consideration of disciplinary proceedings, and invited his submissions within 28 days, as required by section 40 of the *Health Care Complaints Act*.

25 September 2009 – Dr Gorman asked the Commission to provide him with a copy of the Commission's brief to the expert, which the Commission did on 7 October 2009.

21 October 2009 – The Commission received Dr Gorman's submissions on the matter.

23 October 2009 – The Commission finalised its investigation report, and provided a copy of this report to the Medical Board for the purposes of consultation with the Board about the matter, as required by section 39(2) the *Health Care Complaints Act*.

29 October 2009 – The Commission received further material in relation to the matter from Dr Gorman.

17 November 2009 – The Medical Board advised the Commission that it agreed with the Commission's proposal to refer to the matter to the Director of Proceedings.

20 November 2009 – The Commission advised Dr Gorman that it had decided, following consultation with the Medical Board, to refer the matter to the Director of Proceedings.

Consideration of the matter by the Director of Proceedings

4 December 2009 – The Commission finalised its preparation of the brief of evidence and provided this brief to the Director of Proceedings.

31 March 2010 – Following her consideration of the brief, the Director of Proceedings decided that, subject to consultation with the Medical Board, the Commission should institute disciplinary proceedings against Dr Gorman before the Medical Tribunal.

1 April 2010 – The Director of Proceedings advised the Medical Board of her proposal to institute disciplinary proceedings against Dr Gorman before the Medical Tribunal, and requested the Board's consultation advice on the matter, as required by section 90B(3) of the *Health Care Complaints Act*.

15 April 2010 – The Medical Board advised the Director of Proceedings that the Board agreed with her proposal.

30 April 2010 – The Director of Proceedings advised Dr Gorman of the decision to institute disciplinary proceedings against him before the Medical Tribunal. The Commission's Legal Division is currently drafting a formal complaint against Dr Gorman for lodgement with the Medical Board, so that the Board may refer the complaint to the Medical Tribunal.

Discussion

The Court of Appeal's concerns about an apparent lack of expedition in the Commission's investigation between July and November 2009 can be adequately answered as follows:

- The Commission needed to obtain an expert opinion on Dr Gorman's conduct. The expert opinion was requested promptly and obtained in September 2009.
- The *Health Care Complaints Act* required the Commission to seek Dr Gorman's submissions on the matter, and on the proposal to refer the matter to the Director of Proceedings, as a matter of procedural fairness. The Act also required the Commission to allow Dr Gorman a period of 28 days to make any submissions. The Commission received Dr Gorman's submissions on 21 October 2009.

- The Act also required the Commission to consult with the Medical Board about its proposal to refer the matter to the Director of Proceedings. The Medical Board advised the Commission that it agreed with the Commission's proposal on 17 November 2009.

The Court's apparent concerns about the time taken for the Director of Proceedings to decide whether to institute disciplinary proceedings can also be answered as follows:

- The Commission generally allows a period of up to three months for a consideration of the brief of evidence and the making of a determination by the Director of Proceedings on the question of whether to institute disciplinary proceedings. In this case, and taking into account the Christmas break, the determination of 31 March 2010 fell only slightly outside that timeframe.
- The Act also requires the Director of Proceedings to consult with the Medical Board about the matter. The Director of Proceedings promptly arranged for such a consultation, and the Medical Board advised the Director of Proceedings of its agreement with her proposal on 15 April 2010.

Question 9

Some junior doctors have made complaints in the media that they have been working very long hours and this could lead to errors in dealing with patients if they are fatigued. Could that be a factor, the pressure within the public hospital system?

[Transcript of evidence, page 12]

Junior doctors working long hours could be a factor – one of many factors – affecting the treatment of patients in the public health system.

The Commission's mechanisms for capturing and analysing complaint data have not been able to provide ready access to any meaningful information on this issue. However, at an anecdotal level, the Commission's experience is that it has rarely, if ever, received a complaint specifically alleging that the poor medical treatment in question was the result of the treating practitioner being fatigued as the result of working long hours. Furthermore, the Commission can only recall one matter in which a practitioner the subject of complaint raised the issue of their working long hours as a factor affecting their treatment of the patient.

RCA processes, with their emphasis on identifying any "systemic" factors that have led to adverse health events, may provide an avenue through which the issue of long working hours, and other "pressures" on health practitioners within the public health system, can be examined and addressed.

Appendix 1 – Committee Minutes

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 27)

Thursday, 4 March 2010 at 9.30 a.m.
Jubilee Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair)	Mrs Judy Hopwood MP (Deputy Chair)
Hon David Clarke MLC	Hon Kerry Hickey MP
Rev Hon Fred Nile MLC	Hon Nathan Rees MP

Apologies

Mr Matthew Brown MP

The Chair opened the meeting at 9.30 a.m.

3. Review of the 2008-09 Annual Report of the Health Care Complaints Commission

Resolved, on the motion of Reverend Nile, seconded Mrs Hopwood:

‘That the Committee review the 2008-09 Annual Report of the Health Care Complaints Commission at a public hearing to be held on 25 March 2010. The Committee’s report shall consist of:

- questions answered before the hearing by the Commissioner;
- transcript of evidence given by the Commissioner during the public hearing;
- questions answered after the hearing by the Commissioner;
- any other relevant information that is not confidential.’

The Chair noted that questions to be answered before the hearing had been sent to the Commissioner following circulation by email to Members on 18 February 2010.

The Chair declared the hearing closed at 4.47 p.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 28)

Monday, 19 April 2010 at 1.33 p.m.
Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair) Mrs Judy Hopwood MP (Deputy Chair)
Hon Kerry Hickey MP Rev Hon Fred Nile MLC
Hon Nathan Rees MP

2. Apologies

Mr Matt Brown MP, Hon David Clarke MLC.

3. Review of the 2008/09 Annual Report of the Health Care Complaints Commission

i) Questions on notice

The Chair noted that questions on notice from the Commissioner were received on 15 March 2010, and distributed to Members on 22 March 2010.

Resolved on the motion of Mrs Hopwood, seconded by Reverend Nile:

‘That the Commission’s answers to questions on notice be published on the Committee’s website.’

ii) Questions without notice

The Chair noted that the questions without notice were distributed by email to Members on 18 April 2010.

11. Public Hearing - Review of the 2008/09 Annual Report of the Health Care Complaints Commission

The following witness was sworn and examined:

Kieran Pehm, Commissioner, Health Care Commission.

The following witnesses were affirmed and examined:

Karen Bernadette Mobbs, Director of Proceedings, Health Care Complaints Commission.

Robert Ian Wilson, Director of Investigations, Health Care Complaints Commission.

The Chair noted that the Committee had received a written submission from the Commission in response to some questions on notice. She asked Mr Pehm whether he wished that submission to form part of his evidence given today. Mr Pehm agreed.

At 3.05 p.m. Mr Hickey withdrew.

Evidence concluded, the witnesses withdrew.

12. Publication of Evidence

The Chair asked Members for a resolution to publish the transcript of the witnesses’ evidence on the Committee’s website.

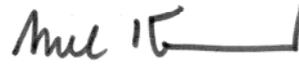
Resolved on the motion of Reverend Nile, seconded by Mrs Hopwood:

‘That the transcript of the witnesses’ evidence be published on the Committee’s website, after making corrections for recording inaccuracy, together with any

submissions made before today, and the answers to any questions taken on notice in the course of today's hearing.'



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 29)

Thursday, 20 May 2010 at 9.17 a.m.
Room 1136, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Mrs Judy Hopwood MP (Deputy Chair), Hon Kerry Hickey MP, Hon Nathan Rees MP.

Apologies

Mr Matt Brown MP, Hon David Clarke MLC, Rev Hon Fred Nile MLC.

3. Review of the 2008-09 Annual Report of the Health Care Complaints Commission

i) Consideration of Report

Resolved on the motion of Mrs Hopwood, seconded by Mr Rees:
'That the draft report be considered *in globo*'.

Resolved on the motion of Mrs Hopwood, seconded by Mr Rees:
'That the draft report be agreed to without amendment.

ii) Adoption of Report

Resolved on the motion of Mrs Hopwood, seconded by Mr Rees:

(a) 'That the draft Report be adopted as the Report of the Committee and that it be signed by the Chair and presented to the House'.

(b) 'That the Chair and the Secretariat be permitted to correct stylistic, typographical and grammatical errors'.

iii) Publication of the Report

Resolved on the motion of Mrs Hopwood, seconded by Mr Rees:
'That, once tabled, the Report be placed on the Committee's website.'

Chair

Committee Manager