REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

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

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At Sydney on Monday 20 February 2012

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The Committee met at 2.15 p.m.

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PRESENT

Mrs L. G. Williams (Chair)

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

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

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

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

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

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

Mr PEHM: That is correct.

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

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

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

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

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

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

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

Mr PEHM: I think that certainly is a concern. Let me say first that I do not think the commission is missing any risks to public health or safety or that it is discontinuing complaints that

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

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

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

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

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

Mr ANDREW ROHAN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Minister about how we measure whether we are delivering a seamless and integrated system on patient care?

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

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

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

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

Mr ANDREW ROHAN: Yes.

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

practitioners' practice group to get all our material into GP practices as well. That would account for the large number that went out that year.

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

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

Mr PEHM: We have fairly well established training opportunities with the established health professionals. Aboriginal health workers have been around for a long time, but it is proposed under the national registration law they will become registered professionals from July 2012. That is why we have reached out to them to get their input and to try as much as we can to explain how we work. Traditional Chinese medicine practitioners will also be registered to practice from July 2012. We will be making similar efforts with the new council that has been set up to co-regulate with us on complaints in that area. The two others are occupational therapists and radiation therapists. They are the areas we will be targeting in the coming year.

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

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

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

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

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

Mr RYAN PARK: It does.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr PEHM: Complaints for 2009-10 and 2010-11 have dropped slightly from previous years. There is a number of things to say about this. Firstly, the 100 per cent is not an achievable target. We put 100 per cent in out of deference to the statutory timeframe. I think the previous committee looked at this whole issue and agreed that 100 per cent is not always achievable and made a recommendation—which I am not sure you took up—that the commission could go beyond that 60 days in suitable cases where the reasons justified it, in order to make a proper assessment. The alternative is, you get to the end of the 60 days, you do not have enough information and you make a flawed decision which is in no-one's interests. So the small drop in the percentage determined within 60 days over the last two years you could attribute to the increasing complaint numbers. The thing we have done to address that is to have a more efficient assessment process in that we do not seek responses in as many cases now as we did before, so that is why we are able to maintain the

above 80 per cent. Whenever a case runs beyond the 60-day timeline, the officers have to put a case to me as to whether it should be extended and they have to set out what has been done, that we have requested responses and the reason why the respondent is in a difficult position. Through January and February the health system often finds it difficult to gather material and get responses in during the Christmas holiday season when a lot of clinicians are on holidays. We have quite a rigorous internal process for making sure that it is a legitimate request for an extension of time and not just that no-one has done anything on the file. That is how we have managed that.

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

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

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

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

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

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

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

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

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

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

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

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

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

not it is proportionate and justified in the circumstances to actually make that call and then we discuss it with the commissioner in relation to what course of action we take.

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

Mr PEHM: There are a lot of competing interests there. I mean the practitioner under investigation believes no-one should be informed because they have not been convicted of anything and it will damage their reputation. Their employer thinks they should be informed so they can mitigate any risk in the way they practice. Patients may well think they should be informed because someone is out there with serious charges against them. There are various mechanisms. The council has the power to hold an immediate hearing and either place conditions or suspend the practitioner, and that can happen depending on the nature of what is against them. Police in a criminal case will generally inform—if it has happened in the public health system they will have to investigate the circumstance, so the employer would be aware through that. We have a duty to inform the employer at the time the conduct occurred of an investigation. The public would not be informed unless, I suppose, there are charges in public court or the registration council holds a hearing and decides to impose conditions or suspend the practitioner.

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

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

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

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

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

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

consultation process and then getting an unfavourable report that is the sort of thing they can protest fairly very vehemently.

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

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

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

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

Mr ANDREW ROHAN: No, 2009-10.

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

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

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

Mr KOFKIN: I do not think it is hugely significant. The numbers in terms of the way we report on our performance do not always give a good account in terms of the complexity of the investigations as well. Some of our investigations are relatively straightforward. For example, they can be a breach of practice conditions, which are very simple; admission has already been made and they can be turned around fairly quickly. Other investigations, as I am sure you are aware, are incredibly complex. They involve a large number of providers—nurses, doctors—sometimes a number of patients, and sometimes more than one facility as well. So when we are measuring in terms of the length of investigations, we are measuring all the investigations. It does not always take into account the actual complexity.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr PEHM: Prescribing is a particularly difficult one, and I might hand over to Mr Kofkin to answer that. Prescribing matters are essentially medical practitioners overprescribing to parties and their patients. As Mr Kofkin said, there might be 100 patients involved. When you prosecute a matter like that it is a bit like a complex fraud prosecution. In effect you have to prove every prescription so there is a process of matching up the medical records with the pharmacy prescriptions and material from the Pharmaceutical Benefits Scheme, Medicare payments and a lot of sources of information. All of that has to be put together before you can get it prosecuted or get an idea of what happened.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr PEHM: Not off the top of my head but we can do that. Whether we have the details from the Ombudsman—often with annual reports we just call them up and get the raw numbers. We might know if we have files that the Ombudsman sent us so we might be able to tell you which ones they have done preliminary inquiries on but perhaps not the ones they have done no inquiries on. We will take that on notice and come back to you and give you an idea.

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

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

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

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

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

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

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

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

Mr PEHM: It is not a significant drain on our resources. We constantly maintain performance data and we undertake reviews all the time. I introduced the quarterly reports because I thought it would be useful for the Committee. The question is whether the Committee finds them useful. If it does not want them, we do not need to provide them. On the broader question, I am happy to explore more frequent or different kinds of communication with the Committee.

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

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

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

Mr PEHM: They have gone through the roof.

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

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

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

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

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

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

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

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

Mr PEHM: No, I cannot. We had some communication with the Ombudsman a few months ago about preparing ourselves to handle the new public interest disclosures legislation. I am not

aware of moves to make us an investigating authority or what that means in terms of the Public Interest Disclosure Act. The Health Records and Privacy Information Act provides that we are exempt, we are also exempt from defamation under the Defamation Act, so it may be an extension of that. I cannot give an update.

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

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

CHAIR: Change in districts?

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

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

Mr PEHM: We just wrote to all the chief executives of the local health districts and asked them to nominate people. It is a huge attendance. There are 196 as of today. We are splitting it into two different sessions. It is mainly complaint handling staff. There are a lot of nurse unit managers. We can probably give you a list of people—directors of medical services. I think anyone who has anything to do with responding to complaints right from directors of medical services, nurse unit managers. They may not do it every day as part of their job but as well as the actual complaint handling staff and the patient safety representatives, a lot of clinicians are coming in as well. We are doing it at five remote sites to north coast, Far West. It is an absolute extravaganza.

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

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

CHAIR: When does the training start?

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

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

Mr PEHM: No, about future needs as well and future training. There are lots of way we could do it. We were talking about this this morning. We can either do one every six months for new staff

that come in, and limit it to about 50 or something, or we could go out and visit the areas as well if there are special issues that are out there. But we need to see what they need first before we decide what we will do.

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

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

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

CHAIR: Have you had some discussions with the Minister?

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

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

Mr PEHM: The other one that I thought might be a bit controversial was the notification of RCA SAC-1 incidents to the commission. Remember I thought the clinicians might have some concerns about that and I knew that the department did. I met with some Minister's staff about a week ago on budget issues and the feedback from them was that the Minister was quite positive about that change as well. I understood they would be talking to you so I am in no position to give you any further feedback on that.

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

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

Mrs ROZA SAGE: Tweaking?

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

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

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

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

Mr PEHM: Yes, you are right, the numbers do not tell us much. I was talking to our consumer consultative committee representative of regional and rural areas and she said that country people do not complain as much as city people so you are never going to get a proper assessment. There are inhibitions on country people complaining too because sometimes, reasonably frequently, it is a sole service provider and in a small town environment they do not want to become known as a complainer. Procedural fairness requires us to notify the practitioner of the complaint and they cannot give a decent response unless they know who it is from, that is the sole general practitioner and they have got to drive 200 miles to see another general practitioner. So there is a reluctance to complain. We do get complaints which people withdraw on that basis or when they find out we have got to send it to the practitioner they say "No, I would rather not. I will sort it out myself." We can talk to them about how to do that. Another area with glaring needs is mental health services in rural and regional areas. It is probably not the number of complaints but their nature and where psychiatric assessments often have to be done by teleconsulting.

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

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

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

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

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

Mr PEHM: Yes, of course.

(The witnesses withdrew)

(The Committee adjourned at 4.12 p.m.)