REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE 2005-2006 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

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At Sydney on 21 November 2007

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The Committee met at 2.00 p.m.

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PRESENT

The Hon. Helen Westwood (Chair)

Legislative Council	**Legislative Assembly**
The Hon. D. J. Clarke	Mr K. A. Hickey
Reverend the Hon. F. J. Nile	Ms J. Hopwood
	Mr A. D. McDonald
	Mr M. A. Morris

CHAIR: I declare the public 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 Parliament upon it, in accordance with section 65 (1) (c) of the Health Care Complaints Act 1993. The Committee welcomes the commission and senior officers of the Health Care Complaints Commission to the table for the purpose of giving evidence on matters relating to the 2005-2006 Annual Report of the Health Care Complaints Commission. I thank you for your appearance today.

KIERAN PEHM, Commissioner, Health Care Complaints Commission, level 13, 323 Castlereagh Street, Sydney and

BRET COMAN, Director, Investigations, level 13, 323 Castlereagh Street, Sydney, sworn and examined:

CHAIR: In what capacity do you appear before the committee?

Mr PEHM: I am appearing as the commissioner.

CHAIR: I am advised that you have been issued with a copy of the committee's terms of reference and also a copy of Legislative Assembly Standing Orders 332, 333 and 334 that relate to the examination of witnesses. Is that correct?

Mr PEHM: That is right.

Mr COMAN: Yes.

CHAIR: The committee has received a detailed submission from the Health Care Complaints Commission in response to a number of questions on notice relating to the 2005-2006 Annual Report. Commissioner, do you wish this submission to form part of your evidence today and to remain public?

Mr PEHM: Yes, thank you.

CHAIR: I direct that those materials be attached to the evidence of the witness to form part of the evidence. Do committee members concur with authorising the publication of the submission?

Reverend the Hon. FRED NILE: Yes, moved.

CHAIR: Commissioner, do you want to make an opening statement before the commencement of questions?

Mr PEHM: No, I do not have an opening statement. I am quite happy to rely on the report and the submission and answer any questions.

CHAIR: The committee has received your answers to its questions on notice. Would you elaborate on the operation and aims of the commission's senior management group, which relates to question 7?

Mr PEHM: Yes, the senior management group was an attempt by us to develop the next level down of management in the commission. After the Campbelltown/Macarthur trauma, I suppose, for the commission all of the senior officers were replaced. We had Judge Taylor as commissioner for a year and I took over after that. I was deputy commissioner during that time. We found, I think, very poor management systems, very poor controls, a lack of supervision of staff and a lack of case management. I think it is fair to say staff were pretty much left to themselves to handle the individual files as best they could and there was not a lot of support by management.

We have put in a whole lot of extensive systems through the commission to address those issues but I think part of the reform of the commission is to develop the capacity of the senior

management group, which are essentially the team leaders. We have restructured all parts of the commission now to really divide the staff into teams of about three to five, each with a team leader and they have been promoted to grade 9/10 level. I think it is probably fair to say that some of them have found it difficult making the transition to a culture of supervision and performance management from what was a fairly laissez faire sort of approach by management.

The idea with the senior officers group was to give them projects to work on on their own without direction from the executive management and hopefully they would display initiative, work co-operatively and start to, I suppose, develop characteristics of leadership for the commission, and hopefully the next iteration of the commission, the executive level would come from those officers. It has not worked as well as I had hoped it would, and it is probably fair to say we have not given it as much support and attention as it probably needed in hindsight. We are going to put a lot more work into that area of the commission, specifically around issues of performance management with staff. The one thing I think our team leaders have found difficult is—confronting is not really the right word—dealing with issues of performance with staff members. These are people with whom they have been colleagues for a long time and they have not had the role of a manager, which is to set clear expectations and see that staff live up to them. So the initial focus will be around managing that performance management interaction with staff.

Another project we will be giving them—and this was Bret Coman's suggestion—is to work on a service level agreement between our investigation staff and our legal staff. The problem there essentially is investigators will investigate a matter and gather evidence in various ways. It will then be transferred to the legal division, potentially for a prosecution. Evidence has to be in legally admissible form. Lawyers might pick up things that we missed in the investigation. It is also fair to say in the past those two divisions have not worked in a very co-operative way. To encourage that co-operation, rather than just leave the file with legal, and expect the lawyers to gather all the extra evidence and get it in admissible form, we have started to send it back to investigations for them to fill out the investigation brief. It is an education for the investigators where their work might need some improvement. So the senior officers group, which will be the senior managers of investigations and legal, will now co-operate on developing a service level agreement which will, I suppose, articulate the terms on which material will be forwarded back and forth and the way the communication will work.

CHAIR: In your answer to question 10, you state that it is not clear what has caused the increase in complaints against public hospitals and pharmacies. Does the commission intend to make any investigation into these upward trends?

Mr PEHM: I had not intended to. I think we need a trend to develop for a bit longer than perhaps one year. It may be a spike. It may be unusual. There may be activity out there that we are not aware of, such as the Pharmacy Guild may have issued information about us. There is a real difficulty with the whole trends analysis. We have put a lot of work into this because it is one of our functions, I think under section 80, to advise government, the profession and other interested parties about trends in complaint handling. It is a laudable aim and it is a logical consequence of a function of a complaints body.

The difficulty is that our complaint numbers are extremely small in relation to patient-health service provider interactions. It is hard to lay my hands on the figures but we might get complaints against medical practitioners of about 1,200 or so. There are 28,000 registered medical practitioners in all sorts of areas. When you start to look at the number of patient interactions, like the number of admissions to emergency departments in the large central Sydney teaching hospitals there are 60,000 to 70,000 a year. We may get two or three complaints out of the emergency department of that hospital. So it is very difficult to draw conclusions, I think, from such small numbers of complaints when compared with the volume of health service provision.

I think another thing we need to do, and we will be doing this more, is to make those comparisons. Rather than just saying there were 20 complaints one year and it has gone up to 30, we will look at it in the broader context of what were the patienthealth service provider interactions, and is that a statistically significant increase? We can say that is a 50 per cent increase, is that important, if patientprovider interactions have gone up a significant amount.

Other factors also play into it, like the level of awareness of complaints processes. One thing we will be doing this year is putting a lot more effort into education and promotion. We have started doing that already. The likelihood is we will get more complaints as a result of that. It does not mean that medical or health service provision is getting worse necessarily; it may just be that people are more aware of the avenues of complaint. We could inquire into it but my feeling is that the inquiry would end up with a whole lot of factors and a whole lot of reasons and explanations as to why conclusions could not really be drawn on increases like that.

Dr ANDREW McDONALD: I will keep you on the topic of trends. Does the commission report complaint trends in relation to individual hospitals?

Mr PEHM: It never has, and it has not done that in its annual report. It has the capacity to do that. We have improved our data capture significantly now so it is not difficult to retrieve the information. We are much more careful, I think, than we have been in the past about correctly recording data, so we capture it fairly well.

The Hon. DAVID CLARKE: Do you think it would be a good idea to keep statistics on individual hospitals so that they can be compared to see whether something is out of kilter?

Mr PEHM: They are kept. They are not reported. It is a question of how much data do you report. If you go down to every hospital in New South Wales, you will be publishing pages and pages of information with zero return or one return when you are looking at small community or rural hospitals and that sort of thing.

The Hon. DAVID CLARKE: But it does show that there is a particular problem in one hospital as opposed to other hospitals—

Mr PEHM: Yes.

The Hon. DAVID CLARKE: —where processes and procedures need to be looked at. Would that not be something of importance to the commission?

Mr PEHM: Yes, it is of importance to the commission, certainly. We are doing that more and more. We are also working with the department to gather that contextual information I was talking about—what does the number of complaints mean in relation to the number of presentations and so on. We do need to do more on that. There is a lot of data that is now capable of capture and capable of production. Precisely what we report on regularly is another question. There are often issues of particular moment for the reason that people are interested in very specific information. But to publish all of that data every year, you would be looking at a lot of paper, and not necessarily productive paper.

Mr COMAN: Could I just add something? We are just making our early steps into data analysis with our recommendations. We have met with our information technology [IT] people. We are looking at categorising recommendations and then keyword searches, et cetera, so that we can then start to analyse trends and the recommendations that we have made, avoid duplication in recommendations, and look at accessing coronial and other data as well—that sort of thing. That is the first step into the analysis of data and we hope that we can step into further areas as well.

Mr KERRY HICKEY: Commissioner, question 10: You say that that is just a spike in regard to complaints made about pharmacy and public hospitals?

Mr PEHM: It may be.

Mr KERRY HICKEY: Does the commission look at this data very closely? When you are seeing 5.1 per cent compared to 4.5 per cent increase in pharmacy and the increase in public hospitals, do you not analyse that when that data comes in?

Mr PEHM: When it comes in, you enter it into the database and then it is capable of reproduction, and you interrogate the database.

Mr KERRY HICKEY: So you are saying that you have enough staff to analyse the data closely?

Mr PEHM: No. The principal time at which we analyse data is the annual report. That is where we interrogate the database over what has happened over the year and the trends. We have provided more information in this annual report. You will see there is more again in the one for the current year than the commission has ever done before. I suppose the issue is: What does it mean? What conclusions can be drawn from this? What I am saying is that I am quite happy to provide data. What conclusions can be drawn from it I think is really problematic, given the small numbers of complaints we get in relation to the numbers of patient-health service provider contacts.

Dr ANDREW McDONALD: That brings me to the next question. You talk about individual hospitals and how you can aggregate within an area health service. What about various areas of practice such as emergency or obstetrics or anaesthetics? Do you keep that sort of data as well?

Mr PEHM: Yes, we do. There is some reporting in there on that I think. We have given you the 10 most common areas on page 30 of the annual report, and on page 29 there is a bar chart there with the number of complaints assessed in relation to the issue of complaints, whether it is inadequate diagnosis or medication incidents and so on. Again, I guess, what does that tell us? There are obvious things like the justice health area. There are a lot of complaints about access to services because they are prisoners and their access is restricted to certain times, and that is the obvious one. We tend to try to resolve a lot of complaints in the mental health areas. There is a higher proportion there than in other areas necessarily because it is obviously better to put those people back in touch or try to resolve fractures that might have occurred in the relationship between service provider and patient.

Dr ANDREW McDONALD: My next question is about that. What would you do if you did notice, say, in a hospital or an area a significantly higher than average level of complaints?

Mr PEHM: The director general is notified of all complaints, the Director General of the Department of Health, under section 17 of the Act, and the identity of the complaint and the nature of the complaint as soon as practicable. We have an electronic information system there so all that information is available to Health. The further question is: What happens when we notice a spike? We have, or I have, three monthly meetings with the director general of the department and something like that I would bring to her attention.

Dr ANDREW McDONALD: About the monthly meetings of each of the registration boards, which boards do you meet with?

Mr PEHM: There are 13 boards. The monthly meetings are to assess new complaints. Under the legislation we are obliged to consult with each of the registration boards where the complaint is against a registered practitioner. On what should be the procedure for dealing with the complaint, it depends pretty much on volume. With the Medical Board we meet weekly to do the assessments. With the nurses we meet fortnightly, once at a monthly meeting and once by teleconference, and all the others, because of the numbers of complaints being low, we meet monthly.

Dr ANDREW McDONALD: When you meet with, say, the Medical Board, you do that on a case-by-case or doctor-by-doctor basis?

Mr PEHM: Yes. Every complaint is the subject of an assessment brief. What happens when we get a complaint is we generally send it to the respondent unless it involves some question of intimidation or harassment of the complainant, and we would not do so in that case. We would ask the practitioner for a response. We may seek medical records where it is a complex clinical issue. We have internal medical advisers who will give us advice on whether the conduct in question is a significant departure. All of that material is digested into a brief and that becomes the basis of the consultation between us and the boards.

Dr ANDREW McDONALD: That brings me on to another question relating to respondent contact. You have talked about how things have changed. In previous years the respondent would only hear of a complaint when there was a fair level of substantiation. Now they hear about many more of these—that is my understanding. In the old days there was a verification process before it went to the

respondent and now I think your report stated there are many more and that part of the assessment process is contact with the respondent to get the other side of the story.

Mr PEHM: Generally we will always provide the respondent with the complaint and ask for a response. There are some cases where you will not, where it is clearly vexatious or there is some mental health issue, and on the face of it you would not trouble the respondent with it. But even for the less serious complaints, we think it is important for the respondents to, one, be aware of them, and, two, just take it as feedback about their practice, if there are communication issues and those sorts of things, and just to hear their side before we make an assessment decision. In the past the commission used to assess the complaints without the benefit of the provider's response.

Dr ANDREW McDONALD: So the respondents are getting more contact with the Health Care Complaints Commission [HCCC] than before, which is a good thing, but what effect are you aware of that it has on the respondent—the fact that they have more contact than they used to?

Mr PEHM: It varies. Some people are very happy to get the chance to respond and put their side of the story. There is some feedback we have had, both from individual respondents and also from conferences and so on that I have been to. Health service providers can be very offended by complaints. I think it has to do with their feeling that they are really just helping people and doing their best. The upshot of that has been through a misunderstanding or, for whatever the reason, the complainant has complained about the conduct.

I went to one conference in Melbourne where a psychiatrist down there had described it as similar to the stages of death. The first reaction was anger, denial, then hopefully acceptance, but his experience was that most practitioners never got past the anger and denial in Victoria. You probably could speak better than I could about how practitioners respond. Despite that culture, I suppose, I still think it is important for them to be dealt with and for practitioners, even though they may have an instantaneous reaction, just to recognise that they are providing a service and there is a system of regulation around how that service is provided, and for them to be able to put their case. I think as long as we are fair about the way we assess them and make decisions, it is beneficial for them, even though they may not like getting them initially.

Dr ANDREW McDONALD: Do you explain to them that things have changed in the last, say, 10 years?

Mr PEHM: I still think we have got a broader job to do there. I think the commission has been concentrating very much on its internal processes. As I have set out in the annual report, there has been a lot of work to do to ensure that we do have fair processes and timely processes. My position has been it is a mistake to go out promoting yourself until you have your own house in order and you actually deliver a service that promises what you are delivering. I briefly alluded in an earlier question to this year going out and promoting the commission much more because I think we are now in reasonable shape to handle any increase in complaints, if that is the result.

Mrs JUDY HOPWOOD: Just in relation to staff and time taken to assess complaints, it seems that there has been a significant rise in the average days to assess complaints in 2005-06, yet you have two fewer staff listed in your staff allocation. I am wondering if you would like to comment on whether there is any correlation between fewer staff and increasing assessment dates?

Mr PEHM: The previous commission's method of assessment was simply to read the complaint and make a decision as to whether it should be discontinued, conciliated, or investigated. The result of that quite low threshold at the front gate, if you like, was a certain reluctance to discontinue things, so lot of complaints had made it over that barrier. A lot of complaints went into investigation, probably more in the past than do now.

We have changed the assessment process to really provide a more thorough analysis of the complaint and the reasons for it, and what the likely outcomes might be before we make the assessment decision. So, previously when you just had a complaint, it came in the door, you read it and made a decision, your time frame is going to be short. We now go to the respondents. We ask them for their response. There can be difficulties in older and more complex cases where you have multiple providers. Often in hospital settings there is a visiting medical officer or consultant, there are

registrars and resident medical officers, and there are nurses. So, to get all of that information in can take some time. It also happens that you might get an initial response from the hospital and that will raise an issue around the conduct of an individual practitioner. So then you have to get that information in. That has been the principal reason for the extension of time in the assessment process.

The other contributing factor I think is that this was a really significant change for staff in the commission. Previously, assessment staff got the complaint in, made up a file, submitted it to the assessment panel and wrote the letter saying, "This is the outcome." Now they are interacting a lot more both with the complainants and the health service providers. They get the responses in, then they analyse them and put together a brief with recommendations about what should be done. There were significant, I suppose, cultural issues around that change in their role. Certainly a lot of them did not respond well to it. They did not see it as their job and what they had always been doing. We had the union in about that. While all those things are going on and while you are managing those changed processes, they are all distracting you from the actual file work.

We think that it is all over now and that is all bedded down. It is in fact much more rewarding for the assessment officers in that they are actually thinking and analysing material and they are interacting with people in a way they never did before. One of the real problems in the old commission was that it kept people at arm's length and did not inform them about what it was doing. So, we put a lot of work into staff interacting with complainants particularly, and also providers, making that adjustment for staff and also in our management systems. We had to redesign the computer systems to implement that process and provide procedures manuals and train staff. All of that contributed to the extended assessment times. The upside I think is that the assessment process is much more robust now and much fairer to all parties involved.

Mrs JUDY HOPWOOD: Could I just ask one question in relation to a concurrent coronial inquiry and a Health Care Complaints Commission inquiry. In relation to a serious complaint, how does the HCCC inquiry work in concert with the coronial inquiry? How much information can be shared, if you like? Could you just explain how that happens where some coronial inquiries may take years to resolve and your ongoing inquiry is there as well?

Mr PEHM: Initially my position was that if there were going to be an inquest, I would leave it to the coronial inquest in the interest of not duplicating investigative effort and expending public funds in that way. I suppose it is fair to say there were, and have been—and I am not sure of the situation now, I think it has improved—significant delays in the conduct of inquests. There were a couple of matters that I thought were unreasonably delayed waiting for coronial outcomes, which took much longer than I thought they would. Now we generally proceed independently of the coroner. If a complaint is made to us and it raises significant issues, we will go through our process and we will investigate it. There is interaction in that the coroner often refers complaints to us that arise at the closure, at the outcome of inquest. They will also refer people to us in that early stage where they are in the counselling process with a complainant and they may not yet have decided about an inquest. So, we will take those and treat them as complaints.

The question about the interaction when both of us are investigating serious matters can be complex and it will depend on the nature of the complaint. There is good liaison generally. We will exchange statements with them. They will provide us with material that they may have found to be relevant to any investigation of ours. There are occasions where, for their own reasons—they might be questions of law and privilege or the interests that other parties have put to the coroner at the inquest—where they will not share information with us, immediately at least. In situations like that we will wait until the coronial procedure is concluded.

Mrs JUDY HOPWOOD: I know I have asked this question before, but I wonder how independent is "independent" in relation to the HCCC regarding system failure? I know that you have explained that if it is a practitioner, it goes off to the relevant board, but if it is a system failure you investigate it and it goes to the director general, who then makes recommendations on what you have provided. Could you explain that again?

Mr PEHM: Yes. If it is a systems failure, essentially, we have the power to make comments and recommendations. The comments might be, "The system failed in that the scans were not delivered to the surgical team so that they were not aware of this complication with a patient." We

might make recommendations to address that and we would look at the systems in the hospital and look at how the scans are transferred and make some recommendations for improvement. We follow up the implementation of recommendations with the director general. We are required to do that by the Act. That is the main topic of the three monthly meeting I have with the director general, and there is lots of contact at the officer level about following up the implementation of those recommendations.

Mrs JUDY HOPWOOD: Is that before those recommendations are made public?

Mr PEHM: We will provide the complainant with a copy of the investigation report, which will include the comments and recommendations, set out all the reasons for it, at the conclusion of the investigation.

Mrs JUDY HOPWOOD: Before it goes to the director general?

Mr PEHM: At the same time; at the final report. If we are not satisfied that the director general has taken sufficient action to implement the recommendations, we can report that to the Minister. If we are not satisfied with the Minister, well, that no sufficient action has been taken within a reasonable time of reporting it to the Minister, then the commission can ultimately report to Parliament. It has never done that, as far as I am aware, in the past on a complaint issue. We have been making a serious effort to systematise our making of recommendations, we capture the information now so we are in a good position to follow up. You will see in the next annual report that 80 per cent of the recommendations we made in this financial year have been implemented. Often they take time as well, depending on the complexity, but we do have a fairly robust system now for following up the implementation.

Mrs JUDY HOPWOOD: Why has the past annual report not been published? Why is it taking this long?

Mr PEHM: Our report is made to the Minister. We are required to do that by 31 October under the annual reports Act. It is then a matter for the Minister as to when it is tabled in Parliament. We may be a contributing factor there in that the first print run was very sloppy and we had to go back. We are expecting the final print run at the end of this week. I do not know, we just kept the Minister informed about that.

Reverend the Hon. FRED NILE: Following on your remarks a moment ago, you said that 80 per cent of your recommendations are implemented?

Mr PEHM: Yes, 80 per cent of recommendations we made in the 2005-06 year were implemented.

Reverend the Hon. FRED NILE: It is a question I suppose as to whether the 20 per cent had major matters that were not implemented or would you regard those as minor issues? In other words, the important issues were responded to by the department?

Mr PEHM: We have not been concerned with a failure to implement anything. It may be that you might make five recommendations and the implementation of three might obviate the fourth, or they might come up with a different way of implementing a recommendation. There have been a few matters that have taken some time to resolve because of concerns, I suppose, at the clinical level. It is very important that the clinicians that are delivering the service have an input as to how they change practice. But there has been no case where I have been dissatisfied with the implementation of recommendations such as to prompt that statutory process of taking it further to the Minister and then up to Parliament.

Reverend the Hon. FRED NILE: So there is no case of you taking a recommendation to the Minister?

Mr PEHM: No. There is no case where we have had to report to the Minister that we are dissatisfied with the action taken by the department—so far.

Reverend the Hon. FRED NILE: You mentioned earlier—I may have it wrong—that there were 60,000 to 70,000 admissions in emergency departments?

Mr PEHM: I think attendances at emergency departments.

Reverend the Hon. FRED NILE: And only three complaints did you say?

Mr PEHM: We just did some work arising out of the work you are currently involved in. Obviously, it is of great interest to anyone in the area. I think back to some earlier questions, I was interested to see whether complaint numbers indicated a cause for concern, perhaps a cause that something might have been picked up before the public disclosure of all these events. We went back and looked at our complaint numbers for the three big teaching hospitals—Royal Prince Alfred, Prince of Wales and Royal North Shore. I can give the Committee exact figures later, but I think we are looking at about 20 to 30 complaints a year, roughly. When you stack that up against the number of emergency department attendances and also the number of in-patient separations—they call people discharged as in-patients—it was not something that would give you cause for concern, just those numbers.

Reverend the Hon. FRED NILE: That is partly what I am getting at, whether you are only getting the tip of the iceberg with complaints?

Mr PEHM: That may be. It is very difficult to know what you are getting or to measure what the hidden element might be.

Reverend the Hon. FRED NILE: Unless some patients do not realise that something that has happened to them is a complaint-value item? They may feel, well, it is a public hospital, this has happened to me, I just have to accept it. Do they realise?

Mr PEHM: It may be that there is a tolerance level there. My feeling is, and it is nothing more, the question is the impact on the complainant. If they have suffered an adverse incident that has left them with a disability or mortality of a family member, those are the really difficult things for people to come to terms with, and they form the core subjects of the serious complaints. People will complain about less serious things, but I think a lot of patients, probably if they have no lasting adverse ill effects—I do not know, I am speculating at the moment—will think, "Oh well, it was not a pleasant experience and I might not have liked the treatment" but they get on with their lives, I guess.

Reverend the Hon. FRED NILE: If there are some major complaints published in the media or a problem is reported in the media, it is not a complaint to you as far as you know, would you check to see whether perhaps there has been a complaint to you?

Mr PEHM: Yes.

Reverend the Hon. FRED NILE: Would you be surprised if it had not come through to you as a complaint, if it is a major item?

Mr PEHM: Surprised, not necessarily. As I was saying earlier, I think the commission has a job to do to promote the awareness of the commission and people's rights to complain. That is something we are looking at doing in quite a concerted way now.

Reverend the Hon. FRED NILE: You could contact those people? Are there any powers you have to say, "We have become aware of a situation?"

Mr PEHM: We do not have an own-motion power to investigate things of our own volition. We have contacted people.

Reverend the Hon. FRED NILE: I mean to encourage a person to make a complaint to you?

Mr PEHM: Yes, we have contacted people in those situations where we think there is an issue that really needs looking at or that they should be aware of our services. We certainly have done that.

The Hon. DAVID CLARKE: Did you say there were 20 to 30 complaints per year from the four hospitals you mentioned?

Mr PEHM: Roughly in that band against each of the hospitals.

The Hon. DAVID CLARKE: That is 20 to 30 a year?

Mr PEHM: Yes.

The Hon. DAVID CLARKE: Of those 20 to 30, that is between 80 and 100 complaints a year from those four hospitals? Do I understand you correctly?

Mr PEHM: With the three hospitals you would be looking at 60 to 90.

The Hon. DAVID CLARKE: Sorry, the three hospitals. What percentage of those would you regard as serious or substantial complaints?

Mr PEHM: Well, I have not gone into the disposition of those complaints and how they have been dealt with. We publish broader information on the number of complaints against public hospitals generally. But I just cannot answer that at the moment.

The Hon. DAVID CLARKE: Do you get matters referred to you to investigate by the Minister?

Mr PEHM: We have had. It is not common. We also have matters referred to us for investigation by the heads of area health services—that is not uncommon.

The Hon. DAVID CLARKE: When you say it is not common, on an average how many complaints of matters have you had referred to you by the Minister, according to your records?

Mr PEHM: Well, I think there is a bit of a difficulty there because, as I was explaining, we do not have an own motion power. If a matter is referred to us the Minister becomes the complainant.

The Hon. DAVID CLARKE: But can't there be matters where complaints have been made to the Minister and then the Minister refers them to the Commission for investigation? I am talking about those matters.

Mr PEHM: There are a lot of complaints to the Minister about incidents that happen in hospitals. Some we may already have as complaints and some we may not. If the Minister writes to us about those we will generally get in touch with the patient or the family member and seek them out as the complainant.

The Hon. DAVID CLARKE: Yes, but what I am getting at is how many referrals come through from the Minister on an average per year?

Mr PEHM: I am not sure what you mean by "referrals". I can give you the number of Ministerial complaints where we are asked to either explain what we have done—if you are talking about referrals by the Minister for us to investigate complaints—

The Hon. DAVID CLARKE: Yes, that is what I am talking about.

Mr PEHM: Look I cannot give you the figure off hand. It would be very rare. Actually we do have—well, it is a double category on page 118 of our annual report where there is a table at 14.2 and "Parliament/Minister" is recorded as the source of complaint in the 2005-06 as 39 complaints, the year before it was 44, the year before that it was 49, and 41 in the year before that.

Reverend the Hon. FRED NILE: That was the Minister referring and members of Parliament?

Mr PEHM: Yes and I cannot give you a breakdown between the two.

Mr KERRY HICKEY: The Minister referring backbenchers' correspondence on to the Hospital Care Complaints Commission?

Mr PEHM: It can come that way.

Mr KERRY HICKEY: That is where it would be coming from. You would actually contact the complainant, not the Minister or the backbencher? You would go straight to the constituent?

Mr PEHM: Yes. That is right.

Mr KERRY HICKEY: So it would not be recorded in there totally?

Mr PEHM: We prefer to have the patient as the complainant because under the Act that is who we provide the report to and as it is really their grievance they should know the outcome. If the Minister becomes the complainant then the patient is not the complainant. I can give you the number of Ministerials and so on.

The Hon. DAVID CLARKE: Yes, could you do that?

CHAIR: You can take that on notice if you like.

Mr PEHM: I will certainly check whether it can be done or take it on notice. I am sure it will not be a problem.

CHAIR: If I could just take up on the Reverend the Hon. Fred Nile's earlier question about the number of complaints we see reported in the media and whether or not you have received complaints from those individuals. I did understand your answer but I am wondering do you think it would be of any use to the Commission to make contact with those people to find why it is they chose to go through the media rather than through the Commission? Were they aware of the Commission's services or was it just given the nature of the complaint in those circumstances?

Mr PEHM: It might be useful. We have had a number of complaints arising out the recent publicity and we have spoken to—we have very experienced people on our inquiry service and we have had a number of complaints arising out of miscarriages specifically.

The Hon. DAVID CLARKE: How many complaints in that category have come to you—

Mr PEHM: In the last three months or so?

The Hon. DAVID CLARKE: Yes.

Mr PEHM: I am thinking, five, six, eight or so.

The Hon. DAVID CLARKE: That is an increase of over, say, a similar period last year or two years ago? Would that be the average?

Mr PEHM: I have not gone back to do the comparison but I mean if there is an increase it is likely down to the publicity. There is one complaint I am thinking of in particular. These are very emotional and grievous experiences for the women and they cope with them in a lot of different ways. Making a complaint may not necessarily be what is uppermost in their mind at the time it happens. The one I am thinking of is about two to three years old and reading the publicity brought it back.

The Hon. DAVID CLARKE: Did it bring back just bad experiences or did it bring back mistreatment?

Mr PEHM: It brought back the bad experiences and the complaint is about mistreatment. It brought back the whole bad experiences but miscarriages—I mean I have talked to women who it happened to 10 years ago and they still have not really resolved it.

The Hon. DAVID CLARKE: It can be bad experiences but no mistreatment. I am trying to distinguish between the two.

Mr PEHM: It can be. We deal with complaints about the poor delivery of health services and that is why they would come to us, if they felt they were mistreated. We are not a counselling service. People have not rung up just to speak generally. They have come to us because they have a complaint and we have taken those complaints throughout normal processes and we are dealing with them.

Reverend the Hon. FRED NILE: Chair, the Inquiry that I am chairing has made a decision not to investigate individual complaints. We are telling those people to contact you.

Mr PEHM: Yes, and I have had some contact with the secretary of your committee. There have been no problems there as far as I understand.

CHAIR: Are you preparing for a possible increase in workload of the Commission following this recent publicity?

Mr PEHM: There has not been a significant workload increase. There have been a number of complaints but you will see from our next annual report that the number of written complaints we have received in the last financial year has gone down from the year before. Again it is this point about how accurate it is as a measure of health service delivery. One of the main reasons I think it has gone down is because we have put a lot more effort into our inquiry service—we have more senior people on the phones now and they can speak more practically about what is the best option for the complainant. In the past we might have got things about Medicare or outside jurisdictions and because our inquiry service was perhaps not as sophisticated as it is now, I think we are much better at directing people who ring up who might be interested in making a complaint as to the best place to go to deal with their grievances. So consequently we get a fall in written complaints. Now I do not think you would draw from that that the health system is better because written complaints have gone down: telephone inquiries have gone up. There are so many factors that you cannot measure that impact on those figures that it is very dangerous I think and difficult to draw conclusions.

Mrs JUDY HOPWOOD: Can I ask whether or not when somebody makes a telephone inquiry whether you ask them to write down their inquiry and send it in formally?

Mr PEHM: The Act says that complaints must be in writing. We also have a duty under the Act to assist complainants to put their complaints into writing. So the inquiry service will generally talk about the grievance and get them to explain for the purpose of assessing whether it is something we should be dealing with or whether it should go better elsewhere. It depends on the urgency. We have had cases where a complainant might be concerned—there is a fairly significant problem with the discharge of elderly people into nursing homes out of accommodation, a lot of pressure on hospitals to do that. We might have, and this is a real-life example, a call where a son has rung up very distressed, "My mother is going to be discharged today" and I think it is permissible by the Act that in a case like that the inquiry officer will take the written complaint over the phone, we will assess it as a written complaint - that is, the inquiry officer's reduction to writing - and refer that to the resolution service if we can get on to it on the same day. It all depends on the nature of the complaint.

Mr COMAN: Could I also add to? Say, for example, we get a complaint of alleged sexual assault. We may take that over the phone and we will send an investigator out to get a statement straight away.

Mrs JUDY HOPWOOD: Does the investigation of a complaint and further processing of the complaint ever relate to resources available, human or financial?

Mr PEHM: That is a really interesting area. There is a section in our Act, which unfortunately I did not bring with me, that says—I wish I had brought it with me because the wording

is quite interesting—it says the Commission must have regard to the resources available when making recommendations. Again I will have to get the section, but I think it is something to the effect that we shall not make recommendations that are inconsistent with the Minister and the Department's allocation of resources. So I think it is a very difficult area.

Mrs JUDY HOPWOOD: Would you ever not take on investigating a complaint relating to human or financial resources?

Mr PEHM: No. I mean our complaints will relate to the provision of a health service. Now as we investigate it may be that the lack of resources might be a contributing factor—

Mrs JUDY HOPWOOD: I am talking about the actual Health Care Complaints Commission resources?

Mr PEHM: No. We need—for a complaint against a health organisation, and this is leaving individual practitioners aside, we need an individual incident of patient care. We cannot investigate the health service at large.

Mrs JUDY HOPWOOD: No, I am actually talking about your resources not any one else's? Your resources being able to implement an investigation, not necessarily about lack of—

Mr PEHM: No, it has not been a problem. After the Campbelltown-Macarthur—I still have not found quite the correct word to refer to that—

Mrs JUDY HOPWOOD: Inquiry.

Mr PEHM: —implosion I was going to say as far as the Commission was concerned, the Commission's budget was fairly substantially increased in broad terms from about $7.2 million to $10 million. Along with all the restructuring and the redesign of processes we have done, resources have not been a problem; certainly it has not impacted on the quality of the Commission's complaint handling service.

The Hon. DAVID CLARKE: Getting back to what you understood was the intention of Mrs Hopwood's question where you thought the resources—she was talking about not your resources but the resources of the institution.

Mr PEHM: The department say or a hospital, yes.

The Hon. DAVID CLARKE: Are you suggesting that there could be a different standard applying into whether there has been a breach or negligence depending on the resources that have been allocated to that medical institution?

Mr PEHM: No, I think what I was saying is the Commission does not investigate general complaints of, "This hospital does not have enough resources." That is what I was saying. The Commission investigates complaints of individual patient care. Now during the investigation of that it may be that a practitioner will raise, "I did not have a consultant available" or "I did not have this support" or "There were only three registrars on and I do not feel that was adequate. That is why I was under pressure and that is why." That may be a contributing factor.

The Hon. DAVID CLARKE: Say you get somebody coming to you complaining of negligence, as an example, and you investigate and you feel it was a question of resources. Would that be something that you would comment upon or bring to the attention of the Minister?

Mr PEHM: Yes. We have made recommendations concerning staffing levels in particular facilities but our recommendations are based on our investigation of the patient incident.

The Hon. DAVID CLARKE: I understand. How many of those would you get? How many would be in that category?

Mr PEHM: They do not come in, in that way. That is a factor that might emerge during investigation. As I say, it may be raised by an individual practitioner in their defence.

The Hon. DAVID CLARKE: But you will come to a decision on whether it was a valid defence of that practitioner?

Mr PEHM: We will generally seek expert advice.

The Hon. DAVID CLARKE: And how many cases do you come across on average per year that involve a situation where you believe that lack of resources is a contributing factor to the unsatisfactory outcome to the patient?

Mr PEHM: It is very rare that it is raised explicitly.

The Hon. DAVID CLARKE: No, but when you investigate yourself. The patient may not raise it—

Mr PEHM: I mean raised in any way by the investigation, by the individual clinicians. It is not a defence clinicians tend to rely on. So it is raised very rarely in any way.

The Hon. DAVID CLARKE: Even if it is not raised, you are saying even by your investigators, if they became aware that that was the problem, for instance, lack of staffing, would not that the something that would figure in your outcomes?

Mr PEHM: Yes, it does.

The Hon. DAVID CLARKE: How many of those cases would there be?

Mr PEHM: I cannot give you an exact number but they would very rare and they would be the subject of recommendations we would make to the Director-General and to the facility.

Dr ANDREW McDONALD: If somebody rings the Health Care Complaints Commission with a complaint about a specific hospital and they have not been through the complaints mechanism of that hospital and they are recommended by the Health Care Complaints Commission to go to that hospital and the complaint is resolved, how is that data captured by the Health Care Complaints Commission? What is it counted as? They have done no investigation—

Mr PEHM: We were just count that as an inquiry and the outcome would be—I think we set out the outcomes of our inquiries somewhere in here. I will find it. Inquiry service. No, actually we have not; it would probably be after this annual report. We have a number of different outcomes for inquiries and it might be written complaint received, complaint form material sent to the complainant, or if anything about making a complaint might be referred to another agency, that would be counted as an inquiry that was referred for self-action by the complainant.

Dr ANDREW McDONALD: And you would not investigate that?

Mr PEHM: No. I think generally the approach is to take the lowest point of resolution or, not the lowest, the most appropriate. Obviously if a complainant can resolve it directly with the health service provider, that is the best thing because they are in the local area, they may have to see them again, they may have to use that facility again, so wherever that is an option, that is the way we would like to see it done.

Dr ANDREW McDONALD: Are there area health staff employed as patient representatives in most hospitals now?

Mr PEHM: There are. I think this is another area that the commission has to look at and in the last annual report you will see we have met with the heads of all the area health services. We are looking at improving the liaison between them and us, and certainly all the area health services have complaint handling staff—patient representatives, I think they are called.

Dr ANDREW McDONALD: How do their staff relate to the commission's 11 resolution officers who are located in metropolitan Sydney?

Mr PEHM: We do not think there are problems there. It varies. On the whole it is pretty cooperative. With difficult complainants, or difficult complaints, it can often be useful for a patient representative to get an outside or a more independent person in to help with the process. They all work fairly well together.

Reverend the Hon. FRED NILE: Are they under the investigation director or do they operate separately?

Mr PEHM: No, we have a division called assessments and resolution, so assessments handle that initial process of assessing the complaint and the director of that area is also responsible for the resolution service. There is a manager of the resolution service. There is also a conciliation registry.

Dr ANDREW McDONALD: Moving on to the complaints process, what does the commission have in place to help patients with mental illnesses or intellectual disabilities when they are making a complaint?

Mr PEHM: The inquiry service again not only handles telephone calls but handles people who walk in off the street. They are the resolution officers. They are very experienced in dealing with people and they are very sensitive to those issues, and one of them I know sits on the Mental Health Tribunal and so on, so we have staff who are quite attuned to those sorts of issues. Certainly, if people walk in, they will be interviewed and a written complaint taken. We also go out and visit people. If they phone and we cannot really get a sensible complaint over the phone or they are not comfortable talking about it we will send people out to interview them in their home and assist them to make a written complaint.

Dr ANDREW McDONALD: What about those with language difficulties, with English as their second language?

Mr PEHM: We have been using translation services for a long time. We use the telephone interpreter service regularly. We are getting our front-page letterhead to have printing on the back in the most common community languages—I think 13 or so—saying to ring the telephone inquiry service numbers and they can hook them up with telephone interpreters. We also use the translation service for written material and we can get people to come in as interpreters in our interview rooms.

Mrs JUDY HOPWOOD: How many resolved complaint cases are reopened and how many of these would have initially been deemed not to be serious; and for what reason and with what result thus far, if there have been any resolved that have been reinvestigated?

Mr PEHM: A more serious matter has then had to go to investigation? There would be very few.

Mrs JUDY HOPWOOD: But has it ever happened that the Health Care Complaints Commission has deemed something not to be serious and with further persuasion from whatever pressure it has had to look at that complaint?

Mr PEHM: Yes, that has happened. The complainant has a statutory right to request a review of the assessment decision and if the assessment decision is to refer it for resolution they may come back and say, "That is not appropriate, I don't like that and I want the matter investigated." They will often do that. There is a review process conducted by officers—at least the investigatory work—and they are independent of the assessment process. Those are the resolution officers. It is rare. The review process, page 128 of the annual report: 89.8 per cent of the original assessment decisions were upheld and 10 per cent were changed.

Mrs JUDY HOPWOOD: Do you have any examples—not specifics, but where they started to be resolved, were considered a minor issue, and were really very serious?

Mr PEHM: Nothing springs to mind in that vein. It may be that during the review process more information becomes available; the complainant is able to produce more information, scans or relevant medical evidence, that changes the view of our expert advisor who would have given the original view. It is quite rare. A significant number of that 10 percent would be variations probably from discontinued towards resolution options. It would be rare that a decision to discontinue or to send a matter to a resolution option would be reassessed for investigation, but not impossible. It happens.

(Short adjournment)

CHAIR: Does the commission undertake a survey of satisfaction of stakeholders, such as the registration boards?

Mr PEHM: No, not a survey. We have very direct contact with the registration boards on a pretty consistent basis and the feedback from all of those has been positive about the way the commission is now working. Also I have met once a year at the combined meeting of the registration boards and uniformly they seem pretty happy with the way we are operating.

CHAIR: So you think that is enough in terms of measuring their satisfaction with the commission?

Mr PEHM: I have a very close relationship with all of them. I do not know that I need to send them a survey. We exchange views and we are both fairly frank with each other. They make recommendations about how they think we should do things and we take those on board. They are good relationships. They are robust at times. We might disagree about particular complaints, but generally I think the relationships are strong and positive.

Dr ANDREW McDONALD: you talked about stakeholders such as registration boards. What about your relationship with professional bodies such as the AMA, which I put on the record I am not a member?

Mr PEHM: I have met with the AMA a few times. I have also met with the insurers. Avant is the new principal one we deal with. There is also the medical defence associations. I had a joint meeting with the AMA and the insurers—it is probably going back nine months ago now. Again, the feedback is very positive. It is partly because such a low bar was set by the previous commission. It is fair to say that professional groups were concerned about perceptions of bias in the way the commission operated. I think we are demonstrating, in the way we are handling complaints now, to all those health service provider representative groups that we are fair and straightforward. Uniformly, the feedback has been very good.

CHAIR: The complaints resolution service undertook a satisfaction survey of the services during 2005-06. Does the commission intend to undertake a similar survey in relation to its assessment and investigation processes?

Mr PEHM: We have had a close look at the resolution services patient satisfaction survey as part of an internal audit. One of the other things the commission has done is we have contracted Deloittes to conduct internal audits and they have done the assessment process and it got four out of five. They have done the resolution service as well. One thing they picked up about the resolution service satisfaction surveys is that they are selective, which is not the way you do surveys, and not for bad reasons either. In some cases the resolution service did not want to stir up grief. A significant proportion of the resolution matters involve families and people who have lost loved ones and who are in deep grieving situations. In cases like that the resolution officer might make the assessment, "I don't want to send them a survey form to say 'are you satisfied with the service' because I know it will bring it all up again." They have probably had quite a few meetings with them.

The problem is that we are selective so we cannot say it is a random survey. I guess there is always the suspicion that it is selective in the sense that it puts the commission in the best light. We are starting soon—and again I do not have the date at my fingertips—we will be sending every complainant a brief satisfaction survey. We have had to draft it and have a look at it for all the

processes—for the assessment, the discontinues, the resolution and the conciliation processes. There is no reason why we would not do it for investigations. It is just that the number that go to investigations are far smaller and the context generally much more intense with the complainants. But certainly for those high-volume processes we plan to do a more randomised complaint satisfaction survey.

CHAIR: Is Deloittes suggesting you do something such as with your final correspondence with complainants you send out a survey at that time?

Mr PEHM: That is right. I do not think they made any suggestions about what we should do but I think we have discussed that with them and that is what we will be doing. Every complainant now will get a survey. We will see what the response rate is. We will put in a self-addressed stamped envelope.

CHAIR: When are you planning to start that?

Mr PEHM: It is in process. I have not seen the drafts of the surveys yet. We are still doing the survey form. I cannot tell you exactly when we will start but we do intend to do it and it will happen.

CHAIR: Perhaps you can take that on notice. It will be good to know when that is going to start.

Reverend the Hon. FRED NILE: Obviously the investigation processes need to be improved. Can you outline some of those improvements that you have made as director?

Mr COMAN: Part of that is professional development. The other part is improving our systems and processes such as developing an investigations manual. Just on the investigators course, we have tailored a certificate 4 in government investigations for the Health Care Complaints Commission. It pretty well follows a full investigation process from the beginning to the end. It is broken up into a number of modules—at the beginning the evidence gathering or collection module and then we have our investigators interviewing. We need to develop our skills in statement taking and interviewing people. Then we have our investigation reporting, writing up our final reports, developing briefs of evidence. We identified brief preparation as an area that needs to be improved on and we are doing that. The final one is just intelligence applications, data analysis, those sorts of things as well. Then we have a couple of mandatory subjects that are dealt with in distance education, working in the public sector and compliance.

We commenced that in November and we have one more workshop to go which will be held in the first week of December. Then there is some distance work and then, providing they pass, they will gain that certificate 4 in government investigation. With the procedures manual, we have drafted it. We just need now to finalise it. We are looking at, for some of the important things, next week introducing policy directives. A lot of that is to do with receipt and allocation of investigations; that we get the managers involved a lot more in the initial stages. They were not getting involved until the back end of the investigation so we are getting them involved in the early stages. I get the file, I read it, I form views as to general direction, then we give it to the investigation manager who will prepare a file note which will identify the general direction, lines of inquiry, fast-tracked actions and also what the challenges are. Perhaps we need to keep the complainant apprised every couple of weeks, those sorts of things.

There are also common elements, keeping the complainant apprised at least once a month—those types of things. Actively tracking that investigation and taking any corrective action that needs to be. They then meet with the investigator and develop an investigation plan. I was concerned with the initial investigation plans that we had. They looked like a table and they just sort of followed the statutory steps. Now we are adding a lot more meat, where we are looking at the evidence gathering phase of the investigation plan. We have some generic lines of inquiry that we would do and then we would put tasks underneath that. So we have a framework for the general investigation plans—general direction or terms of reference, lines of enquiry, and then identify tasks following that. Then the manager sets the time frames with the investigator, not the investigator. It is not 12 months. We are looking at reporting periods or triggers, say, three months—they should have completed the evidence

gathering phase by three months and then we are reporting by exception and we will keep following that process and if we need to we can get involved and take corrective action.

Reverend the Hon. FRED NILE: I know in your answers to questions that the average time taken for an investigation fell from 352 days in 2005-06 to 318 days in 2006-07 and that 70 percent of the investigations were completed within 12 months. Do you still feel that this a long period for investigations and the impact that is having on the complainant?

Mr COMAN: We do.

Mr PEHM: We do. We have been very concerned about the delays. Obviously there has been a problem with the commission for a long, long time. I guess the level we are at now—we set that 12-month benchmark in light of files that had been open for five, four and three years—we thought that was a realistic goal to set to give people something to aim towards. I think probably now they have gotten comfortable with the 12-month time frame. With the sorts of experience, skills and reform that Bret brings to the position now we think they can be done substantially quicker than that.

Reverend the Hon. FRED NILE: If there are investigations in three months, as you said a moment ago, perhaps you can complete them in six months rather than 12 months.

Mr PEHM: We do them as quickly as possible. There are some inherent procedural delays. There are sometimes problems obtaining expert evidence simply because of the commitments of your experts in other areas—they are all busy clinicians. And there are other consultation processes that we have to go through with the boards, which generally meet once a month. So there are inherent procedural delays. But we certainly think they can become a lot quicker, and they will be in future.

Reverend the Hon. FRED NILE: Can you make a decision without the board meeting? Can you make it by some other means, such as teleconferencing or emailing? Does it have to be a formal board meeting?

Mr PEHM: That is the way it is done. We introduced a teleconference with the nurses board to get them done fortnightly. It is another situation where we think we still have work we can do internally before we start telling boards that we want them to do things differently. We want to get our part of the process absolutely up to speed. Then I think we will be in a position to ask the boards to reconfigure the way they work slightly, if it will make a difference.

Mr MATTHEW MORRIS: Before we move on to a different line of questioning, in terms of investigations—given that they still potentially take around 12 months—what mechanisms do you have in place to feed back to the original complainants about the investigation? How often do you talk to them over the 12 months to keep them at least generally informed of how you are progressing?

Mr COMAN: Ideally they should be informed at least every two weeks or once a month. I encourage investigators to contact the complainant and to work it out. Some do not want to be informed every two weeks but generally once a month or something like that—whatever they are happy with. Sometimes they might initiate regular email contact and that sort of thing. We find, too, that if we initiate contact and keep them apprised—even if we do not have a great deal of progress to report because, for example, we are waiting on the expert or for certain records—we find that they are a lot happier with that. That is built into our procedures manual: the manager has to ensure that they have regular contact.

Dr ANDREW McDONALD: I have two quick questions for Mr Coman. What qualifications do the investigators have?

Mr COMAN: They are mixed. We have a mixture of police, who are designated or former designated detectives. We have former lawyers and we also have people with clinical or nursing backgrounds—that type of thing. So it is a good mix and we have a pretty good skills base for sharing that. We have got some very, very talented young people with dual degrees, people who had their own law practice and that sort of thing. We have got very talented people. We advertised about four months ago and we had 70 applicants. We were able to pick the best applicants from those people as well.

Dr ANDREW McDONALD: Do you read all briefs for investigation?

Mr COMAN: Yes. In fact, I read every investigation that comes through—every investigation file—and I add a file note. I get a general view of what needs to be done. I will flag the more important ones and will be kept apprised and add it on the internal reporting group, which meets once a fortnight. Then I read the briefs of evidence. The briefs of evidence may need little bit more work, and we have got the senior officers group working with the managers from legal to develop some processes about that as well.

CHAIR: Turning to staffing issues, the annual report notes that the commission employs no Aboriginal and Torres Strait Islander staff and only half the proposed target for staff with a disability. What strategies does the commission have in place to remedy this situation?

Mr PEHM: We now have an Aboriginal-designated position in the resolution service that is filled and operating. We have a disability action plan, which we are required to have by government legislation. Part of that is workplace inspections and accommodation for people. We have done that in a significant number of cases—for example, we have special Dragon Speak tools to make it easier for people to use computer equipment, and we make accommodation in the form of office furniture and that sort of thing. A number of other strategies are set out in the plan.

CHAIR: I have another question about staffing. Earlier we talked about staff turnover and I think you suggested that you are more satisfied with the rate of staff turnover that the commission is currently experiencing.

Mr PEHM: I do not think we have talked about it. You asked a question about the rate of attrition reported in this report. There has been substantial staff attrition from the commission. I do not think that has been a bad thing for the general productivity and quality of the commission's work. I talked about the assessment process and the change in the nature of the role. Some people are uncomfortable with that and were much happier working in the way the old commission worked—which was minimal contact with people on both sides. We have made it very clear what we expect the commission should do, and I think we have improved the performance of the commission significantly. A number of people have not seen their future with the commission. A proportion of them have just gone on to other jobs—they were there for a certain time, it was time for them to change and they have been promoted elsewhere. But there is an element who made the decision to leave because they did not like the direction in which the commission was heading.

CHAIR: Is the current staff turnover as high as it previously was?

Mr PEHM: Next year's annual report has exactly the same information—the current one that is about to be tabled. It is not a concern for me. We answered this question on page 21 of our written response. The staff attrition for 2006-07 was 14 compared with 21 for the year before. So it is significantly less.

CHAIR: Are you consulting current staff about the issue of staff satisfaction?

Mr PEHM: We are consulting staff continuously through team meeting processes, through directors divisional meetings and through staff meetings, which happen monthly and that I address.

CHAIR: Do you conduct exit surveys or exit interviews with staff who leave?

Mr PEHM: I am not sure about that. I think it is something we should do if we are not. I have certainly talked to many of the staff who have gone. But I am not sure whether we have that formal exit survey process in place.

CHAIR: But it is something you would be willing to consider.

Mr PEHM: Absolutely. I think it is a good thing to have. I think the more feedback we get the better. I will check that and if we do not, we should—and we will.

Reverend the Hon. FRED NILE: In one of your answers you said that the commission does not have a process for monitoring the outcome of legal proceedings where the quality of a medical report is at issue. Is there any reason why you do not monitor the outcome? Would that not be important if you are initiating investigations? It is under item 11.

Mr PEHM: I see—I was thinking of our own legal processes where we prosecute practitioners. A lot of people complain to us about the outcome of workers compensation proceedings and other disability benefits. We get a lot of misdirected complaints against the Commonwealth about entitlements to disability services. Part of all of those processes involves medicolegal reports. In a significant number of those cases people are more dissatisfied with the outcome of their compensation claim but will attack the veracity and accuracy of the medico-legal report. There are very comprehensive processes in place to deal with those, such as the Workers Compensation Commission and the motor vehicle negligence processes. We generally take the view that unless there is something significant or glaringly obvious in the medico-legal report we will get a response from the practitioner and they will give us a completely different version of events about the conduct of the consultation. We let those matters be dealt with by the legal forum to which they are related. We do occasionally get references back from those commissions. I think the Workers Compensation Commission recently referred back its concerns about a medical practitioner's report to it. But we rely on that process. If that tribunal or that forum has a concern about the quality of evidence given they will refer it back to us. We do not go out of our way to monitor the success or otherwise of those proceedings.

Dr ANDREW McDONALD: Is there any overlap between your work and that of the Clinical Excellence Commission?

Mr PEHM: Not at this stage. We have met with the Clinical Excellence Commission a few times—and I am having another meeting with them in early December. They are generally looking at very high-level data analysis. The Department of Health has in place an incident management system and clinicians report adverse events and near misses through that system. All of that information is collated and analysed by the Clinical Excellence Commission and out of that information they will look at areas where they think improvements—such as handover and communication, falls and obstetrics or whatever they might be—can be made. We come from quality improvement—completely the opposite end. Our focus is the individual patient complaint and the clinical incident that arises. Where there may be some potential for overlap would be through the recommendations we make for systems improvements. They are all reported to the director general, and we meet three monthly with the director general about the implementation of those. The department's quality and safety branch also deals regularly with the Clinical Excellence Commission. In fact, the meeting I am having with the commission will include the quality and safety branch. That is the area where there would be an intersection. But there has not been a lot of direct interaction because we are coming at the same issue from very different angles.

Dr ANDREW McDONALD: Do they make referrals to you on the basis of an incident reported or a cause analysis?

Mr PEHM: No. They have made a couple of referrals where there have been high-profile publicity matters—not as complainants but so we are aware of the incident. But it is very rare.

Dr ANDREW McDONALD: So you usually go through the health services. Do the health services refer people?

Mr PEHM: The health services refer individual matters to us, yes.

Dr ANDREW McDONALD: Is that common?

Mr PEHM: It is not very common, no. It happens. It is another one of those areas where there is probably a lot of hidden data that we do not know. We do not know how many complaints are being made and how many clinicians are reporting or not reporting. There is also a culture in health to deal with things in an informal way, such as chats between clinicians. I do not know; it is awkward to speculate and I am not sure anything practical comes of it. For that reason I cannot comment on whether the number of matters they refer to us is high or low or what conclusion you could draw from that.

CHAIR: The annual report notes that a training needs analysis was completed in 2005-06 and that a facilitator would be sourced to provide the required training. What were the results of this analysis and what priority needs were identified?

Mr PEHM: The training needs analysis identified the need for telephone communication skills in the assessments area, for written communication skills—and both of those have been delivered—and for resolution management in the assessments area. Part of the new assessments process is for us to attempt to try to resolve complaints before we have to assess them. If we can work out something between the practitioner and the complainant, that is terrific, so we are trying to skill up the assessment staff to do that. Investigations have had an extensive needs analysis done. I think Bret has already talked about the outcomes of that and what we are putting in place there.

Legal tends to be pretty much self-regulating on the training front. There is mandatory continuing legal education—they go to presentations and issues of particular interest them. And the resolution service is an area where we think there is a need for more formal resolution management and that has not been into place, but that is under consideration now. A lot of it is involving staff input and consultation and I am currently consulting with the resolution service about the sort of training that it would find useful.

CHAIR: At what stage of preparation is the commission's records management policy?

Mr PEHM: I would probably have to take that on notice. We may have a policy in place now but it is a very extensive process. The records management in the commission was very poor. Files would be lost routinely, so there is an enormous job. The whole records management system is really about a 2½ to 3 year project. As I say, I will provide you with a more detailed answer in writing. We do have a policy in place but the policy will need to be continually revised because the systems are being improved. We have let tenders for a document management system. I think we have selected the tenderer for that but there is a three to six-month process for them to assess needs and build the system and so on.

We are talking to the State Records Office regularly about its requirements. I will correct this in writing if I am wrong but I think it was very happy with the progress we had made from where we were starting as well, and we might be reporting that in the annual report that is about to come out. It is a very big job in the commission, not just a question of issuing a policy but a real change in systems, again, in culture and practise and all of those things are being done concurrently. In fact, we have created a specialist position, a 9/10 position, to manage the whole introduction of a proper records management system. That is how much work is needed.

Reverend the Hon. FRED NILE: Item 19 relates to the investigation division and says that the commission has frequently had to resort to using its coercive powers to obtain documents and require statements of information. What are those coercive powers?

Mr PEHM: Principally the power to require documents.

Reverend the Hon. FRED NILE: Is it a summons?

Mr PEHM: It is a notice that the Act empowers us to issue. It is not a summons as such but the effect is the same and there are penalties for non-compliance with the production notice. Statements of information—less often. A statement of information we give a person when we require information in writing, and we will set out the information we are after. There is a lot of concern with health service providers about confidentiality, justifiably so because they have all that private health information. In many cases it is a concern that is not one that is based on the actual law in that they could give us the information without the requirement of notices, but often to protect themselves they will ask us for a notice before they will respond.

Reverend the Hon. FRED NILE: Is that signed by you?

Mr PEHM: Yes, they are all signed by me. We can also require a person to attend before the commission to give oral evidence, and we have done that to facilitate an interview between

investigation officers and a witness who was fearful of repercussions and would rather have had the compulsion exercised than simply to give the evidence voluntarily, so we have done it in that sort of situation. We generally try to work in a co-operative way, and our initial approach is to simply ask the respondent or the health service provider for a response. We would only think about exercising the powers where there is reluctance to give a voluntary response for the reasons I mentioned or where the delay is really getting excessive and we are not getting the information we need in a reasonably timely way.

Dr ANDREW McDONALD: Appendix B shows a small number of complaints made to the commission about medical records. Did they relate to privacy issues or to the availability of records to successive health care providers?

Mr PEHM: Generally it is the availability of records. It is where patients have gone off to a new practitioner and they have asked for either copies of the records or transferred records, and the former practitioner has not shown much alacrity in getting that done. We generally get those resolved through resolution. It just takes that little bit of extra pressure from our office for the provider to provide the records to the new provider.

Dr ANDREW McDONALD: In relation to the availability of medical records in complaints against practitioners is a frequent issue when a practitioner says the records are unavailable and there has been a finding against them?

Mr PEHM: One practitioner complaining about another practitioner?

Dr ANDREW McDONALD: Or in an adverse event, the practitioner saying "the old records were not made available to me, that is one of the reasons there was an adverse event."

Mr PEHM: It is pretty uncommon. I am struggling to think of a case where that has been an issue where one practitioner has raised the lack of records. In the hospital setting the availability of records can be problematic because of the number of attending practitioners and the high volume. Communication through medical records is always difficult and they are rarely has full as we would like them to be as investigators of these incidents, to say the least.

Dr ANDREW McDONALD: Is legibility still an issue?

Mr PEHM: Yes, the handwriting of doctors is legendary. I would not have anything to add to the general myth on that one.

CHAIR: I thank you and your senior staff, for attending this afternoon. I have no doubt that members may have further questions and we will forward them to you and expect some timely answers.

Mr PEHM: We will do our best to get them to you.

(The witnesses withdrew)

The Committee adjourned at 3.53 p.m.