REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

INQUIRY INTO HEALTH CARE COMPLAINTS AND COMPLAINTS HANDLING IN NSW

At Sydney on 19 November 2012

The Committee met at 9.00 a.m.

PRESENT

Mrs L. G. Williams (Chair)

Legislative Council	Legislative Assembly
The Hon. P Green	Mr R. J. Park
The Hon. H Westwood	Mr A. B. Rohan

CHAIR: Thank you for attending the public hearing of the Committee on the Health Care Complaints Commission. This Committee is holding hearings in relation to its inquiry into health care complaints and complaints handling in New South Wales. The purpose of this inquiry is for the Committee to hear from both health consumers and health professionals about the complaints-handling procedures in place and we are trying to identify ways to improve general awareness of the procedures as well as overall improvements.

For the benefit of those in the gallery, I note that the Committee has resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of the guidelines governing coverage of proceedings are available. I will now declare open the hearing in relation to health care complaints and complaints handling in New South Wales and warmly welcome our first witness.

KA KI NG, Senior Policy Officer, NSW Consumer Advisory Group, Mental Health Inc., affirmed and examined:

CHAIR: Can you please advise us in what capacity you are appearing before the Committee today?

Ms NG: I am a senior policy officer at the NSW Consumer Advisory Group, Mental Health Inc. We represent people with a lived experience of mental illness and mental health consumers at a policy level in New South Wales. Although we do work that sometimes has a national kind of coverage and we are funded by the Mental Health and Drug and Alcohol Office within the Department of Health we are a non-government organisation, so we are independent of the Department of Health.

CHAIR: I draw your attention to the fact that your evidence is given under parliamentary privilege and you are protected from legal or administrative action that might otherwise result in action in relation to the information you provide. I also note that any deliberate misleading of the Committee may constitute contempt of the Parliament and an offence under the Parliamentary Evidence Act 1901. Before we commence with questions would you like to make a brief opening statement?

Ms NG: Truly I am okay. Thank you.

CHAIR: Overall the Health Care Complaints Commission [HCCC] reports that there is an improved awareness of its work in the complaints-handling process in New South Wales. I note that in your submission, however, you have highlighted what you believe to be a lack of awareness amongst mental health consumers. What do you think we could do to improve the awareness of the HCCC amongst mental health consumers?

Ms NG: As we have recommended in our submission, we really recommend the HCCC to carry out comprehensive community engagement activities, particularly with people who are working in the mental health sector and also people who are accessing mental health services. We are aware that the HCCC has in the past done something similar with Aboriginal communities and services, so we recommend a similar approach in that regard. We also recommend providing more information about people's rights in regards to making mental health care complaints and making sure that those materials are in plain English and in an easy to read format, which means that the design and layout makes it easy for people to read and understand the information. It is also important to make sure that the information is actually physically available and easy to access, particularly for people who are in hospital for involuntary treatment, for example, and also making it accessible via the HCCC website. We know, for example, that the booklet that I think is called, "Are you unhappy with your doctor?"—

CHAIR: "Not happy with your doctor?"

Ms NG: That is right. That booklet is actually available on the HCCC website but it is not easy to locate.

CHAIR: You talked about some community engagement activities. What sort of things would you envisage? What sort of activities would be useful for mental health consumers?

Ms NG: I think a starting point would be to carry out education activities within hospitals and inpatient units. Most of the complaints that we have heard from people are to do with their treatment within hospital. When they are in hospital people generally do not have internet access and information about how to make complaints is often not placed within the wards. Imagine if you are in a locked ward situation where you cannot get out and there is no way for you to access that kind of information, so I think that would be a really good starting point.

The Hon. HELEN WESTWOOD: On that point regarding access to information for patients or people who are in hospital, I understand there would be some difficulties both for the provider and for the patient accessing information. Apart from having information brochures there, what else do you think realistically we could do or recommend to the HCCC or even, for that matter, the health services?

Ms NG: I think there are two sides. Well, maybe saying two sides is a bit limiting. Certainly it would be beneficial if the HCCC can educate service providers about the complaint mechanisms because we have come across a lot of people working in services either within hospitals or in the community at mental health services who are not aware of the formal complaint processes. We have heard from consumers in hospitals that when they try to make a complaint the staff are not necessarily responsive, which potentially suggests the staff may not even be aware of the hospital internal complaint processes. So it will be important, I would imagine, for the HCCC to work with mental health services to, firstly, make sure that they have strong enough internal complaint processes in place, that staff are aware of those processes and that staff understand both consumers' rights and also staff responsibilities in relation to when they hear a complaint. To be honest with you, providing written information is important but that is probably a really small section of it. Ensuring that the services' culture is responsive to complaints is probably a much more important issue for the HCCC to deal with.

The Hon. HELEN WESTWOOD: My question is meant in no way to diminish or devalue the fact that many people in hospital, particularly those who are in hospital because of a mental health episode, particularly those who are there involuntarily, have legitimate complaints about the service they are provided. Given the nature of mental illness, I think there will be complaints that are perhaps a consequence of the person's mental illness rather than an actual incident. I am foreseeing that you will get services saying, "It's just because of the mental illness that they've got this complaint. It isn't real." First, have you experienced that? Secondly, is there a way you think that we can ensure that we deal with complaints so that we can assess whether or not there are reasons for legitimate complaints or whether they are a consequence of the person's mental illness?

Ms NG: I guess going back to the first question about whether we have seen it, I would like some clarification as in whether we have seen people's complaints being discounted because they have been diagnosed with a mental illness versus the possibility that people are making complaints that are false but are just a result of, for example, psychosis.

The Hon. HELEN WESTWOOD: Yes.

Ms NG: To be honest with you, from our consultation the sort of things that people complained about, they do not sound like it was an imagined situation. Even when we do consultations we know that the majority of people do not even lodge a complaint to begin with. Most of the time, by the time the person actually goes through to a formal complaint process it is normally something really severe already, so the chance of that being just part of someone's mental illness, I find that a problematic assumption.

The Hon. HELEN WESTWOOD: Is that sometimes a response of health services? Is that the reason given either not to have information there or not to have some mechanism for accepting complaints and dealing with them?

Ms NG: From my slightly more limited interaction with the service providers, I get a sense that most services have some kind of complaint process but staff either generally just discount peoples' complaints as just a mental illness and there is no need to do anything about it. I think that is quite common from the people I have spoken with. By that, I mean the consumers I have spoken with. Lots of people feel that when they have tried to provide feedback, particularly when it is more of a criticism, it gets discounted. But I think generally hospitals, I am pretty sure, have complaint processes that people just do not use. I have come across staff who said "consumers/people know that they can give us feedback, they know that our doors are open at any time". They do know that our doors are open any time, and I guess that is probably true. The only problem is when people try to give feedback and staff do not believe them.

The Hon. HELEN WESTWOOD: Maybe that is an area that we can look at. It will be interesting to know whether that is an experience of people with mental illness who are in hospital, and equally whether there is that cultural attitude among service providers that it is a consequence of their mental illness. I have no doubt there may be some incidents of that but, as you say, probably on your research it is very limited.

Ms NG: With staff discounting people?

The Hon. HELEN WESTWOOD: No, with people complaining, people not having legitimate complaints. That is what I mean.

Ms NG: Yes.

The Hon. HELEN WESTWOOD: That would be a small number from your experience?

Ms NG: Yes, from our experience, certainly.

The Hon. PAUL GREEN: In terms of your comments, do you have any examples of best practice for providing information to mental health consumers? Is there anywhere that we can learn from across the globe?

Ms NG: In terms of providing information about complaints and people's rights, best practice, I do not know if there has been any systematic kind of best practice. I have not come across anything that has been documented. But certainly having gone out to different services and spoken to consumers and asking people for examples when they felt that their complaints were well handled, one example would be—I think we have provided that briefly in our submission as well—of a service where there was an incident at the service. It was a community service where people could come in and go as they liked and there was an incident there and staff handled it in a particular way that other consumers who were there witnessing the incident were quite discontent about.

They hold regular meetings at that service with staff and consumers together. The issue was raised and the staff were surprised to find that consumers were quite unhappy with the way they handled the situation. The staff actually thought that what they did was in the best interests of everybody who was at the service at that point in time. Although surprised, the staff were quite happy to hear what consumers had to say—their suggestions, how they felt and the reasons for those feelings. The staff also were really open about explaining why they made the decision at that point in time, that they really genuinely thought that it was the right decision to make based on the circumstances. But they acknowledged what the consumers said and in the end they came up with a different approach that they now know in future staff should use. That situation was only relayed to me by consumers, but certainly the consumers who were at that service at that time and participated in those discussions reported that they felt really positive about the service. Most importantly, they felt that they were heard, that their concerns were heard, acknowledged, understood and responded to.

I suppose, in terms of best practice, I do not know if it is really a matter of what you design and what materials you give out, it is more about the fact that people, when they have a concern, need to be taken seriously and their concerns have to be respected. It is not good enough to say, "Well, you have a mental illness, so"—you know, already thinking maybe it is not a legitimate concern. I think the starting point always has to be that this person has a concern, let us sit down and listen to the person and work out what is the concern. Without doing that, you are never going to be able to work out whether or not a concern is a real concern or actually this person is feeling quite unwell at the moment and if you have further discussion you will find out it might just be something that is happening to them in their minds. I hope that makes sense.

The Hon. PAUL GREEN: Yes. We were just trying to see if anyone was leading where you think we should be heading. I take on board what the Hon. Helen Westwood was saying earlier, but I notice you mentioned a locked ward situation.

Ms NG: Yes.

The Hon. PAUL GREEN: One would expect that a locked ward situation would normally be for the protection of the individual and therefore their capacity to be in a situation where they might complain as opposed to the capacity of a mental health person in the public system would be totally different. Would that be your observation of how you would handle both situations?

Ms NG: I am sorry, I do not know if I—

The Hon. PAUL GREEN: Someone in a locked ward situation complaining—

Ms NG: That is still within the public mental health system.

The Hon. PAUL GREEN: Yes, but I am talking about a locked ward psychiatric hospital as opposed to a public hospital where there is an individual who has mental health issues. Would your experience be that how you handle those situations might be different?

Ms NG: I do not know if I completely understand. As in the staff response might have the potential of causing someone to turn around and make a complaint?

The Hon. PAUL GREEN: Exactly, the way the staff would process that situation might be different.

Ms NG: I have certainly heard that staff responses are often different, especially when staff perceive that they are being confronted with a crisis situation. A lot of the feedback we have heard from consumers is that the approach tends to be very heavy handed. We have heard of complaints from people who were tackled to the ground and stabbed in the back with a needle when they were having a mental health crisis or even in public having their pants pulled down in public and injected in front of their family and everyone else in the community. I would imagine that is grounds for complaint because, without being there, I do not know how necessary it is for people to be treated that way. I have also met with people who work in the mental health sector who have turned around and told me they have never had to use that approach. I am aware of some inpatient units that generally do not practise that sort of approach.

So I do not know whether it would be incorrect to assume that in that situation it is more likely that people will end up wanting to make a complaint, but from my point of view it sounds like there is a high possibility that those are legitimate grounds for complaint because people should not be treated that way to begin with. Being in a mental health crisis situation is not an excuse to tackle people to the ground necessarily. I am not discounting that there might be times when someone is really in a strong psychosis where they are posing a danger, but I just do not know how many times that truly is the case.

The Hon. PAUL GREEN: No-one is trying to lessen the value of an individual, but what we are trying to say is that different things require different approaches. Is that approach in an acute mental health situation different from the approach taken in a public system? I think you mentioned that when you have a person with a mental health issue complaining, one of the quickest ways to understand if they are psychotic or not is to look at the pattern or consistency of the answers. Because normally those can line up to say, "Hey, this person is not psychotic, they have a genuine concern because we have seen that it is noted in this term and that term and that would be consistent with a lot of other things, so we can approach it as a genuine complaint." Is that what you are saying about how we can help those people to register their complaints?

Ms NG: No, not at all.

The Hon. PAUL GREEN: I am just trying to work out how you suggest we can help people in an acute psychotic situation if they have been devalued. How do we help them to register their complaint so that it is taken note of?

Ms NG: I guess my suggestion would be that those complaints are not different from any other complaints we receive in the health system. Without investigating it properly, you are not going to be able to know whether it is a legitimate complaint or not. There is no quick answer, and I think there is a big danger. One of the things I hear from consumers a lot is that if people keep making complaints they end up being branded as a troublemaker or someone with a particularly severe—basically it just gets blamed on their mental illness. But if you talk to some of the other more empathetic staff, people tell you that it is not. There is a certain culture in some services that seems to think it is okay. I do not have a quick answer to be able to say, "Hey, if you look at someone's mental health history and if they make a lot of complaints, it must mean that it is part of their psychosis." I completely disagree with that. If a complaint is being investigated genuinely, I think you will be able to identify whether it is in fact a legitimate complaint or not.

I understand that there could be difficulties in the sense that I have heard of people who have made complaints and when they finally go through the process of getting their file they find that the information is not recorded correctly in the file. People end up in a situation where they are completely lost because what happened to them is not the same as what is recorded on the medical records, and I do not know how you can get around that. Having said that, I wonder, because we tend to get complaints about particular types of services or sometimes even particular units—and we are not a complaint handling agency, we just hear feedback from people that some services seem to be particularly bad—if it might be worthwhile having a look at the sorts of complaints you get and trying to work out where those complaints are from. It might be worthwhile for some of those services to investigate the service process rather than necessarily questioning whether the people making complaints are doing it legitimately or not.

Mr RYAN PARK: In the survey you asked people to indicate whether they are from metropolitan or regional areas, which is something that interests this Committee because we have a mix of regional and metropolitan members. Were there any significant responses? Was one group focused on a certain component, or was the metropolitan group saying very different things from the regional people?

Ms NG: Surprisingly, no, not really. Basically we have found across the board that people are not aware of complaint processes, both internal and external. We have come across consumers who have tried to make complaints to the Health Care Complaints Commission, although it seems that there are more people in metropolitan areas that are more likely to make a complaint than people in remote locations. But, for example, in terms of satisfaction with the process, we have not noted any major differences.

The Hon. HELEN WESTWOOD: Have any service providers approached you to carry out workshops with their staff about awareness of complaints handling?

Ms NG: No, we have not because that is not part of what we do as an organisation.

The Hon. HELEN WESTWOOD: Is there any group that would work with Health Services to assist it to develop skills around complaint handling?

Ms NG: Actually, no. The New South Wales Consumer Advisory Group [CAG] was supporting the mental health, drug and alcohol office in a project called MH-CoPES, which is Mental Health Consumers' Perceptions and Experience of Services, but that is not really a complaints-handling process; it is a continued quality improvement process for services. The way it works is for consumers to complete a written survey and the data gets collated and analysed. From each individual service participating in that process we get a report about what people said was good about them and not so good about them. Then they would workshop with the workers and consumers together to find solutions to three of the major problems that have been identified. That is a quality improvement thing and not really a complaint thing, but I guess it does deal with certain complaints people have.

Mr ANDREW ROHAN: Your submission refers to the brochure "Not Happy with Doctor?"?

Ms NG: Yes.

Mr ANDREW ROHAN: And it indicates that the HCCC should distribute that brochure further. In your opinion, what are the key features that make this brochure effective?

Ms NG: I think the use of graphics certainly was very, very effective. We did one particular consultation with a group of people who spoke limited English, but even they found the brochure useful. I do not know whether they completely understood all the materials in it, but we had someone interpreting at the time to explain the brochure as well. They certainly found the information useful and not too difficult to understand. I think it was the format, the layout and design that made it really useful. A piece of paper normally is supposed to be issued to people, particularly when they have been through hospital inpatient care, telling them about their rights and responsibilities, and sometimes information about who to approach if they have a problem and how to do it.

I do not know if anybody has seen an example of it. It is normally a two-page A4 size paper that is jam-packed with information typed in about a size-seven font. Imagine if you were going into hospital experiencing a psychosis and amongst everything else done and given to you is that piece of paper about your rights. It is not going to go very far. You are not going to remember ever receiving that bit of paper and it will probably go straight to the bin. Whereas with the booklet, which we also took to some inpatient units, people found it easy because they could keep it and look at it again later. I guess being in a booklet they can share it with other people and it is easier to identify because of the way it was designed.

The Hon. PAUL GREEN: Are you suggesting that every complaint in a mental health institution, for instance, should be recorded as a genuine complaint?

Ms NG: Yes.

CHAIR: Could you clarify recommendation 8 in your submission? You said it concerned the HCCC providing feedback to the public on mental health complaints and suggested doing so by each local health district. What would be achieved by doing that?

Ms NG: A few things came up from the consultations, particularly from people who tried to make complaints before. They found the process to be ineffective and, generally, we did not come across anyone who said that their complaints were responded to by the HCCC to begin with. This made people feel like the HCCC existed purely to protect services and is not transparent and accountable. When we looked at the annual report of the HCCC we realised that it does report very minimally but on the types of complaints it received. From memory, complaints related to mental health make up a fairly significant portion of complaints the HCCC received. We think that if the HCCC can be more transparent in providing information about the kinds of complaints it receives and the proportion of complaints that get dealt with and the kinds of outcomes, and also provide information at least about which local health district it comes from, it gives people some faith in the complaint process, but it gives them also a sense of what is happening within their own local health districts when it comes to quality of services et cetera. It is not just used for information for people in the community, but probably for people working in the services to be able to compare the sorts of complaints they are getting to how things are being resolved and how effective that is happening for them in their own local health district. Does that address your question?

CHAIR: Yes. If individual local health districts provided that information, and I understand what you say about comparing health districts, is there any benefit in having a standardised approach across health districts or would it be sufficient for each individual health district to have its own complaints process regarding to mental health patients specifically?

Ms NG: Perhaps I am incorrect, but I would have thought that because each local health district is kind of its own governing body, it should already have its own complaints process. How much of that is standardised, to be honest with you, I am not completely aware. I would have thought that the whole point of the HCCC is that when structures at the local health district level do not resolve the problem, people have to then go through a set process. Am I incorrect in understanding that what you are suggesting pretty much already exists?

CHAIR: The Committee has been on a number of regional visits and the HCCC has clear guidelines are about how complaints are made, but we have been finding that perhaps different local health districts may have different complaints processes. Would it be more beneficial for people, particularly those with a mental health issue, if the process were standardised across the State so that if they presented in Lismore and then in Wagga Wagga they would know that the internal complaints process was the same?

Ms NG: I understand what you mean. From what we have understood from consumers, consistency certainly is useful so people do not feel like every service they go to, if they go to different places, that they are being treated differently. Yes, I understand what you mean now—my apologies.

CHAIR: You probably have not gathered this information because you are not a complaints service as such, but from your anecdotal evidence, can you generalise the sorts of complaints mental health patients would make?

Ms NG: It is difficult to say. I think the ones that end up getting escalated to more formal structures, such as the HCCC, normally involve a fair degree of traumatisation, for example, people being abused to some extent, as I was saying before, people being tackled to the ground and forcefully injected in really aggressive and violent manners that cause a lot of trauma. However, for just complaints generally, people raise concerns about a lot of different issues, such as quality of food and attitude of staff. Sometimes the physical environment: people being in situations where they have no control over anything that happens to them. They are being forced into a situation and then feel completely disempowered. I guess it is hard to say what sort of things people complain about because there are a lot of things that people raise concerns about. It is generally the more severely people are treated the more likely their complaints will get escalated.

The Hon. HELEN WESTWOOD: Madam Chair, you covered the one that I was interested in. I would not mind taking it a bit further. The survey that you conducted did not ask people about the nature of their complaint but, as an advisory group, have you had enough representations from your constituency to have a sense of the nature of the complaints. You said it is about abuse. Is it mainly those people who are in hospital or is it people who are receiving outpatient services from a health service? Are they more likely to be in a mental health unit or in a general ward of a public hospital? Also, do you have any sense of which health care professionals they are most likely to complain about? You have looked at the Health Care Complaints Commission's annual report and we do get that detail. I would be interested to know whether the complaints from people with mental illnesses mirror the complaints that you are getting from other health consumers.

Ms NG: We do get a lot of feedback from people raising various issues. I find it hard to generalise because everywhere we go people raise different issues and concerns. Certainly when we did this lot of consultations, there were a lot of complaints against psychiatrists and a lot of complaints about medications.

People are being given medications that are either not suitable for them or have side effects that are quite damaging but they are having difficulty getting those medications reviewed or changed. I am fairly certain we have had some quotes from people making complaints about how unapproachable they have found the psychiatrists to be. Generally we do not get that much negative feedback about people working in non-governmental operations support services. A lot of complaints generally surround the public health care systems. For example, there are a lot of problems with inpatient care. There are also things such as community treatment teams where people have tried to access services but have not been able to or people's treatment was not properly followed up. I am trying to think of a lot of the stuff. It is usually people who feel they might have questions about the diagnosis and medications but that their concerns are not heard and not responded to and are often discounted. I think they are probably the most concerns.

The Hon. HELEN WESTWOOD: Thank you. That is really useful.

Mr ANDREW ROHAN: One idea raised in your submission was to put the onus of recording the complaint on whoever receives it rather than requiring the consumers to put complaints in writing. Why would you suggest this and, if this were the case, how would the consumer ensure that the complaint was lodged and correctly recorded?

Ms NG: Many consumers are from fairly disadvantaged backgrounds. Literacy is a problem for some people; requiring things to be written is not helpful. I understand that with the Health Care Complaints Commission process people can call up and get assistance, but I do not know how many people actually know that they can do that. A lot of people are under the impression that they can only provide written complaints. I know that some services do insist that you either write a complaint or the complaint might disappear into thin air. Part of that recommendation is really to put the onus back onto services to record the feedback and complaints that they receive and to follow up and to let the person who made the complaint know what is going on, rather than expecting someone who is already possibly struggling with mental illness and a whole range of other problems in life to then try to find out what is going on with their complaints.

A lot of people who do try to make complaints then do not hear back find it a disempowering experience. They feel their concerns are not listened to, they are discounted. It is traumatising for them to try to contact the service and then be referred, and referred, and referred, and then be told, "We do not know what you are talking about. Can you lodge it again?" I am sure in the submission we mentioned one person said she has written 12 separate letters and none have been responded to. It makes you question why should the person who has already been through so much have to do this when, really, it is the services and the Health Care Complaints Commission who has a responsibility to respond and to let people know what is going on and to provide support to people who make complaints.

CHAIR: I have one further question. As a group, have you approached the Health Care Complaints Commission and talked to them? You have put some very good recommendations in your submissions and we thank you for that; they are very helpful. Have you made an approach to the Health Care Complaints Commission about some of those suggestions that could improve the services, particularly for mental health patients?

Ms NG: The New South Wales Consumer Advisory Group sits on a committee within the Health Care Complaints Commission, so we do have links with the Health Care Complaints Commission. I am not the staff member who sits there, so I do not know all the details of the suggestions and discussion that has taken place but, when we can, we make suggestions to the Health Care Complaints Commission on how they can improve things from the perspective of mental health consumers.

CHAIR: Your organisation has not been around for a long time, has it?

Ms NG: Since the early 1990s.

CHAIR: Sorry, I am getting confused with another group that has put in a submission. Have you seen any improvements in the Health Care Complaints Commission, particularly as it pertains to mental health patients?

Ms NG: I would need to be honest and say I have not been in the organisation for a very long time. As far as I am aware, our consultations with people suggest that they have not seen any improvements. Having said that, our organisation probably has not done enough work in that area to be able to give a definitive answer.

CHAIR: There are no further questions. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

Ms NG: Certainly.

CHAIR: Thank you very much. That concludes our questioning today. Thank you for the time and effort you have put into the submission. As a Committee, we really appreciate it.

(The witness withdrew)

BRETT HOWARD HOLMES, General Secretary, New South Wales Nurses and Midwives Association, affirmed and examined:

LINDA ALEXANDER, Legal Officer, New South Wales Nurses and Midwives Association, sworn and examined:

CHAIR: I draw your attention to the fact that your evidence is given under parliamentary privilege and you are protected from legal or administrative action that might otherwise result in action in relation to the information you provide. I also note that any deliberate misleading of the Committee may constitute contempt of the Parliament and an offence under the Parliamentary Evidence Act 1901. Before we commence with questions, would you like to make a brief opening statement?

Mr HOLMES: I would like to address our submission which was put in on 30 January 2012 and acknowledge that where we have raised our concerns with regard to the Health Care Complaints Commission's use of legal counsel, barristers, in the professional standards committee we have noticed that since this letter there has been a change in that process and they have now reverted to using in-house counsel. We had particular concerns around that process where the Health Care Complaints Commission [HCCC] had introduced a far higher level of adversarial approach in the professional standards committee. We understand that that may have been as a staffing issue. However, the consequences of introducing counsel into a committee that is supposed to be at the level where the parties can represent themselves largely and to speak about their practice makes that an overly legalistic, expensive and time-consuming approach.

It certainly is not a desirable way that we would like to see the professional standards committee proceed. Whilst we have welcomed the ability to have legal representation at the professional standards committee, we believe that it needs to be conducted in a way that still allows that the people sitting on the committee and our members are able to follow what is going on and not be caught up in what becomes a contest between the barristers rather than being focused on the issue at hand. We welcome that and we would hope that the Health Care Complaints Commission is able to maintain its internal staff and not get to the point where it is continually briefing out and causing problems in that area.

The other issue, however, that we do continue to press is our concern that the Health Care Complaints Commission should make further efforts to inform the health professions of the role of the Health Care Complaints Commission and to also continue to inform the community about its role. That is an important thing for the Health Care Complaints Commission to undertake and whilst we can reach many thousands of members of the association in our communication the reality is there is still significant numbers who are outside of that membership and therefore outside of our reach in terms of the education and information that we can supply. We would continue to suggest the Health Care Complaints Commission look at its communication with the professions. If the professions themselves do not know about its operation and its processes, then it is highly likely that the community is not well informed of what the Health Care Complaints Commission is trying to achieve, nor the powers that it has or the results that it can achieve.

We raised issues around an expectation by the Health Care Complaints Commission that our members would be attending the process of resolution. However, we continue to have serious concerns for our members should they decide, after receiving advice from us, to participate in that resolution service. The unfortunate reality is that nurses and midwives at a resolution service are not in a position to be able to explain the lack and failure of the service to provide the outcomes expected by the complainant patient. It also puts the nurse or midwife at further risk of ongoing complaints or reopening an investigation. We make clear to our members what the consequences are of that resolution service and the fact that you can end up back in investigation is another serious issue that they have to take into consideration should they want to partake in the resolution service.

One of the other areas we addressed was the process of reinstatement to the register. Should they be in a position where they are struck off the register there is usually a time determinant on that period of being struck off. We understand that the HCCC has an obligation to test people when they come back, and that its obligation is to appeal against a person's request to re-enter the profession. However, we are concerned that when a nurse or midwife has undertaken the requirements placed upon them when removed from the register—maybe to undertake courses, programs or further education—there is an overly aggressive response from the HCCC to make every possible effort to prevent the nurse or midwife from re-entering the profession. We think that can go to an excessive level where the nurse or midwife has demonstrated, both in writing and verbally, that they have met the suggested requirements from the tribunal or the council.

There is another issue that we wish to raise before I go back to the issues that the inquiry particularly wants to focus upon. That is of course the continuing tragedy of the length of time that it takes to go through a process of investigation and transgression and then tribunal. This is becoming even more challenging as new national laws of recency of practice require at least three months of nursing practice in a five-year period should you fall off the register or if you are not able to ascertain that that is what you have been able to undertake. Because of the length of time it can take to go through a process of complaint and investigation, recently the Nursing and Midwifery Council has started imposing conditions on those who have a complaint against them; so those conditions are imposed before the process is gone through.

It is not uncommon for those conditions to make it almost impossible for the nurse or midwife to remain in their position; and then it can be three to four years before the whole process is concluded. So, even if they are found to have not deserved being taken off the register, they can find themselves ineligible to practise because of the lengthy periods of time involved in the process. So our ongoing concern about the HCCC and the processes that then flow with the tribunal is that it needs to be properly resourced so that investigations can be timely, and that our members are not subjected to a process that takes three to five years from point of complaint or transgression through to an outcome. Of course, if they are put off the register, recency of practice will catch them as well. So it becomes a life sentence for some nurses who are accused of not performing in accordance with their professional standards.

If I can go back to the issues that the Committee is interested in, that is, is there a difference between rural and city in terms of reporting and issues. It is our observation that it is much more difficult to have the correct skill mix and staffing in smaller regional hospitals, particularly the peer group C and D hospitals, which are the district and community hospitals. We have recently seen instances where complaints that have been made against our members are largely the result of staffing and skill mix issues, which are common to those smaller district and the community hospitals. I suppose this is where you can have one registered nurse in the hospital reliant on enrolled nurses or assistants in nursing to provide them with assistance in carrying out their roles.

Just recently, in a regional town not so far from a regional city, we had an incident where a relatively new nurse, in their first or second year as a registered nurse, was working with some very ill patients. We are told that the medical officer was trying to have patients evacuated to the local regional hospital, which was saying, "No, we won't take them; we are full." The nurse is now being investigated because she had an enrolled nurse undertake observations of a patient which fell outside the magic colours within the reporting for those observations. The Committee would be aware that there is a colour scheme under which someone who falls into the yellow is supposed to be immediately reported.

Unfortunately, this is a patient who, the doctor agreed, should not be in this hospital. But the registered nurse is being asked, as is the enrolled nurse, to explain why all the processes were not put in place, why they could not achieve a better outcome for this patient, when in fact the patient should have been in a larger hospital with more resources. So that registered nurse and the enrolled nurse are facing the jeopardy of losing their livelihood as a result of a system failure—of an inadequacy in the health system rather than a complete inadequacy in their own professional practice. So there are tragedies that can occur. The unfortunate thing is that that whole situation came to a complaint because there was a tragedy; a patient did not receive care that might have saved the patient's life. The nurses are the ones left to take responsibility for that. That is of major concern to us.

We see decisions made in the health system on the basis of economics that then affect the practice that nurses are able to give. That puts nurses at a grave disadvantage. As I said, that links to my earlier comments that nurses, when they are facing complaints from patients, are in an invidious position of not being able to satisfy a complaint about the fact that the health system simply does not have enough resources to meet everyone's expectations; and yet it is the individual nurse who faces the tribunal, who faces being prosecuted by the Health Care Complaints Commission. That then is an unfair situation because it is not the people who make the financial decisions who have to lose their jobs as a result of practice that results out of that. I might conclude my opening remarks there.

Ms ALEXANDER: I would like to add two comments—one is maybe beyond the terms of reference. Letters that are received by our members from the Health Care Complaints Commission, they advise them to consult their insurer or employer when preparing their response. When nurses consult their employer that gives rise to perhaps suspension or disciplinary proceedings within the facility they work. So we would like the commission, if at all possible, to remove the words "notifying the employer", because it can cause problems.

The other issue would be in relation to costs. It is in the legislation, the new national law, that costs can be awarded. But the commission, when dealing with matters before the tribunal and before the Professional Standards Committee when nurses are the subject of the complaint, they seek an order for costs when they are successful. We all know that costs follow the result, but in relation to nurses it has prevented a lot who have been taken off the register from reapplying to get back on the register because of that issue. They have been out of work for a period of time and there is no way they can satisfy that costs order. So it has been, of late, preventing a lot of nurses from making that application to get back on. That is the reason why they do not reapply, and I find that a tragedy when they have met all the conditions that the tribunal has placed on them and it is to no avail in the end. That is really all I need to say at this stage.

CHAIR: Can I just ask quickly about one of those issues you raised about removing those words "notifying the employer" from the letter from the Health Care Complaints Commission? Have you made that request to the Health Care Complaints Commission? Have you raised that with the Health Care Complaints Commission?

Ms ALEXANDER: We have, yes.

CHAIR: And the response?

Ms ALEXANDER: Not received yet. It is only a recent request.

CHAIR: You would have made that request in writing to the commissioner?

Ms ALEXANDER: Yes.

CHAIR: At the very beginning, Mr Holmes, you talked about the issue of communication. Obviously that is something that interests this Committee under our terms of reference for this particular inquiry. You also talked about communicating the role of the Health Care Complaints Commission effectively both to medical professionals and to consumers. Bearing in mind that the Health Care Complaints Commission has a website and has brochures and so on, what else do you think they could do to effectively get the information out to health professionals, and I will include, as a nurse previously, to nursing staff and I guess generally staff in an acute setting about what the role of the Health Care Complaints Commission is? I guess included in that question is: Are you aware of what training the staff, for example in an acute setting, already get about the role of the Health Care Complaints Commission and the complaints handling process generally?

Mr HOLMES: If I could defer to Ms Alexander?

Ms ALEXANDER: We do run legal seminars for our members, and on occasions non-members attend these seminars, and we give advice on what the commission can do and does. I think a way of overcoming information that is lacking in the community would be for facilities to have information supplied to them and make sure that it gets to employees in those facilities about what the Health Care Complaints Commission can and does do, because we do not get to all our members. We attempt that but we do not have all the nurses employed in New South Wales as our members.

CHAIR: My understanding is that not just nurses but anyone, any allied health staff who commence in a public hospital would have to undertake an orientation. Are you aware whether or not they would receive any information about the complaints process during that orientation?

Ms ALEXANDER: I am not aware that they receive information about the Health Care Complaints Commission.

The Hon. PAUL GREEN: I appreciate your comments, Mr Holmes, about nurses being made the scapegoat for a failing system or lack of resources. That takes on the other concern that suddenly they are held to account for up to three or four years while they move through a process in terms of the recency of practice initiation that has come into place. Are you aware if the Nurses Registration Board has discretion to address those cases individually in terms of reapplying for that position if that situation arose where a person's registration is at risk because of the time constraints?

Ms ALEXANDER: Can I just ask for clarification? Are you asking if what is now the Nursing and Midwifery Council, or AHPRA, can reinstate a nurse who is no longer registered?

The Hon. PAUL GREEN: Yes, the Nurses Registration Board of old, whoever addresses the issues. For instance, recently I found that you could actually appeal to them with your recency of practice if you want to argue that you can meet the terms of that three month thing based on other information, and that they will review your application. Is that not the same situation that arises there? Can they not apply to that board to be reinstated?

Ms ALEXANDER: For recency of practice, yes, they can, but not if they have been taken off the register by a nursing and midwifery tribunal; they have to reapply under the legislation through a differently constituted tribunal and have the matter heard all over again. It is at that stage that the commission opposes the application, and that is understandable to a point because the commission's role is to ensure that the public health and safety is maintained and they want to ensure that the nurse that has been removed from the register is no longer in need of being off the register. But, as Mr Holmes as already stated, they do vigorously oppose that reapplication and there is always a costs order at the end of that, which again is prohibitive to a lot of nurses—most.

Mr HOLMES: If I can clarify as well, the new jeopardy that is there, of course, is that the council imposes limitations on a nurse practice whilst the investigation is underway. We can understand that that is in the interests of the public safety, but the problem really is that it is the length of time that they can be under those conditions. And the result of those conditions can be such that further work becomes impossible because they can require supervision where supervision may not be available; they can require certain practice which is not conducive to their ongoing employment. So the nurses are caught in that time period. I suggest that if a council has determined that the nurse should have those conditions then it is possible to go back and ask them to review the conditions because it is preventing them working. But the people on the council are caught with the idea there is a complaint that is under investigation and has not been resolved so the person is caught. Our principal position I think would be that we would like to see the process appropriately sped up in order to get justice done, not justice delayed.

The Hon. PAUL GREEN: That is another point you raise about the length of time for prosecution of the tribunal hearings. In your experience is there any way that that can be quickened or is it, as you see it, unnecessarily slow or tedious? How can it be quickened? You make that comment. How can it be improved? Where can you gain time in this process, which is quite lengthy because of investigations and who knows what else?

Ms ALEXANDER: We understand there are a few hiccups to that time frame and sometimes it is unavoidable, but to suggest that three years cannot be improved upon is a furphy. I do not know the reasons why the commission takes that long. Some investigations are not as slow but those that are as slow, I cannot answer why they are that slow.

The Hon. PAUL GREEN: Have you done some research to see what categories are slow? You mentioned some are quick. Have you done any research to see which ones are slower?

Ms ALEXANDER: No, just from experience with matters that we receive. There is a mixture.

The Hon. PAUL GREEN: It is inconsistent?

Ms ALEXANDER: It is inconsistent, definitely.

The Hon. PAUL GREEN: If you had the opportunity to write one recommendation for this Committee, would it be that we further investigate that situation?

Ms ALEXANDER: Yes, investigate why it takes so long in investigating complaints that have come to it, definitely.

The Hon. HELEN WESTWOOD: Are you saying that is the Health Care Complaints Commission in general?

Ms ALEXANDER: Yes.

Mr RYAN PARK: This might have been touched on earlier on but I want to check; you mention there has been an increase in people using the Health Care Complaints Commission against professional rivals per se, or it has been used against professional rivals in the past. Have you had any experience of that in your association? I mean, I am nurse A and Ms Westwood is nurse B and I am in professional competition for promotion and things like that and I use the Health Care Complaints Commission as a vehicle to try to discredit another nurse. Are you aware of any of that taking place or have your members raised any issues about that taking place?

Ms ALEXANDER: Not exactly that example, but there have been complaints by other practitioners against members of ours. The Health Care Complaints Commission is obliged to investigate any complaint that comes before it and, in its wisdom, it has identified that they are vexatious complaints and it does not continue with those. But it cannot do anything about that because anybody can make a complaint about anyone at any time. Unfortunately, some members of ours are caught up in that.

Mr RYAN PARK: Does it get recorded, though, for what it is—a vexatious complaint?

Ms ALEXANDER: Yes, and it does not continue.

Mr ANDREW ROHAN: Mr Holmes, in your opinion, what is the most effective way to educate nurses and midwives on the complaints handling process before the Health Care Complaints Commission?

Mr HOLMES: Education and distribution of information always has to be multipronged. Nurses are continually bombarded by additional information they are required to absorb. I note the Chair's reference to websites and the availability of information should people seek it out. The issue then is there are a thousand other things they want to hear about and, frankly, most nurses operate on the basis that they do not expect to be making someone unhappy or they will end up in front of the Health Care Complaints Commission; they think their practice will be appreciated. There needs to be a proactive approach. I think orientation is one idea, but hopefully we have nurses staying in positions for long periods and not going through multiple orientations. There needs to be an opportunity for in-service and updating and distribution of information from the commission to the employer, and that should include of course all employers—aged care, private, public—for them to be able to distribute to their education services, or if they do not have them directly to the nurses so there is a regular reminder of the role the Health Care Complaints Commission plays.

There is a wealth of information there that would scare the socks off any nurse if they had the time to read what is available, but the reality is they have a whole lot of other things to undertake. It needs to be a range of access points. Obviously, a communications strategy that goes beyond expecting that brochures will do the job, that goes beyond saying. We have a lot of information available should you ask. Some work should be done with employers for them to understand and have their staff understand. So to be a lot more proactive in terms of that and possibly, dare I say, expenditure of money on communication.

Mr ANDREW ROHAN: Just to follow up on that, how familiar are your members with information and functions published online?

Mr HOLMES: As I said, they are probably not going to focus on it until they have a reason to. Nurses and midwives are required to undertake ongoing education. Whilst I would argue that research into the role of the Health Care Complaints Commission would meet their continuing professional development requirements, they are probably more focused on direct clinical issues that relate to them in terms of their obligation to get more education and to bring it closer to their workplaces. They get very focused on what they are doing in their particular ward or unit, and the things periphery to that can be a bit of an information overload.

CHAIR: A number of submissions we received—and I have no doubt you have probably read many of them—have advocated resolving complaints at a much more local level so that they do not escalate to the Health Care Complaints Commission. I wondered what your thoughts are about that. In some instances they are referring to complaints on the ward, for example, that a nurse might receive and sometimes, from our information gathering and from our site visits, it seems that often they escalate further because they are not resolved at that local level effectively. Have you comments to make about that?

Mr HOLMES: My initial comment, before Ms Alexander responds, is that I understand attempts are always made to resolve complaints. But it comes back to what is the expectation of the complainant. It is often the complainant's expectation that the nurse is going to be fired, struck off, that they never be allowed to work in this hospital or any other hospital or that no other patient is ever subjected to this again. As you would know, there are whole processes for investigating issues that arise, whether they be complaints or adverse outcomes, whether they be issues where inappropriate behaviour is identified and they are addressed through local grievances and disciplinary processes. But it is about the expectation then of the patient about what the outcome is going to be, which is often at odds with what is going to be delivered at the local level. Whilst we support the concept of dealing with it quickly, if the expectations are not met then that is where these complaints go outside.

CHAIR: Is the problem therefore that the local complaints resolution within the hospital is not communicated effectively to the patient in the first place? I understand you are saying that there is an expectation that if they complain about something the nurse will just not come back, but is that because the patient does not understand the process? I would surmise that obviously the reason that they have a false expectation is because they do not understand that there is a process to go through.

Mr HOLMES: I think you are correct in terms of saying that the information about what can be achieved or what will be achieved does not always meet the expectations or the understandings of the complainant. There are a whole range of factors that are involved in that, whether that be cultural or educational or the fact that the people making the complaint are naturally very emotionally involved in it and therefore cannot see why management is saying to them, "Look, this is the process. We have to go through a process. We do not just walk onto the ward and sack someone. We do not have the power to remove their registration and prevent them ever working again. That is why we have to go through the process."

It might be the case that, as they have got a right and an obligation to, a referral to the higher body, the tribunal or the nurses and midwives board, and, through the complaints mechanism, the HCCC is sometimes an outcome that is undertaken. It is quite interesting that, as we raised earlier, sometimes the employer is not involved at all and the complaint goes direct to the HCCC. I suppose that means that somebody has done some research to find out that it exists and that that is where you can take matters. The ideal of local resolution remains but meeting expectations is the other issue.

The Hon. HELEN WESTWOOD: Can I revisit four main areas that you have raised with us? I am interested in whether you are aware of any other jurisdictions that are handling these areas of complaint or resolution to an optimum level or perhaps to a level that you think is better than how we are doing it in New South Wales around the issue of re-registration or reinstatement of those people who either have had limits placed on their registration in practice and also those who have been struck off. Is there somewhere that you can point to where you think it is a fairer outcome for nurses but also one in which the consumers are protected?

Mr HOLMES: No, I cannot point to what I would see as a better system. When the whole issue about the complaints process was being addressed and the national registration was undertaken we looked at the mechanisms in other States that were currently undertaken and we were supportive of retaining the independence of the prosecutor from the adjudicator. That is why we were supportive of retaining a system that had the Health Care Complaints Commission in its role. So we are not certainly suggesting that an internal mechanism, which was what some of the other States had, was a better outcome than what we had in New South Wales. We advocated to retain the HCCC as a prosecutorial arm separate from the decision-making of the tribunals and the council so that there was at least seen to be that difference.

The Hon. HELEN WESTWOOD: I am familiar with that because I was around at the time that happened. Your recommendation is that the HCCC not participate in that process of re-registration or reinstatement. What body do you think should form part of that reinstatement authority, particularly with regard to consumer safety?

Ms ALEXANDER: Our recommendation in that letter of January this year suggested that it be heard before the tribunal. It is the tribunal in the end that makes the decision anyway given the evidence put before it by the commission and by the respondent or the applicant. In my opinion it would be the tribunal, after hearing the evidence of the applicant, that could make that decision because its role too is to protect the public. I cannot see that the commission necessarily needs to be involved in that process for reinstatement.

The Hon. HELEN WESTWOOD: Perhaps you might take my next question on notice given that we have run out of time. I am also interested in the area of system failure and nurses being held accountable, responsible and even deemed at risk in terms of their registration for those failures. What do you think is the answer to that? Obviously perfect staffing is one answer, but in terms of what we could recommend what do you think we could do in terms of our system to ensure that it is not nurses who are being held accountable for poor health outcomes and tragic outcomes as a result of those systemic failings?

Mr HOLMES: I suppose what we would wish for is that when the investigation is undertaken by the HCCC a full and comprehensive understanding of the circumstances around it, including the staffing issues, is taken into consideration very early on before the whole prosecution takes its slow and damaging path. That is because it then becomes three years later when you have got to try to say the staffing was absolutely atrocious, who was there and what does it matter? It is imperative that the HCCC have people who understand the concepts of the surrounding circumstances—the staffing problems, the limitations, the skill mix issues—that can lead to nurses being put in that impossible situation and ending up being the scapegoats. Yes, we will continue to advocate for better staffing and a better skill mix, but we would hope that the Health Care Complaints Commission could improve its understanding and knowledge of the limitations of the workplace in which nurses are working and that particular circumstance that arises. Maybe it needs to engage some of its nurse experts who know something about dealing with staffing crises and emergencies that arise when there are insufficient staff and resources.

The Hon. PAUL GREEN: The real world?

Mr HOLMES: Yes. That is the real difficulty for nurses because ultimately they are then judged on what they did. It is not about—

The Hon. HELEN WESTWOOD: It is not about that context.

Mr HOLMES: —what else was happening down the road or what else was happening at the other end of the ward; where were your support staff? Why were you distracted when you did not do the right thing? Was it that there were five other patients who you thought were about to expire or something of the like, which I think you would all appreciate?

CHAIR: The Committee may wish to send you additional questions in writing, the replies to which will form part of your evidence and be made public. Are you happy to receive further questions?

Mr HOLMES: Yes, we are.

CHAIR: Thank you once again for appearing today and for a very comprehensive and helpful submission.

(The witnesses withdrew)

PETER GEORGE DODD, Solicitor Health Policy and Advocacy, Public Interest Advocacy Centre, affirmed and examined:

CHAIR: Thank you for attending to give evidence today. In what capacity are you appearing before the Committee?

Mr DODD: My title is Solicitor Health Policy and Advocacy for the Public Interest Advocacy Centre.

CHAIR: I draw your attention to the fact that your evidence is given under parliamentary privilege and as such you are protected from legal or administrative action that might otherwise result in action regarding the information you provide. I note also that any deliberate misleading of the Committee may constitute contempt of the Parliament and is an offence under the Parliamentary Evidence Act 1901. Before we commence with questions, did you want to make an opening comment or statement?

Mr DODD: I will make a short opening statement. I think this is the first opportunity I have had to appear before this Committee in this Parliament, so just in case people do not know, the Public Interest Advocacy Centre [PIAC] is an independent, not-for-profit law and policy organisation. We have a long history in relation to these issues. In fact, the PIAC was around at the creation of the Health Care and Complaints Commission [HCCC]. We were involved in the Chelmsford royal commission, which people would be aware in some ways led to the creation of the HCCC. We also were involved in discussions around the legislation at that time and since then we have had a long history. Certainly we have an interest in the issues before this Committee.

I will just run through briefly what I see are the significant aspects of our submission. I think everybody in this area believes that local resolution of health care complaints is appropriate and should be encouraged. This submission says that the re-establishment—because it is a re-establishment—of a health care advocacy service certainly would assist in that regard. Additionally, the submission comments about the existing complaints system in hospitals and suggests that it certainly could be more accessible and certainly more consistent throughout New South Wales. The submission also raises several other issues that affect the functioning of the HCCC as well as the safety and quality of health care in New South Wales. The first is the issue of the root cause analysis and the privilege afforded to documents arising out of the root cause analysis.

I think the PIAC would agree with the HCCC in this regard that there should not be a privilege in relation to the root cause analysis. But I think the more pressing thing is that if that is not going to be the ongoing position, at least the Coroner and the HCCC should have some limited access to the outcome of the root cause analysis in New South Wales. The role of the Coroner is prevention of future deaths and for the Coroner not to have access to that information, quite frankly, means that perhaps we might have deaths in New South Wales that we do not otherwise have. I know this Committee cannot go into individual cases, but I believe our submission referred to an inquest held last year in which we did not have access to the root cause analysis [RCA]. Subsequently, because our then clients got access to the document, I have seen the final report and it certainly would have been of great assistance to the Coroner.

Without being very comprehensive, if I can put that criticism of the RCA system, certainly it would have been of assistance. I would submit that there are situations where that information might be vital to a Coroner. Certainly, when the HCCC is also investigating serious matters that concern public safety in the health care system, we would advocate that the HCCC also should have access to all the documents from the RCA. The last issue relates more to the Coroner than the HCCC but advocates that there is a general lack of medical expertise available to the Coroner and suggests that there needs to be greater liaison between the HCCC and the Coroner in relation to those issues. It is a broader problem than the HCCC but the Coroner could have more part. Our submission refers to New Zealand where there is a written protocol between the Coroner and its equivalent to the HCCC.

The Hon. PAUL GREEN: You say we should adopt the New Zealand system here in New South Wales. Can you give us some headlines?

Mr DODD: You are talking about the advocacy service?

The Hon. PAUL GREEN: Yes.

Mr DODD: The history in New South Wales is that New South Wales did have a service like that through the Health Care Complaints Commission called the Patient Support Office which was partially modelled on the New Zealand system. There were then changes at the Health Care Complaints Commission which meant that the Patient Support Office became the Resolution Service. The difference was that when they were the patient support office they were advocates and the Resolution Service only takes written complaints and referrals from the commissioner. It plays a very good role. I certainly would not advocate that role being taken away because it is an informal resolution of complaints which is effective.

The New Zealand model consists of independent advocates geographically spread throughout New Zealand that take referrals from the New Zealand Health and Disability Commissioner but also are available to the public to assist in resolution of complaints. In the submission, I give the exact figures and refer to the numbers that they take in. I personally have been to New Zealand to talk to people in that advocacy service and I think they do a tremendous job and that sort of system could well be replicated here but not necessarily as part of the Health Care Complaints Commission. In New Zealand they are independent of the Health and Disability Commissioner.

The Hon. PAUL GREEN: Would you be able to provide the Committee with some information about that?

Mr DODD: Yes, I could provide more information because there is legislation in New Zealand. I am happy to provide specific information if you have questions.

Mr RYAN PARK: Mr Dodd, your submission talks about a standardised system. Madam Chair and the Committee have talked about it and the way we handle complaints across all health services. It is something that is appealing to me. Regardless of the service you are referring to, there is a commonality such as with the police where if you are in trouble there is a police assistance line and it does not matter where you are in the State, there is a one number or one process arrangement. Can you take us through what you see as that type of system and tell the Committee a bit more about that?

Mr DODD: Yes, I can. The reality is that if you are in a hospital in New South Wales and you want some assistance—I again emphasis it is not necessarily a complaint, sometimes people want to know who they have to talk to. For example, they have a friend or relative in the hospital and they want someone to talk to and find out what is going on. Some hospitals have patient representatives—that is one of the names used—but there is no consistency about that. Some hospitals have them and some hospitals do not.

Mr RYAN PARK: Some hospitals have them and you do not know about them.

Mr DODD: That is exactly right.

Mr RYAN PARK: That is my experience.

Mr DODD: If you wanted to find out online who the patient representative was at Westmead or Coonabarabran hospital, whatever you pick, it would be difficult to do that online. What we have suggested in our submission is that there is some sort of rationalisation of that service at least some sort of central information centre where you can find out where these people are. I think it has to go further than that. I think there has to be funding so there are people in each large hospital where people can go and it is well known, signposted on the internet, everywhere, that that is where you go to get answers to your questions. As I said, it is quite amazing how ad hoc it is at the moment.

CHAIR: You suggested in your previous comments that some people want information. Would you perceive if the patient advocate service was enhanced there would be fewer complaints?

Mr DODD: There would certainly be fewer complaints that would be escalated to either the management of the hospital or to the Health Care Complaints Commission. I know the Health Care Complaints Commission do a good job. If you ring up they encourage people to resolve complaints locally and they have that information, but nevertheless I would anticipate there would certainly be some lessening. I have to emphasise if you had that system plus advocates that would increase the possibility of de-escalating complaints and resolving things at a local level.

The Hon. HELEN WESTWOOD: My concern with re-establishing that role within the Health Care Complaints Commission is that we are going back to pre what is known as the Macarthur period. That separation and the strengthening of the Health Care Complaints Commission came out of that awful period in terms of complaints handling and processing in New South Wales. Do you have a view about whether it should sit within the Health Care Complaints Commission or should it sit within another agency or another arm of Health NSW: Do you have a view on that?

Mr DODD: I think the best model is the New Zealand model where the advocacy services are independent. In New Zealand they are funded through the health trusts and I do not think we have an equivalent here. Obviously, the more independent they are the better. I think that the Patient Support Office did work well within the Health Care Complaints Commission. There was some perception that there was a conflict of interest between having advocates within the Health Care Complaints Commission and the other roles that the Health Care Complaints Commission had but I would rather see it within the Health Care Complaints Commission than not at all. It would be better if it was independent. I am always conscious that raises funding issues and with limited resources I would rather it within the Health Care Complaints Commission than not at all.

The Hon. HELEN WESTWOOD: Did you have an opportunity to read the submission from the New South Wales Nurses and Midwives Association?

Mr DODD: I have not had that opportunity.

The Hon. HELEN WESTWOOD: They made recommendations. Maybe you can take those on notice. Some of their recommendations around reinstatement of registration, particularly where nurses have either been struck off or had limitations placed on their registration in terms of practice, they believe that the Health Care Complaints Commission should not have a role in the hearing of those applications for re-registration or reinstatement. Do you have a view on that? The New South Wales Nurses and Midwives Association say that role should be the tribunal's, not the Health Care Complaints Commission's.

Mr DODD: Currently the Health Care Complaints Commission are a party to the deregistration or disciplinary proceedings.

The Hon. HELEN WESTWOOD: The recommendation of the New South Wales Nurses and Midwives Association is that the Health Care Complaints Commission should not be.

Mr DODD: I would have to take that on notice. I am not sure of their reasons.

The Hon. HELEN WESTWOOD: I would be interested in your view on that.

Mr DODD: Yes.

CHAIR: I wanted to refer you back to your submission. You say that you believe there are improvements in the quality and volume of information that the Health Care Complaints Commission puts out about the complaints process. What we want to see is the very best system. What areas do you think we could further improve or the Health Care Complaints Commission could further improve in terms of providing information to consumers and medical professions about what their role is?

Mr DODD: The Public Interest Advocacy Centre is part of the Consumer Consultative Committee of the Health Care Complaints Commission and we met a couple of weeks ago. They informed us they had received extra funding recently which enabled them to do something they were doing before but stopped doing because of lack of funding, and that was providing full explanations to consumers in response to their complaints—in particular when their complaints have not been proceeded with by way of investigation. I think that is the key. In the past the Health Care Complaints Commission have too often written to people saying that they were not proceeding with the complaint but not explaining why. I think that leads to a great deal of frustration from consumers.

They have gone to a hospital, the hospital says if you have a complaint go to the Health Care Complaints Commission. They write off to the Health Care Complaints Commission and the Health Care Complaints Commission says, "We are not dealing with it", or refers it to reconciliation and conciliation and the consumer is not happy with that. In the past the Health Care Complaints Commission has sometimes written curt letters back that do not explain the situation. Now they say they have funding. It is a positive thing that they have funding to do that. They should continue to do that. I think that is the key. Other things that they are doing, for example, in relation to their website, are good; I do not think they could do any more. They are certainly trying to get out into the communities and tell people about what the Health Care Complaints Commission is about, and I think that is positive. It is when people are at the cutting edge, when they write in about something that is really important to them—and it is really important if it is important to them—and do not get what they think is an adequate explanation about how their complaint is dealt with. I think that is where the HCCC has to do everything it can to explain to people how it has dealt with their complaints.

The Hon. HELEN WESTWOOD: I understand the reasons for the recommendations around root cause analysis and privilege. However, I am sure you would be aware of resistance because the HCCC has made recommendations, and this Committee in its last term made similar recommendations, following a number of tragic events. However, there is resistance amongst health professionals and health service providers. I understand that that resistance is because of lack of privilege not helping with the frankness and the honesty you need to be able to understand what caused terrible incidents and how to put in protocols and practices that would prevent those incidents happening. Do you think there is some way to get a balance so that you really get the data that you need to assist you to put in place the processes, structures and practices that would prevent those tragedies happening?

Mr DODD: I do understand why the health profession and certainly health professionals say that there should be privilege in terms of those documents. That is why in our submission we suggest a compromise that those documents be accessible only by the Coroner and HCCC for investigations. The reason we suggest that, particularly in relation to the Coroner, is that the Coroner is about preventing deaths, and it is so important that that happen. In the view of the Public Interest Advocacy Centre, it is not a good outcome that the Coroner is point-blank deprived of that information.

I think there is a similar argument when the HCCC is investigating serious breaches of public safety in hospitals. Again, the HCCC should have access to that information. The HCCC submission—it is also referred to in our submission—also highlights that the system is not really working. I think the commission says that it is supposed to be getting referrals of serious root cause analysis matters, but it is just not getting them. I do not know what the up-to-date situation is. But the idea is, theoretically, that the root cause analysis will take place in confidence; and if serious breaches of health safety are raised that they be referred to the Health Care Complaints Commission. The Health Care Complaints Commission suggested in its submission that that was not happening. That was a couple of years ago, and I do not know whether there has been a change. But there are problems with root cause analyses.

I think at least the Coroner and the Health Care Complaints Commission should have access to the report. I think that is a compromise; the Public Interest Advocacy Centre view and the Health Care Complaints Commission view is that those reports should be available. I think there is a clear public interest in that information being available. It does not happen in other areas. Aircraft investigations, for example, come to mind. It could be error by a pilot, who is not protected by any privilege. If there was an investigation into me as a lawyer, I would not be protected by any privilege. I am not sure why we give that special privilege to the medical profession.

The Hon. HELEN WESTWOOD: I assume it is because we want to ensure that we get all of the information that will assist in understanding what caused the death or tragic outcome. In terms of convincing the health profession, do we have evidence that privilege does not lead to more individuals being prosecuted than the number of cases prosecuted when information is available from the root cause analysis?

Mr DODD: I think that information would be hard to get. It would be interesting if someone did some sort of study of that. You said earlier, "We want to get that information." I just wonder where that information goes now. It certainly goes to senior people in the Department of Health, but it goes no further.

The Hon. HELEN WESTWOOD: That is true. I would accept that that is right.

Mr DODD: It does not go to the consumers, the people who want to know why something happened. They get a report, but they are not told what happened. It does not go to the HCCC and it does not go to the Coroner.

The Hon. HELEN WESTWOOD: I guess the theory is that it goes to the service, which makes changes to prevent such an incident recurring. I think that is what we all assume, and that is always the argument given to us as to why they have not accepted the recommendations of either this Committee, the HCCC or you on this.

Mr DODD: The one example I have cited is the inquest that we appeared in last year. As I said, we have certainly seen the report of the root cause analysis. The final report of the root cause analysis did not pick up the key issue, and that was a misread report. That came from an expert report that the Coroner requested. There were some other matters raised, but I do not know whether they have been followed through. What happens with all complaint matters is that there is an investigation, maybe a root cause analysis, maybe a HCCC report, and then a recommendation that certain systemic changes occur. The only way to ensure that those changes occur is to have everything upfront and out in the public. The people who are concerned about having those changes occur are quite often the consumers. The consumers say, "I don't want this to happen to anybody else." They are the ones that are likely to go knocking on the door at the district health service and say, "Have you implemented those changes?" I am not in any way suggesting that hospitals and health services throw those reports in the bin; there is no evidence of that. They are busy, and if it is not public there is not that pressure on them to follow through those systemic changes.

The Hon. HELEN WESTWOOD: I was going to ask you about—and I think it leads into it—one of the other issues that the Nurses and Midwives Association raised with us was nurses, for example, being held to account and, indeed, being investigated for deaths that they believe are an outcome of systemic failures, particularly severe staffing shortages or beds at the appropriate level of care not being available and that skill mix not being available. I guess in those cases if the RCA was released the finding would be it was a systemic failure and not a failure of an individual health practitioner.

Mr DODD: I think that is a very good point. The RCAs seem to be the form of investigations that Health takes. It is a worldwide process; it is not something we invented here, it happens everywhere. But that is the hospital investigation and it is a piece of information that is missing, it is a piece of the jigsaw that is missing, that the Coroner cannot access, that the Health Care Complaints Commission cannot access in those situations and may well, as you say, highlight systemic problems that are not brought forward, say, at an inquest or in the Health Care Complaints Commission investigation.

It seems to me an absurd proposition that there is this piece of information out there that the Coroner cannot access and the Coroner cannot even look at what I saw subsequently to that inquest—the final report. How you restrict that in terms of some sort of limited access is very difficult because the principle of justice means that all parties would have to have access to it. So it is a difficult question; it is not simple. But surely we should be able to work our way around that so that those vital pieces of information are not in some drawer somewhere when we have got the Coroner, for example, looking at very serious problems and, I might say, doing it spending public money.

You go to an inquest and, say, in a hospital death you have got the unions involved, you have got the representative, you have got the local health districts involved, you have got maybe Health involved, Justice Health may be involved, Corrections will be involved—all this public money—and the consumers may have representation but there is a bit of information they cannot get access to. It seems to me to be not an outcome which is in the public interest.

The Hon. PAUL GREEN: Obviously the inquiry is looking through all this process that you know of, but what recommendation would you have the inquiry come to if you had the chance to put recommendations on the paper?

Mr DODD: In relation to all issues?

The Hon. PAUL GREEN: Particularly pertaining to our terms of reference here.

Mr DODD: I think that New South Wales really loses not having an independent advocacy service in health care. I think that there are so many aspects of the health care system where people just need somewhere to go that are independent to advocate for them—whether it is with a hospital or whether it is with a private health provider. A lot of those things can be resolved at the local level and it is important that that process be facilitated. People do not have the ability to do that themselves; it is not a situation of equal power negotiating with your local GP, negotiating with your local hospital—you need an advocate.

There is also a need, as I said, to rationalise that system of health complaints in the hospital. It is out there and needs to be rationalised, and there needs to be better information about the services provided. The first one might have the resource factor in it; the second one probably does not; you just need to rationalise existing services and let people know about them, and I think that that is something that NSW Health could do within a short period of time.

The Hon. PAUL GREEN: This is a constant comment that we get, letting people know about them. Given your experience, how would you let people know about them? Because it seems there are gaping holes in this process of community consultation or acknowledgement of what exists.

Mr DODD: I think lots of people access information online in 2012 and I think that is one way of providing information—information on a website, information on the HCCC website would be assistance. But not everybody accesses things online so you need the basics: posters in the hospitals, maybe somebody running some sort of campaign within media, especially in regional areas. It is easy to get onto the ABC and the local media and tell people this is how things happen—the Health Care Complaints Commission does that and there is no reason why the local health districts could not do that as well. It seems to me that you have got to tell people about these things and it is always possible.

The Hon. PAUL GREEN: Most of the hospitals, for instance, have a discharge plan. Do you think it perhaps should be part of that discharge checklist that an opportunity is given to quickly advise the person if they have any issues this is what you do or this is where you go?

Mr DODD: Yes, that would be a good idea but sometimes—

The Hon. HELEN WESTWOOD: It is while in they are in there.

The Hon. PAUL GREEN: I understand, but I am just saying where there is a hole in the system and people are not getting information about where to complain or what to do, what this does is at the end stage of their care it makes sure that they have got the information, because quite often, as most would know, in the health system you do not complain while you are in hospital because many patients are scared of ramifications of that complaint. By getting it on discharge as part of the checklist that you do one would think that may be helpful.

Mr DODD: I think that is a good idea but I think, as Ms Westwood said, some people want to know before someone is discharged. People just want information, this is the thing; they cannot get information about how their elderly parents are being treated; they want to know what the treatment plan is and they want to know who to talk to about that, so that comes before discharge.

The Hon. PAUL GREEN: My comment is not all the solution; it is one part of the solution, trying to be more embracing right across. We should not make null and void all the other processes that are in place.

Mr DODD: And, as I said, it would not have a very big cost element to have something at the bottom of a discharge form saying "If you have got any questions here is the local patient advocate" or whatever you call it, "to call". It should be everywhere; that should be the information that everyone provides. The sad thing is that it is probably one of the hardest pieces of information to find at the moment. I do not want to be too facetious but it is difficult. In talking to somebody who rings up our office to find out who the patient rep is at the hospital, you try and Google it and you just cannot find it. Of course, one of the things is that they are called different things at different places. Even if they had the same name it would be of some assistance.

Mr RYAN PARK: I have asked a question—and this is not a political comment—about the patient advocate at a few of my local hospitals and I have got answers back to say they are no longer called that, they are called this so ask the question again. I thought to myself gee, I am a member of Parliament and I thought I knew what it was in terms of a patient advocate, but it is called a patient liaison or patient rep—20 different names that I have come across.

Mr DODD: If you and I cannot find it, how is a consumer with little English going to find it?

Mr RYAN PARK: Never.

Mr DODD: As I said, some of the submissions we make you could say have a resource factor, a cost factor, but this would have very little in terms of worrying Treasury. It is just a matter of providing information. I guess what should be happening is someone should do some sort of audit when they are doing that about what is available in different hospitals and are there any gaps. I suspect there are a few gaps. There may not be but there is probably somebody at each hospital who has some responsibility for those sorts of things. I do not know how you would find that out. I do not know if we did a search under the GIPA Act or you asked a question whether you would be able to get an answer about what is the extent of those services in New South Wales.

(The witness withdrew)

PETER PROCOPIS, President, Medical Council of New South Wales, and

GREG KESBY, Deputy President, Medical Council of New South Wales, sworn and examined:

CHAIR: I draw your attention to the fact that your evidence is given under parliamentary privilege and that you are protected from legal or administrative action that might otherwise result in action in relation to the information you provide. I also note that any deliberate misleading of the Committee may constitute a contempt of Parliament and is an offence under the Parliamentary Evidence Act 1901. Before we commence with questions, would you like to make a brief opening statement?

Professor PROCOPIS: I am sure you have our submission dated 3 February. That basically says, according to your terms of reference, that the commission is doing a good job within its budgetary allocation. We feel that the commission is somewhat restrained by its budgetary allocation and for that reason may not be operating to its fullest extent. As compared to previous years, the commission and the New South Wales Medical Council are working pretty much harmoniously and we are very pleased with the way the commission is doing its job at the present time. We think the public is well aware of the commission's role. Maybe some little improvements could occur but overall we think the information the commission gives out to the public is good and very full.

CHAIR: Did you want to make any opening remarks, Dr Kesby?

Dr KESBY: No thank you.

CHAIR: I might start with the comments you began with, Professor Procopis. Firstly, you were saying that the restricted budget of the Health Care Complaints Commission has meant that it has not performed its role as well as it probably could. Would you be able to expand on that for us? The question is about which particular aspects could it improve on if it had a more adequate budget in your opinion?

Professor PROCOPIS: It is hard to put forward individual cases but it is possible for it to be able to investigate more cases and more cases more fully if it had an adequate budget. I believe, rightly so, within its budget allocation it has to think of its budget when it decides what action it is going to take in a particular investigation or not. I have to say, there are times when we would like some fuller investigations to occur that do not happen because of its resources.

CHAIR: Further to the comments you made, you said in your opinion you thought the public and consumers were very much aware of the role of the commission?

Professor PROCOPIS: Yes.

CHAIR: Do you have any evidence to substantiate that comment?

Professor PROCOPIS: Before we came here we had a look at its website. It is very full in explaining what the commission does and how to make a complaint. If you Google how to make a complaint against a doctor, the website comes up amongst other things. Even if you put in things like I am not satisfied with my doctor, you will get the HCCC coming up quickly. If you walk down Macquarie Street and ask someone who has just seen a doctor how to make a complaint about doctor, they would probably say, "I don't know, I would Google it." If they do that, they would find things quite easily.

CHAIR: What about people who do not have access to a website?

Professor PROCOPIS: They are becoming rarer and rarer. If they do not have access to a website I am sure they would ask their grandchildren.

CHAIR: I guess everybody on the Committee will know why I asked that question. Certainly the feedback that we have been getting from our regional visits is that people simply are not aware of the role of the HCCC. I am happy for anyone else to make a comment if they wish.

The Hon. PAUL GREEN: I appreciate that glowing remark about the internet but the fact is that out in the villages of New South Wales the internet is not good and a lot of the elderly do not have it on. Given the fact that people over 75 years of age make up three-quarters of hospital attendances it is a cause of concern for us that they are not getting the information. That is just to clarify a couple of findings.

Professor PROCOPIS: I readily accept that. The hospitals and doctors themselves can play a part in that. I know from my own experience that it is not unusual for hospital staff to say to people who have got a complaint that this is the way to go, to the HCCC. In fact it was only a couple of months ago that a pharmacist asked me about a doctor who she had a complaint against. I said that the HCCC is the way to go. I am not alone in that. I am sure that other people do the same thing. I know other people do the same thing. Just on the other bits of evidence, if you look at the complaints that go to the HCCC, and I have got some figures here from the HCCC itself, in 2006-07 it had 1,488 complaints. In 2010-11 it was over 2,500. The number of complaints is increasing. I do not think that means that the health services are being less diligent than they should be; I think at least part of it is due to the fact that there is increased awareness of the HCCC.

Mr ANDREW ROHAN: Just touching on the ability or the unavailability of websites to some people, in ethnic communities and in western Sydney a lot of people do not have access to computers. How can they know their rights? You said people who do not use the internet are becoming rarer and rarer.

Professor PROCOPIS: More unusual, yes.

Mr ANDREW ROHAN: My electorate is in western Sydney and I know as a matter of fact that there are a lot of people especially among the ethnic communities who do not have that sort of access. Even if they have access to computers they will not have access to those sorts of websites or will not understand them as well.

Professor PROCOPIS: I accept there are people who through age or demographics may not have as much access as many other people do. That is why I think it is important for hospitals, emergency departments, et cetera, to make people aware that there is this line that you can take towards the HCCC. Hospitals themselves all have their own internal complaints mechanisms, which is outside the remit of this Committee obviously.

Mr ANDREW ROHAN: I know of one case at least of a person who was in his early to mid forties who was released from hospital and allegedly the release papers belonged to an infant person. He could not understand that. He went home and it was a few days later that he realised that they were not his release papers; they were actually for an infant.

Dr KESBY: I think the other thing is that there does need to be some personal responsibility taken for seeking information. There are a number of outlets of government that should be able to provide appropriate direction and assistance if a patient does wish to make a complaint. It does not simply need to be all computer based. If you are not connected to the internet you do have the option of the local library, the local member of Parliament, and other avenues, even the hospital front desk, which should be able to advise you on submitting a complaint and assist with doing so.

The Hon. PAUL GREEN: We were speaking with the previous witness, Mr Peter Dodd, and we were suggesting having it as part of the process of the discharge plan. You have a checklist, as you would very well be aware, and it may be possible to put that opportunity on the checklist. What are your thoughts on that? What would be the pros and cons of such an initiative?

Dr KESBY: I see nothing wrong with that. The more transparency and making access available to patients who through shyness or otherwise may not speak up by giving them permission by virtue of taking papers away from a hospital with names and addresses is quite a reasonable suggestion.

Professor PROCOPIS: As Dr Kesby says, there are number of other avenues which could be and in fact are available. For example, in hospitals the HCCC has information sheets available in different languages, which is important for people who do not have English particularly as a first language. One of the things that could happen is that that could be increased in volume so that people know what to do if they have a complaint either from their general practitioner, specialist or hospital. It goes across all health providers of course. I mean, even as far down or as far up as a pharmacist or a chiropractor.

Dr KESBY: I think the one concern I would have is that if the focus is going to be on increasing access for making of complaints there does need to be due consideration of budgetary requirements of the HCCC. Whilst we are very pleased with the way they function at the moment, I support Professor Procopis's view that decision-making is influenced by the availability of money, understandably. If we are going to encourage a volume of complaint at one end we need to have it matched at the other with the capacity to investigate or at least triage complaints.

Mr RYAN PARK: When people make complaints to the medical council they will not always be satisfied and they will want an investigation or to have their complaint more wholesomely looked at. Given the often sensitive nature of what they are complaining about, how do you manage those incidents where people are not satisfied? I am particularly interested in not the high profile ones that obviously we all hear about but the ones that are very sensitive in nature, given the role that a doctor or a medical professional plays. People end up in our offices sometimes, they are obviously very concerned about it and believe there has been a cover up by the profession—I use their language, not mine. How do you establish a relationship with them or at least give them some satisfaction that that perception is not right?

Professor PROCOPIS: It is not always possible. The first thing one needs to emphasise is that this is a co-regulatory jurisdiction. It is co-regulatory between the various health councils or professional councils and the Health Care Complaints Commission. The initial assessment of a complaint is always done by joint decision-making between the council and the commission. The commission then may decide to investigate it very thoroughly and at the end of the investigation various things can happen. The complainant may be dissatisfied in the early stages that it is decided not to investigate the matter—even going as far as saying that this is a frivolous complaint and we are not going to investigate it—or up to the later stages of the process where it has been investigated and it is decided after investigation that either no action is necessary or the doctor is interviewed and perhaps reprimanded, cautioned, et cetera, by the council itself. Some people think that the doctor needs to be "struck off" because of what has happened. That cannot be done by the council or the commission; it has to go to a tribunal for that to happen.

If that complainant is dissatisfied what do we do in circumstances like that? They have the option of asking for reconsideration. If that occurs, the appropriate committee does a full reconsideration and may take further action. If no further action is taken, then we explain to the complainant why that has happened. Basically there is not much else you can do after that. The commission itself has staff who are able to communicate with complainants and explain the process and what happened in that process. As I said earlier, it is jointly between the commission and the Medical Council or other health professional councils for that matter.

Mr RYAN PARK: The Nurses and Midwives' Association and others have raised concerns, as have people in regional New South Wales, about the length of time the HCCC takes to investigate complaints against medical practitioners of all forms. Do you share that concern?

Professor PROCOPIS: At times, yes. That is partly a resourcing issue. You said the nursing—

Mr RYAN PARK: Nurses and Midwives' Association.

Professor PROCOPIS: Association, not council?

Mr RYAN PARK: No. the union's representative.

Professor PROCOPIS: Yes. The association expressed concern about the time it takes to investigate doctors?

Mr RYAN PARK: Complaints.

CHAIR: No, complaints generally.

Professor PROCOPIS: Okay. Yes, that can happen. I, and the council, certainly would like investigations to occur more rapidly. It is at least in part, and I think to a large part, resources. Other things come into play. Basically, it is gathering the evidence to be fair to both the health professional and the complainant. The process can be long. When the complaint comes in the council asks the health professional for a response and gives them a time to do it. Sometimes that time is not met, and there is more time and it goes on and on. It is multi-factorial. Again, at every conduct meeting and Greg Kesby can fill in more because he is chair of that committee, we look at the length of time and things that are still waiting to be resolved. There are some outliers, usually for which there is an adequate explanation, but we ask the commission can it please get on with it.

Dr KESBY: If I can just add some comments, the co-regulatory model, as you know, that exists in New South Wales is different to the other jurisdictions.

Mr RYAN PARK: Yes.

Dr KESBY: In our view it is by far superior because it removes that ability for people to say it is doctors investigating doctors or it is just doctors providing a cover-up for their colleagues. It is investigated separately by the Health Care Complaints Commission, some complaints, and prosecuted by the Health Care Complaints Commission. In terms of hold-ups, we visit at every conduct meeting where the bottlenecks appear to be occurring. Historically, there was a greater bottleneck at the level of the HCCC and it put effort into its processes and has improved its processes so that things are remediated from its role far more quickly. There are still delays, and I agree with Professor Procopis, certainly the noises we hear from the HCCC are that some of it is resourced-based; others are just procedural issues that it must follow in getting responses.

The other bottleneck we have, which may be just peculiar to the medical tribunal, although I am not sure, is that there is a delay between the HCCC and the board deciding on a form of action and then referral to the Director of Proceedings, Karen Mobbs. Karen Mobbs has an excellent mind and does a fantastic job, from our view, in deciding whether matters go forward for prosecution. But, again, that is quite a delay in that arm of the whole process. I agree, sometimes we consider matters where particulars come to us from the Director of Proceedings when the decision has been taken to prosecute. The particulars come back for our review and we look at the length of time it has taken for a matter to come to that point. Then, of course, there is a delay in scheduling the matter for hearing. So there are delays at every level, which is very frustrating to the practitioners concerned. We do not like it, but we concentrate on trying to improve the council processes, and I am aware that the other two players, the DP and the HCCC, certainly are acutely aware of those delays as well.

Professor PROCOPIS: Could I add one thing. Ameer, who is seated to my right, has pointed out to me that on occasions some of the delays occur because of coronial inquests or police investigations that occur. If a doctor is complained about for assault or something like that, there are police investigations. We cannot do anything—

Mr RYAN PARK: It is outside the control, yes.

Professor PROCOPIS: —until that sort of thing happens. Those two things are an additional source of delay, though not a large number.

The Hon. HELEN WESTWOOD: How is the co-regulation system going since the national scheme was introduced? It has been in place long enough now for us to understand that if there are some deficiencies or unintended outcomes perhaps we should be looking to government to rectify by legislation or regulation rather than resourcing, being aware of your issues regarding that. Your submission talks about mandatory reporting and perhaps you could expand on that. Are there other areas that you think have gaps?

Professor PROCOPIS: I will deal with mandatory reporting first. As you probably know, mandatory reporting was in place in New South Wales two or three years before national registration came in. The national law was not all that dissimilar in its requirements for mandatory reporting as we had put in place beforehand. There was confusion then and, as we pointed out, there has been some confusion since. It probably has accelerated since the national law because it got more publicity and was a national law. I believe that some people who do mandatory reporting use it as an excuse to report something that they would not have done before because they did not want to be the person who made the report or identified as the person or the institution that made the report. But now they can say, "I'm sorry Bill but I've got to make a report about you because it's mandatory." Even though some of these things may not fit all the criteria for mandatory reporting, it is still treated as a complaint in the same way as any other complaint would be. One could argue that that is a good thing. If there is going to be a complaint and mandatory reporting forced them to make a complaint, then that is a good thing. Although the law is a bit different, I do not think it has made a huge amount of difference to the legal bit itself.

As far as NRAS and the effect on the New South Wales co-regulatory system goes, yes there have been some problems. We have a very close relationship with AHPRA in New South Wales. We talk to it a lot. In fact, Dr Kesby is chair of the New South Wales board of the Medical Board of Australia, which is the AHPRA administration, and I am a member of the Medical Board of Australia itself. We communicate quite effectively and the secretariats also communicate quite effectively to overcome some of the problems that have occurred.

Should there be some changes in the legislation that will help that, yes, there should be. If you ask me exactly what the changes need to be, I would have to take some further advice from my colleague to my right. But there are times when we have had some difficulties and have to work out some patching, as it were, which would make it much easier if the legislation were changed.

The Hon. HELEN WESTWOOD: Could you take that on notice? Would you mind taking a look at that and coming back to the Committee?

Professor PROCOPIS: In a written submission?

The Hon. HELEN WESTWOOD: Yes.

Professor PROCOPIS: Certainly.

CHAIR: The Committee has, in terms of this particular inquiry, done a number of regional site visits, not hearings but information gathering exercises. Certainly one commonality with all of the site visits we have done is that despite the fact that people might know about the local complaints service or the Health Care Complaints Commission what people in regional areas particularly are telling us—I am wanting your comment on this—is that people often are loathe to make complaints because they do not have any options in terms of general practitioners or medical services. For example, in many regional communities if they are lucky they might have one general practitioner but they do not want to make a complaint about the general practitioner because they fear the repercussions. Can you make a comment about that?

Professor PROCOPIS: I can understand it in situations like that. I think the same applies, to a lesser extent because of more availability, in other places. If you have a general practitioner that has been your family doctor for the last 15 years that you previously trusted and your children go to him or her you would be reluctant and to make a complaint. That is human nature. How can we improve the situation? I guess making it known that people can make complaints to the Health Care Complaints Commission. We would take a dim view if a general practitioner got back at the person who made the complaint in some way. We take that as a very bad thing to happen. Off the top of my head—maybe Dr Kesby can think more quickly than I can—off the top of my head I cannot think of ways to remedy that, as much as I would like to.

Dr KESBY: It occurs at other levels in terms of doctors making complaints about doctors in departments as well. From a Medical Council point of view, in terms of maintaining standards, if a departure by a doctor in practice is significant we want to try and encourage those complainants to come forward. If it is a fee or "we waited too long in his office", they may be gripes and we are not concerned if they do not get an airing—from our side of the table. From a patient side I can only make a comment: My experience is that of those small town, single, two or three doctor places that are reliant on area of need practitioners, when complaints have come forward and worked their way through we have had no sense at all that there has been retribution as a result of that. I would like to see it happen more or people feel free to make complaints but, like Professor Procopis, I cannot see how to do that .

CHAIR: There may be no evidence of retribution, it is just a fear, but that is enough to stop someone.

Professor PROCOPIS: The commission has a conciliation and resolution process which can often be beneficial in getting the doctor and the complainant together to sort out those problems.

Mr ANDREW ROHAN: Professor, at your council are there any outreach programs or training sessions that the council conducts for people about the complaints handling process in New South Wales?

Professor PROCOPIS: Not training sessions as such, but we have very extensive information, I am afraid to say, on our website.

CHAIR: You do not need to be afraid, we are just highlighting some comments made previously when we talked about the websites.

The Hon. HELEN WESTWOOD: You mentioned something earlier that I think was similar to the evidence we received from the Nurses and Midwives Association; that the expectations of complainants is that their complaint would lead to a health professional being sacked, deregistered, never being allowed to practice again. I am wondering whether you think there is something we could recommend as a Committee to address that or if that is unavoidable?

Professor PROCOPIS: I think it is largely unavoidable. On the commission's complaint form there is a question for the complainant, which they often do not answer, as to: Why have you made the complaint and what do you want to see as a result of your making the complaint? I think the most common response is—this is anecdotal, I have not looked at it in detail—"I would like action to be taken so this does not happen to other people." A less common response is, "I do not want this doctor to practice anymore." The same applies, I am sure, to nurses and other health professionals. Sometimes that is a reasonable expectation. Often it is not reasonable because often the doctor can be rehabilitated so it does not happen to other people again. One of the things that the medical council or previous medical board have been leaders in is having a performance program in which doctors who are not performing up to scratch will, as a result of a complaint, be put into the performance program with conditions on their registration to make sure that they up-skill and, in broad general terms, be rehabilitated. That sometimes does not satisfy the person who wants the doctor to be really punished. The legislation is not punitive. It is there to protect the public and protecting the public is often not done by deregistering the doctor.

Dr KESBY: If I could make the point that behind the scenes you may be looking at the volume of complaints that are investigated by the Commission. The figure in our submission is around six per cent, it fluctuates between six and eight per cent. Some would think that is a low proportion that goes forward to investigation. You also have to remember that we do have this well-developed performance arm and the Commission is mindful of that. Referrals to Council for matters that are seen to be performance related or borderline performance conduct related will come to the Council for consideration of being managed through the performance pathway. In other jurisdictions in Australia they do not have a well developed performance pathway—although they are looking at developing it—so as a result more goes down a conduct investigation line. So percentages, if you are going to compare across jurisdictions, make us look low on the surface but we are probably comparable if you take into account our well-developed performance pathway.

The Hon. HELEN WESTWOOD: One of the other issues raised with us by the Nurses and Midwives Association was the role of the Health Care Complaints Commission in the tribunal. They did not feel the Health Care Complaints Commission should have a role there as that related to the application for reregistration, reinstatement or the varying or lifting of conditions on a health practitioner's registration: Do you have a view on that?

Professor PROCOPIS: Yes. There are two aspects: one is re-registration and one is conditions. From the re-registration point of view, when doctors apply for re-registration they normally have to go back through the tribunal. In previous years, that was prosecuted by the HCCC, and we found that we got much more satisfactory results by doing it from the council itself, being the council assisting the tribunal as it were. So the commission agreed to do that. In fact, we believe as a result of that things have improved markedly. I would not like to go back to the previous system, where the commission did it, because I think the results are now much more satisfactory.

The Hon. HELEN WESTWOOD: But does not the commission have a role in the tribunal at the moment when you are considering those, or is that only considered by the council.

Professor PROCOPIS: I think it is only considered by the council.

Dr KESBY: Are you talking about re-registration or deregistration?

The Hon. HELEN WESTWOOD: No, re-registration.

Professor PROCOPIS: The council either agrees or disagrees with it. It is easier if the council agrees, which is not all that common but it obviously does happen. If it disagrees, at present the council runs it. That is the change I mentioned—before the commission used to run it. Then the agreement came in, and I think there are much better outcomes from that point of view.

The Hon. HELEN WESTWOOD: In what way are there better outcomes?

Professor PROCOPIS: Because the council, or the previous board, has been involved in it from the word go. This is not an anti-commission statement that I am about to make, but we feel that we have a bigger interest in whether a doctor is re-registered than has the commission; and we have had more success in opposing re-registration than the commission had before. Clearly, we think that is a better result. Other people might not of course; certainly the doctor does not. But, overall, we think it is a more satisfactory reform. Conditions was the second part of your question. It is usual practice for the tribunal to set the conditions down. Obviously the council and the commission have input to that before the tribunal, certainly in the case of the Professional Standards Committee.

Conditions are then imposed on the doctor, sometimes with a timeframe; in others the tribunal will say that the conditions can be reviewed by the council. Again, because the council is responsible for monitoring those conditions, it seems to me that the council is in the best position to be able to say whether that doctor has fulfilled the conditions, has been adhering to them properly, et cetera, and therefore would know, from its expertise in the conduct of health or performance, whether it is appropriate for those conditions to be lifted, sustained or otherwise. In summary, I do not think the Health Care Complaints Commission needs to have a stronger role in either of those two aspects.

The Hon. PAUL GREEN: Your submission also states that council advises complainants to access information through the Government Information (Public Access) Act. Have you received any feedback from consumers trying to access information through that Act? Do you do any sort of survey to get any such feedback? And if so, what are your findings?

Professor PROCOPIS: Unfortunately, my reply is coloured by a couple of doctors who make what we feel is excessive use of that Act. We have, as legislation requires, an officer who is in charge of Government Information (Public Access) Act applications. There are sometimes areas which they ask for which are precluded for various reasons, for example, confidentiality, and excluded reasonably under the Act. Sometimes those doctors are dissatisfied with that. They have options, which they do sometimes take up, of going to as it were to a higher court. My experience is that usually that has been unsuccessful. But most times, if they come and ask for information under the Government Information (Public Access) Act, we obviously give it to them as far as we can, taking confidentiality into account; and most times they are satisfied.

The Hon. PAUL GREEN: Do you have statistics on what you would give out and what you would withhold?

Professor PROCOPIS: We do have statistics, but I do not have them at my fingertips.

The Hon. PAUL GREEN: Would you be able to make those statistics available to the Committee?

Professor PROCOPIS: Yes.

The Hon. PAUL GREEN: Thank you.

Professor PROCOPIS: It has just been pointed out to me that that information is in our annual report. Actually, the annual report is just about to be tabled in Parliament.

The Hon. PAUL GREEN: I am sure that would be intriguing reading, but can we have the statistics particularly dealing with applications under the Government Information (Public Access) Act?

Professor PROCOPIS: Yes. We will give that to you.

The Hon. PAUL GREEN: Thank you.

CHAIR: There being no further questions, I thank you very much, Professor Procopis and Dr Kesby. You have taken a couple of questions on notice. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Are you happy to respond to any further questions that we may have in writing?

Professor PROCOPIS: Yes, I am happy.

CHAIR: I thank you for giving evidence today and for your responses, and we look forward to your written responses to the questions on notice.

(The witnesses withdrew)

BETTY JOHNSON, Chair, Health Consumers NSW, affirmed and examined:

CHAIR: Thank you for coming along. We are sorry to hear that Ms Kokany is not able to join you. We appreciate that you may like to take questions on notice and that is fine.

Ms JOHNSON: Ms Morrison has come to assist me if necessary. Seeing as Ms Kokany is not here, and she was going to make the main presentation, which was to do with mental health consumers and some of their attitudes about the complaints system, would it be alright if she were to write something down to send to you? Because I think this is a very important issue as far as people with mental health problems and they do not often get an opportunity like this to present to people such as yourselves.

CHAIR: Yes, we would appreciate that. I should make you aware that we have heard this morning from the NSW Consumer Advisory Group—Mental Health. But if Ms Kokany would like to provide some additional information that would certainly be appreciated. The transcript of the appearance today by the Consumer Advisory Group will be available for Ms Kokany to look at.

I draw your attention to the fact that your evidence is given under parliamentary privilege and you are protected from legal administrative action that might otherwise result in action in relation to the information you provide. It should also be noted that any deliberate misleading of the Committee may constitute contempt of the Parliament and is an offence under the Parliamentary Evidence Act 1901. Before we start with some questions, would you like to make any opening remarks?

Ms JOHNSON: I would basically like to say that when our previous chairperson, Ms Sally Crossing, accepted the invitation to be involved with this, she did comment that we are a very new organisation and, as such, we would appreciate being given the opportunity in the future of finding out from our members more about that they think about the system of health care complaints. I have been much involved in it in different ways over the years and I was also a consumer member of the Nursing and Midwifery Board and what used to be called—I cannot think what the committee used to be called but it is now a committee that hears complaints from people and works together with the commission. So my association with the commission has been a very good one and I would like to say that I believe that our committee would also like to support the fact that the commission exists and does do a lot of good work for consumers and the community.

CHAIR: You made the comment that you are a relatively new committee. Can you tell us how you see your role as a committee, particularly with regard to complaints in New South Wales, and who your membership is and why do people become a member of the committee?

Ms JOHNSON: Our membership is mainly organisations of consumers; they are the people who can vote at our meetings. We also welcome and have got a lot of individual members. Our aim is to work for the interests of the health consumers in New South Wales. The reason why we are very new is that we were unable to get support to bring this group together, it being the last State to have a consumer representation group. What we basically do is gather the opinions and ideas from other consumer groups and we present them to the Government, to the Health ministry, via various staff members, and the Minister.

We also represent the opinions of these people at other places as well. We have members on many committees of the Government as far as health issues are concerned and we meet together with our other members and other members of consumers to talk about the issues that are of concern to consumers. We are involved with various campaigns, and one of them I would like to mention. There is a rising campaign on what is called health literacy. Health literacy is something that is being talked about a lot throughout the world at the moment as something that particularly affects in our community people from other cultures and people who are disadvantaged in many ways, particularly economic disadvantage.

It has been found that in Australia about 55 per cent of people in the community are not health literate, which means that they do not understand what is happening in the system nor to their own body. I understand from reports I have gathered that about 22 per cent would be somewhat literate but not entirely. So this is something that people do need to have a much better knowledge of what is happening in the system and to their own body. I feel that what is of concern to us is that most people do not know that the health care complaints system functions, and functions on their behalf, would be of no charge to them and has a very good reputation, I believe, in helping people if they have a complaint to make. That is the main thing I want to talk about, based on the need for better health literacy in the community, for the health commission to be better known to the whole of the population.

I do think, and I have read the paper from Merrilyn Walton on data, and I agree with that, and also I note that she says more people are using the health complaints system. I would suggest that a lot of people who do not know and are reluctant to use it are older people. Older people do not like to complain, certainly about things where they feel someone is doing something for them, and although something goes wrong—as happened to me in recent times, and I feel I can look after it myself—most people cannot and I think it would be very good if the Health Care Complaints Commission were better known to the population, better available to them, so they can have a better understanding of what they can do to make things better for their own health by changing things from letting people know when things go wrong.

CHAIR: Thank you. That is a lot of information. I will start on one point you said, and I acknowledge and appreciate the brevity of the submission you put in previously. We look forward to receiving further information from you, particularly about the mental health issue. One of the things you raised was about people's health literacy and not knowing that the Health Care Complaints Commission exists for a start. This inquiry is interested to know how does the commission raise people's awareness about what its role is and what it can do for them as consumers?

Ms JOHNSON: To begin with, in health services, in hospitals, to have signs about so people know that a complaint is not regarded as something that is unwelcome. I believe in some of the groups I have belonged to—I used to be on the executive of the Australian Council for Safety and Quality Health Care, before it became a commission, and I have been involved with them as a commission—people should be informed by having things on the wall just to say that complaints are regarded favourably. I got diverted from my own words: There is a lot of evidence about now that complaints can make changes for the better and people need to be made aware of that, that they are not unwelcome and they can be a great advantage to everybody, including health professionals.

CHAIR: You also made the point, and I think a valid one, with regard to elderly consumers and their reluctance to complain. One of the things we have talked about in this Committee is complaints versus feedback. What are your views on that? If elderly people were given the knowledge that the feedback they were providing would assist in improving the system rather than making a complaint, do you think that would have some bearing on it?

Ms JOHNSON: I do. I know from my experience as far as nursing and the midwifery board is concerned, when we get complaints they are not regarded as being—let us say, we are not there in order to punish people. If they have done something wrong, I know the best way to deal with it is to find out what happened and do something to help people. If they have been at fault it could be from their own lack of knowledge and therefore assistance can be given to them. I think the health care complaints system works like that, not necessarily from the commission alone but by the organisations of professionals involved. So, people need to know that their complaints are not necessarily used as something to punish somebody.

Mr ANDREW ROHAN: From your experience, are there any significant differences in the complaints made by health consumers in rural and regional areas as opposed to metropolitan and city communities?

Ms JOHNSON: No, I have not had any direct experience of people talking about this. I thought one of our other members from the countryside who was on the Health Care Complaints Commission board might come, but she was not able to come today. I would imagine it would be even more difficult for people in rural areas to make complaints. The nature of a small community, the nature of relationships in town with the staff and the community, is a very difficult one if it comes to making a complaint about them.

Mr ANDREW ROHAN: Do you think that everybody knows everyone in these regional communities contributes to that, everybody knows everyone?

Ms JOHNSON: No, I do not think that is necessarily so. I have heard of some country towns where most of the people who are employed are employed in nursing homes and/or hospitals and people would be very reluctant to complain if something goes wrong. In that sort of situation, when they are so dependent on the skills and knowledge of those people, therefore they do not make a complaint. If I can put something more in writing about that, I will get something from Patricia LeLievre about what her experiences are of country towns.

CHAIR: Which organisation is she from?

Ms JOHNSON: She is from rural health consumers.

CHAIR: That would be appreciated.

Ms JOHNSON: Thank you.

Mr RYAN PARK: We have talked with other groups about whether there is adequate support and advocacy for people who are making a complaint.

Ms JOHNSON: No, there is not.

Mr RYAN PARK: Some people have suggested the model of having common patient advocates in hospital clearly marked, et cetera, going back to a system where they are all called one name, they are all well known, this is the person who can advocate for you—I am talking about the health care setting, more than an individual service—what suggestion do you have in relation to the improvement of advocacy?

Ms JOHNSON: A lot of hospitals have what they refer to as the patient's representative. People are reluctant to use them for complaints because they are hospital employees. People basically need to have advocates who are not employed in the system. People like me and other groups—I get involved with older people's organisations—people will speak to us about their complaints, and I would advise them to go to the Health Care Complaints Commission if it is a serious enough complaint. I would mainly advise people to speak to the complaints people in the hospital. I think there are an awful lot of them now able and willing to hear those complaints. I think hospitals make a big showing in terms of being willing and wanting to hear if something is not working properly for their patients. I would say yes, people need to know that it is there. I have never seen a sign around a hospital advising people if they need help, if they want to make a complaint, or, I would prefer to say, if they want to talk about something going wrong. The word "complaint" is a difficult one for people to acknowledge they are making a complaint, but to tell you that something has gone wrong for them is much more desirable and possible.

Mr RYAN PARK: "Complaint" has that element of whinger about it.

Ms JOHNSON: It has, yes.

Mr RYAN PARK: Which, to be fair, most people do not want to be.

Ms JOHNSON: A complaint also indicates that you want somebody to be punished and that is what would be against it. I think it would be a good idea to change the name of the complaints commission.

The Hon. HELEN WESTWOOD: It seems to me that from what you have told us you would support the recommendation we heard from the Public Interest Advocacy Centre [PIAC] this morning, which was for a patient support officer that would be an independent advocate separate to the HCCC.

Ms JOHNSON: Yes, it must be independent.

The Hon. HELEN WESTWOOD: I asked PIAC whether they thought it should be a separate entity and they said they would rather have it within the HCCC than not at all, although their preference would be for there to be an independent patient support office.

Ms JOHNSON: Absolutely. I would agree with that.

The Hon. HELEN WESTWOOD: You would support that?

Ms JOHNSON: Yes, I would. I am sure our organisation would agree with that too. Incidentally our organisation is funded by the government, but we are independent.

The Hon. HELEN WESTWOOD: Yes, I thought that was the case. The other issue that has come up is the need for health consumers and their families to have information or some way of getting support while they are receiving treatment, whether they may be in a hospital or in outpatient care. Do you have a view on that? Perhaps there could be a support telephone line that they could rely on.

Ms JOHNSON: Yes. I had a recent experience in hospital and I will relate this also to the health literacy things. I was in a ward of three people. There was one woman who was Greek. She spoke English reasonably well. She needed some support and had no idea that she could get it. There was another woman who would be economically disadvantaged. She had brought up two sons by herself, having two jobs. She is the sort of person who referred to herself as, "I know nothing." She did not want to put herself forward as knowing anything until I was able to say to her a few times, "You do. Look what you have just said to me." Then I would repeat back what she said. People need to have that sort of support.

These two people were spending time in the hospital worrying about what would happen when they went home. The one who was economically disadvantaged was not even thinking about the fact that she was going out after a heart operation but that she had an arm in a plaster, because they had found out about this heart problem after she had a car accident. She just did not know what she was going to do. She told me her problems and all I could say to her was to talk to a social worker. The social worker should have contacted her when she went there; not later on, not when she is going home because she is worrying all this time. She had been in hospital two weeks by the time I met her, and so had the other lady. Neither of them knew what was happening to them.

One of them did not know why she was not going home. She was not going home because her warfarin had not kicked in. I suggested she ask, and that is what she found out. She was a lot happier. She was confused and did not like to ask, did not like to worry the doctors with her questions. I think if there were something more for the patients it would be very welcome. Carers are doing reasonably well with having signs on walls advising people who are carers or advising people what their carers might need. I think everybody needs something like that. Thank you for raising that with me.

The Hon. HELEN WESTWOOD: I have to say that the evidence that we have had before us has been really useful. Another area which I would be interested in your view on is the issue of re-registration or reinstatement of medical practitioners where they have been deregistered, time has elapsed and they have been deemed to have been rehabilitated, or perhaps where they had restrictions placed upon their registration. I wonder whether you have a view about the existing process for that.

Ms JOHNSON: I have got a problem: I am part of that process. I am on the board of the New South Wales Nursing and Midwifery Board, so I am one of the people who make the decisions. I can give you my personal and frank opinion.

The Hon. HELEN WESTWOOD: I would be interested in that.

Ms JOHNSON: I see that some of the problems happen a lot to women who have given up work to have a child. Sometimes they think it will be one child and then they stay and have two or three and they end up being beyond the five years that they are supposed to come back within. I think it is very difficult for them. On the other hand, one of the things that I appreciate and have said so many times when I was on the Nursing and Midwifery Board and on the New South Wales council, as it has become, was always when we make a decision on that or on the other board that I am now on we always say is it in the interests of the community. That is what comes first. I think that it is terribly important that the staff should be well trained and up to date in their training. Having been in hospital several times in my lifetime and spent most of my childhood in hospital I have seen that it is a real problem in terms of when changes are made. The changes have always got to be on the side of the community. They must also be on the side of the professionals, but the community comes first.

The Hon. HELEN WESTWOOD: One of our witnesses this morning suggested that the HCCC should not have a role in the consideration of re-registration for people and practitioners who have been struck off or a reinstatement of full registration where there have been limitations to their registration or the areas in which they can practice. Do you have a view on that?

Ms JOHNSON: If they could advise the people who are doing the re-registration of other events of similar cases and so on that would be useful. But I think also I agree with the discussion in the paper by Merrilyn Walton and her friends on data and the need for more data. That would be of use to anybody, including the commission, and also to people re-registering.

CHAIR: What is the name of the paper to which you are referring, by Ms Merrilyn Walton?

Ms JOHNSON: I will leave you a copy. It is "Health complaint commissions in Australia: Time for a national approach to data collection" by Merrilyn Walton, University of Sydney; Jennifer Smith-Merry, University of Sydney; Judith Healy, Australian National University; and Fiona McDonald, Queensland University of Technology. Would you like me to leave this with you?

CHAIR: If we could have a copy, that would be great, and we will distribute it to the Committee. Thank you.

Ms JOHNSON: It talks mainly about the need for data collection and what the Health Care Complaints Commission is doing.

The Hon. PAUL GREEN: Has your organisation had any dealings with the Australian Health Practitioners Regulation Agency? If so, do you think such an agency has a role to play in acting as a focal point for consumers? If not, why not?

Ms JOHNSON: We have. Some of our members have attended some of their workshops. I did not know about that.

The Hon. PAUL GREEN: Perhaps if you could take that question on notice.

Ms JOHNSON: Yes, thank you.

The Hon. PAUL GREEN: We will send it in a letter and maybe you could answer that more fully in light of the fact that you did not have any knowledge of that?

Ms JOHNSON: Yes, certainly. We will find out from our members.

The Hon. PAUL GREEN: Has your organisation researched health complaints and health complaints management in other jurisdictions?

Ms JOHNSON: No.

The Hon. PAUL GREEN: You are not aware of where best practice might be occurring across the globe?

Ms JOHNSON: No. We as a organisation have not. All I know is that I have been told that New South Wales is very good. One of the reasons why New South Wales is in a different position as far as the Commonwealth's newly set-up commission on registration is that some of us went from New South Wales to see the New South Wales Minister to say that we wanted to maintain our complaints situation as it is with the Health Care Complaints Commission and that we would not be happy to go in one that covered the whole country. New South Wales is the only one that stands out from that Commonwealth registration board because it apparently said it would not go in with what was happening in the Commonwealth if we were not allowed to keep our own complaints commission. That is hearsay from me.

The Hon. PAUL GREEN: So New South Wales is number one in something?

Ms JOHNSON: Yes, I am sure we are number one in many things to do with the health system.

The Hon. HELEN WESTWOOD: We spoke earlier about the ways in which we thought that health service providers could improve their information to patients about names and terms that could be changed?

Ms JOHNSON: Yes.

The Hon. HELEN WESTWOOD: Have you seen anywhere in New South Wales or beyond where you think they are doing it well or right?

Ms JOHNSON: I would say doing it well. You can always be better.

The Hon. HELEN WESTWOOD: Have you seen somewhere doing it well?

Ms JOHNSON: I think the complaints commission is doing it well. What came out to me when I was on the nursing and midwifery board is that it could have done with more resources to do it a little faster. I could imagine that if we ask, which we would like to do, our members for some experiences and ideas about this, I am sure some of them would tell us that it should be quicker.

The Hon. HELEN WESTWOOD: Do you know of examples around New South Wales where you think health service providers, such as hospitals or area health services, have improved and have it either close to right or somewhere near where you think they should be?

Ms JOHNSON: No.

The Hon. HELEN WESTWOOD: Not one?

Ms JOHNSON: I do not know that. The only hospital I really know well is North Shore and the hospitals around there. I am on the Northern Sydney Local Health District Board and that covers all those hospitals from Hornsby to northern Sydney, Mona Vale, Manly and so on. I know that they are very keen to tell us how many complaints they have dealt with and how successful they are, and I do not know about any others. I will find out more about that one.

CHAIR: Thank you, Mrs Johnson, for providing the Committee with some very informative data and evidence. You have taken a number of questions on notice?

Ms JOHNSON: Yes.

CHAIR: We appreciate that. Those additional questions will form part of your evidence and be made public. Are you happy to provide written replies to those further questions?

Ms JOHNSON: Yes.

CHAIR: Thank you very much for attending today and for the information you have provided.

Ms JOHNSON: Thank you for helping me make it much more interesting to me than it would have been if I had not been asked your questions.

(The witness withdrew)

(Luncheon adjournment)

KIERAN TIBOR PEHM, Commissioner, Health Care Complaints Commission, sworn and examined:

CHAIR: Welcome to the hearing. I thank you for your submission to the Committee and for the evidence you will provide. I draw your attention to the fact that your evidence is given under parliamentary privilege and you are protected from legal or administrative action that might otherwise result in action in relation to the information you provide. I also note that any deliberate misleading of the Committee may constitute a contempt of the Parliament and an offence under the Parliamentary Evidence Act 1901. Before we commence with questions do you wish to make a brief opening statement?

Mr PEHM: Yes. I have been Commissioner for a bit over seven years and I would have to say in general that complaint handling in the public system has improved significantly over that time. I have read through the submissions to the Committee and it is a bit disheartening because the same themes still exist quite strongly as have always existed in this system. So far as consumers are concerned there is a lack of awareness or confusion about where to make complaints, difficulty in accessing relevant complaint mechanisms and finding the right place to go. A number of the submissions say that once the complaint is made they feel the system is not responsive to them, does not deal with their individual concerns and there is a bias towards practitioners.

Submissions from providers, on the other hand, feel the complaint system is unfair to them, it is adversarial and I think it is fair to say that the providers are on a cultural journey from a defensive position to eventually engaging constructively with complaints. There is still a lack of skills in the provider population in dealing with complaints. The Health Care Complaints Commission is caught in the middle of this gulf and gets tarred by the opinions of both sides as to its own performance. I was disappointed to see the Country Women's Association's submission that: The Health Care Complaints Commission are bureaucrats who protect their colleagues and peers. On the other hand, some submissions from practitioners, the Nurses and Midwives Association in particular, said there is an adversarial approach to the complaints system, they will not participate in any resolution processes and do not see why they should have to explain complaints that are the system's fault and not theirs.

The Australian Medical Association says that the commission prosecutes minor matters and abuses its powers under section 34A to hold compulsory interviews—both of which I reject of course. There is a submission from an individual practitioner that calls the commission, "Legalistic, threatening and truculent", which I would also reject. I understand this inquiry is not into the Health Care Complaints Commission but into the complaints system in general. The extracts from those submissions I have outlined demonstrate that the health system has a long way to go towards dealing positively and constructively with complaints and there is still a vast gulf between the consumer and provider side of the equation.

CHAIR: Obviously you have read through a lot of the 18 submissions the Committee received. The questions that we pose today will be drawn from those submissions but also you will be aware that the Committee made three site visits to regional areas other than those where it held hearings in order to gather information. There are a range of issues that have arisen and the Committee will cover a lot of them. In more general terms, and as some preparation for you, the main issues were around communication and, as you have noticed, the apparent lack of awareness of consumers of what the Health Care Complaints Commission does and what its responsibilities are.

There have been issues raised about the timeframes for resolution of complaints and the appropriateness of the information that is out there about the Health Care Complaints Commission. You will note from the hearing list that we have met with some advocates, particularly from mental health, which has been raised on considerable fronts. There were some issues raised about perceived budgetary restrictions of the HCCC, so no doubt we will ask you for some comment on that. Access to root cause analysis documents both in terms of the HCCC and the Coroner was discussed this morning as well. Those are in broad terms some of the issues on which the Committee has heard evidence, but there are probably others.

Mr RYAN PARK: Commissioner, the issue of resourcing has come up quite a bit in evidence. I know all government departments and certainly people at your level, no matter the colour of government, will always want additional resources. But is there a component of resourcing at the moment that you are particularly concerned with? Is it just the quantum, or is it a component to do with specific programs, or allocations to investigations or education, et cetera, where you think there is a definite gap that impacts on the performance of the HCCC? I ask the question because witnesses are telling us that resourcing is a considerable issue.

Mr PEHM: I am in the happy position of being able to say that our resourcing problems have been largely resolved for the next financial year and ongoing. I did express concern in last year's annual report that the commission had to cut the level of customer service that it delivered to complainants because of an increasing number of complaints—something like a 50 per cent increase over five years—and that the commission could put less time into speaking to complainants on the telephone and explaining to them the reasons for decisions. Those things always go easier and more smoothly when people can talk face-to-face. Fortunately, after making submissions to the Minister and to government, the commission has received about a 9 per cent increase in funding for the current 2012-13 year, and that increase will carry on into forward estimates. So there is really no need to go into specific areas that were affected in that eventuality.

The Hon. HELEN WESTWOOD: Mr Pehm, I have a couple of questions particularly around the national scheme and co-regulation. That scheme has now been in place for a couple of years. I asked the Medical Council the same question earlier. Have you had time to assess whether there are gaps, deficiencies and unintended outcomes and whether the Committee could be making recommendations to the Minister about the review of legislation or even further regulation?

Mr PEHM: When New South Wales went into the national system it went in only so far as the actual regulation of practitioners was concerned. So all of the complaints handling, which is the commission's major job, was not really affected in any significant way by the national scheme. We have a lot of contact with the AHPRA [Australian Health Practitioner Regulation Agency], which is just administrative contact getting updates to the register and checking practitioners' registered addresses on the register so we can contact them—very straightforward administrative things. The other interaction with AHPRA is where the end of a prosecution affects a practitioner's registration, so that AHPRA needs to be notified what the outcome is so that if it affects their registration it can go onto the register. But that is all working fairly smoothly, and I am not aware of any problems that require addressing legislatively.

The Hon. HELEN WESTWOOD: We heard this morning from a witness who suggested there was a need for a patient support office; that previously, when the HCCC had that role, it worked well, and that now there is no provider of such a service, an independent advocacy role. Do you have a view on that, and do you think such a role could fit within the HCCC or should be an agency independent of the HCCC?

Mr PEHM: When I started at the commission it had about eight or nine what were called patient support officers; and the feedback at that time from the practitioner side of the equation, from the health service providers, was that they felt a significant apprehension of bias in the commission on the complainants' side. We went through an internal debate with those patient support officers, and those officers in effect became our resolution officers, and we market them as being impartial resolvers of complaints, neither on one side or the other but interested in brokering a solution. I think there is a place for patient advocacy. There are patients who for a number of reasons can find it very difficult to articulate their complaints or are not confident enough to even bring forward their complaints to start with. I think it is an uncomfortable position for the commission to have that function, because that again would raise that problem which I thought we addressed by changing our patient support officers into resolution officers: What precisely would be the commission's role there—to be supporting complainants or to be an impartial complaint manager?

The Hon. HELEN WESTWOOD: A particular case came up during our regional site visits. I will not mention the case; it is more the issues it raised. This was a sad circumstance where quite a young and healthy woman entered the health system and died as a result of an emergency procedure. Her family had made complaints. They spoke to us about the way in which the HCCC was communicating with them; they were not satisfied. I am wondering whether cases where you have very tragic and extreme outcomes should be put in a category that ensures there are not any communication errors, or miscommunications; where extra sensitivity is brought to those cases when there are these really tragic outcomes that leave families incredibly distressed and grieving while the complaint handling process is going on.

Mr PEHM: I am sorry to hear about that case, and I hope it is not too recent an experience for them. The culture that we have tried to cultivate at the HCCC is to engage personally with people, respondents and complainants. The precise degree of attention that people get depends on a whole lot of factors, like their willingness to engage and their capacity. Some people are grieving to such an extent that they cannot even continue with the complaint system. We do engage on a whole lot of levels. Just on Friday my Director of Investigations went out with an investigation officer to a discussion with a family in a similar situation. It was a terrible situation for them; a young man died. So they were meeting his mother and his grandmother to explain to them the outcome of the investigation and why decisions were taken. It is hard to be more responsive without knowing the particular case.

The Hon. HELEN WESTWOOD: In that case, was the family Sydney-based?

Mr PEHM: They were.

The Hon. HELEN WESTWOOD: The case I am referring to was regional, and I think that was part of the issue: there was no face-to-face contact because they were in the southern part of the State. They certainly felt that there was this real disconnect between themselves as the complainant and the HCCC as the agency dealing with and processing their complaint.

Mr PEHM: Again, I am sorry to hear that. I can think of cases where we sent investigation officers out for a week to a regional area to speak to the complainants, to do the investigation, to take statements from respondents and so on. It poses extra difficulties in terms of travelling and expense from time to time, but if it is justified we certainly have no hesitation in doing it.

CHAIR: The Committee has had numerous representations about the length of time it takes to resolve an investigation. That probably relates to a fairly tragic outcome and I accept that these people are grieving. One of the issues raised is that a number of different case managers have been involved and those involved did not feel that there was a person they could contact within the commission. They were also upset about receiving bureaucratic letters. Has any thought been given to flagging those sorts of tragic cases, and sadly there have been a few?

Mr PEHM: Those cases are not uncommon in the health system. It is unfortunate that people die during medical procedures. There is terrible grief associated with that and we are very conscious of it. The complaints are assessed very carefully. Every letter sent out includes a contact name and phone number. I am surprised that they did not know who was handling the case. In the seven years that I have been with the commission there has been a lot of folk lore and stories about bad experiences some time ago. I would be very surprised if they did not have one person to talk to. That is one thing we have focused on providing.

Complaints go through an assessment process and an assessment officer will handle them. That usually involves getting a response from the hospital or the provider so that we can make the right decision. It may be that it is appropriate to investigate something and not to send it for resolution. Many people want investigations. That assessment process involves one contact officer who should be taking them through the process. First, the officer should call the complainant when we receive the complaint to clarify that the written complaint encapsulates their concerns. They should also call them before the decision is communicated to them in writing so that they understand the reasons for the decision. I mentioned earlier that we have had to cut back customer service in terms of talking to complainants over the past year or so because of resources problems. That may have had an impact and that was reflected in our customer survey feedback. People obviously appreciate being spoken to, knowing that we understand what they are going through and that they are being taken seriously. That is very important in effective complaints handling. We are in a position to do that more now and our customer survey feedback has improved significantly in the past three months or so.

With regard to the time taken to resolve complaints, the 2011-12 annual report indicates that 21 per cent were completed within a month, 70 per cent were completed within four months and 95 per cent were completed within nine months. A small number—32 cases—took more than nine months to complete, which is too long. The resolution officers tell me that in these grieving situations the process is often conducted at the pace that is most comfortable and amenable for the complainants. People are often not ready to go into meetings or situations when things are still raw and they are grieving. Again, that is good feedback for us to have. I am sorry to hear that. As I said, it may be partly a result of the past couple of years when resources were tightened and assessment officers could not spend as much time speaking to people as they can now.

CHAIR: The Committee's concern is cases that are still going on after three years. That has rung alarm bells.

Mr PEHM: For resolution?

CHAIR: Yes, and investigation.

Mr PEHM: We can deal with investigation separately. I saw the Australian Medical Association submission and the others that talked about delays in prosecution. No resolution cases would still be going after three years; nothing has been on our books for that long.

The Hon. HELEN WESTWOOD: We have the details and we can share them. The other issue in this case was that it was in a regional town and the practitioner was still operating. It was found that the practitioner did not have the competency to carry out the procedure that resulted in the woman's death. There was a real concern that that practitioner was still the only option in terms of providing that service in that town. That was some of the feedback we were getting from the family and community.

Mr PEHM: There is a bit of confusion on my part with regard to the terms used. That sounds like a case that has gone to investigation and been prosecuted. If the practitioner has been found by a tribunal or someone else to be—

The Hon. HELEN WESTWOOD: I think the Coroner found that the lack of skill on the part of the practitioner caused the death. That is my recollection.

Mr PEHM: The Coroner would not make a decision on competence. There might be a finding of lack of skill, but the Coroner would not remove the practitioner from the register—

The Hon. HELEN WESTWOOD: No, I am not saying that.

Mr PEHM: I provided the statistics about the resolution of cases. They certainly would not run for three years. If a case involves investigation and prosecution it may well take that long. The investigation can take nine months to a year, but prosecution is a delayed process.

Mr RYAN PARK: That is out of your hands; it is a police matter.

Mr PEHM: If it is a police matter that is a further complication. If a practitioner has been charged with a criminal offence we will sit back and wait for the charges to be finalised. That can take one or two years and sometimes more. Once we decide to prosecute we are one participant in the process and it is not entirely within our control. We are the prosecutor, so we have to a compile a brief of evidence and serve it on the defendant—in this case, the practitioner. The defendant will be legally represented by their union in the case of nurses and midwives or by insurers in the case of medical practitioners. They will be well and heavily represented. The timetable for prosecution is in the hands of the disciplinary bodies, the tribunals or the professional standards committees. That can be complicated by all sorts of factors, including the availability of counsel, the amount of time people want to argue about what should be included in the complaint and procedural issues. That sort of thing can drag on for a long time.

I think everyone involved in the system recognises that prosecutions take too long. We now have another complication with prosecutions. We have appeals by practitioners to the Court of Appeal, which has found recently that prosecutions should be done in two stages. The first stage establishes guilt or innocence, to put it simply. There is then a further hearing to determine the penalty. That is the criminal process: first they determine guilt and a further hearing is held to hand down the penalty. It used to be one hearing. Sometimes those second hearings are held six months after the first hearing. I do not think there is a good reason for that in most cases, but that has added to the delay. In a sense, the more professional our prosecutions have become the more heavily they have been defended and the more legalistic the whole process has become. That has been difficult for the disciplinary bodies to manage. On the one hand, practitioners complain about the delay, but on the other hand they can contribute to the delay by arguing every point. I do not condemn them for that; that is their right.

The Hon. HELEN WESTWOOD: I think that was part of the situation in this case. The practitioner took some time to get the information back to the Health Care Complaints Commission. The complainants thought they were delaying the process.

Mr PEHM: That is possible, if there was a coronial hearing as well. I saw in one of the submissions the question of the extent to which we interact with the Coroner, and we have a memorandum of understanding with the Coroner, we exchange information. Depending on the nature of the case, either the commission or the Coroner can take the main running of the investigation, and we have had cases where we have done practically all of the investigation and given our material to the Coroner to determine whether or not to have an inquest.

There are other cases where it is fairly clear early on that the Coroner is going to hold an inquest and they will have the carriage of the investigation, and in those cases we will sit back and wait for the Coroner to finish and then receive the benefit of their evidence, otherwise it is very confusing for the practitioners to have multiple points of inquiry coming at them. So if there was an inquest in that matter, that may well have contributed to the delay as well.

Mr ANDREW ROHAN: In your submission you pointed to an increase of complaints to the commission, which in your opinion is attributed to increasing awareness among consumers. Is there any evidence to suggest that or is it just a case that consumers are faced with more problems or being more likely to complain?

Mr PEHM: That is a good question and one that everyone has been asking for years and years: What is the relationship? Certainly the proportion of the overall number of complaints that we get has steadily increased over the years. So, over the total, more and more consumers are complaining. Why they complain, whether they are more aware of complaint avenues—the health services, I think, are better advising them of where they can complain. But it would be pure speculation as to say why that is. Whether there is a general culture of complaint and people are more willing to assert their rights now than they were perhaps 10 or 15 years ago—I think it is very dangerous to be speculating about the quality of service or to directly link complaint numbers to poor service delivery. I have got a chart here about our website. In the last four years, in 2007-08 it was 278,000 hits and last year was five million. So it is a massive increase, certainly in the website traffic. I do not think they are individual user—

The Hon. PAUL GREEN: They are hits. In terms of the prosecutions and the tribunal hearings, we are hearing that some of those are probably taking too long. Has the commission looked at ways that it can maybe streamline some of this consistent complaint handling? One of the issues is that the recency of practice that nurses need to have, for instance, is being compromised by these prolonged prosecutions or situations and then they virtually lose their right to practise and then have to come back into that as well. Has the commission looked at what sorts of cases and whether there could be a critical pathway for some as opposed to the usual elongated investigation process?

Mr PEHM: The only way that a nurse would not be—since you raised nurses—

The Hon. PAUL GREEN: The Nurses and Midwives Association raised it.

Mr PEHM: The commission does not control the employment of the nurses, and the only way a nurse would not be practising would be if the Nursing and Midwifery Council felt the conduct was so serious that they should be suspended, and in that case it would be very rare that at the end of the prosecution it was not found sustained. So again, I think the Nurses Association's submission is generally adversarial to the whole complaint system and I would question whether the case that they are raising is really a significant problem with the system.

The Hon. PAUL GREEN: In terms of the Medical Council that talked about bottlenecks of the Health Care Complaints Commission, do you see any obvious bottlenecks with the process that you have got and how we can manage them? For instance, they were talking about resources—and you have already addressed that one—the procedures, third-party delays, as you have mentioned parties might try that if they genuinely want to protest. Are there any that you are aware that we are not meeting or trying to deal with that can be delaying times?

Mr PEHM: I cannot say that I am, but you might expect to hear that from me. I am obviously doing everything I can to make sure the commission does everything it can to make things as quick as possible. I am happy to talk to the Medical Council to see if there are any particular areas they do have concerns about and work on them. One area that was relevant in the delay with prosecutions was the decisions of the chairs of the tribunals in setting matters down, and this is a problem in all litigation; it has been a huge problem in the court system and it is the whole idea of setting a timetable and making people stick to it rather than: the barrister cannot turn up on that day—okay we will just adjourn it for three months; they cannot turn up on the third month so we will have another two weeks, and this sort of thing. The chairs and deputy chairpersons of all the Tribunals have recently been recruited, replaced, and we have been in discussion with the councils about how the tribunal should operate in terms of setting firm timetables and making that prosecution process quicker.

The Hon. PAUL GREEN: In terms of complaints regarding correctional facilities and medical centres, I notice in 2002 there was about 3.5 per cent; in 2010-11 it was 8.9 per cent. How are the stats going this year in terms of complaints?

Mr PEHM: They are up again.

The Hon. PAUL GREEN: Sorry, that was a little left-field to what you are probably expecting.

Mr PEHM: No, I was just having a look at this actually: 8.9 per cent in 2010-11 and 11.2 per cent in 2011-12.

The Hon. PAUL GREEN: What do you attribute that increase to? If it is growing is that a concern, or what do you attribute that growth to?

Mr PEHM: Again, it is hard to speculate. Some prisoners, often when they get into the prison system it is the first time they get regular health care so a lot of problems come out. Prisoners have fairly easy access to the commission; they can send correspondence and call the commission. Again, I would be very reluctant to speculate on any link between the quality of service. Prison numbers have been going up fairly consistently for some time, although in the last year I think that has dropped off. The numbers are still small: it is only 35 complaints more than we received last year.

The Hon. PAUL GREEN: It is 166, is it, this year?

Mr PEHM: One hundred and seventy-one. It is quite rare for a complaint from a prisoner against the prison health system to be serious enough to require investigation. So the bulk of them are, again, service issues—the nurse at the unit was rude or I did not get the drugs. There are a lot of complaints related to the dosing of heroin replacement substitutes—methadone and buprenorphine—and there are complaints about the way people are made to take doses and that sort of thing; that is a fairly significant number.

The Hon. PAUL GREEN: Earlier it was suggested to the Committee that New South Wales might benefit from adopting a similar model to one operating in New Zealand in terms of the advocacy program over there, to offer advice and assistance to health consumers who have made a complaint or raised concerns over health services. One of the intentions is that fewer complaints would be incorrectly sent to the commission. Are you aware of the New Zealand Health and Disability Advocacy Service?

Mr PEHM: Yes, I have been to New Zealand and had a look at their service.

The Hon. PAUL GREEN: Would you suggest that that service would be appropriate in New South Wales?

Mr PEHM: I think advocacy is good to assist people who need assistance. Again, I have problems and I think this is a problem in New Zealand but it was particularly a problem in New South Wales in the perception of partiality within the commission if the commission housed that advocacy service, because from a practitioner's point of view they would see the commission in two different lights at one time: on one hand you are supporting the complainant and you are representing the complainant; at the same time you are still supposed to make a decision about whether it will be investigated or prosecuted. For practitioners it created a perception of bias in the commission, which we do everything we can to address and dispel.

Mr RYAN PARK: Commissioner, patient advocates who operate within hospitals—some operate within hospitals—and I am interested in this model. Do you think there should be in those large hospital-type settings—and I am not saying that is the only place where complaints are a problem—but in those large settings such as hospitals, that there should be a person very clearly defined as a patient advocate, not under any other name?

Mr PEHM: They are called patient support service, and some places have them and some do not.

Mr RYAN PARK: I understand they are not in place within every hospital?

Mr PEHM: I think the same thing applies in the hospital setting in that those advocates, whatever they are called—and we have been out to the LHDs and talk to the people who manage complaints out there, and they face the same problems as we do in terms of getting responses from practitioners. I think the advocacy role is better off independent from the hospital because, again, those people are put in a very awkward situation: You are our advocate but you work for the hospital, who is paying your bills. If there is to be an advocacy service it is better off independent. I go back to my opening remarks about this gulf between practitioners and complainants. That is a really complex thing and the reasons it has come about are various. I think for a provider to employ someone to support a complainant puts that support in a very awkward position.

If I can go a bit further on that, the whole advocacy need is predicated on the understanding that patients are powerless to complain or they need support to complain. Really, the onus should be on the providers to engage with patients, as they should all the way through, right from the start, about informed consent when you are going in for an operation. They should be having the hard discussions about unforeseen side-effects, the end of life discussions, which is a big source of complaints, the family is not involved in understanding what is going on. They are difficult conversations to have. Once you let providers abrogate the responsibility for those conversations and for communicating effectively with patients, that is when you need advocates and all these other people to pick up that role. In effect, that is what the commission does in lots of ways with its resolution service.

The real challenge for the system is to equip providers with the skills to be able to engage constructively with people and not see it as an attack or a threat to their professionalism or somehow is going to damage their reputation or expose them to legal liability. There is a lot of fear in practitioners in engaging openly and honestly with people. That is the biggest challenge. In a sense, advocacy and other things are band-aids to that essential problem.

The Hon. HELEN WESTWOOD: One of the areas the Committee has been looking at is awareness of the health care complaints process and the commission's work and role in dealing with and resolving those complaints. We found there is less awareness than we would want about the role of the HCCC and how to make a complaint but there seems to be differences depending on the cohort you are talking about. One of the witnesses we had this morning was from the mental health consumers group. There seems to be real dissatisfaction among consumers with a mental illness and that can be both inpatient and outpatient services. Have you looked at people with a mental illness that you could reach out to and do some awareness or community education work with?

Mr PEHM: Yes, and we have that group on the consumer consultative committee, so I was a bit surprised by that submission, although I did say it was one that struck a chord and I think there is more that we can do there. It is quite rare for us to get complaints about community mental health care. Most of our complaints are in the acute setting, when people are scheduled against their will, and these are fraught, emotional situations. There is often very little we can do practically in a situation like that. It comes back to this thing: You do not believe me, you are taking their side over mine, and it is not just a mental health issue, a lot of the complaint is why you do not believe me, this is what happened to me. It is not that we do not believe the complainant, it is a question of what the outcomes are, what can we do? Is there enough evidence, really, to investigate or prosecute a practitioner? Are you interested in resolution?

Unfortunately, by the time complaints come to us they have often crossed the line of trust where they do not trust the system or the provider or us anymore and we get tarred with the same brush and we have to do a lot of work to try to repair that. That is a particularly acute problem in the mental health area. Certainly, in reading the submission, we can talk about them arranging some training for our staff. We have a couple of resolution officers who are very familiar and have personal experience of the mental health area and they are very good at engaging. So, yes, I was a bit surprised to see that and there is more we can do there. They are a particularly vulnerable group.

The Hon. HELEN WESTWOOD: The other area I was interested in, in your submission is we have talked about the nature of complaints. I notice you say there is not a great deal of difference from year to year. I was wondering about the complaints received about health professionals. In those categories, whether it is medical practitioners versus general practitioners, nurses, midwives and so on, have they varied very much? It seems to me there is a greater percentage of medical practitioners than there have been in the past?

Mr PEHM: I think you are just about to get our annual report, it should be tabled soon, and perhaps it is something we can go into a little bit more at that stage. The numbers are increasing, but so are the overall numbers. The proportions do not seem to be: 57 per cent medical practitioners this year, 52 per cent last year, 56 the year before, 61 and 64 the year before that. So there is not a huge variation. Complaints against nurses seem to be going down as a proportion.

The Hon. HELEN WESTWOOD: That is what I thought. It was a fleeting observation so I wondered whether that was consistent.

Mr PEHM: Just to go back to your previous question about awareness and the lack of awareness. There is a real dilemma for us as to how you promote awareness. We do, hopefully, everything we can on the website and providing health service providers with our information so it is available to people. It is not just a problem for us. From the submission you see complainants or consumers saying we do not know where to go. If you look at the website, and only last week I looked at a couple of the LHD websites, and they are reasonably clear: call this number and these are the patient support officers in each of the hospitals. By that route it is available but the problem really again is on the floor, and it is this issue of practitioners engaging with people. One thing that really annoys me, on our complaint form we have this question, have you approached the health service provider yourself? If you circle yes, what was their response? They gave me this form. So, there is a tendency with the front-line health service providers to think complaints are not really my problem, they are the complaints system problem. I do not need to engage. I can send them somewhere else.

In a way it is paradoxical that you provide a system that is supposed to do those things and it allows people to think that is not my responsibility; that is for the system to deal with. That is not what people want. They want to say that the meal is cold for the third night in the row. They want to be able to complain to the nurse and if she cannot do anything then find the nurse unit manager. Where is the nurse unit manager? And with medical problems, they want to talk to the nurse. The nurse does not know anything or feels he or she cannot respond. The registrar is on the eight-hour shift and the one who has been on last time might not be on this time. The consultant comes around once an evening at 6.00 and if you are there for those 10 minutes then you might catch them. People do not know who to approach and it is not made simple for them to find out whom to approach. The complaint system in that sense just reflects the health system in general

The Hon. HELEN WESTWOOD: It is interesting given the issue that the Nurses and Midwives Association raised with us this morning. It is in their submission so you will have read it. They believe that their members are being held accountable for what are systemic failures—although some have far more serious outcomes than others, such as a cold meal.

Mr PEHM: We investigate 5 per cent of complaints. Five per cent are serious enough to investigate and of those probably half end up in prosecution. Ninety-five per cent are not serious and could be dealt with in a whole variety of ways directly, and that is how people would rather have it. Why have to write to the commission and go through this bureaucratic process? And then of course there are all the legal hoops we have to jump through. We have to give notice to everyone under the sun and engage in bureaucracy because we have to tell people their rights and what the Act says they can and cannot do. For a lot of people that is sort of gobbledygook, it does not speak to them, but we have to do it anyway.

I am disappointed in that Nurses Association submission. The Nurses Association has always taken a fairly unconstructive approach to complaints. They advise their members not to participate in resolution processes. There is no harm to the practitioner in those. There is no professional harm. There might be the awkwardness and difficulty of confronting someone. People do get angry at times and they may vent and yell and scream at a nurse and that is not very pleasant. But again it is this thing of practitioners not taking it personally and just disengaging and being a bit more professional about it, rather than thinking: it is an attack on me, so the hackles go up, and I am going to fight back. That is the normal human thing to do and it is understandable to a point but it is not professional and it is just not constructive. So the complaints get bounced around and then bounced up eventually to us. That is the awareness problem, because if it could be dealt with well on the spot it would probably go away. Because if it is not, then it is, "Where do I send it?" The response generally is, "Send it as far away from me as possible."

The Hon. HELEN WESTWOOD: Have you ever had the opportunity to speak with the Nurses Association about how that could be overcome, by perhaps building some trust and faith in the processes?

Mr PEHM: Not for some time but hope springs eternal and I am happy to try again. I did try early on, and it is probably going back about five years now, but their position is very clear and I think quite trenchantly held. But, you know, I am always open to try again. Over the last eight months or so I have been going out with my director of assessments and meeting the chief executives of the Local Health Districts and doing a half-day complaint-handling workshop. What we concentrate on is exactly this disengaging and responding at the lowest level possible and not being scared if someone sends a letter to the commission and copies it to the Minister, and I am sure you get copied in on these things as well. For the local staff not to freeze up and think that powers greater than me are looking at this so I cannot do anything, but to engage and to call the complainant and say, "We have got your letter. We know you have complained to the HCCC but what can we do to fix it?" I think the executives are quite committed to that in the local health districts and the complaint managers are. I think the next challenge is to get that message out to front-line staff, the nurse unit managers and the people that patients go to with complaints verbally and to have them deal with them in a constructive way.

CHAIR: This is not directly related to the HCCC but I am asking your opinion on it. When we were out on our regional visits overwhelmingly consumers and stakeholder groups said to us that one of the barriers to making a complaint in a regional area particularly was a fear of retribution. I do not know that we have come up with the answer to solving that but I would be interested to hear your comments on it.

Mr PEHM: I think that is a very strongly held belief and it was raised in some of the submissions of the consumer groups. Our own consumer consultant committee has said that is a significant problem. Even if it is only a perception, it is a significant problem. A lot of our resolution work is aimed at re-engaging people where the trust has broken down but in rural areas it is a particular problem because there really is nowhere else to go. Again it just comes back to this issue of that gulf between complainants and practitioners. If the complainants feel if they even say boo they will be cut off without any care at all, that is the level of fear they have about even complaining.

CHAIR: Even in the hospital setting they were saying to us that if they complain about anything there is a fear that there will be repercussions, even if they complain that the food is cold.

Mr PEHM: And it is heightened in the country because the nurse you complain against will be the same one you meet down the supermarket and who knows your mother-in-law. Again if the health professionals could just not take it personally and just see this is a normal part of business, every business has to deal with complaints, and the more constructively you do it the better the outcome for everyone.

The Hon. HELEN WESTWOOD: At one of our regional visits we spoke to the staff about the awareness training that the HCCC carries out. One of the issues that was raised with us was that the length of time or perhaps the structure and components of that training had changed. I think they mentioned that there was a three-day course which they felt was more comprehensive and worthwhile doing. Then they had recently participated in a training program that was a day, or maybe even half a day, which they felt was not adequate. It was really about the content of it because they felt previously that it was really useful and this time they felt that they only learnt about the role of the HCCC, which they could have looked up for themselves on the web. Previously they felt they acquired some skills and knowledge about complaint handling. They were not nurse unit managers that we were talking to in this case.

CHAIR: That was my understanding too.

Mr PEHM: That is good feedback for us.

CHAIR: I think they had actually travelled to have their two or three day course. Do not quote me. I think they acknowledged that you came out to the site and did two or three hours but they felt it was too short and that to focus on that for such a short time probably did not deliver the same benefits as the lengthy training.

Mr PEHM: The commission has not done any training in the public system for years. Not since back in about 2003 or 2004.

The Hon. HELEN WESTWOOD: It must have been something that the area health service itself was doing.

Mr PEHM: I think that is good feedback. We had pretty positive feedback from the feedback sheets we sent out at the end. Part of the idea about educating them about what we do is just to try to reconstruct our relationship with them. Rather than them seeing us as a bogeyman or an adversary, it is to try to engage with them more and to try to get them to take responsibility for things and if they resolve them then they need not worry about us too much. It may be that there was too much emphasis on that. I agree that the most valuable part of the training for them is the practical complaint-handling skills. Perhaps we could do more on that. One thing that I think will come out of this last round of visits is that we will propose a development of a more extensive training course. I have not talked to the director general about the best place to do that. It might be the Health Education Training Institute. I do not think the commission can resource that sort of training program on an ongoing basis. I think I have to try to engage with other partners in the health industry to do that. I think it is really valuable and is where the training needs to be. I think that will go a long way to solving some of these problems about the adversarial nature of complainants and respondents.

The Hon. HELEN WESTWOOD: One consistent thing from our inquiries and site visits is the need for people with complaint-handling skills at local level—every hospital, health service or district.

Mr PEHM: Yes.

The Hon. HELEN WESTWOOD: And that is not necessarily part of people's training and I doubt that it is going to become part of the university's. Do you need to be looking to some other training provider?

Mr PEHM: We have very skilled, experienced people in complaint handling and it might be that we could enter into a joint arrangement with HETI, for instance, and do more extensive training. I am very keen to move that forward.

The Hon. PAUL GREEN: On looking at the statistics in your executive summary, obviously you are doing very well this year, which is encouraging considering the point from which you have come. What are your goals this year? How are you going to improve on those statistics? What are your targets? What are you hoping to build on? You have reduced average days down from 43 to 40 during the reporting period and down per year to 220 days in 2011-12. Are trying to achieve some numerical goals to get further for this oncoming year?

Mr PEHM: Not specific. We have our key performance indicators that do come in at certain times.

The Hon. PAUL GREEN: What are some of those?

Mr PEHM: I think we are up to 90 per cent of investigations within 12 months. Partly it is dependent on the number of complaints coming in. If that is the quarterly report to the end of September you are reading, you can see that complaints have all gone up.

The Hon. PAUL GREEN: Yes it is, because we do not have the annual report at this point in time.

Mr PEHM: Yes. Our complaints have gone up something like 15 per cent on last year's figure in the first three months. If that increases again, all of those figures—

The Hon. PAUL GREEN: Will be readjusted?

Mr PEHM: —will be put under pressure because, as I said earlier, we had an increase in staff, but complaints go up. We had a 10 per cent increase in resources, complaints were up 15 per cent or 18 per cent, so again we may be back in a situation where we cannot give as much attention to each complaint as we would like.

The Hon. PAUL GREEN: Last year, for instance, you changed the way you dealt with pharmacists. How are those statistics going this year? For instance, last year you identified pharmacies, but now identify individual pharmacists?

Mr PEHM: It is pretty much stable: 100 last year and 104 this year. So there is no big increase. The reason we changed, I think you understand, is that it used to be the complaint was just against a pharmacy rather than an individual pharmacist. So individual pharmacists could move around and not have the complaint history follow them. That accounts for the big rise in individual complaints, but not a big increase on the year before.

The Hon. PAUL GREEN: We have been putting to different witnesses how widespread the complaints are and some comments have been that "People still don't know we exist and what we do" and things like that. One thought that has been thrown about is to put on the checklist of the discharge planner another part of the opportunity to share with people that a system exists for them. What are your thoughts on that?

Mr PEHM: I think it is a good idea. I would like to see the complaint avenues promoted at all points of contact with the health system. Our general policy is that things should be dealt with locally as much as possible because, as you see, our numbers are going up and up. I discussed earlier this problem of a system for complaints that is a way for practitioners to say, "go and send it through the system" rather than deal with it themselves. The points of contact should be local first: "If you have a complaint, discuss it with the discharge manager" or the nurse or—

The Hon. PAUL GREEN: Patient Advocacy?

Mr PEHM: Yes, or they could bring it up as well.

Mr RYAN PARK: When I worked with a previous Minister in the police portfolio one challenge was when people walked into police stations there was a heap of information thrown at them which was not consistent or very clear. Sometimes it was very confusing to know what it was about; were they there to report a crime or whatever. This Committee visited Westmead hospital where the signage was very clear and easy to understand, not confusing. This may sound trivial, but I really am asking for your comment on how many complaints could be reduced if basic things like signage on where to go, who to call was a little more clear and consistent across hospitals. I am not picking on hospitals but, obviously, that is where the bulk of presentations take place.

Mr PEHM: Yes.

Mr RYAN PARK: Is it worth investing in that? I know it can be trivialised by saying it is just signage or branding, for want of a bad word, but your complaints numbers are going up and up, which means you are going to come back to government of any colour and say, "We need more and more resources." How much analysis needs to be done to determine how many complaints can be stopped at the front line if signage was uniform, clear et cetera? I do not want to trivialise the nature of complaints, but I want to pat you guys on the back and say that with such a massive increase, surely we have to examine what is going on at the front line as well as at your level, with all due respect.

Mr PEHM: Absolutely.

Mr RYAN PARK: Do you mind just making a few comments and if I am completely off the mark, that is fine.

Mr PEHM: No, you are absolutely spot on the mark. The clearer the mechanisms at the point of contact the better. I think the public are reassured even just to have the sign there and to know that it is somewhere they can go. They might not even use it, but it demonstrates a willingness by the provider to address their problems and shows they are being taken seriously. The whole problem of signage and just finding your way around hospitals is a huge thing. Health literacy they call it. The problem is that patients go in, the hospital is a big sprawling place, they do not know where to go, no-one to tell them and they are relatively uneducated. All the important people are rushing past because they are so busy and they end up asking the cleaners because they are the only ones they feel they can approach. There is a whole program. We have been doing some work with the Clinical Excellence Commission on this health literacy project. It is just about signage being clear: What does the Department of Nephrology mean to anyone? Everything in hospitals is built for the providers so they know about it. It is built for their convenience and not for patients' convenience. Complaints are a subset of that, really. I think your comment is absolutely on the money.

Mr ANDREW ROHAN: We understand that the commission provides information through a variety of languages other than English. How do you identify the necessary languages? Are there any possibilities of increasing the scope of languages to include more?

Mr PEHM: We translate our material into 20 languages. The information is taken from census data about the native speakers of those languages. I think those 20 languages, plus English, account for 85 per cent of all residents of New South Wales. Off the top of my head I cannot recall what the next most prominent groups are in the remaining 15 per cent. That is something we can look at. We consulted with the community relations commission, they are the languages that they most commonly translate information into. We have the translated material on the website, our reception staff at reception areas have scripting non-English speaking languages for people who ask for interpreters. We have our own staff that have a community language allowance to speak to patients and we have a telephone interpreter service which can accommodate just about any language. Any other language that comes in without the material we will engage with the Community Relations Commission and get interpreting services.

Mr ANDREW ROHAN: Are there any specific areas that the brochures are distributed to?

Mr PEHM: The website is the main one, migrant resource centres and the Department of Immigration has a package called "Settling in Australia" for newly arrived migrants and refugees and we are part of that provision of information as well. We have an audio visual DVD that explains the role of the Health Care Complaints Commission and are getting subtitled in Chinese and Arabic, which are the two most common non-English speaking languages in New South Wales.

CHAIR: Where would that DVD be distributed to?

Mr PEHM: It is on our web site and we take it to presentations. We do community and provider presentations and we take copies along there and let people collect it. We do radio interviews with the language specific programs, the non-English speaking background media and the Community Relations Commission email link to notify people.

CHAIR: When we met this morning with the New South Wales Consumer Advisory Group, Mental Health, they talked about a brochure that is linked to your web site called "Not happy with doctor". They praised that brochure. We asked them specifically what it is about the brochure that is effective and they talked about not having as much writing and the use of graphics. What system do you have in place at the commission to re-evaluate brochures? The report they gave us about that particular brochure was impressive. They thought it was very effective.

Mr PEHM: We developed that with the Council of Intellectual Disability. That was a particular need for them in that the usual things we publish were too difficult to understand. I am pleased it has a wider audience. We could look at doing that more widely. I think certain people do need more specifics about what the law provides which maybe read like legal jargon and can be confusing but you have to have that there for lawyers who represent people. You need both types of material. That one has been specifically targeted to intellectual disability and is obviously useful for mental health. We might look at more resources in that vein.

The Hon. HELEN WESTWOOD: The other comment they made was that they found the booklet form of that useful because patients could then take it with them and read it at their leisure. People with mental illness who may have had some treatment or difficulties at the time of being admitted, especially if that admission was involuntary, found it a useful resource.

Mr PEHM: We can look at the numbers on how often that is being requested. We will talk to the mental health people and it may mean that mental health organisations and facilities can take that up as a resource.

CHAIR: Is there a specific brochure that you have done with an indigenous group?

Mr PEHM: No, not at this stage. We are having another look at our Aboriginal and indigenous outreach this year. That is something we can look at.

The Hon. HELEN WESTWOOD: Commissioner, can I ask about whether or not you are working with any other agencies in terms of providing culturally appropriate or age or cognitive ability appropriate information—the Department of Ageing, Disability and Home Care and Health NSW come to mind. Have you been working with any of those agencies to ensure that the resources are appropriate and of real use?

Mr PEHM: I saw the submission from the Department of Ageing, Disability and Home Care and thought that was potentially an avenue we could look at. We have been relying on our consumer consultative committee, which is widely representative and that is where we have the link up with the Council for Intellectual Disability as well. We have a standing invitation which we reiterate with them. They look at all new publications and when we do redrafts we circulate it to them and get feedback. We are fairly tightly engaged with them.

The Hon. HELEN WESTWOOD: Mr Park asked a question of one of our previous witnesses about concerns that there are complaints that are about professional rivalry rather than being a valid complaint. Have you any experience that there is an increase in that? One of the issues that we heard raised was that sometimes mandatory reporting can be used to justify making a complaint against a colleague and there is a sense that that complaint is fuelled by professional rivalry not concerns about health and safety.

Mr PEHM: It happens from time to time but it is not very common. I have not noticed a big increase. The obvious example is where one practitioner moves away from the old practice and opens up three blocks down the street and they are fighting over patients. It is occasionally masked in the mandatory reporting requirement but those sorts of complaints are usually fairly obvious and it is not difficult to discern them from genuine complaints where there are concerns about competence.

The Hon. HELEN WESTWOOD: Do you sense there is any change in the proportion of vexatious complaints?

Mr PEHM: It would have been a practitioner representative making this point, no doubt. They always feel the system is against them and people are making vexatious complaints. I cannot say I have noticed any great change and I do not think mandatory reporting has increased vexatious complaints at all.

CHAIR: How do we appropriately direct information to people about what the Health Care Complaints Commission does? One of the issues raised this morning was about the website and some people made good comments about the accessibility of the web site. The issue was raised about elderly patients and the fact that a high proportionate of patients that present at hospitals are elderly and how do we make sure they get the right information in an appropriate format? I do not know if the commission has thought about that.

Mr PEHM: Yes, we have. I am not sure that I touched on this before, but one of the problems with general awareness campaigns is that people do not think about complaining about health service until something goes wrong, and that is when they need the information. So it is best provided at the point of contact, the emergency department or ward, or on discharge, or by signage, so that they know there is a complaints area that they can go to.

CHAIR: An interesting point that is raised, and I highlight this with you, is that we should change the name "complaint" because a lot of people, particularly elderly people, say that they do not want to "complain" about anything; they just want someone to listen to what they want to say about something in the hospital setting.

Mr PEHM: I think one of the brochures said, "Are you concerned about your health care?" not, "Do you want to make a complaint?" People can get very sensitive about the language. In the national system they are not called complaints, they are called notifications. I do not think the names matter so much; it is how you deal with them that is important. Practitioners get very concerned about complaints, and the reasons for that are quite complicated: nurses, because they think that a vengeful administration up there is going to use the complaints against them; and medical practitioners, because their whole livelihood is based on reputation, which is all word of mouth, so that, "If complaints are made who will hear about it? People will stop referring people to me." The trouble with that is that it is all so nebulous; it is very hard to quantify. So the fear is very real, but how you address the fear is a real problem because the reasons that give rise to that fear are so hard to get hold of. I think Mr Park's idea of accessible signage and information at point of contact is the best way of getting information to people like the elderly who have difficulty accessing the Internet and so on.

Mr ANDREW ROHAN: Commissioner, we heard that not all health practitioners are fully aware of the role of the commission, especially regarding the complaints handling process. What is the commission doing to improve that, especially in rural and regional New South Wales?

Mr PEHM: I am labouring the website a bit, but we work very hard to put a lot of information on that website, specifically for practitioners; and again at point of contact, like what to do if a complaint is made about you, what the commission expects in response, what the process is. We do community presentations to a whole lot of medical education establishments, such as colleges and outreach campaigns. This year we will be concentrating on medical practitioners, nurses and new professions. I think I mentioned earlier the project that we have been engaged in over the last six months to go out to the local health districts and speak to practitioners and service deliverers in hospitals in particular, and that is something that we want to expand in partnership with other agencies over the next year.

The Hon. PAUL GREEN: Commissioner, the Nurses and Midwives Association referred to the fact that letters that go out to certain people when a complaint is registered say that they have to notify their employer. The association spoke of the complications with that, and asked whether the Committee could consider dropping that off. Do you have a comment on that?

Mr PEHM: Yes. I have just sent a letter to the Nurses and Midwives Association today on that very point. It was always our practice to advise individual practitioners that they should consult their insurer or professional association. It is best from our point of view if practitioners have proper support and assistance and they are not overly fearful of providing a proper and adequate response. We have, particularly in the last six months of going out to the local health districts, a lot of feedback from the local health district executive that individual nurses that get complaints in their area come to them and say, "Oh, my god, what is this about? Can you help me respond to it?" Now, we do not have a problem with employers helping them to respond, because in hospital cases it is rare that the complaint will be against an individual nurse; it is usually against the hospital, the system, medical practitioners—a whole lot of people.

Occasionally, though, it will be against an individual. And it is here where they are their own worst enemy. They have structured the Act so that the commission is not allowed to notify the employer for fear of that prejudice. Nevertheless, many individual nurses will go to their nursing manager and say, "Can you help me with this?" and they will go to the complaints people. The employers asked us to put in the letters, "You may consult your employer," which we did. But, unfortunately, we dropped out "consult the professional association", which I found out this morning. The Nurses and Midwives Association wrote to me on Friday saying, "You've dropped 'professional association.'" We have written to them to say we have put them back in, to say now, "You may consult your professional association, employer or professional or medical indemnity insurer."

The other thing they were concerned about was that our fact sheet on resolution did not sufficiently emphasise that it was a voluntary process, thereby leading their members to feel they would be compelled to participate. It certainly is in there, but we have now emphasised that. So, hopefully, that will put them more at ease with the process, although I did see in their submission that they advise their members as a matter of policy not to participate in resolution. So I do not know why they are concerned about whether it is voluntary or not since their advice is not to participate anyway. In the first few meetings I had with the Nurses and Midwives Association I tried to persuade them that it would be a good thing to engage constructively in the complaints process. But it has been their policy for a long time not to engage in resolution, and it obviously remains that way.

The Hon. HELEN WESTWOOD: How would that work for nursing managers or those whose job it is to deal with healthcare complaints at the local level? What happens when nurses do receive complaints if their union is advising them not to participate?

Mr PEHM: If they go to their union, and not to the employer, then the union will consult with them and write a response to the commission, and that response will be: Well, this is the nurse's version of events and the facts as we see them. And they will say, "This response is not for release to the complainant," which makes our position awkward. It helps us to be able to give the complainant an explanation. And then of course they will not participate in resolution. So the involvement of the association is again not very constructive as far as complaints; and their reasons for that are set out in their submission. They believe they should not answer complaints that are the system's fault, not the fault of any individual nurse, and that is a very solidly held position.

The Hon. HELEN WESTWOOD: What about where you get complaints that are clearly about the individual, about them being under the influence or those who access drugs illegally? Do they have a different view there?

Mr PEHM: If it is a serious matter like that, it will be investigated, and they will—

The Hon. HELEN WESTWOOD: Is their attitude different there, or is it the same?

Mr PEHM: In that situation they will protect the interests of the nurse; so they will be defensive. They will respond as required, but they will defend the nurse's interests pretty much, as you would expect.

The Hon. HELEN WESTWOOD: As is their role, yes.

Mr PEHM: No, I am talking more about the customer service types of complaints, the things that are not serious and are going to lead to investigation. They are not interested in engaging in those. Again, I can understand that; it is a difficult job; you are absolutely in the frontline; you have got a lot of demands on your time; not everyone is pleasant to deal with, and there is pressure there. Their position is that they have enough pressure and do not need any more. My position is that if we deal constructively with complaints it might alleviate some of the general pressure.

The Hon. HELEN WESTWOOD: What consultation was there when the Health Care Complaints Commissions it was established?

Mr PEHM: That was before by time. However, when I started there was a fairly entrenched perception on the part of practitioner groups generally that the commission was biased against them.

CHAIR: Thank you very much. The Committee may have some additional questions that we will put in writing the replies to which will form part of the evidence and be made public. Are you happy with that?

Mr PEHM: Yes.

CHAIR: Thank you for appearing before the Committee and for your submission.

Mr PEHM: I am happy to assist.

(The witness withdrew)

(Short adjournment)

GREGORY JOSEPH STEWART, Director Operations, Ambulatory and Primary Health Care South Eastern Sydney Local Health District, NSW Health, and

PETER TODARO, Director, NSW Multicultural Health Communication Service, South Eastern Sydney Local Health District, NSW Health, sworn and examined:

CHAIR: Thank you for appearing before the Committee. In what capacity are you appearing?

Dr STEWART: I am a senior executive of a local health district of NSW Health. My local health district, South Eastern Sydney Local Health District, lodged a submission about people from culturally and linguistically diverse backgrounds because we run the Multicultural Health Communication Service, which is a statewide service managed by Peter Todaro. He has much more expertise on multicultural health issues than I do. As members know, the Ministry of Health also lodged a submission on behalf of the local health districts about complaints management in general. The ministry then approached my local health district and said that given we would be appearing before the Committee to talk about multicultural health matters we could also make some general comments and answer questions about the Ministry of Health and health system issues. I am confident that I can do that because I was the chief executive officer of an area health service some years ago, I was also the Chief Health Officer of New South Wales and I was a member of the Medical Council of New South Wales for 10 or 12 years until I resigned earlier this year to take up a new position with the South Eastern Sydney Local Health District.

CHAIR: Are you here today representing the South Eastern Sydney Local Health District Board?

Dr STEWART: I am not a board member; I am the senior executive. I report directly to the chief executive officer, who would have been here but for the fact that he has another commitment. However, given that the Multicultural Health Communication Service fits within my part of the organisation it is appropriate that I am here. My representation is slightly broader because we had discussions between the local health district and the ministry. I understand the Committee is interested in on-the-ground experiences of complaints and the complaints processes. To some extent, a senior executive from the local health district will likely be able to provide more on-the-ground commentary.

CHAIR: Mr Todaro, are you representing the South Eastern Sydney Local Health District?

Mr TODARO: Yes, I am the director of the Multicultural Health Communication Service, which is a statewide service.

CHAIR: I draw your attention to the fact that your evidence is given under parliamentary privilege and you are protected from legal administrative action that might otherwise result from the information you provide. I also note that any deliberate misleading of the Committee may constitute a contempt of the Parliament and an offence under the Parliamentary Evidence Act 1901. Do you wish to a make an opening statement?

Dr STEWART: I will deal with the broader submission from the Ministry of Health and then Mr Todaro will provide details about the Multicultural Health Communication Service. The cultural and linguistic diversity issues are of more interest to south eastern Sydney and they are dealt with in our short submission. We have also provided some suggestions about improving information collection. Mr Todaro will also comment on his relationship with the Health Care Complaints Commission.

I will not deal in detail with the submission from the Ministry of Health. It provides a comprehensive assessment of complaints management processes and lists various policies and procedures. I simply confirm that complaints management in NSW Health and in the local health districts—formerly known as "area health services"—has developed a lot over the past 20 years. I am a public health doctor by background and training, but I have been in health management since 1985. I was around when the complaints unit was first established; I was a hospital medical administrator at that time.

The Health Care Complaints Commission as a mechanism for resolving complaints is of great assistance to hospitals, local health districts and area health services. Prior to its establishment there was no arm's length or independent mechanism to resolve complaints. Anyone involved in health and hospitals administration as I was came across some difficult complaints that sometimes ended with the Coroner and sometimes in other places. In general terms, the development of the commission and the co-regulatory model that we have in New South Wales, as opposed to the models in other States, is very good and it works well. I know that representatives of the Medical Council of New South Wales have appeared before the Committee and I just saw Mr Pehm leaving the room.

As far as the ministry and the local health districts are concerned, the other really important thing that has led to a better mechanism for dealing with complaints, counting complaints and providing feedback is the development in the late 1990s of a quality framework for New South Wales. The "Framework for Quality of Health Care in New South Wales" was published in 1999 and established much more formal mechanisms for clinical governance. Members have undoubtedly heard the term "clinical governance". It involved a lot more thought about how we deal with complaints, how to respond at the frontline level, training, policies and documents at the institutional, hospital or local health district level and referral, if necessary, to the Health Care Complaints Commission. Of course, there is backward and forward movement between the Health Care Complaints Commission and the regulatory bodies given that it is now subject to national regulation.

My notes indicate that about 1,000 complaints go from the Health Care Complaints Commission to the NSW Health system each year, and that works well. That works well and we have got sophisticated policies in place, and have had for about the last 10 years, and people who apply themselves to a better resolution of complaints, and if things become difficult many local health districts—mine included—have what has normally been called a professional practice unit where there are issues around quality of care provided by staff—not so much quality but sometimes quality of care that needs to be referred to a regulatory body but sometimes just internally, and so we have formal processes that respect procedural fairness in terms of the practitioners as well as in terms of the complainants.

So those are the general issues. I have brought along some documentation because I know there have been submissions in relation to people with intellectual disability and there is some documentation just recently—a document I have got here provided to me by the ministry because we obviously talked before we came in around a framework to improve health care for people with intellectual disability. So I can talk about that or answer questions as you like. They are my introductory comments, but Peter will make some comments in relation to multicultural health issues.

Mr TODARO: You have probably read my submission, and it is probably the smallest submission you have received. My comments essentially are we feel that the Health Care Complaints Commission is somewhat responsive to cultural issues in comparison to a lot of other organisations we work with. One of the things that suggests that is they have a complaints process online that you can log on and lodge a submission in your own language; they then translate that and look at that complaint. We find that to be not new but it shows a degree of willingness to deal with those complaints on a real level.

We are also the Health Care Complaints Commission's preferred translator; we do all of their translations and keep them on our website as well for people, and we have got a number of those. We regularly meet—we have met with the Health Care Complaints Commission a number of times in relation to undertaking some projects on behalf of NSW Health's new care plan that looks at reducing complaints in the care setting. I think from the document there our recommendations were really around the Health Care Complaints Commission is doing some good but complaints procedures need to be more inclusive. There are some things—for instance, the privacy policy is not distributed and because of some of the issues around torture and trauma and migration, some people do not know what level their information is kept private, where that information actually goes. So it would be very useful to have a document made available.

In terms of the health care setting, some people are made aware that the Health Care Complaints Commission exists and they are able to make a complaint, but some are not, and resources need to be made available to ensure that when someone goes into hospital and is having a medical procedure those resources are given to people in their own language so they are aware that if they need to complain or if they want to lodge a complaint there is a process for that. So I guess I am suggesting a broader education process for patients—I suppose outpatients as well or anyone seeing a health care professional.

The other area is data collection. We thought about this and we thought it would be really useful if sets of data, perhaps at the in-patient level and the out-patient level, perhaps through other health care settings, if the commission could collect that so we can have a look where complaints are coming from: Are they newly arrived? Are they more established communities? Is it in relation to in-patient or out-patient? At what level they are made and whether there are any responses taken and whether there was a resolution. I guess that includes some framework which would be really useful too.

CHAIR: Some of the questions that we ask you will probably be based not only on your submission but obviously on issues that have been highlighted in other submissions. We visited three regional areas where we visited local health districts and also talked with health consumers as well as advocacy and stakeholder groups. I will highlight something though in your submission. It states that NSW Health complaints management systems are currently undergoing a review. Can you tell the Committee what that review involves?

Dr STEWART: Unfortunately, I cannot tell you the detail of that, but the ministry will be able to. This relates to our incident management reporting system, but I do not know the detail of that so I would not want to provide information that was not correct. That one I am sure the ministry will be able to provide with no trouble at all.

CHAIR: Can you take that on notice to the ministry?

Dr STEWART: We will, yes.

CHAIR: My additional question is: Is that a regular review or is there something particular that has prompted that review, the IMS?

Dr STEWART: I do not know the answer to what has prompted it, but the system itself, since it has been implemented subject to regular reviews and reviews of the respective roles of the ministry versus the Clinical Excellence Commission, there has been some shift in the last couple of years with the health reforms in New South Wales so that the Clinical Excellence Commission is much more involved in day-to-day activities around quality. There was a quality branch in NSW Health, now the ministry, and, by and large, those responsibilities have shifted over the Clinical Excellence Commission. So it is about how information is collected, how it flows, what feedback is provided. Those are the kinds of things I think that are involved in the review, but I am hesitating because it may be that the IMS system itself might be under review, but I do not know whether that is true or not.

The Hon. HELEN WESTWOOD: One of the consistent themes of our inquiry so far has been the differences from health district to health district, hospital to hospital, in the way that complaints handling generally is dealt with, in terms of awareness, advertising it and then the staff to deal with it so it can be resolved quickly and effectively very early on. Does the ministry have any sense of why that is happening? I understand there is a review going on so perhaps that is part of trying to address it, but do you have any comments on that evidence that we are receiving to date that would suggest that?

Dr STEWART: I suppose the initial answer is it is a big system—100,000 staff—and complaints occur all through the system. Just a person saying, "I didn't get my medication" or there was an issue around the cleanliness of the toilets are just as much complaints as the most serious complaint around a death and so on. Always the policy framework is to try and resolve complaints locally, but with 100,000 people, new people and the issues of induction and training, inevitably there is going to be variation. That is kind of obvious in some ways. The answer to the question about local health districts: I think it is partly because some local health districts—and the one that I am in at the moment, for example, South Eastern Sydney Local Health District—took very seriously the creation of frameworks to develop mechanisms for reporting complaints and investigating and training people. So the clinical governance unit in my local health district does a lot of working with clinicians, often at managerial level but sometimes at front-line staff level.

I think that is partly the answer to that. But I suppose it comes back to the fact that this is an ongoing agenda, this is an agenda of continually trying to improve how we do things. There has been a very good example in recent years with the implementation of the open disclosure policy in New South Wales and maybe half a dozen years ago, something like that. It is not an easy policy to implement, not a mechanism that health care professionals were used to. The idea that you would immediately go to a patient and say there has been an issue was not historically the way that we did things. We were often, I think, a bit concerned around making disclosures and what that meant in terms of liability and all the rest. A lot of work went into understanding that it is a better model to disclose if there has been error so that there is an opportunity for discussion and resolution if possible. That is not to say this closes off the rights of patients or clients or carers about how they can go with complaints, but it is to say that we should try in a way that was formalised around open disclosure. That policy took some time to be introduced. As you can imagine, there were issues around were we creating more difficulties than we solved. But the literature was pretty good on this, the American literature, and the policy was introduced. That is the new system.

I have a niece who is an obstetric registrar. She is at the stage now where she is doing operations and unintentional errors can occur. Not long ago, within the last year, something happened in an operation, the details of which are completely irrelevant, and she told me she had to go and talk to the lady afterwards and how difficult she found it but how rewarding it was. I am only using this example because it is a matter of ongoing training. The variation relates partly to new staff and partly to variations within the way systems work. I emphasise there is a good overarching framework for complaints management in NSW Health.

CHAIR: So at a very practical level do you see the ideal as having a very consistent approach across all LHDs, in other words across all New South Wales, even to the point that it has been raised that brochures look different from one health district to another, the signage on the ward is different from one to another? In some hospitals it is clear where to make a complaint and in others it is not. Is the ideal that there would be a statewide approach?

Dr STEWART: I think it is in terms of the policy framework, yes. It is a big system and policy should be made at the statewide level and should be implemented locally. That is very much the philosophy now of the NSW Health system, the Ministry and the LHDs. Particularly in the last 18 months or so there is more local responsibility. This was an important factor in the national health reforms as well. The drivers for the national health reforms were around an ageing population, the capacity to deal with ill-health and the cost, and also the localism and more involved locally. This is a bit of a trade-off for me. Yes, we need frameworks that are consistent. We certainly need a consistent framework when it comes to serious issues about reporting, about where things are referred, about investigation and all the rest of it. But I am not so concerned about some variation locally provided that the point is gotten across, provided that information is available and there are staff available who can assist people in the issues we are talking about today, to find a way through the process.

It is a big complex system. There is no question at all that it is hard to find your way through the system. I am a doctor but I have had experience with the health system and it is completely different when you are on the other side. You often see these articles in the medical journals, doctors go in and say I can tell you something now about what it is like to be a patient. I think there is, and there ought to be, some capacity for localism. We went through a phase in NSW Health between 2005 and a year or two ago where we had much bigger areas and much more centralised processes and structures. Now we have gone the other way to some extent.

CHAIR: That brings us on to what you raised about people in the system knowing where to get help. In your submission you state that at least one patient representative is available in each LHD. For your information, one of the issues that has been raised is in one health service they are called patient representatives; in another they are called patient advocates and in another liaison officers. These are inconsistencies people have talked to us about. My question is, do you think it is adequate that there is one in an LHD or, bearing in mind that some LHDs will have a number of very large hospitals and obviously a number of patients?

Dr STEWART: The submission says at least one but I know for a fact that there are more in some of the larger LHDs and in some large hospitals. I was in the Sydney Central Area Health Service up until 2005 and there was a patient advocate—that was the title—at Royal Prince Alfred Hospital specifically and people were available in the local area health service as well. I think the answer to that question is it depends on the volume and on the way the system more generally deals with complaint processes. The great advantage of a patient advocate is, it is a person who is employed by the health service and who can be involved on the side of a patient, often when it is the more difficult complaints to resolve. It is sometimes not difficult and serious from a clinical perspective but it is difficult and serious from a communications or a lack of care perspective. The position is critical. Is one enough? Possibly, is answer, but in some places there are more than one.

Mr ANDREW ROHAN: Dr Stewart, the Committee has heard that certain LHDs collect feedback from all patients. Are you aware of this practice—I am sure you would be probably. How many LHDs in New South Wales collect feedback from all patients and would you recommend this for other LHDs?

Dr STEWART: I will take on notice how many, because I do not know. I know that my local health district has done some work in this regard. There has been, for about six or eight years, a statewide patient survey, scientifically run, hundreds of thousands of people who were asked to comment with a response rate of about 30 per cent or 40 per cent. The last one of that was a couple of years ago I think. The answer to the question is yes, patient feedback is critical and doing it systematically is critical as well. You can glean a lot from a complaints-based system because you learn lots. This idea that every error is an opportunity is quite correct, but a more systematic approach about what people think about their care is also important, especially so you can track it. The health care system in New South Wales has a high approval rating—like, 90 per cent of people will say fair or above. That still leaves 10 per cent of people who say that care was less than fair. I think the last statewide patient survey was out a couple of years ago. Mr Todaro might like to comment on specific surveys around multiculturalism.

CHAIR: What Mr Rohan is referring to is where one local health district we went to had a larger hospital. Anyway, on discharge, within 24 hours of a patient being discharged, they would get a phone call from the hospital to check that everything is okay, whether they had any questions. I guess the question was more are you aware that that system works in other LHDs?

Dr STEWART: Yes, I am sure it does, but I think that is the most sophisticated system I have heard of, a phone call after all discharges. I have not heard of that sophistication in any place I have been in the last 10 years or so.

CHAIR: My staff tell me it was Moree.

Dr STEWART: It could be the North Coast.

CHAIR: No, Moree.

Dr STEWART: The North Coast has a very forward-looking chief executive. Chris Crawford is very good from this perspective, no question.

CHAIR: It seemed to us that it was a system that worked very well. Are you able to take on notice whether other LHDs used that type of feedback system?

Dr STEWART: Yes, definitely. That is a simple survey of LHDs, which the ministry will be able to do quite easily. There will be a significant number with variations. But I have not heard of a phone call of all people on discharge in my experience, but it is a good system.

The Hon. PAUL GREEN: The Committee has heard that with the introduction of the national registration accreditation scheme there has been some confusion with the obligations arising from the mandatory reporting. Does NSW Health have any comment on the introduction of the national registration accreditation scheme and the Australian Health Practitioner Regulation Agency?

Dr STEWART: Of course, New South Wales decided not to go with a national scheme in its completeness because of that co-regulatory model. We had the view that the model in New South Wales was a better model than elsewhere in Australia. We did not want to be reduced to the common denominator, if you like. I was involved in some of these discussions because I was on the New South Wales medical board, as it was then, I was on the executive. I know the medical board best, but I think across medical, nursing and clinical boards the model we had with the HCCC works well and should be continued. New South Wales introduced the mandatory reporting requirements six or eight years ago. Maybe it was not that long ago. That has subsequently been picked up by the national scheme but of course it is the New South Wales requirements that apply here. I think in general there is some confusion about mandatory reporting.

The three heads are drunk or under the influence of alcohol, issues of abusing patients and so on, and the other one is a really egregious unsafe act. I think they are the three. I have fortunately never actually had to report anyone or been reported myself so I do not know them completely. But that is not mandatory reporting for every unsafe act or every time you think a person might be a bit sad or unhappy at work or whatever. I think there is some confusion in general among health practitioners around what is required for mandatory reporting. Of course even just the drafting of the legislation allows some leeway there. What is an egregious unsafe act? I am not sure that is the exact wording in the Act but that is the phrase that I know.

On the other hand, it should be the case and I think it is the case especially amongst health managers—and there is a policy about this, which is the policy for managing concern or complaint against a clinician—that if an act requires there to be a suspension and an investigation that must be reported to the proper regulatory authority. Within the people who manage concerns or complaints or error against clinicians I think it is pretty well known about what the requirements are but that does not apply to all health professionals. I think there is also some confusion that all health regulation Acts for a long time have said if you report in good faith then you are covered for reporting in good faith. I think people get that mixed up or kind of forget about it as well.

The summary is that I think there is confusion generally but in this case it is not so much about the fact that we established a national registration framework but rather that people do not know the Acts as well as perhaps could be possible. I think in general that the establishment of the national registration scheme created some confusion amongst health practitioners because the fees changed, the time when you registered changed and you were not quite sure. You got a certificate that was incomplete because they were still sorting out their databases and so on. There has been a Senate inquiry into the Australian Health Practitioner Regulation Agency [AHPRA] so I would not want to comment on that, but I noticed in my latest registration certificate that it was exactly right. It had what it should have. It had the specialties I have got and so on. So I think that they are working on that. Mostly this is about a pretty significant change in the system in Australia. It is a well supported change. Why do we need to have eight different registration authorities?

The Hon. PAUL GREEN: How often does NSW Health run formal training sessions?

Dr STEWART: I would definitely have to take that one on notice.

The Hon. PAUL GREEN: Does NSW Health work alongside the Health Care Complaints Commission to provide training on all forms of complaints handling?

Dr STEWART: I am aware over the years of joint training sessions between Health and the complaints commission. The complaints commission I think has been open over the years to provide better training but I cannot give you the exact detail of that now.

The Hon. PAUL GREEN: You can take that on notice?

Dr STEWART: Yes.

The Hon. PAUL GREEN: Does NSW Health play a role in complaints-handling processes concerning private facilities?

Dr STEWART: The answer to that would generally be no, but sometimes there are issues around patients who get transferred in and out of private facilities and therefore there will be an aspect of it that relates to what happened in the NSW Health facility. There will often be common practitioners, especially doctors. If there is work being undertaken in a private facility and suppose there is a complaint against a doctor that will be dealt with by the commission and the medical council if it needs to go there for whatever reason because it is a co-regulatory model. The local health district [LHD] or the facility will not have any role in that. That raises issues around complaints over here and how they are dealt with in other settings and so on. I do not think it is in the New South Wales ministry's submission, but two or three years ago NSW Health developed a register of people about whom there have been complaints. That is to be consulted if you are employing people and putting them on as visiting medical officers and so on. The exact name of that registry has slipped my mind, I am afraid. I will think of it before the end of the session.

The Hon. PAUL GREEN: The Committee has heard that knowledge about complaints handling is limited amongst certain groups and information needs to be provided to these groups in a specialised manner. Does NSW Health target information sessions at particular groups, for example mental health consumers, or culturally and linguistically diverse [CALD] consumers?

Dr STEWART: I will let Mr Todaro comment on CALD. If we are talking about information for consumers who might want to make a complaint, I think it is a fair comment that we are trying a lot harder to do that. I mentioned earlier that there were some issues around disability. I am very happy to table this document, which is called, "Service framework to improve the health care of people with intellectual disability", dated July 2012. It is quite a new document. It has been developed by Health, and Ageing, Disability and Home Care [ADHC] and the disability commissioner, I think, if that is the right term. It is quite new.

NSW Health and its agencies have clearly been involved in health care for people with disability forever. In fact, we ran lots and lots of services. I do not want to delve into areas that I am not expert at, but disability services have completely changed in the last 20 years. There was the de-institutionalisation and all the big centres were closed but we still run a specialised medical service for people with intellectual disability.

There is a very good one in my local health district. That has been expanded recently to provide a pilot for better care in the Illawarra. I know from the notes that I have got from the ministry that there are two more pilots proceeding. So it depends on what group. That is intellectual disability. There have been lots of efforts over the years to improve the way we deal with people with mental illness because there is that aspect of mental illness around involuntary detention and so on. I have not got the details of that in front of me. In relation to culturally and linguistically diverse communities, Mr Todaro, would you like to comment?

CHAIR: Before you being, I am assuming that paper is on the website?

Dr STEWART: It is but I will leave it so you can track it down.

Mr TODARO: I think in terms of mental health and CALD there is a statewide service called the Transcultural Mental Health Centre and they provide a counselling service but also I know that they are always trying to improve what their clients or consumers or patients know about the capacity they have to complain. I think that is happening. But also I think when you look at training across NSW Health, like Dr Stewart was saying, it is a very big organisation. Some local health districts do, some are in the process of doing it and some do not. It is very difficult to say yes, it happens.

I know from my service we are constantly working with consumers and populations saying do you know what your rights and responsibilities are, do you know where you can complain, do you know where to go, and do you know what happens at the end of that point? That is in place and we do it on an ongoing basis. But I think it is difficult due to the landscape in New South Wales and CALD. Before one could answer a question like that you need to unpack CALD and you need to say, okay, what do we mean? Do we mean newly arrived, where there is a great need in language-specific services, or do we mean older established? So at what point and where do you target your efforts? I think the shift for us is starting to target our efforts towards more the newly arrived where really their knowledge is very minimal in terms of health care, in terms of complaints, in terms of all of it really. In summary, yes, there is but we probably could be doing more.

Dr STEWART: Just a general comment about training and professional development: Again all the LHDs have workforce development units where a whole lot of training occurs. All LHDs will have an induction program. These days it usually lasts about a week. But of course you can imagine how much needs to go into an induction program. We are just about to start in my LHD a rollout for the framework for teaching all staff in cultural competence around Aboriginal and Torres Strait Islander people. It is an enormous task because to teach all staff is quite hard and it is quite an extensive program. It is a couple of hours online and four hours face to face. I am actually chairing the committee that is implementing that because Aboriginal health is one of my responsibilities within the local health district.

Just thinking through the areas of training for that specific issue, you know how much else we should be training as well, whether it be specific or priority populations or about specific issues, sometimes clinical or management and so on. It is an ongoing process. There is no doubt at all that you have to continue to look at systems and change them and keep training the staff. One big change in relation to education and training in New South Wales in the past 12 months or two years has been the creation of the Health Education and Training Institute. You now have responsibility for broader training on the strategic framework. That was a recommendation of the Garling commission three or four years ago. So they have a strategic framework but, again, things have to be implemented locally. I return to something I said earlier, there is a trade-off about being local and flexible and having systems. It is an important management issue around having set frameworks within which you work and then the capacity to have local implementation.

CHAIR: Are induction programs, orientation or whatever at the local hospital level?

Dr STEWART: Yes.

CHAIR: Are they not standard across the State? If I started as a nurse in Port Macquarie and someone started as a nurse in Moree, would we get the same induction program?

Dr STEWART: No you would not, but the content would be similar because there are a whole lot of things we train about.

CHAIR: In that content is there a session on awareness of the HCCC and what it does?

Dr STEWART: I would think by and large they do but, again, I could not say that it happened all the time. We deal with the most basic issues: fire and safety, how to fill in your time sheet and so on. The model is a couple of days of corporate training, if you like, which includes the stuff I just mentioned, plus then some localised orientation to the service you are working in. We do a little bit around disaster planning. I know that because I have been involved over the years in that. We do some around understanding Aboriginal and Torres Strait Islander health.

CHAIR: But across the board will they learn how to handle a complaint, generally?

Dr STEWART: I could not say for everywhere, but my response would be that I would think that would be standard.

CHAIR: Would you take that question on notice?

Dr STEWART: Yes, that one could be on notice as well.

CHAIR: There are two parts to the question. First, is there a standard during orientation or induction where all staff, not just nursing staff, are made aware of the HCCC?

Dr STEWART: Yes.

CHAIR: Second, whether they are made aware basically of the local complaints handling procedure within their particular hospital or district?

Dr STEWART: Yes, certainly.

CHAIR: This morning we heard from a representative from the Public Interest Advocacy Centre who talked about a New Zealand model regarding patient advocacy. It has an independent system that offers advice and assistance to health consumers who have made a complaint or maybe even just raised a concern within the health system. One benefit of that New Zealand model is that, depending on their complaint or concern, the person would be directed to the right place. We know that a high proportion of complaints that go to the HCCC probably should not have gone to the HCCC and should have been resolved locally?

Dr STEWART: Sure.

CHAIR: Do you know about that model, the New Zealand Health and Disability Advocacy Service?

Dr STEWART: I do not know about it, no.

The Hon. HELEN WESTWOOD: I return to an earlier question about complaints from the CALD community. In any work with health professionals or staff within the various health service outlets is there any cultural awareness of the different attitudes towards complaining and even understanding health consumer rights within particular communities?

Mr TODARO: New South Wales has a reasonably good structure in multicultural health in Health. Each LHD has a multicultural director and under that director is a number of staff, some of which have responsibility for training cultural competence, equity and access. Yes it does happen. I know that a number of LHDs are always working towards access and equity trying to ensure that CALD patients or community consumers are aware of what is available to them. One of those areas is complaints. I cannot really say that every LHD does it to the same degree because it is difficult to know, but I am aware that it happens across that structure. South Eastern Sydney in particular has a very good structure or model where each hospital has a Diversity Health Coordinator. Each hospital has a person who can work alongside either the Patient Advocate or clinicians. If the hospital's activities are not too large, they kind of are hands-on if someone is complaining or someone wants to complain. It is a very good model and probably should be across NSW Health. I think it happens but, again, a statewide approach allows us to know that. The reorganisation of Health is still in progress. Perhaps once everything settles, there may be more opportunity to look at the whole State and say, yes or we need to do it better.

The Hon. HELEN WESTWOOD: What about complaints by the Aboriginal community? We received some feedback from one visit that perhaps information available within an LHD was not culturally appropriate for Aboriginal health consumers?

Mr TODARO: I will let Greg answer that.

Dr STEWART: That may well be the case. The general patient rights and responsibility brochures that you all know about are translated into different languages, Braille and all the rest of it, and would not be appropriate for all different groups. The best mechanism to approach issues around Aboriginal and Torres Strait Islander people—Aboriginal people mostly obviously in New South Wales—is to have a good network of Aboriginal health workers and a system whereby there are people known to the community who work within the system. Our manager of Aboriginal health actually reports directly to me. Quite recently, within the last couple of months, she said to me, "I've got to go off to a meeting. I've had a complaint at St George Hospital." I said, "So how did you get involved in that one, Gail?" She said, "The family just rang me. They knew me and they rang me and, of course, I will go along and consult."

There would be no doubt at all that we could improve our culturally appropriate information for Aboriginal people. South Eastern Sydney LHD is just about to develop a better brochure around the local Aboriginal people. But I emphasise that the best mechanism by far to improve the mechanisms for Aboriginal people to be involved in the system and bring issues back to us is one around Aboriginal health workers who are known to the community and a management structure that allows senior Aboriginal people to have access at a high level. That is pretty common. In fact, it is mandated across NSW Health that there is a local manager of Aboriginal health at a pretty senior management level.

Mr ANDREW ROHAN: You mentioned that if a complaint is not able to be managed locally that escalation is available. Can you expand on the types of complaints that require escalation?

Dr STEWART: Yes I can. Sometimes at the initiation of the complaint where there clearly has been a serious adverse event, often if there is a death involved, for example, it is better for the Coroner to be involved immediately. Of course, deaths must be reported to the Coroner if they come under the headings in the Coroners Act, one of which still remains as "unusual death". That is a mechanism. Sometimes it is better at the start to say, "This is a matter that should be investigated independently", which would mean it would go to the Health Care Complaints Commission, but often that is not clear from the start. So the escalation often is within our service from the local ward to the local management. Then within my local health district we have a clinical governance unit that manages the process of complaints. We have a professional practice unit that deals with issues around practitioners who have been involved in complaints where issues have been found to be addressed around training, education, communication and so on. They are the kinds of escalation mechanisms I am talking about. The ministry's submission deals with this issue to some extent.

Mr ANDREW ROHAN: It is basically for more complicated issues?

Dr STEWART: Yes but, unfortunately, sometimes quite simple issues that one would hope could be resolved locally are not. My experience over a long time is that that usually is about communication. Communication is a two-way thing. No doubt, all health professionals should continue to learn how to communicate properly. Communication models and mechanisms have changed over the years. When I was a young doctor, the paternalistic surgeon was everywhere. It was just the case that surgeons, usually male, were kind of paternalistic: "I have a body of knowledge and this is what I am going to do to you." That has changed completely in the last few decades, partly for legal reasons such as the famous case called *Rogers v. Whitaker*, a consent case, but also because of generational change and the way people understand a little more about communication mechanisms. The New South Wales complaints policy and handbook goes into detail about appropriate communication mechanisms, active listening and empathetic listening.

CHAIR: One of the issues raised on all of our site visits to regional areas was in terms of consumers making complaints. A lot of consumers and stakeholder groups said a lot of people, particularly in regional areas, will not put in a complaint because of fear of local retribution because the nurse they might want to complain about is their cousin's niece or whatever, or there might be only one general practitioner or specialist in the local area. I do not expect you to have the answer to the question but I am interested in a comment about how to tackle that perception?

Dr STEWART: I am sure that does occur; a small country community is a small country community. On the other hand, my experience over 10 years chairing the performance committee of the medical board and dealing with 250 to 300 complaints each year that were not of a serious nature—they were not health issues for example, they were not serious matters that the complaints commission would deal with—and often involved small communities. People did complain. They would often say, as complainants usually do, "I am complaining because I think there was something that went wrong and I want lessons to be learned so it does not happen again or we mitigate the risk." That is widely accepted as the major motivation for people complaining.

Sometimes there are people who complain and you do not seem to be able to satisfy them. I have had experience of that myself. By and large people complain because they want things to be better for other people. My experience has been that that does occur. I think the answer is the whole awareness campaign concerning rights, responsibilities, what complaint mechanisms are and an approach from health professionals that says if you feel aggrieved you should say so and we will try and deal with it locally and if we cannot it will be escalated. It is a state of mind issue for health professionals. I said at the start that I think there has been a significant change in the last 10 or 15 years in this system and in other systems about the openness of health professionals to be more willing to say error occurs.

If error occurs, sometimes unintentional and sometimes because of bad performance, we have to address it. If we accept that all errors are opportunities for improvement then we should encourage that. I think in the end the system showed that occurred. The number of notifications is increasing steadily. I heard Professor Hughes, head of the Clinical Excellence Commission, talking about this recently and he said that the number of incidents reported is increasing—that is internal reports. We report for a whole lot of reasons. A roundabout way of saying it is you have to keep working on it. I do think things have improved in the last 10 to 15 years.

CHAIR: I have one further question about the NSW Health patient survey. I noticed that in your submission you said that of overnight patient respondents eight per cent said their care was fair and three per cent said it was poor. In terms of emergency departments, 12 per cent said it was fair and five per cent said it was poor, which is getting up around 20 per cent. Are you able to provide the Committee with further details about what the ones in the fair to poor category complained about? You can take that on notice.

Dr STEWART: I do not know the full details of the survey. Questions are asked about how you rated your care. There was an opportunity to say why and it is just a matter of interrogating the survey.

CHAIR: Could you take that on notice?

Dr STEWART: That is something the ministry can look at and take on notice.

CHAIR: The second part is what does NSW Health then do with those most concerning results that come under the fair to poor category? How do we address those issues? Is there a standard applied to what happens with regard to those?

Dr STEWART: This is an anonymous survey, people are rung up and they respond, so you cannot identify individual people. It has been noted by everybody in the health system that whereas in the general hospitals, and so on, about 10 per cent of people say fair or poor—with a split of seven and three—but in emergency departments those rates are higher. That is partly due to the nature of emergency departments being difficult places to be: There is lots of activity, delays because there are emergency cases and patients and their carers and relatives being upset because someone has had an accident. It has certainly been a matter of discussion and consideration within NSW Health about trying to improve that. I can provide the detail of that to the Committee.

CHAIR: You referred to a document on the website.

Dr STEWART: I can leave it with the Committee.

CHAIR: You can tender it. Were there other documents you wish to refer us to?

Dr STEWART: In terms of disability there is this new framework, it talks about a staged approach and as ever when we are talking about special groups or priority of populations it is not just an issue of specialised staff to deal with priority populations, it is about staff generally and the mainstream staff having more awareness. That applies to culturally and linguistically diverse background people, Aboriginal people and all groups of people. The new framework takes that approach—specialised services but also mainstream. There are two other key documents concerning disability in NSW Health, not just intellectual disability but physical disability as well: First, a Disability Action Plan, and second a policy that was revised in January 2008 and is coming up for revision in a year or two, People with a Disability Responding to Needs During Hospitalisation. I emphasise that having a policy does not mean that all staff know about it but there is the policy framework. They are the three documents about disability. I also have the complaints policy but I am sure you have that.

Documents tendered:

Mr TODARO: I just want to go back to what can be done in country and regional areas. When you are talking about regional areas that are marginal, on the borders, maybe there would be room for the HCCC to look at developing a model for reporting to the patient advocate as the model for reporting to the HCCC or the Coroner is not always appropriate. I know this because, for example, a large population of about 800 or i900 asylum seekers and refugees are living in areas like Wagga Wagga or in the outskirts of those areas. They have similar issues, but perhaps a better way to work through those is to pick out someone who is trusted who could resolve matters at the local level, as both sides would know that this person and trust him or her to be working with them.

That keeps the issue small and closed, as opposed to lodging a formal complaint, and that is important in small country towns. I go to a town called Carcoar that has a population of 350 people. I had a little house on the valley, but I have just sold it. I know that there are a couple of people in the town that people go to and say, "This happened to me. What should I do?" Usually they will say, "We will meet at the pub tonight at 6 o'clock," and they will sit down and have a discussion about what happened and where it should go. Sometimes those little things are overlooked, but they are very important in small societies.

CHAIR: The Committee may wish to send you some additional questions in writing. I note that you have taken some questions on notice. Of course, those questions and the replies that you make to them and additional questions sent to you in writing will form part of your evidence and be made public. Are you happy to provide a written reply to any further questions that the Committee will send to you?

Dr STEWART: Yes, Chair. That would be good. As a matter of fact, although I have not appeared before a committee for some time because I stopped working in head office, my experience in the past was that transcript would be provided, and there would often be a covering letter saying, "Here are the additional items on notice." That makes it a whole lot easier, because I can refer them on.

CHAIR: You will receive a letter outlining the questions to be taken on notice.

Dr STEWART: I will forewarn them that things are happening. They expected that there would be some detail that I did not have with me. Although policies might deal with all issues, probably no-one would have all the information in their head. So they were expecting more follow-up.

CHAIR: Thank you very much for giving evidence today. We appreciate that you have given up your time to speak with the Committee.

(**The witnesses withdrew**)

(**The Committee adjourned at 4.43 p.m**.)