REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

Review of the 2004-05 Annual Report of the Health Care Complaints Commission

---

At Sydney on Wednesday, 8 March 2006

The Committee met at 10 a.m.

PRESENT

Mr J. Hunter (Chair)

Legislative Council	**Legislative Assembly**
The Hon. D. Clarke	Ms T. R. Gadiel
The Hon. Christine Robertson	Mr A. F. Shearan
The Hon. Dr P. Wong	Mr R. W. Turner

Transcript provided by CAT Reporting Services Pty Limited

KIERAN PEHM, Commissioner, Health Care Complaints Commission, Level 12, 323 Castlereagh Street, Sydney, sworn, and

KAREN MOBBS, Director of Proceedings, Health Care Complaints Commission, Level 12, 323 Castlereagh Street, Sydney, affirmed:

CHAIR: Commissioner, before we get into asking you some questions, is there an opening statement you would like to make to the Committee?

Mr PEHM: Yes, I have a brief opening statement, Mr Chair, which I will table onto the record for Hansard's purposes, but I will run through it in a brief paraphrased way. The year 2004-05 has been one of continuing reform and consolidation of the Health Care Complaints Commission. Essentially the commission has been divided into three divisions. The first division is the assessment and resolutions area and, in effect, it is the front end to the commission. We have beefed up the staffing and the management and supervision in the assessments area. The main change is that we are now doing much more careful assessments of complaints than the commission did in the past. Previously the practice was simply to make an assessment decision based on the complaint. We now generally get responses from the respondent. In clinical issues we will obtain medical records and may get expert advice at that stage. The object is to make a more informed and better assessment decision so that the complaint can be dealt with in the best way.

The number of complaints received by the commission rose by 15 per cent during the year. Partly that increase may be due to a change in the Act which came into force from 1 March 2005, which formalised the operation of the former patient support service. We are now calling it the complaint resolution service. It does not begin to deal with complaints until they are made in writing to the commission. Formerly the patient support service was receiving referrals, verbal and telephone, from anywhere and most particularly from hospitals and they dealt with those in an independent way that was not very, I suppose, accountable to the commission. We think that the rise in complaint numbers is probably due in large part to the requirement that those complaints previously informally dealt with are now formally dealt with.

The complaint resolution service is continuing largely in the same manner that it has been, other than being brought into the Act now under Division 9. The Health Conciliation Registry completes that assessment and resolutions area. That has been brought into the commission from 1 March 2005. The investigations division probably was the area that got the most attention during this particular year. We were dealing with a very large backlog of complaints, the flow through from the Macarthur and the Walker Special Commission of Inquiry and the vast bulk of the subject went into the investigations division. The commission completed 870 investigations during the year compared with an average of about 339 for the previous four years. Delays in finalising investigations have always been a feature of the commission as far as I can work out, going back many, many years. We had complaints as old as five years old when I started. We set a goal in our corporate plan to try to complete 80 per cent of all new investigations within 12 months and that proved to be a bit too ambitious and I can go into the reasons for that a little bit later. We in fact completed 51 per cent of new investigations within 12 months.

The legal area is the third division and there has been some considerable change there. The Act has appointed now a Director of Proceedings and Karen Mobbs is appearing before you today. She was appointed Director of Proceedings in March 2005. The director's role is to make decisions on whether or not complaints should be prosecuted before disciplinary bodies, independently of the Commissioner. As a result of the finalisation of the 870 investigations, a significant proportion of those investigations, about 200 during the year, were referred through to the legal area. We have taken on extra temporary staff to deal with that flow through. I understand the tribunals and professional standards committees have made arrangements to appoint extra hearing officers to get that work moving.

In conclusion I would just say that although a great deal has been done at the commission there is still a great deal more to do. While we have got the broad structure in place there is a significant program of cultural change that needs to take place at the commission and we are implementing that in various ways, from more efficient strategic and corporate planning, we have to have a performance management system implemented by the end of this year, and through a structure that promotes much tighter supervision of staff than was the case in the past and imposes more direction on the way matters are handled.

I would like to publicly thank Judge Kenneth Taylor, who was the Commissioner for the bulk of this reporting year and he, I think, finished in May 2005. The judge laid the foundations of the reforms that we are seeing in place now and his contribution in terms of legal expertise was invaluable during that process and I am confident that in the next year we will see a continuation of the reform and further improvements in the commission's performance.

CHAIR: We have a number of questions which you have touched on but we will proceed with those anyway. The number of telephone inquiries decreased by 316 during the course of this reporting year. Is this the result of less promotional activities being undertaken?

Mr PEHM: I do not know how much you can read into one figure. Although telephone inquiries decreased, written complaints increased by 15 per cent. It is true to say that during the year there was not a very concerted or well organised program of promotional activities. We have updated our complaints guides, our brochures and pamphlets. We have redesigned our web site. We have presented papers at seminars and conferences and towards the end of the year we have involved the complaint resolutions officers and this is at the suggestion of our Consumer Consultative Committee in much more, I suppose, systematic and concerted promotional activities and that will involve addressing groups with interests in this area such as Council for Intellectual Disabilities and Physically Disabled People, Council for the Aged and the Combined Pensioners Association. Our Consumer Consultative Committee has suggested this program. We consult with them on the groups that we need to talk to. That is under way and we have done a great deal of work in that area during this current year.

It is always difficult to say what influences complaint numbers. Often it is publicity in more general terms. The Macarthur business obviously generated a lot of publicity and awareness about the commission. That is publicity you cannot self-generate no matter how much promotional work you do. The way complaints are running this year we are looking at a very substantial increase and I am not really sure what all the factors involved in that are.

CHAIR: You mentioned earlier in your opening statement about the decrease in the number of patient support service clients. That has decreased by 1,492 over the reporting period. Can you please explain the factors affecting this number?

Mr PEHM: That decrease of 1,492 is page 25 of the annual report, the figure there for 2004-05 which is 2,657 is only a figure for the nine months of the year because come 1 March 2005, the last quarter of the year, we did not count the old complaint resolution service clients separately. They were just treated as complainants and matters referred to the complaint resolution service, so if you add a quarter on to that 2,675 number it is not the significant level of increase that it seems. We have had a process of going through all of the clients of the complaint resolution service and we closed about 700 files there, mainly for reasons that they were basically inactive files where not a lot had happened for a long time and administrative action was needed to close them off.

One of the problems with the old patient support service was, I think, the lack of accountability to the commission in its daily file handling and we had a very troubling case, which I think might have been the year before this reporting year, but the then Leader of the Opposition held a press conference with a complainant who said that she had taken her matter to the Health Care

Complaints Commission two and a half years ago and they had done nothing. We had no record of it. She was someone who was referred to a patient support service officer through a hospital. We went back through the patient support officer's papers and it seems that there was confusion about who would do what. They had a meeting and the client expected the patient support officer to draft a complaint for her. The patient support officer thought that the client would go away and do her own drafting. Publicly that comes out, and I can understand why the complainant saw it that way, I have been to the Health Care Complaints Commission and they have done nothing with it for two years. That was a problem with the complaints resolution service and in closing off those 700 files we found a lot of files that were inactive or there was nothing practical further to be done.

CHAIR: The number of complaints finalised rose to 3,035. Is that proportionate to the budget enhancement received?

Mr PEHM: It is an increase from 2,777. Whether it is proportionate or not, I think it is not necessarily helpful to take one figure and say that shows you only closed 10 or 20 per cent more but you got a 30 per cent budget increase. If we focus on investigations, they go from 321 to 870. That is a 270 or 300 per cent increase. Do we say you got a 40 per cent budget increase and you increased your investigation output by 300 per cent? It depends on where you are putting your resources and in this particular year because of the concerns about Macarthur and the backlog, the resources were put very strongly into investigations.

The Hon. CHRISTINE ROBERTSON: I would like to extend that last question. Do you have other indicators that would measure the value of that increase in budget other than the number of complaints finalised?

Mr PEHM: The number of complaints, the timing of complaints I think would be an important indicator. Quality of complaint answering is a very difficult thing to measure. We do have a set of performance indicators in our strategic and corporate plan which we will report on next year. A significant amount of the budget has gone into, I suppose, creating a structure of senior management and upgrading the skills of the commission's middle managers. Those sorts of things we envisage will improve the quality and timing of complaints handling but they will take some time to filter through.

The Hon. CHRISTINE ROBERTSON: So that is the outcome of your planning process? The quality is the outcome of your changes in planning process?

Mr PEHM: The quality will improve. It is very difficult to measure the quality. One measure might be the success, or the proportionate success, of prosecutions in tribunals and lack of any adverse comments from tribunals about the quality of prosecutions and in the past there has been some adverse comment. That might be one measure. I suppose stakeholder satisfaction, opinions of the registration boards we work with, we might look at surveying some of those further down the track.

The Hon. CHRISTINE ROBERTSON: I was looking at other indicators of value rather than numbers. While the commission's corporate goal was to complete 80 per cent of all new investigations within 12 months, the result proved too ambitious for current capacity. Only 51 per cent were closed within 12 months. Please elaborate.

Mr PEHM: It seemed like a good idea at the time. It seemed like a reasonable goal to set when we set that goal. I suppose the investigation capacity and skills of the commission are not strong, the commission's investigations officers, and they do need a lot of development. It is very much a paper based investigation process and it is very much a one step at a time process. The practice has been to send the complaint to the respondent. Hopefully we will get a response. If they do not respond for a month, two months, three months we tend to sit back and not do very much rather than go out and gather supporting, interview witnesses, support the complainant, get an expert

opinion. There were big delays through, I suppose - these are the sorts of things we hope to remedy through the tighter supervision and more experienced investigators in senior supervisory positions.

There are some delays that are inherent in the processing. We are obliged to consult with registration boards. I am not critical of this at all. It is part of process, but you can pretty much lock in two or three months on top of what a normal investigation would be for the preparation of consultation papers with boards. They generally meet once a month so if you get in on the staff one month you add a month to it. There are procedural fairness requirements, which again are obvious and it goes without saying that they are a good thing and have to be there, to give the respondents the chance to respond at the end of an investigation, even though you might have a substantive response from them before that.

Getting medical and clinical records there are often delays with, particularly in very complex matters where we have to gather records from a number of different hospitals and area health service providers and also getting our own expert opinions. We get some reasonably significant delay there because our experts are very highly qualified professionals who are busy and, I think, do this as a sort of public spirited public service sort of issue and I think at times the provision of their expert opinion can slow it, so there are some external factors that are, to an extent, out of control. There is a lot more we can do to improve our own investigation process and improve that time. I still think 80 per cent within 12 months is a reasonable goal to pursue and I think that we have been providing the Chair with quarterly reports more recently and I think we have got over that 50 per cent, closer to the 80 per cent.

The Hon. DAVID CLARKE: Given the concerns raised in the last hearing about the effectiveness of the Consumer Consultative Committee, has the committee membership, structure or purpose changed to enable it to be effective and to justify its reconvening?

Mr PEHM: I am not sure that there were concerns about the committee so much as Judge Taylor gave evidence, I think, to the effect that he did not see the committee as having very constructive input during that very difficult reform process that we had within the commission where we had an enormous backlog and we had all of that external pressure from the Macarthur matters. I do not know if it was a criticism or question of a fault with the committee and its structure and processes so much, it was just that at that time, given the priorities of the commission, we were not sure that it could contribute a lot.

We have reconvened the committee now and it has been meeting throughout this reporting year and is continuing to meet. It has provided some very valuable input, particularly in relation to the reach of the complaint resolution service to which I alluded earlier. We had one member of the committee who I think was an aged persons representative who actually worked in one of the hospitals where one of our CROs worked and she was not aware of the service, had never heard of it. Other groups there - I think the representative of the Council of Intellectual Disabilities - requested a CRO to come out and address the Council informally about the processes, and we have had similar requests, in particular the migrant resource centres, and there is a list of those that I will publish in next year's annual report. They have been very valuable in that process.

The committee is made up of a fairly broad representative group of consumer interests in the health area. We have rural representatives, people with physical and intellectual disabilities, aged persons, as I say, and migrant or culturally and linguistically diverse representatives as well. We meet three-monthly now and we find the meetings quite constructive and their input quite valuable.

The Hon. DAVID CLARKE: How close is the five-year strategic plan to completion, given the expected completion date of the end of 2005, which was offered at the last meeting?

Mr PEHM: We have completed the plan. We had a meeting planning day in February, I think on 21 February, where we modified some small things, but it is substantially complete now and it will be finalised shortly.

The Hon. Dr PETER WONG: Can I return to an earlier question about the goal of 80 percent of investigations? Of all the factors that you have mentioned so far, what is the most important factor in delay?

Mr PEHM: Well, the most important factor within our control is our own investigative capacity and the way in which investigations are conducted.

The Hon. Dr PETER WONG: Is it case by case? I mean do you manage every case? If there is undue delay, would there be a red flag to indicate: This case has been delayed, so we have to speed it up?

Mr PEHM: Yes. We have now an investigations review group that I chair that meets fortnightly and every case that is more than 12 months old is on that agenda and a report is prepared for those cases and we go through them. Also on that agenda is every case where a registration board has either suspended or imposed conditions on a practitioner. They are seen to be more urgent because obviously the practitioner's capacity to practise is inhibited and we do not want that extending for years. Within the investigations area you have to have a number of strata of supervision and it may be that we now need to tighten up that 12-month delay, whether it is something like six to nine months.

On top of that, the investigation area is divided into three teams of about four to five investigators with a team leader. They conduct monthly file reviews. There is not a strong culture of supervision and, I suppose, proper management practice in the commission, so the team leaders are perhaps not as rigorous as they could be with, putting it simply, making demands and giving directions. It is not a culture of the commission. They have a very collegiate sort of "suggest you do this" and "perhaps you might try that", more like colleagues working together rather than team leaders giving direction. That is quite a difficult change in culture and it will take some time. We are hoping the introduction of a performance management system will provide the formal framework for that sort of feedback to take place between management and a staff member.

The Hon. Dr PETER WONG: If the goal is 80 percent in 12 months, surely there will be a red flag once six months expire and the case is going nowhere?

Mr PEHM: Yes. It was really a question of capacity and how long you wanted these meetings running. When we started there were so many older than 12 months that, to make it any shorter, there would have been hundreds of cases. It is now down to a much more manageable level, so we can look at tightening that now.

The Hon. Dr PETER WONG: One of the past complaints was that doctors were not cooperating with the commission. Is that still the case?

Mr PEHM: I think that is rare. We are finding that during the assessment process the staff or the professional appreciates getting the chance to respond to a complaint before a decision is made to investigate it or not, and generally the responses are very timely and very constructive. In the investigations area the proportion of doctors who delay in responding would be very small, and it is probably in cases where there are significant issues like impairment or there are very significant matters, but generally they are insured and their insurers respond for them and they are reasonably timely.

The Hon. Dr PETER WONG: I notice that the commission did not prepare an ethnic affairs priority statement. I really want to know, as someone who was Ethnic Affairs Commissioner previously under a different Government, it was necessary - in fact compulsory - for the government sector to prepare a policy report. Is that still the case, that every department must prepare a report?

Mr PEHM: It is an oversight that it was not prepared and I am embarrassed that it wasn't and it should be. I am not sure of the precise status of it and what the nature of the compulsion is, but I take it as something that we must do and we should do and we are doing one for this year. We had difficulties in that area. Our director of corporate services left the commission in the course of

preparing this annual report and it was her responsibility to prepare the ethnic affairs priority statement, which was not done, and in effect by the time we came to preparing the report we did not have one done. We could have, I suppose, tried to knock one up and say we had it done, but I thought it more open and better to sit down with the community relations commissioner and actually prepare a proper constructive one. They were certainly very concerned about the failure to prepare this one and wrote to us and I have been in touch with them and we are working together now.

The Hon. Dr PETER WONG: It was not meant to be a criticism, I just had the perception - maybe I am wrong - that it was not regarded as important.

Mr PEHM: It was not a conscious decision to not do it because we did not think it is important; it was really a question of other priorities and administrative oversight that by the end of the year it had not been done. It is very important for us and I think there are questions later, and in view of the Committee's report on traditional Chinese medicine as well, if that does become law, then obviously with the clients we will be dealing with there will be a lot of issues around communication and cultural difficulties about complaining that we have to come to grips with, so it is only going to become more important for us.

The Hon. Dr PETER WONG: In addition, there have been complaints recently in Queensland and in New South Wales about overseas doctors' performance and ability to communicate with patients. Do you see that as an important aspect of the commission's policy?

Mr PEHM: It is a problem that appears in some of our complaints, but it is difficult to say how widespread it is. I am not sure our plan would go to addressing that particular issue. Our plan would be about how we can best provide our services to culturally and linguistically diverse people and be sensitive to the cultural barriers they face in making complaints, but that is a problem that arises.

CHAIR: A question we were going to ask you related to the TCM inquiry and the fact that you did not have the ethnic affairs priority statement. Did that relate to an inability at that time to identify the cultural and linguistic background of complainants at the TCM public hearing?

Mr PEHM: We sent out a survey to complainants that asked them questions about those issues - Aboriginality, cultural background, whether they needed interpreters, preferred language - and there were responses to that, but that is a general survey, we do not collate to particular complaints. The only way we have of identifying the cultural background of someone is individually from the nature of the complaint. Obviously if it is in Mandarin or Chinese you would need to have it translated, that is fairly clear. It becomes less clear when you are dealing with English speakers who are from a different cultural background. It is not as easy to deal with them. We plan to address that partly through this program about complaints resolution officers going to migrant resource centres and addressing those particular ethnic groups and advising them about the practices of the commission.

The Hon. CHRISTINE ROBERTSON: The change in referrals to the CRS was made for what purpose; what has been the response, and is it appropriate in terms of encouraging easy access and early intervention, plus the method used to monitor the number of complaints made, is any comparison of data pre- and post-March comparable, given the alteration in the recording methods outlined in data given to the Committee recently?

Mr PEHM: The purpose behind the change I am not really sure. I think the draftsman was asked to include the complaints resolution service as a division of the commission and as a source of referral for complaints.

CHAIR: So once in the legislation it came under your general policy?

Mr PEHM: All complaints must be in writing, it is said at the start of the Act, so consequently all complaints being reduced to writing before they can go to the complaints resolution service has become the law. As I said earlier, I think there are certain accountability benefits to that.

Problems that arose where people could just go and chat and nothing was ever reduced to writing - we became aware of those through a number of sources, not the least being embarrassing media reports. It is always a difficult balance, to balance the recording and accountability of a process with the capacity to act quickly and respond. We do not think the requirement to put matters in writing is going to be too onerous. The commission has an obligation to assist complainants to make written complaints. We are currently looking now at the complaints resolution service taking over the telephone inquiry service of the commission and we want to put some protocols in place about that. The sort of complaint where, if they can hook someone up with the right area of the health service, or they can make a quick call and fix something, we are quite happy for them to do that but we do not want that stretching out into a long involvement that does require documentation. If it does reach that point, what we are planning to do is that the complaints resolution officer can simply send an e-mail to the assessment committee which meets Monday, Wednesday and Friday and reduce it to writing. There will be no need for the complainant to actually make a written complaint and sign it, as long as the complaints resolution officer emails the gist of the complaint and suggests, if it is a referral back to the complaints resolution officer as an official complaint, we will take that email as a complaint and send it off to them to handle. Although at first blush it might seem like a bit of a barrier we think that there are ways to resolve that, both in keeping the letter of the law and allow for fairly quick responses.

CHAIR: I know you highlighted earlier an instance where someone has said they had made a complaint through the patient support office or the complaint resolution service on the ground with an area health service and two years had gone on and the commission had done nothing about it and that was because the commission head office had not been notified. I understand that and that may be one good reason why the change in legislation could be beneficial, but we currently have an inquiry looking into how complaints that are made in private clinics can be dealt with prior to them proceeding on to a full blown complaint of the commission and hence save the commission a lot of work. Hopefully it will nip the complaint in the bud at an early stage.

It is quite clear to us that this unintended consequence of the legislation change means that a doctor, dentist in private practice, once knowing that they refer a complainant to the complaint resolution officer at a local level to assist in resolving a complaint, that that is going to generate a written complaint and an official complaint to the Health Care Complaints Commission. I do not see a GP in private practice referring them over to your service. That meant that it is going to cut out, and I think that is evident from the figures, it is going to cut out many hundreds of people who would have had low level complaint resolution done by your former patient support officers and now your complaint resolution officers.

That leaves out a great void out there of people who are dealing with that in a private setting, and that is private practitioners who are not going to refer them to the complaint resolution service because it will generate an official complaint against them with the Health Care Complaints Commission, so I think that there will be a reluctance. How do we go about instigating a service that is able to resolve complaints at that lower level before it becomes an official complaint to the commission? Do we need a separate advocacy service? There are some in some other jurisdictions, such as New Zealand. There was talk about introducing an advocacy service in Queensland. That was one of the recommendations coming out of a major inquiry in Queensland into the problems they had up there.

Mr PEHM: I can understand why you have that impression although I am not - I do not think we know. I really do not think we know that there is this vast proportion of people who are going to go on and not be dealt with.

CHAIR: But your figures show that there has been a dramatic drop since the legislation came into force and the number of people using that service.

Mr PEHM: Those figures were for nine months. If you extrapolate them for a year it is roughly equivalent with the previous.

CHAIR: I think if you deal with them on a month by month basis for the months after the legislation came into force there was a major drop in the number of complaints going through that service.

Mr PEHM: We have closed a lot of the complaints that the complaints resolution service was dealing with because nothing was happening, in effect.

CHAIR: It is something I would like you to have a look at further and give us some suggestions for our other inquiry.

Mr PEHM: Perhaps we can investigate the nature of the matters that the complaints resolution service were dealing with. I am not sure that private practice referred a lot of matters to the patient support service directly anyway. I think most of their work came from the public system and from public hospitals, because that is where they are located. The public systems are aware of them, but we can look further at the proportions.

The Hon. CHRISTINE ROBERTSON: Would you have a perception that possibly private practice perceived these people to be connected with the health system in some way, the public health system, the department and the hospitals?

Mr PEHM: They may. I do not think externally private practice distinguishes between our patient support officers and the hospital patient support service. The hospital had patient representatives.

CHAIR: We had your Health Conciliation Registrar, acting conciliation registrar, appear before the Committee for an informal briefing and she had been a patient support officer in an area health service and she did say that she did deal with private practice.

Mr PEHM: They do, but I am not sure what proportion of those come through as complaints to the commission that were referred to, matters that are referred to direct.

CHAIR: I do not have that information in front of me.

Mr PEHM: I can look into it and try to give you some data anyway.

Mr SHEARAN: Mr Commissioner, what stage is the implementation of casemate at?

Mr PEHM: Casemate went live on 7 March 2005.

The Hon. CHRISTINE ROBERTSON: Did you have a party?

Mr PEHM: We did have a little celebration.

The Hon. CHRISTINE ROBERTSON: It was a long time.

Mr PEHM: It was a long time in production, about four or five years.

CHAIR: It might have spanned two commissioners.

Mr PEHM: It is very much a work in progress, casemate. Its original design reflects a lot of the old practices of the commission because it was designed by a committee, by staff input and participation and I think it has been overengineered in lots of ways in that they are trying to get it to do every little thing in a complaint. We are going through a process of business reengineering, they call it now, where we will be simplifying the stages. That will allow us to get these exception reports

out. At the moment there is so much in it that to find out when something has not been done is quite difficult.

The Hon. CHRISTINE ROBERTSON: It will be a quality tool.

Mr PEHM: It is much simpler. If you have three or four major steps then you can say tell me the ones that were not done by a certain date so there will be an ongoing process of reengineering. It will never be finished. It is one of those things where you are always improving your procedures and you are always modifying casemate to keep up with it.

CHAIR: I am not sure what happened. There was collaboration with other commissions in other states and this was going to be a joint project, but I recall that that cooperation fell over.

Mr PEHM: It did.

CHAIR: What is the latest with that?

Mr PEHM: I think the ACT and Tasmania were in on the project for a while, but it never happened and, in effect, with Macarthur and the Walker inquiry, the Government decided to fund the commission to a much greater extent than it had in the past. We could not tie up those. They are very small, those commissions as well and they did not have the capacity really to commit to it or commit any funds to it. We have had the ACT up to look at it since and South Australia as well is interested in taking it on and I think there is some interest from Western Australia, but that is not health related. Essentially we went ahead on our own and implemented it.

Mr SHEARAN: Several key performance goals from 2004-2005 corporate plan that were not achieved in that time period were not given revised dates for completion. Are you able to provide some indication of the timelines for review of prosecution guidelines?

Mr PEHM: Yes. The former head of the legal division left during this reporting period. The legal process has changed now with the appointment of a Director of Proceedings. The registration acts have all changed with the definition of unsatisfactory professional conduct, so that all has to be written in as well. We are hoping - and this is really largely Karen's responsibility - that we will complete a new prosecutions manual within the next 12 months. We have been working some way along and in fact we have reviewed the guidelines for peers, which is expert opinion, which is a very important part of prosecution process and we have got legal advice and revised our peer guidelines to take into account the new registration act definitions and we have sent those out to peers, so that is the state of play with the prosecution guidelines.

CHAIR: Can I ask whether Ms Mobbs would like to make any additional comment? We have not asked you anything directly yet but this relates to your area.

Ms MOBBS: The only thing that I could add is with the changes to the act there was an introduction of criteria in relation to the decision making process. Section 90C of the Health Care Complaints Act actually sets out criteria which were not previously there. To some extent that is generally part of the prosecution's policy, which takes some of the need to have a policy reflecting what those criteria are, which means that there is much more of a refocus on a prosecutions manual rather than guidelines for the decision making process. To a large extent, because of the amendments to the act, the devolution of the decision in relation to making determinations to prosecute to the legal section, the drafting of complaints, has meant a huge change to those procedures which are really only fairly recently starting to fall into place, so it is probably now a good time to rework the prosecutions manual to reflect those current policies and what is actually occurring.

Mr SHEARAN: Secondly, the development of the code of practice.

Mr PEHM: The code of practice was again one of those things which I thought when I started should not be too difficult. Unfortunately it is quite complex mainly because the commission does not have well developed internal procedures at the moment. There have been changes as to the assessment procedures. We need to develop and finalise our own internal procedures before we go externally. We have, in the assessments area, written assessment guidelines which we circulate to all the registration boards for comment and we have had comments back by the end of January so they can be finalised shortly. We need to finalise our investigation processes as well as to whether they are changing, and they need to be bedded down. It is not until we get that done that we can go into the development of a code of practice, so I find it very difficult to put a timeline on that.

Mr SHEARAN: Are there plans to formalise in any way the liaison with the Clinical Excellence Commission, that is, establish a protocol for information sharing or a memorandum of understanding?

Mr PEHM: We met with the chairman and the chief executive officer of the Clinical Excellence Commission some time back. The roles of the Clinical Excellence Commission and our commission are very different. We come from the individual complaint point of view and they come from a broad systemic area. The point of intersection is, in effect, the Department of Health. Part of the patient safety improvement program, in addition to the Clinical Excellence Commission, is that each of the area health services now has clinical governance, each with directors. Our point of intersection with both the commission and the directors of clinical governance is through the Department of Health through the director general. Starting in November 2005 we set up three-monthly meetings with the director-general. Under the Act we send them all of our finalised investigations where we make recommendations for systemic improvement and send it to the Director General. The individual director of clinical governance in the area health system will notify us whether they are intending to implement the recommendations and the director general will consider whether they have any capacity to be implemented more widely across the system. We have an informal arrangement with the Clinical Excellence Commission where there is an individual case that has significant implications to look at immediately, but our regular liaison and intersection with the Clinical Excellence Commission is through the director general of health.

The Hon. Dr PETER WONG: I wish to ask you about an article published on 23 February in the Sydney Morning Herald regarding an obstetrician. I mention it because Professor Bruce Barraclough had briefed the Committee and mentioned a systemic problem at Camden and Campbelltown, implying that at least in some instances it may not be the doctor's or nurse's fault. I think it is an example of a systemic error and in the tribunal Judge Reg Blanch said, "In my view there is no substance at all to these complaints and they should be dismissed". If the commission contacted Professor Bruce Barraclough early on, would it not know then that, as the judge said and also from information I obtained, there really was either no case or a very doubtful case, and why would the commission persist with cases like that?

Mr PEHM: The decision in that case was made before the director of proceedings came into being by Judge Taylor. Part of the investigation process is for the commission to obtain its own expert opinion and in that case we had the opinion of an expert gynaecologist from Adelaide. A big problem with a lot of these Macarthur matters revolves around this debate of systemic responsibility versus individual responsibility and there was a very widespread view amongst the profession that the problems at Campbelltown were largely systemic in nature. It is not the commission's role to investigate systemic issues as such. In fact that was a course that the former commissioner, Amanda Adrian, embarked on with her report into Macarthur. The idea was that we would not attribute individual blame, we would write a report examining the systemic issues. Now it is a matter of law, and the Parliament's intention, that the role of the commission is to investigate individual complaints. The extent to which an individual is responsible is often an inherently difficult question. One of the reasons we went to Adelaide was - and this happened in a lot of the Macarthur matters, we had to get peers interstate - because a lot of the experts we contacted in New South Wales essentially said they felt very awkward about giving any opinion on Macarthur matters because of the publicity and because of this whole debate about systemic issues. You cannot always predict the outcome of a prosecution at the beginning. That matter was prosecuted on counsel's advice and on the advice of an

expert who we believed to be a very eminent expert. I think one of the turning points in the case was that he was from a tertiary hospital whereas the hospital at the time was not as well equipped as a tertiary hospital, so the clinical decisions made were different.

The Hon. Dr PETER WONG: I am trying to highlight the point that sometimes it is hard differentiate between individual cases and systemic matters and therefore the commission ought to have a closer relationship with the centre of excellence.

Mr PEHM: If we take a matter to a disciplinary body we have to have our own expert. I don't know how the Clinical Excellence Commission would feel. I do not think they would be prepared to provide expert evidence as a witness because that expert is then cross-examined.

The Hon. Dr PETER WONG: I am not saying that, I am referring to consultation. As soon as Professor Bruce Barraclough briefed this Committee I became aware that systemic error could be the case. I had a similar idea to the commission, but once it was mentioned to me that perhaps there was systemic error the alarm bells rang in my head: Maybe I was wrong. I thought it highlighted the need for a better relationship.

Mr PEHM: I take the point.

The Hon. CHRISTINE ROBERTSON: Do you know what the terms of reference and the outcomes expected from the two organisations are? I know you know what yours are, but do you know what theirs is?

Mr PEHM: Theirs is a very broad remit. It is to identify system-wide issues and to set up committees to look at how they might address those issues across the system. They have things like a working group on falls, which is a big issue and contributes to a lot of time. They also have a role to audit what we call root cause analyses. In the health system, whenever there is a serious patient incident of a particular level of seriousness, the hospital must do a root cause analysis, which is going back over what happened and learning what you can from it and making recommendations to improve it in the future. The Clinical Excellence Commission trains people conducting that analysis and has a role to go around and audit that process.

The Hon. CHRISTINE ROBERTSON: So do you perceive the two functions are complimentary?

Mr PEHM: Yes.

The Hon. CHRISTINE ROBERTSON: Are you comfortable with the level of communication that you have at the moment as far as your two separate functions are concerned?

Mr PEHM: Yes, there is no difficulty at all. They are open to any input from us and vice versa. The practical pathway through the director general of health is working well.

CHAIR: Is there any time during the course of the year that you would have either formal or informal meetings with the Clinical Excellence Commission? You have regular six-monthly meetings with other commissioners in other States and in New Zealand. I presume you have regular meetings with the Department of Health. I am just wondering if there is any connection at all with the Clinical Excellence Commission?

Mr PEHM: No, not at the moment. We have three-monthly meetings with the director general of health. Bruce Barraclough certainly left it open to look at regular liaison and at that stage they had not appointed their executive staff.

The Hon. Dr PETER WONG: I suppose the Chairman would be thinking of having liaison with them on a regular basis.

Mr PEHM: I am certainly open to that and we will follow that up.

CHAIR: I have said to previous commissioners - and I think I have mentioned to yourself - that it is important that you liaise with medical boards, in particular in other States, which have the same function as the commission. We might move on.

Mr TURNER: Could you describe the adequacy of administrative and other supports to the Health Conciliation Registry?

Mr PEHM: The registry is adequately supported. At the moment it consists of a registrar and a clerical support officer. There have been no difficulties from the registrar or any complaints or any requests for further resources. It has been managing itself quite well.

Mr TURNER: There was a noticeable jump in the number of referrals to registration boards. Can you explain why?

Mr PEHM: No, I think there might be a bit of a misunderstanding there. On page 22, table 8 of the annual report shows 483 referrals in 2003-04 and in 2004-05 there were 482 referrals, so it is actually a drop of one. I think what has happened is the percentage number of referrals has gone up and that is due to far fewer complaints being referred to area health services, so the actual number sent to registration boards is consistent.

Mr TURNER: There was a pronounced decline in the number of referrals to AHS. Why was this the case?

Mr PEHM: Well, in the past the commission had a practice of referring quite difficult and serious complaints to area health services to directly investigate themselves and to either send a report back to the commission and advise or to deal directly with the complainant. There is a threshold. Section 23 of our Act says that the commission must investigate serious complaints. We have been very careful and that is why we have a more extensive assessment process now to ensure that we fulfil the obligation to investigate serious complaints ourselves. The other problem with those referred to the area health services is that we have had a lot of requests for review from the complainants and from patients who were not happy with the outcome of the area health service investigation and they were entitled to have a review of the decision to refer it out there in the first place.

Mr TURNER: Could that be the result of some people perhaps thinking that the area health service was investigating itself?

Mr PEHM: I think that perception is always going to be there regardless of the quality of the investigation. People will always feel: Well, how impartial can it be? They are investigating themselves. We have also reviewed a number of cases that we had to take on for investigation because the health service investigation had not answered the questions and serious issues remained, so we are referring far fewer matters out to area health services now for that reason. I think it was part of that education and development process that the commission had. It had a sort of partnership unit and the idea I think, which is not a bad idea in principle, is that you refer the matters back to the area health service and they deal with them and we just have a bit of a monitoring role or something. I think it was also partly in response to the big backlog of complaints and the commission had so many itself that it had to deal with.

The Hon. CHRISTINE ROBERTSON: Can you give some examples of the types of concerns raised by CRS clients that are classified as corporate services?

Mr PEHM: Yes. These are national categories and we have changed the categories that the commission used to have. Corporate services include things like hotel services, car parking, cleaning, catering, grounds, laundry, maintenance, security, hygiene, environmental standards and administrative services like clerical process, admissions and those sorts of things, so bits and pieces like that.

The Hon. CHRISTINE ROBERTSON: Do you know any of the details?

Mr PEHM: I have not gone through individual complaints, but it is that sort of thing, car parking, lack of security--

The Hon. CHRISTINE ROBERTSON: Housekeeping?

Mr PEHM: Yes.

The Hon. CHRISTINE ROBERTSON: Does 59.5 percent of outcomes at total or partial resolution seem appropriate to you?

Mr PEHM: I am not sure what you mean by "appropriate". It is a pretty good outcome, we think. 59 percent of the total complaints are resolved either totally or partially. Of the complainants that do not simply say, "I don't want to participate in the process" or "I'll go off and do my own thing and take legal action", 87 percent of matters where complainants actually participate in the process are resolved, and we think that is quite a high rate of resolution.

The Hon. CHRISTINE ROBERTSON: On page 30 you provide statistics on consumer satisfaction from the CRS Satisfaction Survey 2004-05. Was there any notable change in consumer satisfaction following the amendments to legislation and the subsequent change to the role of the CRS? Have you had any indicators that it has made a difference?

Mr PEHM: No, there has been no change really.

Mr TURNER: The response rate to the CRS satisfaction survey 2004-2005 was reported as 27 per cent. Does the commission has have any plans or strategies to increase this rate?

Mr PEHM: Those surveys are sent out to every complainant that participates in a complaint resolution process. The return is voluntary. It is up to them whether or not they return it. I am not sure how 27 per cent compares with other surveys. I do not know whether it is a good or bad number. The only thing I can think of to increase that is to actually have people go out and door knock.

The Hon. CHRISTINE ROBERTSON: That is very expensive.

Mr PEHM: It seems like not a very wise investment of resources.

Mr TURNER: As a politician I often put surveys out and we think we are doing well if we get 10 per cent so 27 per cent is probably not bad. Does the commission have any plans to expand its assessment of stakeholder satisfaction levels to encompass any of the following in the immediate future: One, the complaints assessment, investigation, legal and prosecution processes?

Mr PEHM: I think I have answered this broadly in the answer to previous questions and that is that I still think that we have a significant amount of work to do internally. We know what our problems are. We get plenty of feedback from complainants and respondents through the normal complaint handling process. It is very clear that our problems are delays and response rates, timeliness. I think we have a lot more work to do internally in improving our own performance and procedures before we go out surveying people. You are getting into refinements at that stage where you are looking at how you can fine tune and tweak things when you are looking at stakeholder satisfaction, so no immediate plans.

Mr TURNER: You have probably partly answered this one as well, the internal governance and management arrangements, such as the effectiveness of the case management and records management systems.

Mr PEHM: Again we have a lot of problems there. The case management systems will improve now with casemate. There is still a gap with general commission records. We have had a

consultant in to look at our records systems, or lack thereof, and there is an enormous amount of work to do there. There is no effective electronic records system. We have been talking to State records about that and how to improve it, but that is going to be quite a big project. That is something we will have to go to Treasury for, for funding for a system to do that.

Case management records are much better but the difficulty we have is that when matters come in the door and before they get registered in the case management system there is a gap there that we need to address. Again that is an area where we know what needs to be done. We have had consultants look at our systems and, rather than survey stakeholders, we have a fair idea of what we need to do.

Mr TURNER: The public education strategies for raising awareness of the resolution of complaints about health care.

Mr PEHM: I have covered this, I think, in terms of the complaint resolution service and have had consultations with the Consumer Consultative Committee. They are good forum for assessing consumer stakeholder needs, and they did identify that need for the complaint resolution service to be out there addressing peak groups and bodies, and we are implementing that.

Mr TURNER: The liaison role with the Clinical Excellence Commission and the Department of Health regarding contribution to improved quality assurance systems.

Mr PEHM: We have a very good relationship with the Department of Health and with the area health services, through the Director-General. I think our direct liaison role with the Clinical Excellence Commission, I will take that up.

Mr SHEARAN: What alternatives, if any, exist for consumers given the refocussing of the work of the Complaints Resolution Service?

Mr PEHM: This relates back to the issue that the Chair was raising earlier, that he feels there is a big gap in the service. I am not sure that that is the case and I do not have any data to necessarily support that. Within the public hospital system a lot of hospitals have patient representatives, patient support.

The Hon. CHRISTINE ROBERTSON: Patient representatives usually, are they not?

Mr PEHM: They are Department of Health employees attached to hospitals and people can go to them and they can be liaison points to deal with problems people are having with hospitals. In the private sector I do not think that there is very much to assist complainants, apart from the commission, so I do not think there are many alternatives.

Mr SHEARAN: I must admit that I had a constituent came in who felt that the hospital service was not the best and she complained to the commission and felt frustrated in how the procedure went through, and I must admit that to some extent I agree with the Chair that the CRS process might be in need of a further look, just for that extra facility. The requirements seem to prevent that flow of work.

Mr PEHM: Your constituent is frustrated with the bureaucracy, or the process?

Mr SHEARAN: Overall, and I have made a formal complaint on her behalf, which no doubt will be sent through to you. I think that is the issue about the alternatives anyway. Is cultural competency training included in the training plan for 2005-2006?

Mr PEHM: It has not been. Our training programs have been focussing on very basic skills like communication, analytical skills, investigation, statement taking, interviewing techniques, those

sorts of things, so it is certainly something we need to address and we will be looking at in the next financial year.

Mr SHEARAN: Can you comment on the handling of complaints when the practitioner is not registered with the registration authority?

Mr PEHM: A lot of health practitioners are not registered, naturopaths, homeopaths, psychotherapists and so on. They are still health service providers under our act. People can complain about them. We can investigate those complaints. The difference is in the outcomes. Those registered practitioners can go before disciplinary tribunals, be suspended, or have conditions imposed. The most we can do with non-registered practitioners is make comments to them at the end of an investigation to the effect that their practice was substandard, or dangerous, depending on the nature of the case. We can also refer matters to the Director of Public Prosecutions if we feel there is evidence of criminal breaches.

The Hon. CHRISTINE ROBERTSON: Is this question about people who do have a registration process or do not register when they have got one?

CHAIR: Unregistered practitioners.

The Hon. CHRISTINE ROBERTSON: Practitioners who cannot register.

Mr SHEARAN: Has the commission considered listing the names of deregistered practitioners on its web site?

Mr PEHM: We have considered it and what we would like to do is not just publish names, but do it in a broader context where we publish a decision of the tribunal, but it is quite a big IT project, I understand, because it goes back many years and we are probably the only agency that has a complete collection. The boards might for their own practitioners or they would, I think. The project is to get the IT capacity to do it. All those documents have to be scanned in, in reference to names, and I have talked to our IT section about that and they tell me it is quite big and it will take some time. We will have to look at funding to do it as well.

CHAIR: Could you not start to implement it from 1 July for future cases and the past cases could be something that could be done over time.

The Hon. CHRISTINE ROBERTSON: Excuse me please, the health department actually has a system for listing doctors, because they send it out to the public health practitioners regularly, so maybe the question could be about whether or not it is worth finding out what systems are in place to notify people of deregistered people, how can it be complemented?

Mr PEHM: I was aware not aware that Department of Health had something.

The Hon. CHRISTINE ROBERTSON: They send out a full list of the new deregistrations and the ones that have gone back.

CHAIR: Maybe you could follow up on that and we will be talking to you during our other inquiry which is on those unregistered health practitioners. Dr Wong just came back into the room because he had to go to the Upper House. Could you repeat what you were saying about the cultural competency training? I think he has some more questions on that.

The Hon. Dr PETER WONG: Is the cultural competency training included in the training plan of 2005-2006? Have you been asked that?

Mr PEHM: I am happy to answer it. It has not been. We have been concentrating on basic

investigation skills like statement taking and interviewing techniques and written communication but it is something we will look at for the next year.

CHAIR: Thank you. Dr Wong has a particular interest in that area. In general, you would be aware of the particular case that we sent to you last year where a constituent of a Member of Parliament raised a complaint with the Committee. We forwarded that to you. That was concerning delays in the processing of the complaint and the lack of communication about the progress of the complaint on the part of the commission. In general terms, without referring to the particular complainant or the case, is that case representative?

Mr PEHM: I do acknowledge that we have had difficulties in our assessment process. I was explaining that we are now engaging in a much more careful analysis of complaints and getting responses and so on. We have expanded the area of the commission that is dealing with that. It is not something that the officers in that section are used to doing. Their previous job was simply to make up the file with the complaint and that was really the end of the job. We are now asking them to do a lot more, to analyse the complaint, to get responses and to read it. There have been difficulties there. We are addressing those through training and through changing procedures and in particular when the new act came in on 1 March and for probably six months after that we had a lot of problems in that area. Those things are improving now and I do not think this case would be representative of the way we handle things now.

CHAIR: In the gallery today we have Christine McGillion from the New South Wales Chiropractors Association and Ms McGillion appeared before the Committee last week and we had an informal briefing on the chiropractic association and what they do with handling complaints about their members, and that was part of our inquiry into unregistered health practitioners. We advised Ms McGillion that you would be appearing before us today and that she may like to come along and hear what the commission is doing as it is a public hearing and I will take the opportunity to introduce you to her at the conclusion of the hear. What was your understanding of the role of professional associations in the complaints handling process?

Mr PEHM: There is no formal role in a complaints handling process. A professional association can make a complaint, and that does happen, in which case they are they complainant and they are treated as the complainant and are advised and consulted with on the way through. I suppose it is a question of numbers. Most complaints are against doctors so we have had meetings with the College of Surgeons and the College of Physicians and so on in relation to recruiting peers and experts, but there is no formal role for professional associations in complaint handling.

CHAIR: Are you aware that from the information we have gathered that a number of associations do perform the role of assisting in resolving complaints at a lower level? They may not find their way to the commission.

Mr PEHM: I am aware that some do. We have had some limited contact with professional associations where they have been dealing with complaints, but their member has thrown up the shutters and briefed barristers and they have come to us and say what do we do with it now. In effect there is nothing much they can do because they do not have the power to deal with it without the consent of the person. Limited contact like that, but no regular liaison. There is not a loss of crossover in our experience.

CHAIR: From the information we received from our briefing last week, we think that there are opportunities that could be explored if we could set up a mechanism of a regular exchange of information between the associations, that is why there has been a line of questioning. We will follow it up with you after the public hearing today.

One of the functions of the commission in 2004-05 was to improve the health care system through recommendations from investigations. What recommendations were made in 2004-05, how

many of the recommendations were accepted and what improvements have been proposed as a result?

Mr PEHM: There were 26 investigations that resulted in the commission making comments or recommendations to the health service provider during 2004-05. We have only recently set up the process for monitoring those beyond the individual health service provider and that is the meeting I was referring to with the director general of health every three months, so prior to that time there was no monitoring of the implementation of the recommendations, and that is something we will be reporting on in our next annual report. There is a bit of an issue in the Act with the provision of that information. The way the Act reads at the moment it is solely the responsibility of the director general to publish that sort of information and the Act provides that the commission shall not publish it. I now think it is very important that it should be published and I will be talking to the director general about publishing that in our annual report. I am sure she will have no problems with that.

CHAIR: Going back to the article that Dr Wong referred to in the Sydney Morning Herald on 23 February, the article mentioned two doctors. There was a second case that you had taken to the tribunal and the tribunal cleared both doctors. I was just wondering if you could give us the reasons why the second case was also taken to the tribunal if there was not sufficient evidence to win the case?

Mr PEHM: The second case concerned an allegation made by a nurse that a doctor did not conduct an examination and later falsified medical records to the effect that he did. The nurse was interviewed by counsel before the decision to proceed with the prosecution was made. I am not across all the details of the supporting evidence - Karen might want to add to this later - but I think that essentially it turned on credibility under cross-examination: One witness was believed and one wasn't. You always make assessments of credibility on the way through, during the investigation, but it is not really until the final court or tribunal hearing that it comes to the crunch. We do not prosecute frivolous complaints where witnesses are obviously not credible. We rely on counsel for an assessment of the credibility of a witness, but Karen might be more familiar with that.

Ms MOBBS: I think that is essentially correct, that it really did come down to an issue of credit. The decision to prosecute any matter is really a balancing exercise and that is reflected in the criteria, but what you are looking at is how serious is the offence and the conduct and the consequences on the public safety. You look also at the strength of the evidence and the likelihood of proving the offence, so you do have to look at those issues. Obviously if this matter was established it is a very serious matter and one that the public would want to see tested. We had counsel in the preliminary stages conference the witnesses, provide advice as to the likelihood of the matter proceeding; we had separate experienced counsel running the hearing, interviewing witnesses and again making an assessment that there were reasonable prospects. Matters happen, different issues arise, and I think that is just part and parcel of the prosecution process and the adversarial system.

CHAIR: Would you be able to tell the Committee what percentage of the cases that went before the tribunal were successful? The other question I was going to ask that you might be able to answer also is that in your report is there listed the amount of money that was expended in 2004-05 on taking cases to the tribunal?

Mr PEHM: There is a line item "Legal fees and other adverse costs" on page 78 in expenses. There is some peculiar item there. I think it is running at around $600,000.

CHAIR: $699,000, closer to $700,000. What are adverse costs?

Mr PEHM: Adverse costs are costs orders against the commission. In the medical tribunal, for some reason - I don't know why it is different from the others - costs usually follow the event. If we win the case, the doctor pays our costs, and vice versa. In the other tribunals that is not the case.

Ms MOBBS: In the various tribunals - the nurses tribunal, for example - there is no cost.

Mr PEHM: All of these registration acts were written at different times and for whatever reasons at the time they are all different. It needs really to be a project of regularising them all

because it complicates our processes as well, but adverse costs are where we lose the case and costs are awarded against us.

Ms MOBBS: I think the question was in relation to the number of successful prosecutions. Just referring to page 47 of the report, in this reporting year the commission finalised 85 cases, 73 disciplinary matters. Of those, seven were withdrawn for various reasons, namely that the complainant may have been dead, the practitioner had withdrawn themselves from the register; two were dismissed on the basis that the complaint had not been proved, so I am not sure what percentage that is, but of those 73 disciplinary matters that were heard, two were actually heard and found not to be proved, so a very small number.

CHAIR: At the hearing held in 2005 on the previous year's annual report the commission agreed to make a number of inclusions in future annual reports. Are you able to comment on the absence of two of these inclusions in the 2004-05 annual report? One is the detailed information on any internal committees of the commission and the second is cross-referencing of statistical information in the appendices with the main body of the report.

Mr PEHM: The internal committees of the commission - on page 63 we refer to the Consumer Consultative Commission and list the members of that committee. On page 64 we talk about our Workplace Consultative Committee under commission representatives and Public Service Association representatives. We are a very small commission and other than general management mechanisms, which I don't know whether they are committees, we have management meetings involving directors of the commission every fortnight. We have an Investigations Review Group, to which I referred earlier, that monitors progress of investigations. I do not know whether they are the committees the report on our annual report was referring to. It would not be normal to publish details of the membership of those normally in an annual report.

CHAIR: Does the commission have an internal audit committee?

Mr PEHM: No, that is done as part of our management committee. You need a committee when you have a big organisation where you have a lot of different departments, you have representatives from different departments to put forward a program and audit it over a period of time. That is quite manageable with our management committee.

CHAIR: But the total budget for the year in question was $10.41 million.

Mr PEHM: Yes.

CHAIR: The Committee provided you with a review of the annual report prepared by our consultant, John San-Sue. Are there any comments you want to make about that review, because we will be including that in our report that goes to the Parliament?

Mr PEHM: There are lots of things that I do not necessarily agree with in it. I think the review last year complained that the report before this one had a commissioner's foreword rather than an executive summary. So this year we have an executive summary and it says we should have a commissioner's foreword as well as an executive summary. There is a complaint about including case studies in the body of the report. For some reason he seems to think that they should be put in an appendix. We have had very good feedback on the case studies and the Consumer Consultative Committee and other people think it is a good idea to have real life cases rather than just numbers in the body of the annual report, so I would not be proposing to put those in an index.

The second part of your last question is something that that review raises, which talks about cross-referencing tables in the appendices. The way the report is written is that data that relates to the performance of the commission in terms of complaints process and turnover and timeliness and all of those sorts of factors are dealt with in the body of the report. The information in the back in the appendices is more general information about the categories of complaints, where complaints are made, the types of practitioner they are made against, whether it is public, private, nursing home, those sorts of issues. That data is probably more of interest to academics or people who are interested

in the provision of health services generally. The report suggests that we should cross-reference that data with text in the annual report. I am just not sure what "text" is necessarily referring to. Those are the things that occurred to me just off the top of my head when I read it. There are obviously some good things in there and criticisms that we will take on board and look at next time.

CHAIR: You are aware of the problems that occurred in Queensland and there was initially a Bundaberg Hospital Commission of Inquiry and a Queensland Public Hospitals Commission of Inquiry report, which was released in November 2005. There were also separate reviews into the Queensland health system and a final report released. I was just wondering whether you have had an opportunity to look at those reports or whether, in your liaison with the Queensland Health Rights Commission, anything came out of those reports that would help us in the way we handle health care complaints in New south Wales?

Mr PEHM: I have spoken to the Queensland Commissioner about them and he has advised me of some of the consultations that are currently taking place into what a new system might be. I must say I have not read the report and I am not sure of the extent of his consultations during the reform process and the confidentiality of those. They, like the rest of the Australian states, have a system where the medical board is the principal governor, if you like. The Health Rights Commission there is more in a conciliation and resolution mode. As you know, we have an investigation prosecution role as well as a resolution one. At first blush, from my discussions with him, I am not sure there is a lot coming out of that inquiry that would go to recommending changes in our system.

CHAIR: We will be looking at those reports carefully to see if there is anything to be learned. That brings me back to my earlier comment and something I have raised with previous commissioners and that is that I really believe that it is important that the Health Care Complaints Commission start up a dialogue with medical boards in other states who are charged with this investigation process that your commission here in New South Wales is also. Most of the other commissions, as we know, are into conciliation and not necessarily the investigation and prosecution of cases before tribunals.

Mr PEHM: They are all very distinctive. As I was saying, in New South Wales different registration acts came into power at different times. In the interstate ones there are all sorts of procedures that do not exist in ours. In Queensland, for example, they have the power to get a practitioner to give them unbinding undertakings, so rather than prosecute someone they can stop short of prosecution and say if you undertake to do this course or not to do this procedure we will leave it at that and rely on your undertaking. There are lots of differences that are not necessarily transferable. There are lots of problems in enforcing those conditions. Where I do come into contact is where practitioners move interstate and conditions that are in place in one state might not be enforceable in another because of mutual recognition problems in that the mechanism existing in one state does not exist in the other.

CHAIR: That was one of the recommendations out of one of the inquiries.

Mr PEHM: I think the Productivity Commission has recommended a national registration board.

The Hon. Dr PETER WONG: I briefly mentioned about overseas doctors and as the Chairman indicated part of the finding in Queensland related to overseas qualified doctors. As we in the country need more overseas doctors and nurses I think an accusation either true or otherwise will be constantly in the mainstream. Will the commission brief the Committee or monitor the situation and give us advice on what the problems are, how we can solve the problems, or prevent such an issue becoming a hot topic?

Mr PEHM: It is more within the responsibility of the New South Wales Medical Board. They accredit overseas trained doctors and there are specific categories of doctors, area of need doctors, where their practice is limited to perhaps the rural area and in a particular discipline, but I can

certainly talk to them about it and let you know.

The Hon. Dr PETER WONG: As a complaint comes up maybe you are familiar with the investigation and assessment and you can maybe highlight some problems.

Mr PEHM: I will see what we can find.

The Hon. Dr PETER WONG: Something that we should be aware of.

Mr PEHM: I am happy to look at that.

CHAIR: Commissioner, or Ms Mobbs, are there any closing comments you would like to make?

Mr PEHM: I do not think so. We have been fairly thorough we have covered a lot of ground.

CHAIR: We look forward to seeing you again and speaking you in relation to our other two inquiries that we have under way.

(The witnesses withdrew)

(The Committee adjourned at 11.50 a.m.)