REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE 2007-2008 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

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At Sydney on Wednesday 29 April 2009

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The Committee met at 10.00 a.m.

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PRESENT

The Hon. H. M. Westwood (Chair)

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

CHAIR: I declare the hearing open. I remind everyone to switch off their mobile phones, as they can interfere with Hansard recording equipment. It is a function of the Parliamentary Joint Committee on the Health Care Complaints Commission to examine each Annual Report of the Commission and report to Parliament upon it in accordance with section 65 (1) (c) of the *Health Care Complaints Act 1993*.

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

KAREN MOBBS, Director of Proceedings, Health Care Complaints Commission, Level 13, 323 Castlereagh Street, Sydney, affirmed and examined:

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

Mr PEHM: I am the Commissioner of the Health Care Complaints Commission and I am appearing in that capacity.

Ms MOBBS: I am the Director of Proceedings of the Health Care Complaints Commission and I am appearing in that capacity.

CHAIR: I convey the thanks of the Committee for your appearance today for the purpose of giving evidence on matters relating to the 2007-08 Annual Report of the Health Care Complaints Commission. I am advised that you both have previously been issued with a copy of the Committee's terms of reference and Legislative Assembly Standing Orders 291, 292 and 293, which relate to the examination of witnesses. Is that correct?

Mr PEHM: Yes, that is right.

Ms MOBBS: Yes.

CHAIR: The Committee has received a detailed submission from the Health Care Complaints Commission in response to a number of questions on notice relating to the Commission's 2007-08 Annual Report. Commissioner, do you wish this to form part of your evidence today and for it to be made public?

Mr PEHM: Yes, please.

CHAIR: I direct that those materials be attached to the evidence of that witness to form part of the evidence. Do members concur with authorising the publication of the submission? Commissioner, would you like to make an opening statement before the commencement of questions?

Mr PEHM: No. Thank you for the opportunity, Madam Chair, but I am happy just to take questions.

CHAIR: I will begin before the other members ask their questions. The Committee is pleased to note a significant improvement in the quality of the

Commission's Annual Report. Could you advise what changes have been implemented to bring about this welcome improvement?

Mr PEHM: I think the improved Annual Report is part of the improved capacity of the Commission's work generally. We have much better reporting systems through our electronic database than we did before on the handling of complaints, we put a lot more work into the recording and analysis of the issues raised by complaints and we have much more accurate performance data on the Commission's work. The Commission has also employed a Communications and Public Relations Officer for some time now. I certainly would like to congratulate her on the hard work she put into both the compilation and the presentation of the report.

Mrs JUDY HOPWOOD: Could you advise the Committee of the Commission's input into the Special Commission of Inquiry into Acute Care Services in New South Wales?

Mr PEHM: We had a couple of meetings with the Commissioner, one very early on in his Commission to advise him about our Commission's role, how we worked and what we saw as the issues that perhaps might draw his attention as part of his inquiry. The case of Vanessa Anderson, which in some respects gave rise to his Commission, was also a case that our Commission investigated and, of course, the Coroner did as well. We had particular concerns in that case, which we have published in the Annual Report, about the interaction of the confidentiality that attaches to root cause analysis investigations in hospitals and the explanations that are given to patients. That was the source of a great deal of anxiety for the Anderson family. We think what actually occurred there remains a problem and has the potential to adversely impact on open disclosure to families who have suffered serious loss through health carers. That was certainly an issue we raised with him.

The other issue that I thought was very important was the availability of performance data in the health system generally. The Committee has been interested on a number of occasions in what our complaints analysis tells us about the health system and what conclusions we can draw from it to improve the system. Unfortunately, my answer has reasonably consistently been that our data sample is quite small. There is a much bigger pool of data reported internally within the health system both by clinicians and through patient complaints which do not come to us. Some information about that is published by the Clinical Excellence Commission.

I put to Mr Garling that I thought there could be a great deal of improvement in that area so that clinicians could access that information and be able to compare their performance and compare the performance of their wards, units and hospitals as a performance improvement tool. That aspect of the health system I think has been addressed by Mr Garling's recommendations with regard to the Bureau of Health Information, which I understand the Government is implementing.

Mrs JUDY HOPWOOD: The Inquiry's final report notes that Commissioner Garling referred 213 individual patient complaints to the Commission. What impact has this had on the Commission's operations?

Mr PEHM: It is a fairly high number, but in the context of 3,000 or so complaints overall it is not an extraordinary number. A significant proportion of the complainants had previously complained to the Commission. So in those cases it was a matter of reviewing the old files and contacting the complainants to determine whether they wanted to pursue a fresh complaint. In many cases they simply wanted to raise their case before Mr Garling and be heard. They confirmed they did not wish to pursue the complaint and they were satisfied with the action taken. A small number of those cases were referred for formal investigation—a couple of quite serious ones where perhaps the extra publicity generated by the Garling Commission had encouraged the complainants to come forward—and those were investigated. Investigations are the most resource intensive part of our operations, investigation and prosecution, obviously. From memory, I think only 9 or so of the 213 were referred for formal investigation.

Mrs JUDY HOPWOOD: The Government's response "Caring Together: The Health Action Plan for NSW" does not appear to make any specific reference to the Commission. Do you consider that it will nonetheless impact upon the Commission's operations?

Mr PEHM: It is very difficult to make a call on that. It will depend on the effectiveness of the implementation. If all of the objectives of the plan are met and if it is effectively implemented then one might conclude that a better running, better self-monitored health system could generate fewer complaints. It remains to be seen whether that is the case or not. I certainly do not expect or I would not anticipate an increase in complaints flowing from it.

The Hon. DAVID CLARKE: Commissioner, what do you consider to be the Commission's most important achievements during the reporting period 2007-08?

Mr PEHM: I think since I became Commissioner our focus has been on improving performance on the handling of the core business, which is complaints from the public. It is a slow and difficult process of cultural change as well as systems improvement that has had to be brought about in the Commission, and it has been taking place for a number of years. This year we have seen substantial improvements. I think there is more to be done yet. But if there was one major achievement—and I do not think it is just one that applies to this year; it is one that stretches over the last four to five years in the Commission—it is the continued improvement of the complaints handling process. We are much more responsive to the public than the Commission may have been in past. Our time frames are certainly improving. Probably most importantly, I think the quality of the Commission's investigations is getting much more incisive and starting to generate the potential to impact by creating systems improvements in the health system. We have put a lot of work into investigations where we make recommendations for changes to health practices and we work with the Governance Unit in the Director General's office to look at, for example, where problems are identified in one hospital the recommendations for change might be implemented more widely throughout the health system. I think that is a very important aspect of our work.

One thing that we have been particularly strong on this year—and I referred earlier to the communications and public relations position we have created—is that I

felt that the Commission had spent a lot of work in past years in improving its internal processes and it was time to, I suppose, market ourselves, to use not a very tasteful term, and to provide greater publicity for the Commission's role and capacity. We have seen an increase in complaints. Again, it is hard to put that down to one factor—whether it is publicity about the health system, people being more conscious—but we have gone through the health system and we have provided publicity material, posters and pamphlets. We have put in a lot of work talking to the public through the peak bodies and interest groups. We have spent a lot of time talking to clinicians and practitioners about handling complaints themselves. I think that is quite a significant achievement during the year as well.

The Hon. DAVID CLARKE: What are the key aims of the Commission in the short to medium term?

Mr PEHM: I really think, to extend the previous answer, it is a question of continuing improvement in complaint handling. It is very difficult to plan at the moment on any longer term basis because, as the Committee is aware, there is a proposal for national registration of health practitioners which, in theory, is a good idea, but I think the current proposals would impact substantially on the Commission and reduce its staff numbers considerably and its budget. It would, in effect, separate the conduct of individual health practitioners within the system and give them to a national body, leaving the Commission with the conduct of organisations. Effectively, I do not think that in an investigation you can really separate out individuals from systems and have one body investigating systems and another body investigating individuals. Really for the short term it is to continue doing what we have been doing, continue to improve at it, and hopefully to persuade the public, and the proponents of an alternative system that I think would impact adversely on the Commission, that the Commission model is the preferable one in terms of the protection of public health and safety.

Mr KERRY HICKEY: I welcome the improvements in the Annual Report: they have made it very good and easy to read. The number of inquiries that the Commission got was 8,831. From the number of assessments and investigations it seems that a lot of people make inquiries that do not end up as an investigation. You have talked about complaints handling and communications: I think we need to probably promote what the Commission is really about, because it seems that everyone goes there at the end of the day to try to get some finalisation on issues that are not really appropriate for the Commission, and I think that needs to be spelt out in your advertising material. People actually take away a lot of resources from the Commission and in your marketing that needs to be looked at.

In response to the Committee's questions you note that while complaints are made about public hospitals and private hospitals caution ought to be exercised in interpreting this fact. Is it worthwhile to examine that more closely to determine whether there are significant differences between public and private hospitals in their complaints in respect of similar operations, procedures and patients, given that in some instances private hospitals may, in fact, be setting the benchmark for all public hospitals?

Mr PEHM: I had not, but it is certainly a worthwhile idea and probably bears some examination. The other factor which I may have alluded to in my answer is the different relationship between private and public patients and their practitioners. People who have insurance and choose their own doctor usually have a longstanding relationship with that doctor and, I think, as a result of that trust and longstanding relationship, are less likely to complain than public patients who are allocated doctors, often in surgery cases, and operated on by registrars and people they consider quite junior. I think that has an impact on the number of complaints. The question you raise is slightly different on comparing similar procedures but certainly I will think about that and see what data we can extract on that.

Mr KERRY HICKEY: In your response you also note that in urgent cases a complaint may be separated into those issues which are urgent and those that can be revisited. Has this process led to any problems with the increase in the Commission's workload as a matter of effectively investigating something twice? Similarly, is the Commission aware of whether the processes impact upon doctors, providers, where information is required for an urgent complaint and the remainder of the complaint is dealt with at a later date? Also, is the complaint less likely to proceed if the issues are looked at separately?

Mr PEHM: Would you refer to the answer? I cannot place that comment at the moment.

CHAIR: Question 12, page 7 of your response headed "Inquiry service".

Mr PEHM: Referring there to the inquiry service that deals with phone calls, and not with written complaints—and there is a very small proportion of complaints where the caller is quite desperate. An example of the issue might relate to the placement of an aged relative where the hospital feels that there is no medical need for them to stay and is pushing them out into a nursing home and the person is having trouble arranging that or feels more treatment is needed. In cases like that rather than saying to the complainant, "You have to make a written complaint first", our Inquiry Officers will take down an account of the complaint over the phone. We will use that as the written complaint—legally we treat it as a written complaint. In those urgent cases we will assess them immediately for a referral to our resolution service. It does not usually relate to issues that require investigation.

The Resolution Officer can then get in touch with the institution and the family and try to resolve the situation and take the heat out of it. Under our Act there is a requirement to keep our handling of a complaint under a continuous assessment. So if, in the course of trying to resolve that problem, the Resolution Officer feels that more serious issues are raised he or she will report back to the Commission. It may have thrown up a surgical error or a medication error that they believe needs to be investigated. That matter can then be assessed by the Commission for investigation.

Mr KERRY HICKEY: Is it a small number of complaints?

Mr PEHM: Page 33 of our Annual Report deals with a breakdown of the inquiry service outcomes. You will see there that the vast majority are simply dealt with by providing information to the caller. Discussing strategies for resolution goes

to your point about marketing the Commission. Our approach is always for consumers to raise their concerns directly with the hospital. The inquiry service spends a lot of time talking to people about how best to do that and how to present their case. The figure of 63 is for "letter of complaint" drafted. There were ten cases where the Inquiry Officers feels it is an urgent matter and they will, in fact, draft a letter of complaint as I explained before. That is how it works.

Mr KERRY HICKEY: Are you only talking about 63 letters of complaint that are drafted? Do you do that for the other listings?

Mr PEHM: No "information provided"—all of these are phone calls—is just a discussion about the role of the Commission. The governance of health, if you like, is a little bit fragmented. For instance, nursing homes come under the Commonwealth Department of Health and Ageing. Callers call us because they see it as a complaint about a health service. Information will be provided about our role and perhaps the roles of other agencies. You will see another outcome, "referring to another body", which involves telling people what the responsible body is. Another one is "assisted referral": our officers will contact the Department of Health and Ageing, say, and give the complainant a contact person to deal with them. The vast majority are dealt with by the provision of information. As I say, we try to encourage complainants to raise their issues directly with the practitioners and if they can be resolved that way that is far preferable.

Mr MATTHEW MORRIS: The Annual Report certainly shows that there has been considerable improvement in time taken to complete an investigation and it mentions the implementation of a new procedures manual and staff training as contributing factors to achieving that. Will you advise the Committee of any other measures being implemented to ensure a best-practice approach to the conduct of all investigations, particularly any measures relating to cultural change and improving cooperation with other areas?

Mr PEHM: Certainly better training for staff is central. Clarity about procedures has helped a great deal. There is a much closer teamwork culture. We have recently improved our Casemate database system to provide more regular and earlier reviews of files by team managers and installed processes where investigators must draft an investigation plan for the complaint. From the outset it must be approved by a manager. There is a three-month review on that for progress and monthly reviews after that. We also have an internal governance committee called the Investigations Review Group, which I sit on, and we recently changed the parameters of that committee to look at any complaint more than nine-months old—previously it looked at any complaint more than 12-months old. So overall it is a tightening of management, supervision, giving greater direction to staff and as the quality of the work improves staff are learning more about how to make more effective recommendations and so on.

Mr MATTHEW MORRIS: Many of your targets key performance targets have been achieved or improved but how often are they reviewed and who actually reviews them to ensure that they are progressively increased as a way to achieve continuous improvement?

Mr PEHM: We review all of our performance indicators as part of our annual corporate planning process. We meet every year at the end of February or early March and set our broad strategic plan. Each of the divisions—Assessments and Resolution, Investigations, and Legal—then develops a divisional plan. That process is happening now and the plans are due in early May. We will implement those divisional plans, hopefully improved, and tighter performance indicators, given the continuous improvement from the previous year.

Mr MATTHEW MORRIS: The group meeting makes a recommendation back to you saying, "These are our targets for the coming year". Do you have carriage of that?

Mr PEHM: Each of those divisional plans is incorporated into the corporate plan, which is the Commission's corporate responsibility. Those become the targets. I expect each of the divisions will set realistic and achievable key performance indicators and targets, and I do not expect to have to overrule them. I am sure we will have discussions about that before it happens if I have any concerns that they might be too loose. That is all part of our corporate plan ultimately for the next year.

Mr MATTHEW MORRIS: Are those targets reviewed throughout the 12-month period?

Mr PEHM: They are reviewed annually.

Mr MATTHEW MORRIS: Or do you set them up front and you work to that target for the coming year?

Mr PEHM: We set them up front and work to them for the year. We set them annually. There is certainly also a continuous review process because we are constantly producing data and we provide the committee with a three-month performance report. Perhaps if we see the timeframe slipping or number of cases closed slipping we will investigate that and find out why and see what the problem is and raise it with the staff whose job it is to do that particular task. So throughout the year we are constantly monitoring the achievement of the targets. As I mentioned, we changed the investigating reporting group's parameter from 12 to 9 months because we are feeling now that the majority of investigations should be finalised by 9 months. That is something that occurred during the year rather than as part of the annual process. So adjustments and changes are made throughout the year as well.

Mr MATTHEW MORRIS: You are not in the routine of changing the targets if they are not being achieved at any stage throughout the year as part of those reviews?

Mr PEHM: Once you set your target in a corporate plan it is the target you set and it is the target you report on when you do your Annual Report. Having not met a target you might explain the reasons why or if you have exceeded the target, well and good, and next year you might tighten that, but I do not think we would change the corporate target halfway through the year because we were not meeting it or increase it because we were. We might do that the next year.

Reverend the Hon. FRED NILE: As you know, the Health Legislation Amendment Bill 2009 is going through the upper House at the moment. That legislation will compel any person to produce documents or information to the Commission during the investigation phase of a complaint and increase the Commission's powers to exercise all the powers under section 34A during the assessment phase of a complaint. Could you give an example of how those extra powers will assist the Commission to carry out its duties, perhaps in relation to the Graeme Reeves case, and so on?

Mr PEHM: The Commission did not have that power at all in the days of Graeme Reeves.

Reverend the Hon. FRED NILE: Now you have it, how will this assist you?

Mr PEHM: We now have the power to compel the production of documents and information from health service providers and from complainants. Before we had that power people could simply refuse to respond. The only power the Commission had was to go to a magistrate and seek approval for the execution of a search warrant to obtain documents. Even then, the practitioner was not obliged to provide any information that might explain or go to those documents. This is an extension to extend that power beyond complainants and health practitioners to other persons. One example we had was of a health practitioner who had a complaint made against him by a health insurance company for fraudulent claims. A lot of the claims related to treatment for members of his family, largely, a large extended family, and others. As those persons were neither health service providers nor complainants, the Commission could not compel any information from them. I think ultimately we could not gain sufficient evidence, given the powers we had, to take that investigation any further. That is the sort of example we have in mind in asking for that extension.

Reverend the Hon. FRED NILE: So, it will help you to be more effective in the future?

Mr PEHM: Yes, we think so.

Reverend the Hon. FRED NILE: Just following up in reference to the Committee recommendations, in its report on Graeme Reeves the Committee made a number of recommendations relating to the New South Wales Medical Board. There were a number of recommendations, mainly to ensure the practitioners continue in their studies, performance assessments and so on. Do you consider it is still worthwhile making necessary amendments to legislation so that these would be part of the new national registration and accreditation scheme?

Mr PEHM: I understand from discussions with various boards that the national scheme proposes to include a performance assessment process, which currently only exists in the New South Wales Medical Board, but that would be extended nationally. I think the problem with the Reeves matter was the effectiveness of the implementation and follow-up of that process. I am not sure legislation is the answer to those sorts of administrative matters; it is a matter for the body responsible for administering the process to make sure it is done diligently and calling the practitioner to account.

Reverend the Hon. FRED NILE: Such as the Medical Board, do you mean?

Mr PEHM: If that is the responsible body, yes.

Reverend the Hon. FRED NILE: You have already made reference to the fact that there may be some problems in the future with the introduction of a national complaints handling scheme. Have you had much input into their discussions, indicating some of your concerns to them?

Mr PEHM: We had one telephone conference with the chairperson of the working party—the national health complaints Commissioners did—and I put in quite an extensive submission to the discussion paper on the proposed new complaints system which we have published on our website, and it is also published on the national working party's website. At this stage we are still not sure what the final outcome will be. Certainly, the Commission's position, put fairly clearly in our paper, was that we do not feel it was in the public interest for the investigation and prosecution of individual health practitioners to be conducted by registration boards, and we provided a number of examples in overseas jurisdictions and, of course, New South Wales, and extracted comments from various public inquiries and royal Commissions into that system, concluding that it was not in the public interest.

Reverend the Hon. FRED NILE: What was the main reason for that? It is a peer review type of process?

Mr PEHM: Essentially it is a peer review process. With the best will in the world, peers have a tendency to make judgements that give, perhaps, more weight to their peers. They see themselves in the same position and give quite a sympathetic hearing, more than to the objective public interest. The Commission's position, as I understand, is fairly widely supported by the consumer groups that made submissions to the national working party, who also feel it is inappropriate for the boards to have the investigation and prosecution role and that that proposal is not responsive to health consumer interests. The status, I understand, at the moment is that the working party is considering what its final proposed model will be.

Reverend the Hon. FRED NILE: Is there any more you think the Committee should be doing?

Mr PEHM: The current position is that in March the Health Ministers had a meeting and the New South Wales Minister issued a press release. I do not have it in front of me but it was to the effect that New South Wales felt it had the best system for managing complaints in this area and it did not want to see any changes that diminished the effectiveness of that system. So the Government position is consistent with the Commission's position. It is a matter for the Committee what further role it feels it might have.

Mrs JUDY HOPWOOD: I refer to page 15 of the Annual Report, titled "Legislative Changes" and to the Medical Practice Amendment Act 2008, which introduced mandatory reporting requirements for the medical profession: medical practitioners must report other practitioners who they believe have engaged in sexual abuse, drug or alcohol abuse or gross departure from accepted standards of

professional practice or competence. Have you noticed any difference in complaints forwarded to the Commission relating to the fact that that is now in progress?

Mr PEHM: My impression is that there has been an increase in health organisations reporting medical practitioners. It may be that individual practitioners are raising concerns and are more conscious of their obligations to report other practitioners. With respect to individual practitioners making mandatory reports about other practitioners, I would say there has not been a significant increase. It has been in place since October, I think, last year and I think it is fair to say the cultural change in the medical profession is not an overnight process and I think it is also fair to say that the traditional culture in the medical profession is a very collegiate one. Things are dealt with in house, if you like, by discussion and education between practitioners. It is very much a culture of individual responsibility. The concept of reporting another professional does not sit well with the traditional culture. So I think it will be some time before mandatory reporting becomes the norm.

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

Mr PEHM: I am not sure of the details but I am reasonably sure the Medical Board has taken a role there.

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

Mr PEHM: It is. Certainly, I meet fairly regularly with all the chief executives of the area health services, but I will have a closer look at that. It might be that if the Medical Board is conducting a campaign, as I believe it is, we might have some joint input on that. That would be quite suitable.

Mrs JUDY HOPWOOD: I note in response to the first question on notice that the inquiry's results list Justice Health as being 11.2 per cent of the responses provided. Do you consider that to be extraordinarily high in view of the numbers in Justice Health? I note also on page 113, table 18.15, that Justice Health complaints received about health organisations in 2005-06 was 131 and in 2007-08 was 106, which rates second. It seems to be quite high in view of the number of people involved.

Mr PEHM: Yes, it does seem to be high. Obviously, there are a lot of complicating factors in the provision of health services in prisons that do not apply externally. There is a tension between the provision of health services and security issues. The way the law is, the situation is that a medical officer, being a doctor, can override security considerations, which is the responsibility of the Department of Corrective Services, where, in effect, there is a medical emergency: a person really needs treatment and that treatment is urgent. Short of that, security considerations tend to dominate. For example, in a prison there might be a clinic scheduled on a regular basis, once every two weeks or a month or so, where the doctor attends, and there is a security problem in that jail. Whatever the severity might be, the governor might decide prisoners will all be locked down in cells and there will be no clinic that

day. Those sorts of considerations—and there are many variations on that example; it is a hypothetical one I have made up—can give rise to complaints where prisoners feel their appointments are cancelled for security reasons and they feel their health issues are not being given sufficient consideration. While the number is high, it is difficult to compare it with the situation of an external health service provider.

Mrs JUDY HOPWOOD: Out of those 106 complaints, how many were investigated by the HCCC? It is a bit hard to see how many complaints were actually investigated in the tables I have looked at. I am not sure if you have got a table that represents that. We have got the outcome of complaints assessed by service area.

Mr PEHM: We have got three that were referred for investigation.

Mrs JUDY HOPWOOD: Three out of 106?

Mr PEHM: Yes. The outcomes are all there: 51 were discontinued, 35 sent for assisted resolution. The other issue that we get a significant number of complaints about is prisoners being taken off drugs. There are two types of drug rehabilitation treatments: methadone and buprenorphine, and the methods of administration are different. I think morphine is a liquid that has to be drunk. I am not really sure of all the details, but prisoners are switched off one or off another. We make inquiries of the Department of Justice and the response will be that they were suspected of diverting, which is not actually taking their dose at the clinic and somehow concealing it and diverting it to other prisoners. They are not issues we get involved in; they are questions of evidence. I could not give you the actual numbers on that, but there is a fair cohort of complaints that we would discontinue in that category.

Where the complainant seems to us to have serious medical conditions and there is a problem of appointments being vacated or not being kept raised, those are the sorts of matters that will go to assisted resolution and the Resolution Officer will try to ensure that appointments are made and that they are clearly communicated to the patient and the officer assists them to attend. As I say, the investigations matters are ones where—and you will see there are only three—we think there is a really serious health issue and there is a prospect of making recommendations to Justice Health about how to overcome that or how to deliver its service better.

I have just had my attention drawn to another table on page 115 of the Annual Report which deals with the sorts of issues raised in Justice Health, table 18.18. You will see that 41 of the 138 are about access, and those would be the cancelled appointments and "I didn't get to see the doctor", or "I was locked in my cell and couldn't see the nurse". Treatment is the predominant one: communication—either rude or poor communication. Professional conduct will be about the conduct of—perhaps I had better not go into that. Privacy, discrimination—there is a fairly high proportion of access issues in Justice Health and I think much higher as a proportion than any of the other areas.

Mr KERRY HICKEY: We had a breakdown of complaints by area health services. Do we have a breakdown of the complaints in postcodes in areas where there are few doctors, where there are problems with doctors being brought in? Do we have that data or not?

Mr PEHM: We certainly record the postcodes and we can search by complainants' postcodes, but I do not think respondents'.

Mr KERRY HICKEY: For instance, in Cessnock local government area we were having considerable trouble getting doctors allocated. I am wondering whether that actually generates complaints about not being able to obtain a doctor. People are waiting two or three weeks to get to the GP. They are travelling outside the area to Newcastle and Maitland to get to a doctor. I was wondering whether that was generating any complaints at this level?

Mr PEHM: It does generate some complaints—not the number one might expect from, I suppose, the fairly widely known lack of availability of GPs in rural areas. I think there is some reluctance to complain in rural areas because I think people realise that they feel fortunate that they have them there at all and they do not want to do anything to jeopardise the relationship. We have a small number of complaints where complainants have not got on with the GP in a particular area—and, as you know, doctors are not obliged to treat anyone unless it is an emergency—and they tell us that they have to travel now 150 miles to the nearest other GP. Those are the sorts of complaints we, again, try and resolve. We allocate them to a Resolution Officer to talk to the local GP and see if we can mend the relationship.

Mr KERRY HICKEY: Those complaints would not be a very high in percentage of what we are looking at in analysing this report.

Mr PEHM: No. They would be the access complaints. It has been interesting doing the national dataset. We also report we were working with the other State and Territory jurisdictions and, as you might conclude, without the data the access problems in Western Australia, the Northern Territory and South Australia are a far greater proportion of the complaints. So I guess while rural New South Wales clearly is suffering from a lack of availability of health service providers, it is not a large proportion of the Commission's complaints, and certainly interstate where they have much larger remote areas it is a much bigger problem.

Mr KERRY HICKEY: That is why I would like to see if you have got any data that relates to that because I think there are some areas in New South Wales that it would be a high figure in the postcode availability of doctors and so on but not in the general data.

Mr PEHM: We could certainly look at that, and it may be we can draw some conclusions—and postcodes are a reasonable indication, certainly for local health services. You do get some variation where, as you know, people have to travel, so their postcode may not be representative of the health service they are complaining about from a remote town, where they are going to Dubbo, for instance. The problem with practitioners is that they have to provide an address to the medical board and it is often a GPO box number. But certainly from the complainant angle we could search by postcodes and look at the proportions of complaints.

Mr KERRY HICKEY: The corporate plan for 2007-08 notes that one way to meet key challenges facing the Commission is to develop leadership throughout the organisation. That is on page 4 of the Annual Report. How are you going about doing this?

Mr PEHM: With a number of different strategies. We have had specific training for the managers on performance management and dealing with staff. As part of that training we included them developing a work-base project and we had a lot of outcomes of that. An example of the projects was a service level agreement between investigations and legal about the terms on which matters would be referred and the terms on which they would approach each other.

The Resolution Service has developed a project of starting to record systems improvements from resolved complaints.

As you know, currently we do investigations and we can make recommendations for improvements, but also, as part of conciliations or resolutions, hospitals will agree to change processes, and complainants will be happy with that. So a project was to start to record those, and that is being implemented. The idea is to develop a sense of responsibility and contribution to the overall development of the Commission as an organisation rather than just doing the narrow job of file handling and complaint handling. That has worked quite well. I think people have stepped up to that and the output of those projects has been quite significant.

Mr KERRY HICKEY: The corporate plan also refers to individual staff performance agreements. How are these being implemented and managed?

Mr PEHM: They are developed through the divisional planning process. I spoke earlier about the situation after the executive meets and each division meets and looks at its targets and so on. Part of that process is also to develop individual performance agreements for every member of staff. So for investigations, for example, the team managers might have in their performance agreement about the effectiveness of their management and supervision of staff and you might have indicators such as timeliness in complying with investigation plan approvals.

Managers, of course, give constant feedback to staff. Where problems become evident they discuss those with staff. We have a case where specific individual training is provided to people where there might be weaknesses in a particular area, and there is a more formal review process as well at the end of the year where the managers sit down with the staff member, review their performance and give them feedback. Part of it also is the training and development side where the staff member, as part of their performance improvement, can suggest or volunteer the particular training they might need or particular developments in areas. Wherever that can be reasonably accommodated it will be. It is really an interactive process, and I think the paper process is probably the least important part. The really important part is that interaction between managers and staff.

Mr MATTHEW MORRIS: In relation to assessing complaints, I noted in a response that you provided following questions on notice the issue of local resolution. Whilst the information provided talks about only 41 matters being referred

for local resolution, I noted in your reply that you are not necessarily compelled under the Act to follow those through. Do you not think it would be beneficial for the Commission to get some formal response and get some closure to those particular matters in the interests of looking after those complainants?

Mr PEHM: There is a history to the whole local resolution issue. Prior to the Campbelltown-Macarthur eruption, which had a big impact on the Commission, the Commission referred a great many complaints to area health services—and some quite serious complaints—for them to investigate, and whether or not they would report back was variable. In some cases the Commission would say, "Yes, we want a report back", in others it would not. The review of those reports back—and I reviewed many of them myself—because they were not really part of the Commission's formal processes anymore, I think were not very thorough. There was a great deal of dissatisfaction from consumers and complainants expressed through that whole discussion process that occurred after that on what the new shape of the Act should be, and I understand they were very unhappy with what they thought were quite serious complaints simply being referred back to the organisation they were complaining against, which I take it is the point of your question.

The Act was deliberately changed to stop the Commission referring large-scale numbers of complaints back. But, in keeping with the idea raised earlier in terms of always trying to get the health service provider to deal directly with the complainant, we did feel it was important to have the option there. The sorts of complaints we send that way—and you will see the numbers are very small—really do not raise any serious issue of public health and safety. They are often, I suppose, hygiene and amenity type of complaints—sometimes low-level access to services, sometimes disputes or complaints about attitudes of particular staff—which can be quite easily managed locally.

Really the complainant's only concern is a person they consider to be particularly rude to them. Given the low number of complaints we have not followed up, I am not sure that there is a need to.

It is certainly open to the complainant to come back to us if they are unhappy with the local resolution. We must check with the public health respondent before referring something for local resolution. If they have a long history and do not think it can be resolved they will not consent. Generally the way is paved for those to be fairly smoothly resolved. We certainly have not had much adverse feedback from that process.

Reverend the Hon. FRED NILE: Do you think you should have power to force those area authorities to report back to you? You gave the impression that they can decide to report or not report.

Mr PEHM: No, they can decide to participate in the local resolution process or not.

Reverend the Hon. FRED NILE: But to report the results to you? You indicated that sometimes they do and sometimes they do not.

Mr PEHM: No, I was talking about the previous practice of the Commission when there was large-scale referral of matters. That does not happen any more so it is not a problem for us. We now handle ourselves anything that is even remotely serious and raises a public interest health issue; we will not refer that to the agency to deal with.

The Hon. DAVID CLARKE: Getting back to the Commission's corporate plans, has the Commission developed recommendations guidelines as a means of measuring health system improvements arising from Commission investigations?

Mr PEHM: That is a very good question and the answer is very complicated. The present system is that we make recommendations and if we are not satisfied that the recommendations have been implemented we can report further to the Director General and the Minister, and ultimately to Parliament. We have reported on the percentage of implementation of our recommendations, which is very high, and we get reports back on the action taken by health services. I think there is a role now for us to do some sort of audit or follow-up on the implementation of those recommendations and not simply accept the assurance of the health service provider that what they say has been done has been done. That is a project we are working on now as to precisely how we will do that. It may be that we need power to require reports through those, but we will come back if we think that is the case. Generally I must say they are very cooperative.

The wider issue of measuring the impact of those recommendations on the improvement of the health service generally is an extremely difficult and complicated one. I mentioned earlier the governance unit that the Department of Health has set up in the Director General's office. They take all of our recommendations, coronial recommendations and Ombudsman recommendations and look at their applicability throughout the system. Some investigations of ours have produced recommendations that have then resulted in the Director General issuing a directive to the entire health system about the particular delivery of a service. That in itself is not a measure of effectiveness or whether systems are then actually improved on the ground, which is partly why we are looking at the audit process to measure—you can certainly measure whether people say things have been done and whether directives have been issued to do them, but then measuring whether they are actually done is very complex and time consuming. Certainly at the moment we do not do it and it is something I want to explore. Whether we have the capacity to do it in an effective way to demonstrate a link between recommendations and system improvement, I am not sure. It is certainly something we will be exploring.

Mr KERRY HICKEY: Would you not see a drop in the complaint levels about a certain procedure or issue if they implemented the recommendation? That would be where you would make the judgement.

Mr PEHM: That would be a relevant measure. Certainly you would measure that and you might conclude from that that the system has changed and there are no complaints about that.

Mr KERRY HICKEY: Whereas if the levels remained the same you would just go to wherever you made the recommendation and say to the Minister or Director

General that this was not being implemented and ask why you were still getting these complaints.

Mr PEHM: I agree with you, that is entirely logical. The only problem with it from an evidentiary point of view is the number of complaints you get. Most of our investigations result from fairly rare errors with pretty catastrophic outcomes for the family and, while systems are improved, the number of complaints you get about that particular procedure might not allow you to draw the conclusions that you might draw from a rise or fall in the number. I referred earlier to the availability of information in the health system. If that data was recorded across the whole system through reports by clinicians and you had a very wide pool of data then variations in complaint levels might well be a reasonably reliable measure of whether the system has in fact improved or not. Again, our numbers are small and the extent to which you can draw conclusions is arguable.

Mrs JUDY HOPWOOD: My question arises from a couple of earlier questions and is related to the physical environment of, say, a hospital where, in the context of a complaint, part of the physical environment of the hospital is found to be wanting. For example, a real issue arose of leaking urinals and that had a direct relationship to, firstly, an unpleasant environment and, secondly, infection control. A person reported to me three years ago that something needed to be repaired in a hospital in New South Wales. He made the complaint and yet two weeks ago when he went back to the hospital and out of interest went to the same toilet and same urinal he found nothing had changed. It is in keeping with what you are saying. That might seem like a very small problem in the context of the system but in terms of infection control it might be a massive problem in relation to what it might lead to. You have said you have difficulty following up. That could have been a recommendation on your part to have that entity, or every entity like it, fixed. Do you have any comments to make on the difficulty of checking whether the physical environment has been improved, apart from the more serious things that you have noted?

Mr PEHM: It is not a process we have had a lot to do with because we tend to investigate serious issues of public health and safety and the sorts of environmental issues you raised are often peripheral to the main complaint. They are really more concerned about a surgical outcome and "by the way, the room was dirty" or "my sheets weren't changed" and that sort of thing. We do not tend to make a lot of recommendations on those physical or hygiene—well, hygiene is a different problem; if there is a real infection control risk it is a public health and safety issue.

Auditing and implementing is a very big process. An example might be the Royal Commission into Aboriginal Deaths in Custody, which recommended a hanging point review of prisons nationally. I am reasonably sure the Department of Health has for some time been reviewing mental health facilities because unfortunately and tragically there are suicides in mental health facilities. It is easy to recommend something but the actual implementation of all those capital works reconstructions—the leaky cistern or toilet might seem a very simple problem but when you multiply something like hanging points across a whole system and a number of facilities you have to look at regular inspection teams to identify the problems and a systematic program of public works to fix them. It is a very big job. It illustrates our difficulty in auditing our recommendations, which was referred to in the

earlier question about how we can demonstrate our recommendations result in system-wide improvements. The issue we are wrestling with now is how we can have an effective audit process. It is not a simple issue at all.

Mrs JUDY HOPWOOD: No, I can see that.

Mr PEHM: My attention has been drawn to one case in a mental health facility where the patients had been separated because of a propensity to violence and the complainant was assaulted by another patient. The setup of this facility was such that the nurses at the station did not have a direct line of sight to the patients at all times. This assault happened outside the direct line of sight. We made recommendations about improving that facility and certainly we can follow up the implementation in that facility. That is a question that goes to the Director General's unit. Does the Director General then commit resources to a review of all facilities on that particular issue when considerable resources would be involved? If an inspection team finds a whole lot of those problems then there are a lot of capital works issues and quite big economic issues about expenditure of funds and so on.

CHAIR: I refer to one of the questions you answered earlier about the 213 individual patient complaints that have been referred to the Commission by Commissioner Garling. You said that many of those were complaints that you had previously received and they would be reinvestigated. Is an officer other than the original officer who conducted the investigation carrying out the reinvestigation and, secondly, will you report in your Annual Report the outcome of those investigations that have been referred to you from Commissioner Garling, particularly those that have been reinvestigated, to give us some comparison between the way the Commission was conducting its investigations at that time and its work now?

Mr PEHM: We could certainly look at that and we would not have a problem doing that. Firstly, where a complainant had previously complained to the Commission and then gone to the Garling inquiry and the matter was referred to us the review was carried out by an independent officer. I have signed off on all of those reviews. They read through the old files. In many cases the complainants did not want to pursue their complaint with us. I think the majority said they were quite happy with the way the Commission handled it. Nevertheless, they still had a grievance against the health system, which was the cause of their original complaint. You might go through a process and get a result but I think the grievance does not necessarily go away and they just wanted to draw that to his attention in a public forum because he put out the call for public submissions. I think I mentioned that 9 out of 213 went to formal investigation. We can certainly look at the results of those. Others would have been sent to resolution. I do not think it would be a problem to report the outcome of those complaints.

CHAIR: I think that given the very public nature of the inquiry it is worth the Commission doing that. Certainly it is important in terms of the principles of transparency and accountability. The other matter you answered in questions on notice related to the national data collection, and you referred to it earlier today. In your answer you said that Queensland and Victoria have opted out of national data collection. In light of the national registration and accreditation model that is being adopted, has that been revisited with Queensland and Victoria?

Mr PEHM: No, it has not particularly. I think for Victoria it is question of the capacity of their current database and the resources it would take to alter it into the different categories. I am not sure what the issue is with Queensland. We meet regularly with the national Commissioners and this is an ongoing project. We have taken the responsibility to report comparative data from all the States that are participating. Hopefully those that are not participating at present will see the benefits or advantages of participating. There is a constant process of inclusion and the opportunity to be included. I think it is probably just a case of particular priorities for particular interstate Commissions at a particular time. I think ultimately everyone will come on, provided they can accommodate it within their budget and so on. And, as I say, it is very early days, but particularly with the access issue, which is the obvious thing, it is a very clear difference.

CHAIR: What about in those categories in which currently the numbers are so small that you cannot get a reliable analysis of the data? Do you think that, doing it on a national level, you are going to get some reliable data that can assist with more detailed analysis?

Mr PEHM: Yes. That is one of the reasons we thought it was a good idea to begin with as part of increasing the pool of data, and certainly the national basis would provide us with a bigger pool of data. We meet reasonably regularly with the Australian Commission on Safety and Quality in Health Care. It does not even have a good acronym. We are reporting some data to them in this area. They have just published a patient charter of rights. They have looked at the data that we collect and we have gone through a process with them where we have grouped particular issues in relation to the patient charter. We will be able to report to them on what our issues say about the charter of patient rights and what complaints tell us about whether that is being implemented or not. Those sorts of engagement are going on continually.

CHAIR: I refer to the answers you gave to us in relation to questions on notice. Earlier you referred to the issue of root cause analysis and open disclosure. In your answer you talked about a discussion paper that was going to be released. Have you had the opportunity to have any input into that discussion paper? Do you have any more information on when that is likely to be released now that the Garling inquiry has made its report?

Mr PEHM: I do not have any more information as to precisely when it will be released, but we met with the Director General. We meet three monthly, four times a year. The last one might have been just before Christmas. We might be a bit behind on that. We met in February. They advised that that would go ahead and it would be coming out. I do not have a precise date. Certainly at the time this issue was raised we did raise it with the Health Legal Branch, who I understand are the authors of the discussion paper, and made our concerns very clear to them.

We also made recommendations arising out of an investigation into the Vanessa Anderson case, and it dealt very specifically with that. That also has been provided to the health department. The Commission's Executive Officer and the Health Legal Officer, who then was drafting the discussion paper, had quite a

number of meetings and discussions about the issues and about the legal complications of it all. We have certainly had input. Of course, when the discussion paper is drafted we will also have the opportunity to make a formal submission, which we will do.

CHAIR: Referring to your answers to our questions on notice, in your answer on Indigenous health you referred to offering expertise to assist Aboriginal community control of health organisations in establishing or improving their complaints procedures. I am just wondering whether you have had any response to that offer?

Mr PEHM: Yes. No. Well, the reason I do not know is that, no, we have not. It is something we have just started to do. It is something we have given a lot of thought to. As you can see, we have become involved in this joint complaint agency outreach campaign. We have also been in touch with the Department of Health Aboriginal health service provision area to see what we can do there. I think that is an opportunity to provide some outlets for information about the Commission. The other idea we have had is offering assistance to the Aboriginal Health Service.

It is really an extraordinarily difficult problem, because of the remoteness in lots of cases. There are very significant cultural issues about Indigenous people complaining at all. I just do not think there is any simple way through that or any obvious mechanism. I think we are doing the obvious stuff. I think the challenge now is to come up with something that is effective. We are certainly trying to develop some improved level of interaction with Indigenous health because, obviously, just from generally published data, there are significant problems there. I guess we have not worked out yet a really effective method of how we do engage with that area and how we interact and how we can hopefully contribute to some improvement.

CHAIR: Does the Commission employ Indigenous officers?

Mr PEHM: We do.

CHAIR: Do they liaise specifically with Indigenous communities, or do they just do a general workload?

Mr PEHM: We have a Resolution Officer who is Indigenous and who is based out in Dubbo. She works with Indigenous complainants. We do not specifically refer all Indigenous complainants to her. They are dealt with through the normal process. Her job is as a Resolution Officer, so it is a grassroots service to deal with an individual's immediate problem.

CHAIR: Does she have any role liaising with Aboriginal Health Services or communities in terms of promoting health?

Mr PEHM: She does it as part of her general work, but not as a discrete policy area. The Commission's Executive Officer is looking at that side of it. The Resolution Officer did come up with quite a good idea about presenting to an Indigenous health worker's education program at Charles Sturt University, which unfortunately fell apart—not our side of it, but the course fell apart. That did not proceed. She has

presented at conferences on remote and rural and regional health issues. That is certainly there. I do not want to ghetto-ise that part of our work either. She is a mainstream Commission officer and certainly she can contribute, but I think it is the Commission's responsibility to develop the policy side of that and to generate the mechanisms by which we hopefully become more effective in that area.

Mrs JUDY HOPWOOD: Referring again to the Vanessa Anderson case, has the inquiry on behalf of the Health Care Complaints Commission been concluded 100 per cent? If it has not, what else needs to be completed? When that happens will the family be notified?

Mr PEHM: The investigation has been completed, and the family has a copy of the investigation report. The manager of the team that was investigating that dealt quite closely and extensively with Mr Anderson particularly, or with Mr and Mrs Anderson. I had a couple of meetings with them as well. They do have the report. What remains is the implementation of the recommendations the Commission has made. That is still open, partly because the broader issues of root cause analysis are a problem. I think we also made recommendations about using the case as a case study in education in Royal North Shore, which we are still following up. Monitoring the implementation of the recommendations process remains open. We have no problems keeping Mr Anderson in touch with the outcome of that.

Mrs JUDY HOPWOOD: So whenever the discussion paper is released and whenever the root cause analysis issues are more fully decided upon you will be informing the Anderson family in relation to what is then the subsequent action of the Commission?

Mr PEHM: Yes.

Mrs JUDY HOPWOOD: I understand that you have not progressed some part of it because of the root cause analysis [RCA] discussion paper about the open disclosure.

Mr PEHM: It is our routine practice to report to complainants on the implementation of recommendations. When we are satisfied and we think things will be implemented a letter goes to the complainant saying, "This is what we recommend and this is what we have been advised, and we are satisfied that we need not take any further action." So that would occur. There is a lot of work going around this RCA open disclosure issue. The Commission is also supporting a research project whereby patients are interviewed, or families of patients are interviewed, about their experience.

I referred earlier to the cultural change process in Health. Everyone tells me that the most effective education method in the Health area is people's stories. That is what clinicians learn from. That is what affects them and makes most things real for them. We are interested in encouraging people who, it has become clear to us as part of our investigations, have had adverse experience through that RCA open disclosure problem, and we will be encouraging them to become part of this research project. But certainly we worked fairly closely with the Anderson family throughout that investigation: we certainly will, with the conclusions of the recommendations.

Mrs JUDY HOPWOOD: I have another question relating to children in hospital, specifically children who are admitted to adult wards. I am aware that there are thousands every year. Do you include those children in your paediatric medicine statistics in relation to, for example, table 18.18, "Issues raised in all complaints"? Would Vanessa Anderson's case have been included in a paediatric assessment, considering she was a child even though she was in an adult ward and was not seen by a paediatrician?

Mr PEHM: I do not know specifically whether Vanessa Anderson's case was. The issues are allocated at the assessment process, and it is what the complainant raises. Yes, Vanessa was 16.

Mrs JUDY HOPWOOD: That is correct.

Mr PEHM: But I do not know specifically whether it is part of the statistics or not. Certainly those that are clearly identified as paediatric cases involved paediatric care.

Mrs JUDY HOPWOOD: In your view should she have been included in that specific data? Should further or more consideration be given to children who are admitted to adult wards?

Mr PEHM: I think it is a significant problem. We have, as part of our consumer consultative committee, a group specifically concerned with that issue. A similar issue is in relation to people of same sex being put together in wards. I understand fairly recently, just from the media, that the department has committed to some sort of change in the same-sex area.

Mrs JUDY HOPWOOD: Yes, it has. That is true.

Mr PEHM: I am not sure what the response was in the paediatric area. I am not sure of the intent of your question—whether I am answering it.

Mrs JUDY HOPWOOD: I have read the report. I have a great deal of concern about children admitted to adult wards. I know from not all paediatricians but some I have heard comment that they have concerns about children admitted to adult wards in that the adult needs overtake the needs of the children. The fact that Vanessa was in an adult ward and in a single room had a great deal of bearing, I believe, on her care while she was there.

Mr PEHM: Yes.

Mrs JUDY HOPWOOD: But just as an extension to that, in terms of the appendices on page 104, would you consider devoting in your next Annual Report a section to children specifically having unique needs, being unable to consent without their parents, and finding themselves perhaps in a situation where they are placed in an adult ward and not in a paediatric environment?

Mr KERRY HICKEY: I am just concerned about what that means to rural communities where there are no paediatricians and—

Mrs JUDY HOPWOOD: This is a general consideration of children in relation to—

Mr KERRY HICKEY: Which takes in rural areas, by the way.

Mrs JUDY HOPWOOD: No, I am not specifically saying anything about where. In these appendices—the issues of performance management, access and equity, women, Aboriginal affairs—I am just wondering whether or not the Commission would look at the specifics of children being unable to fend for themselves or unable to consent to procedures, et cetera, being a specific focus, given that there are thousands of children admitted every year into adult wards and they may find themselves facing issues or their parents do by virtue of the fact that they are there.

Mr PEHM: We can certainly look at the data and see what it says. My feeling, without looking at the data, is that where we class the issues as a paediatric complaint is that the concern is more with the care of children in children's hospitals and facilities. Vanessa Anderson is a case in point, but from my own—and I see every complaint—there is not a high—I do not recall a significant number of complaints on that specific issue about children being in adult wards and that being raised as an issue of complaint. But I will certainly look more closely at it.

Mrs JUDY HOPWOOD: Is there a charter of children's rights in hospital?

Mr PEHM: Specifically?

Mrs JUDY HOPWOOD: Specifically.

Mr PEHM: I do not know. I do not think we know. I certainly do not know.

Mrs JUDY HOPWOOD: You mentioned the patient rights. I just thought of children's rights.

Mr PEHM: That is right, the Association for the Wellbeing of Children in Healthcare—AWCH; I only know their acronym so I did not want to say that—is on our Consumer Consultative Committee. I do not know specifically whether there is or not.

Mrs JUDY HOPWOOD: I know there are guidelines but I am wondering about the actual list of rights of children in hospital.

Mr PEHM: I do not think I have seen one as distinct from the patient rights charters, no, but I am not sure. There may be.

CHAIR: We have seen the improvement in the information outreach that you have been doing with health consumers to ensure that they know about the HCCC and its role in handling complaints. Quite recently there was a matter reported in the

media about a woman whose baby died in the southern area of New South Wales, and in the reporting of that it was said that the woman was making a complaint to the New South Wales Ombudsman. I just wonder why you thought we would still have people thinking that the Ombudsman is the appropriate body to make a complaint to rather than the HCCC. Do you monitor cases like this, and do you do any follow up with those?

Mr PEHM: I do not think I saw that particular report, and I would have been concerned about it as well. We certainly get direct referrals from hospitals and health service providers who tell patients about us and where they should come. The Ombudsman would certainly refer a complaint like that to us in any event. I hope it is not a widespread ignorance of our role or misconception of the Ombudsman's role. Certainly, we have done a lot this year and will continue to do more to promote greater public knowledge of the Commission's role.

CHAIR: I have the information so I will refer it to you. The birth was at Moruya hospital, so it would be worth knowing whether or not the hospital did not provide information to the woman about the HCCC. We can refer that one to you. In the diagrams and graphs that have been provided one thing I have not seen is a category of profession by outcome. I know we have outcomes and we have professions complaints. I just think it would be worth a comparison for the category of professions and where the outcomes are, particularly things detailed, even up to whether or not there is deregistration, whether there is a reprimand with conditions. That sort of comparison I think would be worthwhile as well.

Mr PEHM: I thought we did do that.

CHAIR: I could not see one by profession, a comparison with professions. I could see it for—

Mr PEHM: We do complaints received about professions and issues.

CHAIR: Yes. I know it is quite detailed but I just think it would be worthwhile.

Mr PEHM: I do not think that would be at all difficult to do, and I cannot see any problem we would have with it. We do have table 18.30 on page 125, "Outcome of investigations finalised by profession and organisation type". It does not go down—

CHAIR: It does not go down to that detail. You have other charts that demonstrate what action has actually been taken, whether it was conditions, whether there was a reprimand, whether there was deregistration. It is that sort of detail that I would like to see by the category of profession.

Mr PEHM: Yes, certainly, we can look at improving that.

CHAIR: The satisfaction survey, the response to that is around 50 per cent or even lower. Is that still what you are getting?

Mr PEHM: It is roughly about 20, 25 per cent.

CHAIR: I wonder if it would not be worth doing an independent audit of complainant satisfaction, not every year but from time to time, particularly given the very low response. I think most of us know that when surveys are sent out to complainants—I am just not sure how reliable the outcomes of those surveys are. I would certainly like you to consider whether it is worthwhile doing that.

Mr PEHM: We did think about that and thought we would go down this path, at the closing of every complaint, that both sides are sent this satisfaction survey and the response rate may not be very high. We might have even called for tenders on that. We certainly made some inquiries of agencies that did that sort of work. Yes, we can certainly have another look at that.

Reverend the Hon. FRED NILE: On the questions on notice, for unregistered health practitioners there are only 61 complaints. Do you regard that as low or are you happy? I am just wondering whether the public understands that with all those different categories of service, if there is a reason for a complaint, they can make a complaint to you. They may think they should complain only about a registered doctor but not about a chiropractor.

Mr PEHM: When the new code of conduct provisions for unregistered practitioners came in we held quite an extensive education session with all the representatives—not chiropractors because they are registered—of the traditional Chinese medicine practitioners and so on. A lot of these health service providers have associations and groups. They are very happy with the code of conduct and they are putting the word out amongst their practitioners. It is not a high number when you consider the amount of service that is provided by unregistered practitioners and the amount of interaction there is with the public. It may be that there is more we can do to promote that aspect of our work because it is fairly new. It is hard to say what is a good number, given the base was so low to begin with and the powers are new and we have only just started the education process.

The code of conduct requires practitioners to display in their consulting rooms information about the Commission and about their right to complain. That was included, and we have drafted a nice one-page laminated double sheet that can go up and distributed all that to the association. So we have certainly taken some action to publicise the availability of the service, and I guess we just monitor whether complaints increase or not.

CHAIR: Some of the provisions of the Health Legislation Amendment Bill 2009 seem to remove the separation between the Director of Proceedings and other areas of the Health Care Complaints Commission. Can you explain to the Committee what brought about these changes and their expected practical impact upon the position of Director of Proceedings?

Mr PEHM: I am not sure that they remove the Director's independence when it comes to making the decision as to whether or not to prosecute a complaint. I think we have asked for the Director to be able to undertake certain functions of the Commission like reviewing privacy complaints and freedom of information applications because they are best reviewed by a legal person and the Director of

Proceedings is the Director of the Commission's Legal Division. So it is really just a functional operation, and that is not concerned with the direct patient complaints. They are more administrative legal issues. There is another amendment to formalise the process in cases where the Director decides not to prosecute, to refer the case back to the Commission or the Commissioner to consider whether some other outcome should happen, but I do not believe that compromises her independence either. Are there any specific provisions that raise that concern?

CHAIR: There was that one that you just nominated but also that the Director of Proceedings may undertake functions imposed on the Commission by Acts other than the Health Care Complaints Act.

Mr PEHM: We had in mind there the Privacy Act and the Freedom of Information Act.

Ms MOBBS: That is right because on occasion there are matters that come in that are reasonably complex and it would seem more appropriate that they be reviewed by a more senior legal officer and just to allow more opportunity to review those matters, even in terms of a review when the initial review is being done by a more junior officer.

CHAIR: That is what I was referring to. Finally, I refer to the Executive Summary in the Annual Report, which I find useful. There are the bar charts at the bottom of that. While I can see their use in the various headings that you are referring to, I just think as a whole picture it would be better if it actually reflected the data a little more accurately. One bar chart represents 6,003 complaints and another refers to 79, yet they are the same size. Although I understand that these are per heading, I just think it would also be good to have a whole diagram that reflected that data. I know they are for different purposes, I understand the purpose of it, but I do not think it is an accurate reflection of proper processes and the outcomes.

Mr PEHM: The numbers are there. It is a presentation issue. I guess, doing it the way you suggest, you would have a chart with 79 complaints on the same scale as a chart with 8,000 inquiries. You might not even get a blip on the prosecutions.

CHAIR: I appreciate that. I just think it is possible to do it in a whole chart as well. I just had to make that point. Thank you for your evidence here today. I have certainly found it very useful for the Committee's purposes, and I am sure my colleagues concur with that.

Mr PEHM: Thank you for the opportunity to attend. We appreciate it.

CHAIR: I congratulate you on the Commission's performance during our review period.

Mr PEHM: Thank you. We worked very hard to get it there.

CHAIR: I think that is recognised by the Committee and I think it will be reflected in our report to the Parliament.

Mr PEHM: We appreciate that.

(The witnesses withdrew)

(The Committee adjourned at 11.45 a.m.)