REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE 2006-2007 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

At Sydney on Thursday 1 May 2008

The Committee met at 2.00 p.m.

PRESENT

Hon Helen Westwood (Chair)

Legislative Council	**Legislative Assembly**
Hon. D. J. Clarke	Hon K. A. Hickey
	Ms J. Hopwood
	Dr A. D. McDonald

CHAIR: I declare the hearing open. It is the function of the Joint Parliamentary Committee on the Health Care Complaints Commission to examine each Annual Report of the Commission and report to the Parliament upon it in accordance with section 65 (1) (c) of the Health Care Complaints Act 1993. I note that two members of the Committee, Reverend the Hon Fred Nile, MLC, and Mr Matthew Morris, MLA, are unable to attend today's hearing due to longstanding commitments with other Parliamentary Committees. The Committee welcomes the Commissioner and senior officers of the Health Care Complaints Commission to the table for the purpose of giving evidence on matters relating to the 2006-2007 Annual Report of the Health Care Complaints Commission. I thank the Commissioner and staff for their appearance before the Committee today.

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

BRET COMAN, Director of Investigations, Health Care Complaints Commission, Level 13, 323 Castlereagh Street, Sydney, sworn and examined:

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

CHAIR: I am advised that you have been issued with a copy of the Committee's Terms of Reference and a copy of the Legislative Assembly's Standing Orders 291, 292 and 293 that relate to the examination of witnesses, is that correct?

Mr PEHM: Yes, that is right.

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 2006-2007 Annual Report. Commissioner, do you wish this submission to form part of your evidence here today and to be made public?

Mr PEHM: Yes, that is no problem.

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

Dr ANDREW McDONALD: Yes.

CHAIR: For the record, in what capacity are you appearing before the Committee today?

Mr PEHM: I am appearing as Commissioner of the Health Care Complaints Commission.

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

Mr PEHM: No, I am happy to proceed and answer any questions you may have.

CHAIR: On page 5 of the Annual Report, the Foreword notes that the Commission brings a valuable perspective to the health reform process because the information from complaints helps to inform health providers about concerns of patients. What processes does the Commission have in place to ensure that this takes place?

Mr PEHM: The complaints process itself obviously informs health and service providers of individual complaints. The process is to provide respondent health practitioners with the complaint and to ask them for a response. Our complaints resolution processes often involve both conciliation and assisted resolution. They involve complainants meeting with health service providers and, hopefully, in many cases reaching agreement as to changes that might occur as a result of the complaints. The investigations of complaints against health

organisations can result in the making of comments and recommendations. Those are copied to the Director General of the Department of Health. The Director General has set up a central clinical governance unit, which looks at the applicability of the Commission's recommendations across the health system. We have regular meetings with the Area Health Services Chief Executives. I have three monthly meetings with the Director General that go to the implementation of the Health Care Complaints Commission's recommendations. There is a whole range of activity outside the complaints process, such as, addressing practitioner groups, speaking to colleges and doing public talks that inform people about the Commission's processes and the way we work and how we contribute to the improvement of the health system.

CHAIR: Generally, does the Commission use the statistical information it compiles to assist the various registration Boards to provide the most appropriate professional training—for example, by focussing on clinical issues, which frequently form the basis of complaints?

Mr PEHM: We have begun to do that. We provided a report to the New South Wales Medical Board fairly recently which looked at the types of complaints made and the kind of practitioner the complaints were made against. The Board has all of this information itself because we are required to consult with them on complaints as we get them, each and every complaint. I am not aware of the activity the Board has taken in response to the report. I do not think the Board has a very strong education role. I could be corrected by the Board, but I am not aware of that. To address that side of the issue, we are approaching the colleges, which provide regular training for their practitioners, and we are breaking down complaints data in terms of the types of complaints against particular kinds of practitioners - whether it is obstetricians, gynaecologists, surgeons, emergency department practitioners - and speaking to them about the nature of those complaints, how they are handled and outcomes and discussing with them what they can do to address complaints and prevent complaints from being made.

Hon KERRY HICKEY: Has the Commission ever given consideration as to the way it might work with other complaints handling bodies to look at ways of cross-promotion of services?

Mr PEHM: No is the short answer to that. We meet nationally with all the complaints handling bodies in the health area every six months. This year we are developing a public promotion and education strategy. That is quite extensive. We are involved, as I said, in talks to colleges and practitioners and also going out to the Area Health Services and speaking with clinicians. I have not thought of cross-promotion, but it is not a bad idea. I think the Ombudsman may still do country visits and we were planning to do that in our own right, but it may well be worth linking up with them. That is something we could look into.

Dr ANDREW McDONALD: The Terms of Reference of the Garling Inquiry into the New South Wales health system requires the special Commission to refer individual complainants to the Health Care Complaints Commission. How has the Health Care Complaints Commission been assisting the special Commission? Roughly how many complaints have been received?

Mr PEHM: We met with Mr Garling quite early in the piece and discussed the Terms of Reference and we set up a liaison point between us and the Commission. We have been referred, I think, about 40 complaints so far. We might have to come back to you with a particular figure. That Inquiry has gotten quite an impetus up and it is holding public hearings almost daily. The Commission refers the transcripts of its hearings to us. In some cases the matters have been dealt with previously by the Commission. In those cases we contact the complainant to see if they have outstanding concerns. Many of them have said, 'No, I am not making another complaint. I am happy with all this. I just wanted Mr Garling to hear my concerns.' There are a substantial number of new matters coming in and we are treating them as new complaints, getting in touch with the complainant, clarifying the issues and putting them through our assessment process.

Dr ANDREW McDONALD: Are you able to give us on notice information as to the exact number?

Mr PEHM: Yes, we will come back to you with the exact number.

Hon DAVID CLARKE: On page 31 of the Annual Report it is noted that treatment issues accounted for 86.3 per cent of all issues and investigations of health organisations. Given that these issues would necessarily involve individual medical practitioners and the health care providers, does the Commission undertake any further breakdown or use these figures to investigate individuals?

Mr PEHM: There is a breakdown of the sub-categories under the treatment category in the appendices at the back of the report. It is on page 125, Table 18.2. The issues are inadequate treatment, medication, diagnosis, infection control. The largest category by far is inadequate treatment. We actually think these categories are very broad and not particularly helpful in terms of describing them. As I said earlier, we are going out to health practitioners, looking at what our data tells us and trying to have a dialogue with them about how to manage complaints better. We are redoing all of the issue categories, hopefully, with a much greater degree of specificity so that we can be clearer and give a breakdown that speaks more accurately to people.

Hon DAVID CLARKE: What is the time frame on that?

Mr PEHM: We will be introducing it from 1 July this year. We have been working on it for about nine months. We are trying to have it done as a national system. So we have been meeting with the other Health Care Complaints Commissioners and the New Zealand Commissioner as well and trying to get a joint adoption of the new issues.

Hon DAVID CLARKE: Does that look likely?

Mr PEHM: I think it is unlikely. We will proceed with it anyway because we think it is an improvement. I think New Zealand will almost certainly follow us. Queensland, I think, has adopted it. Others have various technical issues. Their database capacity is not as strong as ours. We are having another meeting, I think on 14 May. That will be the last meeting. The discussion will be finalised and people will decide whether they will come on board. The present indication is that I do not think it will be adopted nationally. The other complication is that other States have different legislation. Some of them cover privacy and some cover health and disability complaints. The smaller jurisdictions have a much broader range of issues to deal with apart from health care complaints.

CHAIR: I refer to the New South Wales State Plan. There does not appear to be a reference to the Commission in the State Plan for 2007. Did the Commission play any role in the preparation of the plan?

Mr PEHM: We were aware that it was being developed and as the Chief Executive I went to some of the initial meetings with Chief Executive Officers. However, I was not on any of the working parties that developed the State Plan in particular areas. We are too small and our function is so particular that we probably did not rate a specific mention. The State Plan is a very broad-ranging plan.

CHAIR: Did the Commission have any role in the development of the New South Wales State Health Plan?

Mr PEHM: No.

CHAIR: Is there a reason for that?

Mr PEHM: I did go to a presentation on the development of the plan and I had a look at the draft plan, but I had no particular input. I was invited to have input. Again, our role is very particular. There is an issue around the handling of the complaints by the Health

Department itself. We are getting very interested in that this year. It has come out of analysing our own data. The Committee has asked what conclusions we can draw from our data. The answer is often 'not many', because our sample is so small. The department has a much broader pool of complaints.

The Clinical Excellence Commission just published a six-monthly report that showed 7,000 complaints in six months as well as 51,000 incidents of clinical management. At the moment I am talking to the Chief Executives of all the Area Health Services and the director general. I will be meeting with Cliff Hughes from the Clinical Excellence Commission shortly to see whether we can get greater access to that data. I do not think there is a problem with our getting access generally and, of course, the Commission publishes those six-monthly reports. However, again, they are at a very high level and we need to drill down—to use the common term—to get more individual and particular data.

Dr ANDREW McDONALD: I refer to page 31 of the report and figures 824 and 825. A significant percentage of complaints about health organisations and practitioners have no further action. Is that because your threshold for investigation is quite low in that you tend to investigate a lot and that is why you do not find much? Is it a case of if in doubt you tend to investigate?

Mr PEHM: No. If you go back over previous years' Annual Reports you will see that the proportion of complaints found to have no substance at the end of investigation has been steadily decreasing. So the number and proportion of matters where we do make findings of wrong treatment is increasing. The criteria for us to investigate a complaint are in section 23 of our Act. It states that a significant issue of public health or safety may warrant disciplinary proceedings against a practitioner or may involve gross negligence. So the Act sets a very high threshold. One category raises a question of doubt. It states that if at the end of an assessment a significant question remains about whether adequate care was provided, we must investigate.

Our assessment has become much more thorough over the past couple of years. We still strive to do it within 60 days. With complex matters that is very difficult, if not impossible. At the end of the assessment process we are obliged by force of the statutory mechanism to investigate matters that ultimately may not have anything in them. We cannot always predict at the start after an assessment process. We make our best judgement as to whether there is substance or whether it is a serious issue. On closer and further investigation, that may turn out not to be the case. However, the general answer is that, if anything, the proportion of sustained findings against both organisations and practitioners has been steadily increasing over the past three years.

Table 18.33 on page 150 of the Annual Report indicates that in 2003-04, 78 per cent of investigations into health organisations were terminated without any further action. This year - 2006-07 - that figure is 45 per cent. The same trend occurs with individual practitioners as well. Terminated by the Commission has gone from 49 per cent, to 42 per cent to 34 per cent over the three years.

Dr ANDREW McDONALD: The figures in 2005-06 and 2006-07 for health organisations are identical.

Mr PEHM: Yes, and that is not a mistake. I noted that when we were doing the report and we double-checked it. It is simply a coincidence.

Dr ANDREW McDONALD: I refer back to chart 823. Page 30 refers to conciliations finalised in 2006-07. A large number are not resolved. What does that mean in effect?

Mr PEHM: It means that the parties cannot reach an agreement in the conciliation process.

Dr ANDREW McDONALD: What is the usual consequence of that?

Mr PEHM: That is the end of the matter if the parties cannot reach an agreement. Matters are sent to conciliation and resolution processes where they do not reach that threshold for investigation. It is a completely voluntary process on both sides. If agreement cannot be reached there is no compulsion that the Commission can exercise to take further action. That is the end of it.

Dr ANDREW McDONALD: So these cases are not being investigated because they do not fulfil the criteria in the Act.

Mr PEHM: If the decision at the end of the assessment process is that they do not fulfil the criteria of the Act, complainants can always request a review of the assessment decision. A substantial number of complainants refuse to participate in the resolution processes. If they believe that their matter is more serious and that it warrants investigation, they can request a review and a review will be conducted. That may vary the assessment decision, and occasionally those matters are looked at in more detail or the complainant might provide more evidence and matters can be investigated.

Mrs JUDY HOPWOOD: I note that there were fewer investigations into public hospitals in 2006-07 than in 2005-06. Do you consider that there is any correlation between the Commission's failure to use its coercive powers and the apparent failure to identify the very serious complaints that have come to the attention of the public in the past 12 months?

Mr PEHM: There is quite a lot in that question and I am not sure where to start in breaking it down. I was not aware that there was a failure to use coercive powers. Coercive powers are used where we consider it necessary and appropriate. Each complaint is judged on its merits and a fair assessment is made of whether it reaches the criteria for investigation. Can you point out the part of the report where that reduction is stated?

Mrs JUDY HOPWOOD: It is on page 151 of the Annual Report and relates to fewer investigations finalised into health practitioners and health organisations.

Mr PEHM: Do you mean that the numbers were going down?

Mrs JUDY HOPWOOD: Yes.

Mr PEHM: There are a number of reasons. The 2004-05 figure of 675 investigations finalised represents action taken to deal with the accumulated backlog of complaints in the Commission and all the matters that came out of the Macarthur period. There were 139 investigations solely related to Macarthur. More generally, part of the problem and the reason the Commission accumulated the backlog of complaints and investigations—when I arrived 1,000 matters were under investigation, some of them years old—was that it was not applying the statutory threshold we referred to earlier for the seriousness of the matters that were going through to investigation. The assessment process was not as thorough as it is now. By doing a more careful assessment we are referring fewer matters through to investigation. However, I would say the investigations are also becoming much more rigorous and thorough than they were then, simply as a function of the resources can be applied to a greater number of matters.

Hon DAVID CLARKE: Do you foresee an increase in the number of investigations into public hospitals in the future?

Mr PEHM: It is hard to judge. In the past two months there has been a substantial increase in the number of complaints received.

Hon DAVID CLARKE: How substantial has that increase been?

Mr PEHM: I will have to get back with actual numbers, but it is a significant increase. It is a factor of the publicity generated by the Graham Reeves, Butcher of Bega matter. Many people are reminded of poor health care—not specifically in relation to that individual—when they see publicity about such cases. They are reminded of poor health care they may have

experienced. We get the same when a particular factor has brought the matter to mind and they complain. The Garling Special Commission of Inquiry, as well as referring particular complaints to us is also generating a lot of publicity. As a result of that I would expect the number of investigations into public hospitals to increase in the short term. Whether that becomes sustained is difficult to say.

Hon DAVID CLARKE: So, there are a whole lot of complaints out there that do not even hit the radar unless there is publicity to stir them up, as it were?

Mr PEHM: Yes, it would seem so. That is one of the reasons why we are going on what will be quite an extensive public promotion campaign over the next year. I think I said last time I was here the Commission has been focusing on its internal problems and making sure it was in a position to deal properly with complaints. Yes, I think the more publicity and the more awareness there is of the Commission the more complaints should be received. I can elaborate on what we are doing there. We just completed a rebadging, I think it is called, of all of our promotional literature. We have a range of pamphlets and posters now. We have agreed with the Department of Health to have those distributed through our public hospital system. We are entering into an arrangement with a private organisation to have all that information distributed through general practices in New South Wales—practices that are members of this organisation—along with the public presentations and talks and addressing various public interest groups and practitioner groups.

Dr ANDREW McDONALD: Can I ask you about the North Shore Inquiry? At that Inquiry there seemed to be, as you mentioned, the underreporting of health care complaints. The North Shore Inquiry certainly found there was this significant underreporting. Has that Inquiry had any impact on the work of the Commission?

Mr PEHM: Possibly in the general sense that I mentioned earlier in that it has heightened public awareness of delivery of public health services. I have not done an analysis more recently of the rate of complaints out of North Shore compared to Prince of Wales or Prince Alfred, the big teaching hospitals. I did that at the time of the Parliamentary Inquiry, and our complaint data did not show any larger number of complaints about Royal North Shore than it did for comparable teaching hospitals in Sydney.

Dr ANDREW McDONALD: Now that it has been some months, are you able to take that on notice for us?

Mr PEHM: We can do that. We will have to go to the Department for that information so it might take a bit of time, but I am happy to do that.

CHAIR: As a result of the 2003-04 reforms at the Commission, positions previously concerned with partnership development and education were deleted or realigned to the Commission's principal function of complaint handling. Given the evidence of the general lack of community awareness of the role of the Commission, do you consider that an education position ought to be re-established?

Mr PEHM: We have. We have established a promotions and stakeholder relations position, which I think is in our papers there that we advised you on.

CHAIR: When was that position re-established?

Mr PEHM: Probably from early this year, January or February this year. I can give you the exact dates if you like. It may well be in the answers we have already given you.

Mrs JUDY HOPWOOD: You have answered this in part but what further measures will the Commission include in his Annual Report to allow assessment of the success of its promotions strategies, particularly strategies to reach people with a mental illness, persons with a disability, an Aboriginal person and a person from a culturally and linguistically diverse background? Just some specifics, if you are able to answer that, apart from the brochures and other measures you have indicated?

Mr PEHM: We have a Consumer Consultative Committee as part of our legislation. We meet with it quarterly, and all of the groups you mentioned are represented on that. We have written pieces for all of their newsletters that we transmitted to them—I do not have the exact details of those who have printed them, but we are collecting all of that information. Our Resolution Officers are also going out and speaking to meetings of those organisations. So, there is some targeted action, if you like, of those relatively disadvantaged areas, specialised areas of patient complaint. We have also reviewed the Commission's collection of demographic data from complainants to try to get an idea of who is complaining and whether particular groups are underrepresented or overrepresented. We are starting that from 1 July. We have been doing all the preparatory work for that.

This is not directly related to your question, but it is part of the same process. We are doing customer survey processes with every complaint we handle, so everyone who makes a complaint and any health service provider we deal with we send a form to fill in about how they evaluate the Commission's processes and service. So, we are getting quite a range of strategies and we should be able to produce, I hope, fairly detailed data on that for our Annual Report—not for 2007-08 but for 2008-09 it should all be in place.

CHAIR: So, those demographics would include ethnicity, language group—

Mr PEHM: Yes, Aboriginality—

CHAIR: Mental illness?

Mr PEHM: Yes. We can give you a copy of those forms, if you like.

Hon DAVID CLARKE: According to the report, over 30 per cent of investigations are not finalised within 12 months. Are you concerned about that? What types of matters take more than 12 months to complete?

Mr PEHM: I do have a concern about that because change is not instant in public sector organisations, or probably anywhere for that matter. There has been a process of continuing improvement to improve those times. I will not dwell on how bad things were in the past, lest I be seen to be making excuses, but I might ask Bret Coman, our Director of Investigations, to explain to you some of the measures we are putting in place which we think will result in significant improvement to investigation time frames.

Mr COMAN: Part of that involves the Procedures Manual, so a change of our policy and practice. Part of it is cultural too, to instil an urgency into investigations.

Hon DAVID CLARKE: When you say a change in culture, does that mean there were people dragging their feet in doing these investigations?

Mr COMAN: I suspect so, yes.

Mr PEHM: The Commission had a very linear process of investigation which involved sending the matter to the respondent and waiting for a response. If the response took longer than the 28 days requested, they might wait a bit more and then send a reminder letter. So, that might blow out to two months and they would still be waiting for that response. The essence of the new Procedures Manual is that a multiplicity of lines of enquiry is pursued from the outset. So, we are not waiting on one response before we proceed with other lines of enquiry. Sometimes you do have to wait because there is particular information that will be the source and the foundation of the enquiry without which you cannot proceed, but the Commission's investigation process traditionally has been very linear, and the second step was not taken until the first step had been completed.

Do not forget, the Commission did not have any powers to compel the production of information until post-Macarthur. So, that came in, in March 2005 and I do not think the culture of the Commission geared up very quickly to the availability and the use of those

powers. It is all very well for me to say we have them and to tell people to use them and address staff meetings, but it is not part of their everyday practice and it is not how they think about investigations. It takes time for those sorts of messages to get through. Previously, if a health practitioner did not respond to the Commission there was nothing the Commission could do about it, short of executing a search warrant on their premises, which is completely out of proportion to the nature of the complaints.

The new procedures manual integrates the powers in the investigation process and it is just a much more active approach. Our investigation team structure - we have introduced a lot closer supervision. Previously the culture was that individuals were responsible for their files. They were given to them and no one asked for anything back until they had finished their investigation. So there was very little supervision of the complaints process. We have much tighter control of that now. There is a lot more monitoring, a lot more reporting back, and the new manual will introduce default reports, so that if certain steps are not taken within certain time frames, managers will be notified through the case management system, electronically, and they will be obliged to follow it up. So, the process will be much more active and inevitably it will get quicker.

Hon DAVID CLARKE: What types of matters genuinely take more than 12 months to complete?

Mr PEHM: Complex ones, generally.

Hon DAVID CLARKE: Can you give some examples of that?

Mr PEHM: The classic ones are the complex hospital care matters. Things can be complicated by external processes, by coronial inquiries, and so on, and police and criminal inquiries. So, that can be a contributing factor, or criminal charges being laid. The most complex investigations are those provided in big hospitals where the patient has been in care for a significant period of time, many weeks. Medicine in those contexts is very much a team delivery of service. A classic one would be a post-operative infection where, during an operation, something is nicked and the contents of one organ leak into other areas and peritonitis develops and infection. That can be picked up early or it can be picked up later. So, you have to look at the nurses doing the monitoring during that time, you have to look at the Registrars and the Career Medical Officers reviewing that patient and you have to look at the surgeon and the post-operative follow-up. So, even in a two-week period, if you include the shifts and looking at when the critical deterioration occurred, you are looking at 15 or 20 or more health practitioners.

You then decide how many of those are critical and what level of evidence you need from them. Traditionally the Commission wrote out and waited for responses. I guess it was easy when you had that many people but in a complex care situation the level of individual responsibility for the deterioration of a patient, say, is often very diffuse amongst a lot of practitioners. It is a question of balancing up and weighing up the contribution of one compared to the other. That can require you to go back when you get responses from one practitioner to double check with others. Those other matters do take a long time.

CHAIR: Mr Coman, I was not sure that you had completed your answer?

Mr COMAN: Yes. In essence, Kieran answered it. It was just the management and the ongoing management of those investigations and setting milestones and making sure those milestones are met, and if they are not, taking corrective action to make sure they are met.

Hon KERRY HICKEY: Does the Commission experience any delay going from the assessment stage to the investigative stage?

Mr PEHM: There is a service level agreement between our Assessments Branch and our Investigations Branch. I do not think there are any significant delays but Bret can probably tell you the time that takes.

Mr COMAN: There have not been any significant delays that I can recall at this stage. We have our own time frames and we follow up on them fairly quickly.

Hon KERRY HICKEY: So, you are saying there is no delay from the assessment to the investigative stage?

Mr PEHM: There are administrative things that have to be done. At the end of the assessment process the parties have to be advised of the outcome of the assessment decision, their right to request a review, and the file has to be transferred to investigations. So, letters have to be written by the Assessment Officer, the Case Officer, but I think the transfer rate is three or four days at the moment.

Mr COMAN: Or even less than that.

Mr PEHM: We have an actual number of days specified. I cannot recall what it is at the moment.

Mrs JUDY HOPWOOD: The report notes that unsatisfied complainants have the right to take their matters to the Ombudsman or the Independent Commission Against Corruption. Do you think it would be appropriate to also note in the Annual Report that the Committee has an oversight role with respect to systemic issues at the Commission?

Mr PEHM: I am happy to do that. I think people find it difficult to distinguish between systemic issues and how their particular complaint was handled, but I absolutely have no problem with doing that at all.

CHAIR: The staff attrition at the Commission is certainly down on the levels of 2005-06, but it remains not inconsiderable, particularly in the Assessment and Resolutions and the Investigation Divisions. Has the Commission adopted the process of exit interviews and staff satisfaction surveys recommended by the Committee in its report of the Commission's 2005-2006 report?

Mr PEHM: Yes. Last time we met I was unsure as to whether we did exit interviews. We do, or at least staff are given a form to fill out and they are offered the opportunity for an exit interview. That has been in place for some time. We are also conducting what is known as a climate survey. We have consultants in to undertake that process. At our last staff meeting about three weeks ago all the staff were addressed on that process. A working group will frame the questions and we expect that to be finished by the end of June and have the results of that.

Hon DAVID CLARKE: What did those exit interviews show? Did they show a pattern of complaints or concern as to why people left?

Mr PEHM: No. Since that matter was raised I actually talk to staff that are leaving. It is very stressful work actually and not a lot of people have the right temperament for it. That has been the main reason in the assessments area particularly and there has been a lot of pressure on the assessments area with the number of complaints and I think I have explained to the Committee that we have put in place procedures that require our staff to talk much more directly with people than has been the case in the past. Everything used to be done in writing and led to a lot of alienation of the complainants from the Commission.

It is high volume work and it is very stressful because a lot of the complainants have suffered catastrophic losses in their lives, the deaths of loved ones and so on. They are grieving, and they want to tell their story and people have to deal with that. That has certainly been expressed to me by a few staff who have not had the temperament for it. They have to deal with a fair bit of conflict, if not aggression, and not a lot of people have the right temperament for that either.

Hon KERRY HICKEY: Is the exit level up or down?

Mr PEHM: It is down in the 2006-07 year on the previous year, and I think I went into the reasons for that. I do not inherently see staff turnover as a bad thing and if the idea of staff stability is an inherent good in itself, I just disagree with that.

Hon KERRY HICKEY: It is just that you said that the assessment of the complaint is up, yet the investigative level is down because of the strong assessment.

Mr PEHM: Yes.

Hon KERRY HICKEY: Are staff doing the assessments leaving quicker than they were before?

Mr PEHM: Staff is fairly stable now. I am just responding to the Chair's comment, if I was hearing you right that there has been a high turnover in assessments.

CHAIR: Yes.

Mr PEHM: Assessments is fairly stable now. It is very important to pick the right sort of staff. We put a lot of effort into promotion, recruitment and induction of staff, but it is a stressful job.

Hon DAVID CLARKE: Would more staff relieve the pressure?

Mr PEHM: More staff will relieve the pressure.

Hon DAVID CLARKE: Do you need more staff?

Mr PEHM: We have put on three temporary staff until the end of June to see how this load that I have explained from the increase in complaints in the last couple of months to deal with that and we will monitor it again at the end of June to see whether we need to make some more longer term increase in assessments staff numbers.

I should make the point that I do not think staff turnover is inherently a bad thing. Staff at the Commission since I have been there have probably been under a lot more pressure than they have been prior to that. Although they had significant backlogs, we did not have the sorts of process I have been describing in assessments and in investigations where staff were monitored, supervised and directed, and a lot of staff, particularly in the early days, reacted very badly to that because they had been given complete independence to run their own race. Now when you are going through a cultural change process and trying to get a teamwork environment developed where everyone is working together towards the same ends, I do not think it is a bad thing that people who do not see their future working in that environment decide to go and I do not think that we should be bending over backwards to try to keep people like that either.

Dr ANDREW McDONALD: You talked about the stressful job. I would like you to enlarge on that. You talked about the anguish of the families, the conflict and aggression. Can you expand on the main stresses for the staff who work there?

Mr PEHM: Every complaint that comes in now, assessments staff will call the complainant and discuss the complaint with them, clarify that their written complaint fully expresses their complaint and if not add to it and make sure we have a comprehensive complaint before we go to the respondent. They do deal with a lot of angry people and a lot of people who are grieving. Health is very high risk - not high risk, but people are ill and they die and emotions are involved.

I had to do a lot on the grieving process and the first stage is denial and then anger. People want to look for external causes outside the inherent nature of the situation and they want to look for people to blame. That is one of the main reasons why the level of refusal by complainants to accept the conciliation process is still high and we are working hard to try to

get that down. They can become frustrated when they start to realise that the more extreme actions they might have wanted or anticipated do not take place.

If a loved one is in a hospital situation or paid care and they are dying over a period of time, the complainant or member of the family will build up a relationship; they will be visiting them, they will see the conditions or they might have a run-in with a nurse about how long they took to get there. Personalities come into it and all those human factors. You cannot cut those out of the complaint process. Most staff try to be as professional and dispassionate as possible in the interests of fairness and impartiality, but it is unfair and inhuman not to allow those people to express their grief and frustration at the system, and I think that takes a toll.

The officer I am thinking of in particular is a lovely fellow with a very nice temperament but he likes to be liked. He does not like getting yelled at or being told, 'You are useless; why can't you do anything. What use are you?' and this sort of thing. You do have to put up with a certain amount of conflict. The foreword to this Annual Report - generally the level of public trust in the health service providers is very high, but when something goes wrong it is fractured in a really emotional and often a very bitter way. Staff have to deal with a lot of human situations that are not particularly pleasant.

Dr ANDREW McDONALD: The next question relates to reaction from health providers because after you have taken the information, you then ring the health provider, is that right? Is there stress between the HCCC staff and the health providers?

Mr PEHM: It is the same thing. The Commission is in the most difficult position. It is in the middle of what is often a really fractured relationship. I went to a talk and there is a psychiatrist in Melbourne who works for the college there and he counsels practitioners who have complaints made against them and he described it as the same stages of grieving as Kubler-Ross; their first reaction is anger and denial as well. How dare they? They are biting the hand that feeds them. I am just there to help and look at the thanks I get. There is also unfortunately a culture in the health services, and the medical profession in particular, that sees complaints as an attack against character, standing and reputation. People pride themselves on never having complaints made.

There is not the appreciation that I think there needs to be that it is really a part of doing business of any sort, that when you are dealing with consumers you will always have interactions, and particularly in medicine where the issues are so complex and the treatment can have side-effects and complications that may not necessarily have been foreseen. Even if the consent process has been good, people want to hear the good outcomes. We get a lot of complaints around informed consent where the practitioner will even produce signed consent forms about the side-effects and complications and explaining them and the complainant will swear that they were never told about those adverse side-effects. I am wandering a bit there but does that answer your question?

Dr ANDREW McDONALD: Very much so, thank you.

CHAIR: Earlier in one of your answers you talked about the increase in staffing and that you have created some temporary positions to deal with the increased load of complaints since the publicity following Royal North Shore Hospital and the Mr Reeves matter. Is it only in the area of assessment resolution that you see that you need additional staff?

Mr PEHM: At the moment, yes, but with management everything is constantly under review and you are always monitoring and measuring where the workload is, but certainly that is the big influx of complaints, and until we process those matters and determine the proportion that will go through to investigation or other areas, it is difficult to say whether the increase will be sustained and whether it will flow through to substantially increased work in other areas.

CHAIR: I was thinking of the investigations. You are not expecting that on assessment there would be an increase in the number of investigations?

Mr PEHM: It is on the radar and we have talked about the possibility of that and, if necessary, we will seek supplementation and see whether we can reorganise resources from other parts of the Commission. It is a bit early to say yet.

CHAIR: Do you foresee any difficulty in acquiring people with the skills you need as investigators, if you find you need them very soon?

Mr PEHM: That is another thing, where it is a sort of constant management problem. Bret is a former Chief Inspector of the New South Wales Police Service. We have had a very strong push to professionalise our investigations area. My impression is that the more the Commission is improving its performance and reputation in the health system, the more we are getting applications. We just did a recruitment process in assessments and there was something like 90 applications. Bret is keeping the staffing of the investigations area under review continually.

Mr COMAN: From time to time we get expressions of interest as well and we call for their curricula vitae to identify people who could be good at the Commission. We are looking at one detective who is interested in secondment and we are trying to work through that. We do have a few people in mind, even just for the short term.

Dr ANDREW McDONALD: Thank you very much for providing the draft code of conduct, which is very good. What is the progress of the code because it still has 'draft' on it?

Mr COMAN: Is that our code of conduct or the code of practice? There are two documents.

Dr ANDREW McDONALD: The one you gave us?

Mr PEHM: That is the code of practice under section 80 of our Act. We are also drafting a code of conduct, which is why I asked, so it could well have been the other one. We just sat down yesterday and went through the responses we received from both the health profession and the community stakeholders with the draft code of practice and we will finalise that in the next couple of weeks I think. All the responses have been very good, constructive and useful. They have all practically said it is a good initiative to produce the document. There will be some pretty substantial revision. There will be a bit more detail in it than there is now and the format will be changed slightly but that is all under way and we will have that finished by the end of the year.

Dr ANDREW McDONALD: Shorter is better.

Mr PEHM: Yes but there are people that feel particular things need to be said and that has got to be respected as well so it will get longer. We are trying to keep lawyers language out of it and keep it in plain English.

Mrs JUDY HOPWOOD: With the proposed national registration and accreditation scheme for health professions which will establish new partnerships between the Federal and State registration and education accreditation bodies governing medical professions, what impact, if any, do you consider a national scheme will have upon the operations of the Commission?

Mr PEHM: That is a really interesting question. I do not know what the answer to it will be. I went to a consultative meeting while the national accreditation registration scheme was being drafted and raised that very issue of what impact it will have on the complaints and disciplinary side. The response broadly was that the Commonwealth recognises that is all very difficult and all of the States have different legislation and complaint-handling procedures. They had given it some thought but they had not put in a great deal of work to

the process of harmonising those processes nationally. The national registration scheme is aimed at workforce deployment. It came out of the Productivity Commission originally and it is a good thing. The idea is if you register in one State you are registered nationally.

At the moment if you are in Tweed Heads or Coolangatta you have to be registered in both States, you have got two sets of registration fees and you would be subject to a different disciplinary process in Queensland than you would in New South Wales. Also for overseas trained doctors to be accredited by one central authority and be able to work rather than go to each State and go through a different accreditation process. That is the primary objective. There will inevitably be a flow-on effect from it and it is conceivable in a rational world all of the complaint-handling procedures would be made consistent because the ultimate outcome of a complaint will affect registration. If you are registered you can have conditions placed on registration. I think it will take some time and a lot of negotiation as to precisely the form it takes. It may not become urgent until there is an anomalous case where a practitioner is dealt with differently under one jurisdiction that has impacts in another that really highlights the problem. So there will be an impact but it is very difficult to say what it will be at the moment.

CHAIR: Can you please give the Committee a more detailed account of the Commission's interactions with Justice Health?

Mr PEHM: I was just out at Justice Health this week, on Monday I think. We interact with them in the everyday complaint handling sense, of course. I went out to see them about some particular issues where I suppose the security considerations in the prison had affected the conditions of the patients in the forensic hospital and we had a complaint about that so I wanted to talk about that. We have interaction at a lot of different levels. Our Resolution Officers deal with them quite a bit.

Our complaints follow the normal process. We generally get a response from Justice Health if it can be resolved there or we feel that the matter has no substance at the end of it, but we do refer a lot of matters to our Resolution Service because the complainants are in a vulnerable position and often need representation. So our Resolution Officers deal with them a lot. I will say that Justice Health are very responsive and professional in the way they deliver their services and are very responsive to us.

The other reason for our meeting was that they are also going through a bit of cultural change themselves and perhaps introducing some more strict discipline in their ranks than has been the case in the past. So they are also referring complaints to us against some of their health practitioners.

CHAIR: Just to refer to some of the responses that you gave to the questions that we asked on notice. In answer to one of the questions you said in some instances the Director of Proceedings does not agree with the level of seriousness of the matters referred to her by the Commission, although this was only on a small number of occasions. Do you consider there is any basic divergence in the concept of ‘serious’ between the Director and the Commission staff?

Mr PEHM: No. Complaints can be referred to the Director of Proceedings for a number of reasons. A very common one, and one where the Director might decide not to take action, is where there are allegations of sexual boundary violation—sexual misconduct basically. The matter might go to a criminal prosecution and the magistrate might say they do not find it proved to the criminal standing: beyond reasonable doubt. Now a different standard is applied in a protective jurisdiction before a disciplinary tribunal. I would feel safer referring that to the Director of Proceedings with a prosecutor who can go through the evidence and make her own independent assessment of the prospects of success of a prosecution than making that decision myself at the end of an investigation. There will inevitably be cases referred through to Karen really for safety in the public interest so that a person whose skills are better suited to looking at the prospects of prosecution can make the decision. Do you want to add anything to that Karen?

Ms MOBBS: I think that is all true. The other aspect of it is that when it comes through to the Legal Division we are really looking at it with a view to whether there is sufficient evidence to prosecute. The criteria actually set out the likelihood of proving the complaint. Obviously before the Professional Standard Committees, the tribunals that we deal with, certain views have been taken in relation to types of matters and how they have to be proved. So with the same set of facts that may constitute a departure from the standards, it may well be that in other similar cases a tribunal or Professional Standards Committee has taken a particular view that it will not amount to the legal definition of unsatisfactory professional conduct. So in those cases it may be that whilst there is a departure, it is not worth pursuing it in the disciplinary sense because we are not going to get a finding, and may well incur costs in doing so, and that matter is best dealt with by referral back to the Commission to be dealt with by the Board's comments or counselling or some other disciplinary outcome rather than prosecution.

Another one of the matters that is sometimes a difficulty is that not all of the registration Acts have a Professional Standards Committee. A number of them only have tribunals and what they call Boards of Inquiry. A tribunal will generally deal with those matters requiring de-registration or suspension. In those jurisdictions such as for doctors and nurses there is a Professional Standards Committee that can deal with less serious unsatisfactory professional conduct. In matters such as psychology and podiatry there is not a second lower prosecuting body, which means I do not really have any jurisdiction to prosecute unless it is dealt with in the more serious jurisdiction. So on those occasions I do not have any choice but to refer it back to the Commissioner for him to refer to a Board of Inquiry. So even though there will be a disciplinary outcome it is actually counted as me making a determination not to prosecute just because of the framing of those bodies.

CHAIR: Do you think that it should be standard across the Professional Boards? Have you made any recommendations to Government about a change of legislation that would address that anomaly?

Ms MOBBS: We have made a number of recommendations in trying to have commonality amongst the various registration Acts. I do not know that so much attention has been focused on Boards of Inquiry. We have certainly raised that with the individual Boards.

Mr PEHM: It has always been our position that there should be consistent discipline legislation across all of the jurisdictions. It is moving slowly that way. The pharmacists and I think that dentists now are going into the same scheme as the doctors and nurses.

Ms MOBBS: The Pharmacy Act was a new Act that came in very recently—in February. So it is slowing changing and certainly we would support, and have made a number of recommendations that any changes made, for example, to the Medical Practice Act be reiterated across all of the registration bodies, because it makes it very difficult. We also have to work with the interface between the Health Care Complaints Act and the other registration Acts. The more differences there are between those Acts, the more difficult it is to work them in with our Act. Certainly our recommendation is that at some time, and the sooner the better, all of those Acts be reviewed together to make sure there are as few inconsistencies between them as possible.

CHAIR: I note that the Commission is currently arranging for a suitable replacement for the Commission's Consumer Consultative Committee. Can you inform the Committee on how that is progressing?

Mr PEHM: We might be trying to recruit new members to the Committee. I do not know that we are looking at replacing the Committee. The Committee is actually a statutory creature so I do not think we can replace it without amending the statutes. Is there a particular answer there?

CHAIR: There was an answer that we received.

Mr PEHM: We are reviewing the membership of the Committee and trying to make sure that we have as broad a representation as possible. We put that to the Committee and at the next meeting they will be suggesting other potential members and so –

CHAIR: It relates specifically to a representative from the Ethnic Communities Council?

Mr PEHM: Yes. We are actually consulting with the Community Relations Commission about a suitable member from that area.

CHAIR: It is just progressing. The report notes that the Commission plans to undertake a full review of its publications which are specifically focused on providing information to the Aboriginal community regarding its services. Can you tell me how that is progressing?

Mr PEHM: We have reviewed all of our publications. We have just sent the proofs to the printers to have all of our pamphlets done. The answer I was going to give was really concerned with the multilingual distribution to the ethnic community. We have our Aboriginal Designated Officer as part of this program we have to develop senior management. She is doing a project specifically on the delivery of Commission information to Aboriginal communities. She is stationed in Dubbo and I think she is on leave at the moment working with Charles Sturt University. Her supervisor is not here today but she will be delivering a proposal to us about how we would best do that. It is a difficult and sensitive area and she is best placed to do it but we do not have the outcome of that yet.

My adviser informs me that she has been released from her duties by the Commission to work specifically on the project of delivering Commission information to Aboriginal communities in New South Wales. I am pretty sure she is working with Charles Sturt University on that.

Mrs JUDY HOPWOOD: I seek further clarification in relation to a complaint that covers both a system failure and a health practitioner failure, and the reporting mechanism or communication between the Commission and the family members in relation to the complaint or incident that occurred and is causing concerns. I know that systemic failures are looked at in a different way as opposed to dealing with health practitioners. In relation to the health practitioners, how much information does the family or the significant members of the community –

Mr PEHM: The complainants.

Mrs JUDY HOPWOOD: Yes, the complainants.

Mr PEHM: With every complaint against a health practitioner that is investigated but does not get referred for prosecution the final letter to the complainant telling of the outcome is a fairly full investigation report that sets out the context of the complaint, the conduct the subject of the investigation, all the evidence gathered, the expert opinion on the practitioner's conduct and the reasons for the outcome. They get fairly full explanations. Our Investigation Officers are charged with keeping regular phone contact - at least once a month - with complainants and family, so there is fairly close communication and we believe reasonably full advice of the outcomes at the end.

It can be very difficult for people to distinguish. Often the complaint is about the whole of care and there are reactions on all sides. Some will take a particular dislike to a practitioner and want them deregistered for whatever reason - their interaction with them has not been very constructive during the illness. Others will say when we prosecute individual practitioners, ‘Oh, they're just being made a scapegoat. It's all the system's fault.’ You get reactions on all sides. Some will want us to take stronger action against individuals; others will say, ‘No, I'm not concerned with individuals. I want the system changed.’ We do advise people fairly fully of the outcomes.

With matters that are being prosecuted we do not, because potentially people can be called as witnesses for the prosecution. You do not want them to know the evidence of other parties in case even unconsciously they change their version of events. It just complicates things. They will be party to the disciplinary proceedings if they are witnesses. Tribunal proceedings, of course, are in public; Professional Standards Committees are in private. There is a problem there with the parties knowing the outcome. I think that has been pretty well addressed by the legislative amendments that will be made as a result of the Reeves matter, which require Medical Practice Act Professional Standards Committees to be in public unless there is a good reason for them not to be. Again, on the consistency point, that will apply only to medical practitioners because that is the circumstance that gave rise to it.

Mrs JUDY HOPWOOD: In relation to a Coroner's finding when there is no reference or recommendation for a prosecution relating to a practitioner arising from the evidence and the HCCC finds there should be a prosecution, is there any discrepancy between the fact that the Coroner did not make that finding and you did?

Mr PEHM: It is a question of the different standard of proof. The Coroner is looking at a criminal standard: should a practitioner be prosecuted for manslaughter or criminal negligence? That is a higher standard of proof than we might be required to prove before a Committee. There are also the outcomes of our proceedings, leaving dismissal and suspension aside. There is often a case where it is appropriate for a Professional Standards Committee to impose conditions on a practice. That is a circumstance you want expert panels to judge. They can make finer judgments than the Coroner. The Coroner certainly gets expert witnesses who give opinions, but the proceedings are different.

CHAIR: Commissioner, we may have some more Questions on Notice following the evidence today. I am sure Committee members will go away and consider those. If we have more questions we will forward them to you. I thank you for the very timely way in which you have responded to our Questions on Notice to date. We certainly have appreciated that. It has made the Committee's work a lot easier. Thank you and Ms Mobbs and Mr Coman for appearing before us today.

(The witnesses withdrew)

(The Committee adjourned at 3.20 p.m.)