HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Mrs JR Miller MP (Deputy Chair)
Ms RM Bates MP
Mr SW Davies MP
Dr AR Douglas MP
Mr JD Hathaway MP
Mr DE Shuttleworth MP

Staff present:

Ms S Cawcutt (Research Director)
Ms K Dalladay (Principal Research Officer)
Mr K Holden (Principal Research Officer)

PUBLIC BRIEFING—HEALTH COMPLAINTS MANAGEMENT

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 30 JULY 2013

Brisbane

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Committee met at 11.01 am

PEHM, Mr Kieran, Commissioner, New South Wales Health Care Complaints Commission

CHAIR: Good morning and welcome. I declare this public briefing of the Health and Community Services Committee open. Our purpose today is to be briefed by the New South Wales Health Care Complaints Commissioner about the New South Wales experience with health complaints management. I welcome Mr Kieran Pehm, the New South Wales Health Care Complaints Commissioner, via videoconference. You can see and hear us okay, by the sounds of it?

Mr Pehm: Yes, you are coming through fine.

CHAIR: Thank you. My name is Trevor Ruthenberg. I am the chair of the committee and the member for Kallangur. To my left is Mrs Jo-Ann Miller MP, member for Bundamba and deputy chair; Ms Ros Bates MP, member for Mudgeeraba; and Mr John Hathaway MP, member for Townsville. Also joining us will be Dr Alex Douglas MP, member for Gaven; Mr Steve Davies MP, member for Capalaba; and Mr Dale Shuttleworth MP, member for Ferny Grove. They will be here shortly.

Mr Pehm, I ask you to start your briefing and that will be followed by some questions from the committee. As the New South Wales health complaints system is the closest to what is proposed in the Health Ombudsman Bill 2013, the committee is particularly interested in your comments on how the New South Wales system works and any issues you think the committee should particularly look at or look for. After your presentation I will ask the committee if they would like to ask you questions, so I invite you to make some opening comments.

Mr Pehm: Thank you for inviting me to appear before you. I must say I do not have a presentation as such, but I am more than happy to take questions. A few general issues about the commission: we are different from the rest of the country except now for Queensland. New Zealand, interestingly, has a similar system to New South Wales, where the body responsible for investigating and prosecuting serious complaints is an independent commission. In all of the other states—and still in Queensland I guess for the moment—that function is handled by the relevant council or boards, in your case the medical boards, dental, chiropractic and so on. That is the essential difference.

We have been at it now for I think about 11 years or longer. Before that, the health department had a complaints unit which also performed that function. We have had a lot of time to bed down systems. We get about 4,000 complaints a year. We have an assessment process that we hope is reasonably thorough so that in the end we investigate only 4½ per cent of complaints. That is a little bit over 200 a year. Investigations in this area are very intensive. Often you need firsthand accounts, which require investigators to go out and take statements and so on. The difficult area management-wise is the clinical expertise area. We are not experts, we are not clinicians and we cannot judge clinicians. Where the system allows for that is that the commission engages an expert to provide an opinion on a particular type of clinical conduct. If the matter is prosecuted, that expert will appear as a witness and give evidence to the disciplinary tribunal.

We prosecute between 90 and 100 complaints a year before disciplinary bodies. As a result of that practitioners can be suspended, be deregistered or have conditions placed on their practice. Of the 300 complaints that go through to investigation, about 100 go down to the director of prosecutions, which she then prosecutes.

At the moment we are assessing about 94 per cent of complaints in 60 days. In terms of investigations, we have about 89 or 90 per cent completed in 12 months. Prosecutions take more time. There are more procedural issues before disciplinary tribunals. They are run largely like courts, and practitioners, particularly medical practitioners, are very well represented and vigorously defended. So they do take time. That is about all I have for the generalities about the system, but I am happy to throw it open and answer questions as you see fit.

CHAIR: Thank you, Mr Pehm. I have a follow-up question on some things that we have previously heard. We have heard that the New South Wales health service providers are required to keep a register of the complaints they receive and that they must give you a list of those complaints. Are you able to tell us a bit about how that works in New South Wales and what you see the benefits or drawbacks of that are?

Mr Pehm: I am not sure the source of your evidence, but we are not provided with lists of complaints. If someone goes to a local hospital and complains about the hygiene or the food or even a clinical issue and it can be resolved on the spot by the hospital, there is no legal obligation on the local health district to inform us of that and we generally do not have a problem with that. We think complaints are best handled at the appropriate level. So if it is simple, straightforward customer service matter, it is best dealt with at the point of contact. There is always a balance in this area between oversight and service delivery and how much oversight you have and when regulation gets cumbersome and too restrictive, but that is not a requirement in New South Wales.

Mr HATHAWAY: Mr Pehm, is there within the New South Wales legislation or regulations a requirement for those health providers to maintain a register, whether they provide that to you or not? Are they required to maintain it?

Mr Pehm: I am not aware that there is a requirement. I do not know. There is just one caveat on my previous answer. If a serious clinical issue arises in the New South Wales public health system, it is investigated by way of a root-cause analysis. All of the results of those root-cause analyses are sent to a body called the Clinical Excellence Commission in New South Wales. These are not complaints from the public; these can be generated where clinicians themselves identify a problem or an error or a near miss. The Clinical Excellence Commission in New South Wales conducts its business along the quality improvement line—a bit like that function that your current commission has. So those matters are all fed to our Clinical Excellence Commission. It makes recommendations about future practice as a result of that and does clinical education.

Sorry, just jumping back to the first question, I am not aware of any requirement for local health districts to keep registers of complaints. They do. I visit them and I am in touch with them and generally they are very responsive and good complaint handlers. There may be a legal requirement. I am not aware of it. As a matter of practice they all do keep good records of complaints.

CHAIR: Thank you.

Mr SHUTTLEWORTH: Do you in your role as commissioner have any capacity to undertake immediate action to restrict practice?

Mr Pehm: No, we do not. In New South Wales that is a matter for the relevant council—in your case the boards. So if it involves a medical practitioner, that power is in the Medical Council of New South Wales to convene a hearing and take that immediate action.

Mr SHUTTLEWORTH: Thank you.

Dr DOUGLAS: I am curious about the relative costings. It has been said that the costings should be cost neutral here. You have kept the complaints part and you moved across from the original board structure. Has there been any massive increase or can you give us an idea of what the incremental increases may have been under the model you have at the moment? It is 11 years. It is fairly mature.

Mr Pehm: That is right. It is 10 years, so it is hard to say whether the change from one system to the current system engendered an increase in complaints or costs. In the last five years the commission has had about a 50 per cent increase in complaints. I do not think that is as a result of any particular system. I do not have figures on national boards—I have not been concerned to follow that up—but I think complaints are rising as a general function of people's education and they are less willing to accept authority than perhaps they did of old. You will find across all areas where complaint mechanisms exist—ombudsmen and so on—that complaints are steadily increasing.

Dr DOUGLAS: Can I ask a supplementary question, then? Is the budget for this coming out of the New South Wales budget or does it come across from AHPRA?

Mr Pehm: No, the Health Care Complaints Commission is funded by the New South Wales government and its budget is around $10 million. AHPRA's funds come from registration fees. In New South Wales, a proportion of registration fees go to fund the New South Wales councils—the medical, dental, chiropractic councils and so on. We consult and have a co-regulatory arrangement with them on how we handle complaints. Matters involving the health of practitioners or poor performance where that performance does not raise already significant risk to the public health or safety are dealt with by the council. It is, I guess, more a supportive mechanism for practitioners to

either get them treatment or get them under proper supervision—issues with their practice if it is a performance issue, perhaps—to really support doctors to practise in a safe and competent manner. That is how it works in New South Wales.

Mr HATHAWAY: In your opening comments you indicated that when you need clinical advice for a review of a complaint as you receive it you draw on that expert field. Do you maintain a short-list panel of those experts in particular clinical areas or do you source them from the colleges?

Mr Pehm: Yes, exactly. We have probably about 300 experts on an expert panel that we can call on whenever we need them. In the medical area, which is where the greatest number and most serious complaints are, the college is really the principal source of recruiting for that. They are very good and cooperative. We do not have a shortage of experts so much it is an issue of delays creeping in when experts juggle our requirements with their normal practice and so on.

Mr HATHAWAY: Thank you.

Mr Pehm: But it works fairly well.

Dr DOUGLAS: Are there currently any difficult or grey areas that have emerged since the transition to a centralised system with AHPRA? The rest of the nation has the complaints body centrally and yours is kept regionally. Are there any grey areas that have occurred and what are they?

Mr Pehm: They do not have grey areas in New South Wales because AHPRA has a very small function here. It is just the register. Practitioners apply to AHPRA and the national board puts them on the register. If there is a disciplinary action against them that results in changes to their conditions of registration or cancellation, AHPRA takes them off or puts the conditions up on the register. So that is the only real interface in New South Wales. All of the complaints are handled by the commission, except for those ones I mentioned where they concern a general health service provider's health or performance issues and those are dealt with by council. I am not sure if that answers your question.

Dr DOUGLAS: No, that is fair and reasonable. It is just that there has been an emergence in recent times of organised groups, particularly obstetricians and fertility groups. It becomes very difficult to specify individuals as such. They are registered centrally and they exist in every state. I am curious to know whether you have had specific claims that relate to those types of instances.

Mr Pehm: Are you talking about practitioners who practise in a number of different jurisdictions?

Dr DOUGLAS: Yes, and also practice groupings.

Mr Pehm: Well, individual practitioners that practise across borders are not a problem. The way you would handle it would depend principally on the location of the conduct. Sometimes you will get, perhaps in the Tweed-Coolangatta area, practitioners that operate in both areas on regular basis. We have had a few cases like that, but we liaise with the local state AHPRA people as to who should take the primary responsibility depending on where the bulk or the most serious conduct is and what is likely to have the most impact in terms of a disciplinary tribunal. So that has not been a problem. Those sorts of cases are fairly rare. Health service delivery is a very local business and, true, there are some specialties that move around but it is fairly rare. The other issue seems to involve consumer groups or areas of practice and I am not sure what your question is there.

Dr DOUGLAS: Well, I was not quite going into consumer groups. It is just that some of the specialty groups work within defined parameters of treatment protocols within those groupings. One of the eye groups, for example, is a publicly owned corporation now and it exists in multiple states and has very defined ways it practises which intermittently causes some angst. I am a GP so I see this on the ground.

Mr Pehm: I see. It has not been a big area of complaints. The commission has the power to investigate the corporation, if you like, or the corporate entity that delivers this health service even though it is a private sector entity. In a case like that, if protocols by which these specialty groups operated were found—and we would have to get independent evidence and get some assessment of that and you would have to look at international best practice or whatever—the commission could make recommendations that their practice should be changed. This has not been a big issue in New South Wales in relation to the way specialty groups operate. There have been a few issues with private facilities and the way they conduct procedures where we have been able to recommend augmentation or checking processes that tighten up their procedures. That has happened, but, again, it is not very common.

Mr HATHAWAY: Does your commission publish in any form details of a respondent clinician or facility whilst the investigation is being conducted or is it only post the investigation?

Mr Pehm: No. The commission has confidentiality provisions which make it an offence to publish information obtained under the act unless it is for a purpose to do with the act. So our basic public position is 'no comment'. We do not confirm or deny whether we have complaints to media and so on. That applies right through, up to the stage where a disciplinary body like a tribunal makes an order, and those hearings are in public, the decision is public and the commission has a statutory duty to make it public and make those decisions publicly accessible. But apart from that, there is no disclosure or public comment on investigations as they are proceeding.

Ms BATES: Mr Pehm, I just want to clarify what you said before in terms of practice issues or errors that occur locally—like, if you are a nurse and there were medication errors and that needed to be dealt with through a process of policies and procedures. They are dealt with at a local board level and then, if they need to be, are also dealt with at AHPRA board level. So is it correct to say, then, that your group really looks at major malpractice where it is patient safety related?

Mr Pehm: Yes. On the medication issue, medication administration is a good example. That issue, once it is noticed in a hospital, may well be satisfactorily dealt with by giving some training, a bit of mentoring, maybe a bit of supervised practice. If that does not work and the local health district keeps good records of the failures to achieve the competencies then it can get to a stage where that person is just not safe to practise, that they cannot be trusted to safely calculate and deliver medication on their own. At that stage the local health district will notify the commission.

Again, there are two possible options there. It can go to the Nursing and Midwifery Council, who may have the power to do a performance assessment—and that might be in a clinical situation where they have very experienced nurses assess them and assess their capacity. On the other hand, if it is more serious than that and the assessment of the evidence leads you to believe that this nurse will never be able to safely deliver medication—there may be, for instance, a cognitive impairment that affects their mathematical ability or some health reason—then those matters will be handled by the commission and taken to a disciplinary tribunal to either cancel the registration of the practitioner or apply conditions regarding the use of medication.

Ms BATES: Thank you.

CHAIR: Members, if there are no further questions, Mr Pehm, thank you for making yourself available for us. This is an interesting bill we are debating and we sure appreciate the time you have given us today so that we can consider some of this in a little bit more depth. Are there any closing comments or thoughts that you would like to share with us?

Mr Pehm: There is just one thing I would like to say. I think New South Wales does have the preferable system from the public interest point of view. There is a very heavy, I guess, assumption that only practitioners can judge other practitioners. That has underlined the whole transition we had to AHPRA and the national boards retaining that power. I think that is flawed for two reasons. The first is the lack of distance from the issue and the potential for lack of objectivity. The second is, well, who is making the decision? Within the medical area you may have a specialist. Are they in a position to make decisions on a general practitioner? Should a cardiothoracic surgeon be making decisions on another area of practice? There may be conflict and all those internal hidden issues that go on in any group or organisation. I think the more independence there is to the complaint-handling system, the more objective it is likely to be and I think ultimately it is in the best interests of practitioners as well. So I am very pleased to see Queensland going in the direction that it is. If I can offer any assistance in your transition to the new system I would be happy to do so. Thank you.

CHAIR: Thank you, Mr Pehm. The time available for this briefing has expired. I now declare this briefing closed.

Committee adjourned at 11.24 am