PARLIAMENT OF NEW SOUTH WALES

Committee on the Health Care Complaints Commission

REPORT 1/56 – JUNE 2016

REVIEW OF THE HEALTH CARE COMPLAINTS COMMISSION ANNUAL REPORTS 2013/14 AND 2014/15

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The motto of the coat of arms for the state of New South Wales is "Orta recens quam pura nites". It is written in Latin and means "newly risen, how brightly you shine".

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Terms of Reference

The Committee on the Health Care Complaints Commission is a current joint statutory committee, established 13 May 1994, re-established 2 June 2015.

The Committee monitors and reviews the Commission's functions, annual reports and other reports it makes to Parliament. The Committee is not authorised to re-investigate a particular complaint; or to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

The terms of reference for the Committee are set out in Part 4 of the *Health Care Complaints Act 1993*, sections 64-74.

(1) The functions of the Joint Committee are as follows:

(a) to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act,

(a1) without limiting paragraph (a), to monitor and review the exercise of functions by the Health Conciliation Registry,

(b) to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed,

(c) to examine each annual and other report made by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report,

(d) report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Commission,

(e) to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

(2) Nothing in this Part authorises the Joint Committee:

(a) to re-investigate a particular complaint, or

(b) to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint, or

(c) to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

(3) The functions of the Joint Committee may be exercised in respect of matters occurring before or after the commencement of this section.

Chair's Foreword

I am pleased to present the Committee's Review of the Health Care Complaints Commission's (HCCC) Annual Reports for 2013-14 and 2014-15, pursuant to the Committee's responsibilities under section 65 of the *Health Care Complaints Act 1993* to examine all reports of the Commission. This is the Committee's first review of the 56th Parliament.

The Committee took this opportunity to examine trends and issues over the two year period of the reports rather than examining the two reports separately.

The Commission continued to develop and extend its outreach activities during the reporting years. The Committee was interested to see the growth in electronic communications coupled with a continuing commitment by the Commission to ensure the widespread availability of its printed material.

The Committee was also encouraged by the growing level of sophistication in the way the Commission identifies its target audiences and tailors its messages to their needs. In particular, the Commission is focussing more on vulnerable and isolated groups within the community, aided by the presence of its out-posted officers in regional areas. The Commission's evidence recognises the importance of communication not only in publicising the role of the Commission, but as a tool for resolving or managing complaints about treatment which were likely the product of poor communication by practitioners in the first place.

This was also a period of a continuing increase in the number of complaints received, a trend which the Commission anticipates will not abate. The Committee noted the Commission's continuing high level of achievement in its core business.

The Committee welcomed the Commission's focus on staff welfare and training. Complaints handling, especially in a heated environment like health care, can take its toll on staff, and the Committee will be interested to follow the results of the Commission's application of resilience training for staff in particular.

The Committee was pleased to hear the Commission nominate a number of important areas for future work including the examination of complaint trends in metropolitan and non-metropolitan areas; the strengthening of feedback mechanisms for complaints referred to professional councils for resolution; the identification of support services which may assist vulnerable complainants; and the gaining of efficiencies through the more timely use of early resolution techniques.

I congratulate the Commissioner Sue Dawson on her appointment. I also acknowledge the achievements of former Commissioner Kieran Pehm, and the excellent work done by Acting Commissioner Karen Mobbs. On behalf of the Committee I thank all the staff at the Commission for their dedication and diligence, their professionalism, and especially their patience and compassion in a climate of increasing complaints and workloads.

I also thank the Committee members and the Legislative Assembly Committee staff for their interest in and enthusiasm for oversighting the Commission.

I agree with the Commissioner when she says that an increasing number of complaints is not evidence of failure. The NSW healthcare complaints system is a model for health jurisdictions in Australia and overseas. The system is working, and working well. The citizens of this state know that they have the right to question medical practitioners and are using the health care complaints system to good avail as the legislature intended.

The Committee and I look forward to working with the Commissioner and her staff during the remainder of the 56th Parliament.

The Hon. Melinda Pavey MP
Chair

Glossary

GP	General practitioner
HCCC	Health Care Complaints Commission
ICT	Information and communications technology
PRU	Pharmaceutical Regulatory Unit
TAFE	Technical and Further Education

Chapter One – Introduction

1.1 Section 65 of the *Health Care Complaints Act 1993* requires that the Joint Committee on the Health Care Complaints Commission reviews each annual report made by the Commission and reports to Parliament on matters reported in or arising from each annual report.

1.2 The Commission's annual report for 2013-2014 was presented towards the end of the 55th Parliament, so this is a review of both the 2013-2014 report and the Commission's annual report for 2014-2015 which was presented to the 56th Parliament.

1.3 As part of this review, the Committee held a public hearing at Parliament House on Friday 11 March 2016. The Committee took evidence from four witnesses who appeared on behalf of the Commission: Ms Sue Dawson, Commissioner; Mr Tony Kofkin, Director of Investigations; Mr Ian Thurgood, Director of Assessments and Resolution; and Ms Karen Mobbs, Director of Proceedings.

1.4 The Committee has published the transcript of the evidence heard at the public hearing on its website and the answers provided by the Commission to the questions taken on notice at the hearing are included as an appendix to this report.

1.5 Given that it was reviewing two annual reports, the Committee took the opportunity to examine trends and strategies over the two year period rather than reviewing each annual report in isolation.

1.6 This report is made up of four chapters. This chapter is an introduction to the process which the Committee followed to complete this review. The following three chapters highlight significant aspects of the Commission's operations, namely: Chapter Two – Outreach and accountability; Chapter Three – Complaint trends and handling; and Chapter Four – Organisational matters.

Chapter Two – Outreach and accountability

2.1 This chapter examines the public outreach and accountability activities of the Health Care Complaints Commission during the two reporting periods. The Commission has a corporate goal 'to promote and publicly report about the work of the Commission'.[1]

OUTREACH ACTIVITIES

2.2 The Commission's outreach and accountability activities are focussed on raising public awareness of the role and functions of the Commission and ensuring the Commission has the confidence of both the public and health practitioners and representative organisations.

2.3 It works to achieve this object by making the Commission's services accessible; working with a range of stakeholders, including health practitioners and organisations to ensure complaints handling procedures are well managed and system improvement initiated; and being responsive to the concerns raised by both health consumers and health providers.[2]

2.4 In 2013-14 the Commission provided 97 presentations and workshops to community groups and health professionals.[3] In 2014-15 there were 69 similar presentations and workshops.[4] For both reporting periods the Commission achieved its target of hosting at least 60 presentations.[5]

2.5 The presentations and workshops are designed to provide participants with direct and targeted information about the Commission's role and functions. These events allow participants to ask Commission staff questions and discuss case studies.[6]

2.6 In 2013-14 the Commission's outreach activities focussed on health consumers from non-English speaking backgrounds, which included migrants. It also focussed on Aboriginal health workers and those working in the local health districts and specialty networks.[7]

2.7 During the 2014-15 reporting period the Commission focussed on Aboriginal health workers, staff from the local health districts and speciality networks, and TAFE and university students who are studying to become health practitioners.[8]

2.8 The Commission also aims to raise awareness of the role of the Commission by hosting training sessions for expert advisers who assist with the Commission's

[1] HCCC Annual Report 2014-15, p10
[2] HCCC Annual Report 2013-14, pp14-15; HCCC Annual Report 2014-15, pp 11-12
[3] HCCC Annual Report 2013-14, p14
[4] HCCC Annual Report 2014-15, p11
[5] HCCC Annual Report 2013-14, p13; HCCC Annual Report 2014-15, p10
[6] HCCC Annual Report 2013-14, p14; HCCC Annual Report 2014-15, p11
[7] HCCC Annual Report 2013-14, p14
[8] HCCC Annual Report 2014-15, p11

investigations and may be called as expert witnesses. Commission staff attend conferences and host presentations with other health policy and complaints handling organisations such as the Clinical Excellence Commission and the Health Literacy Network. The Commission's Consultative Committee allows health consumer organisations who are represented on the Committee to provide feedback on the work of the Commission. The Commission also publishes articles and reports for health professional and health consumer organisations.[9]

2.9 The Commissioner of the Health Care Complaints Commission is just one of several health care complaints commissioners across Australia and in New Zealand. The Commissioner works in cooperation with other health care complaints organisations and attends meetings of the Australian and New Zealand health complaints commissioners.[10]

2.10 During the reporting periods the Commission has continued to support a research project, run by the University of Sydney, comparing complaint handling in New South Wales to other Australian jurisdictions. This support will continue in 2015-16.[11]

2.11 During her appearance before the Committee, the Commissioner was asked how the pattern and size of complaints in New South Wales compares to other jurisdictions.[12] This matter, and the Commissioner's response, are discussed in more detail later in the report.

2.12 While the majority of the Commission's staff is based in Sydney, the Commission also has a presence in regional New South Wales through the employment of three regional officers. The Committee was advised that the outposted resolution officers 'identify particular weaknesses in knowledge about the work of the Commission or particular areas of vulnerability.' [13]

2.13 Currently, there are resolution officers located in Lismore, Dubbo, and Newcastle. The Commission also has plans to locate an officer in Wollongong.[14]

COMMUNICATION PROGRAM

2.14 In addition to its presentations and workshops to raise awareness about its role and functions, the Commission's website is becoming an increasingly important means of communication.

2.15 When asked during the public hearing to explain the Commission's outreach and accountability processes, the Commissioner responded by highlighting the importance of the Commission's website:

> The Commission's outreach program is extensive. As you would expect, it has a number of dimensions. … Those are intended to cross the spectrum of

[9] HCCC Annual Report 2013-14, pp14-15; HCCC Annual Report 2014-15, pp11-12

[10] HCCC Annual Report 2013-14, p15; Transcript of evidence, 11 March 2016, p17

[11] HCCC Annual Report 2014-15, p15

[12] Transcript of evidence, 11 March 2016, p17

[13] Transcript of evidence, 11 March 2016, p7

[14] Transcript of evidence, 11 March 2016, p12

> communicating and informing the full community and then thinking about how we can target our work to particular areas that will assist us in improving complaints performance across the State.
>
> … in essence, everything hangs off the work that the Commission does to maintain an effective and informative website. It is plain that we are succeeding in that.[15]

2.16 The Commission's website provides information about its services and how those services can be accessed. Resources are also made available in a range of languages, with fact sheets and the complaint form available in 20 languages.[16]

2.17 During the hearing, the Commissioner went on to state that the number of website hits has increased substantially. In 2013-14 there were 6.8 million hits and this rose to 12.7 million in 2014-15.[17] The number of hits in 2014-15 exceeded the Commission's target of seven million.[18]

2.18 The Commissioner advised that the Commission has 'doubled the level of engagement with our website and we are confident we are providing information that is helpful to the community.'[19]

2.19 Further underlining the growing importance of the Commission's website as an effective means of communication, in 2014-15 the Commission recorded a substantial increase in the number of website visitors. There were 374,552 visitors in 2014-15, an increase of 17.4 per cent on the 319,006 visitors in the 2013-14 reporting period.[20]

2.20 During the reporting periods the Commission continued its series of webinars. The webinars cover a range of topics and are directed at health practitioners working in the local health districts and speciality networks, professional colleges and the Health Education and Training Institute.[21]

2.21 During the public hearing on 11 March 2016, the Commissioner noted that the webinars are well received and available to anyone who accesses the Commission's website.[22] The Commission has stated that it will continue to offer webinars in 2015-16 and increase the library of audio visual resources available on the website.[23]

2.22 The Commission is required by legislation to publish media releases about the decisions of disciplinary bodies. In the 2013-14 reporting period the Commission implemented an email subscription service for its media releases, with subscribers notified about each new media release.[24] The Commissioner advised

[15] Transcript of evidence, 11 March 2016, p2
[16] HCCC Annual Report 2014-15, p11
[17] Transcript of evidence, 11 March 2016, p2
[18] HCCC Annual Report 2014-15, p10
[19] Transcript of evidence, 11 March 2016, p2
[20] HCCC Annual Report 2014-15, p10
[21] HCCC Annual Report 2013-14, p14; HCCC Annual Report 2014-15, p11
[22] Transcript of evidence, 11 March 2016, p2
[23] HCCC Annual Report 2014-15, p12
[24] HCCC Annual Report 2013-14, p14

the Committee that there is 'active interest' in the Commission's media releases.[25]

2.23 The increased focus and development of the Commission's website has resulted in a decrease in the need to distribute printed material to stakeholders including health consumers, health practitioners and providers.

2.24 In 2014-15 the Committee distributed 4,385 publications which was less than its target of 5,000. In view of the increased reliance on its website, the Commission will cease reporting on the distribution of printed material from the 2015-16 reporting period onwards.[26]

2.25 Since 2012-13 the Commission has received the majority of its complaints electronically, either via email or through its online complaint form.[27] While there is an increased reliance on the use of its website, the Commission is aware of the need to ensure printed material is made publicly available to consumers, especially in those places where consumers are accessing medical services.

2.26 The Commission distributes a number of printed brochures and fact sheets to stakeholders. The two main publications are booklets titled:

- *Concerned about your health care*; and
- *Resolve concerns about your health care*.[28]

2.27 The Commissioner advised the Committee about where and how the brochures are distributed:

> Through a service called InfoMed, a service that provides hard copy information to individual GP services right across Australia, we provide brochures through them to individual services.[29]

2.28 The Commissioner went on to detail the size of the distribution network and the number of brochures that have been distributed during the past two years:

> I can confirm that we provided in excess of 58,000 brochures in the past two years through that service to 900 GP practices where 3,800 GPs operate and where about 1.5 million patients per month cycle. We have really been quite intensive in providing those resources out there. Obviously we need to refresh from time to time, and that is probably the moment that we are at.[30]

2.29 In addition to general practices, the brochures are made available in private hospitals and a range of other health facilities.[31] The distribution of brochures by

[25] Transcript of evidence, 11 March 2016, p2
[26] HCCC Annual Report 2014-15, p10
[27] HCCC Annual Report 2013-14, p14
[28] Answer to question taken on notice 11 March 2016
[29] Transcript of evidence, 11 March 2016, p6
[30] Transcript of evidence, 11 March 2016, p6
[31] HCCC Annual Report 2014-15, p12

InfoMed during 2014-15 was done on a pro bono basis. When requested, the Commission also distributes brochures directly to health services.[32]

2.30 The Commission continues to focus on maintaining strong relationships with local heath districts. The Commission's presentations and workshops with the local health districts are an important part of maintaining that relationship and creating a culture of responsive complaint handling.[33] The Commissioner informed the Committee that the Commission's:

> … involvement with the local health districts is quite intensive. We offer training and presentations to the local health districts, and we do that on a regular cycle. There was an intensive program of visits to the local health districts in 2012-13, and that was followed up in 2014-15. My intention is to make it a priority to complete a program of visits to all local health districts in this calendar year, in fact, probably this financial year if I can achieve it.[34]

2.31 The Committee was informed that the Commission prepares for the visits to the local health districts by tailoring their presentation and workshop to the specific needs of each district. When the Commission visits a local health district it examines 'the profile of complaints relating to that region' and 'what is happening with providers in that region'.[35]

2.32 Analysis of the complaints within a local health district allows the Commission to identify specific issues of complaint that are occurring regularly. The Commissioner told the hearing what the Commission can offer to local health districts as a result of this analysis:

> We want to offer the local health districts an analysis of what is happening in their region; what is the profile of complaints across the region; and what are we seeing in relation to the public hospitals within that local health district? Are we seeing any particular hotspots in complaints?[36]

2.33 When asked what feedback the Commission has received from the local health districts following the visits, and if the visits resulted in fewer complaints, the Commissioner was positive in her assessment of the visits:

> We are seeing a very high level of responsiveness from the local health districts as a result of their interaction with the Commission. We are seeing quite strong improvements in local complaints resolution at the local health district level, and strengthening of the work in public hospitals on the back of the root cause analysis initiative. So we are finding that there is strong improvement in many health districts.[37]

2.34 The Commissioner referred to specific areas where improvements have been noted and that assistance with putting in place best practice measures is welcomed by the local health districts:

[32] Answer to question taken on notice 11 March 2016
[33] HCCC Annual Report 2014-15, p12
[34] Transcript of evidence, 11 March 2016, p2
[35] Transcript of evidence, 11 March 2016, p5
[36] Transcript of evidence, 11 March 2016, p2
[37] Transcript of evidence, 11 March 2016, p3

> We are also finding that when we go into the local health districts and we offer training on particular issues of concern—open disclosure, ways of communicating, having those difficult conversations—that we can see those are having a good effect in respect of improved local resolution outcomes.
>
> Local health districts and the people who participate in the training we offer are saying that has been incredibly helpful. Theoretically we know what we need to do but helping to get a real sense of what best practice looks like at the coalface is really helpful.[38]

2.35 The need for informative and effective communication by health practitioners with patients is a key component in reducing the number of complaints. The Commissioner advised:

> That is why we say, when we go out to local health districts and to the professional councils pretty much: communication, communication, communication. It is the really important cornerstone of excellent practice and complaints avoidance. It really is. We see that all the time.[39]

2.36 The importance of good communication is a key message that the Commission also aims to instil in those starting out on their career in the health system. The Commission presents to health practitioner students at TAFE and university to educate them on how complaints should be managed and also about their obligations under mandatory reporting requirements.[40]

Identifying target groups

2.37 Acknowledging the increased importance of the Commission's website, the Committee noted that there are those in society, such as the Indigenous community, people affected by mental health conditions and people with disability who lack the resources to access information online.

2.38 The Committee was interested to know how the Commission reaches out to such groups so that they are aware of the role and functions of the Commission and how it can assist them.

2.39 In response, the Commissioner informed the Committee about the Commission's outreach activities with Aboriginal health workers in rural New South Wales:

> Our outposted [resolution] officer, in dealing with the Far West of New South Wales, identified that the 10 Aboriginal health services in the Bila Muuji group, which is located in western New South Wales; the area covering Brewarrina, Bourke, Walgett, Coonamble and so on—really had a need to be upskilled in understanding the role of the Commission and how they could access the Commission.[41]

2.40 In keeping with the strategy of tailoring information to the needs of its target audience, the Commissioner described how the workshops were structured and the issues that were covered:

[38] Transcript of evidence, 11 March 2016, pp2-3
[39] Transcript of evidence, 11 March 2016, p8
[40] HCCC Annual Report 2014-15, p11
[41] Transcript of evidence, 11 March 2016, p7

> … we … did an intensive series of workshops for those 10 Aboriginal health services. We did workshops that covered the whole question of: What is the role of the Commission? How can people access it? What sorts of complaints do we deal with? Then we did one-on-one sessions with particular people from the Aboriginal health services to then coach them through the specifics of how complainants are dealt with, and so on.
>
> We used that way of having our outreach officers identify particular areas of need and that Bila Muuji group presentation initiative is one that we will be repeating across other areas where there are particular vulnerable groups or groups that need increased information about what we are doing and support.[42]

2.41 In response to a question about what plans the Commission has to expand this program to other vulnerable communities, particularly people with a mental health condition, the Commissioner replied:

> We have trialled the method of doing this and we are going to look at other vulnerable groups to target them, and mental health is certainly one of those on the radar.[43]

NATIONAL CODE OF CONDUCT FOR HEALTH WORKERS

2.42 Federal, State and Territory Health Ministers have agreed to set up a National Code of Conduct.[44] The Commission has had continued involvement in the establishment of a National Code of Conduct for health care workers during both reporting periods.

2.43 This new Code of Conduct will not apply to New South Wales. It is modelled on the New South Wales Code of Conduct for unregistered health practitioners, introduced in 2008.[45]

2.44 During the public hearing the Commissioner updated the Committee on the Commission's involvement in the process of setting up the National Code of Conduct:

> We have been able to provide advice through the ministry, and to our other jurisdictions, to talk about how our work with unregistered practitioners looks—what does it involve; what is the scope of it; what processes ought to apply?—and that has been informing the development of the national code. So we are very proud of the leadership we have been able to show in relation to unregistered practitioners.[46]

2.45 The National Code of Conduct sets a minimum standard of conduct and practice for all unregistered health care workers. It also sets out the standards against which disciplinary action can be taken. The Commissioner described how the New South Wales Code of Conduct was regarded as a model on which to base the new national code:

[42] Transcript of evidence, 11 March 2016, p7
[43] Transcript of evidence, 11 March 2016, p7
[44] HCCC Annual Report 2013-14, p15; HCCC Annual Report 2014-15, p12
[45] HCCC Annual Report 2014-15, p5
[46] Transcript of evidence, 11 March 2016, p3

> The National Code of Conduct for healthcare workers is interesting for us because it deals with the question of unregistered health practitioners. New South Wales, since 2008, has been very much ahead of the game in terms of having a code of conduct for non-registered practitioners. That is really good news for us. It has meant that, as the national code conversation has developed—so that all states and territories are thinking about how to bring non-registered practitioners into the fold—the New South Wales model has been very much a lead for what is occurring nationwide.[47]

COMMITTEE COMMENT

2.46 The Committee commends the Commission for its continued focus on engaging with health consumers and health professionals in promoting awareness of the role and functions of the Commission.

2.47 The Committee recognises the importance the Commission places on its relationship with each of the local health districts and speciality networks and all of their efforts in working towards a best practice complaints handling system.

2.48 In particular the Committee acknowledges and supports the Commission's commitment to protect the health and safety of the most vulnerable members of society and assist them in accessing medical treatment.

2.49 Utilising the targeted approach employed when working with Aboriginal health workers, the Committee encourages the Commission to continue its efforts to identify vulnerable groups that can benefit from greater awareness and understanding of the work of the Health Care Complaints Commission.

2.50 The Committee notes the work and resources that the Commission has dedicated to developing its website. Having a single accessible and comprehensive information resource, that will continue to be enhanced, will benefit those who are interested in or working in the health system.

2.51 While the reliance on electronic communication is important, there is also a need to recognise that even in this digital age there are those who do not have access to such communication.

2.52 The Committee supports the Commission's commitment to ensuring there is widespread distribution of printed material and that this information is made available in areas where it can be easily accessed to ensure those without internet access are not disadvantaged.

2.53 The Committee is pleased to see that the active approach that New South Wales has taken in complaints management is recognised at a national level with the introduction of a National Code of Conduct for health care workers.

[47] Transcript of evidence, 11 March 2016, p3

Chapter Three – Complaint trends and handling

3.1 This chapter examines the trends in complaints reported by the Health Care Complaints Commission over the two annual reporting years under review, and several areas of complaints handling which were the focus of the Committee's questions at the public hearing. The chapter also highlights the areas where the Commissioner indicated further work is required to better understand trends or manage complaints handling.

3.2 The Commission's corporate goals focus heavily on complaints handling and the Commission's annual reports provide comprehensive data and analysis of performance measured against its three complaints management goals:

- Comprehensive and responsive complaints handling;
- Investigating serious complaints; and
- Prosecuting serious complaints.[48]

3.3 The Executive Summary of the Commission's 2013-14 annual report begins by stating that 'the 2013-14 year marked the sixth consecutive year in which the Commission has received an increasing number of complaints'.[49] The Commission's 2014-15 annual report states similarly that 2014-15 is the 'seventh consecutive year'.[50]

3.4 In its 2013-14 annual report the Commission gave a detailed explanation of the complaint process in both a flow chart[51] and in writing.[52] This explanation was repeated in the Commission's 2014-15 annual report.[53]

COMPLAINT TRENDS

3.5 In 2013-14, the Commission received 4,767 complaints, raising 8,061 issues or an average of 1.7 issues per complaint.[54] While the average number of issues per complaint declined slightly from 2012-13, the number of complaints in 2013-14 increased 4.7 per cent over the previous year.[55]

3.6 In 2014-15, the Commission received 5,266 complaints, raising 8,940 issues or an average of 1.7 issues per complaint.[56] The number of complaints received by the Commission in 2014-15 was a 10.5 per cent increase over 2013-14.[57]

[48] HCCC Annual Report 2013-14, p140; HCCC Annual Report 2014-15, pp135-136
[49] HCCC Annual Report 2013-14 p6
[50] HCCC Annual Report 2014-15 p6
[51] HCCC Annual Report 2013-14 p16
[52] HCCC Annual Report 2013-14 p17
[53] HCCC Annual Report 2014-15 p13
[54] HCCC Annual Report 2013-14 p19
[55] HCCC Annual Report 2013-14 p6
[56] HCCC Annual Report 2014-15 p16
[57] HCCC Annual Report 2014-15 p6

3.7 In her foreword to the 2014-15 annual report, the Acting Commissioner wrote that over the past five years, complaints about health service providers have increased by 28.5 per cent, and anticipated that complaints will continue to grow.[58]

Issues raised in complaints

3.8 In line with its customary annual reporting practice, the Commission qualified its reporting by noting that its data 'is not a comprehensive indicator of the overall standard of health care delivery in NSW'.[59] The Commission noted that many complaints are addressed by the relevant health service provider directly and the number of complaints to the Commissioner is relatively small in relation to the volume of health services provided.[60]

3.9 The most common issues raised by complainants were treatment (40.2 per cent of complaints in 2013-14; 39.4 per cent in 2014-15), communication (16.5 per cent in 2013-14; 16.5 per cent in 2014-15), and the professional conduct of the health service provider (14.3 per cent in 2013-14; 14.2 per cent in 2014-15).[61]

3.10 The Commission's annual reports provided further detailed breakdowns within each complaint category.

Lack of communication and poor treatment

3.11 In 2013-14, the Commission reported that 62.9 per cent of communication and information complaints concerned the attitude and manner of the health practitioner. Inadequate information provided by the health service provider amounted to 19.2 per cent of communication-related complaints, and incorrect information constituted 16.2 per cent.[62]

3.12 In the Commission's 2014-15 annual report the attitude and manner of the practitioner contributed to 53.2 per cent of communication-related complaints, while inadequate information and incorrect information amounted to 32.1 per cent and 13.3 per cent of complaints respectively.[63]

3.13 At the public hearing held at Parliament House on Friday 11 March 2016, Committee members examined the nexus between complaints and communication. In particular, the Committee questioned the contribution that lack of communication or poor communication by health professionals makes to the number of complaints received by the Commission when compared with poor treatment.

3.14 The Committee asked the Commissioner to comment on whether a lack of communication and poor management of patient expectations more than poor treatment was actually driving complaints.

[58] HCCC Annual Report 2014-15 p4
[59] HCCC Annual Report 2014-15 p16
[60] HCCC Annual Report 2014-15 p16
[61] HCCC Annual Report 2013-14 p19; HCCC Annual Report 2014-15 p16
[62] HCCC Annual Report 2013-14 p20
[63] HCCC Annual Report 2014-15 p17

3.15 The Commissioner responded that, typically, complainants complain about more than one issue, coupling various issues, such as treatment and communication, together.

> What we notice … is that if a practitioner has communicated poorly, it seems more likely that the complainant will also complain about their treatment.[64]

3.16 The Commissioner illustrated this observation with an example of surgeons briefing patients on the possible complications of surgery. When a rare complication occurs, in circumstances where a surgeon chooses not to brief a patient due to the rarity of the complication coupled with the patient's low risk profile, the complaint made might be informed by the patient's view that mistreatment has occurred rather than a lack of communication.

> … it is not actually mistreatment but they conflate the two and nothing in their minds thereafter will uncouple those two things. That is a kind of example where communication and treatment get grafted on to one another. It is an extreme example; there are other kinds of lesser examples but I am just trying to illustrate the point that how practitioners communicate to somebody and then what happens next are kind of irretrievably linked.[65]

3.17 The Commissioner stressed the overwhelming importance of communication as the 'cornerstone of excellent practice and complaints avoidance'.[66]

Medications and over-prescribing

3.18 The Committee also examined the number of complaints about medication reported by the Commission in 2014-15. The Commissioner was asked whether the data had been analysed to determine how often the wrong medication was being prescribed and the prevalence of over-prescribing with a view to addressing issues like doctor shopping and the need for real-time prescription monitoring.

3.19 In response the Commissioner advised that medications are a dominant area of complaint in relation to pharmacists. Complaints received by the Commission may relate to a range of complex issues including dispensing errors, over-prescribing and forged scripts. The Commission's response to this area of complaint is twofold;

- to meet with the pharmaceutical council to discuss the professional response of pharmacists to the need to strengthen standards and ensure best practice dispensing; and
- to work with the Pharmaceutical Regulatory Unit (PRU) of NSW Health which, through its audit and inspectorial functions, identifies individual pharmacists who may be dispensing inappropriately for possible investigation.[67]

[64] Transcript of evidence, 11 March 2016, p8
[65] Transcript of evidence, 11 March 2016, p8
[66] Transcript of evidence, 11 March 2016, p8
[67] Transcript of evidence, 11 March 2016, p6

3.20 Mr Tony Kofkin, Director of Investigations, expanded on the matters arising from complaints about pharmacists. He advised the Committee that real-time monitoring is an ongoing project for the health portfolio. He also described the complex nature of investigating the dispensing of both regulated and unregulated medications, and the time and resources these investigations require, as an:

> …increasing part of our business not just dispensing in terms of regular dispensing, or even in relation to what we would call dispensing of these Schedule 8 drugs, the highly regulated dangerous opiates, but as well peptides, human drug hormones, off label compounding links to organised crime, links to a number of practitioners who are prescribing medication outside therapeutic guidelines—very large-scale investigations for the PRU … which are very complex investigations for the Commission, which take a very long time and a lot of our resources, and are particularly high risk as well.[68]

Other issues

3.21 The Committee also canvassed a number of other matters. In response to questions about the number of complaints received from prisons, the Commissioner advised that approximately 200 complaints were received in 2014-15 relating to correction and detention facilities, amounting to 3.6 per cent of complaints received. [69]

3.22 On being asked how many of these 200 complaints related to the distribution of nicotine patches, the Commissioner advised that it was a low number.[70]

3.23 The Committee asked the witnesses several questions concerning other specific areas of complaints received and investigations undertaken in the reporting years which the witnesses took on notice, including:

- can the Commission provide the number of investigations undertaken in relation to complaints about adverse outcomes?
- has the Commission received complaints regarding decisions or diagnoses made by medical practitioners on behalf of life insurance companies?
- has the Commission ever referred a medical practitioner for prosecution following an investigation into the use and safety of therapeutic devices such as, but not limited to, mesh tissue fixation devices?
- can the Commission provide a breakdown of the issues raised in the complaints received about aged care facilities generally, but with a particular focus on complaints about the restraint, either by physical or chemical means, of residents with dementia?
- regarding treatment-related complaints in both aged care facilities and hospitals, can the Commission provide a breakdown of the specific issues that relate to and come under the heading of treatment?

[68] Transcript of evidence, 11 March 2016, p7
[69] Transcript of evidence, 11 March 2016, p13
[70] Transcript of evidence, 11 March 2016, p14

- in relation to mental health complaints and issues of consent, can the Commission provide a breakdown of the specific issues that relate to and come under the heading of consent?

3.24 The witnesses took these questions on notice, and the Commission's answers are provided in the appendix to this report.[71]

Metropolitan and non-metropolitan trends

3.25 The Committee questioned the witnesses whether trends in complaints showed any differences between metropolitan and non-metropolitan regions.

3.26 In responding, the Commissioner advised that the Commission was able to identify complaints on a regional basis, but noted two difficulties when assigning complaints to regions: firstly the lack of a consistent definition for regions across the whole-of-government, and secondly the problem of deciding whether a complaint should relate to the region in which the complainant lived or to the region in which they were treated.

> For instance, somebody may live in Mudgee and come to Sydney for treatment. Is that complaint counted in the region in the Sydney context where the provider was or do you cut the information by where the complainant came from? We can do both and we do both, but it is complex.[72]

3.27 On the question of whether regional trends could be distinguished and the strategies employed by the Commission to address regional differences, the Commissioner firstly described the Commission's observations of differences regarding the quality of and access to facilities.

> If we look at complaints in metropolitan versus non-metropolitan areas, what we see is that in non-metropolitan areas there are more complaints about the quality of the facilities that the complainant is in. We have more complaints about the access to services. We also have more complaints about discharge and transfer arrangements. You would expect that.[73]

3.28 With regard to complaints about treatment, the Commissioner advised that the levels of complaint were not significantly different between metropolitan and non-metropolitan complainants. When the location of the provider was considered, however, the Commissioner advised that complaints about treatment were higher in metropolitan than non-metropolitan regions.

> The providers in metropolitan areas have a 45 per cent complaint rate about treatment, whereas the providers in non-metropolitan areas have a 40 per cent complaint rate about treatment.[74]

3.29 The Commissioner advised that there were also differences between metropolitan and non-metropolitan levels of complaints concerning conduct.

[71] Answer to question taken on notice 11 March 2016
[72] Transcript of evidence, 11 March 2016, p5
[73] Transcript of evidence, 11 March 2016, p10
[74] Transcript of evidence, 11 March 2016, p10

> For metropolitan providers there is a 7.5 per cent rate of complaint about conduct.
>
> ….
>
> For non-metropolitan providers there is a 14 per cent complaint rate about conduct. This may be about less experienced practitioners working in regional areas. It may be about there being less supervision. There is a question there. It is something that we need to look more into.[75]

3.30 The Commissioner identified these and other regional differences as issues which warranted the Commission's further investigation and analysis, both into the contributing factors, as well as the robustness of the data.

> At the moment we are saying, "What is the picture of metropolitan to non-metropolitan, looking at the provider or the service perspective and looking at the complainant perspective?"
>
> ….
>
> … we are starting to get a richer understanding of the data, but we need to do more because there may be data imperfections. I want to caveat all of what I have just said, because I have asked exactly the same questions since coming on board. I have questions about what there is to see here, so there is more work to do.[76]

Why are complaints increasing?

3.31 The Committee asked the Commissioner to what she attributed the continuing increase in the number of complaints being received by the Commission.

3.32 The Commissioner advised that there is no single factor driving complaints, but that the situation is a complex combination of factors. In particular she nominated the ageing population which results in an increasing number of people using health services, and in comorbidity becoming more common with the result that the treatment environment becomes more complex. The Commissioner also noted a spike in complaints following changes to mandatory reporting in 2012-13.[77]

3.33 The Commissioner also drew the Committee's attention to changes in how health consumers are choosing to interact with the health system.

> More and more of us are going beyond our general practitioner to alternative treatments, to broaden the suite of health services that we use. People might go to natural therapists. They might even go to more experimental treatment.
>
> ….
>
> People are choosing to think about going to the frontiers of medical practice.[78]

3.34 The expanding use of fashion-oriented health services was another factor which in the Commissioner's view contributed to an increasing number of complaints.

[75] Transcript of evidence, 11 March 2016, p10
[76] Transcript of evidence, 11 March 2016, p10
[77] Transcript of evidence, 11 March 2016, p11
[78] Transcript of evidence, 11 March 2016, p11

> … botox, breast augmentation and so on. Complaints about them show up when people go into that adventurous territory and something goes wrong and they want redress for it.[79]

3.35 The Commissioner was keen to point out that an increasing number of complaints was not necessarily negative or evidence of failure.

> There is also good news. The health complaints system is working. People know that they can complain. People feel comfortable about complaining. No longer is your doctor God or a person whom you cannot question. People want to question their medical practitioners. That is a good thing. We are putting that message out: "Question where you need to," and so they come.[80]

ASSESSING COMPLAINTS

3.36 The Commission reported that in 2013-14 it assessed 4,742 complaints,[81] and in 2014-15, 5,002 complaints.[82] In 2013-14 the Commission continued to achieve a high level of assessing complaints within the statutory 60 day period, improving the timeliness of assessment compared with 2012-13.[83] The Commission's high level of performance was generally maintained in 2014-15.[84]

3.37 The Commission reported in both 2012-13 and 2014-15 that the assessment branch managed the increasing number of incoming complaints without compromising on timeliness or thoroughness of assessment.[85]

Referrals and outcomes

3.38 The Committee asked the witnesses to comment on the referrals of complaints to other bodies as an outcome of assessment. In particular the Committee asked about referrals to professional councils, which accounted for nearly 20 per cent of all outcomes of assessment of complaints in the four years up to and including 2014-15.[86]

3.39 Specifically the Committee asked how the Commission categorised a complaint that was referred on assessment to a relevant professional council. The Commissioner responded by advising that a complaint referred to a professional council is classed by the Commission as having been finalised.[87]

3.40 The Commissioner expanded on the issue raised by this practice, namely the role of and need for feedback to the Commission on referred complaints.

> You are raising an important point about how we close the loop on matters we refer to councils. In recent conversation with medical council we have had this exact

[79] Transcript of evidence, 11 March 2016, p11
[80] Transcript of evidence, 11 March 2016, p12
[81] HCCC Annual Report 2013-14, p6
[82] HCCC Annual Report 2014-15, p6
[83] HCCC Annual Report 2013-14, p6
[84] HCCC Annual Report 2014-15, p6
[85] HCCC Annual Report 2013-14, p6; HCCC Annual Report 2014-15, p6
[86] HCCC Annual Report 2014-15, p29
[87] Transcript of evidence, 11 March 2016, p13

> question about confidence in how matters are dealt with when we refer them back to councils. We are close to an agreement about the protocol for the councils reporting back to us on what they have done.[88]

3.41 The Commissioner agreed that the Commission needed to be confident that appropriate action had been taken on referral of a complaint.

> That is important feedback for us and we are seeking that.[89]

3.42 The Committee also asked what advice the Commission gave to complainants when the Commission referred their complaint to another agency. The Commissioner advised that, in determining referral to another agency is the appropriate course of action, the Commission writes to complainants advising them of this decision and the contact details of the agency to which their complaint has been referred.[90]

RESOLVING COMPLAINTS

3.43 In its 2013-14 Annual Report, the Commission reported on the impact on its resolution service of the loss of experienced staff during the reporting year. The report states that the process of recruiting, training and supervising new staff had a negative impact on the timeliness of the Commission's resolution work.[91]

3.44 In its 2014-15 Annual Report, the Commission reported on the outcomes of the staffing issues from the previous year. It noted that it had undertaken a staffing review leading to the identification of areas for improvement, process changes, clear key performance indicators, and improved timeliness in resolving complaints.[92]

3.45 In 2014-15 8.2 per cent of complaints were referred to the Resolution Service, compared with 9.3 per cent in 2013-14.[93]

3.46 To put this figure into perspective, in 2014-15 the outcomes of assessment of the remaining 91.8 per cent of complaints were:

- 2.9 per cent referred to another body or person;
- 5.0 per cent investigated by the Commission;
- 5.2 per cent referred for local resolution;
- 13.2 per cent resolved during assessment;
- 18.8 per cent referred to professional council; and
- 46.7 per cent discontinued.[94]

[88] Transcript of evidence, 11 March 2016, p13
[89] Transcript of evidence, 11 March 2016, p13
[90] Transcript of evidence, 11 March 2016, p14
[91] HCCC Annual Report 2013-14, p6
[92] HCCC Annual Report 2014-15, p6
[93] HCCC Annual Report 2014-15, p34
[94] HCCC Annual Report 2014-15, p29

3.47 The Resolution Service is voluntary, may or may not involve face-to-face contact, and can lead to a number of outcomes including an apology, an explanation, or an acknowledgement of a mistake.[95]

3.48 In questioning the witnesses, the Committee pursued a number of issues around resolution, commencing by asking how the Commission determines that a matter is resolved.

3.49 In response, the Commissioner advised that a matter is resolved 'where the complainant considers the matter to be resolved'.[96] The witnesses had earlier in the hearing confirmed that an apology did not constitute a resolution of a matter.[97]

3.50 The Commissioner also outlined the range of scenarios which may apply to a matter being assessed, and which led to the various outcomes described above and of which only 8.2 per cent of complaints were referred to the Resolution Service in 2014-15.

> At this point in time … about 12 per cent are resolved during assessment. Then the remaining percentage fall into a number of different categories. There is a range of pathways. The matter may be discontinued, perhaps because there was a fairly minor dimension to the problem that does not warrant further investigation as there is no significant risk of harm to the public. A matter may be discontinued with comments, where we say the experience of the complainant was not perfect—yes, they were kept waiting or the doctor did not communicate well. We would discontinue with comments and ask the practitioner to improve their information processes, timeliness or apologies.[98]
>
> Then there is a scenario where the complainant could be referred to the relevant professional council. The circumstances in which that would occur would be where it appears the person has a health impairment and that needs to be examined further and where possible the person put onto the impairment program. They may show a gap in knowledge so their performance as a doctor might not be up to scratch and they need to do more training or be assisted, and the professional council would arrange for that, or there might be a minor conduct matter. Then there is referral to investigation for matters that are clearly serious and there is a risk of harm to the public.[99]

3.51 The Committee was concerned to understand how the Commission regarded resolution of a complaint where the complainant continued to be dissatisfied, especially in the circumstance of a complaint where the Commission had found in favour of the medical practitioner. Committee members gave as an example a constituent who sought the assistance of their local Member of Parliament to continue the prosecution of a complaint where the Commission had completed its assessment, but the complainant did not agree with the outcome. The Committee asked what information a Member could provide such a constituent.

[95] HCCC Annual Report 2014-15, p34
[96] Transcript of evidence, 11 March 2016, p12
[97] Transcript of evidence, 11 March 2016, p4
[98] Transcript of evidence, 11 March 2016, p12
[99] Transcript of evidence, 11 March 2016, p13

3.52 The Commissioner advised firstly that under section 28(9) of the Act (the *Health Care Complaints Act 1993*) a complainant is entitled to seek a review of a Commission decision.[100]

3.53 Secondly, the Commissioner acknowledged that vulnerable complainants or those with special needs or conditions may require support during and after the Commission's assessment process.

> Perhaps they have some mental health issues or perhaps they have been traumatised by the experience. What we try to do there, if the review process uncovers those concerns, is to connect them with support services that they may be able to access.[101]

3.54 The Commissioner cited mental health and domestic violence services as examples of programs which may assist vulnerable complainants to resolve issues. In response to a further question from the Committee, the Commissioner advised that data was not kept on how often the Commission assisted complainants to receive support from such programs, and that the Commission needed to strengthen its ability to refer people to existing programs which could assist them.[102]

INVESTIGATING COMPLAINTS

3.55 In 2013-14 the Commission finalised 226 investigations which was more than a ten per cent increase on the previous year. The Commission also reported improvements in timeliness and average timeframe for investigations undertaken in 2013-14.[103]

3.56 In 2014-15 the Commission completed 194 investigations. Timeliness continued to improve over previous years although average timeframe for investigations increased in 2014-15.[104]

3.57 In reporting on the outcomes of its investigations, the Commission detailed that the options available for prosecution, a prohibition order or some other action were determined by whether the subject of the investigation was a registered or unregistered practitioner, or a health organisation.

Sufficiency of powers

3.58 The Committee asked witnesses their views on whether the Commission's powers to investigate unregistered practitioners were sufficient to protect the public from risk.

3.59 Mr Tony Kofkin, Director of Investigations advised the Committee that the Commission's powers are sufficient. He referred to the Code of Conduct for

[100] Transcript of evidence, 11 March 2016, p15
[101] Transcript of evidence, 11 March 2016, p15
[102] Transcript of evidence, 11 March 2016, p15
[103] HCCC Annual Report 2013-14, p6
[104] HCCC Annual Report 2014-15, p6

unregistered health practitioners as being both well established and sufficiently broad so as to capture 'any alternative health services'.[105]

3.60 For the benefit of the Committee, Mr Kofkin outlined the two stage test which the Commission applies before investigating a matter relating to an unregistered practitioner, namely that there must first be a breach of the code, and that 'in the Commission's opinion the breach is a risk to public health and safety'.[106] He went on to detail various options for pursuing an investigation.

> Once a matter comes into the investigation division a whole raft of legislation is activated. That includes coercive notices under section 34A of the Act where we can obtain information and obtain records. We can direct a practitioner to attend the Commission and give oral evidence. We also have powers to apply for search warrants and execute search warrants as well, so a whole raft of powers are enlivened once the matter comes for investigation.[107]

3.61 Mr Kofkin also outlined the approach of the Commission to determining an outcome for an unregistered practitioner, based on formal hearings and the cross-examination of witnesses and respondents.

> … the Commission will make a determination based on all the evidence in terms of whether or not the breach is sufficient to make a prohibition order or public statement … there are a number of public statements and prohibition orders that the Commission has made over the years, far more than any other state in the country …[108]

3.62 Mr Kofkin described the strong working relationship between the Commission and the New South Wales Police Force, based on the sharing of information under a memorandum of understanding. He also outlined the powers of the Commission to make orders to prohibit a practitioner from providing health services, and the application of prohibition orders made in other states.

> During an investigation the Commission can make an interim order that can prohibit a practitioner from providing any health service for a period of eight weeks. Those orders can be renewed as required and now our prohibition orders are on our register, which is accessible to the public … in the future we are looking at a national portal where prohibition orders throughout the country will be accessible to the whole public.[109]

3.63 Mr Kofkin also described recent legislation which made prohibition orders in other states relevant in New South Wales.

> So if there is a practitioner in Queensland who has been the subject of a prohibition order and then they come to New South Wales and start carrying out the same

[105] Transcript of evidence, 11 March 2016, p8
[106] Transcript of evidence, 11 March 2016, p8
[107] Transcript of evidence, 11 March 2016, p8
[108] Transcript of evidence, 11 March 2016, p8
[109] Transcript of evidence, 11 March 2016, p8

> health services, that prohibition order again applies in New South Wales so therefore we could prosecute for breach of an order.[110]

PROSECUTING COMPLAINTS

3.64 In 2013-14 the Commission reported that it referred 110 investigations to its legal division, which was a 29.4 per cent increase over the previous year. The division finalised 71 matters, a decrease on 2012-13 which the Commission attributed to a lower number of referrals in the previous year and to the establishment of the NSW Civil, and Administrative Tribunal on 1 January 2014.[111]

3.65 In 2014-15 the Commission reported that it referred 93 investigations to its legal division, which was a 15.5 per cent decrease from 2013-14. The division finalised 82 matters, which was a 15.5 per cent increase over the previous year.[112]

Information sharing with other jurisdictions

3.66 The Committee noted the Commission's participation in the statutory review of the Health Practitioner Regulation National Law (NSW)[113] and questioned the witnesses about the Commission's practices regarding information sharing with other jurisdictions to ensure the success of all aspects of the Commission's work including prosecutions.

3.67 The Commissioner advised that the national conference of Commissioners occurs annually, and that Commissioners also meet on an as needs basis. At a forthcoming meeting, the Commissioner noted the inclusion on the program of discussions between Commissioners and the Australian Health Practitioners Regulatory Authority, the national body which registers all health practitioners, to discuss the importance of data exchange between state jurisdictions.

> We need to be sure that we can have access to data that they hold so that when we get a complaint we can immediately ask: who is this practitioner? Where do they practice? Are there any conditions on their practice from the national body and how do we deal with those? There is a regular collaboration between Commissioners around those topics.[114]

3.68 The Commissioner also advised the Committee of her bilateral discussions with the Victorian Health Services Commissioner regarding developments in that state, especially the Victorian 2013-14 study of complainant experience. She reported that New South Wales' initiatives to improve the experiences of complainants was benchmarking well against Victoria, especially regarding improved communication with complainants.[115]

[110] Transcript of evidence, 11 March 2016, p8
[111] HCCC Annual Report 2013-14, p7
[112] HCCC Annual Report 2014-15, p7
[113] HCCC Annual Report 2014-15, p47
[114] Transcript of evidence, 11 March 2016, p17
[115] Transcript of evidence, 11 March 2016, p17

3.69 The Commissioner further advised that she would be meeting with the Queensland Health Ombudsman in the near future to discuss case management systems and technologies.[116]

3.70 The Committee invited the Commissioner to compare and contrast the performance of the other states with the NSW health care complaints regime. The Commissioner responded that all states shared an increase in complaints from year to year, as well as similar patterns regarding which practitioners and issues were complained about, including the clustering of issues about treatment and communication, described earlier in this report.[117]

COMMITTEE COMMENT

3.71 The Committee commends the Commission for its achievements in a climate of an increasing number of complaints, and a health and consumer environment which is growing more complex.

3.72 The Committee is concerned, however, at the increased time the Commission is taking to resolve claims.

3.73 The Committee is satisfied that the Commission understands its role and has strategies in place to meet its objectives.

3.74 The Committee is encouraged by the Commission's analysis of the complaints it receives and the outcomes it achieves.

3.75 The Committee also acknowledges that the Commission is focussed on expanding the scope of its analysis to better understand the health care complaints environment when and wherever the information the Commission gathers suggests new lines of inquiry.

3.76 The Committee notes a number of areas identified by the Commission for further examination in the future including:

- gaining a better of understanding of the observed differences in complaint trends between metropolitan and non-metropolitan regions;
- strengthening practices when seeking feedback on the outcomes of matters referred to other agencies for assessment and resolution. The Committee notes that developing a feedback system was a recommendation of the Committee in its review of the 2012-13 annual report of the Commission;
- improved capacity to identify and refer vulnerable complainants to support services and better data collection to demonstrate that the Commission has succeeded in this area; and
- a more finely tuned focus on identifying and responding to differences in complaint trends between New South Wales and other jurisdictions.

[116] Transcript of evidence, 11 March 2016, p17
[117] Transcript of evidence, 11 March 2016, p17

Chapter Four – Organisational matters

4.1 This chapter examines organisational matters reported by the Health Care Complaints Commission over the two annual reporting years under review.

4.2 Mr Kieran Pehm, Commissioner completed his second and last five year term on 26 June 2015. Ms Karen Mobbs was appointed Acting Commissioner from 27 June 2015.[118] Ms Sue Dawson was appointed Commissioner on 7 December 2015.[119]

4.3 The overall budget for the Commission in 2013-14 was $11.9 million, and in 2014-15 was $12.3 million.[120]

4.4 The Commission employed a total of 83 staff as at 30 June 2014[121] and a total of 81 staff as at 30 June 2015.[122]

STAFF TRAINING AND DEVELOPMENT

4.5 Staff training and development is a corporate Commission goal, and in its annual reports the Commission reported extensively on the training and development opportunities which staff received during the reporting years.[123]

4.6 Noting the workload trends over the two reporting years and the particular stresses which working in a complaints-driven environment places on staff wellbeing, the Committee questioned the witnesses on several matters relating to staffing and performance.

4.7 The Committee asked the witnesses to comment on the outcomes achieved from the introduction of resilience training for staff.

4.8 In response the Commissioner advised that 55 staff had received resilience training, with a further 15 staff waiting to be trained.

> So we are pretty much making resilience training a core training module for everyone at the Commission because of the type of work that we do. The officers who have gone through the training have affirmed that it really assists them to be grounded in the work that they do and to really think about how best to deal with those who have been traumatised in order that they can assist them most effectively.[124]

[118] HCCC Annual Report 2014-15, p55

[119] http://www.hccc.nsw.gov.au/Publications/Media-releases/2015/New-Commissioner-Sue-Dawson-commences-term

[120] Transcript of evidence, 11 March 2016, p12

[121] HCCC Annual Report 2013-14, p 61

[122] HCCC Annual Report 2014-15, p57

[123] HCCC Annual Report 2013-14, p58; HCCC Annual Report 2014-15, p54

[124] Transcript of evidence, 11 March 2016, p16

WORKLOADS AND CUSTOMER SERVICE STANDARDS

4.9 The Committee asked how, in light of the expected increase in the number of complaints, the Commission proposed to manage increased staff workloads without diminishing customer service.

4.10 The Commissioner acknowledged the doubling of complaints received by the Commission over the last ten years, and that in such an environment the Commission needed to re-examine the assessment process given available resources and stakeholder expectations.

4.11 She described a range of strategies being employed or considered by the Commission to manage increased workloads and maintain service standards. A strategy of particular importance is to take a risk-management or triage approach to complaints and ask upfront 'is this case susceptible to early resolution?' This strategy will involve the upfront scoping of what actions the Commission will be required to take to resolve any complaint. Cases which offer the opportunity for a quick and early resolution will be identified and actively steered in that direction.[125]

4.12 The Commissioner acknowledged the training and development component of early resolution strategies.

> … if we want to use early resolution effectively, there is a different skill base to early resolution than what there is in assessment. What you are actually asking somebody to do is to step forward quickly and say if I get into the best position of understanding exactly what that complainant was wanting, quickly bringing that into reveal for the provider and understanding how far the provider is prepared to go in compromising—with an apology or reimbursement or whatever—you can get a quick solution.[126]

4.13 The Commissioner noted that these were different skills to the more traditional assessment approach of examining medical records to identify facts and complainant expectations.

> For me I am looking at how we get that training going so people are skilled in getting in early and cutting to the chase. Those are the sorts of initiatives we have in place. They will require really diligent pursuit. You can be sure they will get diligent pursuit.[127]

NEW TECHNOLOGY

4.14 The Committee asked the witnesses to outline the role that new technology could play in assisting the Commission to maintain customer service standards in a climate of a continuing increase in complaints received.

4.15 In response, the Commissioner advised that the Commission would continue to build its ICT systems. In particular, she described the Commission's case management system, CaseMate, in some detail.

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[125] Transcript of evidence, 11 March 2016, p16

[126] Transcript of evidence, 11 March 2016, p16

[127] Transcript of evidence, 11 March 2016, p16

> … CaseMate … is quite a powerful instrument because it is able to tell us at any point in time, if you run management information from it, where complaints are up to, how many are over 30 days, how many are over 60 days and it allows you to flag particular complaints and see what is happening with that particular complaint.[128]

4.16 By using technological systems to good effect, the Commissioner explained the Commission's capacity to prioritise complaints and receive early warning about system delays.

COMMITTEE COMMENT

4.17 The Committee notes the reporting in the Commission's 2013-14 of the departure of long term, experienced staff, and the consequent impact on the Commission's capacity to resolve complaints while new staff were recruited and trained.

4.18 The Committee acknowledges the disadvantage of this loss of corporate knowledge and skill from the Commission, and commends the Commission on its achievements in overcoming this disadvantage.

4.19 The Committee also notes the comprehensive staff training and development programs of the Commission and particularly the use of resilience training. Both the content and scale of this training is supported by the Committee.

4.20 The Committee commends the Commission's training of staff to apply early resolution techniques as a strategy to maintain assessment rates and customer service standards. The Committee will examine the Commission's future performance with a view to determining the success of this strategy.

[128] Transcript of evidence, 11 March 2016, p16

Appendix One – List of Witnesses

11 March 2016, Waratah Room, Parliament House

Witness	Organisation
Ms Sue Dawson Commissioner	Health Care Complaints Commission
Mr Ian Thurgood Director, Assessments and Resolution	
Mr Tony Kofkin Director of Investigations	
Ms Karen Mobbs Director of Proceedings	

Appendix Two – Extracts from minutes

MINUTES OF MEETING No 3
Wednesday 24 February 2016
Room 1254, Parliament House

Members present
The Hon Melinda Pavey MP (Chair), Mr Adam Crouch MP (Deputy Chair), The Hon Lou Amato MLC, Ms Jan Barham MLC, The Hon Walt Secord MLC, Ms Kate Washington MP, Ms Eleni Petinos MP.

Officers in attendance
Bjarne Nordin, David Hale, Kieran Lewis, Jennifer Gallagher

The Chair opened the meeting at 9.00am.

1. Minutes of meeting No 2
Resolved, on the motion of Ms Barham, seconded by Mr Crouch:
That the minutes of Meeting No 2 held on 19 October 2015 be confirmed.

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4. Review of HCCC Annual Reports for 2013-14 and 2014-15
Resolved, on the motion of Ms Barham, seconded by Mr Crouch:
That, pursuant to the Committee's responsibilities under Part 4, section 65 (1) (c) of the Health Care Complaints Act 1993, the Committee conducts one review of both the 2013-14 and 2014-15 Annual Reports of the Health Care Complaints Commission.

5. Inquiry planning
Resolved on the motion of Mr Crouch, seconded by Mr Amato:
That the Committee invite Ms Sue Dawson, Commissioner, Health Care Complaints Commission and her delegates to attend a public hearing at Parliament House on Friday 11 March 2016 to review the Commission's 2013-14 and 2014-15 Annual Reports; and that the Committee authorises the Chair to prepare and distribute questions on notice to the Commissioner in advance of the hearing.

6. General business
The Committee agreed to commence the public hearing at 8.30am on Friday 11 March 2016.

****

7. Next meeting
The next meeting will be held on Friday 11 March 2016 in the Waratah Room, Parliament House at 8.20am.

The Chair adjourned the meeting at 9.15am.

MINUTES OF MEETING No 4
Friday 11 March 2016
Waratah Room, Parliament House

Members present
The Hon Melinda Pavey MP (Chair), Mr Adam Crouch MP (Deputy Chair), The Hon Lou Amato MLC, Ms Jan Barham MLC, The Hon Walt Secord MLC, Ms Kate Washington MP, Ms Eleni Petinos MP

Officers in attendance
Bjarne Nordin, David Hale, Kieran Lewis, Jennifer Gallagher

The Chair opened the meeting at 8.25am.

1. Minutes of meeting No 3
Resolved, on the motion of Mr Crouch, seconded by Ms Barham:
That the minutes of Meeting No 3 held on 24 February 2016 be confirmed.

Review of HCCC Annual Reports for 2013-14 and 2014-15

2. Public hearing Friday 11 March 2016
Resolved, on the motion of Ms Barham, seconded by Mr Secord:
That the Committee invites the witnesses listed in the notice of the public hearing for Friday 11 March 2016 to give evidence in relation to the Review of the Health Care Complaints Commission's Annual Reports for 2013-2014 and 2014-2015.

2.1 Media
Resolved, on the motion of Mr Crouch, seconded by Ms Barham:
That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 11 March 2016 in accordance with the NSW Legislative Assembly's guidelines for coverage of proceedings for parliamentary committees administered by the Legislative Assembly.

2.2 Transcript of evidence
Resolved, on the motion of Ms Barham, seconded by Ms Washington:
That the corrected transcript of evidence given on 11 March 2016 be authorised for publication and uploaded on the Committee's website.

2.3 Answers to questions on notice
Resolved, on the motion of Mr Secord, seconded by Ms Petinos:
That witnesses be requested to return answers to questions taken on notice within 2 weeks of the date on which the questions are forwarded to the witness, and that once received, answers be published on the Committee's website.

2.4 Documents tendered during the public hearing
Resolved, on the motion of Mr Amato, seconded by Mr Crouch:
That documents tendered during the public hearing be accepted by the Committee and published on the Committee's website.

The public hearing commenced at 8.30am. Witnesses, the public and the media were admitted. The Chair welcomed the witnesses and the gallery.

The following witnesses representing the Health Care Complaints Commission were affirmed and examined:

- Ms Sue Dawson, Commissioner
- Ms Karen Mobbs, Director of Proceedings

The following witnesses representing the Health Care Complaints Commission were sworn and examined:

- Mr Tony Kofkin, Director of Investigations
- Mr Ian Thurgood, Director, Assessments & Resolution

Evidence concluded, the witnesses withdrew.

The hearing concluded at 10.07am.

3. General business
Members agreed to send to the Committee staff any questions on notice they would like referred to the Commission, as soon as possible.

4. Next meeting
The Chair closed the meeting at 10.10am. The next meeting will be held on a date to be determined.

UNCONFIRMED MINUTES OF MEETING No 5
Thursday 23 June 2016
Room 1254, Parliament House

Members present
The Hon Melinda Pavey MP (Chair), Mr Adam Crouch MP (Deputy Chair), The Hon Lou Amato MLC, The Hon Walt Secord MLC, Ms Kate Washington MP

Officers in attendance
David Hale, Kieran Lewis, Abegail Turingan

The Chair opened the meeting at 9.00am.

1. Apologies
Ms Eleni Petinos MP, Ms Jan Barham MLC

2. Minutes of meeting No 4
Resolved, on the motion of Mr Crouch, seconded by Mr Amato:
That the minutes of Meeting No 4 held on 11 March 2016 be confirmed.

****

Review of HCCC Annual Reports for 2013-14 and 2014-15

4. Consideration of Chair's draft report
The Chair spoke to the draft report previously circulated.

Resolved, on the motion of Ms Washington, seconded by Mr Secord:
That the Commission not only rely on averages for measuring complaint assessment and resolution, but that the extremities of timeliness be reported by percentile.

The Chair invited members to propose amendments to any part of the report.

Resolved, on the motion of Ms Washington, seconded by Mr Secord:
That the following words be inserted after paragraph 3.71: "The Committee is concerned, however, at the increased time the Commission is taking to resolve claims."

Resolved, on the motion of Mr Crouch, seconded by Ms Washington:
That the Chair's Report Review of the Health Care Complaints Commission Annual Report 2013/14 and 2014/15 as amended be adopted by the Committee, to be signed by the Chair and presented to the Houses; that the Chair and the secretariat be permitted to correct stylistic, typographical and grammatical errors; and that, once tabled, the report be published on the Committee's website.

5. General business
The Chair confirmed that the report would be tabled in both houses today.

6. Next meeting
The Chair closed the meeting at 9.08am. The next meeting will be held on a date to be determined.

Appendix Three – Answers to questions taken on notice at public hearing

Question 1

For the reporting periods 2013-14 and 2014-15 can the Commission provide the number of investigations undertaken in relation to complaints about adverse outcomes?

Response

The Commission has compiled data on all investigations undertaken in 2013-14 and 2014-15 that raise the following issues:

- Wrong/Inappropriate Treatment
- Unexpected Treatment Outcome/complications
- Inadequate treatment

Table 1 (below) shows that during 2013-14 the Commission finalised 226 investigations which raised 385 issues. Of these 65, or 16.9%, related to the issues above. During 2014-15 the Commission finalised 194 investigations which raised 320 issues. Of these 64, or 20.0%, related to the issues above.

Table 1: Investigations finalised which raise issues of: Wrong/Inappropriate Treatment; Unexpected Treatment Outcome/complications; or Inadequate Treatment

Issue raised in complaint	2013-14		2014-15		Total
	No.	%*	No.	%*	
Inadequate treatment	52	13.5%	47	14.7%	99
Unexpected treatment outcome/complications	10	2.6%	15	4.7%	25
Wrong/inappropriate treatment	3	0.8%	2	0.6%	5
	65	**16.9%**	**64**	**20.0%**	**129**

Counted by issues raised in complaint
**of all issues raised in investigations finalised*

Question 2

Please provide a sample of the two information brochures that the Commission distributes to GP practices, and details of where the brochures are distributed (a summary distribution list)?

Response

The Commission distributes a number of brochures and fact sheets to its stakeholders, the main two being booklets titled:

- Concerned about your health care
- Resolve concerns about your health care

Samples of these brochures are provided in Appendices A and B to this response. During 2014-15 these brochures were distributed on a pro bono basis through a media distribution service

called 'InfoMed', whose distribution run includes 825 general practitioner practices across NSW. During 2014-15 the Commission supplied brochures to the following InfoMed distribution hubs:

Table 2: Brochures distributed through InfoMed 2014-15

Distribution Hub	Concerned about your health care	Resolve concerns about your health care
InfoMed Sydney	28,000	28,000
InfoMed – Newcastle	3,000	3,000
InfoMed – Wollongong	1,500	1,500
InfoMed – Gold Coast	500	500
Mailing services	2,000	2,000
Total	**35,000**	**35,000**

In addition the Commission also distributed brochures directly to health services on request.

A list of postcodes that are included in the InfoMed distribution run, as well as a list of those postcodes where brochures were supplied directly from the Commission is attached at Appendix C.

Question 3

Has the Commission ever received a complaint regarding a decision or diagnosis made by medical practitioners on behalf of life insurance companies? If so, how many complaints were received?

Response

The Commission regularly receives complaints raising issues of regarding medico legal reports and certificates, the majority of which relate to reports made by medical practitioners on behalf of insurance companies.

Table 3 (below) shows that during 2013-14 and 2014-15 the Commission received a total of 293 complaints regarding reports/certificates.

Table 3: Complaints received in 2013-14 and 2014-15 in the issue category reports/certificates.

Complaints regarding reports/certificates	2013-14	2014-15	Grand Total
Accuracy of report/certificate	112	129	**241**
Cost of report/certificate	1		**1**
Refusal to provide report/certificate	20	20	**40**
Report written with inadequate or no consultation	1	3	**4**
Timeliness of report/certificate	3	4	**7**
Grand Total	**137**	**156**	**293**

Counted by issues raised in complaint

Question 4

Has the Commission ever referred a medical practitioner to the Director of Public Prosecutions (DPP) following an investigation into the use and safety of therapeutic devices such as, but not limited to, mesh tissue fixation devices?

Response

No, the Commission has not referred a medical practitioner to the Director of Public Prosecutions (DPP) following an investigation into the use and safety of therapeutic devices such as, but not limited to, mesh tissue fixation devices.

The *Health Care Complaints Act 1993* (the Act) allows the Commission to refer complaints at various stages of the complaints process to the Officer of Director of Public Prosecutions (the ODPP), the NSW Police or other investigative bodies. A complaint can be referred at the receipt and assessment stage pursuant to s20 and s26 of the Act. Specifically in regards to the ODPP, a complaint may be referred at the investigation stage pursuant to s42(1)(c) or s39(1)(f) of the Act. At the prosecution stage, the Director of Proceedings can refer a complaint for prosecution by another body pursuant to 90B(1)(a) of the Act.

Since 2009, the Commission and the NSW Police entered into a Memorandum of Understanding which governs the exchange of information between the two parties in relation to joint and separate investigations into health service providers. Since the signing of the MOU more matters are referred to Police or ODPP prior to an investigation being finalised rather than as an outcome of an investigation.

Question 5

Can the Commission provide a breakdown of the issues raised in the complaints received about aged care facilities generally, but with a particular focus on complaints about the restraint, either by physical or chemical means, of residents with dementia?

Response

Table 5 shows the issues raised in all complaints received about aged care facilities in 2013-14 and 2014-15. A further breakdown is provided for public and private facilities.

Table 5: Complaints received in 2013-14 and 2014-15 regarding aged care facilities.

Issue	2013-14 Public	2013-14 Private	2013-14 Total	2014-15 Public	2014-15 Private	2014-15 Total	Grand Total
Access							
Refusal to admit or treat	1	1	*2*				**2**
Access Total	1	1	*2*				**2**
Communication/Information							
Attitude/Manner	2	10	*12*	2	5	*7*	**19**
Inadequate information provided	1	5	*6*		9	*9*	**15**
Incorrect/misleading information provided		1	*1*		2	*2*	**3**
Special needs not accommodated					1	*1*	**1**
Communication/information Total	3	16	*19*	2	17	*19*	**38**

Issue	2013-14 Public	2013-14 Private	2013-14 Total	2014-15 Public	2014-15 Private	2014-15 Total	Grand Total
Consent							
Consent not obtained or inadequate		1	*1*		2	*2*	**3**
Consent Total		1	*1*		2	*2*	**3**
Discharge/transfer arrangements							
Inadequate discharge		1	*1*		1	*1*	**2**
Discharge/transfer arrangements Total		1	*1*		1	*1*	**2**
Environment/management of facilities							
Administrative processes	1	4	*5*		11	*11*	**16**
Cleanliness/hygiene of facility	1	2	*3*		1	*1*	**4**
Physical environment of facility		4	*4*		7	*7*	**11**
Staffing and rostering		3	*3*		5	*5*	**8**
Environment/management of facilities Total	2	13	*15*		24	*24*	**39**
Fees/costs							
Billing practices					2	*2*	**2**
Fees/costs Total					2	*2*	**2**
Grievance processes							
Inadequate/no response to complaint		2	*2*	1	5	*6*	**8**
Grievance processes Total		2	*2*	1	5	*6*	**8**
Medical records							
Access to/transfer of records		1	*1*				**1**
Record keeping					3	*3*	**3**
Records management					1	*1*	**1**
Medical records Total		1	*1*		4	*4*	**5**
Medication							
Administering medication		10	*10*		7	*7*	**17**
Dispensing medication		3	*3*				**3**
Prescribing medication		2	*2*		1	*1*	**3**
Supply/security/storage of medication		1	*1*				**1**
Medication Total		16	*16*		8	*8*	**24**
Professional conduct							
Assault	1		*1*				**1**
Breach of guideline/law		1	*1*				**1**
Competence					1	*1*	**1**
Illegal practice	1	2	*3*				**3**
Sexual misconduct					1	*1*	**1**
Professional conduct Total	2	3	*5*		2	*2*	**7**
Treatment							
Coordination of treatment/results follow-up		2	*2*				**2**
Delay in treatment		2	*2*		2	*2*	**5**
Diagnosis					4	*4*	**4**
Inadequate care	2	17	*19*	2	27	*29*	**48**
Inadequate treatment		29	*29*	3	19	*22*	**51**

Issue	Public	2013-14 Private	Total	Public	2014-15 Private	Total	Grand Total
Infection control		1	*1*				**1**
Rough and painful treatment		2	*2*		1	*1*	**2**
Unexpected treatment outcome/complications		1	*1*		1	*1*	**2**
Wrong/inappropriate treatment		1	*1*		1	*1*	**2**
Treatment Total	2	55	*57*	5	56	*61*	**118**
Grand Total	**10**	**109**	***119***	**9**	**122**	***131***	**250**

Counted by issues raised in complaint

The Commission was not able to identify any complaints received about aged care facilities in the 2013-14 and 2014-15 period that contained the keywords of restraint and dementia.

Question 6

Regarding treatment related complaints in both aged care facilities and in hospitals, can the Commission provide a breakdown of the specific issues that relate to and come under the heading of treatment?

Response

Table 6 (below) shows all complaints received about aged care facilities and hospitals in 2013-14 and 2014-15 that raise treatment issues. A further breakdown is provided for public and private facilities.

Table 6: Complaints received about aged care facilities and hospitals in 2013-14 and 2014-15 that raise treatment issues

	Public	2013-14 Private	Total	Public	2014-15 Private	Total	Grand Total
Aged care facility							
Coordination of treatment/results follow-up	2		*2*				**2**
Delay in treatment	2		*2*	3		*3*	**5**
Inadequate care	17	2	*19*	27	2	*29*	**48**
Inadequate treatment	29		*29*	19	3	*22*	**51**
Infection control	1		*1*				**1**
Rough and painful treatment	2		*2*	1		*1*	**3**
Unexpected treatment outcome/complications	1		*1*	1		*1*	**2**
Wrong/inappropriate treatment	1		*1*	1		*1*	**2**
Aged care facility Total	55	2	*57*	56	5	*61*	**118**
Hospital							
Coordination of treatment/results follow-up	3	14	*17*	2	31	*33*	**60**
Delay in treatment	2	132	*134*	7	96	*103*	**237**
Diagnosis	5	95	*100*	6	100	*106*	**206**
Excessive treatment		3	*3*	2	4	*6*	**9**
Experimental treatment					1	*1*	**1**
Inadequate care	13	99	*112*	28	141	*169*	**281**

	Public	2013-14 Private	Total	Public	2014-15 Private	Total	Grand Total
Inadequate prosthetic equipment		2	*2*				**2**
Inadequate treatment	30	289	*319*	20	313	*333*	**652**
Inadequate/inappropriate consultation	2	8	*10*	1	8	*9*	**19**
Infection control	2	6	*8*		13	*13*	**21**
No/inappropriate referral	1		*1*		2	*2*	**3**
Public/private election		2	*2*		4	*4*	**6**
Rough and painful treatment	2	27	*29*		20	*20*	**49**
Unexpected treatment outcome/complications	7	53	*60*	9	102	*111*	**171**
Withdrawal of treatment	1	8	*9*	1	8	*9*	**18**
Wrong/inappropriate treatment		39	*39*	3	41	*44*	**83**
Hospital Total	**68**	**777**	***845***	**79**	**884**	***963***	**1808**
Grand Total	**123**	**779**	***902***	**135**	**889**	***1024***	**1926**

Counted by issues raised in complaint

Question 7

In relation to mental health complaints and issues of consent, can the Commission provide a breakdown of the specific issues that relate to and come under the heading of consent?

Response

Table 7 shows all complaints received in 2013-14 and 2014-15 in the service area of mental health that raise consent issues.

Table 7: Complaints received in 2013-14 and 2014-15 in the service area of mental health that raise consent issues

Issue	2013-14	2014-15	Grand Total
Consent	**26**	**40**	**66**
Consent not obtained or inadequate	2	7	9
Involuntary admission or treatment	24	33	57
Grand Total	26	40	66

Counted by issues raised in complaint

Appendices

Appendix A – Brochure: Concerned about your health care

Appendix B – Brochure: Resolve concerns about your health care

Appendix C – InfoMed distribution list

What happens next?

- When the Commission receives your complaint, it will be assessed.
- Sometimes, the information in the complaint is sufficient and there is no need for the Commission to contact the health service provider.
- Usually, the Commission will provide a copy of your complaint to the health service provider.
- If necessary, the Commission can obtain other relevant information, such as medical records.
- The Commission has 60 days to assess your complaint.
- If your complaint is about a registered health practitioner, such as a doctor or nurse, the Commission must consult with the relevant health professional Council, before making a final decision.

What are the possible outcomes?

When the Commission has assessed all relevant information, it will decide how to best manage your complaint. It has several options, including to:

- investigate, if it raises serious issues of public health or safety, or could lead to disciplinary action against a practitioner
- refer it to the relevant professional Council / National Board
- refer it to another body that is more appropriate to deal with the complaint
- refer it to the Commission's Resolution Service
- refer it back to the public health organisation complained about for local resolution
- discontinue the complaint (take no further action).

All the parties involved will be notified in writing of the assessment decision within 14 days of the decision being made.

More information

For more information or to lodge a complaint go to **www.hccc.nsw.gov.au**.

Contact the Commission

Office address
Level 13, 323 Castlereagh Street
SYDNEY NSW 2000

Office hours
9.00am to 5.00pm
Monday to Friday

Post address
Locked Mail Bag 18
STRAWBERRY HILLS NSW 2012

Telephone: (02) 9219 7444
Toll Free in NSW: 1800 043 159
Fax: (02) 9281 4585
E-mail: hccc@hccc.nsw.gov.au

People using telephone typewriters please call **(02) 9219 7555**.

Interpreting Service

If you need an interpreter, please contact the Translating and Interpreting Service (TIS National) on **131 450** and ask to be connected to the Health Care Complaints Commission (9.00am to 5.00pm Monday to Friday).

HEALTH CARE COMPLAINTS COMMISSION

Scan the above code to get to the Commission website

October 2013

HEALTH CARE COMPLAINTS COMMISSION

CONCERNED ABOUT YOUR HEALTH CARE?

HEALTH CARE COMPLAINTS COMMISSION

www.hccc.nsw.gov.au

Concerned about your health care?

If you are concerned about a health service provided to you, talk to your provider as soon as possible. Often this is the fastest and most effective way of resolving concerns.

Complaints are often the result of poor communication between the patient and their health service provider. We recommend that you raise your concerns directly with the provider. In most cases, they will try to resolve them.

Tips on how to resolve your concerns directly with your provider can be downloaded from the website **www.hccc.nsw.gov.au**. If you are not satisfied with the provider's response, you should contact the Inquiry Service of the Health Care Complaints Commission on **(02) 9219 7444** or toll free on **1800 043 159**.

If your complaint relates to the immediate health or safety of yourself or another person, you should contact the Commission without delay.

What is the Health Care Complaints Commission?

The Health Care Complaints Commission is an independent body dealing with complaints about health services provided in NSW.

The Commission is impartial and acts to protect the public health and safety.

The powers of the Commission are set out in the *Health Care Complaints Act.*

Who can make a complaint?

Any person can make a complaint. This may be:

- the patient who received the health service
- a parent or guardian
- a relative, friend or representative chosen by the person
- a health service provider or other concerned person.

Who can I complain about?

The Commission deals with complaints about any health service provider in NSW.
Examples are complaints about:

- registered practitioners, such as doctors, nurses and dentists
- any other health practitioner, such as massage therapists, naturopaths, psychotherapists
- health service organisations, such as public and private hospitals or medical centres.

What can I complain about?

The Commission deals with complaints about:

- the clinical management or care received
- the professional conduct of the health practitioner
- risks to the health or safety of the public.

The Commission does not have the power to:

- direct a doctor or health service to provide a specific service
- award damages or compensation, or order a refund.

How can I make a complaint?

Your complaint to the Commission must be in writing. You can lodge your complaint online at **www.hccc.nsw.gov.au** or you can simply send a letter or email.

Before you send your complaint, you may wish to contact the Commission's Inquiry Service on **(02) 9219 7444** or toll free on **1800 043 159** to discuss your concerns. Sometimes there are more suitable and faster ways to resolve your concerns than lodging a formal complaint. The Inquiry Service staff will advise you how to best address your concerns.

If you have difficulties writing your complaint, you can request help from the Inquiry Service staff.

The Commission uses interpreting services to assist people whose first language is not English. Details can be found at the end of this brochure.

What information should I include in a complaint?

- Your complaint should include what actually happened, where and when the event occurred, and who was involved.
- Include information about any actions you have already taken to resolve your concerns.
- State what outcome you seek from making a complaint.
- Attach any additional information and copies of other relevant documents to the complaint.
- If you complain on behalf of another person, you should get their consent, if possible, so that the Commission can obtain their health records and can also release information about the complaint to you.

Tips for meetings

- When everyone has agreed to meet, it is useful to provide your questions to the health service provider well in advance, so they can respond to all your questions.
- Tell the provider what you want to achieve as a result of the meeting.
- You may ask a support person to join you at the meeting. Let the provider know that you wish to bring another person with you.
- You may take notes during the meeting.
- At the end of the meeting, if something was agreed to happen, make sure that you have the contact details of the responsible person, if you need to follow up.

Contact the Commission

If you want to discuss any of the above suggestions on how you may be able to resolve your concerns, contact the Inquiry Service of the Health Care Complaints Commission on **(02) 9219 7444** or toll free in NSW on **1800 043 159.**

If you cannot resolve your concerns, you can contact the Commission about making a complaint.

For more information about the Commission, please visit the website **www.hccc.nsw.gov.au**.

Office address
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SYDNEY NSW 2000

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HEALTH CARE COMPLAINTS COMMISSION

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October 2013

HEALTH CARE COMPLAINTS COMMISSION

RESOLVE CONCERNS ABOUT YOUR HEALTH CARE

HEALTH CARE COMPLAINTS COMMISSION

www.hccc.nsw.gov.au

Resolve concerns about your health care

If you are concerned about a health service provided, we recommend that you first talk to the provider directly. Often this is the fastest and most effective way of resolving concerns.

Here are some tips on how to raise and resolve your concerns directly with your provider.

Raise your concerns

Start immediately

Start to resolve the problem as soon as possible by making a phone call or writing a letter to the health service provider.

Be fair

It is important to let the person know that you are contacting them because of some concern or dissatisfaction.

Remember that the other person may have no idea that there was a problem and may need time to look into it before they can respond to your concerns.

Be clear

Before you contact the health service provider, be clear about what issues and concerns you have. You may want to write them down, as it will help you to clarify your concerns and you will not forget to raise any of them. The following questions may guide you.

Who was involved?

Remember to state:

- your name, address and telephone number
- whether you are acting on behalf of someone else – if so, state their name and your relationship to them (for example, friend, son, wife)
- the name and title of the health provider/s involved if you do not contact them directly
- the name and contact details of anyone else who was a witness or has relevant information.

What happened?

Briefly describe the events leading to the complaint and state relevant dates and times.

What are your concerns?

List your specific concerns (for example problems with your medication, concerns about your treatment, lack of information about treatment options).

Start with the most important concern.

What are your expectations?

Be clear about what you are hoping to achieve (for example, an apology, information about your condition, an explanation, or options for further treatment).

Let them know whether you prefer a meeting, a written reply, or to talk about the matter on the telephone.

Resolve your concerns

There are different ways to raise your concerns. The following tips can help you to get the information you want and to find a resolution to your issues that is acceptable to everyone.

Remember

- Listen to the information given to you by the other person. Try to see the issue also from their point of view.
- Avoid using language that might upset another person.
- Ask the health service provider to explain information that you do not understand.

Tips for telephone calls

- Ask who the appropriate person is to speak to about your concerns.
- Write down the name and phone number of the person you speak to, note the date and ask if there is a reference number.
- Ask whether they can deal with your concerns over the phone or whether you need to put them in writing.
- Also ask when you can expect to hear back from them regarding your complaint and whether this will be in writing or by telephone.
- You may wish to make notes on what has been discussed.

Tips for writing a letter or email

- When writing your letter or email, include all information you have and what you would like to happen as an outcome of your complaint.
- Before you send the letter or email, read through it again and make sure that you have included everything you wanted. Remember to include your contact details.
- Always keep a copy for yourself.
- We suggest that you call to check whether your letter or email has been received.
- Allow a few weeks for the health service provider to respond.

INFO-MED Report: Practice Coverage By Postcode

September 2014

Region: NSW

Region	Suburb	Post code
NSW	CIRCULAR QUAY	2000
NSW	HAYMARKET	2000
NSW	SYDNEY	2000
NSW	BROADWAY	2007
NSW	ULTIMO	2007
NSW	PYRMONT	2009
NSW	WOOLLOOMOOLOO	2011
NSW	REDFERN	2016
NSW	WATERLOO	2017
NSW	EASTLAKES	2018
NSW	ROSEBERY	2018
NSW	BANKSMEADOW	2019
NSW	BOTANY	2019
NSW	MASCOT	2020
NSW	BONDI JUNCTION	2022
NSW	BRONTE	2024
NSW	BONDI	2026
NSW	NORTH BONDI	2026
NSW	EDGECLIFF	2027
NSW	ROSE BAY	2029
NSW	CLOVELLY	2031
NSW	RANDWICK	2031
NSW	KINGSFORD	2032
NSW	EASTGARDENS	2035
NSW	MAROUBRA	2035
NSW	MAROUBRA JUNCTION	2035
NSW	MAROUBRA SOUTH	2035
NSW	SOUTH MAROUBRA	2035
NSW	LITTLE BAY	2036
NSW	MATRAVILLE	2036
NSW	ANNANDALE	2038
NSW	ROZELLE	2039
NSW	LEICHARDT	2040
NSW	BALMAIN	2041
NSW	ENMORE	2042
NSW	NEWTOWN	2042
NSW	TEMPE	2044
NSW	HABERFIELD	2045

NSW	ABBOTSFORD	2046
NSW	FIVE DOCK	2046
NSW	PETERSHAM	2049
NSW	NORTH SYDNEY	2060
NSW	NORTHBRIDGE	2063
NSW	ARTARMON	2064
NSW	CROWS NEST	2065
NSW	GREENWICH	2065
NSW	LANE COVE	2066
NSW	CHATSWOOD	2067
NSW	CASTLECRAG	2068
NSW	WILLOUGHBY	2068
NSW	ROSEVILLE	2069
NSW	WEST LINDFIELD	2070
NSW	EAST KILLARA	2071
NSW	GORDON	2072
NSW	TURRAMURRA	2074
NSW	ST IVES	2075
NSW	NORMANHURST	2076
NSW	ASQUITH	2077
NSW	HORNSBY	2077
NSW	BEROWRA HEIGHTS	2082
NSW	BELROSE	2085
NSW	FRENCHS FOREST	2086
NSW	FORESTVILLE	2087
NSW	MOSMAN	2088
NSW	NEUTRAL BAY	2089
NSW	CREMORNE	2090
NSW	BALGOWLAH	2093
NSW	MANLY VALE	2093
NSW	FAIRLIGHT	2094
NSW	MANLY	2095
NSW	COLLAROY PLATEAU	2097
NSW	DEE WHY	2099
NSW	BROOKVALE	2100
NSW	NARRABEEN	2101
NSW	MONA VALE	2103
NSW	NEWPORT	2106
NSW	MACQUARIE UNIVERSITY	2109
NSW	GLADESVILLE	2111
NSW	RYDE	2112
NSW	TOP RYDE	2112
NSW	MACQUARIE PARK	2113
NSW	WEST RYDE	2114
NSW	ERMINGTON	2115

NSW	TELOPEA	2117
NSW	CARLINGFORD	2118
NSW	BEECROFT	2119
NSW	PENNANT HILLS	2120
NSW	THORNLEIGH	2120
NSW	EPPING	2121
NSW	EASTWOOD	2122
NSW	MARSFIELD	2122
NSW	WEST PENNANT HILLS	2125
NSW	NEWINGTON	2127
NSW	ASHFIELD	2131
NSW	CROYDON	2132
NSW	BURWOOD	2134
NSW	STRATHFIELD	2135
NSW	CONCORD	2137
NSW	MORTLAKE	2137
NSW	RHODES	2138
NSW	HOMEBUSH	2140
NSW	HOMEBUSH WEST	2140
NSW	BERALA	2141
NSW	LIDCOMBE	2141
NSW	GRANVILLE	2142
NSW	REGENTS PARK	2143
NSW	AUBURN	2144
NSW	GREYSTANES	2145
NSW	PEMULWUY	2145
NSW	PENDLE HILL	2145
NSW	SOUTH WENTWORTHVILLE	2145
NSW	WENTWORTHVILLE	2145
NSW	WESTMEAD	2145
NSW	TOONGABBIE	2146
NSW	KINGS LANGLEY	2147
NSW	LALOR PARK	2147
NSW	SEVEN HILLS	2147
NSW	BLACKTOWN	2148
NSW	MARAYONG	2148
NSW	PROSPECT	2148
NSW	HARRIS PARK	2150
NSW	PARRAMATTA	2150
NSW	NORTH ROCKS	2151
NSW	PARRAMATTA NORTH	2151
NSW	NORTHMEAD	2152
NSW	BAULKHAM HILLS	2153
NSW	BELLA VISTA	2153
NSW	WINSTON HILLS	2153

NSW	CASTLE HILL	2154
NSW	BEAUMONT HILLS	2155
NSW	KELLYVILLE	2155
NSW	KELLYVILLE RIDGE	2155
NSW	ROUSE HILL	2155
NSW	THE PONDS	2155
NSW	ANNANGROVE	2156
NSW	DURAL	2158
NSW	MERRYLANDS	2160
NSW	GUILDFORD	2161
NSW	CHESTER HILL	2162
NSW	SEFTON	2162
NSW	VILLAWOOD	2163
NSW	SMITHFIELD	2164
NSW	WETHERILL PARK	2164
NSW	FAIRFIELD	2165
NSW	FAIRFIELD HEIGHTS	2165
NSW	FAIRFIELD WEST	2165
NSW	CABRAMATTA	2166
NSW	CABRAMATTA WEST	2166
NSW	CANLEY HEIGHTS	2166
NSW	CANLEY VALE	2166
NSW	LANSVALE	2166
NSW	BUSBY	2168
NSW	GREEN VALLEY	2168
NSW	HINCHINBROOK	2168
NSW	CASULA	2170
NSW	CHIPPING NORTH	2170
NSW	HAMMONDVILLE	2170
NSW	LIVERPOOL	2170
NSW	LIVERPOOL WEST	2170
NSW	LURNEA	2170
NSW	MOUNT PRITCHARD	2170
NSW	MT PRITCHARD	2170
NSW	PRESTONS	2170
NSW	AUSTRAL	2171
NSW	CECIL HILLS	2171
NSW	HORNINGSEA PARK	2171
NSW	WEST HOXTON	2171
NSW	WATTLE GROVE	2173
NSW	HORSLEY PARK	2175
NSW	BOSSLEY PARK	2176
NSW	EDENSOR PARK	2176
NSW	GREENFIELD PARK	2176
NSW	PRAIRIEWOOD	2176

NSW	ST JOHNS PARK	2176
NSW	BONNYRIGG	2177
NSW	GREENACRE	2190
NSW	BELMORE	2192
NSW	HURLSTONE PARK	2193
NSW	CAMPSIE	2194
NSW	LAKEMBA	2195
NSW	PUNCHBOWL	2196
NSW	ROSELANDS	2196
NSW	BASS HILL	2197
NSW	YAGOONA	2199
NSW	BANKSTOWN	2200
NSW	DULWICH HILL	2203
NSW	MARRICKVILLE	2204
NSW	ARNCLIFFE	2205
NSW	WOLLI CREEK	2205
NSW	EARLWOOD	2206
NSW	BEXLEY	2207
NSW	BEXLEY NORTH	2207
NSW	KINGSGROVE	2208
NSW	BEVERLY HILLS	2209
NSW	NARWEE	2209
NSW	PEAKHURST	2210
NSW	RIVERWOOD	2210
NSW	PADSTOW	2211
NSW	REVESBY	2212
NSW	EAST HILLS	2213
NSW	PANANIA	2213
NSW	PICNIC POINT	2213
NSW	MILPERRA	2214
NSW	BRIGHTON LE SANDS	2216
NSW	ROCKDALE	2216
NSW	KOGARAH	2217
NSW	RAMSGATE	2217
NSW	RAMSGATE BEACH	2217
NSW	CARLTON	2218
NSW	SANS SOUCI	2219
NSW	HURSTVILLE	2220
NSW	PENSHURST	2222
NSW	MORTDALE	2223
NSW	OATLEY	2223
NSW	SYLVANIA	2224
NSW	SYLVANIA HEIGHTS	2224
NSW	COMO	2226
NSW	JANNALI	2226

NSW	GYMEA	2227
NSW	MIRANDA	2228
NSW	CARINGBAH	2229
NSW	CRONULLA	2230
NSW	ENGADINE	2232
NSW	KAREELA	2232
NSW	KIRRAWEE	2232
NSW	SUTHERLAND	2232
NSW	ENGADINE	2233
NSW	ALFORDS POINT	2234
NSW	BANGOR	2234
NSW	ILLAWONG	2234
NSW	MENAI	2234
NSW	ERINA	2250
NSW	GOSFORD	2250
NSW	LISAROW	2250
NSW	WEST GOSFORD	2250
NSW	KINCUMBER	2251
NSW	UMINA BEACH	2257
NSW	KANWAL	2259
NSW	LAKE MUNMORAH	2259
NSW	TUGGERAH	2259
NSW	WADALBA	2259
NSW	WOONGARAH	2259
NSW	WYONG	2259
NSW	BATEAU BAY	2261
NSW	BERKELEY VALE	2261
NSW	KILLARNEY VALE	2261
NSW	THE ENTRANCE	2261
NSW	BUDGEWOI	2262
NSW	SAN REMO	2262
NSW	GOROKAN	2263
NSW	LAKE HAVEN	2263
NSW	BELMONT	2280
NSW	CAVES BEACH	2281
NSW	SWANSEA	2281
NSW	WARNERS BAY	2282
NSW	BLACKALLS PARK	2283
NSW	RATHMINES	2283
NSW	TORONTO	2283
NSW	EDGEWORTH	2284
NSW	CARDIFF	2285
NSW	GLENDALE	2285
NSW	FLETCHER	2287
NSW	WALLSEND	2287

NSW	KOTARA	2289
NSW	CHARLESTOWN	2290
NSW	MT HUTTON	2290
NSW	MEREWETHER	2291
NSW	BROADMEADOW	2292
NSW	HAMILTON	2292
NSW	STOCKTON	2295
NSW	WARATAH	2298
NSW	JESMOND	2299
NSW	COOKS HILL	2300
NSW	NEWCASTLE	2300
NSW	MAYFIELD	2304
NSW	WARABROOK	2304
NSW	NEW LAMBTON HEIGHTS	2305
NSW	NELSON BAY	2315
NSW	SALAMANDAR BAY	2317
NSW	MEDOWIE	2318
NSW	LORN	2320
NSW	RUTHERFORD	2320
NSW	MORPETH	2321
NSW	THORNTON	2322
NSW	EAST MAITLAND	2323
NSW	RAYMOND TERRACE	2324
NSW	TEA GARDENS	2324
NSW	CESSNOCK	2325
NSW	KURRI KURRI	2327
NSW	DENMAN	2329
NSW	MERRIWA	2329
NSW	SINGLETON	2330
NSW	GRETA	2334
NSW	MURRURUNDI	2338
NSW	QUIRINDI	2343
NSW	INVERELL	2360
NSW	TAREE	2430
NSW	NAMBUCCA HEADS	2448
NSW	COFFS HARBOUR	2450
NSW	MOONEE BEACH	2450
NSW	BYRON BAY	2481
NSW	GWYNVILLE	2500
NSW	KEIRAVILLE	2500
NSW	WOLLONGONG	2500
NSW	WARRAWONG	2502
NSW	BERKELEY	2506
NSW	THIRROUL	2515
NSW	WOONONA	2517

NSW	BELLAMBI	2518
NSW	CORRIMAL	2518
NSW	FIGTREE	2525
NSW	UNANDERRA	2526
NSW	ALBION PARK	2527
NSW	BARRACK HEIGHTS	2528
NSW	WARILLA	2528
NSW	WINDANG	2528
NSW	OAK FLATS	2529
NSW	SHELL COVE	2529
NSW	SHELLHARBOUR CITY CENTRE	2529
NSW	DAPTO	2530
NSW	KIAMA	2533
NSW	KIAMA DOWNS	2533
NSW	GERRINGONG	2534
NSW	ULLADULLA	2539
NSW	SUSSEX INLET	2540
NSW	CLAYMORE	2559
NSW	AMBARVALE	2560
NSW	APPIN	2560
NSW	BRADBURY	2560
NSW	CAMPBELLTOWN	2560
NSW	PARK CENTRAL	2560
NSW	ROSEMEADOW	2560
NSW	MACQUARIE FIELDS	2564
NSW	INGLEBURN	2565
NSW	RABY	2566
NSW	HARRINGTON PARK	2567
NSW	MOUNT ANNAN	2567
NSW	MT ANNAN	2567
NSW	NARELLAN	2567
NSW	CAMDEN	2570
NSW	CAMDEN SOUTH	2570
NSW	ELDERSLIE	2570
NSW	THE OAKS	2570
NSW	BOWRAL	2576
NSW	GOULBURN	2580
NSW	MURRUMBATEMAN	2582
NSW	COROWA	2583
NSW	CROOKWELL	2583
NSW	LAVINGTON	2641
NSW	DENILIQUIN	2710
NSW	BARHAM	2732
NSW	GLENMORE PARK	2745
NSW	KINGSWOOD	2747

NSW	WERRINGTON COUNTY	2747
NSW	CRANEBROOK	2749
NSW	EMU PLAINS	2750
NSW	PENRITH	2750
NSW	PENRITH SOUTH	2750
NSW	SOUTH PENRITH	2750
NSW	RICHMOND	2753
NSW	NORTH RICHMOND	2754
NSW	MCGRATHS HILL	2756
NSW	PITT TOWN	2756
NSW	SOUTH WINDSOR	2756
NSW	WESTMEAD	2756
NSW	WINDSOR	2756
NSW	ST CLAIR	2759
NSW	COLYTON	2760
NSW	ST MARYS	2760
NSW	GLENDENNING	2761
NSW	HASSALL GROVE	2761
NSW	SCHOFIELDS	2762
NSW	QUAKERS HILL	2763
NSW	ROOTY HILL	2766
NSW	DOONSIDE	2767
NSW	WOODCROFT	2767
NSW	GLENWOOD	2768
NSW	STANHOPE GARDENS	2768
NSW	BIDWILL	2770
NSW	BLACKETT	2770
NSW	EMERTON	2770
NSW	HEBERSHAM	2770
NSW	LETHBRIDGE PARK	2770
NSW	MT DRUITT	2770
NSW	SHALVEY	2770
NSW	TREGEAR	2770
NSW	SPRINGWOOD	2772
NSW	BLAXLAND	2774
NSW	BLAXLAND EAST	2774
NSW	FALCONBRIDGE	2776
NSW	KATOOMBA	2780
NSW	LAWSON	2783
NSW	BLACKHEATH	2785
NSW	LITHGOW	2790

Postcodes where Commission distributed brochures directly:

2013-14

Suburb	Post code	Brochure: Concerned about your health care	Brochure: Resolve concerns about your health care
Waverly	2024	10	10
Penrith	2751	20	
Lismore	2480	10	10
Braidwood	2622	30	30
Worrigee	2540	200	300
Armidale	2350	20	40
Botany	2019	50	50
Queanbeyan	2620	20	20
Hornsby	2077	10	10
Kingswood	2750	50	
Wollongong	2500	50	50
Hurston Park	2193	50	50
Blacktown	2148	100	
Collarenebri	2387	15	15
Lismore	2480	2	2
Finley	2713	25	25
Ryde	1680	50	50
Collaroy	2097	5	5
Liverpool	1871	100	100
South West Rocks	2431	20	20
Miranda	2228	100	0
Nulkaba	2325	20	20
Tweed Heads South	2486	25	25
Corrimal	2518	25	25
DRUMMOYNE	2047	50	50
Waverley	2024	50	50
SYDNEY	2000	50	50
Port Macquarie	2444	25	25
Austinmer	2515	50	50
Earlwood	2206	1	1
Newcastle		50	50
TOTAL		**1283**	**1133**

2014-15

Suburb	Post code	Brochure: Concerned about your health care	Brochure: Resolve concerns about your health care
Carlingford	2118	100	100
Bella Vista	2153	100	100
Rouse Hill	2477	1	1
Nyngan	2825	25	25
Armidale	2350	100	100
Smithfield	2164	20	
Melbourne		3	3
Seven Hills	2147	2	2
Vincentia	2540	30	30
Penrith	2751	20	
Penrith	2750	20	
Hamilton	2303	5	5
Corndale	2480	3	
Carcoar	2791	2	2
Kempsey	2440	50	50
Gloucester	2422	50	50
Moruya	2537	20	20

Orange	2800	20	20
Seven Hills	2147	2	2
Alstonville	2477	10	10
Bathurst	2795	50	50
Mount Druitt	2770	100	100
TOTAL		**533**	**470**