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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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Chair's foreword and summary

I am pleased to present the Committee's Review of the Health Care Complaints Commission's Annual Report 2015-16, 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 second review during the 56th Parliament.

Increase in number and complexity of complaints

The Commission continues to see an increase in the number of complaints. Complaints increased by just over 15 per cent during the reporting period. Over the past five years the number of complaints has increased by 47 per cent.

We found the increase in complaints in New South Wales is part of a broader trend as some other national and international health complaints agencies report similar increases. We heard the increase is driven by social factors and does not reflect a decline in health services. With an ageing population greater demand is being placed on health services. In addition, people are increasingly more comfortable questioning medical practitioners and seeking independent assessment of their complaints.

We heard that in addition to increasing numbers, complaints are also becoming more complex as multiple issues may be raised within a single complaint. The combination of increased complaints and complexity is having an adverse impact on the Commission's workload.

Ability to meet timeframes

During 2015-16 timeliness was a challenge for the Commission. Some performance targets were not met. These included the assessment of complaints within 60 days, and the completion of requests for review of assessment decisions within four weeks. However, other targets were met including a 97.2 per cent success rate in prosecutions, exceeding the 90 per cent target.

We welcome the Commissioner's statement that the Commission is not sacrificing quality in order to meet performance timeframes. It is clear however that the Commission needs to process complaints in a timelier manner. We heard that the Commission is aware of the need to reform its business processes as a means of improving its overall performance.

It is for this reason that we have recommended the Commission look at how it can improve its administrative processes. Greater use of technology and the streamlining of administrative processes may improve the time taken to assess and resolve complaints. We have also recommended that the Commission consider undertaking more detailed analysis of complaints data. We believe that having a better understanding of this data may help the Commission to better identify and respond to trends and spikes in complaints.

Cooperation with public and private health sector

The Commission has strong working relationships with each of the local health districts. Its efforts have led to improvements in the way complaints are managed at the local level. During the reporting period the Commissioner visited the health districts to share information and receive feedback from them about the Commission's performance. We were pleased to hear

that the Commission now receives feedback on the outcome of complaints it refers to the health districts for local resolution. This closes a previously identified gap in the referral process.

We believe the Commission needs to develop a stronger relationship with the private health sector. Local resolution of complaints is not available for complaints about private health facilities. Private facilities are also less inclined to agree to assisted resolution. We have recommended the Commission increase consultation and cooperation with private hospitals and health providers. We believe the Commission's knowledge and experience may assist private health facilities with their complaints management processes.

Public warnings

Following 2015 changes to the Health Care Complaints Act 1993 the Commission now has the power to issue a public warning at any time during an investigation. It can issue warnings when it identifies a threat to public health and safety.

During the reporting period the Commission issued its first public warning while still investigating a complaint. The warning was about the dangers of cosmetic surgical and medical procedures performed by non-registered health practitioners. The warning was issued as the procedures were carried out in non-sterile environments, such as residential and hotel premises, and by people who were not qualified to perform them or to administer prescription drugs.

We heard the Commission currently has no means of measuring the impact the warnings may have on raising public awareness. Considering the importance of these public warnings we have recommended the Commission consider ways to measure their effectiveness. We believe it is important to be able to assess the impact and reach of the warnings. This could also assist in refining the targeting and distribution of future warnings.

Community outreach

We noted that the Commission's community outreach activities were significantly reduced during the reporting period. The Commission provided 32 presentations which is less than its target of 60 presentations. This activity benefits health service providers and community groups by informing them about the role and functions of the Commission.

We were told that the increased volume of complaints meant the Commission did not have the resources available to provide more presentations. While the Commission is pursuing greater use of electronic communication for its outreach efforts there remains a need for face-to-face training. We have recommended that the Commission maintain a strong commitment to its community outreach activities, particularly to vulnerable community groups. This will help ensure equal access to the health complaints system.

Mental health

During the reporting period the Commission had a particular focus on how it could better manage mental health related complaints. The Commission recognises that greater sensitivity is needed when responding to these complaints. We welcome the Commission's emphasis on dealing with mental health complaints from the patient's perspective. We also welcome the Commission's cooperation with the Mental Health Commission to address systemic issues the Commission may identify during the course of its work.

Discontinue with comments

We were pleased to see that the Commission has amended the way it deals with complaints that are discontinued because they about minor issues or practices. These complaints, about issues that do not pose a threat to public health and safety, were previously discontinued without action. The Commission has now introduced a new category of 'Discontinue with comments'. The focus is on providing feedback to both the consumer and the health practitioner or service. The new category has been welcomed by consumers who appreciate having their complaint acknowledged. Health providers also welcome suggestions to improve their service delivery.

Interjurisdictional cooperation

We were also pleased to hear that the Commission continues to be seen as the best practice model for other state based health care complaints agencies. Additionally, the Commission is also playing an active role in establishing an information sharing agreement between state health regulators and their Commonwealth counterparts.

Our health complaints system continues to work well but the Commission needs to take action to better meet the challenges raised by its increasing and complex workload. We are confident the Commission has the ability to take the necessary action to meet these challenges.

On behalf of the Committee I thank the Commissioner and her senior management team for appearing before the Committee and all the staff at the Commission for their continued hard work, dedication and professionalism.

I thank the members of the Committee for their ongoing support and interest in oversighting the Commission. Finally I thank the incredibly hard working and diligent Committee staff who worked on the inquiry.

Mr Adam Crouch MP
Chair

Findings and Recommendations

Complaint trends and management

Continued increase in complaints

Finding 1

The increase in complaints to the Health Care Complaints Commission reflects similar increases to some other health complaint agencies both nationally and internationally.

1.1 The Health Care Complaints Commission received 6,075 complaints in 2015-16, an increase of 15.4 per cent on 2014-15. Over the past five years the Commission recorded a 47.1 per cent increase in the number of complaints received in total.[1] The Commission noted:

> Over the last 10 years the volume of complaints has more than doubled and the rate of increase has intensified in recent years. This mirrors experience of health care complaints bodies nationally and internationally…[2]

1.2 The Commissioner, Ms Sue Dawson, informed us that the Commission has identified two main contributory factors for the increase. They are:

- increased use of health services by the ageing population, particularly by people with chronic health conditions; and
- increased community awareness and empowerment as patients are now better informed and able to question practitioners about whether they are receiving the correct treatment, and patients want an independent assessment when things go wrong.[3]

1.3 These social factors appear to be reflected in research undertaken by Plymouth University in 2014, and cited by the Commission in its report. The University carried out research to identify and analyse the factors driving the increase in health complaints in the United Kingdom. The research identified that the increase in complaints is due to broader social trends rather than localised issues, such as standards of care.[4]

1.4 Health complaints agencies in Queensland and Victoria also report annual increases in complaints. During 2015-16 the Office of the Health Ombudsman (Queensland) and the Health Complaints Commissioner (Victoria) both reported a 28 per cent in complaints. The United Kingdom's General Medical Council has also seen substantial growth in complaint numbers, with complaints doubling between 2007 and 2012.[5]

[1] HCCC Annual Report 2015-16, p10
[2] HCCC Annual Report 2015-16, p10
[3] Transcript of evidence, 8 May 2017, p4
[4] HCCC Annual Report 2015-16, p15
[5] Transcript of evidence, 8 May 2017, p4; HCCC Annual Report 2015-16, p15

1.5 We note the Commissioner has commented that she anticipates that the increase in complaints will continue in future years.[6]

The nature of complaints

Comparing local health districts

1.6 We were interested to know if any single local health district could be identified as having the largest number of complaints. The Commissioner advised that based on the level of activity – emergency department presentations, discharges and outpatient services – all local health districts are comparable with each other in terms of the percentage of complaints they receive.[7]

1.7 The Commissioner reminded us that when comparing the number of complaints received by each local health district it is important not to do direct comparisons. Each local district and their level of activity is different. The Commissioner explained that:

- the services provided by each local health district vary by type, mode of delivery and complexity, making direct comparisons difficult;
- there can be crossover between emergency department attendees and the number of patients discharged, with people presenting to the emergency department and then admitted to hospital; and
- the complaints received by the Commission relate to a range of services provided by the local health district.[8]

1.8 We heard that the number of complaints as a proportion of the number of services provided is relatively consistent across all local health districts. The Commissioner informed us that no health district has a particularly high or low proportion of complaints considering the quantity of services provided.

Complexity of complaints

1.9 We were informed that complaints are becoming more complex as multiple issues may be considered in a single complaint. A complaint may:

- involve several health providers treating a patient over an extended period of time;
- relate to one practitioner who has treated multiple patients;
- relate to new medical interventions and techniques;
- already be subject to investigation by another agency i.e. local health district or the coroner;

[6] HCCC Annual Report 2015-16, pp4, 15

[7] Transcript of evidence, 8 May 2017, p13

[8] Answer to question taken on notice 8 May 2017

- involve areas of medicine where it can be difficult to identify the provider, such as cosmetic procedures performed by non-registered providers; or
- involve breaches of legislation or criminal matters that require the involvement of state or national regulators.[9]

Confirming validity of medical qualifications

1.10 We were interested to know how the qualifications for registered practitioners are verified, particularly for practitioners trained overseas. We heard that the Australian Health Practitioner Regulation Agency (AHPRA) has national responsibility for registering health practitioners, in partnership with the National Boards.[10] We also heard that AHPRA is discussing with immigration authorities about how best to confirm the authenticity of overseas qualifications.[11]

1.11 It is not uncommon for the Commission to take action against non-registered practitioners who claim to have qualifications or experience that they do not actually possess. Mr Tony Kofkin, Director of Investigations, informed us about the distinction between what could be termed a 'fake doctor' and a non-registered practitioner.

1.12 He explained that a 'fake doctor' is a registered practitioner who uses falsified documents to obtain registration. A non-registered practitioner has no medical qualifications and has never been registered before. They provide a health service that may not need a degree in medicine or enhance their qualifications to falsely claim to be a medical professional, such as a doctor or a physiotherapist.[12]

1.13 During the reporting period, the Commission successfully used its powers to take action against two individuals who were not qualified to provide the services they offered.[13]

Complaints about pharmacists

1.14 There has been an increase of 18 per cent in complaints about pharmacists since 2013-14.[14] Many of the complaints are of a less serious nature involving issues such as dispensing out of date medication or providing generic rather than the prescribed branded medication.[15]

1.15 The most serious of complaints involve the large scale compounding of medications off label. This involves the preparation of drugs such as anabolic steroids, peptides and human growth hormone when there is no prescription or therapeutic benefit. We heard from the Commission that pharmaceutical companies also lodge complaints against pharmacists. They do this when

[9] HCCC Annual Report 2015-16, p14
[10] Answer to question taken on notice 8 May 2017
[11] Transcript of evidence, 8 May 2017, p10
[12] Transcript of evidence, 8 May 2017, pp10-11
[13] Transcript of evidence, 8 May 2017, p11
[14] HCCC Annual Report 2015-16, p17
[15] Transcript of evidence, 8 May 2017, p13

pharmacists compound products that are already commercially available and there is no valid reason for the pharmacist's action.[16]

1.16 Complaints about compounding medications can be complex and time consuming. We were pleased to hear that the Commission has a very good working relationship with the NSW Police Force, the Pharmacy Council of New South Wales, the Pharmaceutical Regulatory Unit of the NSW Ministry of Health, and the Public Health Units across NSW. The strength of these relationships means the Commission can readily obtain the information and evidence it needs to investigate and prosecute offenders.[17]

Complaints about psychologists

1.17 Complaints about psychologists have also increased during the reporting period – an increase of almost 19 per cent from 2014-15. Many of the complaints involve boundary violations by practitioners. Examples include practitioners loaning money to or having a sexual relationship with a patient. The Commissioner also explained that psychologists sometimes work in contested areas. She cited as an example a situation involving a family law matter. A family member, such as an estranged parent, may complain about why a member of their family is seeing a psychologist.[18]

1.18 The Commissioner acknowledged that more analysis is needed before the Commission can clearly identify the reasons for the increase in complaints about psychologists. The Commissioner did suggest that as more people understand the importance of good mental health and seek treatment, the number of complaints about psychologists is likely to increase.[19]

Impact of the National Disability Insurance Scheme

1.19 The introduction of the National Disability Insurance Scheme (NDIS) poses jurisdictional issues that the Commission needs to resolve. Some NDIS related complaints concern personal home care rather than health care services and are not strictly within the Commission's remit. The Commissioner informed us that the appointment of an NDIS complaints commissioner will assist in resolving jurisdictional issues the Commission may face in the future. The Commission will work to establish a complaint referral pathway following the appointment of the complaints commissioner.[20]

1.20 When dealing with NDIS related health complaints, the Commission focuses on the health service being provided and the nature of the complaint. It does this regardless of whether the service is privately or publically provided.[21]

[16] Transcript of evidence, 8 May 2017, pp13-14
[17] Transcript of evidence, 8 May 2017, p20; HCCC Annual Report 2015-16, p17
[18] Transcript of evidence, 8 May 2017, pp15, 18
[19] Transcript of evidence, 8 May 2017, pp17-18
[20] Transcript of evidence, 8 May 2017, p19
[21] Transcript of evidence, 8 May 2017, p19

Continuing disciplinary action against deregistered practitioners

1.21 We asked for further information about the outcome of investigations into practitioners who deregister themselves or retire from practice during the course of an investigation.

1.22 Ms Karen Mobbs, Director of Proceedings, explained that there is no prohibition on the Commission continuing disciplinary action against a practitioner even if they retire and deregister themselves. The Commission's focus remains on protecting public health and safety. Depending on the individual circumstances of each case, the Commission can pursue different options to secure an outcome that safeguards the public.[22]

1.23 For matters before a Professional Standards Committee, the Commission provides AHPRA with the results of its investigation. This ensures that the incident and issues raised by the Commission's investigation are considered by AHPRA should the practitioner apply for re-registration.

1.24 The Commission may also decide that for reasons of general deterrence it may be appropriate to proceed with legal proceedings against a practitioner. It may take this course of action when it is not appropriate that a practitioner is seen to be able to deregister themselves as a means of trying to evade prosecution.

1.25 The Commission can also obtain a prohibition order against a practitioner who may have been suspended or had their registration cancelled. A prohibition order prevents a practitioner from practicing not only within their profession but also in other health related professions. It can prevent a psychiatrist who has deregistered themselves from not only practicing psychiatry but also from offering counselling services.[23]

Ability to meet timeframes

Recommendation 1

That the Health Care Complaints Commission improve administrative processes and information and communication technology (ICT) systems as a way of helping to improve the timeliness of the assessment and resolution of complaints.

Recommendation 2

That the Health Care Complaints Commission undertake closer analysis of health complaints data to better identify the causes for and trends in complaints as a means of taking a more pre-emptive approach to complaints management.

Meeting performance targets

1.26 The increasing volume and complexity of complaints is having a negative impact on the Commission's ability to assess complaints in a timely manner. Under the

[22] Transcript of evidence, 8 May 2017, p6

[23] Transcript of evidence, 8 May 2017, pp6-7

Health Care Complaints Act 1993 (the Act) the Commission has a statutory timeframe to assess 100 per cent of complaints within 60 days. During the reporting period this performance indicator was not met, with 85.8 per cent of complaints assessed within 60 days.[24]

1.27 The Commission also missed its target of completing 90 per cent of requests for a review of assessment decisions within four weeks. During the reporting period the Commission completed only 9.8 per cent of requests within four weeks. In previous years the Commission had a target of completing 90 per cent of reviews within six weeks. In 2014-15 65.6 per cent of reviews were completed in six weeks. In 2013-14 71.8 per of reviews were completed in six weeks.[25]

1.28 Only 50 per cent of acknowledgement letters confirming receipt of a complaint were sent within seven days. The Commission's target is 90 per cent. In 2014-15 94 per cent of letters were sent within seven days. During 2015-16 the Commission sent 88.7 per cent of decision letters within 14 days, failing to achieve its target of 100 per cent. These letters inform all parties to a complaint about the Commission's assessment of the complaint.[26]

1.29 The Commissioner acknowledged the increased volume of complaints is making it difficult for the Commission to meet some performance targets.[27] The Commissioner stressed that the Commission's objective is to protect public health and safety and the focus needs to be on the thorough assessment of complaints:

> … some tolerance around timeframes is quite important because from our point of view the one thing you cannot compromise and you can cannot take shortcuts on is the proper examination of complaints that are about the wellbeing of individuals in a way that delivers procedural fairness to the providers and the health organisations that are involved.[28]

1.30 While it failed to meet some performance targets, the Commission did meet other important targets, including:

- 96.4 per cent of matters referred to the Director of Proceedings were not referred back for further information (target 90 per cent);
- a 97.2 per cent success rate in prosecutions (target 90 per cent); and
- 77.9 per cent of resolutions were completed within four months (target 70 per cent).[29]

Improve performance

1.31 Considering the increased volume and complexity of complaints, and that complaint volume and complexity is likely to continue to increase, we are

[24] HCCC Annual Report 2015-16, p140
[25] HCCC Annual Report 2014-15, pp28, 30
[26] HCCC Annual Report 2015-16, p140
[27] Transcript of evidence, 8 May 2017, p2
[28] Transcript of evidence, 8 May 2017, p2
[29] HCCC Annual Report 2015-16, pp141-142

concerned that the Commission may find it difficult to meet its performance targets. We are aware that it may become necessary for the Commission to review its current timeframes and targets. The Commission needs to ensure it can continue to assess and investigate complaints to a high standard and to do so in a timely manner.

1.32 We wanted to know if more resources, such as staffing and funding, are needed to improve the Commission's performance. While recognising that these resources could be beneficial, the Commissioner acknowledged that the way the Commission performs its functions needs to be improved.[30]

1.33 The Commission's current complaints process is paper based and inefficient. The Commissioner acknowledged that the current complaints management system is cumbersome. The Commissioner advised that this is an area of focus for the organisation.[31]

1.34 The increased number and complexity of complaints is having an impact on the Commission's ability to assess complaints within its statutory timeframe of 60 days. This impact is increased by administrative processes and information and communication (ICT) systems that are not optimal.

1.35 We support the Commission's focus on improving its processes through the greater use of technology. We recognise that moving to an electronic management system could contribute to the more efficient handling of complaints and help better manage timeframes.

1.36 We note the Commission is already incorporating electronic resources to improve timeliness in some areas. The Commission has indicated that the electronic compilation of briefs of evidence is expected to assist in its ability to compile briefs in a timelier manner. During the reporting period the Commission prepared 71.2 per cent of briefs within 28 days which is less than its target of 80 per cent.[32]

1.37 The Commission undertakes analysis of complaints data to identify where it can improve the way it manages complaints. A recent focus has been in the area of mental health and how the Commission can improve its management of mental health related complaints.[33] The Commission's focus on mental health related complaints is discussed in more detail below.

1.38 We are interested to know if more comprehensive analysis of health complaints data could help to better understand trends and spikes in complaints. Such analysis, whether undertaken solely by the Commission or in partnership with another agency, could allow the Commission to take a stronger pre-emptive approach to complaints management. We understand that this analysis could place additional demands on the Commission's resources but believe it may provide long term benefit.

[30] Transcript of evidence, 8 May 2017, p2
[31] Transcript of evidence, 8 May 2017, p2
[32] HCCC Annual Report 2015-16, p142
[33] HCCC Annual Report 2015-16, p56

Completing investigations

1.39 The Commission has a target of completing 90 per cent of its investigations within 12 months. There are times when investigations take longer than 12 months to complete. We heard that complaints like those involving transvaginal mesh implants involve jurisdictional issues that add an additional layer of complexity and take an extended period of time to work through.

1.40 The mesh implants have been used to treat prolapse after childbirth. A number of women treated with the implants have reported experiencing health problems including incontinence and chronic pain. The Senate Community Affairs References Committee is currently conducting an inquiry into the matter. The inquiry is examining a number of issues including, the health problems experienced by women who have received the implants; the information available to patients and doctors about the surgery; and the Therapeutic Goods Administration's role in regulating and monitoring the use of the implants. The inquiry was ongoing at the time of publication.[34]

1.41 Cases like these can involve investigations where the Commission may need to seek information from federal agencies such as the Therapeutic Goods Administration. Additionally, such complaints may have an international dimension as there may be lawsuits in other jurisdictions that impact proceedings here. If the Commission proceeds with a prosecution it can also take some time for all parties to prepare their cases before court proceedings begin.[35]

1.42 While investigations can be time consuming, the Commission does not have to wait until an investigation is finalised before action can be taken against an individual practitioner. While a complaint is still being investigated, the co-regulatory power of the professional councils means they can place conditions on a practitioner's registration or to suspend them if it deems it to be in the public interest. These decisions can remain in place until the final outcome of the complaint is decided.[36]

1.43 The Commission also has authority under the Act to issue a public warning about unsafe treatment or services while still investigating a complaint. The issue of public warnings is addressed in more detail below.

1.44 We are pleased to see that the Commission has memoranda of understanding (MOU) with several state agencies. We heard how the Commission's relationship with the NSW Police Force has been enhanced through an MOU as the two agencies work closely together. The MOU with the Pharmaceutical Regulatory Unit allows the Commission to obtain detailed information about the activity of individual pharmacists who are illegally dispensing drugs.[37]

[34] Parliament of Australia, Senate Standing Committees on Community Affairs, Community Affairs References Committee, Number of women in Australia who have had transvaginal mesh implants and related matters, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MeshImplants, accessed 23 August 2017

[35] Transcript of evidence, 8 May 2017, pp4-5

[36] Transcript of evidence, 8 May 2017, pp5-6

[37] Transcript of evidence, 8 May 2017, p20

Discontinue with comments

1.45 During the reporting period the Commission introduced 'Discontinue with comments' as a new assessment outcome category. This category is for complaints that raise low level issues, such as practitioner rudeness, or poor information about scheduling appointments. While important, these complaints do not raise issues of significant public health and safety.

1.46 Instead of simply discontinuing these complaints, the Commission now provides feedback to the practitioner about how they can improve their service. The Commission expects the number of complaints that are simply discontinued will decline while the number of complaints discontinued with comments will increase.[38]

1.47 We were pleased to hear that the introduction of the 'Discontinue with comments' category has been well received by both consumers and practitioners. Consumers appreciate that their complaint is acknowledged and action taken. Practitioners welcome the suggestions from the Commission about how they can improve their behaviour or practices.[39]

[38] Transcript of evidence, 8 May 2017, pp21-22; HCCC Annual Report 2015-16, pp27, 29

[39] Transcript of evidence, 8 May 2017, p22

Outreach activities

Increased cooperation with private hospitals and health providers

Recommendation 3

That the Health Care Complaints Commission increase consultation and cooperation with private hospitals and health providers.

1.48 The Commissioner visited most local health districts during the reporting period. The visits have enhanced the Commission's existing relationship with each health district. The Commissioner met with senior management of each district and discussed issues related to the volume and pattern of complaints within their district. The Commissioner also advised how the health district compared to other districts and any differences in the issues raised in complaints.[40]

1.49 In return the local health districts told the Commissioner about their efforts to resolve more complaints locally. In recent years the Commission has identified the local resolution of complaints as an important avenue for the early resolution of complaints.[41]

1.50 In contrast, the Commissioner acknowledged that the Commission's relationship with private hospitals and providers requires further development.[42] We note that local resolution is not available for complaints about private health facilities. Private facilities are also less inclined to agree to assisted resolution. While the overall number is low (113), there was a 13 per cent increase in the number of complaints about private hospitals during the reporting period.[43]

1.51 We support and encourage the Commission in developing a stronger relationship with the private sector. We recognise that the Commission's knowledge and experience may assist private health facilities with their complaints management processes. We are mindful that this may take time. We are also aware that it may add to the demands on the Commission's resources.

1.52 The Commissioner highlighted some of the benefits of the Commission's relationship with the local health districts. A key complaints management message the Commission gives to local health districts is to minimise the time between the incident occurring and responding to the complaint. The Commission emphasises the importance of responding to patients and/or their families and gives local health district staff the skills to do this confidently.[44]

1.53 The Commission's training includes getting staff to look at real-life case studies where a complaint was not well managed. They then learn how to better manage such complaints in the future. There is an emphasis on open disclosure which can

[40] Transcript of evidence, 8 May 2017, pp11-12

[41] Transcript of evidence, 8 May 2017, pp11-12; HCCC Annual Report 2015-16, p28

[42] Transcript of evidence, 8 May 2017, p19

[43] HCCC Annual Report 2015-16, pp19, 31

[44] Transcript of evidence, 8 May 2017, p7

be a difficult process for practitioners. Giving practitioners the skills they need to have these hard conversations benefits both patients and their families and also practitioners.[45]

1.54 Ongoing close cooperation with local health districts has also helped the Commission improve its administrative processes. We heard how feedback from the districts has streamlined how the Commission requests patient medical records. Previously, the Commission sent a broad request that could capture a large amount of patient information, particularly if the patient had multiple treatments and admissions over an extended period. Much of this information may not have been relevant to the complaint.

1.55 The Commission is now refining the scope of its requests for patient records to make the requests more specific. Requests may now relate only to the particular episode of treatment that is subject to complaint. The result is the Commission only receives the information most relevant to its investigation and the local health district takes less time to collate a smaller and more specific volume of records.[46]

1.56 When the Commission previously referred complaints to the relevant health district for local resolution it was not informed of the resolution outcome. We were pleased to learn that this gap in the referral process is now closed. Each local health district now provides the Commission with advice on how it resolved every complaint referred to it for local resolution. Having this additional information allows the Commission to know more about people's experience of the complaints management system.[47]

Public warnings

Recommendation 4

That the Health Care Complaints Commission consider ways to measure the effectiveness of public warnings and publish this information in its annual report.

1.57 Following 2015 changes to the Act, the Commission now has the power to issue a public warning during the course of an investigation. Prior to this the Commission could only issue a warning at the end of an investigation. This limited its ability to raise awareness of practices that posed a threat to public safety. The Commissioner informed us that this is a power the Commission will exercise whenever it believes it is prudent for it to do so.[48]

1.58 During the reporting period the Commission issued its first public warning. This followed receipt of several complaints about cosmetic procedures performed by non-registered practitioners in residential premises and hotel rooms, particularly in the Sydney area.[49] Mr Kofkin explained that the warning was published on the

[45] Transcript of evidence, 8 May 2017, pp7, 12
[46] Transcript of evidence, 8 May 2017, p12
[47] Transcript of evidence, 8 May 2017, p12
[48] Transcript of evidence, 8 May 2017, p9; HCCC Annual Report 2015-16, p50
[49] HCCC Annual Report 2015-16, p50

Commission's website and via media release. The professional councils and AHPRA were also informed.[50]

1.59 We wanted to know if the Commission is able to measure the effectiveness of public warnings. Mr Kofkin acknowledged that this is difficult to measure. He informed us that other Commission publications, such as prohibition orders or public statements, issued by the Commission are noted by the media.

1.60 Mr Kofkin said that people performing reference checks will often do an internet search of a candidate's name. If the Commission has issued a public statement about that person, the statement will show up in the search results. He also advised that he receives phone calls from people wanting to discuss a statement issued by the Commission. Statements issued by the Commission are also sometimes featured in television news broadcasts.[51]

1.61 It appears the Commission currently has no formal means of measuring the impact of public warnings. We recognise that some Commission publications receive media attention.

1.62 Considering the importance of public warnings we believe the Commission should consider ways to formally measure their effectiveness. This is additionally important since the ability of the Commission to issue warnings during an investigation has only recently been provided.

1.63 We consider the real benefit of the public warnings is dependent on their reach and impact in the broader community. We believe a formal mechanism should be developed to evaluate how well a warning is received and understood by the public. This could help identify ways to improve the effectiveness and distribution of future public warnings.

1.64 We were interested to hear how the Commission decides to issue a public warning. We heard that once the Commission becomes aware of an issue it gathers information from various sources. The information is then reviewed by senior management. The Commission will issue a public warning when it establishes that the service or procedure is a risk to public health and safety and to delay issuing a warning poses a further risk.[52]

1.65 In the case of non-registered practitioners performing cosmetic procedures, the Commission issued the warning on 30 June 2016 as it established a real risk to public health and safety. The procedures were performed in non-sterile environments by people who were not authorised to perform them. They involved a range of skin penetration procedures and administration of prescription-only medications.

1.66 The procedures included double eyelid suturing, nose bridge lifts and protein suture facelifts. It also included the administration of Botox, dermal fillers and glutathione skin whitening injections. The medications used were not on the

[50] Transcript of evidence, 8 May 2017, p10
[51] Transcript of evidence, 8 May 2017, pp9, 10
[52] Transcript of evidence, 8 May 2017, p8

Australian Register of Therapeutic Goods and there was no way of confirming if the medications were safe.

1.67 The warning advised people wanting the cosmetic procedures to exercise caution and to be vigilant before proceeding. It provided advice on issues such as how to confirm a practitioner's qualification, and how to identify that the facility is appropriately equipped. The procedures were advertised through social media, particularly through "WeChat", a Chinese social media app. The warning was published in English and Chinese.[53]

1.68 Mr Kofkin suggested that should a matter similar to the concerns about transvaginal mesh implants occur in the future, the Commission could potentially make a public warning.[54]

1.69 The Commissioner informed us that cases like those involving cosmetic practitioners and pharmacists have tested the way the Commission exercises its powers, particularly in terms of its search and notice powers. The Commissioner informed us that having a good working relationship with other agencies, such as the NSW Police Force, has allowed the Commission to achieve good results.[55]

Community outreach

Recommendation 5

That the Health Care Complaints Commission maintain a strong commitment to community outreach activities, particularly to vulnerable community groups.

1.70 Each year the Commission gives presentations and workshops to community groups and health practitioners about the role and functions of the Commission. The Commissioner explained that this outreach activity benefits a variety of groups in the community, including those whose first language is not English; people living in remote communities; or people with mental health issues.[56]

1.71 Targeted presentations and outreach efforts are provided to particularly vulnerable groups that may have difficulty accessing the complaints system. The Commissioner highlighted the Commission's ongoing support to Indigenous communities about how to use the complaints system as an example.[57]

1.72 During the reporting period the Commission also focussed on outreach to mental health service providers. The Commission sought to provide information to those service providers about the role of the Commission and how they can help

[53] Health Care Complaints Commission, *Public Warning under s94A (1) of the Health Care Complaints Act 1993: Cosmetic surgical and medical procedures performed by non-registered health* practitioners, http://www.hccc.nsw.gov.au/Hearings---decisions/Public-statements-and-warnings/Public-Warning-under-s94A-1-of-the-Health-Care-Complaints-Act-1993--Cosmetic-surgical-and-medical-procedures-performed-by-non-registered-health-practitioners, accessed 5 July 2017; HCCC Annual Report 2015-16, p51

[54] Transcript of evidence, 8 May 2017, p9

[55] Transcript of evidence, 8 May 2017, p14

[56] Transcript of evidence, 8 May 2017, p7

[57] Transcript of evidence, 8 May 2017, p7

patients lodge complaints.[58] More information about the Commission's activity in the area of mental health is discussed below.

1.73 In 2015-16 the Commission gave 32 presentations, significantly less than its target of 60 presentations.[59] The Commissioner informed us that this was due to the increased number of complaints and the demands this placed on the Commission's time and resources.[60]

1.74 We note the Commissioner's comment that the Commission will focus on providing more webinars and electronic communication as part of its outreach activities. We support this but also share the Commissioner's view that face-to-face communication is best, particularly when it concerns more vulnerable members of the community.

1.75 Community outreach is an important part of the Commission's work. It is important that it retain the ability to provide a high level of outreach activity and support. It is also important that the Commission continue to identify other vulnerable community groups that need its support. The Commission can help these groups, and the health practitioners that work with them, to ensure they are aware of and can access the health complaints system. This is an area of ongoing interest for us. We will continue to monitor and review this activity in the future.

Mental health

1.76 During the reporting period the Commission had a particular focus on mental health and how to improve its handling of these complaints. Mental health complaints make up around 12 per cent of all complaints received by the Commission annually.[61]

1.77 Most complaints relate to issues concerning communication and information and also consent to treatment. Complaints about actual treatment comprise a smaller proportion of complaints. This reflects the sometimes involuntary nature of mental health treatment and the importance of communicating with both patients and their families.[62]

1.78 While relatively small in number, complaints related to mental health require the Commission to exercise a high degree of sensitivity when responding. The Commission recognises that people with mental health issues are particularly vulnerable.[63]

1.79 The Commission is aware that the local resolution of mental health complaints may not be appropriate. Often family members are concerned that their relative is not receiving appropriate care from a particular facility. The Commission's Resolution Service can bring together the family and health provider to facilitate

[58] HCCC Annual Report 2015-16, p51
[59] HCCC Annual Report 2015-16, p143
[60] Transcript of evidence, 8 May 2017, p7
[61] HCCC Annual Report 2015-16, p56
[62] HCCC Annual Report 2015-16, p56
[63] Transcript of evidence, 8 May 2017, p16

an agreement. This process can give the family the reassurance they want and ensure continuity of care the next time their loved one is ill.[64]

1.80 The Commission is also looking at broader systemic issues in mental health care. Using a complaint about a mental health inpatient unit at a regional hospital, the Commission identified several practices that were of concern. These practices related to issues such as the observation of high risk patients overnight and the co-location of high risk patients in one room. The Commission made recommendations to the local health district to improve its treatment of mental health patients. These recommendations included staff training and a risk assessment framework for when patients are co-located.[65]

1.81 We note that the Legislative Assembly Public Accounts Committee is currently conducting an inquiry into the management of health care delivery in New South Wales. As part of the inquiry the Committee is examining management issues in mental health care delivery. The inquiry was ongoing at the time of publication.[66]

1.82 The Commission's own staff will also receive training to improve the Commission's ability to deal with mental health complaints. The Commissioner informed us that, in cooperation with the Mental Health Commission of NSW, staff will learn how to deal with these complaints from the individual's perspective. The Commission will also inform the Mental Health Commission of any systemic issues it identifies during the course of its work.[67]

1.83 We would welcome the inclusion of further analysis and information of mental health complaints in future annual reports. We believe it would be beneficial to include information such as:

- a breakdown of regional and metropolitan access to mental health services;
- information of any particular issues faced by regional consumers; and
- increases in the number of mental health patients and mental health complaints.

[64] Transcript of evidence, 8 May 2017, p16

[65] Transcript of evidence, 8 May 2017, p17; HCCC Annual Report 2015-16, p58

[66] Parliament of New South Wales, Legislative Assembly Public Accounts Committee, Inquiry into the management of health care delivery in NSW, https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2423, accessed 25 August 2017

[67] Transcript of evidence, 8 May 2017, p16; HCCC Annual Report 2015-16, p59

Organisational matters

Interjurisdictional cooperation

1.84 While the Commission has a good relationship with Commonwealth agencies, such as Medicare, it recognises the need for a formal information access and sharing agreement. There are occasions when the time taken to get information from Commonwealth agencies, such as Medicare and the Therapeutic Goods Administration, is longer than the Commission would like.

1.85 The Commissioner informed us that for some time there have been calls for greater cooperation between state health regulators and their Commonwealth counterparts. Having a formal agreement between these parties could give health complaints agencies better access to the information they require to complete an investigation.[68]

1.86 The Consumer Health Regulators Forum was recently established to examine how the impediments to interagency information sharing can be overcome. The forum was convened by the Australian Competition and Consumer Commission. It includes the Private Health Insurance Ombudsman, the Therapeutic Goods Administration, and AHPRA.

1.87 The Commissioner welcomed the forum's establishment. We were pleased to note that the Commissioner was appointed to the forum as the representative for all state health care complaints agencies. She also explained that she will use her term on the forum to provide a state perspective on the barriers that impede the exchange of information.[69]

1.88 The Commissioner also attends the National Health Commissioners conferences where matters that cross jurisdictional boundaries are discussed. The Commissioner is a member of the Medical Board of Australia's Consultative Committee on revalidation for medical practitioners.[70]

1.89 We were pleased to note that the Commission continues to be seen as a best practice model for other jurisdictions, particularly in the area of unregistered practitioners.[71]

1.90 NSW has had a Code of Conduct for unregistered health practitioners since 2008.[72] With plans for a National Code of Conduct for unregistered practitioners, other health complaints commissions are looking to NSW for best practice in this area. The Commission's experience in dealing with unregistered practitioners includes how to assess the quality of care they provide; how to get witness statements; and how to conduct hearings. Through workshops and seminars the

[68] Transcript of evidence, 8 May 2017, p5
[69] Transcript of evidence, 8 May 2017, p5
[70] HCCC Annual Report 2015-16, p53
[71] Transcript of evidence, 8 May 2017, p14
[72] Health Care Complaints Commission, *Information for unregistered health practitioners*, http://www.hccc.nsw.gov.au/Information/Information-for-Unregistered-Practitioners, accessed 12 July 2017

Commission has shared its expertise with its Queensland, Victoria and Australian Capital Territory counterparts.[73]

Retaining corporate knowledge

1.91 Retaining corporate knowledge is an important part of ensuring the Commission can meet the challenges it faces in managing complaints. The Commissioner outlined the main steps the Commission is taking to promote the sharing of knowledge and experience across the organisation.[74]

1.92 The Commission is committed to providing all staff with resilience training. The training gives staff the skills and strategies to deal with complainants, especially those who may be traumatised and stressed as a result of their experience. The training also gives staff the coping skills they need to continue working in a difficult and challenging environment.[75]

1.93 The Commission wants to draw on the skills and knowledge of all staff when redesigning its business processes to improve the Commission's performance. By asking staff what they do, why they do it and how it could be improved the Commission is hoping to identify areas where improvements can be made.[76]

1.94 We also heard about the Commission's master class program. As a way of promoting better practice, the program allows staff to share case studies of matters that went well and not as well. The Commission also encourages feedback from partner agencies about their perceptions of the Commission and how they can work better together. The Commissioner referred to its work with the local health districts as an example. Another example was the Commission's work with Justice Health. Representatives from Justice Health are regularly invited to the Commission to tell staff about policy changes in areas such as treatment and access.[77]

[73] Transcript of evidence, 8 May 2017, p14
[74] Transcript of evidence, 8 May 2017, p14
[75] HCCC Annual Report 2015-16, p63
[76] Transcript of evidence, 8 May 2017, p14
[77] Transcript of evidence, 8 May 2017, p14

Appendix One – 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) to 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.

Appendix Two – List of witnesses

8 May 2017, Macquarie Room, Parliament House

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

Appendix Three – Extracts from Minutes

MINUTES OF MEETING No 6
Thursday 6 April 2017
Room 1254, Parliament House

Members present
Mr Crouch (Deputy Chair), Mr Amato, Ms Hodgkinson, Mr Secord, Mr Taylor, Ms Washington

Officers in attendance
Carly Maxwell, Ben Foxe, Derya Sekmen

Mr Crouch as Deputy Chair opened the meeting at 9.00am in accordance with Standing Order 284, which provides for the Deputy Chair to act as Chair, in the Chair's absence.

1. ***

2. ***

3. Minutes of meeting No 5, 23 June 2016

Resolved on the motion of Mr Amato, seconded by Mr Secord:
That the minutes of Meeting No 5 be confirmed.

4. ***

5. Review of HCCC Annual Report for 2015-16

Resolved on the motion of Mr Taylor, seconded by Ms Hodgkinson:
That, pursuant to the Committee's responsibilities under Part 4, section 65 (1) (c) of the *Health Care Complaints Act 1993*, the Committee conducts a review of the 2015-16 Annual Report of the Health Care Complaints Commission.

Resolved on the motion of Mr Secord, seconded by Mr Amato:
That the Committee invite the Commissioner and her delegates to attend a public hearing at Parliament House to review the Commission's 2015-16 Annual Report.

Committee staff were requested to consult with Committee members regarding availability for a public hearing date.

The Committee agreed that staff would consult with the Commission and with the new members of the Committee regarding availability for an informal meeting with the Commissioner.

6. Next meeting

The meeting adjourned at 9.07 a.m. until a time and place to be determined.

MINUTES OF MEETING No 7

Monday 8 May 2017
Macquarie Room, Parliament House

Members present
Mr Crouch (Chair), Mr Taylor (Deputy Chair), Mr Amato, Mr Secord, Ms Washington

Apologies
Ms Hodgkinson

Officers in attendance
Carly Maxwell, Ben Foxe, Kieran Lewis

The Chair opened the meeting at 9.51am.

1. Minutes of meeting No 6

Resolved, on the motion of Ms Washington, seconded by Mr Amato:
That the minutes of Meeting No 6 held on 4 April 2017 be confirmed.

Review of the 2015-16 Annual Report of the Health Care Complaints Commission

2. Public hearing Monday 8 May 2017

Resolved, on the motion of Mr Taylor, seconded by Ms Washington:
That the Committee invites the witnesses listed in the notice of the public hearing for Monday 8 May 2017 to give evidence in relation to the Review of the 2015-16 Annual Report of the Health Care Complaints Commission.

2.1 Media

Resolved, on the motion of Mr Amato, seconded by Mr Secord:
That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 8 May 2017 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 Mr Taylor, seconded by Ms Washington:
That the corrected transcript of evidence given on 8 May 2017 be authorised for publication and uploaded on the Committee's website.

2.3 Answers to questions on notice

Resolved, on the motion of Ms Washington, seconded by Mr Taylor:
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.

The public hearing commenced at 10.01am. Witnesses and the public 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
- Ms Celia Murphy, Acting Director of Assessments and Resolution

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

- Mr Tony Kofkin, Director of Investigations

Evidence concluded, the witnesses withdrew.

The hearing concluded at 12.05pm.

4. Next meeting

The Chair closed the meeting at 12.05pm. The next meeting will be held on a date to be determined.

UNCONFIRMED MINUTES OF MEETING No 8

Tuesday 10 October 2017
Room 1254, Parliament House

Members present

Mr Crouch (Chair), Mr Taylor (Deputy Chair), Mr Amato, Mr Pearson, Mr Secord, Ms Washington

Officers in attendance

Simon Johnston, Ben Foxe, Kieran Lewis

The Chair opened the meeting at 12.32pm.

***

1. Minutes of meeting No 7

Resolved, on the motion of Mr Amato, seconded by Mr Taylor:
That the minutes of Meeting No 7 held on 8 May 2017 be confirmed.

2. Committee membership

The Chair welcomed Mr Pearson to the Committee and noted that Mr Pearson had replaced Ms Barham. The Chair also noted the vacancy on the Committee following the resignation of Ms Hodgkinson.

***

Review of the HCCC Annual Report 2015/16

4. Consideration of the Chair's draft report

The Chair spoke to the draft report previously circulated.

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

Resolved, on the motion of Mr Secord, seconded by Mr Pearson:

That Finding 1 be amended by inserting the word “some” between “to” and “other”.

Resolved, on the motion of Mr Amato, seconded by Mr Taylor:
That the draft recommendations and the finding as amended be agreed to.

Resolved, on the motion of Mr Taylor, seconded by Ms Washington:
That the draft report as amended be the report of the Committee, and that it be signed by the Chair and presented to the Houses.

Resolved, on the motion of Mr Secord, seconded by Mr Amato:
That the Chair and committee staff be permitted to correct stylistic, typographical and grammatical errors.

Resolved, on the motion of Mr Taylor, seconded by Mr Amato:
That, once tabled, the report be published on the Committee’s website.

Resolved, on the motion of Ms Washington, seconded by Mr Pearson:
That the Chair circulate a media release once the report has been tabled.

The Chair noted that he would table the report in the Legislative Assembly and Mr Amato would table the report in the Legislative Council on 11 October 2017.

5. General Business

***

4. Next meeting

The Chair closed the meeting at 12.49pm. The next meeting will be held on a date to be determined.