JPC REVIEW OF THE HCCC 2017-18 AND 2018-19 ANNUAL REPORTS

HCCC RESPONSE TO QUESTIONS ON NOTICE

IMPACTS OF COVID-19 – QUESTIONS 1-3

<u>Question 1.</u> With the COVID-19 pandemic placing an increased focus on the healthcare sector, is the HCCC planning for an increase of complaints relating to COVID-19 treatments, tests, or other COVID-19 related matters?

Yes. From the outbreak of the Covid-19 as a global pandemic, the Commission expected to receive complaints about Covid-19 testing, treatments and related matters and instituted specific processes so that we could:

- Monitor and report on the nature and volume of these complaints.
- Ensure that they were managed consistently.
- Ensure that information and evidence gathering processes were effective but not disruptive to front line service delivery.

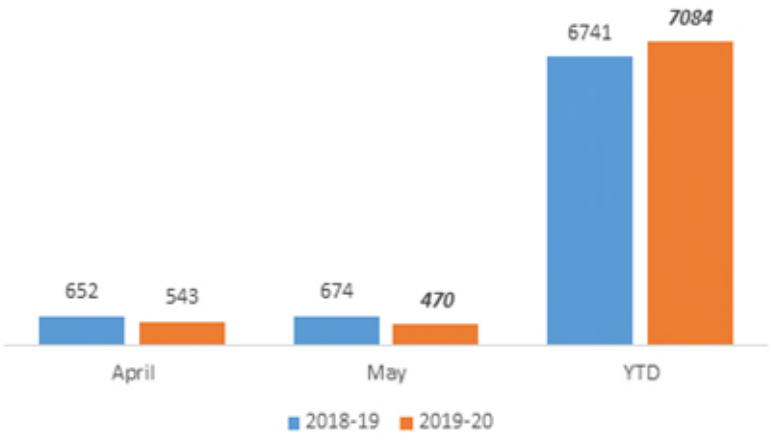
All incoming Covid-19 complaints are being separately logged, recorded, and triaged by and through a designated Senior Assessment Officer.

All logged COVID complaints are examined by the Executive Director, Complaints Operations, and triage instructions are provided to the Senior Assessment Officer. All assessment recommendations and decisions on the logged COVID complaints are assessed by the Executive Director, Complaints Operations.

Weekly reports on COVID complaints are produced for Executive review and analysis in the context of all incoming complaints, to understand the impact on the nature and volume of complaints.

While COVID related complaints have continued to come to the Commission, it is important to note that the *overall* volume of complaints received since the end of the third quarter 2019-20 has decreased compared to the corresponding months last year, as seen in <u>Chart 1</u> below. This decrease was not unexpected, noting that many health services have been repurposed, scaled back or even prohibited during the Covid-19 period.

CHART 1. TOTAL COMPLAINTS RECEIVED APRIL, MAY AND YEAR TO DATE: 2018-19 COMPARED TO 2019-20



Question 2. What percentage of HCCC staff are working from home due to the COVID-19 pandemic?

100 percent of Commission staff have the option and support to work from home. Throughout the pandemic management period, around 90% are doing so, either for a full working week or a large portion of it.

Question 3. How has this impacted the operations of the HCCC and what has been done to minimise these impacts?

To date no staff have been directly impacted through a positive Covid-19 test for themselves or their close family.

The Commission has been able to continue all of its complaints handling functions, through a rapid and managed transition to remote working.

- The Inquiries Service has been fully operational.
- All complaints received have been assessed in the usual way, and the timeliness and volume of completed assessments has been maintained.
- Matters have still been able to be referred for resolution.
- Review requests have been processed and acted on.
- Investigations have been progressed and finalised in the usual way.
- Prosecution decisions have not been disrupted.

There have, of course, been operational impacts and adjustments to business processes have been required, as summarised in Table 1 below.

At this point, the aspect which seems likely to have the most significant ongoing operational impact is the suspension of face to face hearings with the NSW Civil and Administrative Tribunal. These hearings are typically required for the more complex and serious matters and such matters will not be heard until after September/October and into 2021. Listing of new matters will, in turn, be delayed.

TABLE 1. IMPACT OF COVID-19 ON COMMISSION'S OPERATIONS

IMPACT	RESPONSE
ASSESSMENT FUNCTIONS	
Inability to receive complaints by hard copy mail	Notification on website to explain other mechanisms to lodge complaints eg. use of *eComplaint*s portal , email. Continued operation of Inquiry Service to assist those without computer access or capability to draft and lodge complaints. Hard copy mail held by Australia Post has been reviewed to identify and expedite any actions that remain to be taken.
Change in the nature of complaints and many complaints out of jurisdiction of Commission	System implemented for consistent management of COVID-related complaints: - Dedicated triaging and registration of these complaints at senior level - Timely upfront referral to other bodies - Manager level sign-off on decisions.

Potential delays in finalisation of assessments due to : • Delays in receiving records and responses from practitioners and providers • Delays in receiving clinical advice for external experts due to priorities of practitioners	Communication with all LHDs and service providers to foster negotiated solutions to providing material without disruption to service delivery. Additional calls to providers to reduce level of reliance on written responses. Clear communication of timeframes to complainants.
Inability to consult face to face with professional councils	Telephone and video conferencing arrangements immediately implemented to retain full consultation opportunities.
RESOLUTION FUNCTIONS	
Inability to conduct face-to-face resolution meetings	Immediately enabled contact via telephone conferencing and then video conferencing for vast majority of cases. A small number of matters have had to be deferred due to highly sensitive nature of matter and consideration of wellbeing of complainant. These matters are now being gradually picked up as social distancing restrictions are eased and as health services become available to participate.
Inability to conduct outreach work and presentations	Telephone and video conferencing is occurring wherever possible. Major face to face training rescheduled. The Web Site rebuild is setting up improved capability for delivery of online training and presentations.
INVESTIGATION FUNCTIONS	
Delays in receiving reports from experts engaged to review and comment on clinical care and treatment and/or conduct	Direct communication with experts re understanding the challenges and pressures arising from Covid19-related priorities. Clear communication with parties to complaints where a delay is occurring.
PROSECUTION FUNCTIONS	
Inability to conduct face-to-face hearings at the NSW Civil and Administrative Tribunal	The Tribunal is continuing to proceed wherever possible with hearings on the papers; directions hearings via teleconference; and less complex hearings with witnesses via videoconferencing. The Commission has responded with flexibility and adaptability to these changes, in order to continue to progress matters and avoid unnecessary delays. Matters requiring in-person hearings are currently anticipated to be listed between September and December 2020.

MANAGE THE INCREASE IN COMPLAINTS – QUESTION 4

<u>Question 4.</u> The Commission has highlighted a number factors that contribute to the growth in complaints. Is it possible to quantify the extent to which each of these factors contributes to that growth by, for example, attempting to categorise new cases to one or more of these areas? This may enable a better allocation of future resources, or allow actions that could reduce demand growth through prevention or alternative means of dealing with some issues.

The factors that have been identified from research and complaints data as drivers of complaint numbers include:

- population growth
- an aging population, whose members are more likely to have more interactions with the health system
- growing demand for healthcare services
- advances in medical research and technology combine to offer more new and experimental health services and treatments
- greater consumer expectations of the health system and access to medical information through the internet and social media
- greater awareness of complaint management pathways and bodies
- expanding types of health services and alternative therapies, and
- mandatory reporting requirements.

Proportional quantification of the contribution of each factor to a defined proportion of complaints is not possible. This is because the different drivers for increased complaints are interrelated and a single complaint can be attributable to combination of these factors.

To use the example of people electing to use new or experimental health services. In that scenario, there are at least two factors that may drive any consequent complaint – ie the availability of the new type of treatment or service and awareness that they are able to make a complaint if there is a problem. There may also be more factors involved, considering that a reason why the experimental treatment may be that the health consumer has complex co-morbidities that are increasingly associated with an aging population.

The Commission does have strategies that aim to prevent formal complaints. These include:

- Continuing our Inquiry Service which assists and coaches people on methods for raising and resolving concerns directly with health service providers so that a formal complaint is avoided.
- Providing corrective comments to service providers when assessing complaints to help avoid repeat complaints on these issues.
- Our outreach program:
    - Trains private and public facilities in managing complaints at the point of service delivery
    - Educates the community on what they should expect of a service provider and how to raise issues with them in a constructive and effective way
    - Educates practitioners and students on the importance of high quality, patient centric communication.
- Collaboration with professional associations to build awareness and profession based accountability for communicating and maintaining professional standards and responsibilities, in a shared effort to avoid complaints.
- Focusing public statements and public warnings on newly evolving, high risk areas such as cosmetic surgery and extreme body modifications, as well as a continued focus on ongoing risks such as anti-vaccination messaging and conduct.

CATEGORIES OF COMPLAINTS – QUESTIONS 5-9

<u>Question 5.</u> Among medical practitioners the most common category by specialty is general medicine. Does this refer to General Practice? Or are other areas of medicine included? If so, what are the figures for these categories?

General medicine does include "General Practice" and is defined as:

- a service provided by a specialist physician in a medical centre rather than private rooms, or
- services provided within the inpatient hospital setting by general physicians, who are specialists with expertise in the diagnosis and management of complex, chronic and multisystem disorders in adult patients.

In 2018-19, of the 2,119 complaints relating to general medicine:

- 50.2% took place within medical centres
- 31.3% took place within hospitals
- 5.2% took place within correction and detention facilities
- 12.8% took place in other settings.

<u>Question 6.</u> Is it possible to get figures on the number of complaints in a profession as a ratio to the numbers of practitioners practicing?

Yes.

Figures on the number of complaints in a profession as a ratio to the numbers of practitioners practicing are available for registered health professions (excluding students) for 2018-19, as set out in the table below.

TABLE 2. COMPLAINTS ABOUT REGISTERED HEALTH PRACTITIONERS AS A PROPORTION OF THOSE REGISTERED IN NSW, 2018-19

Registered health practitioner	No. of complaints	Number of NSW registered practitioners*	% of practitioners subject to a complaint
Medical practitioner	2,377	36,194	6.6%
Nurse/midwife	791	113,067	0.7%
Dental practitioner	417	7,100	5.9%
Psychologist	277	12,318	2.2%
Pharmacist	272	9,637	2.8%
Paramedic	88	4,417	2.0%
Physiotherapist	59	9,739	0.6%
Chiropractor	57	1,840	3.1%
Chinese medicine practitioner	57	2,003	2.8%
Podiatrist	47	1,506	3.1%
Occupational therapist	38	6,245	0.6%
Optometrist	27	1,933	1.4%
Medical radiation practitioner	20	5,489	0.4%
Osteopath	12	586	2.0%
Aboriginal and Torres Strait Islander practitioner	1	133	0.8%

*Registration figures are based on the number of practitioners registered with NSW as their primary place of practice as at 30 June 2019.

<u>Question 7.</u> What are the factors behind the significant increase in complaints about psychiatric hospitals/units in 2018/19 (p24)?

The Commission has not undertaken specific research on this topic, but factors that may be associated with the increase in complaints about psychiatric hospitals/units could be:

- Advocacy and client support work (by agencies such as the Mental Health Commission NSW, the Official Visitors Program and community based organisations) is appropriately providing additional assistance and support to mental health patients and their families to have a voice and to raise issues and concerns when they arise.
- The growth in mental health related Emergency Department presentations and consequent transfers to these units.
- The 2017 "*Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities"*, was produced by the NSW Chief Psychiatrist. The review arose from concerns that systemic practices in this area were having traumatic and damaging outcomes for mental health patients. Some highly publicised incidents led to greater awareness and public commentary on this issue. In addition, other patient experiences were also heard throughout the inquiry, via consultation workshops and submissions, which also gave health consumers greater awareness and insight, including their ability to complain to the Commission where they had concerns about the quality of their care.

<u>Question 8.</u> Does the Commission have any view on the differences in issues raised between metropolitan and regional complainants? (2018/19 report p 26)

Annual report data on metropolitan and non-metropolitan complaints identifies some differences in the issues raised. The small volume of complaints received relative to the total volume of services delivered regionally does not provide a broad enough basis on which to determine with confidence the factors driving these differences. The Commission's observations on these differences are therefore somewhat speculative, but we also draw on the findings and observations made by other authoritative sources.

- The data indicate that complainants located in non-metropolitan areas were more likely to complain about issues relating to treatment (including inadequate treatment or care, diagnosis, inappropriate or delayed treatment and unexpected outcomes) than complainants in metropolitan areas. Issues relating to workforce capacity and capability are central here, and measures such as the actions under the NSW Health Professional Workforce Plan 2012-2022 and the work of the National Rural Health Commissioner in promoting quality in rural health directly relate to addressing these issues.

  There is also an observation made in the section 122 inquiry into Chemotherapy patients treated in the Western NSW Local Health District about the need to consider action to strengthen quality and continuity of care where treatment is primarily provided by Visiting Medical Officers, in terms of: clinical record keeping; clinical care in the absence of the treating practitioner; clinical governance quality improvement and service planning.

- Complainants in metropolitan areas were more likely to complain about professional conduct issues than non-metropolitan complainants. While it is possible that patients in regional areas are less comfortable to complain if there are not readily accessible alternative services, another factor may be that generalist and allied health providers in rural and regional areas may have a smaller, more regular client group with whom they develop a rapport and/or have the potential for incidental social visibility or contact which could potentially guard against more reckless conduct.

- In 2018-19 non-metropolitan complainants were more likely to raise issues related to communication/information than metropolitan complainants (13.3% compared to 9.4%). This may again relate to workforce capacity or capability and perhaps to the question of the availability of consumer support services.

<u>Question 9.</u> There has been a marked increase in 2018/19 in complaints about counsellors/therapists - does the Commission have a view on what might have led to this?

These providers are a segment of the growing numbers and types of unregistered practitioners about whom complaints are made.

The Commission has been actively promoting awareness of the *Code of Conduct for Unregistered Practitioners* amongst health consumers over recent years, including through highlighting its actions and powers for this class of providers in the Annual Report. It is also noted that there is a gradual expansion of the regulation of unregistered practitioners nationwide. As a result there is a growing understanding of the ability to make complaints about these types of practitioners under the health regulation system.

In relation to the specific counsellor/therapist group within the unregistered practitioner cohort, the proliferation and advertising of informal counselling and therapy modes - such as life coaching, energy rebalancing, shamanic rituals, dream therapy, and various forms of spiritual guidance – appears to be a driver for the growth in the number of complaints.

Further, as with all unregistered practitioner groups, this category of providers does not come within a formal oversight system. There are no set qualification requirements, accreditation requirements, documented standards of practice, or accountability frameworks. The fact that approximately 50% of these complaints feature misconduct elements such as misrepresentation of qualifications, boundary violations, and poor management of private information may be a consequence of this. Inadequacies in treatment and care are also noted.

TABLE 3. COMPLAINTS RECEIVED ABOUT COUNSELLORS/THERAPISTS BY ISSUE, 2018-19

Issue	No.
Professional conduct	
Misrepresentation of qualifications	7
Boundary violation	6
Inappropriate disclosure of information	2
Advertising	1
Breach of condition	1
Sexual misconduct	1
Subtotal	**18**
Treatment	
Inadequate care	7
Inadequate treatment	4
Diagnosis	1
Inadequate/inappropriate consultation	1
Subtotal	**13**
Communication/information	
Attitude/manner	7
Subtotal	**7**
Medical records	
Record keeping	1
Subtotal	**1**
Grand Total	**39**

ASSESSMENT AND RESOLUTION OF COMPLAINTS: QUESTIONS 10-12

<u>Question 10.</u> How many complaints are directed to the HCCC annually that are considered a high priority e.g. are the result of a serious injury or death?

How are such complaints dealt with currently and specifically what measures have been put in place as a result of the recommendations of the 2012 inquiry to ensure that such complaints of a serious nature are dealt with as a matter of priority?

Background to the question

In 2012, the Committee on the HCCC conducted an inquiry into the handling of health care complaints and one of the concerns was in relation to the management of complaints of a serious nature i.e. where the actions of a health care professional resulted in serious injury or tragically death.

The Government Response to the 2012 Inquiry Report was presented in February 2014. It confirmed that the Commission had detailed procedure manuals that guide staff through the correct process for managing complaints. Following the recommendations of the Joint Standing Committee, the Commission had amended its procedure manuals to provide for increased engagement and communication with affected parties in extraordinary circumstances and for more serious matters to be expedited if necessary.

As a result of further refinements to these processes over more recent years, all complaints are triaged and assessed using a structured risk based framework. This framework examines the seriousness of a matter from the outset. This includes matters where there has been a serious injury or death that is attributable to the substandard care, but also extends to matters where serious harm has not yet occurred but there is a real risk to public health and safety. This framework considers four risk domains and examples of the elements considered in each domain are as below:

- **Factors relating to the practitioner** – Any current conditions on practice; a history of complaints; Any concurrent investigation disciplinary/performance actions within the Commission, the relevant professional council, AHPRA or by an employer? Years in practice, age and health status; admissions; place of training; indications of insight and/or remorse; action taken to address agreed deficiencies; future work intentions, etc.
- **Factors relating to the complaint** – Nature of alleged departures or conduct; number of events and outcomes; parallel inquiry, regulatory or enforcement action on the matter (eg by Police, Coroner, other Commissioners, Ministry of Health, Pharmaceutical Regulatory Unit, Therapeutic Goods Administration, Medicare); elements of willfulness, intent, criminality; sufficiency of evidence (including strength of clinical opinion); disciplinary outcomes for matters of similar kind, etc.
- **Factors relating to the providers practice situation and status** – Area of practice; location of practice; practitioner currently subject to supervision/mentoring /performance oversight and monitoring by the professional council ?; sole practitioner v delivering services in group practice; working under supervision and/or with appropriate incident response measures in place? Working across jurisdictions?
- **Factors relating to the Complainant** – e.g clinical condition; vulnerability; capacity; harm suffered.

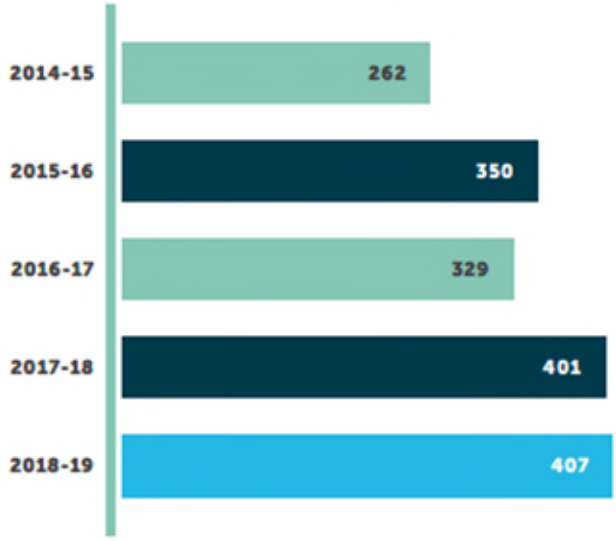
If the complaint is identified as potentially serious at the point of triaging it is entered onto the Sensitive Complaints Process. The cornerstone of this is a Sensitive Complaints Log, under the oversight of the Executive Director, Complaints Operations, which is updated every week to: add new sensitive complaints; enable the progress of the complaint to be monitored at Executive level; and, that there is appropriate oversight of all correspondence and communication relating to the matter. For every matter on the Sensitive Complaints Log, the case management system has an alert about the provider in the event that other matters relating to that provider are received in the meantime;

Complaints assessed as serious through the triaging and assessment process are referred for full formal investigation under Divisions 5,6, 6A, and 7 of the *Health Care Complaints Act*. This will apply if the complaint:

- raises a significant issue of public health or safety, or
- raises a significant question as to the appropriate care or treatment of a client by a health service provider, or
- if substantiated, would provide grounds for disciplinary action against a health practitioner, or
- if substantiated, would involve gross negligence on the part of a health practitioner, or
- if substantiated, would result in the health practitioner being found guilty of an offence under Division 1 or 3 of Part 7 of the *Public Health Act 2010*.

The number of serious complaints referred for investigation over the past 5 years is presented in Chart 2 below.

CHART 2. COMPLAINTS RECEIVED FOR INVESTIGATION, 2014-15 TO 2018-19



As stipulated in the Investigations Procedures Manual, investigations where the outcome for a patient has resulted in death, significant trauma and or life changing conditions, are prioritised. The Executive Director will identify such investigations when allocating the file to the relevant Manager and it will be flagged as a 'Category A' investigation in the Commission's case management system. Senior staff meet with the relevant parties in such complaints and discuss the investigation process, manage expectations and agree a regime of communication throughout the investigation. The relevant parties are expected to be provided with regular updates concerning the progress of the investigation and telephone or email updates are acceptable. Monthly contact with complainants is an absolute minimum requirement.

Within the investigation process, a change in practice over the past five years is that the Commission no longer awaits coronial reports where these have been delayed. This does not mean that the available coronial material is not gathered and considered, but rather than the investigation is not put on hold indefinitely when coronial processes occur over many years.

Weekly investigation clinics are also held. These are a forum for individual investigation officers to present complex and high priority matters for guidance and confirmation on investigation directions and outcomes.

Question 11. ***In relation to the review of assessments the Annual Report 2018-19, with specific reference to the 90% target for the completion of same refers to more staff and process improvements have been put in place to improve this area. What process improvements have been implemented and how confident is the Commissioner this will achieve the 90% target?***

<u>Question 12.</u> Reviewing assessments – well short of target of 90% completed within six weeks (35.3%). Additional officer added – is this sufficient? Is this a realistic target?

Structure and process changes for the review function have been implemented. They have delivered improved performance, but it is acknowledged that the 90 % target requires reconsideration.

In 2018, the Commission changed the operational model for conducting reviews. It initially established a designated Review Officer role to accommodate the increase in review numbers that was a logical consequence of the year on year increases in complaint numbers and complexity. Prior to this, reviews were one function undertaken by Resolution Officers. Once the benefits of the designated review officer role were realised, an additional Review Officer was added to improve timeliness.

At the same time as this structural change, system and process improvements were made, as follows:

- A formalised and structured triaging system to set the direction and timeframe for each review immediately upon receipt of the review request
- Case management oversight by the Director of Resolution and Customer Engagement
- Executive level monthly performance reporting forum has been established to oversee performance of the review function and consider any individual reviews that are sensitive or overdue.

These changes have improved performance, as the number of reviews completed each month is increasingly closer to the number received. In the last six reporting months (November 2019 to April 2020) 274 reviews were received and 256 completed – a completion rate of 93.4%. However, time taken remains a concern.

The Executive level performance reporting forum has noted the following concerns about the performance target for reviews:

(i) Prior to 2015-16 the performance target was 90 percent completion within six weeks. This performance target was not able to be met year on year.
(ii) In 2015-16 the performance target was reset, to 90 per cent completion within four weeks. It is not clear on what basis it was reset. While performance against this stricter target has been significantly improving over the last three years, each year the target has not been met.
(iii) Neither a four or six week target appears realistic, noting the nature and expectation of a review.

In considering what target may be appropriate and realistic, the Executive has noted a number of factors:

- A review process needs to be undertaken by a person with no prior knowledge or involvement in the matter.
- A review requires thorough reconsideration of all material and evidence obtained when assessing the original complaint. It also offers the opportunity for a deeper consideration of complex clinical issues where required.
- This may necessitate:
    - A complainant to submit additional records or information they feel should have been considered as part of the complaint but were not provided to the Commission for the original assessment.
    - Consideration of new information that was not available at the time of the assessment.
    - Identification and correction of any errors in interpreting the information during the assessment.
    - Potential need for further clinical expert opinion to determine a matter if uncertainty or a difference of perspective remains.
    - For registered practitioners, a repeat of all consultation with the relevant professional council required under the *Health Care Complaints Act* if the review identifies a need to change the original decision .

The emerging picture is the need to recognise that reviews are at least as complex and time consuming as the original assessment, and often more so. Therefore the target of 60 days that applies to the completion of an assessment should arguably also be the timeframe that applies to a review.

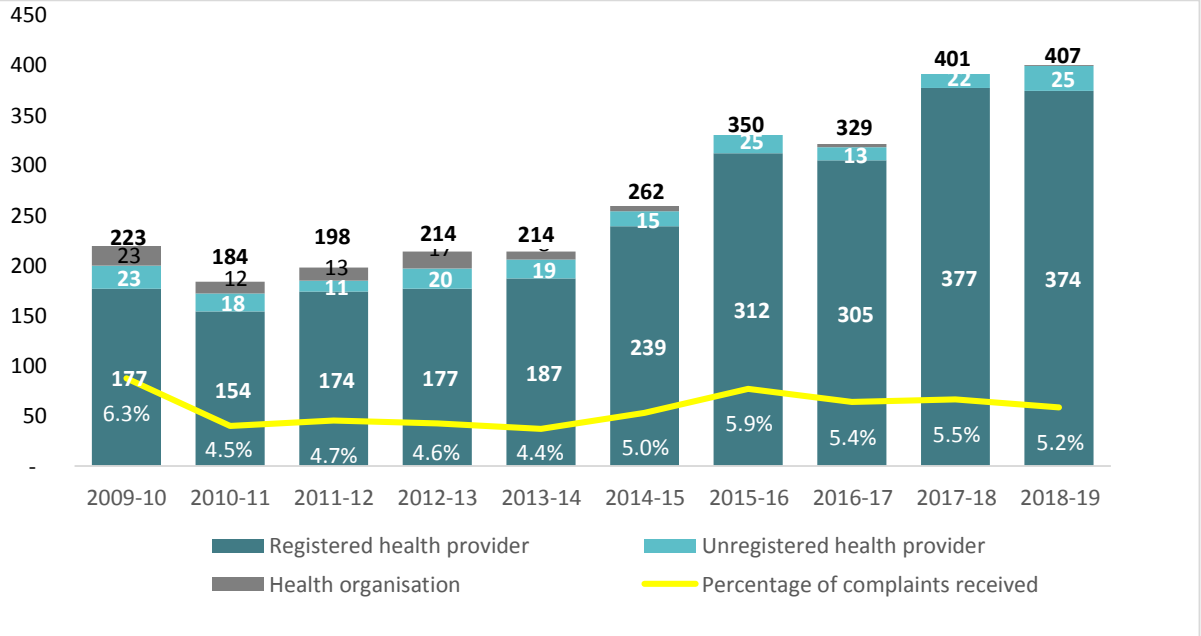
Further consideration is therefore being given to resetting this key performance indicator as part of the Commission's current strategic planning process.

TIMELINESS OF INVESTIGATIONS: QUESTION 13

Question 13. What is the Commission doing to improve the timeliness of its investigations? (pp13, 66, 67, 2018-19 report)

In 2017-18 the Commission carried out a review of the investigation function which identified a number of areas where adjustments were necessary to restore the timeliness of investigations, in the climate of growing complaints and the consistent proportion of around 5% of those complaints being referred for investigation (as reflected in Chart 3 below) .

CHART 3. INVESTIGATIONS RECEIVED 2009-10 TO 2018-19, BY PROVIDER TYPE



The review indicated that investigation processes has tended to be 'one size fits all', with insufficient differentiation of investigation planning and method based on the nature and seriousness of the risks presented. There was a clear need for changes in process to foster increased transparency, consistency and proportionality in all investigation decision making, and for more structured risk analysis to be embedded in these changes. The review further identified a number of areas where process improvements were likely to have a significant positive impact on the performance, timeliness and efficiency of the function.

As a result, the risk-based approach to managing investigations was further developed and implemented. This included the following actions:

- A new investigations structure, providing stronger leadership and greater oversight of investigations.
- Additional investigation officers, with more diverse investigation capability and experience.
- A focus on finalising the most complex and longstanding investigations.
- A stronger emphasis on upfront scoping and planning of all investigations.
- Additional case review practices throughout the lifecycle of each investigation.

This approach has substantially improved the Commission's performance. In 2018-19 a total of 359 investigations were finalised, compared to 282 in 2017-18. There was a lag in improved timeliness as many of these finalised matters were longstanding. Timeliness is now improving as older complaints have been cleared.

In the first three quarters of 2019-20 (July 2019 - March 2020) 360 investigations were completed (an increase of 78.2% on the corresponding period in 2018-19). Importantly, the average days taken to complete an investigation has decreased to 315 days (down from an average of 335 days in 2018-19).

UNREGISTERED HEALTH PRACTITIONERS: QUESTIONS 14- 16

Question 14. ***What is the Commission doing to better target and engage with unregistered practitioners, particularly through member-based organisations, and what is the response from the organisations? (p37, 2018-19 report)***

The Commission established a dedicated stakeholder engagement position in October 2018. An immediate project for this position was to take actions to promote awareness of the responsibilities and obligations under the *Code of Conduct for Unregistered Practitioners* and increase compliance with it. This includes a focus on working with member-based organisations to promote awareness and understanding of *the Code*.

In the planning phase of this work, the Commission analysed the patterns of complaints about unregistered practitioners over the last five years. This identified 25 health occupations that have been the subject of complaints over this time, and enabled us to identify related membership organisations and professional associations that should be the focus of this work.

The next step was to establish a program of presentations and workshops for these organisations and membership bodies. Workshops were delivered to audiologists, sonographers, natural therapists, orthoptists, counsellors, psychotherapists, nursing assistants, herbalists and genetic counsellors. These workshops were evaluated and in the evaluations 100% of attendees found it helpful, with a 94% satisfaction rate across all feedback questions.

Further initiatives have included distribution of explanatory materials via newsletters and other information pathways used by professional associations to communicate with their members. The content has covered expectations of unregistered practitioners as well as the role and processes of the Commission in receiving and assessing complaints about them. Noting also that these associations may receive complaints about their members, the Commission has discussed the types of issues that are raised with them and the options for referral of such matters to the Commission.

A related activity is working with TAFE, the Laureate Group, Macquarie University, UTS, and the Australian Institute of Health Care Education to develop and deliver training content for students studying in relevant health service fields.

Question 15. ***What factors contributed to the increase in the number of complaints about unregistered health practitioners in 2018-19 and are complaints about them under-reported? (pp18, 33, 2018-19 report)***

Factors contributing to the increase in complaints about unregistered health practitioners include:

- An increase in the number and types of health related services delivered by unregistered practitioners.
- The nature and manner of advertising – particularly on social media.
- Evolving consumer understanding of the nature and extent of the obligations of unregistered providers and the ability of the Commission to regulate these practitioners.

- Increased public media attention on the adverse outcomes from the practices of a number of service providers in areas such as cosmetic treatments, naturopathy, and body modification.

It is possible that concerns about unregistered health practitioners are underreported, but it is difficult to confirm as there is literally no means of establishing how many unregistered providers are practicing and the number of services they provide. For this reason the Commission will continue to place strong emphasis on educating both community and provider organisations to raise awareness of this part of the jurisdiction.

<u>Question 16.</u> Can you provide information about the national working group for the development of a National Code of Conduct for unregistered health practitioners? (p86, 2018-19 report)

In NSW the regulation of unregistered practitioners was introduced much earlier than other jurisdictions and the *NSW Code of Conduct for Unregistered Practitioners* commenced in August 2008.

In June 2013, Health Ministers agreed in principle to strengthen state and territory health complaints mechanisms via:

- a single national Code of Conduct for unregistered health practitioners to be made by regulation in each state and territory, and statutory powers to enforce the National Code
- investigating breaches and issuing prohibition orders
- a nationally accessible web-based register of prohibition orders
- mutual recognition of prohibition orders across all states and territories.

The purpose of the National Code of Conduct, also referred to as the National Code or code-regulation regime, is to protect the public by setting minimum standards of conduct and practice for all unregistered health care workers who provide a health service in Australia. It will set national standards against which disciplinary action can be taken and if necessary, a prohibition order issued, in circumstances where a health care worker's continued practice presents a serious risk to public health and safety.

Each state and territory is responsible for progressing legislative changes to give effect to the National Code or code-regulation regime. As NSW already had a *Code of Conduct for Unregistered Health Practitioners* this Code already met the obligation to be a part of a national approach. Victoria, Queensland and South Australia have since passed legislation giving effect to the National Code.

There is a National Working Group (of which NSW is a member) responsible for co-ordination of some other administrative actions associated with implementation of the national regime. This Group has undertaken the following tasks:

- administrative arrangements and support for jurisdictions implementing the National Code
- developing and maintaining explanatory materials;
- establishing a common framework for data collection and performance reporting; and,
- the administration of a national register of prohibition orders, via a national website which we understand is to be launched in coming months.

REVIEW OF THE COMMISSION'S POWERS – QUESTION 17

<u>Question 17</u>. What can you tell us about the review of the Commission's powers that's being led by the Ministry of Health? (p37, 2018-19 report)

In response to the recommendation of the Joint Parliamentary Committee in its Inquiry into Cosmetic Services, the Ministry of Health has consulted with the Commission and other stakeholders to determine whether any changes were required to the *Health Care Complaints Act 1993*, or other legislation, to enable the Commission to more effectively exercise its functions.

It is understood that a number of amendments will be pursued, noting that timeframes may be delayed due to COVID-19.

COMMUNITY OUTREACH – QUESTION 18-19

<u>Question 18.</u> How is the Commission supporting and responding to the needs of vulnerable groups, such as mental health consumers, and people with disability? (p19, 2018-19 report)

The Commission has three relevant lines of activity.

The first is to foster a strong community wide understanding of our services, to ensure equitable access to them and to provide quality support when interacting with the Commission. We do this by:

- Providing a full time Inquiry Service staffed by people with customer service expertise, to deliver information and complaint support specific to an individual's needs and requirements
- Providing complaint forms and fact sheets in a number of community languages
- Including a section for complainants to identify any disability related support requirements as a standard question on all complaint forms
- Providing interpreters to assist in discussions with the Commission and translating correspondence to complainants into their preferred language as required
- Where possible, linking complainants with bilingual Assessment Officers to allow them to communicate in their preferred language
- Working with complaints staff within the LHDs to monitor Local Resolution complaint outcomes for vulnerable complainants (especially with regards to mental health complaints).
- Developing internal Assessment referral pathways for mental health matters that are likely to benefit from direct management and support from the Commission's skilled Resolution Officers
- Referral of the most complex mental health complaints to the Chief Psychiatrist.

Secondly, we deliver targeted and customised outreach programs for health care providers, community organisations and services providing support to vulnerable groups – recent examples include:

- Engagement with Carers NSW
- Participation in the Mental Health Forum/CALD Consumer Expo
- Presentation for the Health Education and Training Institute - Mental Health Accredited Persons Training
- Active involvement in the Anti-Discrimination Board's JOIN Engagement Meeting to collaborate on new outreach initiatives with other complaint handling bodies including Anti-Discrimination NSW, Legal Aid, Carers NSW, the Energy Ombudsman and the NSW Ombudsman.

Importantly, the Commission also has partnerships with the specialist regulators and advocacy at National and State levels (including with the NDIS Quality and Safeguards Commission, the Aged Care Quality and Safety Commission, the NSW Aging and Disability Commissioner, the Mental Health Commission of NSW, the Office of the Information and Privacy Commissioner) so that there is clarity of roles and responsibilities for consumer and smooth transfer of information between the entities. .

<u>Question 19.</u> Have you identified any emerging communities that are accessing the Commission's services and are there specific reasons for this? (p68, 2017-18 report)

Our services continue to be used by a diverse range of health consumers, their families, carers and advocates. Our complaints do not appear to be showing any specific new emerging communities and we are continuing to ensure that our services are widely accessible and that there are not barriers to any community cohort using them.

COLLABORATION WITH PRIVATE HOSPITALS – QUESTION 20

Question 20. What progress has the Commission made in developing stronger relationships with private hospitals and training them in best practice complaints management? (p19, 2018-19 report)

The Commission's Stakeholder Engagement Strategy has been developed and strengthening connection with the private hospital system is part of that strategy.

We have the training materials to do this, but delivery of the training has been disrupted by COVID19.

In the meantime, we continue to use our day to day complaints handling interactions to drive improved practices. This is achieved by:

- Continuation of Assisted Resolution processes with all facilities.
- Providing comments to hospitals to correct lower level departures identified during assessments.
- Making Comments and Recommendations under Division 7 of the *Health Care Complaints Act 1993* at the end of investigations about private health organisations.

We remain ready to reschedule and deliver the training in coming months once the COVID pressures diminish. Ideally, this would occur alongside possible legislative amendment to enable the Commission to refer matters to private hospitals for local resolution (noting that local resolution is only presently available as an outcome for complaints relating to public health organisations). Joining these actions would give greater visibility and impetus to complaints handling practices within private hospitals and guide the Commission's outreach and training work with them.

EFFECTIVENESS OF PUBLIC WARNINGS – QUESTION 21

Question 21. The Commission has given a public health warning in regard to anti-vaccination campaigners. Has this been effective? Has any action been taken against individuals? Are stronger powers needed in this area? Is this included in the Ministry of Health's review of the powers of the Commission?

It is noted that anti-vaccination campaigning is a significant public health issue and one that is subject to broader Commonwealth and State programs and policies. The Commissions actions are an important and ongoing complement to these broader actions. The purpose of our public warnings is essentially to reinforce the public health messages of the State and Commonwealth Authorities and to provide consumers with advice about how they can address relevant issues and concerns they may have.

The Commission also continues to take corrective action in relation to anti-vaccination activities of individual providers and organisations.

The current Ministry of Health review of the powers of the Commission does include consideration of the ability to issue prohibition orders against specific organisations and to name individual providers in public warnings. Penalties for breaches of orders are also under consideration. Such powers could potentially have some application in relation to this issue.

IMPROVE ONLINE ACCESSIBILITY – QUESTION 22

<u>Question 22.</u> You note that an upgrade of the Commission's website is due by early 2020. What is the status of the upgrade and how will it improve user accessibility and the number of inquiries made online? (pp76, 77, 100, 2018-19 report)

The Commission's upgrade is now completed and the new website is up and running.

A number of key steps have been part of the development of the website to ensure improved user accessibility and navigation including:

- It has been developed to AA Accessibility rating. NSW Government websites are expected to conform to Level AA of the Web Content Accessibility Guidelines 2.0 (WCAG 2.0 AA) as a requirement of the Web Accessibility National Transition Strategy and the Australian Government's Digital Service Standard.
- A combination of stakeholder feedback and Google Analytics has been used to identify high traffic pages. The new website has been developed to ensure easy navigation to this information.
- All content has been reviewed and rewritten to ensure currency.
- Information for health consumers has been reframed to better explain our complaints process and what to expect.
- Focus groups comprised of representatives from organisations that support health consumers, health providers and regulatory partners assisted us to test the new site and ensure it met needs before it was launched.
- It also has the ability to prominently display new information about matters that would otherwise be the subject of written or phone inquiries.

eCOMPLAINTS PORTAL AND COMPLAINTS AUTOMATION – QUESTIONS 23-24

<u>Question 23</u>. What impact has the eComplaints portal had on the way the Commission manages complaints, and what feedback have you got from staff and complainants about it? (pp11, 77, 79, 2018-19 report)

The eComplaints portal has provided substantial efficiencies in complaints handling and has been a fundamental contributor to our improved productivity and timelines in assessing complaints.

At present, around 40% of complaints are received via the eComplaints portal and the feedback from assessments managers and staff is very positive in the following ways:

- Significantly reduced time to commence a complaint assessment. Prior to eComplaints complaints could take up to two weeks to set up and allocate to an assessor, due to the manual data entry, the reliance on clerical administrative support, paper file set up and transfer of physical files. Complaints are now able to be set up and allocated within a day or two.
- This quicker allocation enables the Assessment Officer to:
  - Understand the issues raised in the complaint at an earlier point.
  - Make contact with the complainant and share information about steps being taken to assess their complaint, and likely timeframes. This helps establish a rapport and to understand expectations.
  - Identify early strategies and actions to progress the complaint, particularly if it seems likely that one of the resolution pathways is a likely outcome, in which case rapid referral to that pathway is necessary and beneficial to the parties.
- It has provided more time to undertake the assessment actions with much improved ability to complete the assessment within 60 days.
- eComplaints and associated measures to move to paperless assessments, has contributed to the ability to successfully transition to working from home.

In terms of complainant feedback, most feedback tends to focus on aspects on the management or outcome of a person's complaint rather than the eComplaints tool. Some feedback has mentioned the following:

- greater accessibility
- ease of adding additional supporting material and documents
- receiving automatic acknowledgement
- improved timeliness.

<u>Question 24.</u> Your 2018-19 report refers to a planned acceleration of technology solutions, such as, automating complaint assessment, artificial intelligence tools to triage and analyse complaints, and paperless complaint handling. (p5) Can you update us on progress with this?

In September 2019, the Commission appointed a new Director, Technology & Systems Transformation, reporting directly to the Commissioner. The Director commenced with a full stock take and health check of our technology systems and capability and setting a roadmap for the transformation.

As would be expected, COVID pressures have diverted resources and effort away from the more forward looking and strategic aspect of this roadmap to focus on immediate business continuity.

Impact of COVID-19

To ensure that the Commission remained operational as the COVID-19 pandemic unfolded, it was necessary to improvise a tactical program of technology enablement, focused entirely on rapidly enabling individuals and teams to be able to work remotely.

Key achievements included:

- Accelerating replacement of outdated desk-based computers with laptops for all staff, and providing home computer setups to ensure safe and productive staff working from home arrangements.
- Augmenting home computer set ups for staff whose roles involved high volume complex document management and exchange.
- Roll out of software to link each officer to the Commission based telephony service to enable them to undertake phone based Commission work without risk or personal cost.
- Rapidly deploying Microsoft Teams to enable internal and external collaboration via video, audio, and chat-based conferencing
- Deploying a new IT service desk capability making it easier for staff to request support, and to ensure effective direct support for users who are working remotely.
- Design and procurement of video conferencing meeting rooms to enable group based video conferencing as COVID restrictions ease.

Actions to strengthen systems

Actions to stablise, improve functionality and confirm the security of core systems have been completed as follows:

- Substantial upgrades to existing Case Management and Electronic Document and Records Management systems
- Additional external expertise procured to maintain IT programs and infrastructure and respond more immediately to any systems issues
- Achieving attestation against the Australian Cyber Security Centre's 'Essential Eight Maturity Model' (August 2019) and achieving ISO27001 recertification of the Commission's Information Security Management System.
- Collaboration with all business areas to identify and scope areas for process improvements and opportunities to respond to user needs and to prioritise the technology enhancements that are required to deliver the improvement.

The next steps
The Commission now has a Technology Vision, Strategy & Roadmap arising from the early work of the Director, to guide our transformation progress over the next 2-3 years. We are currently revising our roadmap to take into account the impact of COVID 19, our new ways-of-working, changed technology landscape, and likely budgetary environment for 2021. The revised roadmap will be finalised by end of June 2020.

The next steps in the transformation will include:

- Reviewing and augmenting IT capabilities and skills.
- Selecting and implementing case management tools that help drive performance and quality in assessment functions.
- Considering new software solutions to improve the efficiency and effectiveness of investigation and prosecution functions.
- Implementing tools that support joint online and virtual consultation and decision making with professional councils.
- Exploring and utilising cloud-based solutions.
- Strengthening tools, capabilities and products in relation to performance data quality, analysis and reporting.

ABORIGINAL HEALTH SERVICES – QUESTION 25

Question 25. Complaints about Aboriginal Health Services decreased from 10 in 2015-16 to 2 in 2018-19 (p147). What do you attribute this to?

It may be useful to clarify in the first instance that an "Aboriginal Health Service" in this reporting context refers to a community health facility specifically offering health services to Aboriginal persons. It does not relate to service delivery by or to Aboriginal people generally.

The small number of complaints about Aboriginal Health Services makes it difficult to draw firm conclusions about year-on-year movement in complaint trends.

It is also noted that complaints about Community Health Services rose from 74 in 2017-18 to 94 in 2018-19. As many Community Health Services also offer Aboriginal health clinics and targeted services within their service model, it is possible that some complaints regarding Aboriginal health service provision are included in that broader organisation category.

ROLE OF THE STAKEHOLDER ENGAGEMENT AND COMMUNICATIONS OFFICER – QUESTION 26

Question 26. What is the role and function of the new Stakeholder Engagement and Communication Officer? (p76, 2018-19 report)

Primary purpose of the role
To plan and implement actions that communicate and promote the objectives, functions and achievements of the Health Care Complaints Commission to key stakeholders.

To undertake, initiate or participate in projects that embed a customer focus in all of the functions of the Commission, and that strengthen pathways for input and feedback from our customers.

To establish partnerships that assist the Commission to influence the standards for health service delivery in NSW.

Key functions

- Development and drive implementation of the Commission-wide Stakeholder Engagement Strategy
- Create, review and produce Commission publications which foster clear and consistent communication about what we do, how we do it and what we achieve.
- Establish and maintain an accessible and highly functional website in collaboration with the IT team, including regular review and update of content.
- Establish outreach pathways and programs that ensure that information about the Commission and training on complaints handling techniques is available to the community, community support organisations, and health service providers.
- Represent the Commission to external stakeholders and train and support staff in representing the Commission externally.
- Foster partnerships with professional membership bodies, academic institutions, and professional councils and advocacy bodies which increase awareness of the nature of professional obligations and standards for registered and unregistered health service providers.
- Analyse and communicate customer feedback to the Executive and the Commission as a whole.
- Work with operational teams to take and maintain actions that improve the customer experience of complaints handling.
- Liaise with other health care complaints entities to improve information and communication on all aspects of the national and state based complaints processes.

COLLABORATION WITH NATIONAL AND STATE AGENCIES – QUESTION 27-28

<u>Question 27.</u> How is the Commission developing relationships with agencies such as the NDIS Safety and Quality Commission, the Aged Care Quality and Safety Commission and the NSW Ageing and Disability Commissioner?

The Commission's strategic directions and priorities include establishing and maintaining strong operational linkages with other health and health related regulators at Commonwealth and state levels. This is to ensure coordination of effort and appropriate and timely information sharing where there are potentially overlapping or complementary responsibilities and to foster consistent approaches to complaints handling.

The Commissioner meets with the Aged Care Quality and Safety Commissioner and the NDIS Quality and Safeguards Commissioner on a regular basis, including as part of the structured biannual meetings of the National Health Complaints Commissioners. These meetings are an opportunity to discuss strategic shared priorities and interests; organisational performance; and, current issues that may require a coordinated approach and response.

At an operational level collaboration arrangements are typically set out in formal Memoranda of Understanding or Information Sharing Agreements with key federal and state agencies, including:

- NSW Police
- Coroner's Court
- Aged Care Quality and Safety Commission
- Australian Sports Anti-Doping Authority
- Joint agreement with NSW Ombudsman Office, Legal Services Commission, Information and Privacy Commission and Anti-Discrimination Board of NSW.

Other day to day operational protocols are in operation with other newer bodies such as the NSW Ageing and Disability Commissioner and the NDIS Quality and Safeguards Commission, and over time these will be converted into formal memoranda.

<u>Question 28.</u> Can you provide more information about the work of the Consumer Health Regulators Group? (p86, 2018-19 report)

In April 2017, the Consumer Health Regulators Group (the Group) was established to facilitate even greater collaboration at a national amongst those with responsibilities and interest in consumer health regulation. The Group consists of the Australian Competition and Consumer Commission (ACCC), the Australian Health Practitioner Regulation Agency (AHPRA), the Private Health Insurance Ombudsman, the Therapeutic Goods Administration (TGA), Victoria's Health Complaints Commission and the NSW HCCC. Group members meet quarterly (or otherwise as needed) and exchange information, identify emerging issues of common interest or concern, and ensure the responsibilities and functions of each regulator are understood, co-ordinated, consistently applied and appropriately targeted.

While the operational deliberations of the Group are not able to be disclosed, and the meeting schedule has been disrupted by COVID priorities across the member organisations, some topics covered include:

- Collaborative work around cosmetic and beauty clinics
- Advertising codes and reforms.
- Web-based medical services.

PERFORMANCE OF INQUIRY SERVICE – QUESTIONS 29-31

<u>Question 29</u>. Can you update us on the Commission's review of its Inquiry Service and how its performance will be measured to ensure it meets the needs of consumers? (pp78, 79, 2018-19 report)

The Commission's review of the Inquiry Service has resulted in its redesign. The Service is now under the direction and oversight of a designated full time Inquiry Coordinator and staffed by two permanent client service officers, who are trained in providing information, advice and alternative resolution support to callers. Prior to this, the management of inquiries was part of the broader duties of Resolution Officers who delivered the service via rostered shifts.

Establishment of the designated client services officers aims to deliver a high quality first contact experience for those who are seeking general information on where to get help or how to go about making a complaint. It also provides direct assistance and support to prepare a complaint for those unable to do so themselves.

The scope of the work to be conducted has also changed. This is a result of the review findings that inquiries from inmates within the NSW correctional system were a dominant proportion of all inquiries and that these inmate inquiries were primarily matters that can and should have been handled within the Justice Health Service. The service redesign included a move to general day to day health inquiries from inmates being managed directly by health clinics within correctional facilities, whilst still enabling inmates to access to the formal HCCC complaints management processes for more serious and/or complex concerns.

The Commission has established new performance measures to ensure that the provision of the Inquiry Service continues to meet public needs and expectations. It will measure the action taken on inquiries in the following categories:

- *Information provided,* which covers those matters where the caller received advice and information tailored to their specific needs, questions and concerns. This may include an explanation of the Commission, role, functions and complaints processes, but it will often be much broader covering information about the health system in general, specific health services that are of concern for the caller, or rights and responsibilities as a healthcare consumer.
- *Complaint support provided* which may include:

    - Discussing strategies for resolution with the caller, to enable them to address their concerns with their healthcare provider directly which may avoid the need for a formal complaint;
    - The Inquiry Officer making direct contact with a provider to resolve straightforward concerns directly on behalf of the caller; and
    - Contacting frontline complaints management staff within public health organisations and directly referring the caller so that prompt action may be taken.
- *Referral to another body* applies when the issues raised are within the jurisdiction of another body – such as Fair Trading, the Information and Privacy Commission, the NDIS Quality and Safeguards Commission or Medicare – and that body is more appropriate to assist the caller with their concerns. In such cases, the Inquiry Officer will explain the role of the relevant organisation or government body and why it may be able to assist and provide the caller with the appropriate contact details.
- *Complaint form sent*, for a caller who ultimately wishes to know how to make a complaint, even if other information or support was provided in the lead up to that
- *Complaint drafted* is for vulnerable, disabled or other complainants who may have difficulty providing a written complaint and the Inquiry Officer will offer assistance and support in drafting a complaint for them.
- *No further action possible* which are generally written or online inquiries where no contact information is provided, and so the Inquiry Officer is not able to make contact to assist with resolution of the query.

Each inquiry is assigned a primary outcome category and monitoring the proportion of inquiries within each category allows oversight of service activity and performance over time.

The Commission's relaunched Website also provides a direct avenue for feedback on and aspects of the Commission's work, including the Inquiry Service.

***Question 30.* In the 2018-19 report, it's noted that the needs of consumers contacting the Inquiry Service are 'evolving'. In what ways are they evolving? (p78)**

As the healthcare system and its services change and broaden, so too do the needs of callers to the Inquiry Service. For instance, it is becoming increasingly common for individuals to see a number of different practitioners and access a variety of services to meet their healthcare needs. This has resulted in consumers requiring advice and support on navigating the healthcare system; seeking information on their rights and responsibilities; and advice on whether their interactions with a broader range of health providers compared to the past have been appropriate.

Many providers are also increasingly offering information on services and procedures through their own practices/clinics and their websites. This may prompt consumers to contact the Commission for clarification and advice about this information. This is particularly relevant in regard to unregistered health practitioners for whom consumers may be uncertain as to whether any oversight or professional membership bodies exist and where they can direct questions or concerns.

Consistent with this, and coupled with the rapid expansion and use of social media platforms, the Inquiry Service also takes many questions about advertising, including whether particular providers are allowed to offer specific treatments, procedures and services. There has also been an increase over time in consumers seeking advice and clarification about healthcare issues, services or advice they have seen advertised or mentioned on social media.

<u>Question 31.</u> There has been a considerable decrease in inquiries in 2018-19. It appears that all of this and more can be attributed to a decrease in corrections inmates inquiries: 30% of 11398 (approx. 3400) as compared to 10% of 10112 (approx. 1000 cases), which seems to be a decrease of 2500 approximately. Is this the case? If so, what was the contribution of the other factors mentioned as being linked to the decreased number of inquiries.

The Commission observed a decrease of approximately 750 inquiries from inmates between 2016-17 and 2017-18 with a further decrease of approximately 1,400 inmate inquiries in 2018-19. This accounts for the majority of the decrease in Inquiry Service activity over this period.

The launch of the Commission's eComplaints portal in July 2018 also seems to have impacted on the 2018-19 inquiry numbers, noting that the portal embeds key pieces of information and guidance on issues that have historically been raised by callers to the Inquiry Service, including:

- The Commission's role and jurisdiction as a complaints handling body
- How and when to make a complaint
- Circumstances in which the Commission does not have the power to direct a service provider to take action
- Advice on when and how to raise concerns directly with a health care provider.

FOLLOW-UP AUDITS OF HEALTH ORGANISATIONS – QUESTION 32

<u>Question 32</u>. Is there any information available on the follow-up audits of health organisations, in particular in regard to compliance with recommendations?

One outcome of an investigation into a health organisation may be that formal recommendations are made to it. These recommendations formally set out expected remediation of the systemic issues identified and the specific actions required to achieve this. The Commission also requires the organisation to report on its progress in implementing these substantive recommendations, typically specifying the frequency of reporting (eg. every six months) as well as reporting the completion of implementation. An organisation is obliged to provide documentary evidence that it has successfully implemented all of the Commission's recommendations to an appropriate standard.

Such investigation recommendations are notified to the Health Secretary and the Commission may request advice from the Health Secretary on action taken on the recommendations. The recommendations may also be notified to the 'pillars' of the NSW Health system, such as the Clinical Excellence Commission, Agency for Clinical Innovation and Higher Education and Training Institute for their information and appropriate action.

Where these follow up and reporting processes confirm that the necessary action has been taken, an audit is not required.

Each year the Commission's Annual Report reports on the implementation of recommendations. In 2017-18 the Commission made eight recommendations following four investigations, and in 2018-19 all of these recommendations were implemented by the relevant health organisations.

RE-REGISTRATION OF SUSPENDED HEALTH PRACTITIONERS – QUESTION 33

<u>Question 33.</u> Can you outline the process for practitioners applying for re-registration after a period of suspension for previous poor practice?

In the first instance, a point of clarification is necessary. This is to distinguish 'suspension' from 'cancellation/disqualification'.

- A practitioner who has been suspended will automatically be on the register again at the end of the suspension or once it is removed, and be subject to the any conditions that may have been imposed by a professional council or the NSW Civil and Administrative Tribunal.
- A cancelled/disqualified practitioner must apply for re-registration if they wish to be re-registered after cancellation/disqualification period specified by the Tribunal. The practitioner must first make an application to the NSW Civil and Administrative Tribunal ("the Tribunal") to apply for a review of the order.

Once a re-registration application is made, the Tribunal must conduct an inquiry. In conducting that inquiry, the Tribunal must determine the appropriateness, at the time of the review, of the cancellation order.
The most important considerations for the Tribunal in making this determination are:

1. The protection of the health and safety of the public;
2. The protection of the public through ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.

The principles that the Tribunal tends to apply when determining a reinstatement application are briefly summarised as follows:

- The practitioner must prove that he or she is a fit and proper person to be engaged in the profession.
- The standard of proof to be applied by the Tribunal is the civil standard of proof, that is, the balance of probabilities.
- The jurisdiction exercised is for the protection of the public (i.e. not punitive).
- The power to reinstate should be exercised with great caution and only upon solid and substantial grounds.
- In making an assessment of the Applicant's worthiness and reliability for the future, the Tribunal may draw inferences from what has happened in the past and, in particular, what led to their being removed from the Register.
- The view that re is no public interest in forever denying the chance of reinstatement to former practitioners.

Once it has conducted such an inquiry, the Tribunal may, among other things:

- Make a reinstatement order, with or without imposing conditions on the practitioner's registration.
- Dismiss the application, and the Tribunal may give guidance to the practitioner on the principles that they should address in any future application.

In the event the Tribunal makes a reinstatement order, the practitioner must then apply for registration with the Australian Health Practitioner Regulation Agency (AHPRA). The practitioner must meet any criteria required by AHPRA, including, but not limited to, recency of practice requirements, before they can be registered.

PROSECUTING COMPLAINTS – QUESTION 34

Question 34. What action do you, as Commissioner, take when the Director of Proceedings decides not to prosecute a complaint and refers it to you for action?

Under section 90B(3A) of the *Health Care Complaints Act 1993*, if the Director of Proceedings determines that a complaint should not be prosecuted before a disciplinary body, the Director may refer the complaint back to the Commission.

The actions available in these circumstances are set down in Section 39 (1) (c)-(g) of the Act and are:

- refer the complaint to the appropriate professional council for consideration of the taking of action under the Health Practitioner Regulation National Law (NSW) , such as the referral of the health practitioner for performance assessment or impairment assessment
- make comments to the health practitioner on the matter the subject of the complaint
- terminate the matter
- refer the matter the subject of the complaint to the Director of Public Prosecutions
- take action under section 41A - i.e if the matter relates to an unregistered health practitioner impose a prohibition order or make a public statement (identifying and giving warnings or information about the health practitioner and health services provided by them).

EXPERT REVIEWERS – QUESTION 35

Question 35. What prompted the Commission to 're-invigorate' its Expert Reviewer Training program, and what impact has this had on how expert reports are compiled? (p85, 2018-19 report)

The Commission is assisted in its investigations and prosecutions by panels of expert clinical advisors (often referred to as 'experts'). The expert's purpose is to provide information about subjects requiring specialised knowledge and to provide opinions concerning acceptable standards of practice and whether a respondent's conduct and/or clinical care and treatment accorded with accepted standards. An expert's opinion about a respondent's conduct will not, of itself, determine the action the Commission will take at the end of the investigation but it will hold considerable weight in investigations that involve complex clinical matters.

At regular intervals the Commission refreshes its panels, to add experts in specialties of high demand or emerging specialties and remove practitioners who are no longer available.

In 2018-19 such a refresh occurred and training of new experts as well as retraining existing experts is a part of the overall refresh protocol.

Training for experts is essential to their effectiveness in preparing expert advice that will be structured in a way that addresses the statutory tests for disciplinary action. It is critical for them not to have conflicts of interest that will compromise their advice and to know and understand the acceptable standards and whether the respondent's conduct fell 'significantly' below the standard reasonably expected. If the expert is of the opinion there was a significant departure from reasonable standards of care and evidence exists to establish the factual elements of an allegation, referral to the Director of Proceedings is likely to be warranted. The expert must, in all circumstances where they have found a significant departure in standards, state whether or not this departure invites their strong criticism. If strong criticism is noted, this may mean that a tribunal may be the appropriate disciplinary forum as the expert believes the conduct amounts to professional misconduct

LOCAL RESOLUTION OF COMPLAINTS – QUESTION 36-37

Question 36. Has there been any pushback from local health districts about the increased referral of complaints for local resolution? (p20, 2018-19 report)?

No. Local Health Districts (LHDs) are consistently co-operative and supporting of receiving matters that are suitable for local resolution.

Through our day to day interactions and our outreach training, the Commission experiences LHDs as appreciating that local resolution offers an opportunity for less serious complaints to be addressed quickly and directly with the provider, in order to reach a timely resolution for a complainant and hopefully prevent or avoid a more serious and challenging complaint.

LHDs also understand that acceptance of matters for local resolution is integral to actions that they are taking under the National Safety and Quality Health Service (NSQHS) Standards, which includes

obligations to establish and maintain effective complaints management under the 'Clinical Governance' standard. As such, they have increasingly robust complaints management policies and guidelines that make them well placed to manage the type of complaints that are referred for Local Resolution.

<u>Question 37</u>. How do you ensure that referring mental health complaints for local resolution is effective*?*

LHDs are required to provide the Commission with written advice on the outcomes of each Local Resolution matter. As well as a description of actions and outcomes, these responses generally include copies of letters from LHD Executive to the complainant and other complaint related documentation. It is therefore possible for the Commission to identify actions taken by the LHD to facilitate a satisfactory outcome for the complainant, as well as process changes and/or improvements that have been implemented as a response to the complaint (where applicable).

Staff within the Commission's Resolution and Customer Engagement function are also working with LHDs through the training and outreach program to develop stronger relationships with Complaint Management Officers to ensure that complex complaints, such as those regarding mental health, are referred appropriately to ensure best possible outcomes for the complainant.

Noting that complaints regarding mental health can often have an additional layer of complexity and sensitivity, the Commission has also introduced processes to foster closer consideration of the suitability of such complaints for Local Resolution before this decision is taken.

INDIVIDUAL PRACTITIONERS SUBJECT TO MULTIPLE COMPLAINTS – QUESTION 38

<u>Question 38</u>. What impact do individual practitioners that generate multiple complaints have on the Commission's resources, and how are these complaints managed compared to others? (p61, 2018-19 report)

Individual health practitioners who generate multiple complaints tend to be significantly more resource intensive, and the resourcing impacts magnify if the complaints reveal serious risks.

In the assessment stage of the process, each complaint needs to be separately assessed, even though the complaints are related. There is a need to avoid fragmented and potentially inconsistent management of the complaints. The related complaints therefore need to be recorded and monitored, relevant records and responses obtained and if appropriate, clinical reviews need to occur in each case. In determining outcomes, consistent principles need to be applied for each individual assessment and each assessment has to be determined having regard to the outcome in the related matters (as well as the outcome of any other prior complaint).

Such matters therefore need to be assigned to the Senior Assessment Officer level, for coordination of the individual assessments.

If the assessments result in referral for investigation, there will be multiple complaints being investigated in parallel. This then triggers:

- Early high level triaging and investigation planning, involving the Executive Director and in some cases also the Commissioner. This involves :
  - Confirming the spectrum of issues that are to be considered, noting that some of the multiple complaints may raise slightly different issues or additional compared to each other.
  - Potentially targeting the most intensive evidence gathering to a selection of the most serious and representative events.
  - Identifying key witnesses.
  - Establishing a communication plan and protocol to ensure consistent communication with the complainants and the provider.

- Setting in place measures to ensure that new complaints arriving for assessment during investigation are visible to the investigator.
- Instituting case review milestones to monitor progress and to review strategy.

The complaints are then allocated to a Senior Investigation Officer and there is early involvement of the Legal Officer.

If one or more of the investigation complaints is to be referred for disciplinary action, the Director of Proceedings must then make a determination on each investigation referral and whether any consequent prosecutions will occur as one matter or separately. This determination may require additional external legal advice.

Where multiple complainant prosecutions proceed they invariably involve additional resources over longer timeframes because:

- they require collation of extensive amounts of evidence and expert advice, so take longer to prepare
- the number of days required for a hearing are frequently larger, as they require multiple experts and witnesses
- the hearing dates are often scheduled well in the future so as to be able to accommodate the schedule of all the prosecuting forum members and the experts and witnesses
- the prosecuting forum may require more time after the end of proceedings to consider and write its decision.

Consequently these multiple complainant matters are much more costly to prosecute.

PERFORMANCE OF RESOLUTION SERVICE – QUESTION 39

<u>Question 39.</u> How is the Resolution Service being supported as more complaints are referred to it and the need to improve timeliness? (p54, 2018-19 report)

The Resolution Service business model has been reviewed and redesigned over the past two years and there has been a significant investment in capability building as well.

Key changes have included:

- The removal and reassignment of a number of functions from the roles of Resolution Officers, to enable them to focus on ensuring they have the time and bandwidth to focus on resolution cases. Specifically, during 2018-19 :
    - The conduct of section 28 reviews were reassigned from the Resolution Officers to new designated review officers.
    - In 2018-19 the Inquiry Service ceased to be managed by Resolution Officers, with the establishment of the dedicated Inquiry Coordinator and Customer Service Officers.
    - Outreach presentation and training that had been the responsibility of Resolution Officers is now shared across the Commission, coordinated by the Stakeholder Engagement and Communications Officer.
- A change-up to the approach to delivery of rural and regional resolutions. All resolution matters across the state are now shared among the Resolution Officer, so that all have an exposure and a contribution to regional service delivery and there is the capacity to adjust the resources deployed to an area to meet fluctuations in need.
- Provision of specialised skills development training for Resolution Officers.
- Improved complaint assessment triaging processes to clearly identify and refer matters amenable for resolution, supported by process changes to ensure early referral to the Resolution Service.
- Protocols for earlier complainant engagement in the resolution process.

- Stronger focus on case management practises including regular case review to ensure that matters progress within an appropriate timeframe.

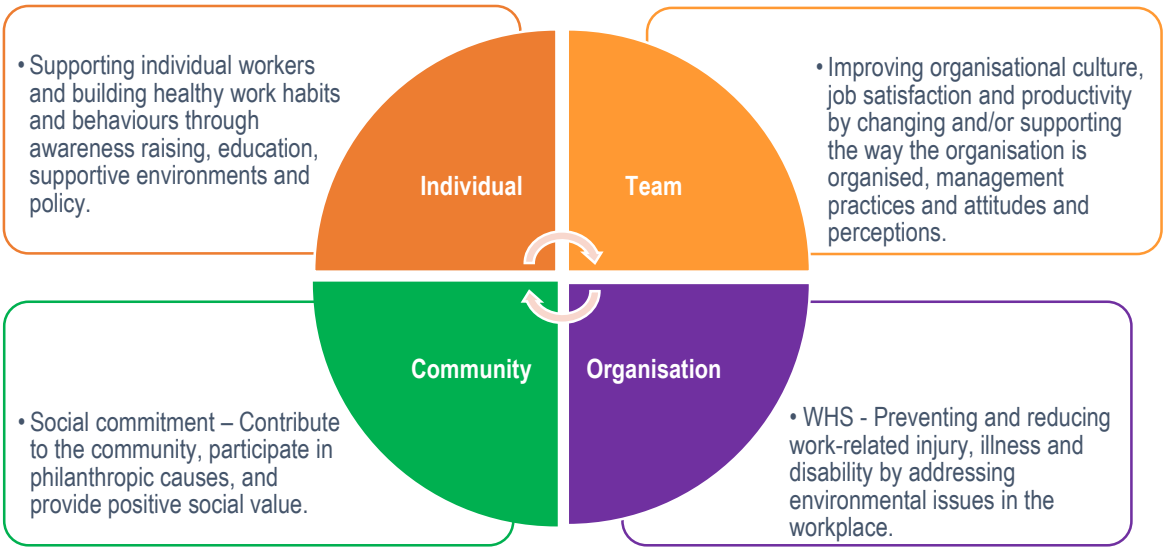
Quarterly performance data for 2019-20 shows that these measures and actions are having a positive impact both on resolution outcomes and timeliness.

EMPLOYEE WELLBEING – QUESTION 40

<u>Question 40</u>. Can you give more detail on the plan to expand the Commission's wellbeing program, and learning and development initiatives for staff. (p5, 2018-19)

Wellbeing Framework

A Wellbeing Framework has been developed in consultation with the WHS Committee, Public Service Association, 'Our People' Committee (the Commission's social committee) and the Executive and management team. Its fundamental objective is to provide a safe and healthy workplace where our employees can make a difference. It identifies four pillars of Wellbeing, with initiatives in each pillar to help employees maintain their mental, physical and psychosocial health, as in the below diagram.



Within each pillar are a series of initiatives and actions designed to assist and support staff wellbeing. Some of the key current or future initiatives for each of the four pillars are listed below:

Individual:

- Access to flexible work arrangements – including increased support for working from home
- Debriefing pathways after dealing with difficult cases
- Resilience based training for all Commission Staff
- A buddy system for all new recruits to ensure that they are supported in their entry to the organisation
- Lunch time walking group
- Continuously highlighting access to Employee Assistance Program (EAP) for all employees and their families

Team:

- Regular All Staff meetings and communication
- Consultation and engagement applied through all business improvement and change management processes
- Cultural awareness training

- Team meetings and information sharing
- Fostering feedback within and across teams
- Rollout of *Microsoft 365 Teams* to provide a new platform for collaboration within and across teams
- Monthly HR update with a focus on transparency in recruitment and to embed improved job mobility within and across Divisions

Organisation:
- Ergonomic assessments
- Core and role specific training and development
- Safety oriented training (E.g. Emergency procedures, *Mental Health First Aid*)
- HR Policies (e.g. Code of Conduct, Positive and Productive Workplace Policy)
- Annual flu vaccinations

Community:
- Regular blood donation drives
- Raising awareness and funds for various charities (e.g. Black Dog Institute, RU OK day, White Ribbon Day, Drought affected farmers)
- Volunteering drives

The Commission released a *Working from home* edition of the Wellbeing Program to support staff adjust to working from home and the new challenges and pressures of the COVID-19 pandemic environment. This was also based on the four pillars and included:
- advice and tips on working from home and how to use various platforms to 'stay connected' such as tele and video conferencing; use of group chats on Whatsapp
- access to free online yoga and meditation classes
- online exercise/workout videos
- links for maintaining good mental health.

Learning and Development Initiatives

The Commission has an organisational growth plan and a culture plan that includes increased emphasis and investment in Training and Development. The appointment of a designated Learning and Development Advisor in 2019-20 has enabled us to make progress on establishing a structured, capability based Learning and Development framework. The principles of the Learning and Development framework are to:
1. Create a learning culture
2. Align learning with the business
3. Provide appropriate learning options
4. Manage learning effectively
5. Support application of skills in the workplace.

For individuals we will be seeking to deliver training that assists all staff to be:
1. *Job ready* as soon as possible after joining the organisation – induction to the Commission, the division, team and role
2. *Job confident* and have technical mastery - achieve desired performance and personal and professional goals
3. *Career mobile* - Learning to support career development and mobility

The Framework builds on the training that is now being delivered and integrates delivery of core training for all staff from the time they commence work at the Commission and onwards with more role specific training relating to more specialised functions such as mediation, investigation and legal drafting. To date additional funding has supported the following activities.
- Increased focus on Induction:

- The Commission has focussed on improving the induction training and experience for all new starters to ensure they are assisted to quickly understand the corporate strategy and directions, the work of the Commission, their role and accountability, and the systems that they work on.

- Resilience training:
  - Complaints management is challenging and often confronting work.
  - Delivered quarterly, the Commission provides resilience training to all employees, with the ability for employees to refresh their skills and knowledge as required.
  - Training on how to manage unreasonable complainant conduct is also delivered by the NSW Ombudsman to staff at least once a year.
  - Both of these training modules are important in assisting staff to work in a sustainable and constructive way and develop additional skills in handling aggrieved, distressed, angry or abusive clients or contacts during investigations.
- Leadership Development training:
  - A central element of the culture plan and an action arising from PMES results is a focus on building leadership and manager capability.
  - A leadership program for managers was delivered throughout 2018-19 to improve people manager capability and enable leaders and managers to build a culture of performance, accountability, collaboration and capability.
  - A total of 13 current managers participated in the 15 month program.
  - The Senior Executive Group also undertook executive Leadership training and coaching and 2 executives participated in the Public Sector Commission's (PSC) training on Delivering Business Results and Executive Leadership Essentials.
- Performance and Development Planning:
  - All employees of the Commission have personal development discussions and plans set as part of their annual Performance and Development Plans.
  - All new starters are provided with training on the Commission's Performance Management cycle and how to complete their PDP on the online tool. All current employees are offered refresher training on the system and process.
  - Each employee's performance agreement also includes a development plan, with objectives and actions to build capabilities required in their job. The key development themes across these plans have been identified and inform consideration of learning and development funding decisions.
- Effective Communication across all of our functions:
  - The Commission's commitment to customer centrism and to clear articulation of reasoning behind all of our decisions and actions, has been a driver for role specific training in a number of areas:
    - Crisis Communication Skills training to provide relevant staff with the skills and knowledge to address crisis and distress in calls. This includes relieving distress, basic mental health awareness and dealing with aggression.
    - Investigation Officers were provided training by the Plain English Foundation to write reports and letters that are clear and to the point, applying plain English tools and style in a highly practical way.
    - Investigation Officers were also provided Investigation and Statement Taking Training to provide them with best practice skills to obtain a statement from a complainant or witness based on the environment of the Commission.
- Training in specialised skills:
  - The Commission provides special skills training as the need arises:
    - Relevant staff attended Managing Sexual Assault Complaints training which is a central plank of the Commission's project to implement the recommendations of the Royal Commission into Child Abuse. The training is directed to early identification of allegations of this nature, to that there is effective and compassionate assessment.

- Staff of the Resolutions & Customer Engagement division were provided with training on Healthcare Resolutions and coaching to enhance their skills to deliver messages to complainants and providers and deal with adversarial complainants.
- Legal professionals were assisted in continuing education to maintain knowledge and skills relevant to their role.

USE OF SOCIAL MEDIA – QUESTION 41

<u>Question 41.</u> Is there a reason the Commission does not have social media accounts such as Twitter, Facebook or Instagram?

The Commission recognises social media's ever growing breadth and applications, and the increasing role and influence it plays in people's day-to-day lives, both professionally and personally.

On balance, the Commission has been of the opinion that it is not in a position to pursue a social media presence at this time, for a number of reasons:

- Given the instantaneous and "multiplier" nature of social media communications, an effective social media presence requires careful planning, active management and monitoring. The Commission does not presently have specialised media and communications positions or resources. Therefore establishing such a function would divert scarce resources from core operational functions.
- A key requirement of the Commission is that it remains objective throughout individual complaints and in public controversies about health services. Social media commentary by the Commission, advocacy from parties to complaints via social media, or third party commentary on matters before the Commission has the potential to strain against this.