REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

INQUIRY INTO THE REVIEW OF THE 2013-14 AND 2014-15 ANNUAL REPORTS OF THE HEALTH CARE COMPLAINTS COMMISSION

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At Sydney on 11 March 2016

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The Committee met at 8.30 a.m.

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PRESENT

The Hon. M. Pavey (Chair)

Legislative Council	**Legislative Assembly**
The Hon. L. Amato	Mr A. S. Crouch
Ms J. Barham	Ms E. M. Petinos
The Hon. W. W. Secord	Ms K. R. Washington

CHAIR: I now declare the hearing open. I welcome the Commissioner and senior officers from the Health Care Complaints Commission to the Committee for the purpose of giving evidence on matters relating to the 2013-14 and 2014-15 annual reports of the Health Care Complaints Commission. Before the proceedings commence, may I remind everyone to switch off their mobile phones as they can interfere with Hansard recording equipment. If your phone is on silent, please switch it off completely.

In accordance with section 65 (1) (c) of the Health Care Complaints Act, it is a function of the parliamentary joint Committee on the Health Care Complaints Commission to examine each annual report of the Commission and to report to Parliament any matters arising out of it.

SUSAN ELIZABETH DAWSON, Commissioner, Health Care Complaints Commission, and

KAREN BERNADETTE MOBBS, Director of Proceedings, Health Care Complaints Commission, affirmed and examined:

TONY ALAN KOFKIN, Director of Investigations, Health Care Complaints Commission, and

IAN THURGOOD, Director of Assessments and Resolution, Health Care Complaints Commission, sworn and examined:

CHAIR: Does anyone have any questions before we proceed?

Ms DAWSON: Chair, if I may, I will make a very brief opening comment. I am honoured to be making my first appearance before the Committee and to talk about the important work of the Commission. I know from our earlier meetings that we share the aspiration that the Health Care Complaints Commission be absolutely central to maintaining the integrity of the health system. I note that the purpose of today's meeting is to review the 2013-14 and 2014-15 annual reports. I make that obvious statement because I want to acknowledge the work of former Commissioner Kieran Pehm, which is reflected in these annual reports, and thank him for his work and also the work of Acting Commissioner Karen Mobbs. I also wish to note that during the course of today's hearing, having taken up the role in December 2015, there may be occasions when I am taking more questions on notice that I would normally. It is not my intention to obfuscate, but I want to ensure that I can give full and accurate information. I will be attending to every question in the best way, but should that incident of questions on notice occur, I beg your indulgence.

CHAIR: Thank you. As local members we have a lot of people come through our office doors relating to health issues. Will you give us a rundown on the Commission's outreach and accountability process? How do you reach out to all sections of the community within the health services to ensure that the Health Care Complaints Commission plays a pivotal role in showing integrity of the health system in New South Wales?

Ms DAWSON: The Commission's outreach program is extensive. As you would expect, it has a number of dimensions. It has 10 broad spheres of activity that I will quickly run through. Those are intended to cross the spectrum of communicating and informing the full community and then thinking about how we can target our work to particular areas that will assist us in improving complaints performance across the State. In terms of those 10 domains, in essence, everything hangs off the work that the Commission does to maintain an effective and informative website. It is plain that we are succeeding in that. The website hits have increased from the period of 2013-14 to 2014-15 from 6,800 to 12,700.

We have doubled the level of engagement with our website and we are confident we are providing information that is helpful to the community. I will get to our webinars in a moment, but we ensure that our webinars are posted on the Commission's website so that they have an enduring life. I am being advised that what I really meant to say is that the figures are 6 million to 12 million. My commas were in the wrong place; my bad. It is all going very well so far. Webinars are fantastic. They sit on the website; they are enduring; everybody loves them and 12 million people have access to them. Media releases about the Commission's prosecutions are also on the website and we see a fairly active interest in those.

Moving on to some of our outward engagement, our involvement with the local health districts is quite intensive. We offer training and presentations to the local health districts, and we do that on a regular cycle. There was an intensive program of visits to the local health districts in 2012-13, and that was followed up in 2014-15. My intention is to make it a priority to complete a program of visits to all local health districts in this calendar year, in fact, probably this financial year if I can achieve it. What we do in those regional visits is two-fold. We want to offer the local health districts an analysis of what is happening in their region; what is the profile of complaints across the region; and what are we seeing in relation to the public hospitals within that local health district? Are we seeing any particular hotspots in complaints?

CHAIR: Can I interrupt you for a moment. Ms Mobbs might be better placed to answer this question. Was there feedback and visits to the local health districts the following year? We are looking at the two annual reports? You have had intensive discussions. Did you see fewer complaints the next year?

Ms DAWSON: Can I take that question first and others might want to comment. We are seeing a very high level of responsiveness from the local health districts as a result of their interaction with the Commission.

We are seeing quite strong improvements in local complaints resolution at the local health district level, and strengthening of the work in public hospitals on the back of the root cause analysis initiative. So we are finding that there is strong improvement in many health districts. We are also finding that when we go into the local health districts and we offer training on particular issues of concern—open disclosure, ways of communicating, having those difficult conversations—that we can see those are having a good effect in respect of improved local resolution outcomes. Local health districts and the people who participate in the training we offer are saying that has been incredibly helpful. Theoretically we know what we need to do but helping to get a real sense of what best practice looks like at the coalface is really helpful.

Mr ADAM CROUCH: I have been engaged with my Central Coast Local Health District. The feedback you are giving is very positive. In addition to that, what can the Commission report with respect to its work with other agencies, on a national code of conduct for healthcare workers at this time?

Ms DAWSON: Thank you for that question. The national code of conduct for healthcare workers is interesting for us because it deals with the question of unregistered health practitioners. New South Wales, since 2008, has been very much ahead of the game in terms of having a code of conduct for non-registered practitioners. That is really good news for us. It has meant that, as the national code conversation has developed—so that all states and territories are thinking about how to bring non-registered practitioners into the fold—the New South Wales model has been very much a lead for what is occurring nationwide. We have been able to provide advice through the ministry, and to our other jurisdictions, to talk about how our work with unregistered practitioners looks—what does it involve; what is the scope of it; what processes ought to apply?—and that has been informing the development of the national code. So we are very proud of the leadership we have been able to show in relation to unregistered practitioners.

The Hon. WALT SECORD: Ms Dawson, you are probably the person to refer this to. I would like to go into the area of clinical errors or mistakes. For 2013-14 and 2014-15, can you give me the number of cases or investigations you have undertaken involving clinical errors or mistakes.

Ms DAWSON: Are you asking about the number of matters that were referred to investigation that involved clinical and treatment errors? Is that correct?

The Hon. WALT SECORD: Errors or mistakes, yes.

Ms DAWSON: Are you in a position to profile the investigations in that way, Mr Kofkin?

The Hon. WALT SECORD: I guess my real question is: Has it increased and is it increasing?

Mr KOFKIN: It depends what you mean by an "error", for a start, in terms of how we describe an investigation in terms of clinical treatment. Under national law we are looking at a judgement and care exercise, by the clinician. There are occasions when there are clear errors or mistakes—for example, wrong-side surgery in back surgery. We do encounter those investigations. Those types of errors are quite few and far between in terms of those matters which are the cases. Predominantly, when a practitioner is referred for investigation and it is a clinical matter, a whole host of issues are raised, rather than a specific error of sorts—

The Hon. WALT SECORD: Let me assist you. I am talking about something that would come under the New South Wales Ministry of Health's open disclosure policy. I guess these would fall under that.

Mr KOFKIN: With respect to the open disclosure policy are you referring to what the ministry would call a SAC 1 or SAC 2 event, where there is an adverse outcome which would have been unexpected?

The Hon. WALT SECORD: Yes. Any adverse outcome would be unexpected. Yes, that is commonly known as an error.

Mr KOFKIN: Okay, I beg your pardon.

Ms DAWSON: Or it may be a rare complication that may be caught up by this. That is just a point of clarification.

The Hon. WALT SECORD: To assist, I mean an error—not an unexpected death that may occur during a procedure. I am talking about an error, such as under-dosing.

Mr KOFKIN: In relation to what the numbers are, I think we would have to take that on notice because it is a very specific question. How we record matters in terms of clinical treatment—

The Hon. WALT SECORD: To assist, if you are taking it on notice, I am talking about the period 2013-14 and 2014-15. I would be grateful if you could give us an answer on that. On that note, are you familiar with the open disclosure policy?

Mr KOFKIN: Yes.

The Hon. WALT SECORD: In your assessments of the resolving of a matter, it says here, "I am sorry," or "We are sorry," constitutes an apology. Does that resolve the matter in your investigation?

Ms DAWSON: Can I have a bit of a go at where I think you are coming from? An apology is an important mobiliser for open conversation in order to get the complainant, or the person who has experienced a problem, and the provider, on the same page in the hope that the matter can be resolved. In relation to investigations, whether there was an apology or not is not the primary focus of our interest. Our primary interest is in whether there were clinical judgements or performance aspects that led to a significant risk of harm. So the focus is on the clinical questions. Of course we hope that there is good performance in open communication, but that is not the primary focus of the investigation.

The Hon. WALT SECORD: Does an apology constitute a resolution of the matter?

Mr KOFKIN: No.

The Hon. WALT SECORD: I take you to the recent matter involving the under-dosing of 70 chemotherapy patients at St Vincent's Hospital. Have you been in contact with individual cases?

Ms DAWSON: I will be fairly cautious in the scope of my commentary on this, given that it is an active investigation.

The Hon. WALT SECORD: But your organisation did confirm in the public arena that you are investigating. I remind you of that.

Ms DAWSON: That is correct. What I can say is that through the normal course of our investigations we would be seeking responses from any individual practitioners identified.

The Hon. WALT SECORD: Are there legislative impairments to you investigating this St Vincent's Hospital matter?

Ms DAWSON: I do not believe so.

The Hon. WALT SECORD: In the upper House we have a situation with Standing Order 52—a call for papers. We were advised in the Chamber that some of the materials could not be released to the Parliament because St Vincent's Hospital is a network. Does that impact on your investigation of the matter?

Mr KOFKIN: No, not at all.

The Hon. WALT SECORD: You are able to access or obtain any information that is wanted. Are there any limitations that you are experiencing?

Mr KOFKIN: There are at times limitations in relation to legal privilege but certainly throughout my experience on the Commission for nearly six years, whenever the Commission has requested material in relation to an investigation—particularly a serious matter such as the one you are talking about here—we have coercive notices which we can use if necessary, and I have never come across a situation where we have made a request for information which is proportionate and justified that we have not received it.

The Hon. WALT SECORD: Is St Vincent's Hospital cooperating with the HCCC?

Ms DAWSON: Can I just ask that we try not to drill down too deeply.

The Hon. WALT SECORD: I am not going into individual cases. As a matter of principle, are they cooperating?

Ms DAWSON: We are very early on in the investigation at this stage; we are satisfied that there has been an open exchange of relevant information.

The Hon. WALT SECORD: Are you confident that the patients in Bathurst and Orange, who were on the regional outreach program connected with the doctor involved, have been contacted?

CHAIR: I think that the Commissioner has answered the question to the best of her capacity at this time. We probably need to move beyond the specifics of that, given it is a matter of investigation.

The Hon. WALT SECORD: Chair, I would just like to remind you that in Ms Dawson's opening statement she said that the role of the HCCC is to "ensure the integrity of the health system". That is why I am asking questions about St Vincent's Hospital. There are concerns in the community that St Vincent's Hospital refused to comply with an order for a call for papers from the New South Wales Parliament—from the Legislative Council, Australia's oldest parliamentary Chamber. I just want to seek an assurance from Ms Dawson and her investigators that St Vincent's Hospital is cooperating in all matters involving the investigation.

Ms DAWSON: We are in the process of framing what our information requests are of the individual practitioners. So there is a focus, here, on receiving clinical records relating to the practice of the individual oncologist involved. I want to go back to our standard investigatory procedure, if I may, as it is quite routine and we are confident that it works well. It is a practice of going back through the clinical records and identifying those who may have been affected by the practice of the practitioner. That is the essence of good investigation, and that is what will occur here.

The Hon. WALT SECORD: Was the HCCC aware of the matter at St Vincent's prior to the *7.30 Report* investigation?

Ms DAWSON: We became aware of the St Vincent's matter through a range of media commentary on it**.**

The Hon. WALT SECORD: Not until the *7.30 Report* came out

Ms DAWSON: I cannot pinpoint the exact time in regard to the chronology of when the *7.30 Report* was mapped against when our first knowledge is, but there or thereabouts throughout that period.

Ms JAN BARHAM: I was interested to know whether or not you reported complaints by region and then breakdown by time? That does not seem to be in the report. Are any further details available?

Ms DAWSON: Is your question whether we distinguish between metropolitan and non-metropolitan complaints?

Ms JAN BARHAM: I am interested in health regions that have ongoing problems and the fact that regions differ for whatever portfolio you are looking at. In regard to the regions one would hope that in the present day government would have regions defined across a whole-of-government approach. However it is done, is it done and does that give us some information?

Ms DAWSON: We share your challenge with regional reporting based on the lack of consistent definitions. It is one of the fundamental issues that we find in terms of where do we draw the region? Health regions are a little bit out of sync with other regions. So I acknowledge the difficulty that you have. The short answer is that we are able to, which is what I was touching on before when I talked about the outreach activity. When we go into a local health district we step back and have a look at the profile of complaints relating to that region. We have a particular difficulty that I just want to reflect on for a minute.

When you are looking at things regionally, and in a complaints context, there is a little bit of a challenge as to whether you are looking at the region in which the complainant was located or the region in which the provider is located. They are two different things. For instance, somebody may live in Mudgee and come to Sydney for treatment. Is that complaint counted in the region in the Sydney context where the provider

was or do you cut the information by where the complainant came from? We can do both and we do both, but it is complex. So the short answer is yes. When we go out to the local health district we have a look at what is happening with providers in that region.

Ms JAN BARHAM: My interest is in whether that is done and it is available and whether it informs you and others about the effectiveness of the complaints process and also the knowledge. I am from the far North Coast and I have done my own little survey of people about whether they know that this service operates and there is a place for them to make complaints. I went to the community centre and to the doctors and I did not see any nice little leaflet. I know you have your website stuff but do you have a hard copy leaflet that shows them how to complain about health matters?

Ms DAWSON: Yes, we do. We have two in fact. Through a service called Info Med, a service that provides hard copy information to individual GP services right across Australia, we provide brochures through them to individual services. I am struggling to find the number.

Ms JAN BARHAM: It would be terrific if you were able to provide a copy and a distribution list.

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

Ms JAN BARHAM: Terrific. I refer to community centres at which people access resources through the regions. I refer to page 18—

Ms DAWSON: Which report?

Ms JAN BARHAM: For 2014-15. I am interested in chart 7.3 issues raised—complaints procedures about medical practitioners and pharmacists. There are a huge number of complaints about medications.

Ms DAWSON: Yes.

Ms JAN BARHAM: Is there a breakdown about issues relating to medication? Is it the wrong medication or is it just overprescribing? I am particularly interested in overprescribing relating to doctor shopping and opioid dispensing and the fact that we do not yet have valid real-time monitoring. It seems to have stalled. I am wondering whether or not in that area you have information to the effect that there is a remedy or at least an opportunity to reduce the number of complaints about that facet? Is that part of your role?

Ms DAWSON: Yes. It is very clear that medications are, not surprisingly, a dominant area of complaint in relation to pharmacists. Those may relate to errors in dispensing, they could relate to overprescribing, they could relate to forged scripts that might be then passed on, and so on. So a range of complex issues sit within that. What we would do in relation to that and, in fact, what we are doing is we would sit down with the pharmaceutical council and say, "What are you doing to strengthen standards and performance across the profession in relation to this core business of best practice dispensing?" Are any trends coming through in our complaints that shine a light on what is going wrong and whether there are particular hotspots out there?" That is the first thing to say.

The second thing to say is we have an incredibly close operational connection with what was once called the Pharmaceutical Services Unit and which is now called the Pharmaceutical Regulatory Unit [PRU]. Through its audits and inspectorial functions, which Mr Kofkin might wish to elaborate on should you wish to know more, it will identify particular pharmacists that appear to be engaging in inappropriate dispensing practices and those would typically be referred over to us as complaints and, if assessed to be serious or confirmed, would go into investigation.

Ms JAN BARHAM: I appreciate you saying that you can obtain this information and that is I wonder whether your role is not also to be advising government or making recommendations about a well-learned practice that will impact on that.

Mr KOFKIN: There has been recent consultation with a change or an update in the legislation to the Poisons and Therapeutic Goods Act where the Commission provided submissions to the ministry in relation to

that. In terms of live-time dispensing, that is an ongoing project for the ministry and which I believe may hope to go live. I am not sure when the date will be but maybe in a couple of years. It is certainly something which will be a game changer without a doubt in relation to prescribing and dispensing these medications. As the Commissioner said, we have a very close working relationship with MPRU. I would say I speak to the deputy chief pharmacists of New South Wales three times a week for updates in relation to what they are doing and what complaints were referred to them and what is coming over the horizon for the Commission.

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

Ms ELENI PETINOS: I hope you will forgive me to going back to something that both Madam Chair and Ms Barham have touched on. We talked earlier about outreach and where the Commission directs its communications. It is exciting to hear that 12 million people look at your website and engage in webinars. However, you would appreciate that it is often the most vulnerable in our society who need assistance and might not be best placed to actually engage in that form of media such as the Indigenous community, people with mental health problems and people with other forms of disability. Occasionally they come into our offices and ask for referrals but where they are not able to do that, how exactly does the Commission target these groups and try to reach out to them so that they know who to come to?

Ms DAWSON: An excellent question.

Ms ELENI PETINOS: We deviated slightly; I know you were going there.

Ms DAWSON: Had I given you the full tutorial on outreach the really important thing that I would have got to is what our targeted outreach effort really looks like on the ground, so thank you for taking me back to that. I will give an example that I think really illustrates this well. We have outposted resolution officers in three locations throughout the State. In those areas the resolution officers identify particular weaknesses in knowledge about the work of the Commission or particular areas of vulnerability. Our outposted officer, in dealing with the Far West of New South Wales, identified that the 10 Aboriginal health services in the Bila Muuji group, which is located in western New South Wales; the area covering Brewarrina, Bourke, Walgett, Coonamble and so on—really had a need to be upskilled in understanding the role of the Commission and how they could access the Commission.

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

Ms ELENI PETINOS: Do you have anything similar for people experiencing mental health issues at present or did you just start with the Aboriginal community?

Ms DAWSON: Yes. We have trialled the method of doing this and we are going to look at other vulnerable groups to target them, and mental health is certainly one of those on the radar.

Ms ELENI PETINOS: I move to complaints now and the 2013-14 annual report which touched on the fact that inadequate treatment, diagnosis and unexpected outcomes or complications were the most common issues regarding treatment. As local members we often see that when people come into our offices and complain. Do you think it is a lack of communication and poor management of patient expectations more so than poor treatment itself that actually facilitates that outcome?

Ms DAWSON: Yes, it is a really interesting question. The thing I note is that typically complainants do complain about more than one issue, so they will couple issues together. What we notice in this tricky

territory of treatment and communication is that if a practitioner has communicated poorly, it seems more likely that the complainant will also complain about their treatment. The sorts of scenarios that make us see this trend are, for example, is if somebody has presented for surgery and the surgeon knows when they are doing their consent and pre-briefing that a very rare complication of that surgery might be heart failure in, let us say, 1 per cent of cases but they do not believe that it is a likely complication here; the patient might be relatively young or whatever. So they tell them all about the other complications that might occur but do not want to make them fearful by saying, "Oh, and by the way, you might have heart failure during the surgery."

There is a communication that has gone on but during the surgery the rare complication occurs, the person experiences heart failure on the table, fortunately survives, but in their minds there is a malpractice thing. They have been mistreated because the rare complication was not communicated to them and in fact is just a rare complication. It is awful but it is not actually mistreatment but they conflate the two and nothing in their minds thereafter will uncouple those two things. That is a kind of example where communication and treatment get grafted on to one another. It is an extreme example; there are other kinds of lesser examples but I am just trying to illustrate the point that how practitioners communicate to somebody and then what happens next are kind of irretrievably linked.

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

The Hon. LOU AMATO: This question might be more for Mr Kofkin. With regard to the Commissioner's powers to investigate unregistered practitioners and organisations, do you believe the powers are sufficient to protect the public from risk?

Mr KOFKIN: The short answer is yes. The code is very well established and is very broad. It covers all types of health practitioners. One of the clauses within the code says "any alternative health services", which is incredibly broad, it also includes meditation services, and the Commission actually prosecuted in the Local Court for a breach of a prohibition order a practitioner who was actually carrying out meditation services and we were successful in that prosecution. For the Commission to investigate a matter of a non-registered practitioner there is a two-stage test.

Number one is a breach of the code; number two, in the Commission's opinion that breach is a risk to public health and safety. Once a matter comes into the investigation division a whole raft of legislation is activated. That includes coercive notices under section 34A of the Act where we can obtain information and obtain records. We can direct a practitioner to attend the Commission and give oral evidence. We also have powers to apply for search warrants and execute search warrants as well, so a whole raft of powers are enlivened once the matter comes for investigation.

When it comes to actually determining an outcome for a non-registered practitioner the Commission will have hearings that will be chaired by the Commissioner or me. We have our own lawyer within our division who would actually lead the witnesses and cross-examine respondents and then the Commission will make a determination based on all the evidence in terms of whether or not the breach is sufficient to make a prohibition order or public statement. As you will probably see from our website there are a number of public statements and prohibition orders that the Commission has made over the years, far more than any other state in the country—probably more than all the other states put together I would say. So in relation to our powers and how we manage investigations of unregistered practitioners, I would say that we do have sufficient powers.

We also have a very strong working relationship with New South Wales Police and we have a memorandum of understanding [MOU] where we share information with the police as well. The really important part of our legislation in terms of our powers is the interim orders. During an investigation the Commission can make an interim order that can prohibit a practitioner from providing any health service for a period of eight weeks. Those orders can be renewed as required and now our prohibition orders are on our register, which is accessible to the public, and certainly in terms of going forward in the future when we are looking at the national code—in the future we are looking at a national portal where prohibition orders throughout the country will be accessible to the whole public. There has also been recent legislation, as you may be aware, that prohibition orders in other states are now relevant in terms of New South Wales. So if there is a practitioner in Queensland who has been the subject of a prohibition order and then they come to New South Wales and start carrying out the same health services, that prohibition order again applies in New South Wales so therefore we could prosecute for breach of an order.

The Hon. LOU AMATO: With your indulgence my next question is in relation to CommSec at the moment and I will happily withdraw it if I am required to. Apparently some doctors have been persuaded to change their diagnosis for patients with a terminal illness. Have there been any complaints about that matter?

Ms DAWSON: Sorry?

The Hon. LOU AMATO: Patients with a terminal illness get a payout.

CHAIR: It is a life insurance policy issue.

Mr KOFKIN: I understand, yes.

The Hon. LOU AMATO: So they have changed their diagnosis to deny them payment. In other words, if by some miracle a person could perhaps live that little bit longer it would deny them payment. Had they received payment beforehand some may have chosen to use that money perhaps for alternative medicine or even to go overseas to try some treatment because at the end of the day if you are going to die you might decide to try anything. Time is obviously of the essence so they might even want to access medicine beforehand rather than waiting in a queue. Are you aware of any complaints in New South Wales to this point in time about that?

Mr KOFKIN: Not that I am aware of.

The Hon. LOU AMATO: Will the Commission be looking into that?

CHAIR: I think the issue there is the policy itself.

The Hon. LOU AMATO: No, I am talking about the way a doctor has altered it in favour of the insurer—apparently they have altered it. An investigator was asking the other night whether any complaints have been received about this matter.

Ms DAWSON: I am not aware of any such complaints but we can take that on notice and confirm that.

Mr KOFKIN: With every complaint that comes into the Commission we are duty bound to record it and assess it. Regardless of the complaint, that is part of our role. So it is not something that would be ignored; it would be assessed like every other complaint.

The Hon. LOU AMATO: It was drawn to my attention actually last night and I thought I would ask the question. I am happy to withdraw it if it is necessary to do so.

CHAIR: No.

Ms KATE WASHINGTON: I appreciate that the Commission is responsible for medical practitioners and everything involved with their practice but in terms of practices that involve products, what are the protocols involved with complaints involving products that purport to be of therapeutic benefit that the Commission in its investigation might review if that were maybe not the case?

Ms DAWSON: Can I test a scenario to check that we are on the right page there? Would you be thinking about a situation where it was asserted that a dosing up of vitamins plus, plus, plus had a therapeutic benefit or are you thinking more about devices?

Ms KATE WASHINGTON: More along the lines of devices and specifically in relation to mesh. This purports to be of therapeutic benefit for recovery from pelvic floor and incontinence and along those lines.

Ms DAWSON: Mr Kofkin you might be in a position to comment on that sort of scenario, which is familiar to us.

Mr KOFKIN: Certainly. It is very topical and there is a lot of media attention in relation to meshes—tissue fixation system [TFS] is one of those. It is not only something that has been of great interest in Australia but also overseas, particularly in the United Kingdom as well. There are investigations that the Commission looks into where it is not necessarily about the device but the use of the device and it is about the clinical

competence of the individual using the device during surgery. It will cover issues not only in relation to clinical competency of the surgeon but also in terms of the consent process and whether or not that individual is aware of the type of device and whether or not it is an approved device and whether or not it used to be an approved device and is no longer an approved device. It is out in the media in terms of TFS—it used to be an approved device by the Therapeutic Goods Administration [TGA] but it no longer is. It is out there in the media as well that TFS has recently been removed from the Food and Drug Administration [FDA] in the United States. I think that is the type of issue that you are asking.

Ms KATE WASHINGTON: Indeed.

Mr KOFKIN: So the point is, yes. In terms of the actual device itself, there are other organisations that are responsible for that in terms of registration—which will be the TGA—but we will be looking closely in terms of the practitioner and the use of the device and the disclosure and the consent process in terms of patient knowledge.

Ms DAWSON: So the two dimensions that we would look at would be: if a practitioner was using a device that was not approved by the Therapeutic Goods Administration; and whether in using that device there was poor practices that caused harm to individual identified patients.

Ms KATE WASHINGTON: Further along that same line, is there a point at which the Commission refers complaints? I know you have got your own internal legal process but that does not also cover criminal complaints. Is there a point at which the Commission then refers complaints that it has received into the criminal process?

Ms DAWSON: The answer is yes. Mr Kofkin, would you like to elaborate?

Mr KOFKIN: Yes, it is very rare. Certainly since I have been at the Commission it has not occurred but I am aware that it has occurred previously and I am sure that Ms Mobbs would possibly have an answer in relation to that. But there is an option in terms of when we finalise an investigation and we can refer the matter to the Director of Public Prosecutions [DPP].

Ms DAWSON: May I elaborate? If during the course of an assessment or an investigation the Commission becomes aware that there is criminal conduct—an example might be sexual abuse or supplying medications inappropriately for drug use—then those are the sorts of things that we would refer onto the police because we have an MOU with the police that is quite clear about us receiving information from them and us appropriately reporting anything of a criminal nature that we become aware of.

Ms KATE WASHINGTON: So you do not need to resolve your process in order for that referral to be made?

Ms DAWSON: No, that is made in real time.

Ms KATE WASHINGTON: I am assuming from your answers that is a live issue for the Commission and that there are referrals and complaints that have been made to the Commission with this product and practitioners. Has there been any referral to the DPP in relation to any of those complaints?

Ms DAWSON: I will take that on notice. I am not aware of such but we will double check.

Mr ADAM CROUCH: I come from a regional area. The Central Coast has a very large local area health district. Does the Commission have the ability to identify the trends in complaints between metropolitan and non-metropolitan areas across New South Wales? Do you find that there are different types of issues based on geographical location? What strategies does the Commission have in place to address those geographical differences?

Ms DAWSON: I touched earlier on some of the complexities in examining patterns regionally and in metropolitan and non-metropolitan areas. That referred to the question of whether, in your data, you are looking at the location of the complainant versus the location of the service. Setting that aside, the short answer is, yes, we can and do. If we look at complaints in metropolitan versus non-metropolitan areas, what we see is that in non-metropolitan areas there are more complaints about the quality of the facilities that the complainant is in. We have more complaints about the access to services. We also have more complaints about discharge and

transfer arrangements. You would expect that. That is to be anticipated. Interestingly, the complaints about treatment are not significantly different when we compare metropolitan to non-metropolitan. In metropolitan areas 41 per cent of complaints are about treatment. In non-metropolitan areas about 44 per cent of complaints are about treatment. There is not a huge difference. They are some of the trends that we see in what the complainants are saying.

I turn to what we can say about the issues that arise in relation to providers that are based in metropolitan or non-metropolitan areas. We see some interesting things there that I confirm that I would like to have a closer look into, because there are questions about whether the data is robust. The pattern there that is of particular interest to me is that the complaints regarding treatment by providers located in metropolitan areas are significantly higher than in non-metropolitan areas. That is a surprise. It is a question, not necessarily a surprise. It makes one say, "Okay. What does that look like?" The providers in metropolitan areas have a 45 per cent complaint rate about treatment, whereas the providers in non-metropolitan areas have a 40 per cent complaint rate about treatment.

Mr ADAM CROUCH: So it is the other way around.

Ms DAWSON: Yes. So there is a question, isn't there? I would like to signal that I am interested in drilling down into that further. Looking at another metric, I noticed too that conduct complaints differ between metropolitan and non-metropolitan areas. For metropolitan providers there is a 7.5 per cent rate of complaint about conduct. I am rounding the figures here. For non-metropolitan providers there is a 14 per cent complaint rate about conduct. This may be about less experienced practitioners working in regional areas. It may be about there being less supervision. There is a question there. It is something that we need to look more into.

I will not go on, because you can see what I am getting at. At the moment we are saying, "What is the picture of metropolitan to non-metropolitan, looking at the provider or the service perspective and looking at the complainant perspective?" I will provide one final example because it relates to the rate of complaint that I talked about. In non-metropolitan areas the rate for complaints about facilities and the environment—the quality of the facilities—is about 4.5 per cent, whereas it is 3 per cent in metropolitan areas. Again, that is probably not unexpected, but it says something.

CHAIR: Once all the new hospitals in the country come online it will be better.

Ms DAWSON: Absolutely. That is something to attend to. So, yes, we are starting to get a richer understanding of the data, but we need to do more because there may be data imperfections. I want to caveat all of what I have just said, because I have asked exactly the same questions since coming on board. I have questions about what there is to see here, so there is more work to do.

The Hon. WALT SECORD: Ms Dawson, on page 3 of your executive summary you say that you expect an 8.6 per cent increase in 2015-16 due to 5,700 written complaints. What do you attribute the 8.6 per cent increase to?

Ms DAWSON: Having looked at this from every possible direction since 7 December, upon my arrival, I have concluded that there is no single driving factor. There is a complex cocktail of drivers of complaints. There are the obvious suspects, which are the ageing population and an increasing number of people using health services. As the population ages, there is quite a lot of comorbidity. That creates complexity in the treatment environment that knocks on to an increased number of complaints. Mandatory reporting has been washing through. Since 2012-13 you can see a little spike if you look at it in graphical terms.

There is also something about how we as health consumers are choosing to interact with the health system. More and more of us are going beyond our general practitioner to alternative treatments, to broaden the suite of health services that we use. People might go to natural therapists. They might even go to more experimental treatment. I am about to say something controversial, which I will probably regret, but I will press on with it because I have started.

The Hon. WALT SECORD: Press on.

Ms DAWSON: You will be kind to me, will you not, Mr Secord?

The Hon. WALT SECORD: I will.

Ms DAWSON: An example of experimental treatment is the use of medical cannabis for cancer sufferers.

The Hon. WALT SECORD: I thought you were going to say something controversial.

Ms DAWSON: Thank you. You have been generous. People are choosing to think about going to the frontiers of medical practice. There are also the fashion-oriented health services: botox, breast augmentation and so on. Complaints about them show up when people go into that adventurous territory and something goes wrong and they want redress for it. They are some of the factors.

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

The Hon. WALT SECORD: I have a few technical questions. What was the overall budget for the Health Care Complaints Commission for 2013-14 and what was it for 2014-15?

Ms DAWSON: Bear with me. I want to be precise about this, so I will attend to my notes. The overall budget for 2013-14 was $11.9 million. The overall budget for 2014-15 was $12.3 million.

The Hon. WALT SECORD: How many staff do you currently have?

Ms DAWSON: We have 76 full-time equivalents—week to week that might go up and down, so I do not want to mislead you, but 76.

The Hon. WALT SECORD: Of the 76 how many have worked in assessment investigations?

Ms DAWSON: Of the 76 in assessments, we have about 21 to 22; in investigations we have about 21.

The Hon. WALT SECORD: Are those 21 with no overlap?

Ms DAWSON: No overlap.

The Hon. WALT SECORD: So that is 42 people?

Ms DAWSON: Yes, correct.

The Hon. WALT SECORD: Do you have officers in the regions or is everyone based in Sydney?

Ms DAWSON: We have three out-posted officers.

The Hon. WALT SECORD: Where are they?

Ms DAWSON: Mr Thurgood can give the exact locations of the out-posted officers.

Mr THURGOOD: One is in Lismore, one is at Dubbo and one is at Newcastle. We have been endeavouring for a considerable time to try to locate one officer in Wollongong but that has been somewhat difficult in negotiations with the LHD in terms of office space. We will continue to pursue that. They are the four main regions.

CHAIR: That is great.

The Hon. WALT SECORD: When does the HCCC determine that a matter is resolved?

Ms DAWSON: We determine that a matter is resolved during the assessment process and where the complainant considers the matter to be resolved. If the complainant says, "I was very cranky that I was overcharged by my GP" we would only consider that to be resolved if the GP either reimburses or apologises

and partially reimburses and the complainant says, "I am totally happy with that". It is about whether the complainant is happy and that happens during the assessment process.

The Hon. WALT SECORD: What percentage of your current cases are in limbo or unresolved? What do you do in a case where the complainant is not happy?

Ms DAWSON: There are a range of scenarios in matters that are assessed. At this point in time—I will round up again to respond in the spirit of the question—about 12 per cent are resolved during assessment. Then the remaining percentage fall into a number of different categories. There is a range of pathways. The matter may be discontinued, perhaps because there was a fairly minor dimension to the problem that does not warrant further investigation as there is so significant risk of harm to the public. A matter may be discontinued with comments, where we say the experience of the complainant was not perfect—yes, they were kept waiting or the doctor did not communicate well. We would discontinue with comments and ask the practitioner to improve their information processes, timeliness or apologies.

Then there is a scenario where the complainant could be referred to the relevant professional council. The circumstances in which that would occur would be where it appears the person has a health impairment and that needs to be examined further and where possible the person put onto the impairment program. They may show a gap in knowledge so their performance as a doctor might not be up to scratch and they need to do more training or be assisted, and the professional council would arrange for that, or there might be a minor conduct matter. Then there is referral to investigation for matters that are clearly serious and there is a risk of harm to the public.

The Hon. WALT SECORD: Do you get many complaints from prisons?

Ms DAWSON: Yes, we do.

The Hon. WALT SECORD: Can you give me an idea of the scale or volume of that?

Ms DAWSON: Yes, I can. The scale of that for 2014-15 was just under 200 complaints relating to correction and detention facilities, which was about 3.6 per cent of the complaints received.

Mr ADAM CROUCH: You mentioned referrals going to council for professional practitioners. When that happens, is that classed as a conclusion by the Health Care Complaints Committee or does the council go through the training of the practitioner and then come back to the HCCC? Does it remain open during that time? We have talked about the time a complaint is finalised. Is it still classed as open when you hand over a complaint to council?

Ms DAWSON: It is classed as being finalised by the referral to council. You are raising an important point about how we close the loop on matters we refer to councils. In recent conversation with medical council we have had this exact question about confidence in how matters are dealt with when we refer them back to councils. We are close to an agreement about the protocol for the councils reporting back to us on what they have done. We need to be confident that if somebody has been referred for an appearance of an impairment, they are on an impairment program or, upon further assessment, there was not much to see or whatever. That is important feedback for us and we are seeking that.

The Hon. WALT SECORD: Of the 200 complaints from prisons, what are the concerns? Do the complaints concern the distribution of nicotine patches and smoking bans in prisons?

CHAIR: You are not referring to the annual reports that we are looking at, because that is a new policy.

Ms DAWSON: Indeed.

The Hon. WALT SECORD: But of the 200 complaints you have received.

Ms DAWSON: For the years to which we refer the pattern I can see and looking from my current experience—

The Hon. WALT SECORD: Maybe your officers could assist there.

Ms DAWSON: Yes, they could.

The Hon. WALT SECORD: We have been doing this too long.

Ms DAWSON: It is enjoyable, is it not? There is a profile that is fairly constant for us. There are complaints that relate to access to the methadone program and they are very common. There might be complaints relating to adjustments to medication whilst incarcerated, and those could relate to either the person's clinical characteristics changing and therefore the medication needs to change but they do not understand that, or their medication may be adjusted because they are using the original medication not for their own personal uses but are passing it on.

The Hon. WALT SECORD: I see.

Ms DAWSON: There is a range of reasons for those sorts of complaints. Then there is the time taken to get assessed for a particular complaint. They are across that spectrum.

The Hon. WALT SECORD: In 2014-15 did you receive complaints about nicotine patches for prisoners?

Ms DAWSON: I can comment that we got quite a lot of inquiries or we expected to have inquiries about that, but I believe that they did not knock into a huge number of complaints about that topic. Mr Thurgood, would you like to correct me?

Mr THURGOOD: I certainly think that it is correct that Justice Health were proactive in the implementation of that policy. They involved us and the Ombudsman's office in a number of discussions about their strategy. Obviously the unions were involved. Interestingly while we had a number of inquiries about the introduction of that policy there may have been one or two complaints. They tended to relate more to "I want this kind of patch," as opposed to the kinds of patches that obviously are available in the corrective services.

Ms DAWSON: That is as I understood it.

Ms JAN BARHAM: At page 19 of the 2014-15 annual report, if I am reading it correctly chart 7.4 shows that in the reporting period for the annual report there is a doubling of complaints about aged-care facilities. Is there a breakdown available of all the issues that were raised?

Ms DAWSON: I do not have that to hand. We can certainly take that question on notice and try to drill down into that. What I can say about aged-care facilities is that often the complaints will deal with issues that are very appropriate for the aged-care regulator to look at, and we would typically refer those on. They might relate to those in a palliative care situation or those seeking improvements in nursing treatment and so on.

Ms JAN BARHAM: I am particularly interested because I hear from lots of people, but it does not seem to be well documented anywhere else, about the restraint, whether chemical or physical, of people with dementia in these facilities. It is something that people talk about and that they fear.

Ms DAWSON: We will take that question on notice. But I would have to say that I do not believe that I have seen anything along the lines of chemical restraint. That would certainly be something that we would have a very close look at were we to receive complaints of that type.

Ms JAN BARHAM: It is interesting. In a speech I gave the other night I quoted from something Adele Horin wrote about how she watched her mother change after her entry into a nursing home in a very short period of time. She felt it was as a result of chemical restraint. People talk about it but I am interested to find out whether or not there is evidence about it and to really clear this up. Following on from that, you made a point about when you refer complaints. How do complainants deal with that referral? Are they involved once it is referred to another agency? Are they informed? How do they find resolution of the issue once it is beyond you and it goes to someone else?

Ms DAWSON: In determining that referral to another agency is the appropriate course of action when we write to them we would say, "Your matter has been referred to another agency." So in the example we just

used it would be the aged-care regulator. We would provide contact details to assist them with that. That would be the normal approach that we would take.

Ms JAN BARHAM: So in your loop of resolution is it resolved when it goes to another agency or do you still track it?

Ms DAWSON: That goes to the thorny question of what feedback we get when we refer. At this point in time that complaint would be considered to be assessed and finalised once it is referred. The question is how we can strengthen our practices with other agencies once we do refer, and there is work to be done there.

Ms JAN BARHAM: I am particularly interested in Aboriginal and Torres Strait Islander people. Do you receive complaints about culturally inappropriate treatment or racism that people experience from government or non-government organisations? Is that a field of concern that is raised and do you identify it?

Ms DAWSON: We see it from time to time.

Ms ELENI PETINOS: Commissioner, I have seen constituents, in my 12 months here so far, who have raised issues around coming to the Commission with situations which they have complained about and having their complaints found to have no basis—that is, the Commission finds in favour of the medical practitioner. They are advised of that but they are still unhappy. For various reasons, they disagree; and then we are in the position where we end up dealing with constituents who are unhappy with the outcome. Undoubtedly that is going to happen, and I do not have any gripe with that whatsoever.

Effectively I am assuming that in your reports they are treated as being assessed and resolved even though the person is unhappy with their outcome. Do we provide these people with any information about how to potentially avoid getting into a similar situation in the future? Some of these people have other issues, and it is my belief that there are probably patterns. So how do we keep these people to not go down the same path in the future? How do we arm them with that information even though they do not get the outcome they would have liked in those particular circumstances? Does that make sense?

Ms DAWSON: Yes, it makes perfect sense to me. I want to say two things about this. The first important point to make is that under section 28 (9) of our legislation a complainant is entitled to seek a review. This enables them to come back to us and say, "Hey, there's something that I'm sure you've missed. There's a piece of information that I'm sure you haven't looked at." If we have explained to them our reasoning and they see that the reasoning is flawed then they can say, "I can't see how you could have concluded that on that set of facts." So we do offer that review and it is really an opportunity to have a look at whether our decision-making the first time around is sound. That review may or may not lead to a change of decision. That is the first point to make.

The second point is that we may find during that process that the individual does need some support. Perhaps they have some mental health issues or perhaps they have been traumatised by the experience. What we try to do there, if the review process uncovers those concerns, is to connect them with support services that they may be able to access. So we may say to them, "Look, we think you may well benefit from support through a particular mental health service or a domestic violence service or whatever it is," depending on what their situation is. We need to try to hook them up to programs that allow them to resolve their issues in the best way possible. So that is the approach that we take.

Ms ELENI PETINOS: Commissioner, do you have any information available about how often the circumstance that you have just outlined occurs—that is, that people are put in touch with additional services once their complaint is actually finalised to give them support? Are we aware of the frequency of that?

Ms DAWSON: No, I cannot give you exact data on that. It is something that we need to get better at as well. This is about collaboration between the Commission and the actual service providers and we need to talk that through. One of the issues that we need to talk about in our regular meetings with the Ministry of Health is what are the available programs to assist people who have been traumatised by an event or who have an underlying issue that may lead to them having continuous points of conflict with the health system? We are not an organisation that actually has the resources or the remit to develop services and programs for these people; but we certainly want to strengthen our ability to refer people to existing programs that we know will help them.

CHAIR: In relation to resilience training for staff, and I know you have appointed a grievance officer, has this new measure had some good outcomes?

Ms DAWSON: Yes, we have put about 55 of our staff through resilience training so far, and we are about to put through another 15. So we are pretty much making resilience training a core training module for everyone at the Commission because of the type of work that we do. The officers who have gone through the training have affirmed that it really assists them to be grounded in the work that they do and to really think about how best to deal with those who have been traumatised in order that they can assist them most effectively. So the answer is yes, and it will continue to be a focus for us, absolutely.

CHAIR: And with the expected increase in complaints how are you dealing with increased staff workloads without diminishing customer service and is technology assisting you in that process?

Ms DAWSON: There are a range of things we are doing. Basically one of the important things to do is to acknowledge that in a world where ten years ago we had roughly 3,000 complaints we are moving to a world where we are almost nudging 6,000 complaints, there is a doubling of complaints. Obviously the complaints assessment process cannot look the same. What we are doing in our business process review is to say what would a more risk-based approach to managing assessments look like, a triaging if you will, borrowing from the health language. We say right up front: Is this case susceptible to early resolution? We steer in that direction. Is this case one in which it is very clear that quite quickly, based on the information that the complainant has provided us, we can make a quick and early determination or is this complaint plainly complex and we need to invoke an up-front scoping of exactly what we need to resolve this complaint in a timely way. It is all about adopting a risk based approach up front.

Second, technology, yes. We need to continue to build our systems. We have a good case management system, CaseMate. A friendly name, CaseMate. It is quite a powerful instrument because it is able to tell us at any point in time, if you run management information from it, where complaints are up to, how many are over 30 days, how many are over 60 days and it allows you to flag particular complaints and see what is happening with that particular complaint. What I am talking about here is using systems to good effect, so if delays are starting to occur there is an early warning signal about what those are. There is that technological system to make sure that important complaints do not get lost in the bundle of the 6,000 complaints.

There is a training and development dimension, going back to the earlier part of your question. What I am noticing is that if we want to use early resolution effectively, there is a different skill base to early resolution than what there is in assessment. What you are actually asking somebody to do is to step forward quickly and say if I get into the best position of understanding exactly what that complainant was wanting, quickly bringing that into reveal for the provider and understanding how far the provider is prepared to go in compromising—with an apology or reimbursement or whatever—you can get a quick solution. It is a different skill to, "what do these medical records tell me about how Mr Smith was treated in the emergency department of St Vincent's." For me I am looking at how we get that training going so people are skilled in getting in early and cutting to the chase. Those are the sorts of initiatives we have in place. They will require really diligent pursuit. You can be sure they will get diligent pursuit.

Ms JAN BARHAM: All complaints must be made in writing, is that correct?

Ms DAWSON: That's correct.

Ms JAN BARHAM: So, other complaints of a verbal support service, are you thinking of those?

Ms DAWSON: We have that service. We have an inquiry service and if an individual is wishing to make a complaint but it is plain that there are obstacles to them preparing a written complaint you will see in our data about our inquiry service that there is a category called "assisted complaint writing" where we might sit down with somebody and say, "How do you want to frame your complaint", and then it will be lodged. The written complaint requirement should never stop someone getting something into the complaint system. Our inquiry services officers are very attentive to that point.

Ms JAN BARHAM: Does that mean you also take a verbal complaint? Is there a service whereby you can ring up and make a verbal complaint that is registered?

Ms DAWSON: It would be more that our inquiry officers would actually—with the inquiries we get we have an inquiry service which is separate to our assessment service.

Ms JAN BARHAM: That is assisted?

Ms DAWSON: Yes, that's correct. The person would give an assisted referral. Interestingly enough that referral might be entered in to the complaints system or it might be assisting the person to connect with the local hospital complaints system or another complaints body that is more suited to their situation. It is really about supporting complainants.

Mr ADAM CROUCH: You mentioned earlier that you believe the NSW Health Care Complaints system is leading the way nationally with the way it deals with complaints. To elaborate on that, do the Commissioners meet on a regular basis? If you are looking at a national code of conduct do you meet with your colleagues from Victoria, South Australia and Queensland? How often does that take place and what sort of exchange of information takes place during that? Do you engage internationally as well?

Ms DAWSON: Ms Mobbs can probably comment on international engagement. In relation to national engagement, yes. The New South Wales Commissioner is a part of the national conference of Commissioners which occurs annually and also on an as needs basis. In fact, there is a meeting of Commissioners next week, it is a two day meeting. That meeting will be a combination of rich information exchange and more operationally oriented discussion with the Australian Health Practitioners Regulatory Authority [AHPRA] and others about important issues such as data exchange.

CHAIR: AHPRA is?

Ms DAWSON: I am sorry, the Australian Health Practitioners Regulatory Authority. It is the national body that registers all registered health practitioners. We need to be sure that we can have access to data that they hold so that when we get a complaint we can immediately ask: who is this practitioner? Where do they practice? Are there any conditions on their practice from the national body and how do we deal with those? There is a regular collaboration between Commissioners around those topics. I have also embarked on bilateral discussions with a couple of jurisdictions. I have made a visit to the Victorian Health Services Commissioner. The purpose for that is that the Victorian jurisdiction is going through some very significant change to its focus. It has done some very good practice things.

Victoria did a comprehensive study in 2013-2014 on the experience of their complainants. On the back of that study has examined what improvements to their process they could make to improve complainant experience. I was interested to see whether what they saw in that study resonated with what I was seeing as a new Commissioner and whether they had anything new and bright and shiny about improving the experiences of complainants that I could learn from. I was comforted to know that the initiatives that we have got about improving the experiences of complainants is benchmarking well against them. That was good to calibrate with them and say, are we both on the same page in terms of improved communication with complainants. That bilateral conversation was really important for sharing best practice and can I learn from my colleagues. But, secondly, the interesting thing about Victoria is that they have had a system in Victoria that focuses more on conciliation.

It is a conciliation-based system where people can actually go and the Commission has powers to offer compensation, effectively. It is a very different system to New South Wales. They are now moving much more towards a New South Wales based system, because conciliation is really only suitable in a small segment of the complaints suite that you see. Victoria is moving towards a broader spectrum of complaints management that allows them to go into resolution, as we do, and refer to councils and so on. It is something much more akin to New South Wales. That was very interesting to me. I was able to share with my Victorian counterpart what our experience was.

In the case of Queensland, you would know that the change in terms of the establishment of the Health Ombudsman over the past 18 months or so is an important initiative. In the coming weeks I will be talking to the Queensland Ombudsman to learn not just about the systems they are putting in place—the really good thing about Queensland is, as it is a new entity, they are having a fresh look at the best available case management systems and the best available technologies. I really want to be able to understand what they have learned from that. It is a long answer to your question but there has been really rich exchange and it is something that I want to continue.

Mr ADAM CROUCH: It is only early days for you in your position but have you found that the information and statistics New South Wales gathers about patterns, performances and complaints are similarly matched across other State jurisdictions? Is it like for like, effectively? We are not saying we have a massive issue in a particular area that does not exist anywhere else, are we?

Ms DAWSON: I would agree that there are very similar patterns from what I have looked at so far. It is clear to me, for instance, from looking at Victoria that the pattern of an increase in the volume of complaints is very similar. Victoria in 2013-14 had a 23 per cent increase in complaints volume and in 2014-15 a 10 per cent increase. They too are showing an increase in the volume of complaints. So too is Western Australia. That seems to me to be a common picture from what I have looked at so far. There is more to see.

In relation to the matters complained about and who is complained about, there is again a predominance of complaints about medical practitioners, nurses and midwives, dentists, psychologists. The classes of people who are complained about are very similar and the issues that are complained about are very similar. As to the clustering of issues that are complained about, treatment and communication is really where all of that sits. Yes, there is a common picture. I need to keep looking and we have our radar up for anything that spikes up as a New South Wales specific phenomenon. I think that was the guts of your question.

Mr ADAM CROUCH: Absolutely. Thank you.

Ms JAN BARHAM: Do you have a breakdown or analysis of complaints in the category of treatment? When I look at aged care facilities, do the complaints have to do with not just medication but also wait times for treatment that might be improved by higher staffing levels, for example? Is there somewhere we can find a breakdown of treatment? Likewise for hospitals. Treatment is a big issue, so is it defined further?

Ms DAWSON: We have a typology. Here is the kind of simple answer: When we assess a complaint we will identify the complainant, the provider and what the issue is. Sitting under "treatment issues", for instance, there will be a whole subset of categories that we can identify as being related to that treatment. I think the answer is yes, we can drill down into the data more. I will take that on notice.

Ms JAN BARHAM: And whether or not you are able to provide a list?

Ms DAWSON: I think the answer is yes, we can provide that level of granularity. Just to be clear, in the category of treatment there are about 15 or 20 specific issues that we could say are related to treatment. They would be inadequate treatment, diagnosis, inadequate care, delay, rough or painful treatment—I could go on. There is really quite a set of micro sub-issues that we can identify.

Ms JAN BARHAM: That is good to know. I wondered whether or not the reports might be more relevant if they contained more of that information. At page 21 at chart 7.6 the big category under mental health is consent. Again, it would be good to know what the particular issues are about consent. Is that a matter that you can take on notice and get a breakdown of what the consent category means?

Ms DAWSON: We will take that on notice. If it assists can I draw your attention to the appendices of the annual report? Some of this rich information is embedded there. I notice, for instance, that table 16.2 has a breakdown of the complaints received not just by issue category but by those sub-issues that I just referred to. It is on page 106, for your assistance. Secondly, another one that might be of use to you is on page 116, table 16.10, which for the aged-care facilities that you mentioned actually breaks down the types of issues that were raised by facility. Those two things together will help you but I will certainly take on notice whether there is anything more granular that we need to do to fully answer your question.

Ms JAN BARHAM: And the analysis. I am wondering whether it forms part of your role to do that sort of analysis.

Ms DAWSON: Yes.

CHAIR: Commissioner, we have very much enjoyed the testimony of you and your officers today. It is good to hear that you will be focusing on some of those regional versus metropolitan issues and drawing out some issues there. I am particularly keen about the extra training of staff to get to a resolution more quickly for lower end complaints. Is there anything else you would like to leave us with today in wrapping up?

Ms DAWSON: No, Chair. I think I have had an opportunity to cover the many performance aspects and commitments into the future for the Commission. I really thank you for the opportunity to go through those issues.

CHAIR: Thank you.

(The witnesses withdrew)

(The Committee adjourned at 10.08 a.m.)