REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE HEALTH CARE COMPLAINTS COMMISSION'S 2017-18 AND 2018-19 ANNUAL REPORTS

At Jubilee Room, Parliament House, Sydney, on Friday 31 July 2020

The Committee met at 10:00.

PRESENT

Mr Gurmesh Singh (Chair)

Legislative Council	**Legislative Assembly**
The Hon. Mark Pearson	Dr Joe McGirr (Deputy Chair)
The Hon. Walt Secord	Ms Kate Washington
	The Hon. Leslie Williams

The CHAIR: I acknowledge the Gadigal people, who are the traditional custodians of this land. I pay my respects to the Elders of the Eora nation past, present and emerging and extend that respect to other Aboriginal and Torres Strait Islander people who are present. I declare the hearing open.

SUE DAWSON, Commissioner, Health Care Complaints Commission, affirmed and examined

TONY KOFKIN, Executive Director, Complaint Operations, Health Care Complaints Commission, sworn and examined

The CHAIR: Good morning and thank you for attending this public hearing for the review of the Health Care Complaints Commission's 2017-18 and 2018-19 annual reports. Before we start, do you have any questions about the hearing process?

Ms DAWSON: No, Chair.

The CHAIR: Would you like to make a short opening statement before we begin the questions?

Ms DAWSON: I would, thank you. First of all, the Health Care Complaints Commission [HCCC] sits within a very large and complex health system. I think that in these challenging and difficult times I would just like to pay tribute to the tireless work of everybody across the health system. It is very evident to me every day, frontline workers and health administrators alike. I just wanted to record my thanks and respect for the work that is done across the system.

In terms of this hearing, it was an interesting opportunity, given that the hearing covers our 2017-18 and 2018-19 annual reports, and given that we are in the progress of preparing our 2019-20 annual report. It gave me an opportunity to just sit and reflect on the last three years of the work of the Commission. A couple of headline messages stood out for me that I thought I would like to convey to the Committee. The first is that over that period we have had a climate of increasing complaints—a 25 per cent increase over the last three years from 2017-18 onwards—and our complaints have become more complex. I think what our annual reports for 2017-18 and 2018-19 show is the journey that the Commission has been on in managing that challenge, really undertaking in a very purposeful way the substantial systems and process reforms that have been necessary to respond to those challenges. That was supported by some additional resourcing, which was very welcome.

I hope you will agree that the reports show considerably strengthened efficiency and effectiveness over that time. Some of the things that I think really stand out for us are that the number of complaints assessed between 2017-18 and the current day has increased by 33 per cent. We are at a point where the number of complaints assessed well exceeds the number received. The good message out of that is that naturally that means you can avoid a backlog in complaints and it means that you can considerably improve your timeliness of assessing complaints. Whereas in 2017-18 it was taking more than the 60 statutory days to assess a complaint—in fact, 72 days—and only 54 per cent of complaints were being assessed within the 60-day time frame, we are now at a point where the average number of days to assess a complaint is 39 days, and 89 per cent of our complaints are being assessed within the 60-day time frame. That is a really great achievement and I think it reflects the success of the systems and process improvements that we have put in place.

I think it is clear from our annual reports that our emphasis on resolving complaints and having a really high-quality resolution service is paying dividends. In 2019-20 we have completed 412 resolutions, whereas in 2017-18 we were only in a position to complete 185. You will see also that there has been a very, very intensive focus on progressing the investigation of our more serious matters. This year we were able to complete 501 investigations, whereas in 2017-18 we were only able to complete 282. That is a 78 per cent improvement in investigations output, and something that I am very proud of. It is a tribute to the work of Mr Kofkin and his team. I think you will agree when you look at the 98 per cent success rate of our prosecutions, and the increasing number of legal matters that we are finalising, that our performance in the prosecutorial space is very strong as well. I acknowledge the efforts of all staff of the Commission and welcome your questions.

The CHAIR: Mr Kofkin, would you like to make a short statement?

Mr KOFKIN: No. I completely echo the sentiments of the Commissioner.

The CHAIR: I would like to formally thank the witnesses for their flexibility in the different and changed environment of doing this inquiry. The purpose of today's hearing is to touch on issues that were not adequately answered in the written responses.

Dr JOE McGIRR: Commissioner, I have a number of questions and I am seeking clarification on some matters in the reports. My first question relates to question three. You have detailed there what you have done in relation to the situation we are now facing with COVID-19. I am wondering whether the use of video technology has in fact improved the performance of the Commission and response times. If that is the case, will that continue?

Ms DAWSON: Yes, I am very pleased to say that not only has complaints performance not been affected by COVID, but we have had the opportunity to accelerate our technological reforms. That has actually assisted us to improve performance. I have made mention already that in 2019-20 our ability to assess complaints in a more timely fashion has further improved, such that we are assessing complaints within an average of 39 days, as opposed to 48 days the previous years. Some 89 per cent of our complaints are being assessed within 60 days. I have talked about the increase in the ability to finalise resolutions. That has been a particularly interesting part of our business throughout COVID. It would be unsurprising to you that it has been very difficult to do our normal face-to-face mode of running mediation meetings and attending open disclosure meetings, which are all such a fundamental part of that resolution space.

We have had to really think about new ways of doing business, and new ways of making sure that our resolutions are able to still gather really high-quality open information and create an opportunity for the parties to a complaint to interrogate that information. That has been an interesting change in process, as well as using some of the video conferencing techniques that we will use. The short answer is, yes, performance is very good and it will be sustained, because even though we have been very readily able to roll out improved technology and improved processes, we still have a way to go. I was just communicating with the Chair about the fact that we are three-quarters of the way through the process of setting up video conferencing rooms much like this facility. We have not had those in the past. We have long awaited the equipment that we need from the far shores through COVID to get those set up. Yes, we are looking forward to continuing our improvement in performance.

Dr JOE McGIRR: Can I just make an observation—

The Hon. MARK PEARSON: Can I just ask a question to that, sorry?

Dr JOE McGIRR: Yes.

The Hon. MARK PEARSON: Are there any disadvantages that you have discovered through having to use this technology of video-linking and assessment via that method?

Ms DAWSON: I echo the phraseology of my IT Transformations Director. We are using Office 365 and the Teams functionality under that, which is the videoconferencing functionality. He says to me with pride, "Sue, Teams is an absolutely great tool for us to do business, but face –to- face is better." I think that, particularly with our more difficult and serious complaints, the quality of the communications is really paramount to us. We will continue to do everything we can through these more virtual communication techniques, but I do think we look forward to the time when we can make sure that we are able to have that face-to-face communication and we are able to sit in the round and work through difficult issues.

The Hon. WALT SECORD: Ms Dawson, in your opening remarks you introduced the issue of working in a COVID environment. What has been the impact? Have you seen an increase in complaints or a drop in complaints? What has been the nature of complaints? What has happened during COVID with healthcare complaints?

Ms DAWSON: Thanks for that question, Mr Secord. Overall, the experience during COVID has been that the number of complaints received has decreased. I just took a snapshot, as I was preparing, for the period between April and May 2020. The number of complaints received during those two months was roughly 20 per cent lower than we would have expected to receive in those months in a normal year. That has been an interesting phenomenon.

I think that also during July—Mr Kofkin may be wishing to comment as well—the decreased number of complaints has continued, so there is a suppressed number. That is not unsurprising. As you would expect, as health services have been repurposed and people have been isolating, we know that emergency department presentations and so on are down. That is all reflected in the lower number of complaints overall. As for the complaints about COVID itself, I gather from your question that you would be interested in the extent to which complaints relate to the COVID experience—how many of those there have been, and of what type?

The Hon. WALT SECORD: Also, have there been any investigations involving practitioners claiming that they have been able to respond to or prevent or treat COVID?

The CHAIR: Ms Dawson, just before you answer, I believe a question similar to this was already asked and answered in the written response. Could you limit your response to be outside of what has already been provided?

The Hon. WALT SECORD: I am seeking an update.

Ms DAWSON: In relation to the total volume of COVID complaints during 2019-20, during the period of March to the end of June 2020 we received 445 complaints relating to COVID. Of interest in relation to those

was that there were only 3 per cent or 4 per cent of those complaints that required us to take action in relation to referring matters to the professional councils or investigation—so a very small number with significant issues to deal with. The corollary of that is that the vast majority of those complaints related to issues that arose from confusion about issues relating to testing and issues relating to telehealth consultations, as opposed to face-to-face consultations with GPs and the like. It was a very small proportion where there were considered to be either serious issues or clinical departures or consequences, if I could put it that way.

The Hon. WALT SECORD: In the last couple of hearings there were discussions about the status of the HCCC involving a former employee—that was in 2017 and it came to a head in 2019. What is the current status of that report? The Minister is on the record saying that he was going to carefully consider the report and make recommendations or actions involving the HCCC. Without going into details of the matter, what has been the response and the Government's actions towards the HCCC involving that case?

Ms DAWSON: Investigation reports were reports to me, as the Commissioner of the HCCC. All of the recommendations of those reports, in terms of appropriate improvements to administrative measures and so on to avoid recurrence of those issues, have been implemented. I have communicated that to this Committee in the past.

The Hon. WALT SECORD: What are those "appropriate improvements"?

Ms DAWSON: I am happy to summarise further for the Committee in writing following this meeting as to what the recommendations are.

The CHAIR: Sure.

The Hon. WALT SECORD: Why do you not just take the occasion now and do it quickly to save yourself time preparing a report?

Ms DAWSON: There is no obfuscation involved here, Mr Secord. It is simply that our focus in preparing for this supplementary hearing related to the annual reports and the performance of the Commission over 2017-18 and 2018-19.

The Hon. WALT SECORD: This occurred during that period.

Mrs LESLIE WILLIAMS: Through you, Mr Chair: I think it is appropriate that the Commissioner is allowed to take that question on notice. She has indicated her preparedness to do that. I think that is perfectly acceptable.

The CHAIR: Thank you. I am happy to accept that as well.

Dr JOE McGIRR: Can I just finish on question 3 by making a comment? The use of video technology, clearly a number of businesses are finding that very effective and I do not see why the HCCC would not take advantage of that. However, echoing the concerns raised by Mr Pearson, I think we need to be mindful of the impact on people making complaints and their experience. I guess the question related to that is: Have you got any mechanism for making sure that the experience of complainants is not altered by that?

Ms DAWSON: Absolutely, particularly in our resolution and investigation functions, where we are needing to have the most frequent interaction with all parties. We have clear plans for how we execute those resolutions and investigations. Those plans involve what is the most appropriate way of communicating with the parties. We can foresee a situation absolutely, as you say, where we are more frequently using videoconferencing, but there will be circumstances where our plan will say there is a vulnerability or there is a complexity here that will very much reward a face-to-face hearing or face-to-face communication. It is through the good planning of each and every one of our resolution and investigation matters that we will achieve that.

Dr JOE McGIRR: I guess I am just looking for a process whereby you will actually assess the experience of the complainants and make sure that they are happy or they are satisfied with the process.

Ms DAWSON: My apologies if I missed the thrust of your question. Two things that we are doing in that regard: We have just finalised a full review of the survey and feedback instruments that we use right across all of our functions of the Commission. Every person who lodges a complaint and whose complaint we determine receives the opportunity, through our revised survey and feedback form, to provide feedback about any aspect of the process and their experience of it, including open fields for inadequacies that they would like to point out, or things that they would have preferred that they did not get. We are now also moving towards introducing some software whereby we can analyse all of that survey feedback and identify areas for improvement. From my point of view that is a very, very important improvement as a result of our stakeholder engagement initiatives.

The second thing that we are moving on to, going to the question of Dr McGirr, is that we are going to take a look at the trends in feedback that we are getting from the analysis of those feedback forms. We are going

to move towards having more of a focus group-style way of interacting with the users of the complaints system, be they providers or be they health consumers. We are going to bring people together in those focus groups to not just understand what has not worked for them but to get their input into the solutions for how we do business better? That feedback loop is now much more well embedded today than it has been in the past.

Dr JOE McGIRR: Information on that will be in future quarterly and annual reports?

Ms DAWSON: In annual reports, yes, it will be.

Ms KATE WASHINGTON: Commissioner, just going back to COVID-19, the experience since the beginning of the year and the complaints that have been made to the HCCC, have any of those complaints been about professionals holding themselves out as having cures for COVID and perhaps misrepresenting their capacity to respond to COVID? Has the HCCC issued any public notices about either any individuals or practices?

Ms DAWSON: Mr Kofkin may well wish to contribute to this as well, but certainly there have been some complaints relating to the opinions presented by various health practitioners on social media about COVID and its genesis, and various perspectives about COVID and what sorts of treatments or approaches might work.

The Hon. MARK PEARSON: Dettol.

Ms DAWSON: Yes, amongst others. We had one particular complaint that in fact went to investigation regarding a naturopath, the concerns in relation to whom were, firstly, that this naturopath was advertising for sale "COVID testing kits". The second issue was a suggestion that that practitioner was also making claims about the efficacy of certain treatments to cure or address COVID. Those were the allegations. As it turns out in that particular one, there was a much more complicated story in relation to the testing kits, which was dealt with by the Therapeutic Goods Administration. In relation to the issue of claims regarding cures, examination of the information on that social media site did not support that suggestion, so we were not able to substantiate that aspect of the complaint as far as I can recall. Mr Kofkin, are you wanting to contribute?

Mr KOFKIN: Surprisingly, no, they have not been complaints in relation to individuals saying that they can cure COVID. As the Committee knows, in the past we have had investigations into unregistered practitioners who claim they can cure cancer and dementia, but we have not had any complaints in relation to that. As the Commissioner was saying, many of the complaints in relation to COVID-19 have been about accessibility to health services and that confusion when a medical centre, if there are symptoms of COVID, will ask someone to be tested or do a telehealth consultation. Accessibility has been one of the issues. Other issues have been cancellation of elective surgery and confusion around that and continuity of care, particularly in dentistry—if somebody is halfway through a root canal and cannot get follow-up treatment, et cetera. That is the flavour of complaints that we have been getting over the last three or four months.

The CHAIR: I imagine it would take some time after the fact of the actual medical procedure for complaints to get to the HCCC. Do you foresee more complaints of this nature coming in the latter half of this year?

Ms DAWSON: I think that there will certainly be a continuation of complaints. As your question suggests, the nature of the complaints will probably change and shift over time. For those for whom the timing of their elective surgery has been affected, we can imagine that that delay will become an issue for them, as it will for those whose treatment regime for chronic or other illnesses may be affected. I think that we will continue to see complaints coming through as the time goes by.

The Hon. MARK PEARSON: Do you foresee the likelihood of complaints in relation to isolation, loss of civil liberties—in terms of how it has affected the health of the patient or the health of the family, do you foresee that there may be some complaints in relation to that coming after this settles down? And is it your brief?

Ms DAWSON: Yes, that was where I was going to go. There may well be those experiences. I think we have all heard and observed issues relating to the mental health impacts of COVID generally. There is a massive health system response to that issue, which I think we all value and appreciate. From the Commission's perspective, our jurisdiction relates to the delivery of a health service. If the standard of care for somebody seeking help and support because of their isolation is found to be deficient, that may find its way to us. But the question of the social impacts and the health impacts of isolation per se is probably for the health system more at large.

The Hon. MARK PEARSON: It is going to be a new animal on the horizon, I think, this question.

Ms DAWSON: I do think so, yes.

The Hon. WALT SECORD: Ms Dawson, I want to return to cancellation and delays in treatment. Did you have an increase in reports of people concerned about chemotherapy and oncology cancer treatment?

Ms DAWSON: It has not come to light in the COVID-related complaints that I have seen. Mr Kofkin, do you have a different insight into that?

Mr KOFKIN: No, not at all. We have not had any complaints in relation to ongoing cancer treatments. It has not been an issue that I have seen.

Dr JOE McGIRR: I had a question in relation to question four, where you have provided a response into the factors contributing to the growth of complaints. In essence your answer is: "Look, these are some general factors that have led to that and, beyond that, we cannot do anything more in terms of the analysis, or it is difficult". Have you considered partnering with a university to undertake some more formal research in this area, or a review of the literature?

Ms DAWSON: There is much to be said on this topic and I will try to be brief. Our response to the question was not intended to be evasive on that point; it was, in fact, to really highlight that there is a seminal piece of work, a seminal academic study from Plymouth University on the question of what drives the volume of complaints?. I am happy to table that with the Committee for the benefit of anybody who wishes to read it. It is quite a superb piece of work. What that study shows—and the findings of it are essentially utilised by each of the healthcare complaints entities across the country—is that there are many, many factors that drive the increase in complaints. We have endeavoured to recite those in our response to the question on notice.

But your question goes to whether there is therefore more that we could be looking at ourselves or in partnership. Let me first of all reflect on what we as a commission ought to be doing. What I think we can most effectively do, given that it is hard to know how all of these factors come together, is to really take the opportunity to analyse all of our complaints and examine whether there are particular cohorts of complaints where, with more agility and a more preventative approach to complaints handling, we could avoid a complaint and have the systemic issues for that cohort of complaints addressed more effectively—and that the Commission could influence that. That is a very big focus for us at the moment. We are doing well in some areas. The area that really stands out here as being a good example of what you get from good analysis of complaints is the work that we did on examining complaints from detention centres and inmates.

You will notice from the annual report information that back in 2015-16 the Commission received close to 14 per cent of its complaints from the inmates of detention centres. We needed to understand what that was about, so we sat down with Justice Health and we said, "What's causing that?" What became clear is that at the service delivery point in the clinics within Justice Health there was not a place where the inmates could go to inquire about their next appointment; "Could I have an X-ray?", "You have changed my medication". Because there was no immediate interface for them to ask about the health issues, they came via the HCCC. It was not actually a complaint. They just wanted to know something.

We negotiated with Justice Health that they would introduce the equivalent of an inquiry service for their Justice Health clinics and, happy days, complaints from inmates are down to about 5 per cent of all complaints. That allows us to make sure that the ones that are coming to us are really questions about, "Was the adjustment to my medication appropriate?" "Was it not?", and failures to have access to services and so on. It is that sort of work we are doing. I could use other examples but I think you get the idea that we are wanting to take the opportunity to understand our complaints, introduce new strategies that avoid complaints coming in the first place and give better service for health consumers across the system.

The other area where we are actually partnering—and going back to your fundamental question about partnering—is that we are working very closely with other specialist regulators in the health-related space. As you would know, there are very new players in the regulation space in relation to areas like ageing and disability: The Aged Care Quality and Safety Commission are at the Commonwealth level, the NDIS Quality and Safeguards Commissioner, and we have the elder abuse focus of the NSW Ageing and Disability Commissioner. What we are doing is getting together with all of those Commissioners to say: How can we ensure that there is much greater clarity for health consumers about which pathway they go into in the first place, so that they do not do the round robin of complaints entities? We are getting much better at that. Those are just two examples.

As for pure research partnerships, we are doing work in that space as well. I know that Dr McGirr has an interest in relation to the experience of Aboriginal health consumers, and whether there are barriers to them using the complaints system. In that regard we are wanting to form an engagement with the Aboriginal Health Service and Medical Research Council, for instance, to look at how we can do some research to understand those issues. It is a rich set of things we can do ourselves within the Commission using our own data and using our own analytical capability, things that we can do in partnership with other regulators and things we can do with the research and academic communities.

The CHAIR: Is the rise in complaints in line with other jurisdictions?

Ms DAWSON: Yes. It is an international phenomenon, which is why the Plymouth University study is very much a touchstone for all health complaints entities looking to understand this. The UK experience is very similar to ours. If you look at the annual reports of each of the health complaints entities, the Health Ombudsman in Queensland and the Australian Health Practitioner Regulatory Agency, or AHPRA, it is the same picture. There is just the trajectory of year-on-year increases, yes.

Dr JOE McGIRR: I did have a question in relation to question No. 25 and the small number of complaints related to Aboriginal health services. You have just made a comment on that. I do think that small number is a concern.

Ms DAWSON: Yes.

Dr JOE McGIRR: I would hope that we would get some more information on what you are doing in that regard. I do not accept, actually, that those services do not have issues. From my experience the small number of complaints probably reflects the fact that you are not engaging with them in a meaningful way. I am very pleased to hear that you are doing some work around that and I hope that we would see some more information on that in the future. Is that an appropriate question to ask? Can we have some more information on that in the future?

The CHAIR: I guess that is a question, yes.

Dr JOE McGIRR: What would be the time frame for some analysis of that?

Ms DAWSON: We had a plan to meet with the Aboriginal Women's Consultation Network via the Women's Legal Service of New South Wales back in April-May, which was disrupted by the COVID situation, for the very purpose of understanding this. Please do not take it that there is any indifference to this issue. I want to understand a lot more about how we can be accessible and responsive to the needs of our Indigenous community and their health care arrangements. That meeting with the Aboriginal Women's Consultation Network was our first point of entry to say, "What is the dynamic here? Is this to do with the way the Commission itself works? And how we can change our point of entry and access to support those who wish to make complaints? Is it to do with whether the health services themselves need encouragement to deal with their front-line complaints activities, or so on?" The short answer is, yes, we will give you some feedback on what we learn from those discussions and what we can do to respond to the issues that arise.

Ms KATE WASHINGTON: The use by the HCCC of clinical opinion in the assessment of claims and/or investigations, can you describe the role it plays and whether or not the input from nurses is gained in assessment of claims as well? Is that clinical opinion something that is within the organisation or external to the organisation? In addition, has there been a change in the way that you are gaining that clinical opinion and/or expertise?

Ms DAWSON: I will take it in chunks, but if I miss anything, please pull me up on that. Let me just talk about the manner in which we gather clinical advice and the points in the assessment and investigation processes at which we use that advice. If a complaint has a clinical complexion, and not all complaints do—for instance, there might be complaints about sexual assault and so on, and those can be dealt without clinical input. But to the extent that the complaint has a clinical complexion, there are four sources of clinical input and advice.

First of all, we would typically look across our own cohort of assessment officers, many of whom have clinical experience. We have nurses and midwives and people who have been in the allied health professions and so on, so we would typically allocate those to people who have some clinical acumen. Secondly, the other option is that once we gather medical records and responses, we have two options for the scrutiny of the clinical aspects of the matter. The first is that we have three internal medical clinical advisers, who are experienced GPs with broad generalist experience and who can provide us with either a verbal or a written opinion on the quality of the clinical care provided and identify any omissions.

If a matter has a more specialised character to it—it might be about an obstetrics or gynaecology matter or a cardiothoracic matter, or whatever—we have another option, which is that we have a panel, a very large panel, of peer clinical experts to whom we can refer the matter and seek their written clinical advice. At that point we will make a recommendation that draws on the clinical advice and, in relation to all matters relating to registered practitioners, we would then consult with the relevant professional council. Through that process they would have their clinical experts examine the quality of the clinical opinion and any of the primary documentation from first principles. We would arm doors and crosscheck, if you like, through that consultation process to determine whether there were clinical departures.

Ms KATE WASHINGTON: I have a question on the back end of that: Has there been a change in the way that you are accessing the clinical opinion in the process?

Ms DAWSON: Yes, there has. We found that as the complaint volume grew and as the complaints became more complex we needed to find a broader base of clinical advice and have a larger number of clinical advisers. So we did a refresh of our clinical experts, and we recruited more experts, and we are using those more often to ensure that we are getting timely clinical advice and that it is from the right people who have got the appropriate qualifications to do them. So, in other words, we have augmented our internal, on-staff medical advisors with clinical experts outside of the Commission that we can draw on. And, as part of that initiative, we have also redelivered a suite of training for all of our clinical advisors, irrespective of whether they have been with us previously or whether they are new, just to refresh what we are looking for in clinical advice and the quality and nature of the advice that we receive.

Ms KATE WASHINGTON: Sorry, I thought I understood but then you said something that made me unsure.

Ms DAWSON: Oh, I have undone myself.

Ms KATE WASHINGTON: No. So internally you have augmented the clinical opinion opportunities as well as on the panel?

Ms DAWSON: No. We still have the same three internal clinical advisers. We use those now in two different ways. They might sit down with the assessment officer and give a verbal opinion and a written opinion. So, the change there is the mix between verbal and written advice, but with the same number of internal medical advisers. The extension of the number of advisers comes through the panel.

Ms KATE WASHINGTON: I understand. Thank you.

Dr JOE McGIRR: My next question relates to question 5 taken on notice by the HCCC. I will not go through every single question. Originally I asked for some information on general practice versus general medicine. The answer provided to question 5 does not clarify that. General medicine, as practised as a specialty, is quite different to general practice.

Ms DAWSON: Yes.

Dr JOE McGIRR: From reading the response, it seems to me that they are, in fact, lumped together.

Ms DAWSON: Correct.

Dr JOE McGIRR: To be frank, that would make the information provided about that group almost impossible to interpret. Is there any way you can distinguish or collect data that distinguishes which of the general medicine complaints are related to general practice and which are specialty-related?

Ms DAWSON: We do not do that at the moment because, as you have pointed out, the category—the service area of general medicine—does capture both specialist general medicine physicians and GPs and, indeed, other health service providers, so, nurses in a general medical environment. I think what you are indicating is that that does not necessarily allow you to differentiate between the complaints that might relate to general practitioners as a cohort relative to others. I think what we would need to do there is examine whether there is potential to do a little bit of a deep dive into the data and extract out data relating to GPs. But our classification, it is a Casemate classification system that has just a general category at the moment. I hear your concern that it puts a broad suite of things together, and it makes it difficult to understand complaints relating to one specific cohort of that. I understand that.

Dr JOE McGIRR: It makes it almost impossible to understand. What is the reason that they are lumped together? Is it the software or is it the way the collections system was set up? I do not understand.

Ms DAWSON: It is just the nomenclature and the hierarchy of classes of complaints and practitioners as it was set up in the system. So, yes, it is the way in which things are classified, in order to make sure that over time you are measuring complaints in the same way. It does not mean that that is perfect, but that is the explanation for it.

Dr JOE McGIRR: I understand the problem with changing the system is that you cannot get a trend over time, but given that, in my view, collecting information about this general medicine category does not distinguish general practice from, as you have just pointed out, a range of others, that means that the data is not really very valuable now. Should that system not be changed now?

Ms DAWSON: There are two solutions to the problem that you put. One is to review the entire classification system and decide whether there are benefits in differentiating between those two groups, or the second solution is to say the classification system is the classification system and we would deal with your absolutely reasonable question and interest through more of a research project to drill down into complaints

relating to GPs to ask and answer specific questions that we might have. So those are the two choices and I am happy to take that away and give it some thought, and perhaps we could have a further conversation about what that might look like.

The CHAIR: Just to clarify: Are you taking the question on notice for the provision of a written response?

Ms DAWSON: I could do that. I sense that it is something that we might want to explore through conversation. There would be some questions that you might have about gGeneral pPractitioner complaints that might actually reward more of a research-style solution, so that is what I would want to think about.

Dr JOE McGIRR: I think it is a really critical piece of work. We have had a number of questions this morning about the impact of COVID and whether you are going to get complaints about practitioners and services provided. In that environment, the general medical physician environment is completely different to the general practice environment, and it would be impossible to take any conclusions from data unless you separate out those two groups. It sounds as though you are saying you just do not have the capacity now to distinguish. It is almost unbelievable that that does not exist, given, frankly, the importance and the different nature of primary care in general practice to general medicine. It will probably need a fair bit of work. I think that work needs to be done.

Ms DAWSON: I can hear your frustration and I understand it. My commitment is to taking that thought away and thinking about what the best response to the interest in drilling down into that cohort is.

The CHAIR: Okay, and the Committee can discuss that at the next deliberative meeting.

Dr JOE McGIRR: You have listed very helpfully in table 2, in answer to question 6, the number of complaints and registered practitioners, and the percentage of practitioners subject to complaints. The number of complaints is not really helpful if there are multiple complaints about a practitioner and they are all listed separately as a complaint. Is it possible to get data on individual practitioners as opposed to the number of complaints? My understanding is that one individual may have multiple complaints and that each is counted separately.

Ms DAWSON: Yes.

Dr JOE McGIRR: So, in fact, the 2,377 complaints about medical practitioners may not represent 2,377 medical practitioners.

Ms DAWSON: Correct.

Dr JOE McGIRR: And the same would apply for all the other health professionals?

Ms DAWSON: Yes.

Dr JOE McGIRR: So, probably, I am not interested in the number of complaints but in the number of practitioners about whom a complaint is made. Is it possible to provide that data?

Ms DAWSON: I will take that on notice. I will speak to our data gurus.

The Hon. WALT SECORD: But, Dr McGirr, it would be useful to have both sets rather than one replacement set. I just wanted to make that clear.

Dr JOE McGIRR: Yes, exactly. Good point, yes, but we have one set now and I am interested to know—

The CHAIR: I will add a third set and that is the number of incidents. A particular practitioner may have multiple incidents against them, which then might be counted multiple times. Is that correct? So, a particular incident might be counted multiple times as complaints?

Ms DAWSON: One incident?

The CHAIR: One incident, correct.

Ms DAWSON: Maybe. May I just clarify if what you are saying is, Mrs Brown comes into the emergency department with a suspected stroke and there are perhaps three people that complain about that: Mrs Brown's daughter, a nurse who observed something, and the Medical Council that gets it through another avenue.

The CHAIR: Correct.

Ms DAWSON: You are interested in incident-based reporting.

The CHAIR: My understanding is that is counted as three separate complaints.

Ms DAWSON: Yes.

The Hon. MARK PEARSON: Could you explain why that would be? If there has been a decision to deal with them quite separately, even though the complaint might be focused on the same incident, is there an advantage or a reason as to why it is best to look at them separately as different complaints as opposed to one?

Ms DAWSON: Sure, there is. Let us take that example of Mrs Brown at the emergency department with the stroke. The concern of the daughter of Mrs Brown might relate to the triage nurse being indifferent to the family trying to escalate concerns about the condition of Mrs Brown. The daughter may also be concerned about the time that it took to take Mrs Brown to the ward, and then there might be a concern about other things that happened on the ward. So there might be different issues raised by the daughter of Mrs Brown than say, a nurse who observed this and was concerned about it so she lodged a notification. Her issue might be that the emergency department practitioner who assessed Mrs Brown routinely assesses people presenting with strokes in an inadequate way, so there may be other practitioners who the nurse may be complaining about. That is an example of where the issues might be different, and it is important that we understand all of the issues so we take the scope of the complaint and deal with it for that reason.

Dr JOE McGIRR: Question 12 relates to a target regarding completion within six weeks of reviewing assessments, and performance is well short of that target. My question is related to whether the target was appropriate, and my supplementary question is: What target do you think is appropriate or possible?

Ms DAWSON: It is a difficult area. This relates to the question of the time that it does and should take to undertake a review of an assessment decision. At the present point in time, and truth to tell, without clarity as to how this target was arrived at, there is a target of—well, actually, there are two targets, that makes it even more confusing, that reviews ought to be completed within either four weeks or six weeks of the receipt of the review request. What we find is that when someone is seeking a review there are a few things at play. First of all, they have had the initial trauma or experience of inadequate care in their view, and they are experiencing difficulty with that. Then they have had the complaint assessed and they are unhappy with either the outcome or the process. From my point of view, a review is a moment to say, "Let's just hold the bus here. Let's just have a deep dive into this and examine what has really gone on." Whether we have missed anything in the original complaint—after all the person has come back. Have we missed anything? Have we done our best work or have we not? Do we need additional clinical advice because we did not get the sufficient clinical advice or the right expert clinical advice or understand fully the issues?

In a review it is the time to actually give quality attention to this matter, so that it does not continue to go on. Now my view is, in response to your question, that essentially if you are repeating a full assessment process and an initial assessment is able to take 60 days to do, then my view is that a review to be done well should also take 60 days. The consideration that we are giving to is whether that is a reasonable adjustment to the KPI. It does not mean that every review would take 60 days, because there are occasions where you examine the review, you triage it, and you say that it is very clear that the outcome of the assessment is disappointing to the complainant, but it has nevertheless been based on rigorous consideration of all of the issues, which were not substantiated. So those reviews can be done much more quickly, but, more often than not, they are of that character of, "Really, we must check if we missed anything", and we need to take the time to do that.

Dr JOE McGIRR: What you are saying is that as part of that assessment process you actually seek alternative external opinion about what has gone on?

Ms DAWSON: With reviews, we often do, yes. We will seek a second clinical opinion, or if the initial assessment did not include written clinical advice—it might have included verbal clinical advice—we will just get that second opinion through that process. Dr McGirr, we may have in the assessment, for instance, not asked for all the relevant clinical records. We might not have asked for all the discharge summaries that would give us a bigger picture. Sometimes we need to go back and ask for more.

Dr JOE McGIRR: What you are suggesting is rather than the target changing that the time frame change?

Ms DAWSON: The target is the time frame.

Dr JOE McGIRR: Sorry, rather than the percentage completed within six weeks, which is 42 days, you are suggesting a longer period of time.

Ms DAWSON: Correct.

Dr JOE McGIRR: You are suggesting 60 days and not 42 days.

Ms DAWSON: Correct.

Dr JOE McGIRR: That is actually very helpful, thank you. Question 17 is about the review of the Commission's powers that is being led by the Ministry of Health. Is there any update on that?

Ms DAWSON: I think that, without wishing to be unhelpful in that regard, my difficulty in commenting on that one is that the Commission, as you know, is the operational arm of health regulation and the Ministry of Health is the policy arm. The Ministry is running the legislative reform project and we have been involved in those consultations, but I do not have the ability to advise on exactly where it is up to and its likely time frame.

The CHAIR: I think that is maybe more a question for the Minister.

Dr JOE McGIRR: Regarding question 20, can you give us any update relating to private hospitals and referral back to them to resolve complaints?

Ms DAWSON: We engage with private hospitals very actively through our assisted resolution function, just as we do with public hospitals. The limitation in relation to private hospitals is that we are unable to refer matters back to them for local resolution, because the legislation limits us to referring back for the facility to resolve as an outcome only for public health organisations. One of the issues that is being examined in the legislative reform and in consultations that we have been involved in, is whether it is appropriate for us to be able to refer matters to private hospitals for local resolution as well. It is in that conversation.

Dr JOE McGIRR: Just to be clear, what is your view about that? Would that be helpful?

Ms DAWSON: My view is that it would be extremely helpful. One of the things that we found about referring matters to local resolution is that it has really enabled us to contribute to encouraging stronger frontline complaints management. I say often that one of our objectives in the Commission is to contribute to there being the least possible daylight between an event occurring and somebody responding to it. What we find is that in the public hospital system we have an ability to connect with public hospitals and say, "We really want you to sit down with this patient or this family and address their issues in real time. Will you do that? Do you commit to doing that?" They are very cooperative and responsive, and I think it delivers a better result. I would like to have that same result for folks in the private health sector as well.

Dr JOE McGIRR: My next one relates to question 21 and the issue of public warnings. Again, this is something that the Ministry of Health is reviewing. Do you have any information or update on that, or the view of the Commission in relation to it?

Ms DAWSON: That matter is being discussed in consultations, so I can indicate that it is under discussion.

Dr JOE McGIRR: Do you have any view on it?

Ms DAWSON: I think that the Commission has indicated that it would be a useful adjustment to the provisions.

Dr JOE McGIRR: My next one relates to question 24, which is the technology road map. I was interested to know when that road map would be available. I had a supplementary interest in the use of artificial intelligence, or chatbots, which I have recently been quite exposed to, and I think many more organisations are now using them. I wanted to know if it was something you had explored or if it was on the horizon in any way in terms of expediting processes? Of course, there would be risks associated with that.

Ms DAWSON: Let me take the segments of your question, if I can. The first one I think related to the IT road map. The situation there is that we were very well advanced and almost completed our IT road map in March 2020 and then an international incident occurred. The COVID pandemic has meant that we have had to pivot around our IT effort to set ourselves up for fully remote working and videoconferencing, which has changed our journey on IT transformation. At the moment we are revising our plan to take account of what progress we have made on our accelerated remote working capability, and returning then to what else we need to do with our system as a whole to improve it. That road map is, as I say, in the process of being reconfigured as we speak.

With regard to chatbots, the first point to be made is that we have launched our new website, as you will know from our responses to your primary questions, and that revised website has chatbot functionality. We may turn it on if and when we wish. I have to confess that I have got a question about this that I want to explore more deeply. My experience and understanding of chatbots is that it is a good functionality to have for businesses where there is predictable, routine sets of questions and almost scripted-style responses that you can roll out through just screening, "Oh, yes, this one is about my insurance being up for time, can I renegotiate my premium?" or whatever it is. That functionality suits very well routine business practices. My question is—our inquiry service being face-to -face and having a person on the other end of the phone isn't about answering just a specific question, it is about exploring a range of issues for that health consumer, then directing them to the right place on a very diverse range

of experiences. I think that there may be some potential for chatbot in relation to frequent questions that we get, but I cannot imagine a world where a real person on the other end of the phone using an inquiry service would be replaced by that functionality.

Dr JOE McGIRR: I agree, and the reason that I am raising this is to highlight my concerns that the complaint process is not turned into some sort of automated means of ticking boxes and meeting targets. There are people who complain and the interaction with them in that process is an important part of their care and often the outcome of their treatment and it requires the human touch.

The CHAIR: I think the Commissioner has indicated the same thing.

Ms DAWSON: That balance between using technology wisely and using people equally wisely is what we are into. In relation to your third domain of artificial intelligence, there are a couple of things to be said about that. That is a very fast-moving world. My own view is that if healthcare complaints handling is moving in that direction—and I am sure that there will come a point where it is necessary to do so—I think that we need to make sure that the artificial intelligence tools that are deployed are consistent across the nation. I don't see any benefit in unilateral decisions about how you set your screening about risks in complaints on a jurisdiction-by-jurisdiction basis. You would want to have a common approach to that. I think that there is a lot of water to go under the bridge on artificial intelligence. Certainly AHPRA, the national body, is starting to think about that, and I am going to watch that progress with interest. But I would say that we are some years away from that point in the health complaints space.

The Hon. MARK PEARSON: You said that the response, or the outcome, of a complaint is much better when the person, or the complainant, receives a response faster rather than later. Apart from the obvious reason as to why that might be, are there any surprising reasons why the outcomes are better because the initial response to the person making the complaint is quicker? For example, I read some material where the sooner it is acknowledged when there might have been a mistake, rather than dismissing it over and again, the outcome was often better for everybody. Is that correct?

Ms DAWSON: That is the research that I have read as well, and it is also my lived experience. One of the reasons why complaints get caught, if I can use that word, in the complaints handling journey is because that early acknowledgement and acceptance did not occur. So people do not feel heard, they do not feel that their pain and suffering is understood, and they hang on to the grief of that. You see it a lot. It is a very interesting and challenging part of complaints handling. If we can make sure that we do no harm—and part of doing no harm is that acceptance early, and helping people to move on from a traumatic event.

Dr JOE McGIRR: I have just got one more question, and that relates to question 38—the answer about individual practitioners subject to multiple complaints. Clearly, that is a very time-consuming part of the work of the Commission. I note in your answer that it seems to me that you deal with each complaint individually and you have someone coordinate them. Is there anything that can be done to expedite that process? Following on from that, I have a concern that when complaints are dealt with individually. I want to make sure that there is not a pattern that is missed that would immediately trigger referral—in other words, each complaint gets dealt with separately and the overall picture is missed.

Ms DAWSON: I am going to try to take that in three segments, if I may. The first observation I would make is that it is actually not a bad thing when we get multiple complaints about a provider. It is helpful to us partly for the reason that I mentioned earlier, which is that each complaint might pick up a different aspect of either the same incident or similar incidents on other occasions. So it does help to build a picture of the pattern. The second point is that in triaging each and every new complaint, we generate an automatic readout of prior or current complaints relating to that practitioner. So whilst you are needed to assess that new complaint, you are doing it with line of sight to any other prior complaint and any other current complaint that is in place.

The third point is that one of the sophistications that we tried to introduce in the Commission to improve our efficiency and effectiveness is to say that once a matter gets into investigation, if you have got 10 complaints that are all related to the same practitioner—starting to get much better right at the front end of the investigation planning, you say, "What is the real gist of these complaints? Where are the gems in the evidence? Which of the patients within the 10—which of the incidents—are really emblematic of the strength of this matter?" Then you really focus in on those and, perhaps not progressing with a certain number of those complaints but being respectful to the complainants, say, "We have got 10 complaints on the same thing. Yours is very relevant, but we are going to be using these other complaints to take forward a prosecution." We are being more and more finessed in that. We still have a way to go, it is true to say, but it is very much an area of concentration.

The CHAIR: Thank you for appearing before us today. We may send you some further questions in writing. You have indicated that there is one question that you will be answering in writing. Your replies will

form part of your evidence and will be made public. Would you be happy to provide a written reply to any further questions?

Ms DAWSON: I would.

(The witnesses withdrew.)

The Committee adjourned at 11:22.