REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE HEALTH CARE COMPLAINTS COMMISSION'S 2019-2020 ANNUAL REPORT

At Jubilee Room, Parliament House, Sydney on Friday, 19 March 2021

The Committee met at 8:25 am

PRESENT

Mr Gurmesh Singh (Chair)

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

The CHAIR: Welcome to the public hearing for the inquiry into the review of the Health Care Complaints Commission's 2019-2020 annual report. Before we start, I acknowledge the Gadigal people who are the traditional custodians of this land and I pay respect to the Elders past, present and emerging of the Eora nation, and extend that respect to other Aboriginal and Torres Strait Islander people present. I declare the meeting 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: I advised the witnesses that there will be staff from the Legislative Assembly attending to take photos and as they have both requested they will not be in those photos. Do you have any questions about the hearing process?

Ms DAWSON: No, Chair.

Mr KOFKIN: No.

The CHAIR: Ms Dawson, would you like to make a short opening statement before we begin questions?

Ms DAWSON: I would, Chair, thank you. I would, first of all, echo your acknowledgement of the traditional owners of the land on which we meet, the Gadigal people of the Eora nation, and pay respect to Elders past, present and future. Another acknowledgement, if I may; I would like to acknowledge those who have worked across the health system so tirelessly and in a committed way over the last 12 months, during a time of remarkable challenge. We see up close at the Commission the benefits and fruits of that work, the effort that goes on behind the scenes, the responsiveness of setting up testing stations and responding to hotspots, and I think it is appropriate that we acknowledge all the good work that we see. Finally, I want to acknowledge the work of the staff of the Commission. The Commission does really important work. It is work that sits at the centre of often really sensitive and challenging matters. The staff of the Commission work tirelessly and in a manner that I respect and am very proud of. It is only through that work that we see through the annual report the fruits of that commitment.

It is a remarkable achievement that the organisation has been able to assess more than 8,000 complaints during the period that we are going to be talking about today, during 2019-20. That is a 39 per cent increase in the percentage of complaints assessed since the 2015-16 period. In addition to assessing more complaints, we have assessed complaints in an ever more timely way. We are now at a point where we are taking an average of 39 days to assess a complaint compared to 48 days in the prior year. And 89 per cent of our complaints are now completed within the statutory KPI deadline of 60 days. The emphasis we are placing on resolving complaints is also working well. In this reporting period, there was a 34 per cent increase in the number of complaints referred to the Commission's resolution service, and more than an 18 per cent increase in the completed resolutions. This is a really important part of our function: we bring parties together to come to an appreciation of what has occurred in very sensitive matters, and to resolve issues that have arisen.

Our intensive focus on investigation of serious matters is delivering really good results. We finalised 40 per cent more investigations in 2019-20 than in the previous year, and the average time taken to complete these investigations was 313 days. We really have got to a point where finalising more than 500 investigations a year is a massive effort, and a tribute to the work of the investigations team. I think you would also agree, looking at the annual report, that our prosecutions performance remains incredibly strong. I just want to say that I am proud of those achievements, it is a tribute to the work of the staff of the Commission, and I welcome questions on that work. Thank you, Chair.

The CHAIR: Because we have two members that will be leaving early we will give them the first questions and we will start with Mr Amato.

The Hon. LOU AMATO: Thank you for being here today. You mentioned that 500 investigations were finalised and that was due to the staff. Can you tell me how many more staff were employed and also tell me what the new processes were?

Ms DAWSON: We have received a number of budget increases over the last couple of years and it is worth saying that in the year 2019-20, right across the Commission, there are an additional 14 full-time employees that were able to be recruited. A number of those went into the investigation team.

The Hon. LOU AMATO: You said they are full-time, did you not?

Ms DAWSON: FTE, full-time equivalent staff, that is correct. That meant we were able to invest a great deal more in our investigations area, and that was really central to lifting that performance in investigations in the

manner I have spoken about. The process improvements are really very central to this achievement though. What they are is this: each matter that is referred to investigation receives very careful triaging, and that triaging is designed to identify very early the central issues in the complaint, and the lines of inquiry that might be pursued, so that the investigation effort is very targeted. Who do we need to talk to? What more evidence do we need to gather? How do we understand more fully what has occurred?

Then within that investigation we are also very attuned to thinking early about, what expert advice do we need? How do we get an independent expert opinion that will allow us to understand exactly what the extent of a departure from a standard has been – what is the departure, how serious is it, what are the implications of it, and what can we conclude about the risk to public health and safety from that? These process improvements that we have been putting in really concentrate on those efforts.

A final process improvement that is really important for us is that, each and every week in the Commission, we come together to review investigation files and key investigations that may involve a number of different practitioners, or they are complex in nature. Then we will examine them in the round and have myself and Mr Kofkin, together with the relevant senior investigators, looking at what decisions we need to make about further lines of inquiry. These are some of the process improvements that have delivered a great deal of improvement in that performance.

The Hon. LOU AMATO: Just going on from the process—and I will be very quick as I am mindful of time—there were 228 investigations that were referred to the Director of Proceedings compared to 168 the previous year. That increase in investigations put forward, is that because of this new process and new staff?

Ms DAWSON: There are two aspects to that, Mr Amato. Thank you for that question. The first aspect is the sheer increase in the volume of investigations will naturally lead to an increased number of referrals to the Director of Proceedings for prosecution. That is the dominant factor for the increase in those referrals. The second thing is that the volume of referrals to the Director of Proceedings is always difficult to predict, because it naturally turns on the types of matters that you have received for investigation. In that scenario, it would be a function of those two things combined. Mr Kofkin sees this up close each day. Do you have any comment on that?

Mr KOFKIN: You are correct, Commissioner. It is difficult to determine, certainly in terms of the increase in investigations and the types of matters that we refer to the Director of Proceedings. Sometimes it can be as a result of proactive regulation by the Ministry of Health, in terms of the Pharmaceutical Regulatory Unit or the Dental Council, in relation to proactive activity in terms of carrying out inspections when they identify significant infection control matters, where they are so serious that we do need to seriously consider referring those matters to the Director of Proceedings. It is on a case by case basis, but certainly last financial year and this year, as well, there has been a significant increase in matters referred to the Director of Proceedings.

The Hon. LOU AMATO: Thank you, Mr Kofkin. I will pass to my colleague.

The Hon. WALT SECORD: Ms Dawson and Mr Kofkin, thank you for attending today. I would like to follow up on some of the matters Mr Amato raised and your responses to them. You talked about process improvements and new staffing at the Commission. Does that extend to hiring practices at the Commission? You said that you had taken on 14 new full-time employees. Are there new procedures are in place involving new staffers coming on board?

Ms DAWSON: New procedures in what sense?

The Hon. WALT SECORD: Well, there was the matter in December 2017—

Ms DAWSON: Recruitment procedures. I see.

The Hon. WALT SECORD: The recruitment of the convicted sex offender, yes. You guys mentioned that you have taken on four new staff and I just want to know if you now have procedures in place. Do you screen them? If you are a convicted sex offender, are you now prohibited from working at the Health Care Complaints Commission [HCCC]?

Ms DAWSON: The recruitment processes for the Commission were fully reviewed and our policies and procedures were strengthened. As a result of that, there are a number of background screenings that each and every person proposed for appointment to the Commission is subject to. That includes routine police checks. It also includes an additional Working With Children Check, which was introduced at that time. As a result of that, those screenings are required for each and every person who would be considered for appointment, and our recruitment decisions would flow from that.

The Hon. WALT SECORD: I am not going to name the person, but has the matter involved with the person that was the subject of controversy in December 2017—a former police officer who was convicted and then was employed, not screened and did not disclose. Has that matter now been completely resolved?

Ms DAWSON: Yes. As we advised the Committee in response to a question on notice at the last proceeding, all recommendations relating to that matter have been implemented and our practices are intact and are following those recommendations.

The Hon. WALT SECORD: When the person was terminated, I think there was a period of time where that person was put on paid leave. Is that correct?

Ms DAWSON: Mr Secord, we are talking about a period that was back in 2017. We have dealt with all of these questions, both in this Committee and on notice, and I am happy to—

The Hon. WALT SECORD: Sorry, Ms Dawson. We decide what questions to ask.

Ms DAWSON: I am happy to reiterate what I have advised in response to those previous questions, which is that there was a full and thorough investigation. It was an external investigation. It was independent. Reports were produced—

The Hon. WALT SECORD: Excuse me, Ms Dawson.

Ms DAWSON: The recommendations of those reports were implemented—

The Hon. WALT SECORD: My question was simple. You are not answering my question.

Ms DAWSON: —and I am comfortable with that.

The Hon. WALT SECORD: My question is: Is the matter resolved?

Ms DAWSON: The matter is resolved.

The Hon. WALT SECORD: That was my question. I said, "Is the matter resolved?" As part of the resolution of that matter, was any payment made to the person in question?

Ms DAWSON: In the normal manner of exiting an organisation, the entitlements that person was entitled to—

The Hon. WALT SECORD: I know you would not have it with you right now, but would you be able to provide on notice the full and final payment made to that person?

Mrs LESLIE WILLIAMS: Mr Chair, I am not sure that is an appropriate question in this forum. This is actually supposed to be a review of the 2019-20 annual report, and the incident you are talking about goes way back further than that. I think the Commissioner has answered that.

The Hon. WALT SECORD: I would like to put to the Commissioner that she provide on notice the final payment made to the person in question. My question relates to the taking on of new staff and procedures in place, and my questions flowed out of those questions. I would like to know what the final payment provided to that person was. Without identifying that person, I would just like you to provide the dollar figure.

Ms DAWSON: What I can tell you, Mr Secord, is that there was no payment other than that person's accumulated leave entitlements. If you wish to know what the value of their accumulated leave entitlements was, then I will take it on notice as to whether it is appropriate for me to convey that private information about that individual. If the suggestion is that there was any additional or extraordinary payment or ex gratia payment or anything that was out of the ordinary, the answer is unequivocally no.

The Hon. WALT SECORD: Ms Dawson, I await the figure if you can provide it. I urge you to consider it because in budget estimates hearings and other parliamentary inquiries senior public officials provide information like that without identifying the person by name, very clearly. All salaries are on public record. You have attended budget estimates hearings with the Premier and the health Minister; I have seen you sitting in the rows. Questions about salaries and departure payouts are commonplace in this Parliament.

The CHAIR: Mr Secord, just for clarity, are you seeking a figure of what this person's—

The Hon. WALT SECORD: Exit payment.

The CHAIR: Exit payments can come in many different and varied forms.

The Hon. WALT SECORD: Well, that would be a matter for—

The CHAIR: The Commissioner has answered already that there was no payment other than what the person was entitled to in terms of leave entitlements. Are you asking for a number of what this person's—

The Hon. WALT SECORD: I will leave it to the discretion of the HCCC Commissioner as to how much information she wants to disclose, but I think it is in the public interest and I think that it is very, very commonplace. I have actually asked this question in similar forms and received the answer.

Ms DAWSON: Perhaps in different scenarios, Mr Secord.

The Hon. WALT SECORD: I am being very polite and I am humbly asking you to answer my question. If you want to take it on notice and give an alternative answer, we can then revisit it later. May I now turn to COVID? According to the report there were 457 COVID-related complaints. What were those complaints related to? Were they related to COVID itself or were they related to the impact of COVID on the health system? Can you take me through that?

Ms DAWSON: Yes, I can.

The Hon. LOU AMATO: Would you excuse me, please? We need to go.

The Hon. WALT SECORD: Okay. I just want to hear the answer to this. Thank you, Lou.

Ms DAWSON: I can say that the issues raised in those COVID complaints related to the experience that individual health consumers had during the period of COVID in relation to their interactions with the health system. It may be something as straightforward as seeking a consultation with their GP, and they may have felt that they preferred a face to face consultation when all that was on offer was perhaps a telehealth consultation. It may well be that they had concerns about the nature of the COVID test that they got—whether the swabbing was conducted in the right way. By and large, what I can say about those COVID-related complaints is that they were across such a wide spectrum of issues, but they typically were not serious in nature. They were really a function of people coming to understand what the COVID world was in terms of testing, getting appointments, elective surgery, some of the changes in rules for elective surgery, the use of personal protective equipment and so on.

The Hon. WALT SECORD: You mentioned telehealth. Did concerns, problems and issues related to telehealth come into play?

Ms DAWSON: There were complaints about telehealth. When we were looking at these complaints what we found is that there were such evolving rules and requirements around telehealth, in relation to who could access telehealth, what billing applied to telehealth, and obligations relating to particular cohorts of people who must have access to telehealth, whether it was homeless folk and so on. There were a lot of complex rules that changed throughout the COVID process. Some of the complaints that we received looked to be more a function of confusion about what those rules were; you know, whether you could bulk-bill for them or whether you could not.

Dr JOE McGIRR: Thank you, Commissioner. Can we follow-on from the question around the COVID-related complaints? Clearly this particular report relates to the start of the year that was affected by COVID because it goes up to June 2020. Nevertheless you have made comment about the impact on the Commission's work. Previously we have heard about systems that you have introduced. You have talked about a couple of COVID-related complaints that were referred for investigation. I am just interested in what they were about and whether they are now finalised?

Ms DAWSON: I can comment on those. Bear with me. Mr Kofkin, you might be able to come in.

Mr KOFKIN: Sure. There are some that are currently in the investigation phase, and I am not really at liberty to talk about those matters. There was one particular matter that did get a fair amount of media publicity. That was in relation to a naturopath who was advertising that she had access to COVID tests, and that she could actually carry out the COVID test, or she could send testing kits to clients or patients, who could then send on the testing kits to a laboratory. That raised a number of concerns for us. As a result of that investigation there was very close liaison with the Ministry of Health and the Therapeutic Goods Administration [TGA], because it was a very fast-moving environment where there were a number of testing arrangements and devices and kits that were approved by the TGA. It transpired that this particular kit had not been approved by the TGA and therefore the TGA took out an enforcement notice against the individual, and the Commission eventually resolved that investigation by making comments.

That individual was also a registered practitioner, so therefore there was an intervention by the Nursing and Midwifery Council in relation to that individual. What I can say is that that individual had been registered for quite some time, but that person is no longer registered as a nurse, so therefore that individual is now purely working as a naturopath. So it is one of those matters where there is an intersection between non-registered and

registered and also, as well, the intersection between the Commission, the Ministry of Health, the TGA, and the Pharmaceutical Regulatory Unit. That was a really fast-moving matter that occurred over a weekend, and we managed to resolve it fairly quickly. Certainly, the TGA was very quick in terms of issuing enforcement notices in New South Wales, and also in Melbourne as well, because the devices were actually shipped from Melbourne to New South Wales.

Ms KATE WASHINGTON: Joe McGirr, if you do not mind, can I just ask Mr Kofkin if the nurse is no longer registered as a result of the investigation that the HCCC undertook?

Mr KOFKIN: Yes and no. Not in terms of disciplinary proceedings before NCAT, but certainly, as a result of the Commission's investigation and then intervention by the Nursing and Midwifery Council of NSW, that individual decided that it was prudent for her to no longer be a registered nurse.

Dr JOE McGIRR: Can I just follow on from that on a couple of areas that relate to COVID? First of all, you mentioned registered and unregistered practitioners. Can you make any comment about COVID-related issues or complaints involving unregistered practitioners?

Mr KOFKIN: There have not been that many to be honest with you, Dr McGirr. In the main it has been, as the Commissioner was saying, in relation to registered practitioners, access to health services, issues about infection control—wearing a mask, not wearing a mask, and PPE—as well as complaints in relation to the quarantine hotel process, the triaging of passengers at airports, and then making decisions in terms of, "Do they go into a police quarantine hotel or to one of the special health accommodations?" So there were a number of matters in relation to that, but not too many in terms of unregistered practitioners. We had a few matters in relation to the crossover between unregistered practitioners and Chinese medicine, and the use of herbal supplements to prevent COVID, but it was not overwhelming.

Ms DAWSON: Dr McGirr, I have a couple of supplementary observations. There were a few complaints regarding cosmetic services; you know, whether, under the public health orders, it was appropriate for cosmetic clinics to be open or not. And for massage therapists, as well, there was a little bit of confusion there. There were some suggestions of people being in breach, and there was some social media commentary by those sorts of practitioners. As Mr Kofkin said, generally infection control and mask wearing by unregistered practitioners, as well.

Dr JOE McGIRR: I guess where I am heading with this is in relation to public health messaging and, in particular, misleading information that gets provided in relation to vaccines currently and, prior to that, as we have discussed, in relation to testing and alternative therapies and remedies. You have partly answered my question by saying that most of the COVID-19 issues related to things like procedures, access, washing hands and so on. But I am interested to know whether you have observed issues relating to misinformation, specifically around vaccinations, now? That may have been much less of an issue back then, so perhaps this is an issue that we will continue a discussion around. So, misinformation and then of course that relates to your capacity to make public health warnings and so on. Perhaps you could offer some reflections on that issue. Again I accept that this hearing relates to 2019-2020 and that has emerged as much more of an issue recently, but nevertheless I think it is pertinent and it does still relate to this period.

Ms DAWSON: Yes, certainly, Dr McGirr. I guess my response to your question would start with observing those situations in which we do have jurisdiction to deal with misleading information or comments of the kind that you are referring to. It is a complicated area. I use that unwelcome phrase, "It all depends." It all depends on the circumstances, it all depends on the standing and qualifications of the person making the comments, as to whether they are registered or unregistered, it all depends on the type of comments that they are making, and it all depends on the context of the comments. So let me just unpack it briefly.

If you are a registered practitioner then the national law requires you not to make misleading or deceptive observations about the efficacy of treatment, or the lack of scientific basis for treatment. So that is in the national law. In addition to that, in the Health Care Complaints Act in the New South Wales jurisdiction, if you engage in egregious and repetitive sceptical advice to health patients, and if that leads them not to take the normal health protections that they might take, or to engage in treatment that they need, then we would take that as a departure from acceptable standards. As per any normal registered practitioner, there would be a range of actions that we could consider.

Then we move on to unregistered practitioners and health organisations, and that is a little bit more murky. If you are a person providing a health service, then we have jurisdiction over that. In relation to unregistered practitioners, the Commission can issue prohibition orders against those practitioners, and it can also make public warnings, now, against individual unregistered practitioners. It can also make various public warnings about health organisations. In the past we have had organisations like the Anti-Vaccination Network

and/or the Vaccination-skeptics Network—they have adapted their names at various times. We have issued public warnings in relation to those organisations, in terms of their anti-vaccination campaigns and so on.

There is an even murkier area, though, where you may have an individual, perhaps an eminent individual, perhaps a well-recognised individual, who may perhaps use the platform of their populism to convey anti-vaccination sentiment. That is a very different question, and something over which, unless that person can be considered to be providing a health service, we would not have jurisdiction. That sort of complaint would sit more with the Australian Competition and Consumer Commission, or other organisations that deal with that sort of thing. That is where our jurisdiction sits, and perhaps we can go from there, in terms of more specific questions that you have got. Mr Kofkin, would you like to add anything to that?

Mr KOFKIN: No. The only thing I would add, Dr McGirr, is that it is not unusual for us to get complaints in relation to anti-vaccination messaging. Certainly my experience in the Commission over a number of years, starting off with the Australian Vaccination Network [AVN] many, many years ago, when the Commission made a public warning in relation to AVN, then the Supreme Court hearing, when that was overturned, and then changes in the legislation. What I can say is over, certainly the last three or four years and particularly since October, the Commission's powers have been significantly strengthened in terms of our ability to make warnings, and to make quick warnings as well. Because when we are looking at, for example anti-vaccination, it is important that we act quickly to get the messaging out. As the Commissioner said, we have a role to play, but education, education, education is really significant in terms of how we liaise with the Ministry of Health and the Department of Health and primary health workers as well. We do our bit wherever we can.

The CHAIR: Dr McGirr, we will go around the room, then come back to you.

Dr JOE McGIRR: Sure, but can I just finish on that point?

The CHAIR: A supplementary question, yes.

Dr JOE McGIRR: My apologies. I am interested in this issue of prominent individuals and parliamentarians who may promulgate very inaccurate health information and what capacity you clearly do not have at the moment. I flag that as an issue and wonder whether you might reflect on that, perhaps, and whether there is anything that might be done to address that from your perspective. There is no need to go further on that at this stage.

Ms KATE WASHINGTON: I will start by thanking the Commission for its work during this difficult time. Reading the report, it is apparent that you did not seem to lose a step, and in fact stepped up, as did all the staff at the Commission. I thank you all for your work during a difficult period, you obviously pivoted well, and managed to continue and improve what you have been doing. I start with that comment and a thank you.

Ms DAWSON: Thank you.

Ms KATE WASHINGTON: I ask about the recent reports about Blacktown Hospital and a number of newborn deaths and whether or not any of the reports or investigations being undertaken by the HCCC relate to any of those newborn deaths that have apparently occurred in the past two years?

Ms DAWSON: Ms Washington, I will be a little circumspect in terms of responding. We do have a matter before us that deals with that particular issue, but we do not have complaints about all of those matters. The issue there is that there is a great deal of work, as you know, going on with the Clinical Excellence Commission. There are a number of root cause analysis reports, and we are very much involved in examining that work and working alongside it, and thinking very deeply about how our involvement can contribute to recommendations or thoughts about improvements in that area.

Ms KATE WASHINGTON: Your involvement is by virtue of a complaint?

Ms DAWSON: Correct.

Ms KATE WASHINGTON: Is it a complaint relating to only one of those fatalities?

The CHAIR: I am not sure if we can delve into individual cases, just for the matter of privacy.

Ms KATE WASHINGTON: My broader question is whether or not the Commissioner has any indication or sense that this relates to a broader issue in terms of capacity at the hospital, or whether it does relate to an individual or particular individuals at the hospital?

Ms DAWSON: The focus of the work that we are involved in is work that is being done to examine the broader systems issues, and that is, as we understand it, the focus of the Clinical Excellence Commission report. Naturally, the focus of a Root Cause Analysis tends to focus on systems, processes, policies and the like. That is really the emphasis of the work that we have a line of sight to.

Ms KATE WASHINGTON: Understood. Thank you very much. There is reference in your report to one request for an internal review of an alleged breach of privacy. I understand that a review was undertaken and the conduct was proven and an apology was made. Can you talk through that to the extent that you are able to?

Ms DAWSON: Yes, I would. My recollection of that is that it will have been a matter where there was probably a request for certain aspects of a complaint not to be released. My sense of it is that there may have been a piece of information released, and lack of attention to separating that out. That is my broad recollection of it. Beyond that, I would have to take it on notice.

Ms KATE WASHINGTON: When you say "released", released to whom?

Ms DAWSON: When we receive a complaint, we seek consent to release that complaint to the service provider about whom the complaint is made, in order that the provider can respond to the allegations that are put. On occasion, somebody may ask that their complaint not be released, or that the complaint be released but they not be identified, or that a particular piece of identifying information might not be released. It is a very complicated set of protections, and on that occasion I suspect that the situation is that that piece of information may have been released with a document bundle that it should not have been, perhaps. That is the sort of scenario I think that would refer to.

Mrs LESLIE WILLIAMS: I want to start by reiterating the comments from Ms Washington in relation to the work and the stepping up by you, Mr Kofkin and your staff during this challenging time over the last year as a result of COVID. I think broadly we would all agree that the health network as a whole, whether it be the Commission or our frontline workers, have done an incredible job. We are all enormously grateful for that. I will ask questions around COVID and reflecting on the impact that it has had on the Commission specifically, then looking forward to the vaccination rollout. Commissioner, do you perceive that there will be a need for additional resources to manage that? The first part of the question is: Do you perceive that there will be more complaints once the vaccination rollout continues? Obviously that will ramp up in the year ahead. Will there be a need for additional resources? What are your thoughts about that?

Ms DAWSON: We have done our projections for complaint numbers for this year and we are expecting that at year's end our numbers of complaints will sit around 8,500, which will be roughly an 8 per cent increase on last year. In relation to COVID itself, there have been some interesting things that we have seen in the complaints profile. That is that even though we continue to get COVID-related complaints—as we call them—those wax and wane. They fall off and then an issue arises that spikes them again. At this point, we are up to about a total of just over 900 complaints about COVID since January 2020. So I do not see that the COVID impact is unsustainable and driving complaints to an extreme point. The other thing to observe about the information is that as the COVID complaints come in, some other complaints are falling off.

We saw that through the middle and end of last year, as health systems were repurposed, or we saw the effect of the fall-off in elective surgery being put on pause—complaints about that therefore fell off—or complaints perhaps relating to dentistry, when dental services were pared back and only emergency dental services could be provided. So it is a little bit of swings and roundabouts. I am not seeing an extreme push evolving at this point in time; it is difficult to predict. In relation to your question about vaccination rollout, I think it will be difficult to predict, but the thing I would say about that is that I think there will be, as we have already seen, a large amount of commentary across the health policy and service delivery system as a whole—a lot of commentary from the Commonwealth and state health service providers. We hope that, over time, that will ensure that there is clear consumer information, so issues regarding bookings and so on do not start to flow into the complaint system. But time will tell.

Mrs LESLIE WILLIAMS: That is actually a very good segue into my next question, which is about people's first contact to the HCCC. Would it be right to say that from when COVID started there would be a certain percentage of people who would contact the HCCC more with questions rather than complaints? That is the first part of my question. The second part is: Is there a different way that we can address that? I think, as members of Parliament, we often get people who ring up our office with questions and clarification, rather than a complaint itself. I am wondering if you see that there is a way—I guess I am reflecting on the resources available to the HCCC and how we might be able to use those more effectively in terms of people contacting with questions of clarification rather than a complaint itself.

Ms DAWSON: It is a really good question. The short answer is, absolutely yes. We saw much increased demand for our inquiry service. You will know that we have an inquiry service that sits right at the front end of the work of the Commission. Individuals who are not sure whether they have a complaint can ring that inquiry service. Also those who are not sure where else to go, we found, during the period during 2019-20, were certainly contacting us. I think there was a 6.1 per cent increase in the volume of inquiries that we received, and a large number of those were COVID related. That said, I think it is interesting that, throughout COVID, what I have

observed is that, even though you always get folk who are wanting to just jump into an immediately available inquiry service, we have also seen a great maturing, through COVID, of public information.

I have been interested to see that. It is fascinating to think about our own behaviours, and how many of us became, "Oh, it is the 11.00 a.m. briefing." We would jump on to hear about what the hotspots were, what the latest advice was, and what the latest public health order was. I think that maturing of communication has made a big difference throughout the latter part of our year. So we have not seen the demand on the inquiry service continue to grow exponentially; it has sort of now normalised, as a result of that.

The Hon. MARK PEARSON: I uphold the comment saying that you have obviously kept on top of things and done great work during this crisis. I am interested to know whether it has come to the Commission's attention that there have been misdiagnoses as a consequence of not having face-to-face consultations with medical professionals? With the increase in that, has it come to your attention—it might take a while—whether there has been an increase in misdiagnoses?

Ms DAWSON: It is not a prominent issue for us at the moment, no.

The Hon. MARK PEARSON: I am interested in a person who rings up and has taken the time to get the courage or the impetus to ring up and look at whether they should make a complaint, how is that triaged? Who actually takes that initial call and what is the process after that for the consumer—the person who is making the complaint initially?

Ms DAWSON: All of our complaints are triaged at the point of receipt. Part of that triage is to identify particularly vulnerable complainants or complainants who we need to jump in very early—

The Hon. MARK PEARSON: Sorry, when you say "we", who is that person at the front and what qualifications do they have?

Ms DAWSON: It is interesting that we have just commenced a new structure within our assessments division. Mr Kofkin is responsible for the assessments division and can probably talk about this a little more. Basically, we now have a triage and intake team and that team is a group of assessment officers and senior assessment officers—very experienced, typically our most experienced assessment officers—who can review a complaint quickly, and make early decisions about what kind of assessment needs to be undertaken, including supporting assessment officers to whom that matter might be allocated to make early contact with the complainant, to have a discussion about the issues, and to make sure that there is clarity around what sort of clinical advice might need to be sought, or so on. In terms of the qualifications of those triage officers, we have a wide range of qualifications amongst our assessments staff. They may be people with health or allied health background, they may be lawyers, they may have a range of other skills and experience. So it is a broad church.

The Hon. MARK PEARSON: So quite qualified.

Ms DAWSON: Yes. Mr Kofkin, did you have any more comments on the triaging process?

Mr KOFKIN: No, not at all. But, certainly, Mr Pearson, in relation to your question about somebody building up to phone the Commission, to get to that inquiry service, if there are complaints, for example, where somebody wants to get access to their records, or they are really concerned about getting access to a health service and they do not particularly want to raise that with a practitioner, but they do wish to make a complaint, our early resolution team is very good at getting the parties together and coming to a resolution very quickly. So, therefore, that individual can get access to their medical records, or get access to a GP or a mental health planning session. I think you may be thinking about that particular scenario?

The Hon. MARK PEARSON: Yes, that is right. So it is the initial contact and all the sensitivities surrounding that.

Mr KOFKIN: Yes. But our inquiries officers, as the Commissioner noted, are very skilled. They can actually resolve those issues as well, and make phone calls on behalf of the individual. But if it comes into a formal complaint, then it is really important for us to deal with those types of matters quickly, not let them fester, and try and resolve them, which is why we have dedicated teams of skilled officers who actually do that. They are fairly successful in relation to it.

The Hon. MARK PEARSON: I am glad to hear that.

Ms DAWSON: May I just make one more comment?

The Hon. MARK PEARSON: Sure.

Ms DAWSON: I should have thought of this earlier. One of the very important functions of our inquiries officers is that, if an individual is in distress or unclear about how to frame their complaint, our inquiries officers

will sit with them, draft the complaint with them and ask them particular questions—"Can you tell me a little bit more about the situation or the circumstance?"—so that the complaint is clearly framed. So there is that support in complaints drafting for those who feel like they need a little bit of assistance to do so.

The Hon. MARK PEARSON: That is very helpful. I know that usually complaints are probably about individual practitioners, but I am wondering if it comes to the Commission's attention whether there is a pattern of complaints, which might be related to, let us say, a culture in the service or pushing staff to work overtime and too many hours, say, registrars et cetera being asked to work long 12-hour shifts back to back et cetera, and that the complaints are starting to come from several people from a service and it does not look like it is an individual practitioner but rather a systemic problem. What things trigger that to be the problem rather than individual practitioners?

Ms DAWSON: The first thing to be said is that we do receive complaints about organisations as well as individuals. We may well see that either there are complaints about an organisation that are becoming a pattern, that suggest some systemic problems, and part of the reason why we have reconfigured our triaging in the way that I just talked about is to start to be really attuned to patterns in complaints. Whether they are patterns in complaints about individual practitioners, or organisations, it is the same. It is, "What is the pattern here?" and not just taking the individual complaint in isolation. So, yes, we do get complaints about systemic issues and we look at those very seriously and try and understand. We look at it from the perspective, Mr Pearson, of the risk to patients. If there is a systemic problem of whatever nature, be it a weakness in policy, training and whatever, that we are seeing manifesting in risks to patients, then that is our core business.

The Hon. MARK PEARSON: At what point do you make a referral to the Aged Care Quality and Safety Commission? What is the trigger that says that you would not investigate this area and you would refer it to the aged-care commission?

Ms DAWSON: That is a little bit more along the lines of if there is an individual practitioner whose care and treatment is deficient in any way, we will retain that within the Commission and take appropriate action. If we see that the factors relating to the complaint are more in the nature of the general environment in the facility—the training and qualifications of the staff in the facility, the regime of attending visiting practitioners or whatever and those systemic issues in aged-care facilities—we would typically send it to the Aged Care Quality and Safety Commissioner.

The CHAIR: I will ask a question around the pharmacies and pharmacists. We have seen a very large increase in the number of complaints received about this sector. What is driving that increase?

Ms DAWSON: I think Mr Kofkin might be well placed to address this.

Mr KOFKIN: Sure. There are many drivers in relation to that. Pharmacy is a very high-risk business, and it is highly regulated as well, particularly by the Ministry of Health. The issues that the Commission continues to see in relation to pharmacies relate to the poor recording of Schedule 8 medication, so a lack of accountability, Schedule 8 medications not being appropriately put in a safe, drug registers not being appropriately filled out, or drugs of addiction being dispensed when it appears there is not a therapeutic basis. There are also a number of matters that the Commission receives in relation to the compounding of pharmaceuticals. That will involve, for example, products being imported from overseas, from China or India, so therefore they are not approved by the TGA [Theraputic Goods Administration], and have not gone through the appropriate safety and efficacy testing.

There are also a number of complaints where pharmacists will compound medication when there is a commercially available product; for example, Duromine. They will compound phentermine. There are times when that can occur, for example, if it is a slow release medication, but on the whole it is not allowed because there are strict guidelines. The Opioid Treatment Program [OTP] as well—the Pharmaceutical Regulatory Unit, over the last 18 months, has been carrying out a number of visits to community pharmacies throughout New South Wales, to make sure that they are in full compliance with OTP dispensing protocols. Many have not been, so therefore that has generated a significant number of complaints, because it is high risk. Those complaints have come to the Pharmacy Council and the Commission for investigation. I think it is fair to say that there are some pharmacists who are commercially minded, to make profit rather than be focused on patient safety. They are the types of matters that the Commission focuses its resources on, and we prosecute those matters before the NSW Civil and Administrative Tribunal.

It has been noticeable, and you have seen it in our annual report, in terms of the significant increase in matters that have come to the Commission. We are working very closely with the Ministry of Health and the Pharmacy Council of New South Wales, in terms of enforcement, prevention, and education as well, but clearly there is still more work for us to do in relation to that space. But what I would say is that it is not a bad thing, in many ways, that the Ministry of Health is being proactive, because we need to know what is going on, and the

more we know, the more we can intervene and make sure the public is safe. Certainly in New South Wales we are very proactive compared to other states. I think perhaps if you compare and contrast the figures in New South Wales with other states, there may be issues there, in terms of proactive enforcement, as well in relation to those matters.

The CHAIR: Is the Commission working closely with the pharmacy sector to try and resolve these issues? In what way is it working with the sector?

Mr KOFKIN: Yes. Our interface is with the Pharmaceutical Regulatory Unit, the Ministry of Health and the Pharmacy Council. We are also working with the Pharmacy Council, in terms of performance regimes and education. The Pharmacy Council has those links with the Pharmacy Guild of Australia, and the national boards as well, so it really is a partnership approach, in relation to these types of matters. The Ministry and the Commission are also discussing how we can get into the universities and get into the final-year students, and where we can deliver modules in relation to regulation, why it is important, what happens if you do not actually comply with the regulations, and what it can do to your career.

Myself and key members of the Ministry of Health are looking at how we can work with the Council, and get into those individuals at a fairly young age as well. But we certainly focus our resources on those individuals who are responsible for the egregious and wilful diverting of Schedule 8 drugs for profit. There are some out there. That is where we focus our resources. It is important for us, as the Commissioner was saying, when we triage our complaints in terms of, how do we distinguish between performance issues that are perhaps a bit sloppy or there is a training issue, and those who are clearly premeditated and diverting drugs of addiction to make profit? We do that pretty well, but education is really important.

Ms DAWSON: To add to that, Chair, the Poisons and Therapeutic Goods Act is a complex piece of regulation with highly detailed regulatory obligations. Going to Mr Kofkin's point, we are really intent upon encouraging the Australian Pharmacy Council and the Guild to ensure that pharmacists across New South Wales are fully aware of their obligations, and that the regulatory regime is stepped out for them, so that they are not inadvertently in breach of those. Education really is central to this. As Mr Kofkin said, our effort and energies need to go into those circumstances where it is clear that there is more than a misunderstanding or a minor technical breach—where there is something more purposeful that is genuinely posing a risk.

Dr JOE McGIRR: Can I just follow on from your question, Chair? I just want to be clear: Mr Kofkin, you indicated that the increase in complaints around pharmacies and pharmacists was not related to a particular area. It seemed to be, in your answer, that it was an increase overall and then you highlighted a number of areas that you deal with. Can you just clarify that?

Mr KOFKIN: Sure. Many complaints the Commission receives in relation to pharmacies or pharmacists—in terms of those matters that are really serious, where there is a risk to public health and safety that would involve the Pharmacy Council and urgent action—come from information from the Pharmaceutical Regulatory Unit. It administers the Poisons and Therapeutic Goods Act, so it has strong powers of entry, and it can go in and carry out audits—drug audits et cetera. A lot of the complaints are driven by the Pharmaceutical Regulatory Unit.

Dr JOE McGIRR: To be clear, then, the reason for the increase in complaints is a more active approach by that unit?

Mr KOFKIN: Completely. That is a big driver, absolutely.

Dr JOE McGIRR: Okay. That is important. It is not from the public so much as from that unit?

Mr KOFKIN: I would say yes, it is overwhelmingly from that unit.

Ms DAWSON: Yes.

Dr JOE McGIRR: Can I just put on notice that I would be very interested in a little bit more detail and a breakdown of that increase in complaints? You have highlighted Schedule 8 drugs, compounding—OTP practices? What is that?

Mr KOFKIN: Opioid Treatment Program in the community.

Dr JOE McGIRR: Okay. I guess that is methadone; and profit versus safety. You commented on those areas and I would be very interested in some more detail—not today, but would it be possible to receive some more detail on that?

Mr KOFKIN: We can definitely do that, Dr McGirr. We have some documentation to hand already, I think, in relation to that type of breakdown, so we can do that fairly quickly.

Dr JOE McGIRR: Thank you.

The CHAIR: Dr McGirr, what we might do is just go to one question per member because we will run out of time otherwise. We will go to Ms Washington.

Ms KATE WASHINGTON: In relation to rural and regional health, there is a public hearing of the parliamentary inquiry into rural and regional health starting today. Given that there are significant disparities in health outcomes between people living in rural and regional areas versus metropolitan areas, is that in any way reflected or seen in the HCCC's work, or reflected in the complaints received? When I have looked at the number of complaints received, I feel like the percentage between people living outside metropolitan areas versus those living in them reflects population differences and does not reflect an increased number of complaints coming from rural and regional areas, despite the fact that there is a significant disparity of health outcomes. I am just wondering if it is something that is seen by the Commission, or if it is reflected somewhere else in the Commission's results that I just cannot see?

Ms DAWSON: Thank you for that. The thing about the Commission's data, and its ability to shine the light on these important issues that you are talking about, in terms of rural and regional health, is that the Commission's complaints are a very small window into what is a huge volume of services delivered across the state. You will see in our annual report that we do break down the data by metropolitan and regional areas, and it does not show anything that would give us pause for thought, as you say. I think that is because the complaints are a relatively small proportion of the total number of services delivered. I am not sure that you can conclude too much from the metadata—the meta complaints data, if I can put it that way. As you say, when you look at the rural and regional breakdown, I think we find that two-thirds of our complaints relate to metropolitan areas and one-third relates to rural areas. In terms of the issues, we see some slight differences, but nothing that really helps us get to the heart of the sorts of issues that the parliamentary inquiry in another place will be examining.

Ms KATE WASHINGTON: I suppose if people cannot access the health services they have got no health services to complain about. That is just an observation and not something—

Mrs LESLIE WILLIAMS: That is probably your comment. I just have a quick question, actually. It goes back to COVID and the provision of—bearing in mind that during this period information has changed pretty well on a daily basis. As you said, we often, in the past, have just gone to that 11 o'clock media report for everyone to be updated on what has happened in the last 24 hours. My question is about what the Commission has done to provide that really up-to-date information to your staff, particularly those at the front end, in relation to COVID questions, as I referred to before, but also potential complaints.

Ms DAWSON: I am hoping I have understood your question, so if I have not then please pull me up.

Mrs LESLIE WILLIAMS: It is probably because I have not asked it.

Ms DAWSON: No, it is my deficiency, I am sure.

Mrs LESLIE WILLIAMS: I guess it is more that it is such a quickly changing environment. Firstly, are you getting the information you need as fast as you need it, so that then your frontline staff can provide that information to the public? For your part, what have you done proactively to make sure the staff does have the best information to answer those questions from the public?

Ms DAWSON: The first thing to note is that, as the communication has matured, we have had less reliance on our inquiries service to be able to answer the question—"What are the new public health orders?" or whatever it might be. That has fallen off. But to the essence of your question, in terms of how we equip our inquiries service to be responsive to the questions that it is getting, we provide it on a regular basis with scripts for various issues that are coming up. We say, "If asked this, this is the sort of response you would give."

What I would say to you is that we do encourage our inquiries staff not to overreach, though. They are not the experts on COVID. There are a whole bunch of people sitting in the Ministry of Health and the Commonwealth department who are really the pre-eminent advisers on that. In that sort of circumstance, what we do is make sure that they know exactly what the referral information is that they could give to the person, to get the answer that they need most directly. That is probably the way we would go about it, more so than trying to "expert up" our inquiries service too much—not to overreach, yes.

The Hon. MARK PEARSON: I was reading that it looks like dentists are starting to get a little bit interested in cosmetic surgery. Can you elucidate a bit on how that is happening?

Ms DAWSON: Yes, it is certainly a good observation. From where we sit, and from our detailed discussions with the Australian Dental Council on this, it appears that the scope of practice is evolving, because dentists have a perspective that anything that might cause an impact on the jaw or the—

The Hon. MARK PEARSON: Cheeks.

Ms DAWSON: Yes, the movement of a mouth and, therefore, the grinding of teeth or the alignment of teeth, may be something that could be within their scope of practice. Whereas we once understood dentistry as being about the mouth, there is now a perspective that perhaps it might relate to muscles or other parts.

The Hon. MARK PEARSON: But is that a good thing, in part, or is it an excuse?

Ms DAWSON: The thing that I would say about that, without being evasive, is that all professions evolve into new areas of practice. Do I think that some of the evolutions in practising dentistry are a bit adventurous, or are evolutions that might be problematic? Yes, I do. I think that this is an area where we will have to have a very deep conversation with the dental sector to understand what risks arise from some of those frontier-type treatments that are being engaged in. That said, there are some totally legitimate, more cosmetic-style interventions that dentists can and should deliver. It is about a conversation rather than being black and white about it.

The Hon. MARK PEARSON: But it is a problem that has developed because of some sort of drive by certain companies and industry.

Ms DAWSON: It has developed because of a broadening perspective on what a dentist might be able to offer.

Dr JOE McGIRR: Can I just clarify that before asking my question, Chair? Just to confirm, was a public health and safety issue discovered when you investigated those continuing professional development seminars for dentists in relation to cosmetic surgery or is that work ongoing?

Ms DAWSON: That is an issue that is being dealt with at national level. Those training programs have been conducted in many jurisdictions. You will find that there are other regulatory jurisdictions that are involved with that issue. That is probably as far as I can go with that.

Dr JOE McGIRR: Do we need to be kept apprised of a possible emerging public safety issue there?

Mr KOFKIN: I think it is fair to say, Dr McGirr, from my experience of those matters, that the issue was not necessarily a risk to public health and safety. It really does come down to, what is scope of practice, how a national board defines scope of practice, and whether it has an appetite to actually define certain procedures as either within or outside the scope of practice.

Dr JOE McGIRR: Okay, I am comfortable with that.

The CHAIR: Can I ask a supplementary question? If the scope of practice for dentistry increases but the training does not increase to meet that—so if dentists are now considering muscles, for instance—does that open a lot more risk to patients? What is the role of the HCCC in that regard?

Ms DAWSON: That is exactly the conversation that we are having with the dental sector at the moment. Our expectation is that, whatever a practitioner is doing, it is within their training and qualifications to do it safely. That is at the centre of the conversation that we are having.

Ms KATE WASHINGTON: And another supplementary question, if I might: Mr Kofkin, you are saying it is an issue about scope of practice, but it could easily slip into a public safety issue. If anyone is operating outside their scope of practice, then it is a public safety issue, surely?

Mr KOFKIN: I think there are certain procedures where the risk is not as acute as other procedures. For example, carboxytherapy is one of the main therapies that dentists are getting involved in. It is infusions of carbon dioxide that are apparently good for stretch marks, cellulite, and darkness under the eyes. Those are the types of courses that are being run throughout Australia.

Dr JOE McGIRR: For dentists.

Mr KOFKIN: By dentists. That is why there has been a number of conversations between the Commission, the Dental Council of New South Wales and going up to the national boards, in terms of their view in relation to this. If the Commission is going to regulate this space, then we do need some guidance and clarity, in terms of whether this is something that is within the scope of dentistry. It appears that there are some differences of opinion in relation to that, so we need to land on that. In terms of your question about risk, if there is any broadening of the scope of practice, then there needs to be training in tandem with that, to make sure that the individuals who are carrying out these treatments are qualified to do it. That should be carried out by institutions that are accredited by national boards.

The CHAIR: If hypothetically there is an increase in risk, what is the role of the HCCC?

Ms DAWSON: If that risk is present, and that individual practitioner is not attending to their obligations to be properly trained, in order to avoid that risk materialising, or if the risk has materialised and harm has been done, then the role of the HCCC is to examine that and take the appropriate disciplinary action.

The CHAIR: Commissioner, that is speaking about a particular practitioner. We are talking about an industry-wide approach. In the example you used, you said it was low risk. Let us say they start moving into some high-risk treatments. What is the role of the HCCC in managing that risk?

Ms DAWSON: First of all, we have talked about the collaboration that we have with the dental sector, in order to get some wise settings around scope of practice. Secondly, we are working with what we call the NSW Health Regulators Forum. It has a dental stakeholders' group as a conjoint committee examining what education needs to be provided, and what information needs to be given to practitioners to take personal responsibility for that. Those are two important things on the educative front. And then, of course, we need to take our individual action on complaints that come before us in a timely and concerted way.

Mr KOFKIN: Just in addition to that, it is the Dental Council of New South Wales that manages the risk to public health and safety in terms of the practitioner. The Commission will carry out an assessment or an investigation of a complaint but when it comes to a risk to public health and safety, it is the councils that have the power to take urgent action and to put conditions on practitioners' registration. It is that co-regulation.

Ms DAWSON: One final comment that goes to the issue of how we deal with individual practitioners: going to the Chair's point about organisations and business models that start to go into this more commercialised dimension of dentistry, we have new powers relating to the ability to make public warnings relating to either individual health organisations or types of treatment. That is the sort of technique that we might want to use if we see high-risk types of dental services emerging.

Dr JOE McGIRR: Just to finally clarify that: what I am picking up from what you have said is that you are concerned about a possible increased risk to public health and safety, and that you are monitoring the situation in relation to that.

Mr KOFKIN: What I would say is, we have not come across any adverse outcomes by any patients at all. That was when I was talking about risk in terms of—have there been any adverse outcomes that we were aware of? No, there have not. But is there this issue about scope of practice? Yes, there is.

Dr JOE McGIRR: Okay, thank you. That has clarified it.

Ms DAWSON: Early emerging signs, Dr McGirr. Yes.

Dr JOE McGIRR: Okay, that is something I think we should be mindful of in future hearings. I would like to ask a question about your engagement strategy with consumers and, in particular, with Aboriginal and Torres Strait Islander communities, and how you are making progress in that regard—just noting that I think there still continues to be quite a low level of complaints from those communities. That certainly would not be consistent with their health status or their experiences of health services.

Ms DAWSON: Thank you for that. As we said previously in this forum, we are very focused on trying to come to a better understanding of what barriers there might be to people in Indigenous communities from using the complaint system, because we hear your question. Throughout 2020 we have been pursuing discussions with the Aboriginal Women's Consultation Network, and the purpose of that was to take some soundings on what those barriers might be. I think that what we have learned about that is a couple of really important things. First of all, there is not a lot of awareness of the HCCC out there in community. There simply is not. That is the job for us to do. I will talk in a minute about how we are going about that.

The second thing is that there is a job of work for the Commission to do, to think about how it can link in with other supports for those in Aboriginal communities, and particularly the Aboriginal Liaison Officers, and whether there are ways in which we can work with them to get a level of comfort in those communities about people being supported to make complaints. So we have learnt those things from our discussions through that forum, and that has led us to take a more active approach to linking in with the Centre for Aboriginal Health within the Ministry. We have a closer engagement that we are developing with the Centre for Aboriginal Health, and a couple of things about that are important to us. The first piece of that work is that we really want to make sure that we have got access to the cultural competency offers of the Centre for Aboriginal Health, in terms of respecting the different training and other tools that we can use, to make sure that each person in the Commission builds their cultural competency.

Secondly, within the Centre for Aboriginal Health, as you would be aware, there is a health improvement and support team within that centre, and the job of that team is to identify strategies that can be adopted at the service delivery level to drive systems improvement. What we are doing is working very closely with them to find

points of connection that we can make to feed in information that we have got about service weaknesses, patterns that we are seeing in our complaints, that might be the focus of the effort. The next layer of our strategy in this area is that we are working very closely with the local health districts [LHDs]. We are prioritising a connection with the Aboriginal Liaison Officers who are attached to the LHDs, and the purpose of that is to improve their awareness of our role as an independent complaints body and to identify, as I said earlier, ways of providing support to people to be able to make complaints. We are also making connections with the Aboriginal Health Coordinators who, as you know—unlike the Aboriginal Liaison Officers, who work essentially within hospitals to deal with the quality of service delivery there—are more outward focused, in terms of connection with Aboriginal community. We are looking at working with them on community-based dialogue about health services.

We are also increasing our role in broader regional consumer outreach. For instance, in the Murrumbidgee LHD, of interest to you, Dr McGirr, we have done a number of things. We have provided some training to the integrated care and allied health team, which includes all of the folk who are working not just in Aboriginal health, but in community care, aged care, and so on, and from there we are connecting with the Aboriginal health coordinator, who will be connecting us with some Aboriginal community groups and leaders. We are also taking opportunities, like the regional presence that we will have in Seniors Week, for instance, to have Health Care Complaints Commission people down there talking to health consumers, talking to community organisations about the role of the Commission. So, it is a very broad reach, and it goes at a number of levels: working within the hospitals, working with the service providers, and then working with community.

The final thing I would say about that is that we are also prioritising forming a partnership with the Aboriginal Health & Medical Research Council, in terms of getting a connection with the Aboriginal-controlled health services. So, there are the two elements: working across the system as a whole, and getting that connection in with Aboriginal-controlled health services. It is a strategy that has multiple levels, and we are very active in it. As time goes by, and we can get back to more face-to-face work with community, that work will intensify.

Ms KATE WASHINGTON: This might not warrant a short answer, either, but we might see how we go.

Ms DAWSON: Okay.

Ms KATE WASHINGTON: The Committee has heard from individuals about cultural issues within the Commission. I just want to go to that issue and draw attention to some of the results from the People Matter Employee Survey that we have all seen, and draw it back to the report that we are inquiring into today. So, from the People Matter survey—and I appreciate that I am just focusing on some of the less satisfactory results whereas there are a number of satisfactory responses in the survey—on that front, just in terms of some of the more concerning elements of it relating to perhaps the response whether anyone has seen any bullying behaviour in the organisation, and that is: "I have seen bullying at work", that is 40 per cent compared to 33 per cent public sector wide; "I have witnessed misconduct and wrongdoing", 38 per cent compared to 27 per cent public sector wide; and then a movement or people saying that they are considering leaving the organisation, which I think was 60 per cent. Then, in the report I see that there are 15 resignations and 33 staff who have moved. Are the resignations and that level of mobility a style, a reflection of any cultural issues within the HCCC, or is that a usual level of movement? I will just ask you to speak to any of those issues.

Ms DAWSON: Any, or all of the above.

Ms KATE WASHINGTON: Sorry.

Ms DAWSON: That is okay. I am going to try to take this in a structured way and, I think, hopefully hit on the touchpoints that you are interested in. First of all, thank you for acknowledging that there are some positive aspects to the People Matter Employee Survey for the Health Care Complaints Commission. The thing that I would say about those is that there are eight of the domains within the People Matter Employee Survey where our Health Care Complaints Commission performance well exceeds—well exceeds—the sector benchmark. I mention that not to—I will come back to your specific questions about turnover and bullying issues and so on—but those eight areas are really the cornerstones and signals of growth of a very positive culture in any organisation. So you look at the results relating to senior managers. You look at the results relating to: communication and change management; flexible work satisfaction; feedback and performance management; recruitment. Mr Secord is not here, but a really strong result, in terms of the quality of our recruitment, teamwork and collaboration—

Ms KATE WASHINGTON: Commissioner, just being mindful of time, if we could drill down to the less satisfactory elements of it, where you have got 60 per cent of staff looking for or thinking of finding a new role within the public sector outside of the Commission, compared to 41 per cent in other public sector areas. Will you address that?

Ms DAWSON: I will address that. The thing that I would observe about the Commission, and I observed it in my opening remarks, is that this is very difficult work. It is relentless. There is no pause in complaints. I do not recall a day when no complaints came in. Therefore, it is a kind of work where people want to come and give their best, and then they may well want to use that experience to go onto other roles, and that is fair enough. Another thing about the public sector is, we have promoted a sector that, rightly, fosters mobility. People want to move throughout their career, and so, mobility, from my point of view, runs both ways—it is a positive and you can see it as a negative.

The other thing about the Health Care Complaints Commission is we have unashamedly said that, as an employer of choice, our job is to invest in people, train them well so that they can then go on and use what they have learned in other areas. I think those factors together may well reflect in, looking at what people's aspirations are, for moving on at some point in time. I do not take all of that as a negative. I celebrate people's personal aspirations. My job is to develop them to realise those aspirations. In terms of your commentary about resignations, people resign for all sorts of reasons. Some of the reasons are what I have just referred to. They resign to take a promotional position, they resign because they are ready to retire—there are all sorts of reasons why people do. I think that is important to recognise as well.

In relation to bullying and harassment, what I can say to you is that the Health Care Complaints Commission is an organisation where, if ever that is in my line of sight, if ever there is a matter of a complaint about bullying or harassment in this organisation, that will be responded to in the most appropriate, timely and serious manner. I think that the People Matter Employment Survey is a measure at a point in time of people's experiences. The best I can do is to keep up the commitment that I, and every member of the executive and the leadership team of this organisation, have to making a positive culture.

I am confident that these results show a culture of growth, improvement and positivity—I really do—and that is not to shy away from the fact that, like any organisation, there is room for improvement. Our grievance procedures must continue to improve. They must continue to evolve, as should the grievance processes in any sector. We are attending to that. We have a culture plan, but I am pretty proud of the growing culture of this organisation. I like going there each day, and I know that many people in the organisation do.

The CHAIR: Thank you for appearing before the committee today. We may send you some further questions 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 further questions?

Ms DAWSON: Of course.

(The witnesses withdrew.)

The Committee adjourned at 09:58.