REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE HEALTH CARE COMPLAINTS COMMISSION ANNUAL REPORT 2016-17

At Jubilee Room, Parliament House, Sydney on Monday, 12 March 2018

The Committee met at 9:00 am

PRESENT

Mr Adam Crouch (Chair)

Mr Austin Evans
The Hon. Mark Pearson
The Hon. Walt Secord
Mr Mark Taylor
Ms Kate Washington

The CHAIR: I declare the hearing of the review of the 2016-17 annual report of the Health Care Complaints Commission open. I welcome Commissioner Dawson and senior officers from the Health Care Complaints Commission to the hearing. In accordance with section 65 (1) (c) of the Health Care Complaints Act it is a function of the Committee on the Health Care Complaints Commission to examine each annual report of the Commission and to report to Parliament on any matters arising out of that report. My name is Adam Crouch, I am the Chair of the Committee on the Health Care Complaints Commission, and the member for Terrigal. Today I am joined by my colleagues from the Legislative Assembly: Mr Mark Taylor, the member for Seven Hills; Mr Austin Evans, the member for Murray; and Ms Kate Washington, the member for Port Stephens. From the Legislative Council we have the Hon. Walt Secord and the Hon. Mark Pearson. I remind witnesses that these proceedings are being broadcast and web streamed, and a transcript of the evidence will be published by the Committee. During the hearing a photographer may be taking some photographs.

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

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

TONY ADAM KOFKIN, Executive Director, Complaint Operations, sworn and examined

EDWARD VAN DEN BEMPT, Chief Financial Officer and Director, Corporate Operations, sworn and examined

The CHAIR: Commissioner Dawson, would you like to make an opening statement?

Ms DAWSON: I have no opening statement as such, although I do acknowledge the new member of the Committee before us today, Mr Austin Evans. We really look forward to working with him. It is always an honour and a privilege to appear before the Committee.

The CHAIR: I have to acknowledge that when I became a member of this Committee the Commissioner and her staff made me more than welcome in understanding how the Commission works. The time I spent with them was invaluable. On page 41 of the report it states that the average time taken to assess complaints has increased from 47 to 60 days. What is the Commission doing to improve the time taken to assess complaints?

Ms DAWSON: I would like to contextualise my response by talking about what we think the drivers of those timeliness challenges are. First, from the Commission's perspective the question of timeliness is really the most significant and immediate challenge that we face. It is driven by three major factors and it is really important to articulate that because our response needs to align with those factors. The first is the accumulation of the growth in complaints over time. Historically, year-on-year growth causes us particular challenges. That growth does not stop. In addition, on the back of historical growth we have increasing growth going forward. In the year in question there was actually an interesting slow in growth but, nevertheless, when you look at it on the back of the 15.4 per cent the year before and the 10 per cent the year before that, you can see the challenge that we confront. The other issue that drives timeliness is the whole question of complexity. The Committee will see throughout the annual report a real effort by us to try to dig beneath what that complexity looks like and how we can refine our processes to deal with the complexity.

We have really got what I would consider to be a four-point plan of attack on this. First of all, really importantly, we want to make sure that we maintain our performance on the most serious complaints that we deal with. The Committee will see a continued focus throughout the annual report on our investigation and prosecution work. That is critical. We want to make sure that we tackle the backlog of complaints that have built up as this year-on-year growth in the volume of complaints has occurred. What we are doing there is as follows. We have adjusted our resource distribution to invest more in our assessments function. That means that we have got additional people assigned to assessing complaints. We have got additional people assigned to preparing decision letters when we finalise those complaints. We have also thought about how we use our resources. I have talked before in this forum about the importance of our early resolution function. That is the function where we are looking at how to identify very early and upfront those complaints that we can dispense with very quickly while we focus on others later that require more intensive effort.

This whole question of how we improve our business processes becomes critical. We have to look at the complaints coming in. We have to say which ones are at a lower level of significance and seriousness, which ones can we quickly resolve without a lot of formal exchange of paperwork through good conversation and excellent resolution techniques, and then which ones do we need to really quickly identify as being best dealt with at the point of service delivery. We can quickly say that the best resolution for those is going to come through referring them to the service provider for early resolution for connection with the complainant. Then there are those we go through for fuller assessment. So we are really triaging them. Effort is proportionate to seriousness and we can get a greater proportion of complaints dealt with more quickly. That is quite important.

We also have a really important initiative that commenced at the end of last year. I would like the Committee's indulgence, either now or at some point, to explain that probably the most significant game changer for us in regard to timeliness is the introduction of an e-complaints system. At the moment there is an opportunity for complainants to lodge their complaint electronically, but the irony is we deal with that manually. Every complaint that sits behind an electronic lodgement attracts a whole set of manual processes. We are going through a project that perhaps Mr Kofkin could talk a little bit more about that is all about electronic complaints

management, and that is going to be the thing that will really cut through some of these timeliness problems. I will pass to Mr Kofkin.

Mr KOFKIN: Just a little bit more context: last year 6,300 complaints; this year I estimate that we would maybe get 7,000 complaints. For every complaint the Commission receives—if you were making an online complaint, the Commission will print that complaint, scan it, will link it to a TRIM file and we then provide that complaint to one of our assessment managers, who will then fill out the form to identify the key issues, identify who the respondent is, carry out checks via the Australian Health Practitioner Regulation Agency [AHPRA] database for the registration number to make sure we have got the correct individual, and then pass that file to another support officer, who will then have to data entry that into our CaseMate management system.

That means that sometimes it can take 14 days before a complaint is allocated to an assessment officer. That does not mean we are not triaging the complaints and it does not mean that we are not reading the complaints as soon as they come in and identify the most significant risk. But, just for context, that is what we do and we have been doing that for a considerable period of time. Certainly over the last 18 months to a year it has been a massive wake-up call to the Commission in terms of how we carry out our business and how we process complaints. We have not kept up with technology. So this e-complaints is a huge game changer for us.

What does e-complaints mean? My colleague Mr Van Den Bempt can go into more detail, but what it means now, or what it will mean hopefully in May, is that when you make a complaint or if you were to make a complaint to the Commission you can go online and there is a newly designed complaint form where your details will be input. It is clearly designed so we know whether or not you are making a complaint on behalf of yourself or on behalf of a third party. You can put in the details of who the respondent is or where the public or private hospital is. You can identify the key issues, and all of that data then goes into our CaseMate process. It will give you a case file number, and we will be able to give you the details of the assessment officer who is dealing with that complaint. So, for us, that is a huge saving in time, and our objective is to go paperless as well.

Within our e-complaints portal as well there is going to be what is called "My Complaints". You can have your own account, you can go in, you can see who your assessment officer is, you can see what stage the complaint is at—for example, Is it information gathering? Have records been received? Is it about to go to an assessment committee hearing? Is it awaiting consultation with the professional council? The respondents as well can go into the e-complaints portal and find out the status of a complaint. That is phase one of our e-complaints. As the Commissioner was saying, that is a game changer for us but also as well in relation to our customer focus. Individuals can go online at any point and get that instant feedback in terms of where they are, where their complaint is in the complaint process. I think Mr Van Den Bempt could probably articulate, since he is an IT specialist, more than me in terms of some of the advantages of that.

Mr VAN DEN BEMPT: If I could maybe walk you through the experience of a complainant at this stage in the current context. They would have to navigate to our website, click onto our complaint form—which is an online form—or download a copy of the form and manually complete it. They would have to have sufficient time to go through the form and complete it and also have all the information relevant to complete it. If they do not, they do not have the ability to save the form and come back to it later, so they will have to recapture whatever information they have captured previously. In addition, they have only got the capability of appending two supporting documents to the form when they submit it; any additional documents have to be emailed to the HCCC inbox, which then requires manual matching with the original complaint by the HCCC staff.

At the Commission, the complaint is triaged, as Mr Kofkin has mentioned, and they will then identify the relevant provider details, whether there is a facility involved, the appropriate facility and the issues associated with that complaint. After it has been data captured and data entered by a clerical staff member, only then is a complaint ID actually allocated to the complaint, and an acknowledgement email is then sent to the complainant. This could happen several weeks after the complaint has been lodged, which, from a customer perspective is obviously poor.

From the Commission's perspective, we are looking forward to the e-complaints portal because it is a game changer for us. It does mean eliminating waste in terms of manual effort involved. From May/June onwards, a complainant will be able to log onto the system and the form that they will land on will be completely intuitive. So dependent on whether the complainant is the actual provider or the subject of the complaint, it will open up relevant sections of a form that is applicable to them. It will allow an unlimited number of attachments and documents to be appended to the complaint and as soon as they submit that form all the documentation together with all the data captured in that form is electronically on boarded into our CaseMate management system—no manual intervention whatsoever.

Immediately upon submission, the complainant will receive a submission ID. That ID they can use to re-enter the portal at a later stage to track how their complaint is being assessed and at what stage it is at. This is done through the "My Matters" page, which is updated electronically again as the case progresses through the complaints pathways. They will also have information as to who the assessment officer is that is assigned to their matter. From the back-end perspective, as I have indicated, there is no manual intervention; all of the documentation is attached to the case and does not need any scanning to attach it to that case. The portal also supports consultation with the Health Professional Councils Authority [HPCA] and AHPRA.

In terms of the consultation process with the health professional councils—the 14 councils that we have—we are able, through a consultation page, to display all of the cases that are open for consultation. The recommendation briefs are made available to the 14 councils and they can review those recommendation briefs together with all the documentation associated with that and either consider agreeing with our recommendation or consider discussing it at a formal consultation process. This definitely is revolutionary for us as an organisation in terms of how we deal with complaints. The project is on budget at the moment and will be delivered in May/June this year.

The CHAIR: This will help address some of those issues such as response times to complainants, which are outside the 14 days currently, given what you explain about the time to physically process manually all of that data. We are looking at improvement over the next 12 months effectively of that sort of response time to complainants?

Ms DAWSON: That is correct. Please be assured, and I am hopeful that you will take comfort from that, that we have responded very energetically to the idea that much of the solution of improving our performance in this area rests in business efficiency. We have just described one, which is the complaint portal. Please be assured that sitting behind that, within a broader business improvement project, are a number of initiatives that relate to removing unnecessary steps in our processes, streamlining electronic signatures, a whole range of initiatives that are really a project designed to respond to the Committee's own recommendation from the last annual report, with the expectation that we look at efficiency measures to deal with timeliness. As Mr Van Den Bempt indicated, with each initiative to improve timeliness we are also taking the opportunity to improve the customer experience, because from our point of view timeliness, quality, responsiveness are all in lock step, and that is what our project is designed to continue to achieve.

The CHAIR: I note the Hon. Mark Pearson has joined us.

The Hon. WALT SECORD: In one of your earlier answers you talked about serious complaints and triaging them within 14 days. I refer you to the tragic case of Michaela Perrin, a 26-year-old mum who died on 22 October 2014 after giving birth to a healthy girl at Lismore Base Hospital. She was discharged three days after a caesarean section but developed wound pain and she died of sepsis. On 27 February 2018—13 days ago—the Deputy State Coroner, Magistrate Harriet Grahame, reported that Ms Perrin received "grossly inadequate care" at Lismore Base Hospital and that she would have survived with the appropriate care. Concerns were also expressed about Dr Cristina Penaneuva, that her clinical practice was not limited to a single mistake and that:

> Any practitioner can make an error of judgement, especially when busy. We are all imperfect and capable of human error.

The Deputy State Coroner said that Ms Perrin would have survived if she had received appropriate care and the doctor who treated her had a wholly inadequate knowledge of the condition. Item 107 of the Deputy Coroner's findings says that the Deputy Coroner's report should be sent to the Health Care Complaints Commission to investigate the doctor's "clinical conduct". What has happened?

Ms DAWSON: Thank you for that question, Mr Secord. Immediately upon becoming aware of that particular matter the Commission itself proactively contacted the coroner, from whom we had not heard. At that point we asked for all and every piece of material that was available, and some days later we received it. We have now received that as a formal complaint. We have identified that it is an immediate, serious and significant matter, which for us means that we accelerate the assessment of it, we consult with the relevant professional council immediately—which we either did last week or will do imminently—and that matter will be treated very quickly as a serious matter. We have a technique. I talked about our triaging process. Our triaging process puts an absolute flag on a matter such as this and accelerates it through, if necessary, into investigation following consulting with the relevant professional council that that is the appropriate outcome. That is what we have done with this matter.

The Hon. WALT SECORD: Is the doctor involved at Lismore Base Hospital being investigated now?

Ms DAWSON: That matter is the subject of a complaint to us. I will have to take on notice exactly where it is in the process of assessing it, but that matter is under active assessment and we would regard it as a serious matter.

The Hon. WALT SECORD: Have you had discussions with the relevant medical boards about the doctor's conduct?

Ms DAWSON: We have, and I will ask Mr Kofkin to comment further. He may have more detailed data on that.

Mr KOFKIN: Yes. First of all, the coroner referred that complaint to the Commission for consideration of the investigation. That matter has been discussed with the Medical Council. I have actually had a conversation with the Medical Director of the Medical Council of New South Wales. As the Commissioner states, we are in the process of actually assessing that complaint, receiving responses, obtaining all of the clinical information and then we will be in a position to make a decision in terms of what the outcome of that assessment will be. But these are the types of complaints which we do fast-track.

The CHAIR: Mr Kofkin and Commissioner, before you go any further, I remind members of the Committee that the job of this Committee is not to look into individual cases specifically. Should the Commission be undertaking an investigation, it obviously does not have to give answers to those particular questions today should it not wish to.

The Hon. WALT SECORD: I understand that but this a very, very important case. A woman died.

The CHAIR: All the cases before the Commission are important, Mr Secord.

The Hon. WALT SECORD: I just want to wrap up the question—sorry, Ms Dawson.

Ms DAWSON: I would like, if I may, to interject to make two important points. These cases attract immediate responsiveness from the Commission because we too feel the deep need to act quickly in such very, very sensitive and disturbing situations: first point. Second point: Please remember that under the co-regulatory system in New South Wales when we receive a complaint we are obliged to manage it in a particular way, including consulting with the relevant professional councils, to determine what the appropriate action is. That is a strength of our system and it takes some days to achieve that. It is a joint decision. It allows us to bring the clinical knowledge of the relevant professional council to the table to make good decisions going forward, Mr Secord, not just in relation to whether we investigate but what aspects require investigation. It helps us to scope our work. That is a very important step, but it does take some days and it is important that we have all the material to support that consultation. Thank you for your indulgence. I think that is a very important point.

The Hon. WALT SECORD: I have one wrap-up question. As part of your discussions with the regulators, is Dr Penaneuva still practising in New South Wales?

Ms DAWSON: It is the job of the relevant professional council to consider whether immediate action is required in relation to a practitioner. So—

The Hon. WALT SECORD: I understand she still is.

Ms DAWSON: I will seek—I am tentative on this.

The CHAIR: The Commissioner does not need to answer this question, as the Hon. Walt Secord knows.

The Hon. WALT SECORD: She can if she wishes.

The CHAIR: She does not have to if she does not wish to.

The Hon. WALT SECORD: I think this is about the integrity of the health and hospital system.

The CHAIR: The Hon. Walt Secord knows—we have had this discussion before—that individual cases are not the purview of this Committee during these hearings.

The Hon. WALT SECORD: I think this is a very important case and it is in the public arena. The coroner's report stated that it should be referred to the HCCC.

The CHAIR: I believe the Commissioner has already confirmed it already has been.

The Hon. WALT SECORD: I am very pleased that Ms Dawson says that they are investigating. The community has a right to know whether this doctor is practising in New South Wales or not.

The CHAIR: It is not the job of this Committee here today to decide that.

The Hon. WALT SECORD: I think she could answer the question very simply and reassure the community. Is the doctor practising in New South Wales at this moment or not?

Ms DAWSON: Mr Secord, you made the most fundamentally important point just a moment ago. You said that this is an incredibly important and sensitive case: All the more reason why every due process should be followed, and every due process will be followed by the Commission—who has certain roles and responsibilities here—and by the professional council that has certain roles and responsibilities. I do not think I need to elaborate further.

The CHAIR: With that, Mr Secord, I will move to Mr Taylor. The question has been answered.

Mr MARK TAYLOR: Thank you, Commissioner, and thank you for the submission of your annual report. The complex environment and the difficult tasks that the Commission undertakes is not lost on the Committee. I appreciate that very much. With the overall number of complaints being small in private hospitals, what is the Commission doing to enhance its relationship with private hospitals? Can you discuss the relationship of complaints between public and private hospitals?

Ms DAWSON: Thank you, Mr Taylor, I can certainly do so. The first thing to be said is that our powers and our actions following a complaint are identical, irrespective of whether the complaint relates to a private or a public hospital. We in earnest, when we get a complaint, seek responses and records from private hospitals. We enjoy every amount of cooperation from them, as we enjoy from the public health organisations. We also work with them throughout individual complaints—in the same way again that we would with a public hospital—to determine whether that private hospital is able to utilise its own local resolution capability to deal with a complaint. On occasion, they will be able to reaffirm with us the way they will use their own patient liaison staff and so on to deal with complaints.

We also have great cooperation from private health organisations in relation to their participation in resolution matters. As members know, a resolution matter is a matter when a complaint has been made and there have been some difficult and complex issues. We are seeking to bring the complainants together with the health deliverer to get a better understanding of what has gone on and whether it relates to their own care or the care of their loved one. A resolution process is incredibly helpful in putting the practitioners together with the complainants and in working through how things have gone and whether people can come to closure on the issues that have caused challenges and traumas. We get great cooperation from the private health sector in that regard, for which we are very grateful.

Of course, when we are investigating matters we have the same coercive powers for private hospitals as we do for public hospitals. We find that they are very responsive to participating in our investigations. To step the Committee through to the end of that, where we have a private health organisation that we have investigated, we will typically make recommendations about improvements in their processes, be it their governance, training or recordkeeping processes, or their accountabilities. We find that they are very responsive to those recommendations. That is how things work at the moment.

The great area of improvement from my perspective is that much as we have an extremely strong, proactive education and training program across each local health district in New South Wales, we are looking to see what the best points of entry are into the very diverse private health system to ensure we are making an offer of training for practitioners in the private system in relation to their understanding of our roles and responsibilities within the Commission. We also want to train them in best practice complaints management so that we are getting to the point where frontline responses to the difficulties that patients have are stronger and stronger both in the public system and in the private system.

In relation to that, we have some early work we have done in delivering our training program to private hospitals and private facilities. There is room to do more and it is an area for further development. The final element that I think is worth articulating is that in the Commission's education and outreach program we have a number of initiatives, including delivering training to students and to new medical practitioners. We hope that that training reverberates through the public and the private health systems with individual practitioners and entities alike.

Mr MARK TAYLOR: Is there an education program for the non-registered practitioners?

Ms DAWSON: That is a very good question. Obviously we post on our website our expectations about the need for unregistered practitioners to meet the code of conduct that applies. In a sense, our difficulty with targeted education is that we do not know who they are. They range from dieticians to various other kinds of new practitioners, such as massage therapists and the like. It is very difficult to structure a program. An increasingly powerful part of our work is that whenever we get a complaint about an unregistered practitioner we ask ourselves whether this is a good opportunity to make a public statement or to issue a public warning that

sends a broader message, not only to the health consumer about the possible risks associated with the treatment provided by unregistered practitioners but also to those unregistered practitioners themselves about the standards of performance we expect. We have a clear code of conduct, but what else sits behind it? Members will have seen in the annual report examples of the use of our public warning powers. We drill down to a granular level about what we expect. That is very important from our point of view. I hope that answers the question.

Mr MARK TAYLOR: Is there an issue about non-registered health practitioners and practitioners whose registration status is unknown? It is reported that 2.4 per cent of complaints were about non-registered health practitioners and practitioners whose registration status was unknown. Are there issues that prevent the Commission from identifying the registration status of practitioners?

Ms DAWSON: I know the metric concerned, but I may need to take the question on notice. That may be the safest thing to do. I would not want to mislead the Committee about what is in that category and what circumstances give rise to that. Please do not get the impression that if there is an unknown categorisation that we do not take action. It may simply be that there is some confusion about whether a practitioner was registered but is no longer registered. I am happy to take the question on notice to explain what that category includes. Perhaps Mr Kofkin can help.

The CHAIR: For reference, I think it is on page 14 or page 15 of the annual report.

Mr KOFKIN: The only thing I can say in addition to the comments about non-registered practitioners is that, as we know, the very fact that they are not registered does not mean that we do not have jurisdiction over them. We make several prohibition orders and several public statements every year. We also liaise closely with professional associations whether or not they are statewide or Australia-wide. For example, the massage therapists and the naturopaths of Australia have their own professional associations. We will link in with them, particularly if we are looking at a complaint history. These individuals move around; they are mobile and they can work all over Australia.

As members know, as a result of changes in legislation Queensland prohibition orders are now valid in New South Wales and South Australia. That has been an important development in terms of the national model and the national codes for non-registered practitioners. However, we do liaise closely with those professional associations and they will also contact us for information about whether someone who is applying to be a member of the association has been the subject of a complaint. If we can, we disclose that information. We are getting a lot better and we are strengthening our ties with those associations, and they are becoming more professional. Some of them harbour ambitions to become registered in the future.

The CHAIR: I remind all members, especially the new members, that the Committee is dealing with the report provided by the Health Care Complaints Commission for this year. Members should not ask questions about specific ongoing cases. I allowed Mr Secord some leeway earlier, but should those questions arise again, I will declare them out of order.

Mr AUSTIN EVANS: Reference was made to the ePortal and having it up and running by May or June this year. I assume that is the switch-on time.

Mr KOFKIN: Correct.

Mr AUSTIN EVANS: You will obviously then need to train staff, which means there will be a lull before we start to see the benefits. How long do you expect staff to take to get up to speed on it and for it to become their way of operating? When do you expect to see an improvement? It will not happen straightaway.

Ms DAWSON: It is a really good question. What I want to say about this project, Mr Evans, is that we take great pride in the Commission in ensuring that when we are designing a business improvement, we design it with staff input right from the get-go. We sit down with a focus group of staff, we talk to them about how things work now, how they could work in the future, and how would the changes in the way that we are configuring this new e-complaints portal work. They are involved from the beginning to the end of the project. We are also very disciplined about testing phases for introducing something new. In fact, the first phase of starting to bring this e-complaints portal into action is starting very shortly so that that lag time that you talk about is absolutely minimal.

What I would say about this e-complaints portal is that it is incredibly intuitive. That is what it is meant to be. It is meant to be a system that is for the complainant's navigation of their complaint and it is designed to make sure that there is no guesswork in it. There is no real need for endless iteration and button pushing; it takes you right through the process and the same applies for the staff. So the key people that will be advantaged by this e-complaints portal are those who currently sit with every complaint and need to enter the data from a

complaint into our complaints management system. That complaints management system and each case file will now be automatically populated.

So in a sense it is not like a typical IT rollout where there is a whole new program and everybody says all of a sudden, "Wow, I was so in love with the old program, given that I have got this new one." It is actually doing something different. We are very hopeful that it will kick up very quickly. That said, we will be looking as it rolls out week on week to make sure that there are not glitches in the system that disrupt people's work. So give it a month or so through the transition. I think we can look to see it being fully functional—unless Mr Van Den Bempt has a different view—by 1 July.

Mr AUSTIN EVANS: I am fully supportive of it. I think it is a great initiative and it will have huge benefits. I am also conscious of setting unrealistic expectations. If you expect to report a huge increase in efficiency next year, that is good to know. But if not, I do not want to build up unrealistic expectations.

Mr VAN DEN BEMPT: Obviously, we are cognisant of the fact that it will take a couple of months for people to get used to the new system or the new portal. We also are not expecting every complaint to come through the portal. We do recognise that there are people that would prefer to still continue downloading the form.

Mr AUSTIN EVANS: As in staff or users?

Mr VAN DEN BEMPT: As in a user of the system. They might still want and prefer to download a form from the website and complete it manually and send it off. So we do have to continue catering for those individuals. But definitely, we have a changed management plan that articulates each and every staff member that is impacted by the new system internally and how they would be impacted. Obviously, we will be training them as to the change in process alongside that.

The Hon. MARK PEARSON: Mr Van Den Bempt, is it correct that when somebody makes a complaint via the "my complaint" online system to which you are referring, but for whatever reason they cannot complete it when they come back to it, do they have to start again from scratch?

Mr VAN DEN BEMPT: That refers to the current system that we have in place. If they log on and start completing the form and they do not have all the information available at that point in time they then have to obtain that additional information. When they come back they do not have the ability to save that information. So the new e-complaints portal does have that functionality.

The Hon. MARK PEARSON: That answers the question.

Mr VAN DEN BEMPT: They can complete any section of the form, save it, come back to it later—several days later—and they can call it up, complete the missing information and submit it at that time.

The Hon. MARK PEARSON: Commissioner, are you satisfied that mentally ill people or intellectually or cognitively impaired people have ease of access to the complaints mechanism, particularly if their disorder or illness is of a chronic nature or they are in a restricted environment, such as an institution or a locked ward, and therefore access to that mechanism of complaint could prove to be rather obstructive or difficult for them or their advocate or guardian? Have you turned your mind to that question, or has your department done an analysis of the ease of access to the complaints mechanism for those people?

Ms DAWSON: We have turned our minds to it. From my point of view, an accessible complaints system to all is a cornerstone organising principle of any complaints system. Yes, we turn our minds to it on a daily basis. You will see in our annual report that part of our solution to this is the delivery of our inquiry service. Our inquiry service performs a number of functions. One of them is that people can be guided through the complaints-making process in order to make their own written complaint. Each complaint must be written; that is a legislative requirement. There are a number of ways that we deal with that. We can sit with somebody through our inquiry service, face to face. We maintain a face-to-face access point for people. They can come in, we can show them how to step through making their own complaint or we can draft their complaint for them, sitting with them and saying, "Talk us through your issues. Who was the practitioner? Was your concern on this day or that day?" We can really walk people through that. It is a really wonderful service. When I watch people going through that complaints process with vulnerable complainants, that is great.

The Hon. MARK PEARSON: That sounds like a good, responsive mechanism. But what alerts the service that a person with extreme brain damage or the symptomatology of extreme mental illness needs assistance to make their complaint?

Ms DAWSON: A complaint can be made by a range of individuals. A complaint can be made by, in this case, the patient themselves if they are able and if they have the capability and awareness to do so, or a

complaint can be made by a third party, and that may be somebody who is their advocate and carer, a sibling or a parent. A complaint may be made by an advocacy service that may be connected with that individual. So the complaint can be made by a third party and be dealt with in that way.

The other scenario that comes to mind there—because it is a really good question—is that we also have folk, for instance, in the Forensic Hospital, so in the Justice Health system. In those situations, recognising that there is limited or no access to computers, we maintain now and we will continue to maintain in an e-complaints environment the ability for a person to send us a written complaint in the form of whatever documentation they feel they are able to assemble to us and we will enter that complaint into the system. So there are a range of mechanisms that we use, but it is a difficult scenario and we are always looking for additional ways to try to ensure that our doors are open and that we are reaching out to those vulnerable complainants.

Ms KATE WASHINGTON: Commissioner, concerning the difficulties that the Commission is facing about the time taken to assess complaints and one of those difficulties being the complexity of the complaint, what lessons has the Commission learned as a result of the pelvic mesh cases that no doubt have come to the notice of the Commission, given it is a device that has now been banned in Australia and more than 700 women are involved in a Federal Court class action. Mr Chair, I heard your previous warning about specific cases. I am not asking about specific cases; I am asking about a class of cases that no doubt has occupied a great deal of time of the Commission. What lessons have been learned as a result of that class of cases?

Ms DAWSON: Thank you for that question, Ms Washington. First of all, you have picked the emblematic example of complexity—deep, deep complexity in this matter. As I have indicated in our thematic write-up on complexity in the annual report, we have learned a number of things. The first thing is being much more effective at triaging matters as they come in and identifying patterns or trends in complaints where we have a number of complainants who appear to be raising the same issue. How we quickly pick that up, given that they may be disbursed between right at the beginning of the assessment process and then they might have already gone into the investigation process. We might even have matters already in prosecution. It is a question of how—what systems and processes we use to make sure we keep a line of sight on the range of complaints that might be about a single topic. That is really important for us.

The second thing that is related to that is that once we identify a complaint that raises a similar issue to something that is already under investigation, how do we make sure that very immediately we connect that new complaint with the investigation that is already underway? We have some new up-front assessment processes where we assess matters for investigation of that kind very quickly. So I guess being attuned to looking at these patterns and responding to them. The third issue for me that is slightly more thorny is how we make sure that we are able to identify and access experts in a particular field who can help us nail the issues for our investigation very quickly and assemble the most compelling and clear evidence base for any action that we might take forward.

In relation to the mesh devices issue, without going into that example too deeply, one of the issues of course was that that whole area of treatment was evolving and changing differently and the knowledge that practitioners had was evolving. In our investigation process we needed to be very clear about what point in time things were happening and who ought to have had what knowledge. Finding experts who can really ground you in a good investigation and any possible prosecution going forward is very important. In terms of matters that go forward into prosecution, the real issue is, again, when matters are very highly complex we find that they will need larger chunks of hearing time, depending on how many patients are involved. It is being realistic about what sorts of time frames we might be able to expect for finalisation of hearings relating to these sorts of matters. That is, of course, unfortunately not an aspect that is within the Commission's control. For me, those are some of the standout things. Mr Kofkin, this is a matter of some deep knowledge to you. Do you have anything to add?

Mr KOFKIN: The only thing I would add in addition to that is the relationship between State agencies and the Commonwealth when it comes to obtaining information. The Commission tried on many occasions to obtain some information from the Therapeutic Goods Administration [TGA] in relation to the original licensing of the device. That was very problematic for us. In fact we obtained information from one of the complainants who actually obtained the information from a freedom of information request in the United States of America and provided us with the documentation. I think a key issue as well, which has been raised during the Senate inquiry in relation to this, is should the product have been recalled? There is a distinction between a product being cancelled and recalled. In terms of the legislation, if a product is cancelled by the TGA but there are still products in circulation, they can still be used. Whereas if a product is recalled, they cannot. I think the big lesson here is whether or not the product should have been actually recalled rather than cancelled. That has been an issue which has been discussed on many occasions.

Another issue for the Commission, if we are looking at that particular investigation—and at moment we are not going to get into other investigations but the Commissioner and I were here for the select committee inquiry in relation to the underdosing of chemotherapy. These are really big investigations and, going forward, we need to be scalable at the Commission. These take up a lot of resources and this is one investigation out of 250 investigations which are open. Then when you get another investigation, such as the underdosing of chemotherapy, that is another investigation, and we have another 250 investigations which are open. We have finite resources and we focus those on risk and the high-risk matters. There is another issue, as the independent complaint regulator, in terms of how scalable we are in the future when we get these big investigations, because that impacts on timeliness.

Ms KATE WASHINGTON: Mr Kofkin, you referenced jurisdictional issues between the State and the Commonwealth. Are there also jurisdictional issues between the different States about the sharing of information and, if so, have there been any advances made by the Commission to rectify those going forward?

Mr KOFKIN: The legislation in terms of the National Law enables information sharing. Certainly the Commission liaise with our colleagues such as the National Medical Board in Western Australia and we were able to source material. We were also able to source material from Victoria. The biggest obstacle for the Commission was really sourcing material from Commonwealth agencies rather than State agencies.

Ms DAWSON: Ms Washington, it may assist—I was going to add some comments about data sharing and not just data sharing but information sharing with organisations such as the Therapeutic Goods Administration. There has been some accelerated and intensive activity building up that partnership much more strongly so that there is open exchange of information. I take great comfort from the fact that some of these cases have been the trigger for the establishment of a new national body called the Consumer Health Regulators Group which has the Therapeutic Goods Administration, the Australian Competition and Consumer Commission, Australian Health Practitioner Regulation Agency, the Private Health Insurance Ombudsman and some of the State regulators as well, including Fair Trading NSW and the Health Care Complaints Commission.

I represent all of the healthcare complaints commissions across the country on that forum. One of the primary objectives of that is to foster improved intelligence and data sharing and to enable the more rapid deployment of joint investigations and operations that are required when these sorts of nationwide and, in fact, international issues arise. That is the forum that has just commenced; I think it was February 2017. That has been a really important response to these sorts of complex issues.

The CHAIR: At our last hearing we discussed the interaction between local area health districts, especially in regional areas. Mr Austin Evans and I are regional members. Given the interaction the Commission would have over the last 12 months, do you see any trends in complaints and do the local area health districts have the ability to process in a timely manner those complaints as well as the complaints referred back to them?

Ms DAWSON: I must say that my experience in relation to complaints handling, local resolution and open disclosure practices in local health districts across the State is going from strength to strength. There is always room for improvement. That is what we work on with the local health districts in terms of our training and development, but I am very satisfied with the level of responsiveness of local health districts to taking matters to local resolution. The Committee will see from our annual report that there has been an increase in the number of matters being referred for local resolution. We only do that when we have had a conversation during the assessment process that gives us confidence that the local health district understands the issues and is embracing the idea of addressing them in collaboration with the complainant. I see that right across the State

I do not see any difference, if that is the nub of your question. I am not seeing any particular difference in the quality of the complaints management responses at the regional and rural level compared to metropolitan districts. In fact, we have a number of outpost officers in the Commission in Dubbo, Lismore, Newcastle and Shellharbour. I pay tribute to them here. They do wonderful work. Their job is to be on the ground and fostering that interaction with local health districts to make sure that there is a presence from the Commission there to work with the local health districts in their face-to-face work with patients and their families.

The CHAIR: Last year we also discussed the outreach programs that the Commission would be running across New South Wales. I note that the number of outreach programs is lower than the target in the Commission's report. What do you put that down to and what will the Commission be doing to increase the number of outreach programs over the next 12 months.

Ms DAWSON: Please be assured that we have committed to sustaining our outreach program. There has not been any diminution of effort but it has been of concern to me that I have not been able to build that program as much as I would like to do. Mr Taylor raised earlier the interactions with the private health system and what more we can do in terms of training and development. I consider things like our website and webinars

to be part of our outreach agenda and suite of activities. We need to do more there. We need to be identifying topics that are of concern and getting those out there in modern world webinar work and training work on our site. It is taking that next step and really doing that technology-enabling outreach that I think we have been struggling with. There are a couple of things that are important to do there. The first is to make it a priority.

In the day-to- day thrust and parry of complaints management it is important to say, "This outreach work matters in preparing us for the future and making the experience of working with the Commission a good experience." We have established a new area called customer engagement and resolution. The focus of that area, headed by an executive member, is to actually build a whole engagement strategy for the Commission that looks at what more we need to do and how we need to do it in order to be the most effective. We are investing in that, we are prioritising it. The real question becomes how we balance our resources across our frontline complaints management work against our outreach work. For this particular financial year it is a priority but it will also be looking to be strengthened going forward.

The Hon. WALT SECORD: Commissioner Dawson, in response to one of the first questions this morning you said that processing times have gone from 47 days to 60 days and you expressed some concern about timeliness. What lessons have been learnt about complex cases? Do you think it is acceptable that it is now 745 days since your office confirmed it was investigating Dr John Grygiel and the chemotherapy underdosing scandal? Your office confirmed that on 25 February it is now 745 days later. What is the status of that investigation?

Ms DAWSON: I am not going to go deeply into profiling each of the steps in the investigation. That is well-travelled ground. What I will say is that I am incredibly proud of the work that this Commission has done on the underdosing of chemotherapy at St Vincent's Hospital, in the Central West, Macquarie University Hospital and elsewhere. That is, without a doubt, one of the most multifaceted, complex investigations that I have seen. I always take my cue from Mr Kofkin, with deep experience in health complaints investigations, who says likewise. I am proud that that investigation was focused and it unpacked the issues in an incredibly structured and decisive way. We were able to move towards making decisions on disciplinary action very quickly. These matters are really ones that reward discipline, structure and measured activity and I am satisfied that that is what we delivered. Is there room for improvement in the timeliness of investigations? There is room for continuing to focus on keeping investigations timely.

I point to a particular metric in the annual report, that is, that the average for investigations actually held at 273 average days, down from 275 days, albeit marginally but I celebrate the whole. That is a great achievement in the light of the increased number of investigations finalised. The finalisation of 350 investigations, all well done, supporting 60 per cent of those going through to prosecutions and for 95 per cent plus—I think I am underselling myself, I think it is 96.7 per cent or 97 per cent—of prosecutions succeeding, that tells me that we have discipline, focus and excellence in our investigation space.

The Hon. WALT SECORD: So 745 days is an excellent result? It is still ongoing. Dr Grygiel was the subject of a parliamentary inquiry and in the public arena the *7.30 Report* was nominated for a Walkley Award for its prominence. What is the status of the investigation?

Ms DAWSON: That matter is in legal proceedings. I am not going to comment on it any further.

The Hon. WALT SECORD: So 745 days—

The CHAIR: Mr Secord, earlier I made a ruling about specific cases not being discussed at this hearing.

The Hon. WALT SECORD: The Commissioner's colleague raised it twice before I asked the question. He actually put it before the Committee.

The CHAIR: He also paraphrased it by saying that he would not go into specific details about that particular case when he mentioned it.

The Hon. WALT SECORD: I am going to dissent from your ruling on this. I think this is before the Committee and we have a right to—

The CHAIR: You can dissent if you wish, but I rule the question out of order.

The Hon. WALT SECORD: Then I am dissenting from your ruling.

The CHAIR: We will go to a deliberative if we need to.

The Hon. WALT SECORD: I think this is very important; 745 days and it is still not resolved.

The CHAIR: You are out of order. We will go to a deliberative. We will clear the room.

(Short adjournment)

The CHAIR: Commissioner, I would like to make you aware that the last question was ruled out of order. We will move on to Mr Taylor.

Mr MARK TAYLOR: Commissioner, what is the Commission's system for gaining stakeholder satisfaction from various medical providers?

Ms DAWSON: For each complaint that we assess and finalise, the decisions letters are sent to both the complainant and the providers and each of those would receive a satisfaction survey to fill out as they wish. There is a different satisfaction survey for the providers and a different one for the complainants dealing with their respective perspectives. We do seek that feedback. One of the reasons I have taken the step of establishing a customer engagement and resolution function and separating that out is that I want to examine the feedback that we get from those surveys much more closely. Each piece of feedback that we get is gold in terms of us understanding how we can be more effective.

At the moment, our response rates are not high. Providers respond about 12 per cent of the time. What I am interested in is what are the other 88 per cent of providers experiencing? So there are two questions for me: the silent majority and trying to strike up a conversation across the profession as to what their experience of complaints is. What I do know anecdotally is that each practitioner receives a complaint with a heavy heart; it is a serious matter for them. Their experience of the complaints process itself, we need to manage that experience respectfully and make sure that they feel like they are communicated with and so on.

So there is work to do there, and I want to use those feedback surveys to really good purpose, to continue to improve the way we engage with our customers, be they providers, be they individual providers, be they organisations or be they complainants themselves. The satisfaction level of providers, as we can see, is around 67 per cent. But again, that is not too bad, given how sensitive and tension-making a complaint is, but still we can do better and that is what we are seeking to do.

Mr MARK TAYLOR: That is only from 12 per cent of respondents though, is it not?

Ms DAWSON: That is correct. We have got a very small kind of window into what the level of satisfaction is. I want to open that up and really start thinking about how we can improve the experience of working through a complaint for all those parties involved.

Mr MARK TAYLOR: On the business of stakeholder satisfaction, Mr Kofkin, how is the relationship between other authorities, the Commonwealth and other States or other bodies concerning your requirements for investigative material? Is there any room for improvement there concerning them?

Mr KOFKIN: The Commission has a very strong relationship with the NSW Police Force and we have an MOU for joint information sharing. The same applies for the State Coroner as well. We have a good relationship with NSW Fair Trading. We recently have signed a new MOU for the first time between the Commission and the Australian Sports Anti-Doping Authority [ASADA] as well in relation to sharing information. As the Commissioner stated earlier on, our relationship with the Ministry of Health has always been very strong, and our relationship with the TGA recently has been very strong as well. The TGA are very keen to work with the Commission and the Ministry of Health in relation to addressing cosmetic services and the importation of non-Australian Register of Therapeutic Goods [ARTG]. Our relationships with those stakeholders is going from strength to strength, and in terms of the State boards throughout Australia, again very, very strong.

Mr MARK TAYLOR: On the TGA, I noticed in the complaints that there were about 200 complaints about pharmacists. Is there a generic kind of complaint around those—no pun intended on the word "generic".

Ms DAWSON: That is actually a good point.

Mr MARK TAYLOR: What is the nature and scope of those types of complaints and, of course, without going into specifics?

Mr KOFKIN: In relation to the serious complaints against pharmacists, they normally relate to compounding matters where they are compounding medications when there is an approved product available and they do not need to compound it—for example, phentermine, where there is an approved product, which is duromine. They are some of the more serious investigations we get, and also the compounding of peptides as well and dispensing of human growth hormone without prescription, et cetera. They are the real serious matters we get, and also the dispensing of schedule 8 and schedule 4D drugs on a very large scale, which appear not to be clinically indicated and sometimes when there is absolutely no patient whatsoever. These are matters of fraud.

But generically there are a number of dispensing errors; for example, if a pharmacist fills a prescription and fills it with the wrong type of medication or the wrong type of dose those complaints are assessed by the Commission. We normally obtain a response and those complaints are referred to the council. So there is a fairly broad spectrum, but your original term was "generic", and we often get complaints as well when an individual does not get the prescription filled with the appropriate product and they get a generic product and therefore they make complaints in relation to that as well because they have not been offered the generic product before they fill the prescription.

Ms DAWSON: That is quite common actually. People will get a brand product prescribed by the GP; it will be a particular kind of blood pressure medication, a named product. They will take it to the pharmacist and the pharmacist will dispense the generic product without consulting with them perhaps. Most of the pharmacists are pretty good at that. They will say, "Are you okay with the generic product?" or they will have a sign up saying, "Please let us know if you want the branded one", but some do not, and people sometimes feel aggrieved by that. So we have that sort of complaint right through to, as Mr Kofkin said, the more concerning ones.

The CHAIR: With regard to that lack of communication from pharmacists, are you finding that they are the complaints that obviously can be resolved very quickly?

Ms DAWSON: Yes, we are. In fact, with our early resolution function we are trying to identify particular classes of complaint that lend themselves to very quick initiatives, and the pharmacy ones are a perfect example. Often we will just say back to them, "If you could apologise and say 'We are introducing a new discipline of checking with people whether they are happy with the generic brand' or 'We're putting up a sign'". Those are easily resolved. People are typically happy with that. Similarly, with pharmacies we might get things like whether people are comfortable that their prescribed medicine was at the right temperature—for instance, with insulin, and being able to say, "Can you assure us that your refrigeration of insulin is at this level?", or whatever. Those things are quite easily resolved and really in fact a focus for us in making sure that we have got more timely and rapid conclusion of complaints

Mr AUSTIN EVANS: I am new to this Committee and I have been blessed never to have needed to complain about health issues. I will be honest: I did not know the Commission existed until I joined this Committee. You mentioned the outreach locations before. How do people who want to make a complaint go about it? Do they go straight to the Commission first or do they go to their provider? How does that fit in with that mechanism, and what are the approaches you take to promoting your existence and making it known to people who want to make a complaint?

Ms DAWSON: Let me start with the second and then track back to the first. We have a range of brochures and pieces of information that we put out there about who the Commission is and what it does. We have two particular brochures that deal with, essentially, how to make a complaint and what happens when something goes wrong. Those sit in general practitioner [GP] rooms throughout New South Wales. We have a process for distributing those.

Mr AUSTIN EVANS: Where are they: GP rooms and hospitals?

Ms DAWSON: Yes, GP rooms, hospitals, the Ombudsman's office, the usual kinds of interface places for folk. That is one mechanism. We obviously have a website that in fact is a very well used website. We have about 1.2 million hits a year; I think close to half a million visitors to the website each year. It is well used, it is well-known about. In terms of the other aspects of our outreach, I said earlier that we do go out and talk about the role of the Commission. We do that for community groups as well as for local health districts [LHDs], so it is not just the providers we want to know about our existence; it is actually the health consumers. We might go out to Aboriginal communities. We do things like Probus clubs and that sort of thing, just so that people are aware that we exist and they are able to come forward to us.

In relation to your other question about the relationship between a local complaints system and our system, what we do through our inquiry service is—I talked a little bit about it earlier—for roughly 11,000 people who come to us through the inquiry service, our first question to them is: "Tell us a little bit about how your problem arose. Have you raised it with the nursing unit manager?"—or with the practice manager, if it is a private health facility, or whatever—"Do you feel like you could do that? Would you like us to help you do that?" So there is a piece of our inquiry service work that is called assisted referral, or assistance to resolve something, where we will either make the call for the person, or guide them towards the complaints area and the clinical governance area that is on the ground, because at the end of the day there is a very important principle for us here, which is that the less daylight there is between the incident occurring and the response to it, the better the outcome.

Obviously, we really want to connect people with the local service deliverers to get things resolved as far as possible, and sometimes that is not possible, which is when we say: "If you have tried that and you are not successful, come back to us." Or, if things are quite serious and they are feeling vulnerable, we will say: "Why don't we make a couple of calls for you—you're still in the emergency room, or wherever—see if we can work out what's going on and get some communication to you?" That is another thing that we might be able to do, if the person is in a situation where they are receiving the service in real-time. I hope that gives you a sense of the techniques.

Mr AUSTIN EVANS: Are the outreach locations that you mentioned physical offices that people can go into? The website talks about the one in Sydney and gives the location and directions.

Ms DAWSON: They can be. It is more common that those outreach offices or outpost offices have more of a mode of making sure they are getting out there into the service delivery space. In fact, in most cases they are generally located at a public hospital, so that they are quite accessible and able to be supportive when things come up.

The Hon. MARK PEARSON: If there is a situation where the Commission becomes aware that, after one complaint or a second or a third there is a pattern beginning to appear where a practitioner may be repeating practices which are causing harm to people or are likely to cause harm to people, an investigation has begun but has not come to any conclusion, do you as Commissioner have the power to recommend or intervene—in the same way a Supreme Court may make an order to restrain or injunct while a matter is being resolved—so that no further harm may be done? Are you able to restrict that practitioner, or the practices in a particular facility, from continuing while evidence is being gathered which could show that measurable harm is occurring but at that point there is no evidence enabling the professional body to order the practitioner to cease practising or be disqualified?

Ms DAWSON: I completely understand the question and I am going to try to explain a matter that is a little bit complex as simply as I can, but please stop me if I have lost you along the way. Here in this space we need to differentiate between a registered practitioner. A practitioner can be registered in one of, currently, 14 professions; midwife, nurse, dentist, I could go on—the 14 professions. We need to differentiate between what happens there and what happens with an unregistered practitioner. Let us just keep that thought in our mind. In relation to registered practitioners, decisions about immediate risk—which is really what you are saying—while we go through the journey of investigating or prosecuting, are a decision or a matter for consideration by the relevant professional council.

Each of the 14 professions has their own council: medical council, nursing council, and so on. Those organisations, those entities, have a particular set of powers under the National Law, under the national registration system. Under a section called section 150 they ask themselves, because we are so worried about this, is it in the public interest or is there a significant risk to public health and safety—those are the two tests for a registered practitioner—so that we need to take immediate protective action. That immediate protective action could be putting conditions on the practitioner. The conditions may be, in the example that Mr Kofkin used earlier, "We are worried about your prescribing: You cannot prescribe schedule 8 or schedule 4 drugs of addiction, not until we are satisfied." They may be: "You need to only operate in a practice where you are supervised, so you cannot be a sole practitioner until we are satisfied." That is the sort of condition that the relevant professional council could put on this practitioner.

They could also prohibit that practitioner from treating a class of patients. If the concern were boundary violation and it was directed towards female patients: no treatment of female patients. Or they could suspend them: They could say: "No, there is sufficient risk to public health and safety and sufficient consideration of the public interest that we suspend you from practice." All of those are choices that the professional council will make to protect the public. That is on the registered side. On the unregistered side, those matters are dealt with end to end by the Commission. The Commission has powers under the Health Care Complaints Act 1993. If there is an apprehension of a risk to public health and safety of the kind described, we could consider interim prohibition orders. They would be of the same character that we have just talked about. Those orders would hold, or we would renew them to ensure they hold, throughout the investigation process. At the end of that process we could consider prohibition orders that have a demand time.

The Hon. MARK PEARSON: Could the Commission intervene if it were not satisfied that the appropriate intervention had occurred? Would it have the power to intervene?

Ms DAWSON: No, it would not. The Commission has no oversight or review role in relation to the decisions of the 14 professional councils. To give the Committee comfort that the Commission is mindful of issues relating to risk throughout a process—and using the example provided of whether a professional council should have taken action and the Commission is concerned that that has not occurred—if we get new

information during an investigation we cannot review it. However, if new information does arise, if the Commission learns something more, or if it has a richer apprehension of something as an investigation proceeds, it can and does refer it. We do not wait for the end of the investigation; we will refer that material to the council immediately so that it can give fresh consideration as to whether action should be taken under section 150. We are continually agile; we do not let matters sit as a once-and-for-all thing.

The CHAIR: Your report refers to a practitioner who had been listed multiple times with regard to multiple concerns—I think there were 18 complaints about the practitioner. Would that be a case where the Commission would go back to the authority and raise its concerns if it did not believe the authority was acting quickly enough and efficiently?

Ms DAWSON: If I have understood the question correctly, it is more a case of how effective the Commission itself is on day one of receiving a complaint in pulling up all prior complaints and saying, "Hang on a minute, there is a pattern here." We are getting better and better at that. I talked earlier about our response to complexity. We are getting better and better at asking, "How do we use knowledge about prior complaints to make a quicker decision about what should happen?" Using the example cited of one practitioner with 18 complaints, as things stand, by the second or third complaint we would be presenting that material in earnest to the relevant professional council. We ourselves would be looking at that as a suite of complaints and we would make a decision about what should happen, not in isolation or on the third or fourth complaint but taking account of everything that came before. We are getting much better at that aspect of dealing with complexity.

The CHAIR: I refer to the ePortal. Obviously the collection of data is vital to what you do. Given that information will come in digitally and automatically, will there be systems to flag specific concerns that the Commission might have about a practitioner who was the subject of multiple complaints? Would such a practitioner be red-flagged to the Commission?

Ms DAWSON: We already have the capacity to flag practitioners, and we do flag them. The complaints portal is more about the experience of a complaint coming in rather than how we manage our knowledge about complaints behind the scenes. One of the things that struck me profoundly when I came to the Commission was the richness of our knowledge. We have a huge reservoir of knowledge and really good capabilities in the case management system to flag, for instance, cases which might be one-off but which involve a serious boundary violation or sexual misconduct issue. We want to flag them on day one. We want to ensure that we monitor them very closely so that they move quickly through the complaints process. We also have a queue for any further complaints to be attached very quickly. That capability is built in.

Ms KATE WASHINGTON: Further to the question the Chair asked, when people make a complaint about a frequent offender is the complainant made aware that other complaints have been made about the same person? Is that possible in the new ePortal or is that how your current system operates?

Ms DAWSON: The best answer is that we want to get better and better, particularly where there are sensitive complaints and a pattern is emerging. We must start communicating with every complainant involved in that class of complaint to give them a sense of how we are dealing with the practitioner on the broader canvas. For instance, if you were thinking about the flat-dosing oncology example, obviously there were a number of individual complainants.

The Hon. WALT SECORD: Be careful; do not talk about individual complaints.

The CHAIR: The member will come to order.

The Hon. WALT SECORD: The Chair made a ruling earlier about individual complaints.

Ms DAWSON: If we had a matter of unspecified character where there were a number of complainants raising the same issue, once we saw that pattern emerging one of our first actions during the assessment process would be to call that complainant and to have exactly this conversation about that fact that we had the practitioner under active consideration and the actions we were taking, and we would bring them into the fuller picture.

Ms KATE WASHINGTON: That would similarly apply for a cosmetic practitioner who had poor outcomes. The Commission would receive a complaint and would realise that it was about a practitioner who had been the subject of numerous previous complaints. I know that if there is a poor outcome, it is a very lonely place. People often struggle alone, and it is not until they realise that others have had the same experience at the hands of the same practitioner that their load is lightened.

Ms DAWSON: I am also conscious of that being a very lonely place. One of the reasons we have created this customer engagement and resolution function is that we want to get much clearer about our protocols when we have these classes of complainants. We need to be highly sensitive and to have our

communication with them very clear and frequent. That is important to me as a first priority for the customer engagement person. Not to detract in any way from the commitment that I have just made to focus on that area, but of course there is a particular need to be extremely thoughtful about the privacy and consent issues and a range of other issues. It is a question of how we give complainants confidence about what we are doing and to make them feel connected in a process that has integrity, breadth and depth. That is what we are trying to achieve and to improve our protocols there.

Ms KATE WASHINGTON: I appreciate that confidentiality and sensitivity are important in all the work that you do. It is good to hear that that is where there is a focus. On more than one occasion in the report there are references to the term "scarce resources." In light of the increasing number of complaints the Commission is receiving, the nature of those complaints and the evidence that you have already given about internal efficiencies that the Commission is currently undertaking, is there another answer to turning around those times?

Ms DAWSON: We touched earlier on the e-complaints initiative as one example of the efficiencies that we are seeking to achieve throughout the assessments complaints process. However, there are other dimensions to our business improvement initiative that ensure we get the best value out of each and every resource that we have. First, our resourcing decisions focus on ensuring that we have some agility in our resource allocation and budgeting to be able to augment our assessment resources where we need to—where we see backlogs starting to emerge. We are getting better and better at that. I have talked about the importance of triaging—there is no substitute for delivering on the principle that the amount of time, effort and energy that goes into a complaint should be proportionate to the seriousness and the complexity of the complaint. The better you get at identifying the lower level matters that you can quickly resolve through an informal process, the better off we will all be.

There is a lot more to be done in our systems improvements. Whilst I talk about and will continue to celebrate the potential benefits of the e-complaints system—which gets us to the point where a complaint is set up and people know what is happening with their complaint—there is a lot more to do for the Commission to move towards a paperless complaints management system which is the next big gain in resources. That is the next initiative. Going paper-lite I guess is the contemporary language for it which I learnt the other day. It is a good aspiration for those of us who feel a bit attached to our paper. However, that is another aspect to it. At the end of the day it is a deep combination of committing to business improvement, streamlining processes, removing paper and deploying our resources in an agile way.

The final thing I would say about that, Ms Washington, is that it is important to ensure that we invest in our staff—resilient staff, well-trained staff and staff that are able to deal with the difficult work that we do in the Commission and do it well. So our investment in resilience training, our investment in how we work with difficult complainants and how we do that respectfully, and how we equip people to be excellent case managers—being able to move across their caseload, looking at matters where they are able to determine whether the matter is decision ready, it can go to assessment, or it is ready to be consulted on. These are all the things that we want to continue to improve through our training and support for staff.

Mr ADAM CROUCH: Commissioner, my question to you is about educating early career practitioners. There will be two parts to my question. First, how is the Commission actively engaging with our TAFEs and our universities where there are visits. Secondly, what plans are in place for the Commission to educate career practitioners with regard to the Commission's role and their involvement with it as career practitioners?

Ms DAWSON: We have what I would call fixed cameo appearances at university level and TAFE level. We go to final year practitioners—student health practitioners—and talk to them about the role of the Commission and we give them some fundamental and important insights into how to be a quality practitioner. If I were to summarise what we would say to them, the summary would be that we drill communication—the idea of a patient well-respected, a patient well-consented, a patient who is respectfully dealt with when something goes wrong—and open disclosure processes. Patient-centric care is going to be the best way that practitioners can be both successful in their outcomes and give a good experience for each and every one of their patients. Obviously those are the sorts of principles that we reinforce.

We also run scenarios that really try to bring this to life for student health practitioners. We try to run scenarios where we are talking about end-of-life decision-making and advance care directives—a difficult space that is hard. It is a place where medical practitioners are often right in the middle of sensitive decision-making and often contested decision-making. We run scenario driven work as well. If I were to think about an area for improvement, broadening our work in that space, covering more universities or more disciplines would be a good way to go. However, we do have those strong connections. I do not have enough fingers and toes to count

the number of times Mr Kofkin would have gone and given those presentations to student nurses, student doctors, dentists and so on.

Mr ADAM CROUCH: Earlier in response to a question asked by Mr Pearson you referred to the greater role the Commission has with non-registered practitioners. Obviously you have a lot more influence in that sphere. When career practitioners are located in universities and TAFEs they are obviously easier to access.

Ms DAWSON: Yes.

Mr ADAM CROUCH: My concern would be about some of the non-registered practitioners. How does the HCCC engage with them to the same degree? What more could be done to engage with them, given that they could be spread far and wide? How would the Commission deal with that in the long term? In the health sphere more and more non-registered practitioners are being involved. We will be inquiring into that issue later. How does the Commission deal with them currently and how would it deal with them in the future?

Ms DAWSON: Currently, I would have to say that our connections are what I would describe as opportunistic. We do have a number of national conferences and those sorts of things that we talk to. One of these, that Mr Kofkin might want to talk about, is a presentation that he gives regularly about cosmetic procedures. This presentation is focused mostly on the unregistered space rather than the registered space and the connection between State regulation and Commonwealth regulation. I suspect we can talk more about that at another time. Similarly, we might get various allied health organisations asking us to come and give presentations. So that is one way of doing it.

Going forward, I think the real opportunity here is that most or at least many of these service delivery areas have membership-based organisations where people become accredited—for example, to be a massage therapist or a beauty therapist. I have probably used a bad example, but you can get the idea that there are cohorts of practitioners that come together. What we need to do is to work with those organisations to have the process of accreditation and the setting of standards reflect our expectations about the delivery of all of the care and treatment in accordance with the national code. That is another thing we have got on our agenda, which we need to focus more on.

The final thing, as I said earlier, is that we are being much more strategic and thoughtful about when we use public warnings and statements. We are very conscious that those statements are as powerful for the practitioner. They are the signal that if you are not meeting the expectations of consumer protection by doing this, this and this, then be on notice that that is the standard to which we will hold you. So those public warnings and those public statements are a real message to practitioners at large. What I can promise you is that they watch them very carefully, and again, more in this space in terms of some of the impacts that we have had. But they are messages that we get out there, and there is more to do. I have talked about webinars and technology-enabling practice, and we really are very conscious of needing to be active in that space.

The CHAIR: Thank you, Commissioner.

The Hon. WALT SECORD: Mr Chair, one final question. It is not specific, and I seek the indulgence of the Commissioner. Medicinal cannabis: Have you received any complaints for investigating medicinal cannabis prescription or hemp products in the last year?

Ms DAWSON: Not in the last year that I can recall. Mr Kofkin?

Mr KOFKIN: No.

The CHAIR: Would the Commission like to take that on notice? It being 11 o'clock, I would like to thank all of you for appearing before the Committee today. We may, of course, send you additional questions in writing. Your replies will be part of your evidence and will be made public. Would you be happy to provide a written reply to any further questions should you receive them?

Ms DAWSON: Yes.

The CHAIR: Thank you very much. This concludes the formal session of the public hearing. I now declare the hearing closed.

(**The witnesses withdrew**)

(**The Committee adjourned at 11:03.**)