REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE HEALTH CARE COMPLAINTS COMMISSION 2020-21 ANNUAL REPORT

At Jubilee Room, Parliament House, Sydney, on Friday 20 May 2022

The Committee met at 9:05.

PRESENT

Dr Joe McGirr (Chair)

Legislative Council	**Legislative Assembly**
The Hon. Greg Donnelly	Mr David Layzell (Deputy Chair)
The Hon. Mark Pearson	Mr Tim James

PRESENT VIA VIDEOCONFERENCE

The Hon. Catherine Cusack

* Please note:
[inaudible] is used when audio words cannot be deciphered.
[audio malfunction] is used when words are lost due to a technical malfunction.
[disorder] is used when members or witnesses speak over one another.

The CHAIR: Good morning, and thank you for attending this public hearing for the review of the Health Care Complaints Commission 2020-21 annual report. Before we start I would like to acknowledge the Gadigal people, who are the traditional custodians of this land. I pay respect to the Elders of the Eora nation, past, present and emerging, and extend that respect to other Aboriginal and Torres Strait Islander people who are present.

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

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

The CHAIR: Before we start, do either of you have any questions about the hearing process?

SUE DAWSON: No, Chair.

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

SUE DAWSON: Thank you, Chair, I will. I would like to acknowledge the traditional owners of the land on which we are meeting, the Gadigal people—

The Hon. MARK PEARSON: Sorry, Ms Dawson, would you move the microphone closer to you?

SUE DAWSON: I shall. Is that better?

The Hon. MARK PEARSON: Yes, thank you. We want to hear you.

SUE DAWSON: Fantastic, and I want to be heard. I acknowledge the traditional owners of the land on which we are meeting, the Gadigal people of the Eora nation, and pay deep respects to Elders past, present and emerging. I would also like to say that I am looking forward to working with, and discussing things with, the new members of the Committee and the returning members of the Committee. It will be my pleasure to support you in the questions that you have.

I have a couple of other acknowledgements, if I may. As we will all know, we have lived through very unusual times over the last two years, and the Commission folk see up very close the work that our health professionals do across New South Wales, no matter their place in it. I just wanted to acknowledge the hard work, the dedication and the absolute tenacity and resilience of every health worker and health organisation that is across the state. Our deep thanks for that.

I would also like to acknowledge the work of the Commission staff. They, too, see every day many issues that are challenging, and they bring to their work an objectivity and a professionalism that I deeply admire, and I wanted to acknowledge that. I hope that you will see, when you have read our 2020-21 annual report, the fruits of that work and the really good results that the Commission staff get with the work that they do right across the areas of assessments, of investigation, of resolution and prosecutions. These are all areas that are very important to us.

You can see that the Commission staff are working against a backdrop of very high demand. We are in a situation where the growth in complaints year-on-year is double digits. We see new investigations in the 2020-21 year, that we are talking about today, had increased by 39 per cent, and so this is a very significant growth in the activities of the Commission. Nevertheless, I hope you will also see that we have improved our performance year-on-year in the assessment space. We have continued to deliver additional complaints in 2020-21, a 2.4 per cent higher assessment rate, and that is a great achievement in the context of a 10.8 per cent growth in the volume of complaints.

We are making very good progress in reducing the gap between new complaints received and assessments completed. Our timeliness is still solid, notwithstanding the pressures that we have. We are in a situation where, in 2020-21, I am pleased to be able to say that we assessed 86.6 per cent of our complaints within 60 days. Our average assessment was 43.3 days, against a KPI of 60 days. That is a really fantastic effort in the environment that we were confronting in 2020-21.

Similarly, in the investigation space, the timeliness of investigations was able to be improved and a massive number of investigations were still able to be completed—401 investigations completed in 2020-21. So we are very proud of what we have been able to achieve in difficult circumstances, and I really welcome questions from the Committee.

The CHAIR: Thank you very much, Commissioner. I, too, acknowledge the work of our health workers throughout the state and also acknowledge the work of the Commission staff, as you have done.

The first set of questions relate to current performance, and you touched on that in your opening statement. As you mentioned, there is a growing volume of inquiries and complaints, and that continues. There appeared to be an emerging gap between the number of complaints received and the number actually assessed, and that is quite a lot of work in there. How will you address that gap?

SUE DAWSON: Thank you, Chair. What I can say is that we have already made very significant inroads into reducing that gap, even in a climate of further unprecedented growth in new complaints this year. The gap has reduced from a gap of 480, that you will have seen in the 2020-21 annual report, to a gap of less than 70 at the end of quarter three in this financial year. We have been able to do that through a set of really concerted strategies. We have made some internal resourcing adjustments. As you would imagine, there were resources that we would normally expend on travel, on face-to-face training, on office costs and so on, that in a COVID context we could redirect towards frontline assessment work. That enabled us to put on additional assessment officers to tackle that emerging gap, and really clear it out, and then get ahead of the growth that we knew was coming.

In relation to other initiatives, we adjusted our structures, we adjusted our systems and we adjusted our processes. What I mean by that is that we introduced and consolidated a new triaging model, which involved having a dedicated team up-front in our assessments process where we undertake initial risk-based review and classification of all of the complaints coming in according to the seriousness of the complaint and the intensity of assessment that will be required. We direct those complaints and the assessment plan accordingly, so that lower level complaints can be dealt with more quickly, and more serious complaints can be assigned to those who will need to undertake more intensive assessment. That is important, because you can really start to give attention to not having a "One size fits all" to complaints, but being able to address the issues quickly where you can and then more intensively where you need to.

We have introduced, as members of the Committee who have been here in the past will know, a new clinical advice model. That means that we have on staff a clinical adviser who is able to help us scope very early what clinical issues there might be in complaints of a clinical nature, and design the assessment accordingly to address those clinical issues.

We have also identified, in our case management system, some refinements to that system that allow us to deal with particular pressure points. I will not go into detail on those, but suffice to say that it is the usual solutions of automating steps that might otherwise be manual, and really trying to streamline how the system supports your assessment work.

Finally, another important initiative to reduce that gap is that we have introduced some additional case management and review steps for the most complex complaints, so that we are assisting our assessment officers to move things forward when we have got particularly complicated matters. Those are the steps that we have taken. They have served us well. As I said, we have made great inroads, and the gap has now very much reduced.

The CHAIR: I am just following on from that, Commissioner. In particular, there is a target of making sure that reviews of complaints are completed within 60 days. Can you address how you are going to make sure you meet that target?

SUE DAWSON: Yes. We have taken the step, in the reviews area, of restructuring and increasing our resources. We now have a dedicated team of three people, who are comprised of a case review lead, a senior review officer and a review officer, who work alongside the Director, Resolutions and Customer Engagement to make sure that there is a finely honed approach to managing each and every review. The processes for doing a review have been fully examined and streamlined.

Much as I just described with our assessment function, we have taken the technique of early triaging and put that in place in our review function, so that every single review request is fully triaged, there are review instructions assigned, and there are time frames set at the point of triaging that are tailored to the nature of the matter. Cases are monitored through case management meetings that occur on a regular basis through each week. There is an automated case management report for all open reviews.

Through those techniques, I am really pleased to be able to say, we have been able to deliver the proportion of reviews that are completed within 60 days to about 80 per cent of reviews. That is a really significant improvement in the approach that we are taking to that area of our business.

The Hon. MARK PEARSON: Is there a difference between an investigation and a review?

SUE DAWSON: There is. When you assess a matter, and you make a determination about the outcome and notify the complainant, the complainant may come back within 28 days and say, "I'm not satisfied that you

considered the information correctly. I've got another piece of information that I don't think you had at the beginning and might have made a difference" or "I think you've just missed the issue. I wasn't concerned about the record keeping; I was concerned about the wound treatment" or whatever. The person has an opportunity to come back and crystallise what they would like us to look at. We jump back in and ask ourselves the question, "Would we have made a different decision, based on additional information or clarification?" That is different from a situation where a complaint assessment delves into the complaint and says, "Actually, there are some serious potential risks here that we need to examine more forensically." That is when we refer something for an investigation. It is triggered by our own assessment.

The Hon. MARK PEARSON: Just one other question on case management. Does that mean that there is a person who becomes a case manager of a particular inquiry or a case? Or is case management a sort of a mechanism?

SUE DAWSON: A case will be allocated to an officer. In the assessment space, it is an assessment officer, or a senior assessment officer, or an assessment support officer. In investigations, it is an investigation officer that will be allocated the case, or a senior investigation officer. Those people have a case load. They might be allocated, in the case of investigations, 15 investigations. They will have a manager, whose role is to coach them and to oversee the whole case load that they have, and to guide them in how to progress matters. Then there will be case management reports, where that manager can have a look at the status of each and every matter in somebody's case load and say, "These ones look like they are a bit stuck. Let's explore ways to advance them."

The CHAIR: I have just got one more question in relation to performance, Commissioner. That relates to the new powers that the Commission has in relation to referring to external bodies. What bodies has the Commission been referring the complaints to? What has been the nature of the complaints that have been referred?

SUE DAWSON: Yes. Bear with me. Just a point of context, if I may, perhaps for the new members of the Committee. The Commission has always had powers to refer complaints in various pathways. It has always had the power to refer complaints to a professional council, for appropriate action in relation to performance, impairment and low-level conduct issues. It has also had the power to refer complaints to a public hospital, for local resolution and to another body, if the complaint raises issues that might require investigation by that body. That power has enabled us always to refer matters to other regulatory and enforcement bodies: New South Wales Police, the Therapeutic Goods Administration, the Information and Privacy Commission—you can see the idea—other regulatory bodies, who are better suited to address the issues.

But the further amendments that you are referring to, Chair, to section 26 (1) of the *Health Care Complaints Act*, came into effect on 27 October 2020. As a result of that, the Commission can now refer complaints to private hospitals for local resolution. You will note that, before, we could only refer them to public hospitals. We can also provide them to a wider range of bodies who are not regulatory and enforcement bodies. We can now refer matters, for instance, to the Commonwealth Department of Health, the Mental Health Commission of NSW, the Department of Communities and Justice—a range of other bodies who might have policy or educative functions, or so on, that might be well suited to addressing the complaint.

The CHAIR: Are you able to outline in any more detail the sorts of complaints that you have referred there, or the volume of the complaints that have been referred to those bodies since that new power came in, in October 2020?

SUE DAWSON: What I can say is that we have metadata, high-level data about the number of matters that are referred to other bodies, and those are recorded in the outcomes of assessments of complaints in our annual report, but we have not fully drilled down to identify all the individual bodies that we have referred matters to.

What I can say to you is that in 2021, in the COVID context, this power was used to support all kinds of unusual referrals: referrals to the New South Wales Ombudsman, for those who were complaining about quarantine facilities; referrals to various government departments, be it Commonwealth, primarily, or, in some cases, the state, about vaccination policies and the settings on which vaccinations could be received by which particular population cohorts; vaccination supply and rollout issues. They are plainly not matters within our jurisdiction, but needed to be brought to the attention of, for instance, the Commonwealth Department of Health. That is how we have used those powers.

The CHAIR: That is very interesting that that power came in at the right time, in a way. Could you provide us with a little more detail about the actual volume, the numbers referred and the individual agencies that were referred to? You may want to take that question on notice.

SUE DAWSON: We will have a look at how granular we can get on that, Chair, for sure.

The CHAIR: That would be great. Thank you. I note that the member for Upper Hunter, Mr Dave Layzell, has joined us.

We will move on to the next topic, which concerns Aboriginal and Torres Strait Islander communities' engagement. This is an area that emerged in our last hearing. The Committee was of the view that considerable work should proceed to try to improve engagement with Aboriginal and Torres Strait Islander communities. We are interested in getting an update on that. I will pass over to the Hon. Mark Pearson to take us through this section. He may wish to ask all these questions, or some of them. I will leave that up to him.

The Hon. MARK PEARSON: I am interested initially as to the engagement with Indigenous people. One would assume the Health Care Complaints Commission is a reactive body. What I am seeing is a pattern of proactive engagement. It looks like this has occurred with the Indigenous and Torres Strait Islander people. Can you expand on if that is the case, if I am correct in interpreting that? Why have we moved in that direction, and what has the engagement been like, because of the difficulties sometimes in engaging with Indigenous people?

SUE DAWSON: If I have understood your question correctly, it goes to the point of why have an engagement priority in this area. The simple answer for us is that we were not seeing in our complaints a proportion from First Nations people that we would have expected, knowing what we know about the difficulties that they experience in the health system. Out of a genuine desire to understand whether there were barriers to complaining, whether there were cultural impediments, whether there was a way that we could get a better understanding of the experience of our First Nations people in the health system, we wanted to have a look at what our current points of connection were, whether we should strengthen those and how we went about that. The course that we set upon is that we realised that we needed deep, cultural safety expertise to understand the issues.

We have brought into the Commission a First Nations engagement adviser, a colleague called Justin Noel. Justin, as a First Nations person and a person who practises across the health system, in relation to education and training for junior Indigenous doctors, and who also works closely with community on their experience with the health system, has been supporting us and guiding us on the ways in which we should engage with the First Nations community, to identify points of connection.

Those points of connection are really about two things. First of all, as I said earlier, understanding whether First Nations health consumers have difficulties knowing what the Commission is all about—so promoting an awareness of the Commission in those communities. Second, when we go about our business of resolving complaints and trying to address the complaints that we do get from First Nations people, we are managing those in a culturally appropriate and effective way. Those are the sorts of initiatives that Justin Noel is guiding us in.

The Hon. MARK PEARSON: Do you foresee that there will be some fairly strong recommendations from the Commission to the Minister for Health? As you are working with Justin, and engaging more, are you alarmed in any way about any issue where maybe some recommendations will have to go to the Minister for Health? We know the story of COVID, for example, and the access to vaccinations et cetera. Indigenous people have been well and truly behind most of the community there.

SUE DAWSON: The way in which we draw attention to any particular concerns that we identify through our engagement with First Nations communities is to liaise with the Centre for Aboriginal Health at the Ministry of Health, which is the entity within the health administration that advises the minister on Aboriginal health issues. We have an engagement with them, whereby we meet with them to share any observations that we have about systemic concerns, patterns or matters that we think need to be addressed right across the system. That is the pathway that we use to bring those issues to attention.

The Hon. MARK PEARSON: What have been the main medical conditions—perhaps diabetes or others—that are particular to Indigenous communities? What are the main health areas that have come to your attention that Indigenous people have in a concerning way, more than non-Indigenous people?

SUE DAWSON: I think we understand the different profile of health conditions across the Indigenous community. Our data does not really delve into differentiating complaints by the kind of condition that was involved. Our complaints information will say, "Was the issue in these complaints about the quality of the clinical treatment?" It is coming at it from the position of examining the standards of treatment, not necessarily pulling out the health conditions of the Indigenous person who was experiencing the issue that caused them to complain, if I can put it that way.

The CHAIR: It is a very important point you raise. My experience would be that First Nations people have a lot of trouble interacting with the health system—anecdotally, from across my electorate and from my experience in health—and I think there is an element of unconscious, but strong, racism associated with that. I

guess the concern the Committee had in raising this issue was that perhaps even the system of complaints notification was subject to that unconscious bias, in the way it was structured.

I think the work that you have done to appoint a First Nations adviser is absolutely critical and I suspect it will take a bit of work to try to get the system right. One, as you pointed out, that there is a confidence to make a complaint; and, two, that the mechanisms you have for investigating that ensure that the complaint is appropriately handled and the right outcome. It is excellent that you have taken that step and I am interested to see how that is going to go. I am also interested to know whether you have seen any outcomes from that yet, or is it too early? Have there been any specific recommendations that have come out of Justin's work that the Commission is thinking of implementing?

SUE DAWSON: It is a little early and, you are right, it will take time. What Justin has said to us is that good work in this area starts from each and every person in the Commission understanding cultural safety and what that looks like when they are managing complaints. That is the first thing. The Commission is nearing completion of full mandatory cultural awareness training for every staff member in the Commission. This is already showing that, in our triaging processes for complaints—whether it is at the assessment point, or whether it is at the point of review or investigation—we are able to identify, with complaints that deal with First Nations peoples, what different strategies we might use to interact with the complainant. The opportunities, for the family or the complainant, for us to sit down with them in a way that works for them, to understand what is at the centre of the complaint and how we can safely work with them through the life of managing the complaint—that has been really important to us, and we are starting to build some techniques in our case management practices that reinforce that cultural safety.

We also know from Justin that, when we go out on community, we need to always be in very much a listening mode. It is very important that we take a posture of hearing what matters to our Indigenous health consumers, and are designing any communication that we have with them appropriately, in a way that is accessible to them, in a way that is real and helps resonate with our First Nations peoples. These are the sorts of things that we have learned already. Of course, there is a long way to go on that journey as well.

The Hon. MARK PEARSON: Can you describe exactly what going out to community means, particularly with the engagement of Justin Noel? As you say, Indigenous people are unlikely to proactively seek help. What does going out to them mean?

SUE DAWSON: Thanks for the question. It is a good one. What we try to do is use the opportunity of individual complaints. As you rightly said, we work with the complaints that we get. We are reactive in that sense. But we do not waste those opportunities. What I mean by that is, say we get a complaint that triggers an assisted resolution process in Broken Hill and it involves an Indigenous family, what we will do with that is, first of all, we will get advice from Justin and the local Aboriginal health liaison officer, to design a resolution process that works for those who are at the centre of the complaint. We offer the opportunity for those people to get additional support from a member of community—an Elder, and so on. We design that assisted resolution to deal with the issues in that complaint. But, while we are there, we do not waste the opportunity in Broken Hill to just participate in that resolution.

We get advice from Justin, who will help us to identify who the Elders are in that community that we might sit down with and just have a yarn about their experience. We run that yarn literally as a yarn, a listening opportunity to say we are not working with an individual incident here, or there is not a particular event that we are talking about. We are wanting to understand what is your experience of your local health services, how can we draw any issues that you are having to the attention of the health administration, and how can we also learn about how you might feel safe to make a complaint in the future? It is leveraging off an individual resolution event to connect with community and with the right people in the community, with good expert advice on Indigenous engagement.

The Hon. MARK PEARSON: That is like intelligent engagement.

The Hon. CATHERINE CUSACK: Some years ago, I was on the inquiry into the Bowraville murders, and before we did that, all the members of the Committee undertook training in how to take evidence from First Nations people. I was a bit blasé until I actually did the training and could not believe how bad I, and everyone, was at giving the opportunity, in terms of communication, to draw out the best evidence by listening and not interrogating, not interrupting, if I can put it like that. All of our processes, and our legal processes in terms of judges and how evidence is taken in court—it was an absolute revelation as to how those systems are not just poor, they do not work at all.

I want to know if what you are dealing with is also reflected in medicine, and in doctors, and in how patients are interviewed. The complaints system is full of forms. "You need to attach this document." This seems,

to me, to fundamentally not work. I would like to know what your thoughts are, and if we need to completely rethink and do training. I would like to see every police officer trained in communicating with Aboriginal witnesses, because I am quite sure that the experience is very bad for everyone.

SUE DAWSON: Yes. The reason why we have embarked on mandatory training in this area is precisely that. Every single person in the Commission understands deeply the importance of a culturally safe way of communicating and understands the need to be effective in working with people who have the courage—it takes huge courage to make a complaint, and there are some cultural barriers. So respecting that courage and, as you say, Ms Cusack, really being very conscious of what works to make people feel like they are in a safe place to share information that is very traumatic for them, culturally and personally. That is what our mandatory training for every member of the Commission is all about. Our investigation officers are in that training, our assessment officers are in that training, our receptionist is in that training. Every single member of the executive is in that training for exactly the reason that was a watershed moment for you, of, "Wow, it is really important to do this differently." I echo the sentiment of how important that education is.

The Hon. CATHERINE CUSACK: I thank you, and congratulate you, for taking this on. I feel that, at some point, everyone needs to rethink and redesign. We need to be willing to allow them to have support people to assist and to just feel respected in the whole process, not dismissed. Thank you very much.

The CHAIR: I think Catherine made a really good point there, and that is exactly what the Committee, in its last hearing, was actually concerned about. The low number of complaints coming through the HCCC [Health Care Complaints Commission] reflected a system that I do not think First Nations people, to be frank, had trust in or had a good experience of. That is why we made those recommendations, and it is great that you have taken action on that.

The Hon. MARK PEARSON: I just have a comment. To reflect on what Catherine said, we learn in these inquiries, or when working with Indigenous people, to be quiet and wait, and then they will start to tell you what is going on. It is a totally different process, and I want to support what Catherine said. Something has been raised here, and I wonder if it is something that you could further reflect on. Has COVID-19 disrupted the Commission's partnership with the Aboriginal Women's Consultation Network?

SUE DAWSON: The answer is that yes, it did. The Aboriginal Women's Consultation Network is a network of people who are strongly missioned to do advocacy for the quality of services received. That is a network that meets quarterly. Throughout COVID, we had a number of scheduled sessions with the network. Each of those, as things would not have it, were disrupted by the evolution of the pandemic. Just when we were ready to go to another session, things moved on. So it was disrupted, but that connection for us is very important. In fact, I think just last week we may have been meeting with them to re-engage and to reignite that.

Chair, I wonder if you would indulge me, so that I can record my thanks in relation to the cultural awareness work and bringing in our First Nations engagement adviser, and acknowledge the work of our Director of Resolution and Customer Engagement, for whom this is a very deep passion and commitment. We are all thankful for the benefits of that.

The CHAIR: We are almost finished this section, but I reiterate very strongly how important this is. It is a sort of a lacuna, really; it has been a gap for the HCCC. Finally, are there any other Aboriginal health organisations that you have been engaging with? In terms of engagement, can you comment on the use of social media or printed material—brochures or that sort of approach? Has that continued or been disrupted with COVID? Do you have plans to use that? So, firstly, health organisations and, secondly, how do you reach through printed material and social media?

SUE DAWSON: Yes, a wide range of Aboriginal organisations. As I say, we take advice from Justin when we are going into Country as to which particular community groups we might deal with. That will continue to change and evolve, and may there be many more as time goes by. We obviously work very closely with the Aboriginal Liaison Officers that are based in the local health districts, and I can say that our partnership with the Aboriginal Health and Medical Research Council is particularly important, as well, it being the peak body for research and policy in relation to the Aboriginal-controlled medical services. We try to make sure that our reach in working with Indigenous organisations works at all levels of the system—health consumers, frontline delivery and peak bodies and through, as I said earlier, the policy and strategy pathway through the Centre for Aboriginal Health at the Ministry of Health. We have got all of those pathways into those.

In relation to the question of social media and communicating with Indigenous communities in a way that works best for them, now that we have got the opportunity with the moment that we are in, with much of the pandemic behind us, we are now back in a situation where we are planning a number of focus groups involving Indigenous communities to talk to them about what works. We have all sorts of what they call collateral—

brochures and so on—that talk about the work of the Commission. What we want to know is how would we be presenting that information in a way that would resonate most with First Nations health consumers, so we are going to be talking to various groups about that, to get that guidance. That will include not just the content side but also, "How can we best relate to you? Is social media the better way? Do you prefer print material?"—right down to postcards versus brochures and short form, long form. Good work is being done there.

The CHAIR: Does the Commission have a Reconciliation Action Plan?

SUE DAWSON: We do have a Reconciliation Action Plan. It does require—in fact, part of the work that we are going to do with Justin Noel is to look at how we refresh all of our cultural awareness and reconciliation documentation and initiatives. I would have to say that that is an area that I want to do more work on.

The CHAIR: A reconciliation plan would actually be documented, so are you able to provide us with the current state of that? From my recollection, there are levels in the Reconciliation Action Plan process, so I am just interested to know what documentation is available and what level the organisation is at in relation to that. You can take that on notice.

SUE DAWSON: We will pull out the documentation that we have got about our work in that area and provide that, for sure.

The CHAIR: I make that comment because my experience, having been involved in other organisations, is that the Reconciliation Action Plan process was quite a good one in waking up the organisation. You are doing that work, I understand, but it would be good to see what your plan is.

SUE DAWSON: Yes, I think you raise a good point, because we have been doing that work with a very purposeful approach and with priorities. Whether we have been connecting it to a Reconciliation Action Plan structure and methodology is your question, and I can say that we have not done that approach at the moment. But we need to have a look at whether that might be a good way, as you say, of accelerating and formalising those initiatives.

The CHAIR: And also making sure you do not miss gaps in the approach. That is what I thought was valuable. If you could provide us with some advice on how the work you are doing links to your Reconciliation Action Plan, perhaps that is what we are seeking.

Mr James, if you could lead, we will move on to questions about COVID-19 and its impact on the work of the Commission.

Mr TIM JAMES: Needless to say, COVID-19 has in this period continued to have a major impact upon our healthcare system and community more broadly. Thank you for triaging, managing and dealing with the various dynamics that are borne out of COVID-19, and the community's response to it and the healthcare system's response to it as well. I have a few questions to deepen our understanding and unpack some of the COVID-19 related complaints, if I may. There were 653 COVID-19 related complaints. How many of those raised standards of health care as an issue, from which there was a potential risk of harm to the community or individuals?

SUE DAWSON: I think we are referencing page 20 of the annual report, and I think you will find there that, in terms the initial categorisation of issues in our COVID complaints in 2021, treatment issues arose in around 40 per cent of those complaints—so, in 459 of the total number of COVID complaints. Interestingly enough, that compares to 46 per cent of all complaints relating to treatment issues. That lower level, that lower proportion of complaints raising treatment issues, is really a reflection of the fact that many of the complaints that we received about COVID-19 or related to COVID-19 were of a non-clinical nature. They related to things like waiting times at the testing station, delays in results or concerns about personal protective equipment or whatever. Many of them were not related to the quality of treatment that was received, so that is why the percentage of complaints relating to treatment within the COVID cohort of complaints was considerably lower than the proportion for all complaints.

But, to your questions about situations where there was indeed a serious risk of harm, where a complaint is found in the assessment process to pose a serious risk of harm, these would be referred for formal investigation, as I explained earlier. In 2020-21 there were seven complaints that were referred for investigation, and these related to three practitioners, but none of those complaints related to risks arising from treatment or standard of care. They all related to conduct issues—so, billing, fraudulent billing for NDIS participants, attending work and failing to isolate when you potentially had COVID—those sort of conduct issues, and not care and treatment. I just thought that was interesting to unpack for you.

Mr TIM JAMES: That was a subsequent question, so you have dealt with two in one. I thank you for that. That is interesting—seven complaints, three practitioners. I hear what you say about conduct issues. That is

noted, with thanks. Can the Commission explain why the range of organisations complained about—obviously, in COVID-19 complaints—is more diverse and broader than the overall body of complaints?

SUE DAWSON: Yes, absolutely. Statement of the obvious: every kind of health service was affected in one way or another by COVID. Nobody got a free pass there. In addition to every kind of service being affected, there were novel and diverse types of services that were involved and, in fact, new types of services that were established. We had vaccination hubs. We had COVID-testing sites. We had quarantine facilities. These were unique to the COVID situation.

By definition or by result, there was a much broader range of types of health organisations that came to the fore. For existing types of health organisations, the establishment of which was not triggered by COVID, in areas like pharmacy—pharmacies were doing new and different things to what they would normally do. That is giving you a sense of why a broader range of health organisations were within the basket of COVID complaints.

Mr TIM JAMES: You mentioned quarantine. How did you deal with those quarantine complaints? One can understand, obviously, given what we have all heard and seen and read about in the media, and heard about through contacts, and so on. It is understandable there would be complaints. How, in broad terms, were they dealt with?

SUE DAWSON: I can tell you that the triage chart for quarantine complaints was quite the work of art. It was an A3 sheet that differentiated complaints by whether the complaint related to anything that was to do with the Commission's jurisdiction at all. You can only imagine. The complaints ranged from the cost of the quarantine, to folks who wanted to go to a special medical quarantine hotel, and folks who wanted to go to the Hilton rather than the Four Seasons, or whatever it was. Those complaints were triaged as not within jurisdiction—nothing to do with the Commission.

The complaints that we did need to contemplate were complaints that related to the quality of the health treatment that somebody might have received whilst in quarantine. The way in which we dealt with those differed, depending on whether the quarantine hotel was one of the specialist medical quarantine hotels, which were overseen by Sydney Local Health District.

In those cases, we would either receive records and a response from the local health district or refer the matter to them for local resolution. Or the matter might relate to a quarantine hotel which was outsourced to a health organisation, the name of which is just briefly escaping me, but in those cases our interest was in whether the nursing support or the triaging missed anything. Somebody might say, for instance, "I'm in a quarantine hotel. I've not tested positive for COVID, but my heart condition is worrying me." The question would be, "Did they get the appropriate nursing or assessment treatment?" We triaged it in that way. But, as I said earlier, the power to refer matters that were not within our jurisdictions, to the bodies that owned them, was particularly useful in the quarantine hotel space.

Mr TIM JAMES: That is understood. The next question I have relates to the low proportion of COVID-19 complaints relating to public hospitals. So 54 four per cent overall but 31.9 per cent of COVID complaints pertained to public hospitals. I have got a sense for where we are going here, but can you just try to explain that for us some more?

SUE DAWSON: Yes. On my data, the proportion of health organisation COVID complaints about public hospitals was 31.9 per cent, so 130 out of the 408. We acknowledge that that is significantly lower than the 45.7 per cent that is recorded for public hospitals within the health organisation category for all complaints. This is an arithmetic thing. It is because the health organisation category within COVID complaints had a much wider range of organisations in it. So the public health organisations are naturally going to be a lower proportion.

Mr TIM JAMES: I understand. That is what I thought we would get to. Along similar lines, there is probably an arithmetic matter here too. I want to unpack the increase in complaints about access to medical centres, from 11.2 to 16.2. The report notes that that does pertain to COVID-19. In particular, I am interested to understand what some of those access issues were, what they related to.

SUE DAWSON: Yes, for sure. Across those COVID complaints about medical centres, there were quite a number of issues that will be familiar to us all. There were issues relating to the restriction on face-to-face consultations; issues relating to telehealth appointments, whether you were eligible for one, what the billing arrangements were, those kinds of access questions; issues about the COVID-safe plans that were in place at medical centres and whether, as a result of those, there were restrictions on consultations just being provided for existing patients, whether practices were taking on new patients in that context.

You can also imagine that quite a lot of complaints dealt with issues relating to personal protective equipment [PPE] and other infection control requirements, complaints related to the staff of the practice and them

wearing or not wearing PPE, or the quality of PPE, versus PPE requirements for patients coming to the practice—compulsory masking, distancing, not being able to be in the waiting room. All of those sorts of issues played in. Those are the sorts of access issues that we had. I think it is fair to say that, finally, Mr James, the question about vaccine availability and choice—folks wanted to have the Pfizer vaccine but their medical centre did not yet have it, or they had run out, or whatever. We just loosely categorised those into access issues as well. I hope that gives you a feel for the sorts of matters that were of concern to us there.

Mr TIM JAMES: That is quite a broad range of issues in terms of access, per se. I understand the need to categorise them and understand how they came about. I just make the observation, for what it is worth, in my mind, that there were 653 complaints overall pertaining to COVID-19. In the whole scheme of how much COVID-19 has affected our community, our state, our healthcare system, I think that is pretty good, overall.

My final question, in the COVID area, is not pertaining to complaints but in the broader sense on the theme of risks and issues out there, insofar as the spread of health misinformation on COVID-19, treatments, vaccinations or otherwise—obviously, in too many cases by people who are not healthcare professionals or practitioners— whether it is online, or in the community, or in the media, or otherwise. What sort of solutions and actions has the Commission taken to go about or, indeed, did go about or proposes to go about, to help to meet those risks and those dynamics, as they have presented and, no doubt, continue to present?

SUE DAWSON: Yes. It is a difficult problem. I think it is difficult, it is pervasive, it is a nationwide problem.

Mr TIM JAMES: Yes.

SUE DAWSON: It is not a problem that just sits within New South Wales. The opinions that are typically expressed, in the sort of misinformation documents that you are talking about, are generated via broadcast methods, they are not judicially bounded and they often tread a very fine line in the nature of the commentary that is used. As a result, I think it is fair to say that it is a regulatory morass and there are some gaps in the regulatory framework. In relation to the sort of broadcast misinformation that you might be talking about—pamphlets and leaflets from certain quarters—I think it would be fair to say that the Therapeutic Goods Administration would be considered to be closest to the pin on this.

Mr TIM JAMES: Sure.

SUE DAWSON: But, as you may be aware, the difficulty with the Therapeutic Goods Administration powers is that they relate to misinformation about the efficacy or use of a particular therapeutic good, a medicine or a device. They did not ever really contemplate the sort of misinformation of the nature that is being distributed in these pamphlets. It is arguable that those powers never contemplated a situation where political materials, in particular, might deprecate a public health initiative and threaten health consumer safety as a result. That is the regulatory problem that needs to be examined and one that I think, hopefully, will be examined in the future.

Now, in terms of what the Commission was able to do, in the kind of regulatory morass that I have described, the Commission best saw the potential to use its regulatory powers in the following way. Just to contextualise, the Commission's powers are only enlivened when a complaint is made in relation to a health service, and political commentary on COVID issues, for instance, is not the delivery of a health service. But nevertheless, it was of concern to us that these actions were diminishing and undermining to the public health effort.

So what we did was, we used our powers under section 99B of the *Health Care Complaints Act*, whereby we are able to share information and share complaints with other bodies, who may be better positioned to do something than we are. And so in this case we referred documentation on complaints about misinformation to the Therapeutic Goods Administration [TGA], to the Australian Communications and Media Authority, which can deal with verbal broadcast of misinformation, and to the Australian Electoral Commission, in case there was any breach of electoral commission requirements.

We just wanted to bring any of those kinds of complaints in to reveal for others who had powers. The other thing that we did is to use our more general powers to join with the TGA and AHPRA [Australian Health Practitioner Regulation Agency] in making a joint public statement. We simply went out there and said, "For health consumers, it is incredibly important that you only rely on authoritative advice about health care and treatment, and about vaccination, and matters such as that." We just used our, I guess, public information and public education pathways to try and contribute to countering that sort of unhelpful misinformation.

Mr TIM JAMES: Thank you. How effective do you think that was?

SUE DAWSON: I think we have seen a continuation of a lot of that misinformation. We hope that the public information and education that we offer will make a difference. Hard to know.

The CHAIR: Can I make a comment on that?

Mr TIM JAMES: Yes.

The CHAIR: Because I think this is an absolutely critical issue. When you say that the Commission used its powers to make joint statements about relying on authoritative sources, of course, members of the public receiving professionally printed, glossy brochures from organisations, political parties and celebrities will frequently regard that as authoritative. I think that is where we have got a significant gap here. You have pointed out that there is a range of organisations you can share concerns about those with, but none of them seem to cover this specific issue of the spread of misinformation which could be threatening to public health in an emergency.

I understand that we have got a situation here, about needing to protect free speech, but in the circumstance I was aware of there was a clear attempt to misinform people about the safety of the vaccine by referring to, for example, deaths after vaccination and implying very strongly, if not actually stating, that those deaths had occurred because of vaccination. It was produced in a way that was very impressive, looked very authoritative and, I think, frankly, was dangerous. What you have identified, and correct me if I am wrong, but there does not appear to be any regulatory capacity in any agency to specifically address that issue in a public emergency.

SUE DAWSON: I think it is fair to say that there are regulatory limitations. So, yes, I would agree with that. The one thing I would say in relation to the joint statement that was issued by AHPRA, the TGA, the Commission, and, as a cosignatory, the Queensland Office of the Health Ombudsman, was that it was very clear that political commentary and celebrity commentary would not be regarded as authoritative, in any shape or form.

The CHAIR: That is great, but can you see my point that when something is produced from a member of the federal Parliament, for example, or someone who advertises regularly in daily newspapers and is on the television, that that carries its own weight in the minds of the public? It needs to be used responsibly in a public emergency. Frankly, it seems that we do not have a capacity to address that directly.

SUE DAWSON: As I said, I think there are limitations to the existing regulatory framework.

The Hon. GREG DONNELLY: Thank you both for coming along this afternoon or, rather, this morning, I should say.

SUE DAWSON: It has been a long week.

The Hon. GREG DONNELLY: It will take us to at least midday. Some of my questions are quite specific, and if you need to take them on notice, that is fine. Some are perhaps of a more general nature and might be a bit easy to address this morning at the hearing. This is the review of the annual report. Can I take you to particular references, to help me understand things a little more clearly?

At page 19 of the report, and this perhaps goes beyond this particular question I ask, it is more general, the definitions within the report, specifically on the bottom of page 19, chart 13, referring to the indicative information for that annual report year—health organisation, registered health practitioner, unregistered health practitioner, and unknown. If we take that as an example, and there are charts throughout the report, "health organisation" is defined somewhere and forgive me, obviously, there is the legislation that you operate under. Does the HCCC have its own set of definitions which actually operate in a competent way with the legislation? With respect to definitions captured in the Act itself, which you need for the purposes of reporting, how do you create those definitions?

SUE DAWSON: One of the difficulties, there, is that the nature of health organisations changes and morphs. Only yesterday, we were talking about virtual health platform organisations. Who would have imagined that body modification clinics would have been a thing? There is not a finite set of listed health organisations.

What there is, is real clarity around the fact that the Commission deals with public health facilities, public health organisations; we deal with private health facilities, licensed and unlicensed; and we deal with health organisations of any type that deliver health services.

The real definition that we are working with is not necessarily trying to define the organisation, not necessarily trying to, in a finite way, define the kind of individual practitioner, but anybody who is delivering a health service within the meaning of the Act. The Act defines what a health service is, and then any organisation or individual delivering that kind of service is within our jurisdiction. I hope that helps.

The Hon. GREG DONNELLY: That is fine.

Mr DAVID LAYZELL: In terms of the recent rise in beauty treatments and health centres, does that fall into your scope as a particular area of concern?

SUE DAWSON: That is a really good question. The answer is not the best of answers, but: it depends. If a beauty treatment facility is conducting treatments of a kind that are—it is hard to say. Is there skin penetration, is there suturing, is there something that you and I would think of as an intervention that should be conducted by someone who knows what they are doing? That is kind of the test for it. It is a fine line because we had, for instance, exactly the question that you are asking in relation to a very high-profile complaint a number of years ago—that I am sure you have all read about in the media—whereby we had an individual who went to a tattoo parlour. I think it was a tattoo parlour; it could have been called a body modification clinic—let's not split hairs for the sake of it. That individual sought to have a silicon implant in their palm, a snowflake. As a result of that, that individual died of sepsis from that implant.

Was this a health service? They just went to a tattoo parlour. We took the view that it was, because, in order to insert that snowflake, there needed to be an incision, and then following there needed to be suturing, and there would have been an expectation of sterile treatment practices. We made the decision that it was a health service. There were those who said that we should not regard it as a health service, but we did. You can see the fine judgements that need to be made and the reasoning that we go through when we make those judgements.

The CHAIR: That is a perfect opportunity to segue to the next category of questions. I know there are some more—

The Hon. GREG DONNELLY: I have questions, and I am continuing.

The CHAIR: All right. We do have a number of other questions that we—

The Hon. GREG DONNELLY: I understand that. But this is a review of the 2020-21 report, and my questions relate to the report. Page 31 goes to definitions that are critical for the present and the future. There are lines referring to information, finding the distinction between metropolitan New South Wales and regional New South Wales. What definition do you use for regional New South Wales, for the purposes of your report, for the 2020-21 period?

SUE DAWSON: It is a really good question. We noted, in the recent inquiry report into rural and regional health services, that there were some definitions of what was rural and regional in terms of the—I think it is the seven local health district, or LHD, areas that are in rural and regional contexts, and that there were some metropolitan local health districts that also had a crossover with rural and regional services. I think that the seven, bear with me, if you do not mind—

The Hon. GREG DONNELLY: That is fine. They are on page 6 of the report. I will jump ahead and help you here, perhaps.

SUE DAWSON: Thank you.

The Hon. GREG DONNELLY: The bush ones, if I can use that as a colloquialism to cover the area outside Sydney, Newcastle and Wollongong—that is clause 1.20 of the report. That is the Far West LHD, Hunter New England LHD, Mid North Coast LHD, Murrumbidgee LHD, Northern NSW LHD, Southern NSW LHD and Western NSW LHD. The crossover ones, that pick up what we would see as metro bleeding into bush, include the Central Coast, Illawarra Shoalhaven, Nepean Blue Mountains and South Western Sydney. With respect to those seven, plus the four that start in the city, moving out into the bush, is it fair to say that the definition used by the HCCC—it obviously picks up the seven that I have described, where obviously there is no question in terms of the definition used by NSW Health. But with respect to the other four that have been identified, did you pick up complaints out of those areas as well?

SUE DAWSON: Needless to say, we did not have the benefit of that categorisation in 2020-21, when we were doing this report. We actually distinguish—

The Hon. GREG DONNELLY: Sorry, can I just correct you? That is not the case. On the NSW Health website, those seven are clearly defined, as they are, as rural and regional-remote in terms of what they pick up.

SUE DAWSON: Yes.

The Hon. GREG DONNELLY: With respect to those four, they are split. They are actually described as picking up both metro and non-metro. So, you did have that information in 2020-21.

SUE DAWSON: Okay. I will express myself more effectively, then. We did not refer to those distinctions when we were trying to do our rural and regional analysis. What we have done, because of our data fields in our case management system—we need to extract that information by postcode. There is a postcode extraction, which we have not yet—and this is why it is important—mapped what our postcode split is to those seven, plus the crossover ones, at this point.

The Hon. GREG DONNELLY: That is fine. I will just leave that with you for reflection. Obviously, there is a capturing of "regional" for the purposes of this report, and we will be interested next year when we come back again to find out whether it is much clearer. Can I just say, I think postcodes is not a bad, general way of clustering, subject to some fine-tuning.

With respect to the matter of the report for 2020-21, I am curious to see that there is not specific reference, unless I have missed this, to the complaints either by children and young people—I am using that as a broad definition of less than 18 years of age, or children and adolescents, because there is a joint committee of this Parliament which is specifically for children and young people, and I simply use that age parameter—or complaints by parents with respect to matters of their children's treatment—for the purposes of the definition of the Act. In other words, that is the capturing of information of complaints by children or adolescents, or matters that involve children. Is it correct that that is not explicitly captured by the HCCC, in the collection of the data or the reflection of that data, in any of the reports you produce?

SUE DAWSON: That is right. We do not differentiate complaints by the age of the complainant or the individual, at this point in time.

The Hon. GREG DONNELLY: Bearing in mind that increasingly there are matters that deal with children and young people across a range of areas, and that has been growing over a period of time, do you believe that perhaps there is a need to look at that?

SUE DAWSON: Yes, certainly, we are more than happy to turn our minds to that. It may help to explain to you that our case management system, which draws information from complaints, is close to two decades old. It has been in place for a very long time with, as you can imagine, fairly hardwired data fields. We are currently undertaking a replacement project for that case management system, and in that project we will be thinking about the data fields that we need to respond to, and answering contemporary questions that might be useful to answer, through our complaints data. That is an opportunity for us to ask those sorts of questions, like whether or not we want to enable ourselves to extract age-based complaints information.

The CHAIR: What is the time frame for your review of that? Is there an opportunity for the Committee to have some input into the fields?

SUE DAWSON: We are in the early design stage, so it is certainly not a question of the horse having bolted. We are very much at the point where, over the next three to six months, we will be looking at what sort of information we need to be able to record about complaints. So we can write to you and seek input on that.

The CHAIR: I think that would be very good, actually. As you know, we have asked questions in relation to a number of issues, and one that concerns me is general practice. You have done your best with the system that you have to get that clarified, but that is a good example, and there will be other areas where this Committee would like to see information collected into the future. That is good.

The Hon. GREG DONNELLY: We are very grateful to hear the information about the review, and the consideration of what might be some refinement around the definitions.

I have a finance question. At the top of page 109 of the report, at the commencement of the financials, the preamble includes the statement, "The actual net result of $1,179,000 surplus"—and congratulations; it is always good to be able to report a surplus, is it not?—"was higher than the allowable budget surplus of $980,000 by $199,000, predominantly due to higher other income." With respect to looking at income and the surplus, we can move across to page 117 and page 119, which takes us to relevant footnotes. In summary, could you elucidate the reasons for the higher income and the basis upon which you were able to achieve that?

SUE DAWSON: Certainly. The Commission, as you know, has a prosecution function. As a result of that, we run prosecutions. Where we are successful in a prosecution, we are able to recover our legal costs. The "other income" component on our budget is what we call our legal cost recoveries, and that was the outcome in relation to legal cost recoveries in that particular year.

The Hon. GREG DONNELLY: I think that is very good. Has that been improving over time? Have you perhaps got better expertise, legally, to take cases and prosecute them, or is it just that there was a varying number of cases coming to finality that created that surplus, in that year?

SUE DAWSON: We have very fine legal expertise.

The Hon. GREG DONNELLY: I am sure you do.

SUE DAWSON: Our success rate in our prosecutions still sits around 98 per cent, I think. So we have very skilled prosecutors. In relation to whether legal cost recoveries go up, it is very much a function of the volume of cases and the nature of cases that sit within the prosecution caseload. I will observe that there is a flip side to

that, which is that if we lose, we incur adverse costs. You find that those two pools do shift over time, and they are not predictable. We get the occasional surprise of an injection of funds in June, through a successful case, and it is difficult to manage that. That is why we have got a surplus.

The Hon. GREG DONNELLY: That is very good, because no doubt there is great prudence exercised by the HCCC, you as the Commissioner and your office, in terms of advice from your legal counsel about whether to proceed with a matter. I am sure that is the case, so it is not a case of just going out there. I am sure you are very prudent and careful about the cases that are selected.

SUE DAWSON: That is a really good question. You will find that in the legislation we have an independent Director of Proceedings, much as in the criminal system there is a Director of Public Prosecutions.

The Hon. GREG DONNELLY: Sorry, inside the Commission?

SUE DAWSON: Correct, but they are independent from me. They are not subject to direction or control, in relation to prosecution decisions, by me. They exercise independent decision-making based on the statutory factors that are set down in the legislation, for consideration of all of the things that you would expect them to consider—the seriousness of the matter, the harm done, the likely prospects of success, the strength of the evidence and so on. They must take themselves through a disciplined approach to examining those factors, and they determine whether a matter will be prosecuted, not I.

The Hon. GREG DONNELLY: The accounts are obviously in good shape, so congratulations to both yourself and the Executive Director. You should be very pleased and proud of that. The two years of COVID were obviously extraordinary in a whole range of ways, which we do not need to go through. The way in which the HCCC managed that huge influx of work was very impressive. Looking forward, we are moving out of COVID and hopefully we will not have a pandemic of that dimension again, in our lives—fingers crossed—although there can be other challenges.

Noting the surplus position of income, if one looks forward for the current financial year and beyond—because we are sort of building on 2021—is it your view that the funding and resources at your disposal are sufficient for you to carry out your role as the Commissioner and as the Commission?

If one looks at the various histograms and other charts in the report, things are obviously growing over time, which is a reflection of the enhanced and growing workload. Looking into the future is critical, regarding the resource base and the budget allocation for you to be able to carry out the work that you are wanting to do and progress over time. I would be very interested to know if you have a general statement about the resourcing you have, and whether you think it is sufficient for the immediate future and, perhaps, slightly beyond.

SUE DAWSON: Yes, you have raised an excellent question about the level of activity and the growth of activity. What I can say is that, each year, we negotiate our budget with the Ministry of Health. They allocate our budget. They fully understand that we want to operate on what we call an activity-based funding model. First of all, if activity is increasing, we will always commit to being more efficient and effective. There are refinements to our systems and processes that we always commit to, but we also need to have resource recognition. There is only so much efficiency improvement that you can do, and we enjoy very good discussions with the ministry about our activity, and how our budget might need to be uplifted to recognise that.

SUE DAWSON: In the current budget negotiations, I do believe there is a very good understanding of the importance of some budget adjustments that will allow us to be sustainable, because the year-on increase—

The Hon. GREG DONNELLY: We want to be more than sustainable.

SUE DAWSON: Highly effective, but that our business is sustainable, that workloads are sustainable, that we can do high-quality work, as well as a lot of it. That is where we want to be. I think there is a very good recognition from the Ministry of Health and the Minister of those pressures, and the importance of thinking about options for dealing with them.

The Hon. GREG DONNELLY: With respect to you as the Commissioner, do you actually meet with the Minister for Health directly yourself to discuss matters?

SUE DAWSON: There are meetings that are held with the health Minister. There are also—

The Hon. GREG DONNELLY: How often are they undertaken?

SUE DAWSON: They tend to be on an as-needs basis, but they tend to go off the back of a regular quarterly. There is a quarterly meeting with the Secretary of Health, at which we provide a report on the types of complaints that we are dealing with. We give a report on the complaints about the public health system and particular pressures that we are seeing. We discuss the sorts of areas where we have made recommendations to

public hospitals for improvements. Those are quarterly meetings with the secretary. They go right from the spectrum of strategic issues and policy issues right through down to complaints-based issues. A quarterly report is given to the Minister, a written quarterly report, the same quarterly report that this Committee receives. Off the back of that, we would have discussions with the Minister about any areas of concern that may arise.

The Hon. GREG DONNELLY: There are two columns to this, A and B. There is now a new Minister for Regional Health that you would be aware of. Have you met with that minister?

SUE DAWSON: We have not met with the Minister for Regional Health, at this point

The Hon. GREG DONNELLY: With respect to NSW Health, there is a regional division. You are aware of that?

SUE DAWSON: Yes.

The Hon. GREG DONNELLY: Will you be, in future, reporting to the head of the division of NSW Health with respect to regional health in the same way as you have described with the Secretary, NSW Health?

SUE DAWSON: There are two levels of connection that will occur there. The first is that the Coordinator-General for Regional Health—we have a regular bimonthly meeting on operational issues that will involve the coordinator-general. That meeting involves the Clinical Excellence Commission, as well. That is an operational level meeting that has always been in place for health matters, generally, and will include now the Coordinator-General for Regional Health in that operational meeting and—

The CHAIR: It is a bimonthly operational meeting?

SUE DAWSON: Mr Kofkin, is it bimonthly?

TONY KOFKIN: It is.

The CHAIR: Every two months.

The Hon. GREG DONNELLY: Sorry, I thought that the division had only been recently established and announced.

SUE DAWSON: Correct.

The Hon. GREG DONNELLY: How could you have been meeting in the past with—

SUE DAWSON: Because the person who is now occupying the position of coordinator-general, in his position as the acting executive director in the Systems Management Branch has been a part of that meeting and—

The Hon. GREG DONNELLY: That person's name?

SUE DAWSON: It is Mr Sloane.

The CHAIR: You are indicating that, going forward, those bimonthly operational meetings will now include the coordinator of the division of rural health.

SUE DAWSON: That is our intention. We have not formally set that up yet. As Mr Donnelly just said, that acting appointment or that appointment is just recent. That structure is recent. We will be wanting to discuss how those bimonthly meetings involve both the—

The Hon. GREG DONNELLY: But you would believe that is necessary to meet with that person?

SUE DAWSON: Absolutely critical. We have always enjoyed very strong operational connections with all parts of the ministry in that regard.

Mr DAVID LAYZELL: Could I ask one quick question based on what Mr Donnelly asked. It is about the concept of postcodes because, obviously, regional services are critical to what I need to get out of this report. Understanding how you categorise "regional" is really important. Is it based on the patient and the postcode of the patient, not of the service that they get?

SUE DAWSON: Both, we do both. You will see, in the annual report, one of the real challenges with the metropolitan, and rural, and regional information, is that we have to, as you say, have a line of sight from where the complainant was located as well as where the provider was located. So there are quite a lot of moving parts to it. We do both. Both are done by postcode.

The CHAIR: I want to return to the issue of rural and regional complaints, so I am just going to flag that we do have some questions to cover on that. But before we go there, I want to ask some questions on an issue that, in fact, the member for Upper Hunter alluded to earlier; that is, cosmetic services. Commissioner, I wonder

if you could provide us with some detail on the types of issues investigated in relation to private health facilities, in particular cosmetic and alternative medicine facilities. I have got a couple of follow-up questions in relation to this.

SUE DAWSON: Yes, I can. Bear with me. It is in a different category in my folder. Sorry, Chair, having an index failure here. It is the primary health facility question. I found it. Everything is back on track. Gosh, that was a moment, wasn't it.

The Hon. GREG DONNELLY: We have those moments all the time. I can assure you.

SUE DAWSON: Do you? Folder failures?

The Hon. GREG DONNELLY: Absolutely. We would have more than you can imagine.

The CHAIR: Yes. Commissioner, let us proceed.

SUE DAWSON: In terms of the private health facilities, and cosmetic and alternative health medicines facilities, in 2020-21, we received 10 complaints for investigation that involved seven types of health facilities. The areas that were involved in those seven facilities were: alternative health, gastroenterology, paediatric medicine, radiology, cosmetic services, aged care, psychology and massage therapy. That was the kind of areas covered. You can see that within that there was one cosmetic services facility that was investigated and there was one alternative health facility that was the subject of four separate lines of investigation.

The CHAIR: I guess this raises a question, in my mind. The cosmetic surgery industry is a billion-dollar industry. There is very limited data available on it, but what data there is suggests that it is quite widespread, highly corporatised and, as we have become aware recently, there are issues with the practitioners there. Yet it does, actually, form a very small percentage of the complaints you deal with. I wonder if you could just comment on the reasons that might be the case.

As a follow-up, I wonder if you would comment on the regulation of cosmetic therapists, in terms of providing consumers with some reassurance about the standards of care they are receiving. The first question is, it is a relatively small proportion of the complaints you receive. That seems odd, given that I actually think it is quite a big industry but, admittedly, not publicly subsidised. Then, two, any comments on the issues relating to the regulation of therapists in that space.

SUE DAWSON: It is very interesting, the question of complaints about cosmetic health services. It is complex, because there are a very wide range of types of services that are provided within that area of service. But one of the things that characterises most of these services is that they are to do with basic concerns that individuals have about their appearance, or perhaps taking some alternative and novel approaches to dealing with some of their health issues, and we see, I think, perhaps some tentativeness of people who experience harm in the cosmetics space to complain. I think that there is something about the consumer's own self-consciousness, in this space, that may—

The Hon. MARK PEARSON: Is it because it is a very private, intimate sort of thing?

SUE DAWSON: I think so.

The Hon. MARK PEARSON: If you complain, it connects to shame?

SUE DAWSON: I think so. Often, people will not even talk to others about the fact that they have gone and had cosmetic surgery. It is not something that you necessarily disclose at your dinner party, and it is of a very private nature. So, yes, I think that there is something in this about individuals just being in a very introspective space with this. It may be that there is not an appreciation that the Commission can receive complaints about cosmetic services, which goes to the question of public awareness and public warnings, and so on, which is part of the regulatory response that you are asking about.

The CHAIR: Because, as you have indicated, the decision to have those therapies relates to appearance, which may not be connected in the consumer's mind with health.

Mr DAVID LAYZELL: I agree with that.

The CHAIR: And it is the Health Care Complaints Commission. Yet it is often, certainly in licensed day procedure facilities—which I think, arguably, are the place of highest risk here—they will be provided by health professionals. This fact that it is such a small volume of complaints is concerning, I think. Mr Pearson has indicated it is an issue around, I guess, personal feelings, perhaps even a sense of shame, and I think there is an issue about not connecting cosmetic therapy as a health issue.

Are there any other factors that might be impacting on this? In particular, I notice from the previous work of this Committee and an inquiry held, there were recommendations around improving public education. I note there is some information available on the NSW Health website. But to be honest, I guess the question is: are we doing enough to make people aware that they can raise issues in this space with the Commission?

TONY KOFKIN: I think all of those reasons are very valid. In my experience, a lot of complaints come to us when the refund has not been granted, or free revision surgery or a procedure has not been granted. There are many occasions when a client will not be happy with the outcome or there may be some complications. So long as the surgeon or the practitioner refunds, or will take that seriously and will carry out some revision surgery, or some further care and treatment, invariably, that will be enough to ensure that no further complaint is made to the Commission, or there will be no civil litigation. Because one of the things which I see, when I look at complaints in the cosmetic space, is that there has been often an attempt to a resolution. One of the motivations—not only sometimes when there are significant outcomes, poor outcomes—but the issue of recompense is always there.

So, I think the reasons why perhaps we do not receive as many complaints is because they refund them and we do not know, we have not got the data, in terms of how many times cosmetic surgeons will refund a client. I think that is a big, big factor.

The CHAIR: I think the missing data in this space is really critical, and the comments you have just made highlight the nature of how much that industry is less seen as health care, and more seen as a business transaction perhaps, just from that comment. Have you got any other remarks on this issue, of why there is not such a volume of complaints, and what more can be done to raise awareness with consumers about their rights in this area?

SUE DAWSON: I do not think I have anything more to freshly observe, about why the complaints are so low compared to the volume of services received by consumers. But, in terms of what the responses might be to it, I think this is very much a space where proactive preventative strategies are particularly important. There is a strong role for education and, in fact, as you rightly noted, Chair, there were some education campaigns that arose from the joint parliamentary committee's 2018 inquiry into cosmetic health services. NSW Fair Trading ran a significant public education campaign, including through some of the niche media, you know—WeChat spaces and so on—which was heavily directed at some health consumer groups that heavily use cosmetic services.

The Ministry of Health strengthened the information on its website, regarding licensing and other regulatory requirements for private health facilities, and AHPRA [Australian Health Practitioner Regulation Agency], I think, launched in 2020 a campaign called #besafefirst, which was a campaign about consumer information about what they should be asking, and preparing for, when they are thinking about undertaking cosmetic surgery. So, for me, there is some action that has been taken in the education space. I think the question is whether that education is touching on all of the right issues of concern. You can educate, but then it is a question about what are you educating about. I think that goes to the Chair's question. There is really good material around what questions a consumer might think about. But I think that there is scope to strengthen education in a couple of key areas.

One is that what we see in complaints, often in the cosmetic space, what we do get is not necessarily about the care and treatment at the time, it is often about the aftercare. Aftercare, in cosmetics, is an absolutely vital issue, because the cosmetic treatment tends to be more of a transactional nature—concern about aftercare, you know: What happens when you go home? What wound care regime should you have? What is the follow-up service that the facility provides? This is where we often see weaknesses in the standard of care. So, I think, in terms of both education and standards, this whole area of aftercare is important. The area of record keeping is important, too. Those are some areas that I think that there is scope to do more work in.

The Hon. MARK PEARSON: Can I just ask a question there? Does corrective surgery of a botched procedure, or where something has gone very wrong in cosmetic surgery, does that automatically trigger a complaint?

SUE DAWSON: No. There is no requirement for mandatory reporting by health facilities or individual practitioners for revision surgery in the cosmetic space.

The Hon. MARK PEARSON: Because, you might remember, the inquiry actually referred to doctors saying that they were very angry because the person rolls up at the emergency department after a botched cosmetic surgery. One would think it would automatically trigger a complaint from the hospital, from the doctor.

SUE DAWSON: You would certainly think that it would be a matter that they would turn their minds to making a complaint about, yes, but it is not part of the mandatory reporting regime, if I can put it that way.

TONY KOFKIN: The Commissioner is absolutely correct. It is not, per se, a mandatory report, but there will be occasions when the care and treatment is of such a poor standard and the outcome is serious. And this is a really good example, where you have the intersection between private cosmetic surgery which is, you know, effectively botched, and then the revision surgery. The ICU is in the public system. So, there will be occasions when there are reports made. There are not many, but there have been a few over the years, and a few recently, where a chief executive or a surgeon will make a mandatory report to the Commission, because of the fact that somebody has landed in their ED in a very poor state.

The CHAIR: Their concern is that the level of care provided, or the aftercare, did not meet standards of professional conduct, and hence it is a mandatory report. Is that what you are saying?

TONY KOFKIN: For that reason, yes. It is not, per se, as the Commissioner was saying, "There is revision surgery, we must make a mandatory report." Sometimes, there would be a number of reasons for complications. But there are occasions where the competency of the surgeon is a big question, and there has been a poor outcome, and the complications are not really complications that one would expect. Therefore, on those occasions, it definitely is a mandatory reporting obligation for chief executives and medical practitioners.

The CHAIR: You used two words there—the competency and the surgeon. In my understanding, these are not actually surgeons, recognised, necessarily, as fellows by the college of surgery. The title of cosmetic surgeon is much disputed. If my understanding is correct, it is the subject of a review currently by AHPRA.

In addition to that, it seems to me that at least one aspect of consumer protection has to be providing the consumer with some assurance about the person conducting a procedure, in terms of their standards of care. I wonder, Commissioner, or Mr Kofkin, if you have some reflections on how that might be best approached, for our information and consideration?

SUE DAWSON: I will comment, and Mr Kofkin might like to add to that. There are actually two national consultations and inquiries going on in this space, at the moment. One, as you say, is the AHPRA independent inquiry into cosmetic surgery by medical practitioners. I think that there are a couple of really important questions that the reviewer, Andrew Brown, is looking at in that particular inquiry. I know that he is looking at the medical board's guidelines for cosmetic surgery, and considering whether there is a need to strengthen those guidelines. Those guidelines refer to issues such as: informed consent processes, at the beginning of an interaction with the cosmetic surgeon; they refer to the potential need for independent psychological assessment of certain kinds of patients; they refer to cooling off periods and so on. They are quite extensive.

It may be that those guidelines need to be strengthened in a couple of respects. One is that the guidelines, as far as I understand, do not actually specify minimum treatment standards. If you are conducting liposuction, or whatever, what are the treatment standards technically—clinically that you might expect? There may be an opportunity for some clinical standards to be injected into, or sitting alongside, those guidelines. I think that is quite important. They are also, in that inquiry, looking into aspects such as education and awareness.

As regards the second national consultation that is going on, that is a consultation on the regulatory impact statement for title protection for surgeons. I think that is an interesting and vexed question. That regulatory impact statement is, I think, at least 100 and something pages long, reflecting the complexity of the issue.

I think the thing that is sitting between both of those exercises—the national consultation and the inquiry—is the question of whether there is scope for a little bit of lateral thinking here, about how to use the National Law to best effect. What I mean, by that, is that there is a provision in the National Law—I think it is section 98 of the National Law—that provides for an endorsed area of practice. An endorsed area of practice is not about title protection. It is not about what you can call yourself, and sanctions for calling yourself something that you are not permitted to—that is the title protection area. An endorsed area of practice is a process by which the knowledge, skills and training of a practitioner can be recognised.

If they have engaged in accredited training, they can be recognised as being in an endorsed area of practice. It may well be that this idea of an endorsed area of practice is a way of saying to the consumer that this person is properly credentialed, and they have got a level of skill that you can be confident in. That only works if you couple the notion of an endorsed area of practice with consumer education that directs them to ask that question. I think that there is scope for some solutions there, and those are certainly matters that we are discussing with the independent reviewer that AHPRA has.

The Hon. GREG DONNELLY: I take you to page 117 on expense and income. In terms of operating expenses, actual for the period is just over $4 million, as I read them. This ties directly to the question about this important ability for the HCCC to project itself into the New South Wales community at large, being aware of the important role that you carry out. Within the annual budget that you have, and obviously the actual expenditure was just over $4 million, how does HCCC promote itself, advertise? I use the word "market", although that is

perhaps not a term that one might like to use. But how does it market itself to the New South Wales community at large, to make them aware of your existence and, importantly, your role? Perhaps the most important thing is how to proceed with a complaint, and to enable people to do that. I presume an increase in the complaints reflects that that has been done quite well. I wonder whether there is provision within your budget that reflects that this is what you are trying to do?

SUE DAWSON: There is not a specific line item within our operating budget, but there is a costed function, if I can put it that way. I referred earlier to our resolution and stakeholder and customer engagement division. Within that division, there is an outreach program. The outreach program is a program of individuals going out to community groups, health organisations and others, delivering training and education on exactly the matters that—

The Hon. GREG DONNELLY: And the First Nations question earlier, that you were just commending.

SUE DAWSON: Correct. All of that is folded up in that function. We also undertook a full review of our website communication, to ensure that that was more navigable and accessible. So we have projects that are funded within the operating budget as well. The answer is yes, we have a strategic plan that highlights the importance of that. We have projects and functions that sit under that that we fund.

The Hon. GREG DONNELLY: I find, dealing with young people today—and my children are now young adults—if you talk about doing anything on a piece of paper, they look at you askance. They do not use paper these days; everything is done electronically. More often than not, they just expect it to be done on the phone. In terms of the enablement of the complaints, I presume there is this ongoing work, as these people now know nothing else other than using IT, to enable them to use your portals, and various ways and means within your portals, of proceeding with complaints et cetera.

SUE DAWSON: Yes, promoting and facilitating online connection with the complaint system, absolutely. One of the things that we are doing, as we design our new case management system, is actually to strengthen our ability to intake complaints from the online portal, and automate the population of the case file along the lines that you are talking about.

The Hon. GREG DONNELLY: That is very impressive.

SUE DAWSON: We are all about trying to understand. The language in the Commission and across government is "the customer journey"—What are their points of entry? How can we make those easier?—segmented by complainant cohorts. For folks who may have a difficulty in lodging complaints, how do we assist them? What is the best pathway in for them? How do we support them? Young folk who want to lodge a complaint by sitting on their tablet or whatever—all of that is part of our design approach.

The Hon. GREG DONNELLY: I am very interested to hear from you about recording complaints that relate increasingly to the matter of virtual care. No doubt within the 2020-21 report it would be not as a specific item, but within a category. But you are obviously thinking into the future, in the medium and long term, about how you will capture, record and interrogate matters around complaints to do with virtual care.

SUE DAWSON: Mr Kofkin is an expert in virtual care.

TONY KOFKIN: Apparently.

SUE DAWSON: I only say that because he has had a project, that he has been leading over recent months, to try to understand the evolution of digital health care and the use of platforms such as Mosh and so on, and really starting to try to drill down into that phenomenon, and understand the challenges that it poses to regulation, given that there are real benefits to virtual health care done well. So, how is it that we can play a role in virtual health care done well?

The Hon. GREG DONNELLY: Or, more to the point, how virtual care is not done well. As the HCCC, you are essentially not dealing with the good reports; you are dealing with the bad reports in the main, are you not?

SUE DAWSON: Truth to tell, we would like to be on both sides of that.

The Hon. GREG DONNELLY: You have "Complaints" in your title as an organisation.

SUE DAWSON: Yes, but I think, without being contrarian, I am sure you would want me to be a thoughtful, preventatively oriented Health Care Complaints Commission that was looking at what we can do to prevent complaints in the first place. That is kind of the space we want to be in as well.

The CHAIR: There was one small item, Commissioner, in relation to cosmetic surgery that came up at the last hearing. That was about dentists performing or conducting educational training relating to cosmetic procedures. Have there been further complaints in relation to that?

SUE DAWSON: I will pinpoint this reference. In 2020-21, there were seven complaints that were investigated that related to one provider. That provider was operating on a national level in many jurisdictions, and those complaints were referred to AHPRA to deal with, as part of one coordinated national response. There were only two other complaints relating to dentists operating in this kind of cosmetic space. One was referred to the dental council; the other was allegations that were not able to be supported, when we eventually delved into the forensic detail of it. There seems to be less activity in that space, certainly in 2020-21.

I think there are two factors there, Chair. One is that COVID affected the ability of dental practices to be performed, full stop. The second is, I would have to say, that there has been some really good work done by the dental profession in this space. The head of the Dental Council of NSW issued a newsletter relating to safe practices in the dental cosmetic space, and that particular newsletter was an education piece that was developed in collaboration with the Australian Dental Association of NSW, the Dental Council, Guild Insurance and so on. It was a collaboration between the regulators and the senior leaders in the profession, to message the profession about the importance of ensuring that they had appropriate skills, education and training in the context of any decision that they made to perform some of the riskier cosmetic procedures—whether it was periocular cosmetic injections, whether it was carboxytherapy, whether it was lipolysis, or whatever—that they needed to be only practising those things if they had the appropriate experience and training. That was a very powerful communication out to the profession, and a very valuable one. I think those two factors are probably in there.

Mr TIM JAMES: A matter in the community and healthcare system that concerns us all is the rise in incidence and impact of mental illness, so my question relates to psychologists. I note the 14.9 per cent increase in complaints about psychologists, so I am eager to understand that. I do not have the data, but no doubt the utilisation of or visitation to psychologists is rising and rising. Do you look at the numbers of complaints and the relative volume of complaints you receive, in the bigger picture sense, as in relative to how many people across this state are seeing psychologists, and the overall relativity in that broader sense?

SUE DAWSON: Yes, we do. We tend to have a look at a couple of things—first of all, the frequency and use of those services and, secondly, the nature of the service being provided and the context within which it is being provided. I would say a couple of things about psychologists. When you think about the nature of this profession, by definition it is a profession where the practitioner is going to be at the epicentre of a person's trauma, in the sense of right in it with them, working through something that has happened on the spectrum of trauma, or something that has disrupted their equilibrium. By definition, there are going to be a lot of sensitivities in that relationship in terms of how it is navigated.

The other thing to be said about psychologists is that there are a lot of what I will call 'third-party complaints'. When we looked at this, I thought to myself, "I really must delve into it a bit more." What I found was that, when I looked across the topic of complaints about the content of reports written by practitioners, psychologists had the highest proportion of complaints, of all professions, about reports—higher than medical practitioners about medico-legal things, or medical certificates.

The Hon. MARK PEARSON: Sorry, but the complaint was mainly made by a third party?

SUE DAWSON: Yes, I will come back to that. I am leading to the punchline; bear with me. Particularly, in the area of family court matters, many psychologists are writing family court reports. They might be court-appointed psychologists, or they might be single-party appointed psychologists, and they are preparing reports for the purpose of family court proceedings. Quite a lot of complaints relate to a third party; so, not the party that was the subject of the report, complaining that the report led to a poor outcome, and its content was biased and inappropriately framed. That is a very common complaint in the psychology space.

The other thing to observe about psychologists, I think, is that often they are working as sole practitioners; often they are not in a group practice. They have supervision, but there might not be all of that kind of peer support. That may lead to some conduct issues around boundaries and the way in which they manage boundaries, and so on. I think that is another issue in complaints about psychologists, as well.

Mr TIM JAMES: To the extent you are aware, do you think that that field, its professional bodies or otherwise, are moving to meet some of those issues and concerns?

SUE DAWSON: Yes. I think, in the psychology space, a bit like the psychiatry space, there is a heavy emphasis on supervision and peer supervision, and so on. There is strong awareness. Certainly, the Psychology Council and the professional bodies have a very dominant awareness of the importance of communicating about boundary management and so on; record keeping. I think, yes, but it is a difficult and sensitive area for sure.

Mr TIM JAMES: Indeed. Thank you. I just want to turn briefly now to pharmacists—obviously, another profession that, through COVID and, in a sense, more broadly, is doing more within our healthcare system. There was an 11 per cent increase in complaints about pharmacists. I am just interested to unpack that, but also I note the engagement you are having with—is it the Pharmacy Council—and the Pharmaceutical Regulatory Unit and just eager to get a sense of how that is progressing and playing out.

SUE DAWSON: Sure. Mr Kofkin.

TONY KOFKIN: The PRU or Pharmaceutical Regulatory Unit—the Commission works very closely with them. They are part of the Ministry of Health.

The Hon. MARK PEARSON: Could you just move the microphone a little bit closer to you?

TONY KOFKIN: Sorry. They administer the *Poisons and Therapeutic Goods Act*. They are very proactive in shining a light, in relation to compliance with the *Poisons and Therapeutic Goods Act*. Over the last, probably, two years, or maybe even three years, the PRU embarked on a compliance program where they were visiting all community pharmacists, throughout New South Wales, who dispensed methadone under the Opioid Treatment Program. What that audit has found—it was the first time, I think, that they had actually ever conducted an audit—is that there has been a fair amount of lack of compliance with the really tight regulations around methadone but, as well, drugs of addiction, Schedule 8 drugs, 4D drugs, documentation accountability, drug registers et cetera. During this audit, they found some fairly significant failures.

Because pharmacy, by its nature, is high risk in terms of the medication, the Pharmacy Council have received a number of complaints from the PRU. That has been one of the drivers of the increase in complaints against pharmacists. It has also been a significant driver in the increase in investigations against pharmacists, as well, because, when there is an audit and there is a lack of compliance, then the Pharmacy Council need to consider whether or not they need to take urgent action under the National Law. Section 150 of the National Law is a power that the Pharmacy Council has. All councils have that power. It is not a Commission power. It is a council power where they can decide whether or not they need to take interim action, for example, put conditions on a pharmacist's registration—not to practise, or not to be the pharmacist in charge. Certainly, New South Wales is very proactive. Ministry of Health,when they are administering that Act, they are very, very proactive. As you may well know, the *Poisons and Therapeutic Goods Act* is an old Act—1966. That Act—

The Hon. GREG DONNELLY: 1966?

TONY KOFKIN: 1966, which was a very good year. It is a very good year.

SUE DAWSON: Were you born in 1966?

TONY KOFKIN: I was not born in '66, but I know it was a very good year. That Act is now being revamped. We believe that it may be before Parliament soon. The Commission has been working quite closely with the ministry in terms of how the Act needs to be strengthened and how it can be simplified as well. That is one of the drivers, really, for the increase in complaints and, particularly, the significant increase in investigations. What the Commission, the council and the ministry have been doing over the last year is looking at ways to prevent complaints, how we can prevent complaints and how we can educate, as well, the pharmacist and what should our regulatory response be when we receive a complaint from, for example, the Pharmacy Council. There has been a fair amount of work conducted over the last seven or eight months.

Very recently, there was a pharmacy stakeholder group which was established. The members would be the Health Care Complaints Commission—two members from the Commission—members of the Pharmacy Council, including the president. There is the Pharmacy Guild, the Pharmaceutical Society of Australia, also: educational providers, universities, hospital pharmacies, et cetera, and indemnity insurers. We have all got together, in terms of how we can address some of these real, important issues in pharmacy, particularly in relation to those high-risk matters, Schedule 8 drugs, methadone et cetera. We had the first meeting three months ago. There is another meeting coming up in June, at University of Sydney. From these stakeholder group meetings, we can devise action plans, in terms of what we need to do and who is going to run certain parts of the business, in terms of education, prevention and regulation as well.

The genesis of that group, really, was as a result of what has been going on over the last couple of years, looking at the trends, recognising there are some issues here, and what is the appropriate regulatory response. In terms of what that will look like going forward, I think there will continue to be complaints against pharmacists. You may know SafeScript has gone live, which is real-time prescribing data for Schedule 8 drugs et cetera. That is going to be really powerful tool for patient safety, for doctors and for pharmacists, when they are actually looking at dispensing or prescribing Schedule 8 drugs. But, as well, it is a good—

The Hon. MARK PEARSON: Can you elaborate on what that is?

TONY KOFKIN: Basically, it is actually a system where the Ministry of Health will have real live data access, in terms of prescribers and for pharmacies who sign up to SafeScript. If you are actually prescribing a prescription, and it is for a Schedule 8 drug, then it will go onto the system. It is real, live visibility, in terms of that drug being prescribed. That means, for example, if there is an individual who will go from one doctor to another doctor to another doctor—otherwise known as 'doctor shoppers'—because they are addicted to Schedule 8 drugs, then it is quite easy to actually access that system, to realise that "Mr Smith has already just been prescribed OxyContin two days ago, by a different practitioner." It gives those practitioners that visibility. In the same way, it gives the pharmacist visibility, as well. But it also gives the ministry visibility, in terms of intervention and education, as well. Not everybody signed up to that because, at the moment, it is not mandatory to sign up to it. It is a voluntary thing. I know there are discussions ongoing, in relation to whether or not that will become mandatory. I think it is mandatory in Victoria.

But, again, that is a tool which New South Wales has never had. That is going to give us huge visibility, in terms of the prescribing and the movement of Schedule 8 drugs as well. A lot of work is going on—and some significant changes in the legislation. But, certainly, in terms of our relationships with the ministry but, as well, now with the major indemnity insurers and education providers as well, it is the very first time we have actually connected together, in much the same way as we do with the dental stakeholders group and, as well, the health regulators' forum, which we have in New South Wales, but it will continue because it is a high risk part of business. So, we need to be very vigilant.

Mr TIM JAMES: The rise, 11 per cent from the previous year, you are saying, is broadly attributable to those cases pertaining to Schedule 8 drugs? Obviously, what we are seeing across our healthcare system, whether it is COVID vaccines or flu vaccines, or otherwise, is a greater role for pharmacists, which is a good thing. But there is not a spike in complaints in that space, it pertains more so to this other—

TONY KOFKIN: Sure. There have been some complaints about vaccination, not too many to be honest with you, but there have been complaints about vaccination, and also, as well about potential infection control in the pharmacy where vaccinations have been administered, but not really widespread, not for the last financial year.

Mr TIM JAMES: The number is pretty low relative to the incidence of the service, no doubt.

The CHAIR: I am going to move on to a number of questions around regional and rural complaints. I know the Hon. Catherine Cusack wanted to ask a question. Ms Cusack, can you hear us? Are you online and ready to talk? I might start off this area then.

I guess our interest in it arises from the recent, very excellent upper house inquiry into rural health, the Chair of which is also a member of this Committee, the Hon. Greg Donnelly. I am interested to know a little about the differences between metropolitan and regional and rural complaints. I note there is a high proportion of professional conduct issues, for example, raised by rural and regional complainants. Clearly, the regional and rural health system is facing a lot of challenges, and the committee heard a lot of concerns raised by people.

It is not clear to me that there was a visibility about those issues in the complaints that came through to the HCCC. I am interested in why that might be the case, and your observations on that. I suppose the important thing, going to the questions that Mr Donnelly raised earlier, is that going forward, now, we hope that the government is going to take some action in this space.

From the Committee's point of view, it is important that we monitor complaints in the regional area, so how we are going to monitor that in the future? There are three areas: firstly, the nature of regional versus metropolitan complaints; secondly, commentary on why the concerns did not come to your attention; and thirdly, how we are going to monitor this through you in the future. Obviously, we are not relying on the HCCC to monitor rural health; I am not suggesting that for a moment. Nevertheless, we want to make sure that any complaints or concerns come through you. Ms Cusack, I notice you are on the screen now.

The Hon. CATHERINE CUSACK: Yes, I am.

The CHAIR: I will let the witnesses start with the questions I have just asked, and then you will be able to follow up.

The Hon. CATHERINE CUSACK: Thank you.

The CHAIR: Over to you, Commissioner.

SUE DAWSON: I will attempt to navigate my way through the three elements of your questions, but if I pull up short, please feel free to seek further, of course.

In terms of the low level of complaints that we receive, it does appear that there are possibly two factors there. One may well be the lower awareness of the existence of the Commission, which is why we are focusing most of our outreach program on rural and regional areas, and why we are leveraging off individual complaints to take the opportunity to deliver community sessions, and so on. I have been all around that.

We are conscious that awareness of us, and comfort with making a complaint, might be the second issue, either because our complaints process is too cumbersome, so there may be process improvements for us to do, but it may be there is a tentativeness in rural and regional areas about people complaining. We want to understand more about that, and it is something that we will be needing to discuss with the Coordinator-General of the Regional Health Division. Is it a concern that, if somebody complains, the service might be withdrawn? Is there a consequences issue there? It is hard to know what all the factors are, but certainly drilling down into those is going to be quite important.

The CHAIR: Can I add, I suspect in smaller communities, people know each other?

SUE DAWSON: Yes.

The CHAIR: Very well.

Mr DAVID LAYZELL: I agree, Chair. That is exactly what I was thinking, there is a fear, not that the service will be withdrawn, but that it will be a very personal attack on someone of the community—nurses, doctors.

SUE DAWSON: Yes.

The CHAIR: Yes, that is a good point.

SUE DAWSON: I think that is right, there probably are both factors. We have certainly seen, in some of the complaints, that we have at the moment, where the sole service provider to a small town, who may be the subject of complaints, there is a strong and understandable community concern about losing the only service that you have. That is a very real issue in our complaints. In terms of the question about how we might monitor going forward, we absolutely need to strengthen our efforts here, we acknowledge that. As I have said, the Commission is commencing the rebuild of its new case management system, and making sure that our ability to capture and then interrogate data on regional health complaints will be central to the design of that. I can give you that assurance.

I can also tell you that our intention is that, in the process of that design, we will be wanting to sit down with the newly appointed regional coordinator-general, and talk to him about what data would be of most interest and utility for the health system as a whole, to shine a light on issues. We will be wanting to make sure that we are delivering relevant data, data that will have a meaningful impact on service planning in regional areas. We do not want to have data for data's sake. We want to have data that actually helps drive decision-making, and that will be a critical design principle that will be—

The CHAIR: To that end, can I make a comment? I think it is going to be important to somehow capture the ability, or provide the ability, for issues to be raised about the absence of services and difficulty accessing services, or to somehow emphasise that. The Health Care Complaints Commission, in a sense, I would argue, is designed to capture information about services provided. I think one of the issues that emerged in the inquiry was there frequently were no services. It would not come to my mind to make a complaint to the HCCC if I did not have a service. I put that forward as a suggestion for consideration. Where a community has a desperate absence of service, let me put it that way, there ought to be a capacity to raise that through the HCCC. I make that as a comment.

SUE DAWSON: They do have the ability now, Chair, but it tends to be off the back of an incident. They had a bad health outcome because there was no imaging service available overnight, or they had a bad health outcome because the transfer from one hospital to another took too long. We do get some lines of sight into absence of services, and those are collected in the 'access' category of the regional complaints data, here. But the point is well made: is there more that we could do, and drawing that to the attention of the coordinator-general, as well.

The Hon. GREG DONNELLY: Can I say there is a mid-point, and that is there can be a service but there is an unawareness of the service. There is service and no service. Forgive me for jumping in, but one of the complaints that came up time and time again was within a local health district, say, at a hospital level, there were a whole lot of services available, but for one reason or another, the website for the hospital was not up to date and did not reflect the range of services which otherwise are available to the community, and they were not picking up on the fact that the availability was there.

The Hon. CATHERINE CUSACK: Can I just rewind and start this a little bit differently? Did the findings of Mr Donnelly's report surprise you? Did you detect those issues in rural health, or did you need to read his report to find out about them?

SUE DAWSON: I think there has been a widespread awareness of the workforce, and other issues, in the rural health area. I commend Mr Donnelly and the committee on the excellent report. I think it helped to dissect what that was all about, what were all the moving parts of it, and what are some of the solutions.

The Hon. CATHERINE CUSACK: When you say, "widespread awareness", I am really wanting to drill down into your Commission's role. What do you mean by "widespread awareness"? Is that because the Commission had detected those issues, or was it from reading the media? What does that look like?

SUE DAWSON: I was referring to the broad community- and system-wide awareness of the challenges. From a Commission perspective, they were visible to us, not just through the small window that we have through our complaints, but also we are out there talking to local health districts every week. We work very closely as well with all of the national health care complaints commissioners, the ministry and the Commonwealth Department of Health. These topics are the subject of conversation and good work on a regular basis.

The Hon. CATHERINE CUSACK: In big organisations—and health is a big organisation—the complaints process is a key source of intelligence to inform and improve policy. It is not so much seen as a small window; it is a big viewing window.

Much of Mr Donnelly's inquiry, for example, was complaints based. Hearing those stories was what shed light on those issues. I am not saying, "Did you miss it?" I am more wondering if an opportunity is being missed, for your organisation to play a better role in analysing data and informing public health policy, if you see that as something you could do. If that occurs at the moment, is there some way that it can be improved? The report was a bombshell. I am from the regions, and we all know it is not very good. But given that you do get that insight through complaints, can that be better utilised?

SUE DAWSON: Yes, I think there are two parts to how complaints can assist in bringing the issues in, to reveal and shaping solutions. When I said a "small window", I was perhaps not clear that what I was talking about was that the Commission's own footprint of complaints is quite small, compared to the volume of services provided—more than seven million services provided, and we might have complaints in the low thousands. That does not mean that we do not take the best opportunity from each and every one of those complaints. For instance, I talked about our assisted resolution service—

The Hon. CATHERINE CUSACK: I understand. At the beginning of this inquiry, in your opening statement, you referred to a substantial increase in the number of complaints that you are receiving, and then spoke about that in terms of the impact on your workload. It was great to hear the measures that you are taking to address that increased workload. But as a member of the Committee, I am thinking, "My goodness, what is going on in health that is driving a big increase in complaints?" Should you not be talking to the director-general on a quarterly basis or something, running through an analysis—there has been this big jump in complaints, they are being more generated by staff or more generated by patients, they are clustered in these areas, and they relate to that procedure?

I understand your primary role is to actually investigate and deal with each case, but that sort of analysis is very valuable for the government and the Parliament to know—that there has been a big jump in complaints, and what is the explanation for that. Do you see what I am saying? It is a more strategic use of the work that you are doing.

SUE DAWSON: Yes, thank you. It is really important that we do bring in, to reveal, on a quarterly basis, the information and data that we have on rural and regional complaints, and we do that. I mentioned, earlier in the hearing, the quarterly meeting that we have at an operational level, with the systems improvements, and now we will have joined into that the Coordinator-General for Regional Health, to discuss what operational matters we are dealing with, what high-stakes complaints have come to us, and what investigations we are undertaking.

We also discuss in those bimonthly operational meetings with the Clinical Excellence Commission, and the systems performance group, the actions that have been taken on recommendations that we have made following investigations into public health facilities. There is quite a granular level of operational discourse there, in addition to your point about getting the strategic benefit of that—a really important point.

The Hon. CATHERINE CUSACK: The big picture.

SUE DAWSON: Yes, completely. That is the information that we discuss with the Secretary of Health on a quarterly basis. We produce a report. We not only give them our quarterly report, but we also look at public

hospital complaints information at a more granular level. We discuss the gravity of that information and what actions we might take as a Commission, working alongside the ministry, to address them. We have that in place. Can we use that to better effect on occasion? Absolutely, and one of the benefits of this inquiry is that it has allowed us to train the lens on some highly specific things that we might want to cover in that quarterly strategic meeting.

The Hon. CATHERINE CUSACK: Can you tell me what is driving the increase in complaints?

SUE DAWSON: In complaints overall, yes. There has been some really interesting research on this topic. The first thing I would say is that, in a sense, we can see an increase in complaints as a concerning thing. But we can also see it as a good thing, that we learn about what the problems are in the system.

The Hon. CATHERINE CUSACK: Sure, but where is the increase occurring? Is it in one area, or is everything rising?

SUE DAWSON: What we have done, in our annual report, is we report on the overall increase generally, and then we break that down by practitioner type or service area, which is where we start to understand what types of complaints are driving the volume. We talked earlier at some length about complaints about pharmacists, and pharmacies, and where they were coming from. We have talked in annual reports in the past about complaints about unregistered practitioners—a small proportion, but it increases year on year.

The Hon. CATHERINE CUSACK: I am just asking what is driving the increase in complaints.

SUE DAWSON: There are a number of factors: population increase, more people, more people receiving more health services, as the population ages—

The Hon. CATHERINE CUSACK: I apologise, I am not being very clear. I am asking what are the complaints about, and are they distributed geographically across the whole health system, or are there some particular locations that are of a greater concern? It is like a performance indicator for the health system, which is why that sort of information is valuable.

The CHAIR: Can I just come in there? It is my impression, reading the last few annual reports, that there has been this pattern of an increase in complaints. I think it is not just in New South Wales, with the HCCC, but I think that is a phenomenon in complaints bodies across health systems in the western system. When I have scoured the reports, I always look for where those areas are. I have to say, generally, you highlight some specific areas. The psychologist was one today. Pharmacy was another. But, the interesting thing is, it seems to be an overall increase in each category over that time.

SUE DAWSON: Correct.

The CHAIR: It seems to me that that reflects increased number of services, increased population and, hopefully, a greater willingness to complain. If there is anything more on that, perhaps you could go back and have a look at that for us, and provide us with some additional data.

Can I just come back to the point I think you were making, Catherine Cusack, which is that, in addition to making sure that there is a greater awareness of the capacity to utilise the HCCC, to raise issues around health services in rural and regional areas, there is some thinking about a more sophisticated, strategic approach to analysing the data to inform the health system.

I appreciate that you meet regularly and, by the sense of it, from what you have said, you go into the nuts and bolts of complaint trends at a pretty granular level. But somehow in all that, I think, the point is that what was going on in rural and regional health was kind of missed. I think there is some opportunities with your new system, some different thinking, to be able to assist us and the state, going forward, to better understand what is going on in rural and regional health.

SUE DAWSON: Yes. In addition to what I have already said, about the design of our new case management system to identify the parameters that shine that broader light on rural and regional services, we are also putting together a business analyst team. We have not had that before. We have not had the resources to do that before, truth to tell. We have been in survival mode for quite a number of years now, just on the business of managing complaints.

We are starting to put our head above the parapet a bit, and to say, "Now that we've worked through COVID and pivoted to remote working, and pivoted here and there, what do we do on a serious note to prepare ourselves for the future of being influential and impactful across the system?" To do that, we are investing resources in both looking at our data extraction, but also our data analysis. A new business analyst capability is what we are investing in to do exactly this, because I appreciate how important it is.

The thing that I say all the time, as the Health Care Complaints Commissioner, is we want to be great at handling every single one of the 8,702 complaints that we get, but we want to also leverage off those complaints, to tell a story about what has happened and what could be better. The only way to tell that story is through good, evidence-driven commentary. I am 150 per cent with you on that. That is exactly what we want to do as well. It is just a matter of how we deploy our resources to achieve that—being a small organisation, 120 people—with that volume of work, but we are really committed to it. It is front and centre of our strategy.

The Hon. MARK PEARSON: Has that involved engaging independent statisticians to look at the data?

SUE DAWSON: We have got at the moment—sorry, Mark. Had you finished?

The Hon. MARK PEARSON: That is it. That is the question.

SUE DAWSON: "Mr Pearson". I apologise.

The Hon. MARK PEARSON: That is all right.

SUE DAWSON: Yes. We have got some people with data expertise in at the moment, to examine what is in our data—people who know data well, who are data architecture experts.

The Hon. GREG DONNELLY: Are they bio-statisticians, though?

SUE DAWSON: I have not asked them that question. I could, though. Can I—

The Hon. GREG DONNELLY: A bio-statistician—I think Mark's question is excellent—provides not just statistical capacity, but the bio-statisticians in the context of health care. It is a very good question.

The Hon. MARK PEARSON: Yes, because they tend to find trends—unexpected trends and analyses. Obviously, it would go to your preventative approach. Sometimes, when they have been engaged—that is why I am raising it—the reports that they deliver are very surprising and are very helpful in understanding patterns. That is why I ask the question.

SUE DAWSON: Yes. That is the sort of capability that we are working on building. We are not in this alone. As I said earlier, we are going to get the best out of our data when we sit with the folks in NSW Health and the folks in the Bureau of Health Information and the experts to say, "What questions ought we be asking of this data?" and "How do we pick the surprises?" and "How do we have a methodology that allows us to pick the surprises"—

The Hon. MARK PEARSON: Is that one of the reasons you engaged with the Mental Health Commission of NSW?

SUE DAWSON: Yes.

Mr DAVID LAYZELL: My questions are based on the regional aspect of the report. Can I just add, as a comment some of what you were speaking about then, in terms of having a business analyst—we have got these challenges now in regional New South Wales, in terms of health. You have a great structure to be able to manage data, be able to manage complaints. From a business point of view, what would you do? You would have various different shopfronts, so that you have different access to that. I suppose, in your business, it could be that there is a virtual shopfront focused on regional New South Wales and that we could direct some of the issues that I receive, as an MP, through into that, so that people knew that this was a complaint service for regional New South Wales. Maybe we could do something on that to raise the profile of everything you do—just another shopfront, probably, not that great an investment. That was just something I was thinking of as you were speaking, and maybe you may consider.

I notice that Hunter New England is one of the organisations that has a larger number of complaints. I am wondering if that is to do with the size of that organisation or whether there is anything—

The CHAIR: I think it is the number one.

Mr DAVID LAYZELL: It is number one. It is 13 per cent of the complaints.

The CHAIR: For three years in a row.

Mr DAVID LAYZELL: Yes, for three years.

SUE DAWSON: I think you will see from the data that it is quite directly connected to the volume of services provided: the number of emergency department attendances—highest in the state; number of discharges—second highest in the state; number of outpatient services—right up there as well. There is something about the volume of services, I think, in the profile of that particular LHD [local health district].

Mr DAVID LAYZELL: Is there any analysis at all that you do in terms of, I guess, patients in versus complaints, to do a comparison between the LHDs, that I could look at to see?

SUE DAWSON: Yes. If you look at page 161—you may be looking for something more, but what page 160 to 161 of the annual report does is maps the number and percentage of complaints for an LHD against the volume and types of services that they have provided. You will see, in Hunter New England, we have got 192 complaints, which make up 13.8 per cent of the total number of complaints against LHDs. Then we map that to the number of emergency department attendances, which is 450,113, the number of discharges and the number of outpatient services. We try and calibrate the number of complaints to the number of services and look for a gap. Then we ask ourselves, in the quarterly meetings that I was responding to Ms Cusack on: "What's that gap about?" and "What do we want to signal to the New South Wales ministry as something that requires some thought and attention?" That is the first thing.

The second thing is that, on the back of this information—COVID has disrupted it. But, in the normal course of events, I would be both addressing the chief executives of every LHD once a year—in fact, I did it just a month ago—to talk to them about their complaints trends, and then I would be visiting them on an annual or biannual basis, just to go out there, have a look at what the board is doing and so on. I have plans in the near future, one to the mid North Coast, for instance. It is that kind of interaction around how we do business and how we reveal the issues to them.

Mr DAVID LAYZELL: Indeed. You are more than welcome in the Upper Hunter any time.

SUE DAWSON: I would be delighted to come.

Mr DAVID LAYZELL: My final question, I noticed here it was talking about the type of complaints in that area. Do you get many complaints about the transport aspect? That was noted because one of the unique complaints I receive, as an MP, is that we have wonderful, great services in Hunter-New England and, quite often, people travel down to our larger centres using the ambulance system and then they are stuck, they are not getting transport back. I receive a lot of those complaints. In future, I may pass them through to your organisation.

SUE DAWSON: First of all, I should acknowledge I completely see that issue. It reverberated through the inquiry report and is a significant issue. The interesting thing is where the touch point with our definition of "health service" is. If the transport is ambulance transport or part of a transfer between hospitals, as part of the treatment regime, yes, we get complaints in that space. But if it is patient transport and support for patient transport, more generally, for logistics purposes not treatment purposes, then we have got a bit of a different question.

Mr DAVID LAYZELL: Yes, it is.

SUE DAWSON: It depends a little bit on what the issues are in there, and whether there has been an impact on the effectiveness of treatment, as a result of a transport-related issue that is provided by the facility and so on—if I have made a complex issue probably simple.

Mr DAVID LAYZELL: Yes, exactly, it is quite a complex issue. But, from a clinical service point of view, that would go to you, whereas if it is just a logistics point of view, it is not necessarily something you would hear.

SUE DAWSON: Yes.

The CHAIR: I think we need to pick that up in terms of the design of your system, and making people aware, because that goes to the issue of: do you make a complaint about the service you do not have?

Mr DAVID LAYZELL: That is spot on, Chair. Exactly what you are saying. The second part of my question was about GP access. The most common complaint is, "I can't get a GP appointment for three weeks", or four weeks, or six weeks in some areas.

The CHAIR: That, I do not think, would be seen as a complaint to the HCCC, and yet it is absolutely critical.

Mr DAVID LAYZELL: I am guessing you get no complaints about that?

SUE DAWSON: We do, but there is nothing we can do about them, in a sense. People will complain to us about them.

The CHAIR: Precisely, it does not consume your resources, so it is not a focus, and yet, ironically, it is fundamental going back to Ms Cusack's point about rethinking what we do with the data that we have got, and Mr Pearson's point about a business analyst and then trying to think strategically about the information you have got.

SUE DAWSON: Completely. One area that we are live to, in terms of how we pick up those sorts of issues, is there is always the temptation in data analysis, in this space, to look at the more serious end of the complaints outcomes, those things that went to prosecution, those things that went to investigation. But what if we looked at the things that were discontinued because we could not do anything about them, but they highlighted a problem about the absence of transport services, or whatever? What could we do with that, to more effectively bring it to light?

The CHAIR: I think it has been a very useful discussion. I am mindful of the time. I am going to ask you a couple of questions and ask you to answer very briefly, then take on notice. I have a question around insight into general practice complaints. I will send that to you.

This question relates to staff leaving your organisation—there seemed to be a fairly large number in the last year—and your responses to the People Matter Employee Survey results. I ask, with the Committee's indulgence, for you to give a brief response to that. I am happy for you to come back to us with more detailed information, in relation to that. Are people comfortable with that approach?

The Hon. GREG DONNELLY: Yes, Chair.

SUE DAWSON: Of course. In relation to staff retention, there are a number of factors at play there. I do not think there is an organisation in government that has not experienced the impacts on staff retention and staff turnover during the COVID period. COVID is certainly a factor in here. But the other factor, very realistically, is in a small organisation, which is experiencing an increase in demand year-on-year, there are workload pressures that are genuine and they are serious.

The type of work does not help. First of all, it is relentless. You never have a day where you think, "I might kind of organise my pencil drawer today." The complaints come. They come every day. They come all day every day. And so there is a relentlessness to it. It is hard work, not just because of that volume, but the nature of the issues are sensitive. So—pressures on people. We have a strong focus on staff retention. I can elaborate on what the elements of those are. But at the centre of everything, that I get up in the morning to do, is to keep my staff safe and motivated and well. That is where I am coming from. I am happy to talk about how I go about doing that, and my executive team and broader leadership team.

Obviously, part of retaining staff is to take the good out of COVID and make sure that we are making the transition to being a really, highly functional hybrid work environment. That is one of the centrepieces of retaining staff. Using flexibility well, and thinking about those points that I made about the relentlessness of it, thinking about how do we give people a reprieve from it, even though that is the core business. What is it about mobility, about secondments out, about designing things so there is a bit of a reserves bench, or people can change gear on the sort of work they do? It is not easy to achieve in a small organisation. But if there's a will, there's a way. So that is where we are coming from.

The CHAIR: I think Mr Donnelly wanted to follow up.

The Hon. GREG DONNELLY: With the indulgence of the Committee, I know it has gone 12 o'clock and we are committed only to 12 o'clock. Mr Kofkin, you did not have a chance—no-one's fault—to elaborate and elucidate on a matter of the complaints and issues around virtual care. You might remember we started that, and then I think another question came in.

TONY KOFKIN: Yes, I am conscious of time. Very briefly, telehealth, digital health care—there are tremendous benefits, and COVID has really accelerated, as we all know, in relation to the benefits of that. But there are some companies who may use telehealth for profit and commercial aspects, rather than patient safety. Without wishing to name names, there are organisations out there where the Commission has received complaints and we have conducted investigations. We have prosecuted doctors and made public warnings, as well. That is a space which will continue to develop and we are very conscious of that.

One of the things we will be looking at, in the near future, is our powers have been strengthened in relation to making prohibition orders against organisations. That is not public health organisations, and it is not private health facilities who are accredited by the Ministry of Health. But everything else is in place, so therefore the Commission will have the opportunity to make prohibition orders and prevent these companies from causing harm, but also prevent these companies from making significant profits in a short period of time.

The CHAIR: I will bring the hearing to a close. Mr Kofkin, I would appreciate if there was any more information that you wish to share with us about that last item, you might provide that to us as a further submission.

TONY KOFKIN: Certainly.

The CHAIR: I thank the witnesses for their attendance today. In my view it has been a worthwhile discussion. I hope there will be some recommendations that will come out of it.

(The witnesses withdrew.)

The Committee adjourned at 12:03.